STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045408	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcoa Pines Health and Rehabilitation	3300 Alcoa Road Benton, AR 72015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46724 Based on observations, record review, interviews, and facility policy review, the facility failed to ensure a physician's order for oxygen was in place before administering oxygen to 1 (Resident #59) of 1 sampled resident reviewed for oxygen therapy. The findings are: 1. A review of Resident #59's Admission Record indicated the resident had diagnoses which included asthma, acute and chronic respiratory failure, sleep apnea, and chronic obstructive pulmonary disease. 2. During an observation and interview on 05/27/2025 at 11:49 AM, Resident #59 was observed in their room, receiving oxygen from an oxygen concentrator at 4 liters per minute via nasal canula. Resident #59 stated they used oxygen all the time and also used their BiPap machine (A BiPap machine supplies pressurized air into the lungs). 3. A review of Resident #59's annual Minimum Data Set (MDS) with an Assessment Reference Date of 05/15/2025, indicated Resident #59 had a Brief Interview of Mental Status score of 15, which indicated the resident was cognitively intact. The MDS also indicated Resident #59 had shortness of breath, received oxygen therapy, and used a positive airway pressure machine (BiPap). 4. A review of Resident #59's Physician Orders did not reveal an order for oxygen therapy. A review of discontinued orders indicated Resident #59 ' s oxygen order had been discontinued on 02/27/2025. 5. A review of Resident #59's Medication Administration Record did not indicate the resident was receiving oxygen. There was no indication the facility was performing ongoing assessment of the resident ' s respiratory status or response to oxygen therapy. 6. A review of Resident #59's Care Plan, with a revision date of 07/17/2024, indicated the resident had altered respiratory status/difficulty breathing and to use oxygen as ordered. The care plan did not specify the type of oxygen delivery system, when to administer, flow rates, or give instructions on how staff were to monitor oxygen levels. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045408	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcoa Pines Health and Rehabilitation	3300 Alcoa Road Benton, AR 72015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. During an interview on 05/29/2025 at 9:40 AM, Licensed Practical Nurse (LPN) #6 stated the nurse on duty for the resident's hall, or the admitting nurse, was responsible for ensuring physician orders were in the electronic health record (EHR). LPN #6 also revealed she puts orders in at times, and the unit manager checks to ensure orders are in place. LPN #6 reviewed Resident #59's EHR and stated she did not see an order for oxygen. 8. During an interview on 05/30/2025 at 11:16 AM, LPN #7 indicated it was important to ensure orders were in the chart, so residents received the care the physicians wanted. She also revealed the nurse who received the order was responsible to ensure the orders were put in the EHR. 9. During an interview on 05/30/2025 at 11:20 AM, the Director of Nursing confirmed the nurse was responsible for ensuring orders were put into the EHR, and to notify the family of any new orders. She stated it was important to ensure orders were put into the EHR to ensure the residents received the care that was ordered. 10. A review of the facility's policy titled, Oxygen Administration, indicated staff were to verify there is a physician ' s order and to review the order prior to administering oxygen, monitor the resident before and while receiving oxygen and to document the rate of oxygen flow, route and the rationale for resident receiving oxygen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045408	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcoa Pines Health and Rehabilitation	3300 Alcoa Road Benton, AR 72015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 Based on observation, interview, and facility policy review, the facility failed to ensure dietary staff washed their hands between dirty and clean tasks, and before handling clean equipment for 1 of 1 meal observed. The findings are: 1. During an observation on 05/29/2025 at 11:55 AM, this surveyor observed Dietary Aide (DA) #3 remove cartons of shakes from a cart, by the steam table, and place them on resident trays, with his bare hands. Condiments were also placed on the trays, with DA #3 ' s bare hands, contaminating his hands. Without performing hand hygiene, DA #3 picked up glasses, filled with beverages by the rims, and placed them on the resident ' s trays, to be served for lunch. 2. During an observation on 05/29/2025 at 12:03 PM, this surveyor observed DA #2 picking up cartons of shakes from a cart by the steam table, and place them on resident trays, contaminating his hands. Without washing his hands, DA #2 picked up glasses, that contained beverages, and placed them on the resident trays, to be served for lunch. 3. During an observation on 05/29/2025 at 12:05 PM, this surveyor observed DA #4 remove a bag of cheese slices from the refrigerator and handed it to the Dietary Manager (DM). Without washing his hands, he picked up glasses that contained beverages to be served to the residents for lunch by the rims and placed them on the meal trays. 4. During an observation on 05/29/2025 at 12:34 PM, DA #3 washed his hands, after transporting an unheated food cart to the 300-hall, into the dining room. After drying his hands, he pulled up his pants, contaminating his hands in the process. DA #3 then used the same contaminated hands to pick up glasses by the rims, and placed them on the resident's trays, to be served for lunch. At 12:37 PM, DA #4 picked glasses by the rims and handed them to DA #3, who also held them by the rims, as he placed them on the resident ' s trays, to be served for lunch. 5. During an observation on 05/29/2025 at 2:08 PM, DA #5 was observed sorting tray cards. Without washing her hands, she then picked up plates and placed them on the plate warmer, with her fingers, which had long nails with polish on them, touching the insides of the plates. DA #5 was asked what she should have done after touching dirty objects, and before handling clean dishes. She stated she should have washed her hands. 6. A review of the facility policy titled, Hand Washing indicated employees should wash their hands before the beginning of shift, and any other time deemed necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045408	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcoa Pines Health and Rehabilitation	3300 Alcoa Road Benton, AR 72015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 46724 Based on observation, record review, interview, and facility policy review, the facility failed to provide appropriate handling and placement, to prevent possible contamination and complications, from an indwelling urinary catheter for 1 (Resident #59) of 1 sampled resident reviewed for urinary catheter. The findings are: 1. A review of Resident #59's Physicians Orders revealed diagnoses which included chronic kidney disease, urinary retention, urinary tract infection, and dysuria (painful or uncomfortable urination). Listed were orders for cranberry tablets for a urinary tract infection, dated 05/15/2025, and a medication that relaxed the muscles in the prostate/bladder for painful urination, dated 04/21/2025. 2. A review of Resident #59's May 2025 Medication Administration Record (MAR) revealed an order, dated 05/28/2025, for a urinary catheter to be inserted for two days. The MAR indicated the urinary catheter was inserted on 05/28/2025 at 1:10pm. 3. During an observation on 05/29/2025 at 7:25 AM, Resident #59 was observed sitting up in a recliner at bedside while Licensed Practical Nurse (LPN) #8 was providing urinary catheter care. Resident #59 had an indwelling urinary catheter, that the resident said had been placed during the previous night. The tubing was secured in place and attached to a urinary catheter bag, that was hung on a trashcan that had trash inside, at the resident ' s chairside. The urinary catheter bag was touching the floor, with no barrier under it to prevent contamination. 4. A review of Resident #59's annual Minimum Data Set (MDS) with an Assessment Reference Date of 05/15/2025, indicated Resident #59 had a Brief Interview of Mental Status score of 15, which indicated the resident was cognitively intact. The MDS also indicated Resident #59 was independent with toileting and was continent of bowel and bladder, transferred self to commode, and had a urinary tract infection in the past 30 days. 5. A review of Antibiotic Stewardship Notes indicated Resident #59 received antibiotics for a urinary tract infection on 09/16/2024, 09/18/2024, 10/10/2024, 03/20/2025, and 04/18/2025. 6. During an interview on 05/29/2025 at 7:28 AM, LPN #8 indicated an indwelling catheter bag should not be hung on a trash can, nor be touching the floor, due to the potential to cause an infection. LPN #8 specified that clean items should not touch dirty items. 7. During an interview on 05/30/2025 at 11:05 AM, Certified Nursing Assistant (CNA) #9 said an indwelling catheter bag should be below the bladder, so it flows, and not hanging on a trash can or the floor. 8. During an interview on 05/30/2025 at 11:12 AM, CNA #10 stated they had been trained to care for someone with an indwelling catheter, and not to hang catheter bags on a trash can or allow the bag or tubing to touch the floor. CNA #10 also stated practicing good infection control helps to prevent infections. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045408	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alcoa Pines Health and Rehabilitation	3300 Alcoa Road Benton, AR 72015

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9. During an interview on 05/30/2025 at 11:16 AM, LPN #7 indicated indwelling catheter bags should be hung to encourage drainage, and not touch a dirty surface or the floor, to prevent a possible infection. 10. During an interview on 05/30/2025 at 11:20 AM, the Director of Nursing confirmed to prevent infection and reduce the risk of a urinary tract infection, a urinary drainage bag should be hung below the bladder and not touch the floor. 11. A review of the facility's policy, Catheter Care, with a revision date of 09/2014, indicated to prevent catheter-associated urinary tract infections, staff were to ensure the catheter tubing and drainage bag are kept off the floor.