STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Health and Rehab	7425 Euper Lane Fort Smith, AR 72903

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 37634 49413 Based on interview, and record review the facility failed to formulate an advance directive or have an acknowledgement of an advance directive on file for 2 (Resident # 108, Resident #10) of 8 sampled residents. The findings are: 1. Review of an Order Summary Report indicated, Resident #108 had a diagnosis of personal history of Transient Ischemic Attack. A review of Resident #108's electronic medical record revealed, there was not an advance directive or an acknowledgement of an advance directive on file. On 10/22/24 at 2:28 PM, the Admissions Director indicated Resident #108 did not have an advance directive, or an acknowledgement of an advance directive on file. He indicated that the advance directive should be formulated or acknowledged upon admission. Review of Resident #10 ' s quarterly Minimum Data Set with an Assessment Reference Data 08/29/2024 revealed a Brief Interview for Mental Status (BIMS) of 6 with medical diagnoses of dementia, Alzheimer's disease and post-traumatic stress disorder. On 10/22/24 at 10:38 AM, Resident #10's electronic medical records contained a Physician ' s Order for Life Sustaining Treatment form without any acknowledgement of advance directive information or option provided to the Resident's Representative On 10/22/24 at 1:27PM, Admissions Director and Administrator stated, the resident representative took the admissions packet home to read and fill out. Resident Representative failed to sign the Advance Directive Acknowledgment form. On 10/24/24 12:12PM, Admissions Director confirmed that the Advance Directive was overlooked. (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: 045413	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Policy for Advance Directives and Do Not Resuscitate (DNR), reviewed and revised 3/6/2023 and 5/29/2024 showed an Advance Directive is a written, signed and witnessed instruction, which state your choices about medical treatment recognized under state law relating to the health care when the individual is incapacitated. Each competent person has the right to make their own health care decisions. Decisions are to be informed, reasonable choices that include the right to refuse or discontinue life-sustaining treatment. On admission, the facility representative will determine whether the resident has an Advance Directive and advise the responsible party of their right to establish one. The facility Social Service Department will identify the primary decision-maker. A BIMS of 7 or lower does not have the ability to establish an advance directive.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37634 50505 Based on observation and interview, the facility failed to ensure 2 (room [ROOM NUMBER], and room [ROOM NUMBER]) rooms were clean to maintain a homelike environment. The findings are: 1. On 10/21/24 at 11:30 AM, trash was observed behind the nightstand in room [ROOM NUMBER]. There was a white cup, an ice cream lid, peanuts, peanut container, pencils, and paper behind the nightstand. On 10/21/24 at 12:30 PM, trash was observed behind the nightstand in room [ROOM NUMBER]. There was a white cup, an ice cream lid, peanuts, peanut container, pencils, and paper behind the nightstand. On 10/21/24 at 2:15 PM, trash was observed behind the nightstand in room [ROOM NUMBER]. There was a white cup, an ice cream lid, peanuts, peanut container, pencils, and paper behind the nightstand. On 10/21/24 at 2:18 PM, Housekeeper #11 indicated there was trash, tissue, and other things behind the nightstand in room [ROOM NUMBER]. Housekeeper #11 indicated that rooms should be cleaned every day, and as needed. On 10/21/24 at 2:19 PM, Housekeeper #12 indicated, there was trash behind the nightstand in room [ROOM NUMBER]. Housekeeper #12 indicated that rooms should be cleaned every day, and whenever dirty. 2. During an observation on 10/21/2024 at 1:56 PM, a black pedestal fan was sitting at bedside in room [ROOM NUMBER] B. Gray/beige, fuzzy-like particles were noted on the fan blades and the fan protective cover. The pedestal base of the fan had large white/beige splatters of an unknown substance on the surface. During an observation on 10/22/2024 at 10:24 AM, a black pedestal fan was sitting at bedside of room [ROOM NUMBER] B. Gray/beige, fuzzy-like particles were noted on the fan blades and the fan protective cover. The pedestal base of the fan had large white/beige splatters of an unknown substance on the surface. During a concurrent observation and interview on 10/23/2024 at 4:20 PM, after being shown the pedestal fan in room [ROOM NUMBER] B, the Administrator confirmed the fan was uncleaned and it was important for the fan to be clean because those particles could be breathed in and could cause a respiratory infection. During a concurrent observation and interview on 10/23/2024 at 4:20 PM, after being shown the pedestal fan in room [ROOM NUMBER] B, the Infection Preventionist (IP) confirmed the fan was not clean and took the fan apart and confirmed that the fan would be cleaned. The IP stated that the particles could lead to respiratory issues. (continued on next page)

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	045413	A. Building B. Wing	10/24/2024

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Methodist Health and Rehab	7425 Euper Lane Fort Smith, AR 72903

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/24/24 at 8:30 AM, Administrator stated the facility did not have a policy for fan use or fan cleaning.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49413 Based on interview, record review, facility document review, and facility policy review, it was determined the facility failed to ensure administration of correct medication to correct resident for 1 (Resident #76) of 1 sample mix residents for medication administration. The findings are: Review of Resident #76's Care Plan with an initiated date of 04/28/2024 noted the resident had an allergy to statin medications. Review of Resident #76's Medication Administration Records (MAR) dated June 2024 noted, the physician ordered the following medications: Amlodipine 5 (milligrams) mg for high blood pressure Fenofibrate 54mg for high cholesterol Aricept 5mg for dementia Melatonin 6mg for insomnia Namenda XR Extended Release (ER) 24- hour (HR) 28mg (memantine) for dementia Fenofibrate 54mg for cholesterol due to the allergy to statins. Review of the Medication Error Report dated June 1, 2024, revealed Certified Medication Assistant (CMA) #13 reported that both Resident #76 and Resident #47's medication were taken to the secured unit dining room where both residents had their dinner trays. Both residents take their medications better crushed and with their meal. CMA #13 labeled each medication cup with first names of each resident. CMA #13 called Resident #76 by first name; Resident #76 responded. CMA #13 gave Resident #76 a bite of the medication. Resident #76 had already swallowed the medication. CMA #13 then immediately realized the medications were mixed up and Resident #76 received Resident #47 medication. CMA #13 notified the nurse who then called the chain of command. CMA #13 checked Resident #76 blood pressure which was 140/80. The medications that Resident #76 received were: Atorvastatin 20 mg Amlodipine 5mg Buspirone 7.5mg Aricept 10mg Hydralazine (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Melatonin 6mg Mirtazapine 7.5mg Namenda 10mg Resident #76 was given a lower dose than prescribed by the physician, Namenda XR ER 24HR 28MG (memantine). Review of the Resident #47 Physician Orders with a start date of 5/1/2024 noted: Atorvastatin 20 mg Amlodipine 5mg Buspirone 7.5mg Aricept 10mg Hydralazine 100mg Melatonin 6mg Mirtazapine 7.5mg Namenda 10mg. On 10/23/2024 at 10:03AM, during an interview with the Assistant Director of Nursing (ADON), ADON confirmed, when Resident #76 was given the wrong medication, the vital signs were monitored. When the blood pressure dropped Resident #76 was then sent to the emergency room . CMA #13 received one on one training. During an interview with the Director of Nursing (DON) on 10/23/2024 at 10:10AM, DON confirmed, the CMA #13 pulled Resident #47 and Resident #76's medications at the same time. Both residents receive crushed medications. Some of the medications were the same for each resident. CMA #13 received counseling with action plan of one-on-one training with four weeks of supervised medication pass (June 14, 22, 25 and July 5, 2024) and 30 days of probation. During an interview with DON on 10/23/2024 at 4:19PM, she confirmed not all staff that administered medication were provided in-service training at that time. CMA #13 did not follow protocol. A skill check off was completed with other medication technicians and nurses. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CMA #13 on 10/23/2024 at 4:10PM, she confirmed Resident #76 was provided the wrong medication. CMA #13 was rushing to get the medications to Resident #76 and Resident #47 before they ate. CMA #13 carried both residents initialed medication cups into the secured unit dining room, in the same hand. CMA # 13 grabbed the spoon from Resident #47's cup and gave Resident #76 the medicine. CMA #13 knew Resident #47 had lots of blood pressure medications. CMA #13 took Resident #76's blood pressure while the nurse contacted the chain of command. Resident #76 and Resident #47 prefer their medications during mealtime. CMA #13 stated medications need to be pulled for one resident at time, so a medication error is not made, to ensure the right medication is given to the right resident and do the five rights of medication administration. After my one-on-one training, I was watched for four weeks, and I am on probation for three months. During an interview with CMA #14 on 10/24/2024 at 8:55AM, she confirmed they (the staff) are to ensure residents receive correct medication by asking their name and birthday. Only one medication at a time should be pulled so you don't get them mixed up or make a medication error. During an interview with CMA #15 on 10/24/2024 at 8:57AM, she confirmed they are to ensure residents receive correct medication and compare medication cards to the Medication Administration Record. Only one medication at a time is pulled so you do not make a mistake, a medication error or give the wrong medication to the wrong resident. During an interview with Licensed Practicing Nurse #16 on 10/24/2024 at 9:35AM, she confirmed they are to ensure residents receive correct medication, verify the resident's medication orders against the Medication Administration Record, and verify name and date of birth by asking resident. Only one medication at a time should be pulled so you do not get them mixed up and to decrease the risk of a medication error. During an interview with Licensed Practicing Nurse #17 on 10/24/2024 at 9:40AM, he confirmed they are to ensure residents receive correct medication, double check the resident ' s Medication Administration Record against the medication card. Check the name, date of birth and picture against the Medication Administration Record. Only one medication at a time is pulled so you do not make a medication error. Review of the facility policy and procedure titled Medication Administration with a revision date of 5/29/2024 noted, check Electronic Medication Administration Record and verify resident, greet and identify the resident. Do not crush or manipulate extended-release medications.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 2 of 2 meals observed. The findings are: 1. The menu for the lunch meal indicated the residents who received pureed diets were to receive 4 ounces (1/2 cup) of pureed shredded lettuce salad and two #8 scoops (1 cup) of chicken and dumpling. a. On 10/22/24 at 12:48 PM, Dietary Aide (DA) #4 used one #8 scoop (1/2 cup) to serve a single portion of pureed chicken and dumpling to the residents on pureed diets, instead of two #8 scoops which was equivalent to 1 cup. b. There was no pureed salad served to the residents on pureed diets for lunch, instead of 4 ounces (1/2 cup) of pureed salad. c. On 10/22/24 at 5:10 PM, DA #5 stated, a replacement should have been given for the pureed salad. d. On 10/22/24 at 5:23 PM, Food and Beverage Director also stated, something else should have been given to the residents in place of the salad. 2. The menu for the supper meal indicated the residents who received pureed diets were to receive 6 ounce (3/4 cup) of pureed baked potato soup. a. On 10/22/24 at 5:07 PM, Dietary Aide (DA) #5 used a 4-ounce spoon to serve a single portion of pureed chicken and dumpling to the residents on pureed diets. During an interview, DA #5 stated that the spoon used was 4 ounces. 3. During an observation on 10/22/24 5:02 PM, the Executive Chef used a knife to dice breaded fried fish, to be served to the residents on mechanical soft diets. He poured diced fish into a pan and placed it on the steam table. When interviewed the Executive Chef stated they do not grind fish, rather they use a knife to chop it. On 10/22/24 at 5:03 PM, the Food and Beverage Director stated mechanical soft diets were supposed to have ground fish and not chopped fish. The physician order will specify if they were supposed to receive chopped meat. On 10/22/24 at 5:22 PM, Dietary Aide (DA) #8 was asked about the size of the breaded fish served to the residents on mechanical soft diets she stated it was 1 to 2 square centimeters (0.39-0.79 inches). DA #8 picked up a crunch piece of the breaded fish and stated, the crunch piece of the breaded fish might be difficult to chew for someone on mechanical diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/24 at 5:23 PM, the Executive Chef and Food and Beverage Director confirmed the size of diced, breaded, fried fish served to the residents on mechanical soft diets were 1 to 2 square centimeters and had crunchy pieces.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 03508 Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 1 of 2 meals observed. The findings are: 1. On 10/22/24 at 11:58 AM, the following observations were made on the steam table: a. A pan of pureed, English peas had a soupy consistency and was gritty. b. A pan of gravy was lumpy and was not smooth 2. On 10/23/24 at 1:36 PM, during and interview the Dietary Manager stated the pureed English peas were a little thin, it is gritty because of the skin, it is hard to puree the skin and they should have pureed it a little longer. She further stated the gravy had been chunky. 3. On 10/23/24 at 1:36 PM, the Food and Beverage director stated the pureed English peas were a little thin, it is gritty because of the skin, it is hard to puree the skin and they should have pureed it a little longer.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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, record review, and facility policy review, the facility failed to ensure foods were covered or sealed in the freezer and or refrigerator; dietary staff thoroughly washed their hands and changed gloves when contaminated and dietary staff and visitors wear hair restraints when in the kitchen. The findings: 1. On 10/22/24 at 11:12 AM, Dietary Aide (DA) #1 used a rag to clean the top of the food cart and then pushed it to the clean side of the dish washing machine. Without washing her hands, she picked up plates and bowls to be used in portioning the lunch meal and placed them on the cart, using her fingers inside the bowls and plates. During an interview DA #1 stated she should have washed her hands. 2. On10/22/24 at 11:13 AM, DA #9, who was in the dish washing machine room, had hair on his chin with no beard restraint. 3. On 10/22/24 at 11:16 AM, DA #2 picked up cartons of ice cream from the refrigerator and placed them on the cart near the refrigerator. Without washing his hands, he picked up glasses by their rims and placed them on the cart to be used in serving beverages to the residents for lunch. 4. On 10/22/24 at 10:22 AM, an opened box of dinner rolls were on a shelf in the freezer. The box was not covered or sealed. 5. On 10/22/24 at 10:31 AM, the following observations were made on a shelf in the freezer: a. An opened box of pizza dough. The box was not covered or sealed. b. An opened bag of dumplings, the bag had no opened date. c. An opened bag of hamburger buns. The bag was not sealed. 6. On 10/22/24 at 11:39 AM, Dietary Aide (DA) #3 was wearing gloves on her hands when she wiped off spilled oil around the deep fryer with a rag, contaminating the gloves. DA #3 removed fries from the bag and placed them in the deep fryer basket to be cooked and served to the residents for lunch. At 11:42 AM, the DA #3, picked up tray cards and placed them on the counter. However, with the same contaminated gloves, DA #3 picked up the plates and placed them on the counter, touching the inside with the contaminated gloves, which would be used for plating food. At 11:43 AM, DA #3 used the same gloved hand to push grilled cheese down on the grill. DA#3, when interviewed, stated she should have changed gloves and washed her hands. 7. On 10/22/24 at 11:46 AM, an opened bottle of soy sauce, dated 8/31/2024, was on a shelf below the food preparation counter. Some of the sauce had already been partially used. The manufacturer's specification on the bottle indicated to refrigerator after opening. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	8. On 10/22/24 at 12:06 PM, Dietary Aide (DA) #2 was on the tray line in the kitchenette, opposite the main dining room, serving lunch meal, DA #2 picked tray cards and placed them on the counter, used a pan to write the date on the tray card and pulled his sleeves up. Without washing hands, DA #2 picked up bowls to be used in portioning food items to be served to the residents for lunch and placed them on the counter with his fingers inside the bowls. At 1:15 PM, DA #2 stated he should have washed his hands. 9. On 10/22/24 at 12:09 PM, DC #3 wiped gloved hands on her apron. Without changing gloves and washing her hands, DC #3 removed cantaloupe and honey dew from the refrigerator and placed them on the cutting board. She sliced them and arranged the pieces on the plates to be served to the residents who asked for it. DC #3, when interviewed, stated she should have washed her hands. 10. On 10/22/24 at12:05 PM, Dietary Aide #4, assisting with lunch meal service, picked up condiments, cartons of milk, shakes, cans of soda and placed them on the trays. Without washing hands, DA #4 picked up glasses that contained beverages by their rims and placed them on the meal trays to be served to the residents for lunch. DA #4, when interviewed, stated she should have washed her hands. 11. On 10/22/24 at 12:10 PM, Dietary Aide #5 was on the tray line in the kitchen serving lunch meal, picked up tray cards and placed them on the trays, contaminating her hands. Without washing her hands, DA #5 picked up bowls to be used in portioning soup and placed them on the counter with fingers inside of them. DA #5, when interviewed, stated she should have washed her hands. 12. On 10/22/24 at 12:16 PM, Dietary [NAME] (DC) #3 was wearing gloves on her hands when she removed strawberries from the original container and placed them on the cutting board. After slicing the strawberries, she arranged them on the plate. While holding the glove box, she took gloves from the box and put them on, contaminating them in the process. Without washing her hands, DC #3 picked up sliced strawberries and placed them on the plate to be served to the resident who asked for it. DC #3 did not rinse strawberries before processing them for consumption. DC #3, when interviewed, stated she should have washed her hands. 13. On 10/22/24 at 12:30 PM, Dietary Aide (DA) #6, while holding the glove box, took gloves from the box and put them on, contaminating them in the process. Without washing her hands, DA #6 picked up the diced tomatoes from the refrigerator and sprinkled them on top of the plated salad to be served to the residents who asked for it. DA #6, when interviewed, stated she should have washed her. 14. On 10/22/24 at 12:35 PM, DA #6 turned on the sink faucet and washed her hands. After, washing her hands, she turned off the faucet, used a tissue to wipe off the water around the sink. Without rewashing her hands, DA #6 then put on new gloves and picked up pans, placing them on the counter using her contaminated gloved fingers. DA #6 removed fried chicken tenders from the deep fryer basket and placed them on the cutting board and began slicing them. DA #6, when interviewed, stated she should have washed her hands. (continued on next page)

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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 - Many	15. On 10/22/24 at 4:07 PM, DA #6 had gloves on her hands when she washed the blender bowl and blade in the 3-compartment sink. After washing them, she removed the gloves that had been saturated with water and threw them away. Placed new gloves on her hands, contaminating them. Without changing gloves and washing her hands, DA #6 picked up a clean blade and attached it to the base of the blender to be used in pureeing food items, to be served to the residents who required pureed diets for supper. At 4:08 PM, when DA #6 was ready to put beans into the blender. The surveyor immediately interviewed DA #6 who stated she should have washed her hands. 16. On 10/22/24 at 4:20 PM, Dietary Aide (DA) # 7 lifted a trash and threw away tissue paper. Without washing her hands, DA #7, Picked up glasses by their rims and poured beverages to be served to the residents for supper. DA #7, when interviewed, stated she should have washed her hands. 17. On 10/23/24 at 1:30 PM, Dietary [NAME] (DC #10 had hair on his chin was around the food preparation counter with no beard restraint. 18. On 10/23/24 at 1:40 PM, there were two visitors with long hair and long beards in the kitchen. One wore a hat with hair handing out and had no beard restraint. The second visitor with long hair also had no restraints on his hair or beard. 19. A facility policy titled, Hand Washing and Glove use initiated 5/1/2019, and provided by Food and Beverage Director indicated, hands should be washed before beginning work and when in contact with unsanitary surfaces.