STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045411	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Health & Rehab Center	506 North Long Avenue Taylor, AR 71861

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50580 Based on interviews, record review, observations, and facility policy review, the facility failed to ensure staff promoted dignity and provided privacy during peri care were not visible to fell ow residents and/or visitors, to maintain dignity for one (Residents #14) of one resident observed for incontinence care. Specifically, staff failed to pull the privacy curtain and close the door completely while providing peri care to Resident #14. The findings are: 1.Review of a Quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 08/15/24 indicated Resident #14 was admitted by the facility with diagnoses of Parkinson's Disease, Anxiety, Depression, Schizophrenia. The MDS indicated, Resident #14 had a Brief Interview for Mental Status (BIMS) score of 01 (0-7 suggests severe cognitive impairment). Section H-Bowel and Bladder indicated the resident is always incontinent of urine and bowel. a. On 10/23/2024 at 10:20 AM, the surveyor interviewed Certified Nursing Assistant #1(CNA). regarding door not completely shut and curtain not pulled when incontinence care was provided to Resident #14. CNA #1 stated it was a privacy and dignity concern and issue, and she should have pulled the curtain and shut the door completely. b. On 10/23/2024 at 1:58 PM, the Administrator stated the facility had no policy for incontinence care. d. On 10/23/2024 at 2:50 PM, the surveyor interviewed the Infection Preventionist/Treatment Registered Nurse (RN) #2, who indicated for incontinence care the curtain should be pulled, the blinds shut, and the door closed completely to ensure dignity and privacy. e. On 10/24/2024 at 8:58 AM, the surveyor interviewed the Director of Nursing (DON) regarding proper procedure for performing incontinence care. The DON replied that staff should first knock on door, shut door behind you, shut the blinds, then perform care.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47916 Based on observation, interview, and facility policy review the facility failed to ensure a refrigerated antianxiety medication was counted and appropriately reconciled each shift by maintaining the documentation of an unopened, expired vial of (Generic) anti-anxiety medication in the narcotic book for 4 months to ensure accurate documentation and reconciliation to prevent the risk of misappropriation of resident owned narcotics. Findings include: 1.a. On 10/22/2024 at 2:07 PM, Licensed Practical Nurse (LPN) #5 stated, a resident's unopened antianxiety medication cannot be found in the narcotic book. Registered Nurse (RN) #6 revealed, the antianxiety medication was not transferred over from the previous narcotic book. Surveyor observed, the antianxiety medication expired 06/2024. b. On 10/22/2024 at 2:31 PM, RN#6 confirmed, she counts narcotics every day, including refrigerated narcotics. When asked how she counts the antianxiety medication without documentation from the narcotic book, RN #6 stated, she puts her hands on it at every narcotic count. RN #6 was shown the expiration date of 06/2024 and confirmed the medication should have been given to the Director of Nursing (DON) to return to the pharmacy. RN #6 provided a narcotic book dated 02/16/2024-06/26/2024, page 44 indicated,1 vial of antianxiety medication. RN #6 confirmed if the expired, unopened antianxiety medication disappeared from the locked refrigerator box she would not know where to look, because there has been no documentation. c. During an interview with the Director of Nursing (DON) on 10/23/2024 at 1:10 PM, DON confirmed that medication and the narcotic page must be in hand to reconcile a medication, and reconciliation cannot be done by placing a hand on the medication. DON confirmed, the antianxiety medication has not been documented in 4 months. DON confirmed, the medication had been at risk of misappropriation due to the lack of documentation. d. Review of an In-service titled Medication Administration, dated 05/26/2024, revealed controlled substances should be counted by the oncoming, and outgoing nurse at the beginning and ending of each shift. Expired medications should be given to the DON, and the surrendering nurse and the ADON/DON should sign the narcotic book, and the health department triplicate form. LPN #5, and RN #6 attended the in-service. e. Review of an in-service titled DON, dated 08/17/2023 revealed that all medications including the refrigerated narcotic box, and the Emergency box should be counted, and discrepancies should be reported to the DON/ADON immediately. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. Review of an in-service titled DON, dated 10/22/2024 revealed, the narcotic count will be done at the beginning of each shift with the oncoming and off going nurse, and the DON or Administrator will be contacted immediately if the count is not correct. Two nurses must verify the transfer of narcotics from one narcotic book to another, and both nurses need to confirm the narcotic count is correct in the new book and matches what was in the old narcotic book. RN #6 and LPN #5 signed the attendance. g. Review of a facility policy titled Medication Storage in the Facility, ID2 Controlled Substance Abuse, revised January 2018, revealed 2 licensed nurses are responsible for a physical inventory of all controlled medications at all shift changes, or if the keys are exchanged. Consultant pharmacist or designees should monitor controlled medication records, change of shift sheets, controlled substance accountability sheets and expiration dates during routine medication inspections.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 Based on observation, interview, and facility policy review, the facility failed to ensure staff appropriately monitored refrigerator temperatures to ensure influenza, and TB vaccines, and insulins were stored at a temperature range of ,d+[DATE] degrees Fahrenheit to prevent freezing and deterioration of medications. Findings include: a. A review of facility policy titled Medication Storage in the Facility, ID1 Storage of Medications, revised [DATE], revealed medications are to be stored at supplier or manufacturer recommendations. Expired or deteriorated medications are to be removed from inventory and disposed of appropriately. A pharmacy designee or pharmacy consultant monitors medication storage conditions monthly. Medication storage areas should be free of extreme temperatures, and refrigerated medications should be stored at the Center of Disease Control (CDC) temperature range of ,d+[DATE] degrees Fahrenheit with a thermometer to monitor temperatures, and a temperature log should be maintained and checked at least twice a day if vaccines are stored there. b. On [DATE] at 1:44 PM, Licensed Practical Nurse (LPN) #5 confirmed the medication room refrigerator was at ,d+[DATE] degrees. LPN #5 stated, there was a small concern because the flu vaccine says to store at a temperature range of ,d+[DATE] degrees Fahrenheit, and not to freeze. c. On [DATE] at 9:32 AM, Registered Nurse (RN) #6 accompanied Surveyor to the mediation room and confirmed the large refrigerator temperature was 32 degrees and counted 55 flu vaccines, 0.5 milliliter (ml) single dose syringes, and confirmed temperatures were checked at midnight daily. RN #6 provided a temperature log showing a temperature of 23 degrees on [DATE], and 28 degrees on [DATE],[DATE],[DATE], [DATE], [DATE], and [DATE]. d. During an interview with Infection Preventionist (IP)#3 on [DATE] at 9:36 AM, IP #3 confirmed she and RN #2 are responsible for vaccines, and confirmed they are stored at ,d+[DATE] degrees to keep the vaccine from freezing or breaking down. IP #3 stated night shift was responsible for documenting temperatures in the small biohazard refrigerator, and the large medication refrigerator in the medication room. If there was a temperature concern, they should contact IP #3 and maintenance. IP #3 said no temperature concerns had been reported by staff to her. IP #3 reviewed temperature logs for the large refrigerator and confirmed staff had not reported to her the abnormal freezing temperatures as low as 23 degrees and stated they (staff) do not seem to understand why they are monitoring the refrigerator temperatures. IP #3 revealed she cannot guarantee the vaccines did not degrade or deteriorate. e. On [DATE] at 9:47 AM, IP #3 and Director of Nursing (DON) confirmed 55 flu vaccines (Store ,d+[DATE] degrees), 2 Tuberculosis vaccine vials (Do not freeze), 1 unopened short acting insulin pen (Do not freeze), and 4 unopened long-acting insulin pens (Do not freeze) were in the large refrigerator. The DON and IP #3 will reach out to the pharmacist consultant for assistance.

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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. 49596 Based on observations and interview the facility failed to ensure food was labeled with a use by date to ensure food was not used beyond its safety period in accordance with professional standards for food service safety. The findings are: 1. On 10/21/24 at 10:00 AM, the surveyor observed food sitting on a shelf in the walk-in refrigerator did not have a use by date on some food items: a. A large, clear, storage bag that contained two prepared turkey sandwiches with a preparation date of 10/20/24, did not have a use by date noted on the bag. b. A large, clear, plastic container of beef vegetable soup with a prepared date of 10/21/24, did not have a use by date on the container. c. A clear, plastic, storage bag of cooked sausage with a prepared date of 10/21/24, did not have a use by date on the bag. d. A clear, plastic, storage bag of cooked bacon with a prepared date of 10/21/24, did not have a use by date on the bag. e. A clear, plastic, storage bag of cornbread with a prepared date of 10/20/24, did not have a use by date on the bag. f. A roll of ground beef, thawing on a tray, on the bottom shelf, with a pull date of 10/20/24, did not have a use by date on the package. g. A package of processed turkey slices with an open date of 10/20/24, did not have a use by date on the plastic bag or package of turkey. h. A bowl of prepared tuna salad, sitting on the shelf, with a prepared date of 10/20/24, did not have a use by date on the container. i. A clear, plastic, container of cornbread with a prepared date of 10/20/24, did not have a use by date on the container. 2. On 10/22/24 at 9:45 AM, the surveyor observed food sitting on the shelf in the walk-in refrigerator did not have a use by date on some food items: a. A clear, plastic, storage bag of ham labeled with two pull dates of 10/14/24 and 10/21/24, did not have a use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A package of processed turkey slices with a pull date of 10/20/24, did not have a use by date on the clear, plastic bag, or on the turkey package. c. A clear, plastic container of cornbread with a prepared date of 10/20/24, did not have a use by date on the container. 3. On 10/21/24 at 10:15 AM, the Dietary Manager (DM) stated a use by date should be noted on the food so everyone would know when to discard the food. The DM said, if the foods are not pulled timely, salmonella could start growing in the food and cause a resident to get sick if they consumed the food. The DM stated the tuna salad should be used within 3 days after being prepared, or it could have salmonella in it. The DM continued the turkey slices should be used within 3 days after opening, or a resident could get sick if they ate the tuna or turkey. 4. On 10/22/24 at 1:58 PM, the Administrator stated the facility did not have a policy for food storage.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47916 Based on observation, record review, and interview the facility failed to ensure staff wore Personal Protection Equipment (PPE) in droplet precaution rooms for 1 (Resident #16) resident of 1 sampled (Resident #16) observed on droplet precautions to prevent the spread of COVID 19. Findings include: A review of Medical Diagnosis revealed Resident #16 with diagnoses of dementia, type II diabetes, and heart disease. Review of The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/21/2024, section O0110, M1 shows Resident #16was under quarantine. a. Review of an Order Summary Report, dated 10/19/2024, revealed Resident #16 was on droplet isolation precautions for COVID 19 for 10 days. b. Review of Resident #16's Care Plan, revealed an intervention dated 10/21/2024 indicating staff were to maintain droplet isolation precautions when providing care to Resident #16. c. On 10/21/24 at 1:21 PM, Resident #16 revealed a diagnosis of COVID on Friday at the hospital. Personal Protection Equipment (PPE) was observed hanging on the outside of Resident #16's door with droplet precaution signage. d. On 10/22/24 at 2:23 PM, Certified Nursing Assistant (CNA) #4 was observed at the bedside talking to Resident #16, and sitting down a pitcher of water without gown, gloves, mask or eye shield. CNA #4 stated she was not concerned, because she already had COVID 3-4 times, and confirmed she had been in-serviced on infection control. e. On 10/23/24 at 11:34 AM, Director of Nursing (DON) stated staff are supposed to wear PPE when entering COVID rooms and dispose of PPE and wash their hands when exiting the room to prevent spreading the disease to others, and to keep themselves safe. COVID policy and procedures as well as in-services were requested. f. Review of an in-service titled Infection Control-Enhanced Barrier, dated 10/18/2024, the Infection Control In-service Training Guide revealed pathogens live in the lungs, blood and digestive tract, and exit an infected person's nose, mouth, eyes, or cuts on the skin, then can travel through the air, on hands and surfaces before entering the body of an uninfected person. Residents on droplet precautions require additional precautions to prevent the spread of disease including gowning, gloving, masking, and wearing face shields, or eye protection.