STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045421	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley Rehabilitation and Health Care Center	2600 N 22nd Street Rogers, AR 72756

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48390 Based on observations, interviews, record review, document review, and facility policy review, the facility failed to ensure a resident was free from abuse for 1 (Resident #5) of 3 sampled residents reviewed for abuse. Specifically, the facility failed to ensure Resident #5 was free emotional abuse. The Immediate Jeopardy began on 09/02/2024, when CNA #4 made inappropriate statements to Resident #5 when she walked into the shower room while Resident #5 was taking a shower with help of CNA #4. CNA #4 and showed an inappropriate picture to Resident #5. The facility failed to investigate this incident until 09/09/2024. The facility had failed to train staff in abuse and neglect. The findings included: The Administrator became aware of the alleged abuse on 09/09/2024 and completed an Office of Long Term Care (OLTC) Incident and Accident (I&A) Report on 09/09/2024 at 11:10 AM. The report indicated that the alleged abuse occurred on 09/02/2024 and indicated that Resident #5 was taking a shower with the help of Certified Nursing Assistant (CNA) #5 when CNA #4 entered the shower room and commented that Resident #5 had a nice butt. The report shows that steps taken during the investigation were as follows: Immediately suspended pending investigation. Abuse and Neglect in-service conducted and that Resident #5's family came to facility and was taking the resident out of facility for a couple of days to de-sensitize him. During this survey it was found that CNA #4 was working in the facility again and had worked on the hall where Resident #5 resided during the night (11:00 PM-7:00 AM) on 10/31/2024. The Administrator and Director of Nursing Services were notified of the Immediate Jeopardy on 11/01/2024 at 1:46 PM. A Removal Plan was requested. Removal Plan was accepted on 11/04/2024. These are the findings: A Review a facility policy titled, Abuse and Neglect Policy and Procedure, revised on 11/20/2017, indicted, Guidelines will be established to protect residents from individuals that have allegedly committed abuse or have shown indication that would cause abuse. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/04/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #5's care plan initiated on 03/24/2020, revealed the resident had an Activity of Daily Living (ADL) self-care performance deficit. Interventions included the resident could perform most ADL functions with one person supervision with limited assistance. Review of a Progress Note, dated 09/08/2024, indicated Resident #5 was upset regarding a situation that occurred earlier in the week with a staff member. Resident #5 had a nightmare last night about the incident and was not in a good mood and didn't want to leave his room. Review of a Progress Note, dated 09/09/2024, indicated that Resident #5 was observed leaving activities and being upset. Resident #5 was observed holding his left wrist to his mouth and biting it causing it to bleed and leaving a bite mark. A review of CNA #5's, OLTC Witness Statement dated 09/09/2024 at 9:55 PM, indicated the following: A co-worker (CNA #4) entered the shower room and made comments to Resident #5 that were inappropriate, and Resident #5 was traumatized by the incident. A review of Resident #5's, OLTC Witness Statement dated 09/09/2024 indicated the following: Resident #5 was taking a shower with the help of CNA #5 when CNA #4 entered the shower room and told resident he had a big, beautiful butt and that she had a big, beautiful butt and proceeded to show the resident a picture on her phone. During an interview on 10/31/2024 at 11:45 AM, the Administrator indicated that he was made aware of the situation and asked his Director of Nursing (DON) to talk to the Resident. The Administrator advised that he was going to suspend CNA #4 over this incident pending the investigation, but CNA #4 was involved in an automobile accident, so the Administrator used this time as her suspension. During an interview on 10/31/2024 at 11:45 AM, the Administrator indicated that he rehired CNA #4 and part of the plan to keep Resident #5 safe was that CNA #4 was to not work on the hall were Resident #5 resided or go into Resident #5's room. The Administrator was asked if CNA #4 worked last night (10/31/2024) and what hall she was assigned to. The Administrator indicated that CNA #4 did work last night (11:00 PM-7:00 AM shift) and that she was assigned to the hall Resident #5 resided on. The Administrator was asked why CNA #4 was assigned to the hall, where Resident #5 resided. The Administrator indicated that if CNA #4 did not work last night, he would not have had enough staff. During an interview on 11/01/2024 at 11:55 AM, the Surveyor spoke with Resident #5. Resident #5 was asked if anyone at the facility had upset the resident. Resident #5 indicated that CNA #4 showed the resident a picture and the resident didn't like it. When asked what the picture was of, Resident #5 indicated her (CNA #4) body with no clothes on her butt. Resident indicated while taking a shower with the help of CNA #5, CNA #4 walked into the shower room where the resident was taking a shower and told Resident #5 that the resident had a big, beautiful butt, and asked the resident if the resident wanted to see her big, beautiful butt. Resident #5 indicated that CNA #4 proceeded to show the resident a picture on her phone of herself with no clothes on her butt. Resident #5 indicated the resident didn't like it and wanted CNA #4 to leave. Resident #5 indicated a few days later the resident was coming out of an activity, and saw CNA #4, and it frustrated the resident so much that the resident bit himself hard on the wrist to the point the resident's wrist bled. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 11/01/2024 at 12:18 PM, the Administrator indicated that CNA #4 was never terminated, that they deemed her as self-terminated. The Administrator indicated that she was never taken out of the computer system, so they didn't have a re-hire date for CNA #4. The Administrator indicated that since CNA #4 was not a rehire, they didn't complete new background checks on her. The Administrator indicated that the facility did not have a policy on rehire of an employee. Removal Plan was accepted on 11/04/2024. The facility will ensure resident safety at all times. 1. Resident #5 was interviewed by social services director on 11/01/2024 and requested to talk to a psychiatrist and have a psychiatric evaluation. Evaluation is scheduled for 11/12/2024. Resident #5 currently attends a day group program at Ozark Community Hospital with a psychiatric Advanced Nurse Practitioner 2 times a week. 2. All current and future admitted residents will have a safety provided at all times. 3. CNA #4 has been terminated as of 11/01/2024. DON/Designee will in-service all staff on abuse and neglect as well as psychosocial well-being starting 11/01/2024 all will continue to in-service all employees prior to next start of shift. 4. This in-service will be done will all new hires and at least annually. 5. Any behaviors documented on resident #5 will be reviewed daily in stand-up ensuring that resident feels safe, and needs are being met. QA committee will monitor 3 x weekly in morning meeting to ensure new hire education on Abuse, neglect and psychosocial well-being will be reviewed, to ensure employees received education. All staff will be reviewed annually. Onsite Verification: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The IJ was removed on 11/18/2024 at 2:16 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 11/01/2024 at 2:00 PM when the Social Services Director interviewed Resident #5. Resident #5 had; a follow up psychiatrist appointment for evaluation scheduled, continued participation with a day program for counseling two times a week, and behavior monitoring with documentation every shift which was reported in the facility's morning meeting. The facility terminated CNA #4. The facility provided abuse, neglect, and psychological well-being in-service to all current staff and new hires; the Quality Assurance (QA) committee monitored three times a week employee in-service education. A total of 14 staff interviews were conducted with staff from all positions to verify training had been completed. The staff interviewed included Certified Nursing Assistants, Licensed Practical Nurses, a Registered Nurse, an Occupational Therapist, the Maintenance Supervisor, the Activities Director, and the Director of Nursing. The staff interviewed verified they had been trained on Abuse and Neglect. A review of in-service sheets provided indicated 47 of 64 staff had been provided training. Those staff who were not physically present to receive the in-services were messaged via telephone by the Administrator, with the in-service information provided and the employee acknowledging receipt and voicing understanding.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 48390 Based on observation, record review, and interviews, it was determined that the facility failed to ensure established abuse policies and procedures were implemented after receiving an allegation of abuse for 1 (Resident #5) of 3 sampled residents for the implementation of abuse prohibition policies and procedures, that resulted in facility and contract staff, involved in allegations of abuse, to remain in the facility and to have continued contact with residents. Findings include: A review of a facility document titled, Abuse & Neglect Policy and Procedure, revision date 11/20/2017, indicated, The facility will implement procedures and TRAIN staff to PROTECT, RESPOND, REPORT & INVESTIGATE any allegations, suspicions or witnessed abuse. Guidelines will be established to protect residents from individuals that have allegedly committed abuse or have shown indication that would case abuse. A review of the Abuse and Neglect in-service dated 09/09/2024 showed that seven (7) people were in-serviced, and none were Certified Nursing Assistants (CNA), direct care staff. A review of the Incident & Accident (I & A) Report completed by the Administrator on 09/09/2024 indicated the incident occurred on 09/02/2024. A review of Progress Note, for Resident #5 from the electronic record indicates on 09/08/2024 Resident was very upset about a situation that occurred earlier in the week with a staff member, one that has been addressed by management per res. Resident indicated that he had a nightmare about the incident and he is just not in a good mood and is worried his roommate is upset with him due to roommate had to wake him up from the nightmare. Resident indicated that the situation with the staff member had been addressed by management A review of Progress Notes for Resident #5 from the electronic record indicates on 09/09/2024 at 10:45 AM, Nurse observed resident shouting, agitated and left the activity abruptly. As resident was leaving activity room, he held his left wrist to his mouth and bit down on his wrist hard enough to cause it to bleed and leave a bite mark. Resident indicated he bit himself because he was agitated. During an interview on 11/01/2024 at 11:45 AM, the Administrator indicated that he was made aware of the situation and asked his Director of Nursing (DON) to talk to the Resident. The Administrator advised that he was going to suspend CNA #4 over this incident pending the investigation, but CNA #4 was involved in an automobile accident, so the Administrator used this time as her suspension. The Administrator indicated one of the conditions of CNA #4 coming back to work was that she was not to work on the hall where Resident #5 resides or go into Resident #5's room. During an interview on 11/01/2024 at 11:45 AM, with the Administrator, it was discovered that CNA #4 worked the 11:00 PM to 7:00 AM shift on 10/31/2024, on the hall where Resident #5 resides. The Administrator was asked why CNA #4 was allowed to work on that hall. The Administrator indicated that he would not have enough staff if CNA #4 would not have worked. The Administrator would not elaborate why CNA #4 could not have worked another hall. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/01/2024 at 11:55 AM, the Surveyor spoke with Resident #5. Resident #5 was asked if anyone at the facility had upset the resident. Resident #5 indicated that CNA #4 showed the resident a picture and the resident did not like it. The Surveyor asked Resident #5 what the picture was of. Resident #5 indicated her body with no clothes on her butt. Resident #5 indicated while taking a shower with the help of CNA #5, CNA #4 walked into the shower room where the resident was taking a shower and told Resident #5 that the resident had a big, beautiful butt and asked the resident if the resident wanted to see her big, beautiful butt. Resident #5 indicated that CNA #4 proceeded to show him a picture on her phone of herself with no clothes on her butt. Resident #5 indicated that he did not like it and wanted CNA #4 to leave. Resident #5 indicated a few days later the resident was coming out of an activity and saw CNA #4 and it frustrated the resident so much that the resident bit himself hard on the wrist to the point the resident's wrist bled. During an interview on 11/01/2024 at 12:18 PM, the Administrator indicated that CNA #4 was never terminated, that they deemed her as self-terminated. The Administrator indicated that she was never taken out of the computer system, so they did not have to rehire CNA #4. The Administrator indicated that since CNA #4 was not a rehire, they didn't complete new background checks on her. During an interview the Administrator indicated that the facility did not have a policy on rehiring an employee. Review of Resident #5's Medical Diagnosis, reported diagnoses of unspecified mood disorder, unspecified mental disorder due to known physiological condition, primary generalized Osteoarthritis arthritis, hypertension, abnormalities of gait and mobility, type 2 diabetes mellitus without complications, unsteady on feet. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/04/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment. A review of Resident #5's care plan, revised, revealed the resident had an activities of daily living self-care performance deficit. Interventions included the Resident can self-perform with assistance when needed for bathing/showering.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925 Based on record review, interview and facility policy review, the facility failed to ensure a written discharge summary (dc) included a condensed summary of the stay in the facility and course of treatment, a reconciliation of medications, and resident status at discharge for 1 (Resident #61) sampled resident reviewed for a discharge. The findings are: On 10/29/2024, Resident #61's discharge summary, dated 08/10/2024, was reviewed and and indicated the resident was admitted on [DATE] and discharged home with family on 08/10/2024. The summary of stay indicated the resident attended physical, occupational, and speech therapy and a wound dressing on the right foot was changed accordingly. There was no indication of the resident's pre- and post- discharge medications, or the resident's status at discharge. There was no physician's signature on the form. On 11/01/2024 at 6:55 PM, the Director of Nursing was interviewed with concurrent observations, and she stated the nurses were responsible for completing the dc summary when the resident was discharged . She reviewed Resident #61's dc summary form and stated the form only included part of the resident's stay and should have indicated the disposition of the resident's medications and belongings. She stated the physician had not signed the form and the medical records [department] was responsible for getting the discharge summary signed by the physician. A Discharge/Transfer of Resident policy, not dated and provided by the Administrator on 11/01/2024, was reviewed and indicated a discharge summary and post discharge plan of care form was to be completed. The policy indicated the dc summary should include a list of medications with instructions in simple terms, instructions for post discharge care, have the resident/resident representative sign the form and the signed original form should be placed in the medical record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 37925 Based on observations, interview, and record review, the facility failed to ensure baths/showers were provided to residents on their scheduled days to promote good personal hygiene and grooming for 1 (Resident #29) sampled resident reviewed for personal hygiene and grooming. The findings are: On 10/28/2024 at 3:42 PM, Resident #29 was interviewed and stated the resident believed the daytime [shift] was understaffed because residents do not receive showers as they should. Resident #29 stated the resident's scheduled bath/shower days were Tuesday, Thursday, and Saturday. Resident #29 stated the resident did not receive a shower on Saturday, 10/26/24, due to the facility on ly had one Certified Nursing Assistant (CNA) working the hall the resident resided. The resident alleged the facility only two CNAs working in the building some nights. A review of Resident #29's medical diagnoses indicated a lung condition which caused difficulty breathing (chronic obstructive pulmonary disease) and a condition which caused the muscles on one side of the body to be contracted (spastic hemiplegia affecting right dominant side). An annual Minimum Data Set with an Assessment Reference Date of 09/07/2024, was reviewed and indicated Resident #29 had a Brief Interview for Mental Status score of 15, which indicated cognitively intact and required substantial/maximal assistance with shower/bath activity. A care plan, revised 09/29/2024, was reviewed and indicated Resident #29 had a deficit in performing activities of daily living (ADLs) and required extensive assistance of one person with bathing/showering as necessary. The grievance logs, provided by the Administrator on 10/28/2024, were reviewed and indicated multiple grievances were filed in August 2024, September 2024 and October 2024 concerning residents not receiving baths/showers on their scheduled days. Resident #29's ADL task, offer bathing every Tuesday, Thursday, Saturday days and as needed, was reviewed and the following was indicated: the resident was totally dependent for this task on 10/05/2024, 10/08/2024, 10/12/2024, 10/24/2024 and was not applicable on 10/26/2024. The Shift Staffing Schedule for the 7:00 AM to 3:00 PM shift on 10/26/2024 was reviewed and indicated halls 100, 200 and 300 had one CNA scheduled for each hall. Hall 300 had one CNA in orientation, totaling 2 CNAs. At 11:00AM, two CNAs were scheduled to come in, one for hall 100 and one for hall 200. On 10/31/2024 at 12:10 PM, the Director of Nursing (DON) provided Bath/Shower Sheet documents for the following dates: 9/3/24 indicated a bed bath, 9/12/24 indicated a shower, 10/15/24 indicated shower and 10/24/24 indicated a shower. She stated those were all the bath sheets she could find. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/01/2024 at 6:55 PM, the DON was interviewed and stated CNAs were responsible for providing resident showers. She stated Human Resources had been helping to ensure bath/showers were done. She stated there were grievances filed regarding the residents not receiving their baths/showers and would have to look at the grievances before stating how the facility addressed the issue. She stated the nursing staff had been in-service/educated on bathing/showering the residents and Social had done the in-services on this task

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48977 Based on record review, interview, and facility policy review the facility to administer Cardiopulmonary Resuscitation (CPR) upon discovering 1 (Resident #62) sampled resident pulseless and breathless despite the resident being a full code. The Facility notified of the Immediate Jeopardy on [DATE] at 1:40 PM. The Facility Plan of Removal (POR) noted the facility will continue CPR upon discovering a resident pulseless and breathless when the resident is a full code signed [DATE]. The findings include: According to the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] Resident #62 had a Brief Interview of Mental Status of 15 indicating cognitively intact. Resident #62 had diagnoses of heart failure and morbid obesity. A review of the plan of care for Resident #62 (initiate date: [DATE]) noted Resident #62 was full code if found pulseless and breathless imitate CPR until emergency medical services (EMS) arrive to take over. Resident #62's family signed a Physician Order for Life Sustaining Treatment (POLST) on [DATE] electing to receive CPR if needed. A review of a Health Status Note date [DATE] revealed about 6:19 AM Resident #62 discovered pulseless and breathless. Resident #62 was assessed by two other nurses in building. EMS was called and arrived 6:25 AM. EMS initiated CPR with 5 rounds of epinephrine, but no signs of life was found. Physician was called and updated on the resident status. A review of the medical records showed the last vital signs recorded was on [DATE]. The was no documentation within the medical records that CPR was initiated, or vital signs were taken on [DATE] when Resident #62 was found breathless and pulseless. On [DATE] at 8:50 AM, during an interview the Director of Nursing (DON) stated the Resident #62 was a full code and plan of care noted if the resident was found pulseless and breathless administer CPR until emergency personnel arrive to take over. The DON stated there was no documentation that CPR was administered. On [DATE] at 09:45 AM, the Surveyor requested the facility policy or procedure on when to initiated or withhold CPR. On [DATE] at 10:00 AM, the Surveyor was provided a policy on CPR administration. On [DATE] at 10:25 AM, the Surveyor requested the facility policy or procedure on when to withhold CPR. The Surveyor specifically asked for something stating the circumstances on when staff should not administer CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:00 AM, the DON stated the facility does not have a policy and procedure on when CPR should be withheld. On [DATE] at 12:22 PM, during an interview the EMS dispatcher stated the EMS report noted when EMS arrived two staff members standing at the resident bedside not administering CPR and one of the staff members stated she had received an order to withhold CPR for the physician. On [DATE] 04:45 PM, the Director of Nursing stated that the nurse called the Physician that morning and he gave orders to withhold CPR. On [DATE] at 8:44 AM, during an interview the Physician stated he does not remember giving an order to withhold CPR for Resident #62 on [DATE]. On [DATE] at 12:37 PM, during an interview Licensed Practical Nurse (LPN) #8 stated she was coming on shift and when she entered the Resident #62's room [ROOM NUMBER] nurses were standing at the resident bedside no one was administering CPR. LPN #8 stated she touched the resident, and the resident was cold to touch so she called Physician and informed him the resident was cold to touch with no vitals. LPN #8 stated did Physician did not give any orders. LPN #8 stated she did not get vital signs, nor did she observe the resident's vital being taken. LPN #8 stated shortly after the Physician was called EMS arrived and initiated CPR. A policy titled Cardiopulmonary Resuscitation noted begin chest compression if the resident is not breathing. Onsite Verification: The IJ was removed on [DATE] at 2:16 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on [DATE] at 2:48 PM when a cardiopulmonary (CPR) in-service was initiated by the Director of Nursing (DON). DON reviewed all physician orders, care plans, and signed Do Not Resuscitate (DNR) documents for code status. Color coded name plates were placed outside resident doors, green for full code and red for DNR. An in-service was provided to staff and new hires regarding color coded name plates and monthly Quality Assurance and Performance Improvement (QAPI) is to ensure continued employee education. A total of 14 staff interviews were conducted with staff from all positions to verify training had been completed. The staff interviewed included Certified Nursing Assistants, Licensed Practical Nurses, a Registered Nurse, an Occupational Therapist, the Maintenance Supervisor, the Activities Director, and the Director of Nursing. The staff interviewed verified they had been trained on CPR initiation and how to identify DNR or full code residents. A review of in-service sheets provided indicated 34 of 64 had been provided training. Those staff who were not physically present to receive the in-services were messaged via telephone by the Administrator, with the in-service information provided and the employee acknowledging receipt and voicing understanding.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48977 Based on observations and interviews the facility failed to ensure lint traps were free from excessive lint build up. The findings include: On 10/30/2024 at 08:34 AM, the Surveyor did an inspection of the clothes dryer and found all three with excessive lint build up. The Surveyor noted a clip board hanging on the wall next to the clothes dryer last entry dated 10/29/24. On 10/30/24 at 08:45 AM, the Housekeeping Supervisor stated the lint was removed from the lint traps after every 3 loads of laundry and documented on the clipboard hanging on the wall. The Housekeeping Supervisor stated there was two shifts morning and evening, and the last entry was done by the morning on the previous day. The Housekeeping Supervisor stated the lint traps looked like they have not had the lint removed which could cause a fire. On 10/31/24 at 1:38 PM, the Housekeeping Supervisor stated she had spoken to the employee who worked the evening shift on 10/29/24 and the employee stated she did enter an entry because she did not remove the lint from the lint traps. The facility provide a policy titled Fire Policy and Procedure which did not pertain anything pertinent to the failed practice.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48977 Based on observations, interviews, record review, and facility policy review the facility failed to ensure 1 (Resident #57) sampled resident received proper incontinence care and the incontinence care was done in a timely manner. The findings include: A review of the quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 9/10/2024 revealed Resident #57 had memory problems and was frequent incontinent of bowel and bladder. Resident #57 had diagnoses of Alzheimer's disease and non-Alzheimer's dementia. A plan of care for Resident #57 (revision on: 3/07/2024) revealed Resident #57 had (urge, stress) bladder incontinence related to r/t activity intolerance, Alzheimer's disease, confusion, dementia, and impaired mobility. An intervention in place noted ensure the resident has unobstructed path to the bathroom. On 10/30/24 at 08:20 AM, the Surveyor observed Resident #57 sitting in wheelchair in hallway common. On 10/30/24 at 10:08 AM, the Surveyor observed Resident #57 sitting in wheelchair in hallway common area. On 10/30/24 at 11:45 AM, the Surveyor observed staff member push Resident #57 in wheelchair to the dining room for meal service. On 10/30/24 at 2:00 PM, the Surveyor observed Resident #57 sitting in wheelchair in hallway common area. On 10/30/24 at 02:15 PM, the Surveyor observed Certified Nursing Assistant #4 and #7 provide incontinence care to Resident #57 who had been incontinent of bowel and bladder. CNA #7 did not clean all areas of the perineal and buttock exposed to urine. On 10/30/24 at 02:30 PM, CNA #7 stated Resident #57 pants were wet at the time removed from the resident. CNA #7 stated she did not certain parts of Resident #57's perineal area CNA #4 stated to CNA #7 you are supposed to wipe anywhere urine touches. On 10/31/24 at 8:50 AM, the Surveyor asked the Director of Nursing (DON) stated staff should clean every surface of the perineal area because not cleaning could cause skin breakdown, bacteria build up and/or urinary tract infection. A policy titled Incontinence Care noted the purpose of incontinence care was to keep skin clean, dry, and free of irritation and odor, prevent skin breakdown, and prevent infections.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 48977 Based on observation, interviews, and record review the facility failed to ensure bed rails were in use only after an assessment for risk of entrapment was completed for 1 (Resident #57) sample resident. The findings include: A review of the quarterly Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 9/10/2024 revealed Resident #57 had memory problems and was frequent incontinent of bowel and bladder. Resident #57 had a diagnoses of Alzheimer's disease and non-Alzheimer's dementia. Resident #57 did not use side rails. A plan of care for Resident #57 (revision on: 3/07/2024) revealed Resident #57 had (urge, stress) bladder incontinence related to r/t activity intolerance, Alzheimer's disease, confusion, dementia, and impaired mobility. An intervention in place noted ensure the resident has unobstructed path to the bathroom. On 10/30/24 at 02:15 PM, the Surveyor observed Certified Nursing Assistant #7 lower the left side rail between the resident and the bathroom after care was done. CNA #7 stated to CNA #4 Resident #57 get up on the left side of the bed. On 10/31/24 at 8:50 AM, the Director of Nursing (DON) stated side rails should not be used but it's only entrapment when it restrains them from moving. After observing the side rails on the resident's bed DON stated the side rail does restrain the resident from moving freely and obstruct the resident's path to the restroom. DON stated the there was no assessment for entrapment completed prior to the use of side rails.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 37925 Based on interview and record review, the facility failed to ensure there was sufficient nursing staff to meet the residents' needs for 7 shifts reviewed from 09/01/2024 through 09/30/2024. On 10/28/2024 at 3:42 PM, Resident #29 was interviewed and stated the resident believed the daytime [shift] was understaffed because residents do not receive showers as they should. Resident #29 stated the resident's scheduled bath/shower days were Tuesday, Thursday, and Saturday. Resident #29 stated the resident did not receive a shower on Saturday, 10/26/24, due to the facility on ly had one Certified Nursing Assistant (CNA) working the hall the resident resided. The resident alleged the facility has two CNAs working in the building some nights. The grievance logs, provided by the Administrator on 10/28/2024, were reviewed and indicated multiple grievances were filed in August 2024, September 2024 and October 2024 concerning residents not receiving baths/showers on their scheduled days. The nursing staffs' schedules and timecards, provided by the Administrator, were reviewed and indicated the following: -09/01/2024 shift staffing schedule indicated CNA #10 and CNA #11 were scheduled to work the night shift, 11:00 PM to 7:00 AM (11p/7a). Registered Nurse (RN) #12 and RN #13's employee time sheets were reviewed and indicated both staff worked the night shift, totaling 4 staff members. -09/02/2024 shift staffing schedule indicated CNA #10 and CNA #11 were scheduled for the 11PM to 7AM shift. RN #13 and Licensed Practical Nurse (LPN) #15 employee time sheets indicated both staff worked the night shift, totaling 4 staff members. -09/04/2024 employee time sheets for CNA #10, RN #13 and LPN #15 indicated all 3 staff members worked 11p/7a. CNA #5 and CNA #11 employee time sheets indicated both staff worked 11p to 3:00 AM, leaving 1 CNA and 2 nurses after 3 AM for the rest of the shift. -09/11/2024 shift staffing schedule indicated CNA #10 was scheduled to work. Employee time sheets indicated LPN #15 and RN #13 both worked 11p/7a, totaling 3 staff members. -09/15/2024 there were no CNAs in the facility for the 11p/7a shift. RN #12, RN #13, LPN #19 and LPN #21 employee time sheets indicated all four staff members worked 11p/7a shift. CNA #10 was removed from the CNA schedule on 09/15/2024 through 10/12/2024 for the 11p/7a shift. -09/16/2024 employee time sheets indicated LPN #15, LPN #21 and RN #13 worked the 11p/7a shift, totaling 3 staff members. LPN #8's time sheet indicated she worked 11p to 2:00 AM (2 hours). -09/17/2024 employee time sheets indicated RN #13 and LPN #15 worked the 11p/7a shift, totaling 2 staff members. There was no shift staffing schedule sheet provided. The CNA schedule for 09/17/2024 did not list any CNAs. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/30/2024 at 11:50 AM, CNA #4 was interviewed by another surveyor and stated often there is one aide on the hall with a float to help with the lift transfers and does not feel there is enough time to get work done. She stated she is unable to complete the scheduled showers on the halls when she works alone. She stated if the resident had a shower the previous shower day, she does not give that resident a shower. On 10/31/2024 at 3:30 PM, LPN #8 was interviewed by another surveyor and stated often there are only 2 nurses scheduled to work a shift. She stated there is not enough time for her to complete her work when there are only 2 nurses scheduled. The Facility Assessment, provided by the Administrator on 10/28/2024 and dated 08/08/2024, was reviewed and did not indicate what the facility's contingency plan was for staff. On 11/01/2024 at 7:21 PM, the Administrator was interviewed and stated the facility was trying to hire more CNAs, but he did not indicate what was being done to retain them.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 37925 Based on observation, interview, and record review, the facility failed to post the daily nurse staffing information, to include the facility name, the current date, the number and actual hours worked by staff, and the resident census. The deficient practice had the potential to affect all residents. The total census was 60. A Shift Staffing Schedule, dated 10/28/2024 for the 7:00 AM to 3:00 PM shift, was reviewed and did not have the facility's name, the number and actual hours worked by staff, the resident census or the licensed staff scheduled to work. The shift staffing schedule, dated 10/28/2024 for the 11:00 PM to 7:00 AM shift, was reviewed and only one Certified Nursing Assistant's (CNA's) name was listed on the sheet. On 11/01/2024 at 6:40 PM, the Director of Nursing (DON) was interviewed by another surveyor about the nurse staffing. The surveyor indicated the DON stated the staffing sheets, which included the facility name, date, census and total and actual number of hours worked per shift for nursing staff, were no longer required and therefore were not done.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 37925 Based on observation, interview and record review, the facility failed to ensure medication was available during a medication administration observation for 1 (Resident #46) of 11 residents who received medications from 3 Licensed Practical Nurses (LPNs) and 2 Registered Nurses (RNs). The findings are: On 10/31/2024 at 8:03 AM, LPN #8, was retrieving Resident #46's medications from hall 100 medication cart. She looked through the medication cart and stated there was no Lactulose and she would need to call the pharmacy. On 10/31/2024 at 4:50 PM, RN #9 was at the medication cart for hall 100 and he was asked to check if lactulose was on the cart for Resident #46. He looked through the medication cart and retrieved a small bottle of lactulose but stated the bottle was for another resident and there was no lactulose in the cart for Resident #46. He stated Lactulose was not in a stock bottle and each resident would have an individual bottle. Resident #46's Order Summary Report was reviewed and indicated Lactulose oral solution 20 grams (GM)/30 milliliters (ML) and to give 20 ml by mouth two times a day for constipation. Resident #46's electronic medication administration record (eMAR) was reviewed and indicated Lactulose 20 gm/30 ml and give 20 ml by mouth two times a day. On 10/30/2024 and 10/31/2024 at 0800 (8:00 AM), the number 9 was inside a box. The chart codes for the number 9 indicated other/see progress notes. Resident #46 progress notes were reviewed and an Administration Note, dated 10/30/2024 at 08:46 (8:46 AM), was reviewed and indicated Lactulose was out of supply and the staff was waiting for the medication to be delivered from the pharmacy. An administration note, dated 10/31/2024 at 12:04 (12:04 PM), was reviewed and indicated the staff was waiting for the medication to be delivered from the pharmacy. The resident did not receive the scheduled 8:00 AM dose of Lactulose. On 11/01/2024 at 6:55 PM, the Director of Nursing (DON) was interviewed and stated the nurses were responsible for ordering refills for the residents' medications. She stated she makes a list of the over-the-counter medications, and the Administrator orders those medications from the company. A Medication, Administration Guidelines policy, not dated and provided by the Administrator on 11/01/2024, was reviewed and indicated the complete act of administration involved removing an individual dose from a previously dispensed, properly labeled container, verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the information.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 37925 Based on observation, record review and interview, the facility failed to ensure the medication error rate was less than 5 percent (%) during the medication administration observation of 2 (Residents #7 and #46) of 11 residents who received medications from 2 Registered Nurses (RNs) and 3 Licensed Practical Nurses (LPN). 27 opportunities of medication administration were observed and 2 of the 27 medications were not administered in accordance with physician's orders, resulting in a medication error rate of 7.41%. The findings are: On 10/31/2024 at 8:03 AM, LPN #8, was retrieving Resident #46's medications from hall 100 medication cart. She looked through the medication cart and stated there was no Lactulose and she would need to call the pharmacy. At 4:50 PM, RN #9 was at the medication cart for hall 100 and he was asked to check if lactulose was on the cart for Resident #46. He looked through the medication cart and retrieved a small bottle of lactulose but stated the bottle was for another resident and there was no lactulose in the cart for Resident #46. He was asked if the lactulose would be in a stock bottle for all the residents or if the resident would have an individual bottle. He stated the resident would have an individual bottle. Resident #46's Order Summary Report was reviewed and indicated Lactulose oral solution 20 grams (GM)/30 milliliters (ML) and to give 20 ml by mouth two times a day for constipation. Resident #46's electronic medication administration record (eMAR) was reviewed and indicated Lactulose 20 gm/30 ml and give 20 ml by mouth two times a day. On 10/30/2024 and 10/31/2024 at 0800 (8:00 AM), the number 9 was inside a box. The chart codes for the number 9 indicated other/see progress notes. Resident #46 progress notes were reviewed and an Administration Note, dated 10/30/2024 at 08:46 (8:46 AM), was reviewed and indicated Lactulose was out of supply and the staff was waiting for the medication to be delivered from the pharmacy. An administration note, dated 10/31/2024 at 12:04 (12:04 PM), was reviewed and indicated the staff was waiting for the medication to be delivered from the pharmacy. The resident did not receive the scheduled 8:00 AM dose of Lactulose. On 10/31/24 at 7:45 AM, LPN #7 prepared Resident #7's 8:00 AM medications. During the medication preparation, LPN #7 was observed placing one capsule from a bottle of Probiotic capsules into a pill cup. After she placed all the medications in the pill cup, she was asked how many pills she had, and she verbalized there were 5 pills and one capsule. Resident #7's Order Summary Report was reviewed and indicated an order for Saccharomyces Boulardil capsule 250 milligrams (mg) and to give 2 capsules one time a day for probiotic. On 10/31/2024 at 9:42 AM, LPN #7 was interviewed with concurrent observations and she confirmed she placed 1 probiotic capsule in Resident #7's pill cup prior to administering the resident's medications. She was asked to review the resident's electronic medication administration record (eMAR), and she stated, Oh no. I see it now. It [the order] shows 2. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Medication, Administration Guidelines policy not dated and provided by the Administrator on 11/01/2024, was reviewed and indicated it is the purpose of the facility that residents receive their medications on a timely basis and in accordance with established policies. On 11/01/2024 at 6:55 PM, the Director of Nursing (DON) was interviewed and stated the nurses were responsible for ordering refills for the residents' medications. She stated she makes a list of the over-the-counter medications, and the Administrator orders those medications from the company.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 food items were prepared and served according to planned written menu for 1 of 2 meals observed. The findings are: 1. On 10/28/2024, the menu for noon meal indicated residents Minced Moist Soft diets were to receive 2#8 scoops (1cup) of chicken spaghetti, 1/2 cup of mash soft vegetables and residents on pureed diets were to receive 2#8 scoops (1 Cup) of pureed chicken spaghetti 2. On 10/28/24 at 12:34 PM, the following observations were made during the noon meal service. a. The DC #1 used a 6-ounce ladle (3/4 cup) to serve chicken spaghetti to the residents on Minced Moist soft diets, instead 2 #8 scoops which is equivalent to 1 cup. b. Residents on Minced Moist Soft diets were served pureed vegetable blend, instead of soft mash vegetables. c. The DC #1 used a #6 scoop (2/3 cup) to serve pureed chicken spaghetti to the residents on pureed diets, instead of 2#8 scoops which is equivalent to 1 cup.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, record review, interview, and facility policy review, the facility failed to ensure food items stored in the freezer, refrigerator and dry storage areas were covered or sealed; expired food items were promptly removed/discard by the expiration or use by dates as when it was delivered,; 1 of 1 ice machines was maintained in clean and sanitary condition, staff washed their hands, and dietary staff washed their hands and between clean tasks when contaminated. The findings are: 1. On [DATE] at 10:54 AM, the following observations were made on a shelf in the walk-in freezer. a. An opened box of cookie dough. The box was not covered or sealed. b. An opened box of garlic bread sticks. The box was not covered or sealed. c. An opened box of Salisbury steak. The box was not covered or sealed. d. An opened container of sugar was under the food preparation counter with no lid on it. e. An opened container of flour was under the food preparation counter. There was no lid on it. The Dietary Manager confirmed the containers should have been covered. 2. The following observations were made on the spice rack in the kitchen. a. An opened container of cinnamon had best used by [DATE]. b. A container of ground ginger with best used by [DATE]. c. An opened container of mustard had an expiration date of [DATE]. d. Two opened containers of poultry seasoning with an expiration date of [DATE]. f. [DATE] 10:57 AM, the following observations were made on a shelf below the food preparation counter. i). An opened gallon of soy sauce. The manufacture specification on the bottle indicated to refrigerate after opening ii). A can of coffee with an expiration date of [DATE]. iii) A container of cinnamon with an expiration date of ,d+[DATE]. iv. A container of poultry seasonings with an expiration date of [DATE]' (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On [DATE] at 11: 30 AM, the plastic panel on the right- and left side corners of the ice machine, close to the ice had wet black residue on them. The Dietary Manager was asked if she could wipe the wet black greasy residue. She did so, the black residue easily transferred to the tissue. The Dietary Manager interviewed stated they clean the machine every month and CNAs [Certified Nursing Assistants] use it for the water pitchers in the residents' rooms. confirmed the left, and the right-side corners of the ice machine panels close to the ice had wet greasy black residue close to the ice. 3. On [DATE] at 11:40 AM, the following observations were made in the refrigerator in the nourishment room leading to the 300-hall. A bottle of nutritional dink, there was no date when received or opened on the bottle. 4. A cup of spaghetti with meat sauce did not have a date of when it was opened or received. 5. An opened bottle of pineapple juice, there was no date when received or opened on the bottle. 6. A container of club sandwich and a container of toss salad, there was no date when received or opened on the containers. 7. A container of fried chicken, there was no name or date when received on the bag. 8. A clear bag that contained discolored spaghetti. The Dietary Manager confirmed it was discolored and old. 9 One carton of strawberry parfait, there no name or received date on the carton. 10. one carton of almond milk had expiration date of [DATE]. 11. A bowl of vegetable soup, there was no name or received date on the bowl. 12. A container of strawberry short cake, there was no name or received date on the container. It had [NAME] color and was melting. The Dietary Manager interviewed stated it is old and was melting. 13. An opened bag of dried fruits with an expiration date of,d+[DATE]. The bag had no name, no opened and or received date. 14. One container of carrot cake. was in the freezer; the container had no received date. 15. One container of turkey slices, the container had no name, no opened, and no received date on it. 16. One package of pepper cheese jack had no received or opened date on it. 17. On [DATE] at 11:45 AM, the following observations were made in the freezer. a. An opened box of burritos with beans and cheese, the box was not covered. b. One box blackened chicken Alfredo, there was no date when received on the bag. (continued on next page)

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	045421	A. Building B. Wing	11/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley Rehabilitation and Health Care Center	2600 N 22nd Street Rogers, AR 72756

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. One container of strawberry cheesecake, there was no name, no date when received or opened on the container. The Dietary Manager interviewed stated they supposed to write names, when received and when opened. 18. On [DATE] at 11:51 AM, the Dietary [NAME] #1 pushed a cart that contained clean dishes towards the food preparation counter and used a rag to wipe off spilled food. Without 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 on the pureed [NAME] diets for lunch. 19. On [DATE] at 12:23 PM, picked up the water hose with bare hands, used it to spray leftover food from inside of the blender. Dietary Aide (DA) #2 placed dirty dishes in the racks and pushed the rack into the dish washing machine to wash. After the dishes stopped washing, DA #2 moved to the clean side of the dishwasher area and picked up a clean blade and attached it to the base of the blender to be used in pureeing foods to be served to the residents who received pureed diets for lunch. DA #2 then picked up clean dishes and stacked them in a rubber container on the cart to be used in portioning food items to be served to the residents for lunch. DA #2 interviewed stated she should have washed her hands 20. On [DATE] at 12:26 PM, was on the tray line serving lunch meal, she picked up tray cards and placed them on the trays. Without washing hands, DC #1 picked up bowls and plates and placed them on the trays to be used in portioning food items to be served to the residents for lunch with her fingers inside of them. DC #1 interviewed stated she should have washed her hands. 21 On [DATE] at 12:30 PM, the Dietary Aide #2 was on the tray line 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 #2 picked up glasses that contained beverages by their rims and placed them on the meal trays to be served to the residents for lunch. 22. On [DATE] at7:09 AM, the Dietary Aide #3 was on the tray line assisting with breakfast meal service, picked up condiments, cartons of milk, shakes and placed them on the trays. At 7:17 AM, the Dietary Aide #3 removed supplements from the refrigerator and placed them on the trays. Without washing hands, DA #3 picked up glasses that contained beverages by their rims and placed them on the meal trays to be served to the residents for lunch. 23. On [DATE] at 10:33 AM, The DC #1 washed the blender bowl and blade in the 3-compartment sink. After washing them, she turned off the faucet with her bare hand. Without 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 who required pureed diets for lunch. At 10:34 AM When DC #1 was ready to put pork chops into the blender. The DC #1 interviewed stated she should you have washed hands. 24. On [DATE] at 10:45 AM, the Dietary Aide #3 removed a box of pie from the freezer and placed it on the counter. DA #3 removed gloves from the glove box and placed them on her hands, pulled her sleeves up, then removed cake from the original container and placed it on the cutting board, contaminating the gloves. Without changing gloves and washing her hands, DA #3 sliced the cake and placed them on the plates to be served to the residents for lunch. The DA #3 interviewed stated she should have washed her hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	25. A review of facility policy titled, Hand washing and Hand Hygiene, initiated 2018, provided by the Dietary Manager on [DATE] indicated, hands should be washed before, during and after food preparation.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 37925 Based on interview and record review, the facility failed to ensure a policy was developed and implemented pertaining to the governing body and failed to ensure the governing body was active in the development and implementation of the facility assessment. The findings are: The Facility Assessment, provided by the Administrator on 10/28/2024, was reviewed and missing necessary components. On 11/01/2024, the Administrator was interviewed, and stated no member of the governing body assisted with the completion of the facility assessment. He was asked to provide a policy for the governing body and documented on an extended survey list the facility did not have a policy for the governing body.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 37925 Based on record review and interview, the facility failed to ensure the facility assessment contained pertinent information to assure the necessary care and resources were allocated to meet the needs of the residents. This deficient practice had the potential to affect all residents of the facility. The total census was 60. The findings are: The Facility Assessment, dated as approved on 08/08/2024 and provided by the Administrator on 10/28/2024, was reviewed and indicated the purpose of the assessment was to determine what resources were necessary to care for the residents competently during day-to-day operations and emergencies. The facility assessment was missing the following components: -resident population -facility resources - facility-based and community risk assessment with an all-hazards approach - staff responsible for completing the assessment - staffing needs to ensure sufficient staff was available to meet the residents' needs - staff training/education and competencies - policies and procedures for provision of care - physical environment and building information - list of contracts and other third-party agreements - list of health information technology resources On 11/01/2024 at 7:21 PM, the Administrator was interviewed and stated he, the Administrator, was responsible for completing the facility assessment. He stated the purpose for the facility assessment was to assess how to care for residents, what training was needed for staff to adequately care for the residents, and to describe the resident population. He stated neither the governing body member or medical director had input in the completion of the facility assessment, and this was the first facility assessment he has completed.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 48390 Based on observations, interviews, record review and facility document review, it was deterred that the facility failed to ensure the Arbitration agreement contained all necessary components including the right to resend the agreement within the first 30 days of admission. The failed practice had the ability to affect all the residents who had signed the arbitration agreement. Findings include: A review of a facility admission agreement on 10/30/2024 at 3:30 PM, revealed, Arbitration, on page 5 section f, This provision for arbitration may be revoked by written notice delivered to the other parties within twenty-one (21) days of signature. The Administrator was provided a copy of the admission packet, on 11/01/2024 at 4:50 PM. The Administrator was asked to locate within the document the right to resend within 30 days. Administrator indicated the Arbitration Agreement may be revoked within 21 days. Administrator indicated the facility did not have a policy for arbitration.

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. 48390 Based on interview and record review, the facility failed to ensure the arbitration documentation includes the selection of a neutral arbitrator and a location that is convenient for all. The failed practice had the ability to affect all 47 residents who currently reside in the facility. The findings are: During an interview on 11/01/2024 at 4:50 PM, the Administrator was asked to identify the language in the Admission Agreement, page 5, section f, of the admission agreement that describes the process for selecting an arbitrator and the neutral location where the arbitration will take place. After examination the Administrator stated, I don't see it. During an interview the Administrator indicated that they did not have a policy for Arbitration. On 10/30/24 at 3:30 PM, a review of the facility arbitration agreement revealed that the facility's admission agreement, section f, pertains to Arbitration. During an interview on 11/01/24 at 4:50 PM, the Admission Director (AD) was asked to identify the language in section f. of the admission agreement that describes the process for selecting an arbitrator and the location where the arbitration will take place. After examination the AD stated, I don't see that in there. During an interview on 11/01/24 at 4:50 PM, the Surveyor asked the Administrator to locate in section f. of the admission agreement where it describes how an arbitrator, and a location is chosen. The Administrator stated, It's in the new part. I didn't see it in the admission agreement. During an interview on 11/01/24 at 4:50 PM, the Administrator reported that the facility has no policy pertaining to arbitration agreements.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 48977 Based on interviews, record review, and facility policy review the facility failed to implement consistent infection surveillance to prevent the spread of possible communicable diseases. The facility also failed to develop and implement a water management plan to prevent the growth and/or spread of waterborne pathogens. The findings include: On 10/30/2024 at 9:00 AM, a review of forms in the binder provided by the facility revealed incomplete forms title Infection Control data Source: infection Control Log analysis should include Trends & Root cause Analysis and blank diagram of the facility for each month. On 10/30/2024 at 3:00 PM, the Surveyor requested any material the facility had on its' water management plan for Legionella. On 10/30/2024 at 3:10 PM, the Administrator stated the facility does not have any policy, procedures, preventions, or management for legionella in place. On 10/30/24 at 03:20 PM, The Infection Control Nurse stated I remember learning about legionella, but I do not know if we have anything in place for it. The Infection Control Nurse stated there was not an infection surveillance process being done at the time. A policy titled Infection Prevention and Control Program noted a facility wide surveillance will be performed to identify opportunities to prevent and/or reduce the rate of infection in our residents, employees and visitors.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 48977 Based on interviews, record review, and facility policy review the facility failed ensure there was a consistent antibiotic stewardship to determine if the antibiotic is indicated or adjustments to the therapy should be made. The findings include: According to the admission Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 7/12/2024 Resident #215 had a Brief Interview of Mental Status (BIMS) score of 15 indication cognitively intact. A review of the order summary report Resident #215 had a diagnosis of cutaneous abscess of right foot and an order for an antibiotic to be given intravenous every 24 hours On 10/30/24 at 9:00 AM, a review of the forms in the binder provided by the facility revealed infection control assessment tools not completed for the months of August, September, and October. On 10/30/24 at 03:20 PM, the Infection Control Nurse stated the infection control assessment are not completed for the months August, September, and October. Infection Control Nurse stated I have no paper evidence that the facility has ensure the antibiotic was indicated or if adjustments should have been made. Infection Control Nurse stated I cannot say if the resident had a true infection if I am not doing the work to investigate. On 10/31/24 at 09:00 AM, the Director of Nursing stated I was told I cannot touch that. A policy titled Surveillance noted Antibiotic Stewardship Program (ASP) objectives were optimizing antimicrobial use for treatment and prophylaxis of infections among patients/residents to improve clinical outcomes, provide the most cost-effective treatment and reduce adverse events that are associated with antimicrobial use. Control antimicrobial resistance through proper use of antimicrobials. Reducing the occurrence of super bugs, which can often be multi-drug resistant.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 37925 Based on interview and record review, the facility failed to ensure required annual in-service trainings were performed to ensure staff received the required information/education needed to care for residents. The findings are: On 11/01/2024, the Administrator was asked to provide the in-services for the past 12 months conducted in the facility. The Administrator provided a binder which included in-services for the year of 2023 and 2024. In-services from 09/30/2023 to 10/27/2024 were reviewed and there were no in-services completed for communication. The Administrator provided a statement which was reviewed and indicated he was only able to provide an in-service completed on resident rights. On 11/01/2024 at 6:55 PM, the Director of Nursing (DON) was interviewed, and she stated the Administrator was responsible for conducting the mandatory in-services for staff and was unaware why some had not been completed. She stated she had been working on completing the in-services since she had been there. The DON provided a monthly all staff in-service, dated 10/16/2024, which was reviewed and included the areas of resident rights/abuse and neglect and enhanced barrier precautions.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. 37925 Based on interview and record review, the facility failed to ensure required annual in-service trainings were performed to ensure staff received the required information/education needed to care for residents. The findings are: On 11/01/2024, the Administrator was asked to provide the in-services for the past 12 months conducted in the facility. The Administrator provided a binder which included in-services for the year of 2023 and 2024. In-services from 09/30/2023 to 10/27/2024 were reviewed and there were no in-services completed for compliance and ethics. The Administrator provided a statement which was reviewed and indicated he was only able to provide an in-service completed on resident rights. On 11/01/2024 at 6:55 PM, the Director of Nursing (DON) was interviewed, and she stated the Administrator was responsible for conducting the mandatory in-services for staff and was unaware why some had not been completed. She stated she had been working on completing the in-services since she has been there.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 37925 Based on interview and record review, the facility failed to ensure required annual in-service trainings were performed to ensure staff received the required information/education needed to care for residents. The findings are: The Facility Assessment, provided by the Administrator on 10/28/2024 and dated 08/08/2024, was reviewed and included no information on ow staff was prepared to care residents who required behavioral health services. On 11/01/2024, the Administrator provided a binder which included in-services for the year of 2023 and 2024. In-services from 09/30/2023 to 10/27/2024 were reviewed and there were no in-services completed for behavioral health. The Administrator provided a statement which was reviewed and indicated he was only able to provide an in-service completed on resident rights. On 11/01/2024 at 6:55 PM, the Director of Nursing (DON) was interviewed, and she stated the Administrator was responsible for conducting the mandatory in-services for staff and was unaware why some had not been completed. She stated she had been working on completing the in-services since she had been there.