STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045417	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arkansas Veterans Home at Fayetteville	1179 North College Avenue Fayetteville, AR 72703

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 50924 Based on interviews, record review, and facility document review, it was determined the facility failed to monitor and notify the resident ' s representative of high trust balances prior to reaching the Social Security resource limit for 1 (Resident #12) for 3 residents reviewed for resident trust fund accounting. As a result, Resident #12 lost their Medicaid benefits and was required to private pay for room and board at a personal cost of $7,817.56. The findings include: A review of a facility document titled, Resident Informational Handbook, dated April 2024 indicated, The facility must manage your deposited funds with your best interest in mind. A review of Resident #12's Admission Recorded, revealed the facility admitted the resident on 07/15/2015 with diagnoses of mood disorder and schizoaffective disorder. A review of Resident #12's Medical Diagnoses, revealed the principal diagnosis was schizophrenia. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/19/2024, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. A review of Resident #12's account ledger #1532, from 03/01/2024 to the current date of 03/17/2025 revealed, Resident #12's balance on 07/03/2024 was $2,721.82, $721.82 above the allowed limit. The balance reached $9,177.24 on 10/09/2024 and remained above the allowed limit through 10/17/2024 when the balance was $7,817.56. During an interview on 03/18/2025 at 8:38 AM, the Financial Analyst stated she was unaware notices were to be sent out regarding Medicaid limits. The previous business office manager stated we had always handled [Resident #12's] financials and she never had me send any notices out either. After the previous business office manager left abruptly, the Administrator and I started looking at the balance in Resident #12's trust and we switched the resident to private pay until they were eligible for Medicaid again, then they were switched back. (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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility statement with a date of 10/01/2024 revealed, Resident #12 was privately charged for room and board starting on 09/27/2024 through 10/31/2024. The charges totaled $7,817.56. The payment was due by 10/10/2024. A review of check #8058 written from the facility to itself on 10/21/20024 indicated that the facility was paid $7,817.56 from trust account #1532. During an interview on 03/18/2025 at 9:35 AM, the Administrator stated there had been no notices sent out for any balance issues. The facility usually issues monthly statements. We do not have any outstanding balance issues right now. The Administrator stated the facility was supposed to let residents or their representatives know before accounts reach $2,000 so they can do a spin down. I believe we are notifying people for spin downs; I have not personally done that. Regarding Resident #12 someone signed the resident in, and later no one wanted to handle the money. The facility did a rep payee to take over money management. I didn't know the resident had that much of a balance. The Financial Analyst reached out to Medicaid and the resident no longer qualified for benefits, so we had to switch the account to private pay and re-apply for benefits later. I was notified of the high balance when the previous business office manager left, and the Financial Analyst told me. I was like, Oh God. I was never aware of a paper given to me for high balance notifications and the risk of losing Medicaid benefits. It would appear in this situation where the facility was the rep payee I should have been notified. It should have been something internal which should have been dealt with well before a balance of $7,000. A review of the Trust Current Account Balance dated 03/17/2025 revealed, Resident #12 had a balance of $2,362.79.

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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 1 of 2 meals observed. The findings are: 1. The 03/17/2025, the supper menu documented the residents on regular diets were to receive 3 ounces of fried fish. The residents on mechanical soft diets were to receive a #10 scoop (3 ounces or 3/8 cup) of ground fish and 1/2 cup of chopped okra and tomatoes. The residents who received pureed diets were to receive a #8 scoop (4 ounces or 1/2 cup of pureed fish and a #16 scoop (2 ounces or 1/4 cup) of pureed dinner roll. On 3/17/2025 at 5:48 PM, the following observations were made during the supper meal service: a. Dietary [NAME] (DC) #5 used a #30 scoop (1.25 ounces or 1/8 cup) to serve a single portion of pureed bread, instead of a #16 scoop (2 ounces or 1/4 cup) as specified on the menu. b. DC #5 used a 2 ounce (1/4 cup) spoon to serve a single portion of pureed fish, instead of a #8 scoop (4 ounces or 1/2 cup) as specified on the menu. c. DC #5 used a 2-ounce (1/4 cup) spoon to serve a single portion of ground fish, instead of a 10 scoop (3 ounces or 3/8 cup) as specified on the menu. d. DC #5 used a 2-ounce (1/4 cup) spoon to serve a single portion of chopped okra and tomatoes, instead of 1/2 cup as specified on the menu. d. DC #5 served a small fried patty to the residents on regular diets, instead of 3 ounces as specified on the menu. On 3/17/25 at 6:37 PM, the Dietary Manager was asked if he could weigh the same amount of breaded fried fish served to the residents who received regular diets. He did and stated it was 2.5 ounces. He was asked if he could weigh the same hamburger meat served to 8 residents who received hamburger patties due to disliking fish. He did and stated it was 2.7 ounces. 3. On 3/17/25 at 6:45 PM, DC #5 was asked what size of scoop she used when serving pureed food items and mechanical soft diets and she stated she used the blue scoops (2 ounces or 1/4 cup). DC #5 was asked how many servings she gave to each resident. She stated, she gave one (1) serving each. DC #5 was asked if she reviewed the supper menu before meal service. She stated she did not. 4. 03/18/25 at 2:28 PM, during an interview the Distract Manager was asked for the policy on how to follow the menu when preparing and serving food. She stated the kitchen staff used the production sheet.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, interview, and facility policy review, the facility failed to ensure opened food items in the freezer and the storage areas were covered and sealed; expired food items were promptly removed from stock to maintain freshness; dietary staff practiced good hand hygiene before handling clean equipment or food items; and hot food items were maintained at or above 135 degrees Fahrenheit on the steam table for 2 of 2 meals observed. The findings are: 1. On [DATE] at 10:17 AM, the following observations were made on top of the food preparation counter in the kitchen: a. An opened half gallon of soy sauce that was partially used was on top of the food preparation counter in the kitchen. The manufacture specification on the gallon specified to refrigerate after opening. The District Manager stated it should have been in the refrigerator and not out. b. An opened box of corn starch. The box was not covered or sealed. c. An opened box of salt. The box was not covered or sealed. The District Manager confirmed the boxes were open and she would place them in zip sealed bags d. An opened bag of sugar. The bag was not sealed. The District Manger confirmed that the bag was not sealed and started to bag it. e. The Dietary Manager verified none of the items observed were being used for meal preparation at the time of observation. 2. On [DATE] at 10:26 AM, two boxes of cookies were on a shelf in the walk-in freezer. The boxes were not covered or sealed, exposing the cookies to air. The Dietary Manger confirmed the cookies were not covered or sealed. 3. On [DATE] at 10:31 AM, the following observations were made on a shelf in the dry goods storage room: a. Three of 3 bags of butter fingers were on a shelf in the storage room and had an expiration date of [DATE]. The Dietary Manager confirmed the expiration dates on the bags. b. Three of 3 bags of [chocolate cream filled] cookies were on a shelf in the storage room and had an expiration date of [DATE]. The Dietary Manager confirmed the cookies were dead . c. A box of spice cake mix was on a shelf in the storage room. The box documented, Best used by , d+[DATE] 2024. The Dietary Manager stated he would remove it from the stock. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. The Dietary Manager verified this area of storage was not used to store dented cans or outdated food items that would be intended for disposal. 4. On [DATE] at 11:13 AM, eight cartons of strawberry pudding were on a shelf in the refrigerator with an expiration date of [DATE]. The Dietary Manager stated they were expired. 5. On [DATE] at 11:17 AM, the following observations were made in the freezer in the Hydration Room on the 600 Hall: a. An opened box of taquitos that contained loose taquitos was in the freezer. The box was not covered, exposing the taquitos to possible freezer burn. b. An opened carton of vanilla ice cream was in the freezer. The ice cream was discolored. The Dietary Manager was asked to describe the appearance of the ice cream. He stated it was a little frost bit. It looks like it was melted and refrozen. 6. On [DATE] at 12:09 PM, the temperature of the corn beef when taken and read by Dietary [NAME] (DC) #4 on the steam table in the dining room kitchen on the 500 Hall was 126.8 degrees Fahrenheit. The meat item was not reheated before serving to the residents. The Dietary Manager stated the meat should have been reheated before serving. 7. On [DATE] 11:22 AM, the following observations were made during the noon meal service in the Kitchenette on the 500 Hall: a. DC#4, who was serving the lunch meal, wore gloves on her hands when she received bags of bread and bags of chips from the Dietary Manager and placed them on the counter by the steam table, untied the bags, picked up tray cards and placed them on the meal trays. Without changing gloves and washing her hands, she picked up plates from the plate warmer and placed them on the trays with her contaminated gloved fingers touching the inside of the plates. b. DC #4 still had not changed gloves or washed her hands before, using the same contaminated gloves, removing slices of bread from the bag. DC #4 placed the slices of bread on a plate and used tongs to place corn beef on one side of the bread, positioned the corn beef on top of the bread with her contaminated, gloved hand, then topped the corn beef with sauerkraut and remaining bread with her contaminated gloved hand to create a corn beef sandwich to be served to the residents for lunch. c. On [DATE] at 12:26 PM, DC #4 stated she should have washed her hands (before touching food intended to be served to residents). 8. On [DATE] at 2: 40 PM, DC #5 was wearing gloves on her hands when she opened the refrigerator and removed a log of cheese and placed it on the counter, contaminating the gloves. Without changing gloves and washing her hands, she started to remove cheese from the original packet and place it in a container to be used when serving the supper meal. DC #5 was asked during an interview what she should have done after touching dirty objects, before handling clean equipment. DC # 5 stated, changed gloves and washed his hands (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On [DATE] 4:05 PM, DC #5 was wearing gloves on her hands when she picked up a box of clear plastic film and placed it on the counter. Without changing gloves and washing her hands, she 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 for who required pureed diets. DC #5 was asked during an interview what she should have done after touching dirty objects before handling clean equipment. DC # 5 stated, changed gloves and washed his hands. 10. A review of facility policy titled, Proper Hand Hygiene initiated 2017, provided by the Dietary Manager on [DATE] indicated, staff should wash their hands with soap and water in between gloves changes, when changing tasks, and after removing gloves and before putting in a fresh pair of gloves. 11. A review of facility policy titled, Food Storage: Dry Goods initiated 2023 provided by the District Manager on [DATE] indicated all food items will be stored in a manner appropriate and timely utilization based on the principle of first in first out inventory management.

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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. 51381 Based on observations, interviews, facility document review, and policy review, it was determined that the facility did not ensure that Enhanced Barrier Precautions (EBP) were carried out for 1 (Resident #31) of 4 sampled residents reviewed for Enhanced Barrier Precautions (EBP). The findings include: The significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/09/2025 indicated Resident #31 had a Staff Assessment for Mental Status (SAMS) score of 5 (indicating severely impaired cognitive skills). The MDS indicated that the resident had diagnoses of cerebrovascular accident (stroke), non-Alzheimer's dementia (a decline in the function of the brain), aphasia (the inability to speak), and a gastrostomy [PEG] (feeding tube going directly to the stomach). A) On 03/19/25 at 08:41 AM, Registered Nurse (RN) #3 was observed attempting medication administration via the PEG tube for Resident #31. Resident #31's room was observed to have signage to the right of the door, indicating the resident was on Enhanced Barrier Precautions (EBP). The EBP signage indicated the need for staff to put on Personal Protective Equipment (PPE), that included both a gown and gloves, when performing care for the Resident. PPE was observed to be available inside the room in plastic containers. Steps observed in the process performed by RN #3 were as follows: 1) Performed hand hygiene. 2) Prepped four medications 3) Performed hand hygiene 4) Put on gloves 5) Began the process to give the medications by pausing the tube feeding and manipulating the PEG, attempting to flush the tube with a syringe and/or pull back on the plunger. No gown was observed to have been put on by the nurse in this process. B) On 03/19/25 at 02:45 PM, RN #3 was observed performing a PEG tube residual check (the process of ensuring the Resident's stomach is not too full) for Resident #31. EBP signage was at the door and PPE was available in the resident's room in plastic containers. Steps observed in the process performed by RN #3 were as follows: 1) Performed hand hygeine 2) Put on gloves 3) Obtained syringe for checking residual (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4) Began the process to check for residual by pausing the tube feeding and manipulating the PEG and the syringe to check for residual. No gown was observed to have been put on by the nurse in this process. C) On 03/19/2025 at 02:49 PM an interview with RN #3 was conducted after care was completed. RN#3 was asked about the EBP signage for the resident. RN #3 immediately acknowledged they did not follow EBP by putting on a gown. RN #3 was asked why it is important for staff to carry out EBP for the resident. RN #3 answered that it was important because it [PEG] was an open portal into a body cavity. D) On 03/20/2025 at 10:07 AM the Medical Director (MD) was interviewed via telephone. The MD indicated that a resident with a PEG tube would be expected to have EBP. Also, the MD indicated that it was important for EBP to be followed to avoid infection and protect the resident. E) On 03/20/25 at 11:20 AM the Assistant Administrator was interviewed regarding EBP. The Assistant Administrator stated that it was expected for a resident with a PEG to have EBP because the purpose was dual fold - to prevent staff from transmitting microbes to the resident and vice versa. The Assistant Administrator was notified that observations were made of EBP not being carried out as directed by the signage posted at the resident's room. F) On 03/20/25 at 03:50 PM the Infection Preventionist (IP) was interviewed. The IP stated that it was expected for a resident with a PEG to have EBP because it was important to protect the resident when they had an indwelling device. G) The facility policy titled Enhanced Barrier Precautions, with a revised date of 06/01/2024, was reviewed and stated gloves and gowns should be used during high contact resident care activities done in a resident's room. In addition, a high contact activity list was provided within the policy that included Device care: feeding tube. H) The educational document titled In-Service Training on the topic Enhanced Barrier Precautions with a date of 01/13/2025 was reviewed. A phrase in the body of the document attached to the training stated EBP includes the use of gown and gloves during high-contact resident care activities. In the list of high-contact resident care activities was listed device care and use of feeding tubes. 50924