

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Murfreesboro Rehab and Nursing, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  110 W 13th Street Murfreesboro, AR 71958	

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)
<p>F 0568</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home.</p> <p>48977</p> <p>Based on observations, interviews, and record review, the facility failed to ensure 2 (Residents #5 and #14) residents and/or resident representatives was notified at least quarterly of the account activities and/or balance.</p> <p>The finding include:</p> <ol style="list-style-type: none"> <li>1. According to an Admission Record, Resident #5 was a Medicaid recipient.             <ol style="list-style-type: none"> <li>a. A review of a Participant Ledger Account Cash Journal Resident #5 had a balance of \$2,176.51.</li> <li>b. According to an Annual Minimum Data Set (MDS) with an Assessment Reference Date 7/25/2024 Resident #5 scored 03 on the Brief Interview of Mental Status (BIMS) indication severe cognitive impairment.</li> </ol> </li> <li>2. According to an Admission Record, Resident #14 was a Medicaid recipient.             <ol style="list-style-type: none"> <li>a. A review of Participant Ledger Account Cash Journal Resident #14 had a balance of \$2,004.20.</li> <li>b. According to Quarterly Minimum Data Set (MDS) with the Assessment Reference Date 8/16/2024 Resident #5 scored 03 on the Brief Interview of Mental Status (BIMS) indication severe cognitive impairment.</li> </ol> </li> </ol> <p>On 08/22/24 at 12:00 PM, the Administrator stated statements are not provided to residents or residents representatives unless they are requested.</p>

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:  045415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Murfreesboro Rehab and Nursing, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  110 W 13th Street Murfreesboro, AR 71958	

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)
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>48977</p> <p>Based on observations, interviews, and record review, the facility failed to ensure the residents and/or resident's representative were notified when 2 (Resident #5 and #14) sampled resident's account were within \$200.00 of the maximum amount a Medicaid recipient can have in cash assets.</p> <p>The finding include:</p> <ol style="list-style-type: none"> <li>1. According to an Admission Record, Resident #5 was a Medicaid recipient.               <ol style="list-style-type: none"> <li>a. A review of a Participant Ledger Account Cash Journal Resident #5 had a balance of \$2,176.51.</li> <li>b. According to an Annual Minimum Data Set (MDS) with an Assessment Reference Date of 7/25/2024, Resident #5 scored 03 on the Brief Interview of Mental Status (BIMS) indication severe cognitive impairment.</li> </ol> </li> <li>2. According to Admission Record Resident #14 was a Medicaid recipient.               <ol style="list-style-type: none"> <li>a. A review of Participant Ledger Account Cash Journal Resident #14 had a balance of 2,004.20.</li> <li>b. According to Quarterly Minimum Data Set (MDS) with the Assessment Reference Date 8/16/2024 Resident #5 scored 03 on the Brief Interview of Mental Status (BIMS) indication severe cognitive impairment.</li> </ol> </li> </ol> <p>On 08/22/24 at 12:00 PM, the Administrator stated neither the resident nor the resident representative was notified when the resident's account was within \$200.00 of the allowed amount of cash assets of a Medicaid recipient. The Administrator confirmed the residents could have Medicaid payments rejected for being over the allowed amount.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Murfreesboro Rehab and Nursing, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  110 W 13th Street Murfreesboro, AR 71958	

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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>48977</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure 1 (Resident #16) sampled resident's personal and health information was properly protected.</p> <p>The findings include:</p> <p>A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/20/24 revealed Resident #16 had a Brief Interview of Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.</p> <p>On 08/20/24 at 11:45 AM, the Surveyor observed Licensed Practical Nurse (LPN) #1 leaving a laptop unattended while Resident #16's personal and medical information was visible on the screen.</p> <p>On 08/21/24 at 11:47 AM, LPN #1 confirmed the laptop was left open and stated the computer should have been pushed down.</p> <p>On 08/22/24 at 11:15 AM, the Director of Nursing (DON) stated the nurse should have put the laptop computer screen down prior to walking away to make sure patient information was hidden. The DON stated it was a risk to the resident's privacy and a violation of the Health Insurance Portability and Accountability Act (HIPAA) if the unattended laptop screen was left up and displayed a resident's personal and health information.</p> <p>A policy titled Privacy Policy for Electronic Health Records (EHRs) 5.3 Confidentiality - Confidentiality: All electronic health records will be kept confidential. All staff must maintain this practice while away from the nurses station. Screens on electronic devices must be hidden.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Murfreesboro Rehab and Nursing, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  110 W 13th Street Murfreesboro, AR 71958	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42965</p> <p>48977</p> <p>50580</p> <p>Based on record review, observation, and interview, the facility failed to complete Minimum Data Set (MDS) assessments accurately for 2 (Resident #3 and #16) sampled residents.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. Review of an Order Summary Report revealed Resident #3 had diagnoses of heart failure, diabetes mellitus, and transient ischemic attacks (mini strokes). <ol style="list-style-type: none"> <li>a. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/17/2024 indicated that the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS) and received an anticoagulant medication.</li> <li>b. A physician's order dated 10/3/23 indicated, .Clopidogrel Bisulfate Oral Tablet 75 MG (milligram) Give 1 tablet by mouth one time a day related to personal history of transient ischemic attack (TIA) .</li> <li>c. On 08/20/24 at 11:45 AM, a review of Resident #3's Order Summary Report from 07/01/2024 through 8/20/2024 did not show the resident had an order for an anticoagulant medication.</li> <li>d. On 08/20/24 at 11:50 AM, a review of Resident #3's Medication Administrator Record (MAR) for July 2024 did not show that the resident received an anticoagulant medication.</li> <li>e. On 08/20/2024 at 1:51 PM, during an interview the MDS Coordinator stated that she had incorrectly coded the antiplatelet medication Clopidogrel as an anticoagulant on Resident #3's quarterly MDS assessment dated [DATE]. The MDS Coordinator stated it was important to code the MDS correctly because the information entered into the MDS was linked to the resident's care plan and the care that the resident receives.</li> <li>f. On 08/21/2024 at 11:00 AM, the Administrator was asked if the facility had a policy on accuracy of MDS assessments.</li> <li>g. On 08/21/24 at 11:30 AM, the policy titled, Accuracy of care plan/MDS indicated, .It is crucial that the Minimum Data Set (MDS) assessment is accurate and comprehensive to ensure proper care and treatment of residents .</li> </ol> </li> <li>2. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/20/2024 revealed Resident #16 had a Brief Interview of Mental Status (BIMS) score of 15, indicating the resident was cognitively intact, and that Resident#16 had diagnoses of bipolar disorder and schizophrenia.</li> </ol> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Murfreesboro Rehab and Nursing, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  110 W 13th Street Murfreesboro, AR 71958	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. A Care Plan for Resident #16, revision on 2/21/2024, revealed the resident was taking psychotropic medications related to bipolar schizoaffective disorder.</p> <p>b. Review of the State Designated Professional Associates letter dated July 23rd, 2018, provided by the facility showed Resident #16 did not require specialized services for the mental illness, intellectual disability, and/or developmental disability beyond the capabilities of a nursing facility.</p> <p>c. On 08/20/24 at 10:55 AM, the Minimum Data Set (MDS) Coordinator stated Resident #16 was considered by the state level II Preadmission Screening and Resident Review (PASRR) process to have serious mental illness and/or intellectual disability, or a related condition and that information should have been reflected on the comprehensive assessment.</p> <p>d. On 08/22/24 at 11:15 AM, the Director of Nursing (DON) confirmed Resident #16 was considered by the state PASRR level II process to have serious mental illness and/or intellectual disability and that information should have been reflected on the comprehensive assessment. The DON stated if the assessment was not accurately completed the resident's care could have been affected.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Murfreesboro Rehab and Nursing, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  110 W 13th Street Murfreesboro, AR 71958	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>48977</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure medications were stored securely in an unattended medication cart.</p> <p>The findings include:</p> <p>On 08/20/24 at 12:00 PM, the Surveyor observed Licensed Practical Nurse (LPN) #1 leave a medication cart unlocked, unattended, and out of view while in a resident's room.</p> <p>On 08/20/24 at 1:46 PM, LPN #1 stated the medication cart should be locked prior to leaving it unattended. LPN #1 stated if the medication cart is left unlocked when unattended someone could get in it and get something.</p> <p>On 08/22/24 at 11:15 AM, the Director of Nursing (DON) stated the nurses should make sure the medication cart is locked and the screen is hidden prior to walking away. The DON stated if the medication cart was left unlocked a resident could have gotten inside the medication cart and gotten something that could have harmed them.</p> <p>A policy Medication Storage noted 3. Security Locking Mechanism: Use the locking feature of the cart to restrict access to authorized personnel only.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Murfreesboro Rehab and Nursing, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  110 W 13th Street Murfreesboro, AR 71958	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48977</p> <p>50580</p> <p>Based on record review, observation, interview and policy review, the facility failed to ensure staff washed hands, changed gloves and followed infection control precautions appropriately during medication administration, wound care for 1(Resident #17) sampled resident, and enteral feedings for 1(Resident #9) sampled residents.</p> <p>The findings are:</p> <p>1. On 08/20/24 at 11:30 AM, the Survey observed Licensed Practical Nurse (LPN) #1 administer medication to 5 residents without using proper hand hygiene before or after medication administration. The Surveyor observed LPN #1 wipe sweat from her face and wipe her nose with her hands without using hand hygiene afterwards or prior to an encounter with a resident. The Surveyor observed LPN #1 handling cups by placing her finger inside the cup used to provide water for medication administration. The Surveyor observed LPN #1 touch computer, medication cart, keys, and mouse with gloves used check blood glucose.</p> <p>2. A review of Physician's orders indicated Resident #9 had an order to receive enteral feed every 4 hours 250 milliliters (ML) and flush with 100 cubic centimeters (cc) of water (H2O) before and after meals and medication administration via Percutaneous Endoscopic Gastrostomy (PEG).</p> <p>a. According to Quarterly Minimum Data Set with the Assessment Reference Date of 8/1/2024 indicated that Resident #9 scored 03 on the Staff Assessment for Mental Status indicating the resident was severely impaired. Resident #9 had diagnoses of cerebral palsy, autistic disorder, and dysphagia (difficulty swallowing). Resident #9 had a feeding tube while a resident.</p> <p>b. A Care Plan for Resident #9, revision on 5/02/2024, revealed Resident #9 required tube feeding related to dysphagia and had nutritional problem or potential nutritional problem related to PEG tube used for feeding Resident #9 was on Enhance Barrier Precautions which required staff to wear gowns and gloves when providing high contact resident care.</p> <p>c. On 08/20/24 at 1:05 PM, the Surveyor observed LPN #1 cough toward the open nutritional supplement held in her right gloved hand then poured more of the supplement into the PEG tube. The Surveyor observed LPN #1 remove left gloved from holding the PEG, wipe sweat from her forehead with left gloved hand, and place left gloved hand back on the PEG tube. The Surveyor observed LPN #1 cough a second time toward to the open nutritional supplement held in her right gloved right gloved hand prior to pouring the remaining amount in the PEG tube. The Surveyor observed LPN #1 cap the lumen on the PEG tube using both left and right gloved hands.</p> <p>d. On 08/20/24 at 1:47 PM, LPN #1 confirmed she did not wash or sanitize hands between administrating medications to 5 residents. LPN #1 confirmed she potentially contaminated the supplement when she coughed in the direction of the open nutritional supplement held in the right hand.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/22/2024
NAME OF PROVIDER OR SUPPLIER  Murfreesboro Rehab and Nursing, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  110 W 13th Street Murfreesboro, AR 71958	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e. On 08/22/24 at 11:15 AM, the Director of Nursing (DON) stated the nurse should have used hand hygiene between each resident and after hands encounter bodily fluids. The DON stated hand hygiene was important to maintain a clean environment and not spread germs from resident to resident or from staff to resident.</p> <p>f. A policy titled Handwashing noted Wash hands: after using restroom, between handling of individual patients, after blowing or wiping nose, leaving an isolation area.</p> <p>3. Review of an Order Summary Report showed Resident #17 had diagnoses of Diabetes Mellitus with diabetic neuropathy, history of transient ischemic attack, non-pressure chronic ulcer to left foot, carrier or suspected carrier of methicillin resistant staphylococcus aureus.</p> <p>a. The quarterly Minimum Data Sheet (MDS) with a date of 8/8/24 indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact).</p> <p>b. A physicians order dated 8/14/24 showed .Order Summary: Cleanse wound to top left foot with NS (Normal Saline) and pat dry. Apply calcium alginate with silver to wound bed. Apply calmoseptine to skin around wound bed. Cover with abdominal pad and wrap with gauze and secure with tape. every day shift for diabetic ulcer PRN (as needed) or if visibly soiled .</p> <p>c. A care plan with an initiated date of 08/08/2024 indicated the resident had stage 2 pressure ulcer left foot and potential for further pressure ulcer with potential for further skin problems due to diabetes and immobility. Goal: The resident will not have further skin issues or skin deterioration.</p> <p>d. On 8/20/2024 at 1:43 PM, LPN # 2 prepared wound care supplies, then applied gloves after using hand sanitizer. Resident # was on enhanced barrier precautions, LPN #2 put on a gown, and gloves, entered the resident's room, removed dressing to left foot, did not remove gloves, touched floor, performed wound care as ordered, did not remove gloves or cleanse hands during wound care and placed dressing on bare floor without a barrier device.</p> <p>f. On 8/20/2024 at 2:00 PM, the Surveyor conducted an interview with LPN # 2. The surveyor asked LPN #2 when gloves should be changed and hands washed during wound care and should bandage/wound care supplies be placed on the bare floor. LPN #2 stated they had only been a nurse since last June and we were never trained on wound care.</p> <p>g. On 8/22/2024 at 11:00 AM, the Surveyor interviewed the DON regarding Inservice training on hand washing or wound care. No Inservice/training was provided.</p> <p>h. On 8/22/2024 at 11:45 AM, the Surveyor asked the DON when a nurse providing wound care should wash hands and change gloves. The DON responded wash hands and change gloves before providing wound care and before applying new dressing.</p> <p>h. The facility provided a policy titled Infection Control, Standard Precautions that indicated, change gloves between tasks and procedures on the same resident after contact with material that may contain microorganisms.</p>		