STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045442	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cavalier Healthcare of England	400 Stuttgart Highway England, AR 72046

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 37634 Based on observation, interview, and record review, the facility failed to ensure nails were clean and trimmed for 1 (Resident #2) of 1 sampled resident. The findings are: Resident #1 had a diagnosis of Type 2 Diabetes mellitus. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/09/2024 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). A care plan for Resident #2 documented, .Check nail length and trim and clean on bath day and as necessary. Report changes to the nurse . On 04/01/2024 at 10:41 AM, Resident #2 ' s fingernails were long with a black substance underneath. She stated, They clean them whenever they have enough help. On 04/01/2024 at 01:04 PM, Resident #2 ' s fingernails were long with a black substance underneath. On 04/04/2024 at 09:19 AM, Certified Nurse Aide (CNA) #3 was asked, Who's responsible for cutting and cleaning Resident #2 nails? She stated, The nurses, because the [Resident] is a diabetic. On 04/04/2024 at 09:22 AM, Licensed Practical Nurse (LPN) # 2 was asked, Who's responsible for cutting and cleaning Resident #2 nails? She stated, The nurses. She was asked, Can you tell me why Resident #2 nails were long and had a black substance underneath them when we entered on Monday? She stated, I don't know. Sometimes the [Resident] doesn't want them cut, but that's not an excuse for them being dirty. On 04/04/2024 at 09:22 AM, the Administrator provided a form titled, Activities of Daily Living. It documented, .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain . grooming .

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 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. 48390 48483 Based on observations, interviews, record review, and policy review, the facility failed to ensure a safe and hazard-free environment for 2 (Resident #43 and #50) sample mixed residents. The findings are: 1. Resident # 50 had diagnoses of Dementia without behavioral disturbance, Psychotic disturbance, Mood disturbance, and Anxiety. 1 a. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/16/2024 showed a Brief Interview for Mental Status (BIMS) of 4 (a score of 0-7 suggests severe cognitive impairment.) The Resident required supervision or touch assistance with personal hygiene. 1 b. The care plan showed Resident #50 has a communication problem related to dementia. Staff are to ensure/provide a safe environment. 1 c. On 04/01/2024 at 10:54 AM, the Surveyor observed aftershave, shaving gel, shave cream, and body lotion sitting on the dresser by the door. 1 d. On 04/01/2024 at 12:34 PM, the Surveyor observed aftershave, shaving gel, shave cream, and body lotion sitting on the dresser by the door. 1 e. On 04/02/2024 at 09:23 AM, the Surveyor observed aftershave, shaving gel, shave cream, and body lotion sitting on the dresser by the door. 1 f. On 04/03/2024 at 02:00 PM, the Surveyor asked Certified Nursing Assistant (CNA) #1, Can you tell me what is on Resident # 50 dresser, and if should it be there? CNA #1 stated there were things on the dresser that are not supposed to be there, body wash, lotion, and aftershave. The Surveyor asked, Who is responsible for putting the items away? CNA #1 stated, The aides are. 1 g. On 04/03/2024 at 02:05 PM, the Director of Nursing (DON) confirmed the items on the dresser and should not be there with demented and confused Residents. 1 h. A document provided by the Administrator on 04/04/2024 at 09:22 a.m. titled, Incident and Accident Reporting effective 05/15/2015 with a revised date of 08/22/2017 showed, .everything possible should be done to avoid accidents or incidents involving patients . 1 i. A document provided by the Administrator on 04/04/2024 at 11:06 a.m. titled, Job Description: Certified Nursing Assistant Effective 01/16/2015 and Revised 11/28/2017 showed, .duties and responsibilities . promote a safe .environment in which the residents may live . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #43 had diagnoses that included Chronic obstructive pulmonary disease with (acute) exacerbation, Pain, unspecified, Gastro-esophageal reflux disease without esophagitis, Hemiplegia and hemiparesis following cerebral infraction affecting left non-dominant side. The Quarterly MDS, with an ARD of 12/21/2023, revealed Resident #43 had a BIMS score of 12 (7-12 indicates moderate cognitive impairment). A review of Resident #43's Care Plan revealed the resident had impaired physical mobility related to CVA (cerebral vascular accident, commonly referred to as a stroke) with left hemiplegia. Interventions included: Assist Resident in performing movements/tasks and educate Resident/Representative on safety precautions. During an observation on 04/01/2024 at 12:27 PM, Resident #43 was observed vaping in his/her room. A review of Resident #43 ' s Progress Note, dated 04/01/2024 at 4:05 PM, documented, Copy of smoking policy explained and given to resident for the use of electronic cigarette. Resident acknowledged and signed policy. Resident gave electronic cigarettes to this nurse. Electronic cigarettes placed inside nursing cart. During observation and interview on 04/03/2024 at 09:56 AM, Resident #43 indicated staff came around and took the vape, and will not allow Resident #43 to vape in the Resident's room. Resident #43 was given a new policy on vaping that showed to only vape outside. Resident #43 stated prior to 04/01/2024 vaping was only allowed in Resdnet's room. On 04/04/2024 at 04:04 PM, the Administrator was asked when the facility became a vape-free facility, because the admission packet indicated they are a smoke-free facility. The Administrator stated, I have no answer, when I came here, they were vaping. A review of facility updated policy titled, Smoking Policy, dated 04/02/2024, indicated, Smoking will only be allowed in designated (outdoor) area(s) in the facility that are not near flammable substances or where oxygen is in use.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37634 Based on observation and interview, the facility failed to ensure the refrigerated narcotic medications in 1 of 1 medication storage room were stored in a permanently affixed compartment to prevent the potential misappropriation of resident property. The findings are: On 04/03/2024 at 11:47 AM, Licensed Practical Nurse (LPN) #1 pulled the medication narcotic box out of the refrigerator and placed it on the counter. The narcotic box was not affixed to the refrigerator. On 04/03/2024 at 11:48 AM, LPN #1 confirmed that the narcotic box hadn't been affixed to the refrigerator. On 04/03/2024 at 01:12 PM, the Director of Nurses (DON) was asked, Can you tell me why the narcotic box is not permanently affixed to the refrigerator? She stated, I'm not sure, but it should be. On 04/04/2024 at 09:22 AM, the Administrator provided a policy titled, Drug Acquisition, Storage and Inspection. It documented, .Medications shall be stored in a secure manner .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 03508 Based on observation, interview and record review, the facility failed to ensure meals were served in a method that maintained the appearance of cold product and at temperatures that were acceptable to the residents to improve palatability and encourage good nutritional intake during 2 of 2 meals observed. This failed practice had the potential to affect 16 residents who receive meal trays in their rooms on the A Hall, 15 residents who receive meal trays on the B hall, 24 residents who receive meal trays in their room on the C hall. The findings are: 1. Resident #41 had diagnoses of Vitamin deficiency, Mood (affective disorder, Hypo-osmolality, and Hyponatremia. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/05/2024 showed a Brief Interview for Mental Status (BIM) of 15 (13-15 indicates cognitively intact). Resident was independent for eating. a. A Physician's Order Summary for April 2024 documented, Regular diet Regular texture, Regular/Thin consistency. b. The care plan showed Resident #41 was able to feed themselves after the tray was set up. c. On 04/03/2024 at 10:26 AM, the Surveyor asked, How is the temperature of the food? Resident #41 stated, The hot stuff is usually cold, and the cold stuff is usually warm. 2. Resident #30 had diagnoses of Type 2 diabetes mellitus, Irritable bowel syndrome, Vitamin deficiency, and Nausea. The Quarterly MDS with an ARD of 01/04/2024 documented a BIMS of 15. The Resident was independent for eating. a. A Physician's Order Summary for April 2024 documented a Regular diet, Regular texture, Regular/Thin consistency. b. The care plan for Resident #30 documented, provide meal support per resident's need. c. On 04/03/2024 at 10:29 AM, the Surveyor asked, Is the food ever cold or the milk ever warm? Resident #30 stated, It happens a lot. They stock the cart and leave it out until they are ready to deliver it. We are at the end of the hall, so our food is not as hot as it should be, and our cold stuff is usually warm. 3. On 04/03/2024 at 07:20 AM, an unheated food cart that contained 15 trays for breakfast was delivered to the B hall by the Certified Nursing Assistant (CNA) #2. Immediately after the last resident was served in their room on front hall, temperature of the food items on the tray used as test trays were taken and read by the Dietary Employee (DE) #1 with following results. a. Milk 50 degrees Fahrenheit. b. Biscuit with gravy 102.7 degrees Fahrenheit. c. Sausage 103 .6 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Pureed sausage 110 degrees Fahrenheit. e. Pureed biscuit with gravy 105.6 degrees Fahrenheit. f. Pureed eggs 105 degrees Fahrenheit. g. Scrambled eggs 110 degrees Fahrenheit. 4. On 04/03/2024 at 07:25 AM, an unheated food cart that contained 24 trays for breakfast was delivered to the C hall by the CNA #3. At 07:36 AM, immediately after the last resident was served in their room on the C hall, temperature of the food items on the tray used as test trays were taken and read by the Dietary Supervisor with following results. a. Milk 45 degrees Fahrenheit. b. Pureed eggs 110 degrees Fahrenheit. c. Pureed biscuit with gravy 115 degrees Fahrenheit. d. pureed sausage with gravy 110 degrees Fahrenheit. e. Ground sausage with gravy 112 degrees Fahrenheit. f. Biscuit with gravy 105 degrees Fahrenheit. g. Scrambled eggs 111 degrees Fahrenheit 4. On 04/04/2024 at 07:45 AM, an unheated food cart that contained 16 trays for breakfast trays was delivered to the A hall by the CNA #3. Immediately after the last resident was served in their room on front hall, temperature of the food items on the tray used as test trays were taken and read by the DE #1 with following results. a. Milk 53 degrees Fahrenheit. b. Biscuit with gravy 106 degrees Fahrenheit. c. Sausage 108 .6 degrees Fahrenheit.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 03508 Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 2 of 2 meals observed. This failed practice had the potential to affect 6 residents who received pureed diets. The findings are: 1. On 04/03/2024 at 11:14 AM, Dietary Employee (DE) #3 used a #6 scoop to place 8 servings of lasagna into a blender, added tomato sauce and pureed. At 11:19 AM, DE # 3 poured the pureed lasagna into a pan and placed it in a pan of hot water on the stove. The consistency of the pureed lasagna was gritty and not smooth. 2. On 04/03/2024 at 11:21 AM, DE #3 placed 8 servings of garlic bread into a blender, added 3 cartons of 2% milk and pureed. At 11:22 AM, DE #3 poured the pureed garlic bread into a pan. The consistency was thick, lumpy, and not smooth. There were pieces of bread left in the mixture. 3. On 04/03/2024 at 11:44 AM, DE #3 used a #8 scoop to place 8 servings of vegetable blend into a blender and pureed. At 11:46 AM, DE #3 poured the pureed vegetables into a pan. The consistency of the pureed vegetable blend was runny. DE #3 placed a pan that contained pureed vegetable blend in a pan of hot water on the steam. At 11:50 AM, DE #3 added thickener to the pureed vegetables and used a spoon to stir it. The consistency of the pureed vegetable was lumpy and not smooth. The thickener was not completely dissolved into the mixture. 4. On 04/04/2024 at 07:40 AM, the following observations were made on the steamtable. a. A pan of pureed bread to be served to the residents on pureed diets. The consistency of pureed bread was thick. b. A pan of pureed sausage to be served to the resident who required pureed diets. The consistency of pureed sausage was gritty and not smooth. 5. On 04/04/2024 at 07:42 AM, the Surveyor asked DE #1 to describe the consistency of the pureed food items. DE #1 stated, Pureed bread was thick and pureed sausage was gritty it needed to be smooth.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 Based on observation and interview, the facility (1) failed to ensure food items stored in the refrigerator were covered and dated, (2) failed to ensure that the kitchen vents were cleaned to provide a sanitary environment for food preparation, (3) failed to ensure floors, dish washer the door frames, baseboard and ceiling tiles were free of chipped, holes, paint peeling, rust, stains, (4) failed to ensure dietary staff washed their hands when contaminated to decrease the potential for food borne illness for residents receiving food from 1 of 1 kitchen, dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen, and (5) failed to ensure hot food item was maintained at 135 degrees Fahrenheit or above on the steam table while awaiting service to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen; The failed practices had the potential to affect 57 residents who received meals from the kitchen (total census: 57). The findings are: 1. On 04/03/2024 at 07:41 AM, the following observations were made in the 6-doors refrigerator: a. There was an open gallon of enchilada sauce on a shelf in the refrigerator with no open on it. b. An opened box of bacon on a shelf. The box was not covered or sealed. 2. On 04/03/2024 at 07:45 AM, the ceiling tile above the 6 doors refrigerator had paint peeling, exposing the wood. 3. On 04/03/2024 at 07:53 AM, the following observations were made in the meat and vegetable freezer. a. An opened zip lock bag that contained onion rings was on a shelf in the freezer. The bag was not covered or sealed. b. An opened zip lock bag that chicken fried steak was on a shelf in the freezer. The bag was not sealed. 4. On 04/03/2024 at 10:03 AM, Dietary Employee (DE) #3 turned on the hand washing sink faucet and washed his hands. After washing his hands, he turned off the faucet with his hands, contaminating them. He then removed gloves from the glove box and placed them on his hands, contaminating the gloves in the process. Without washing gloves and washing his hands, he removed shredded cheese from the original bag to be used in preparing lasagna to be served to the residents for lunch. The surveyor immediately asked DE #3, What should you have done after touching dirty objects and before handling clean equipment? DE #3 stated, I should have washed my hands. 5. On 04/03/2024 at 10:06 AM, the following observations were made in the dish washing room: a. The ceiling tile by the vent hood in the dirty dish washing machine had paint peeling, exposing the cement. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. The right side of the ceiling tile had paint peeling, exposing the cement. The area had water damage, sage color, and a hole in it. c. The floor of the dirty dish machine had black/brown stains on it. d. The left side of the door frame leading to the dirty dish washing machine room was missing, exposing the metal. e. The baseboard on the right side of the door leading to the dirty dish washing machine was chipped. The area that was chipped had rust stain on it. f. 8 of 8 dish racks in the dirty dish machine room had accumulations of white sediments on them. 6. On 04/03/2024 at 10:15 AM, DE #2 was wearing gloves on his hands when he picked up a pitcher of water from the sink and emptied it into the pans on the steam table. Without changing the gloves and washing his hands, he picked up utensils by the area that went into the mouth and placed them in an individual napkin wrapped for the residents to use when eating their lunch meal. The Surveyor asked DE #2, What should you have done after touching dirty objects and before handling clean equipment? DE #2 stated, I should have washed my hands. 7. On 04/03/2024 at 10:28 AM, the following observations were made in the kitchen. a. The kitchen floor around the 3-compartment sink, 2- compartment sink had light green stains on it. b. The floor by the deep fryer and the oven had grease stains on it. c. The floor throughout the kitchen had stains on it. The metal cover on the wall by the oven had dried grease stain on it. The wall by the oven had brown stain on it. 8. On 04/03/2024 at 10:48 AM, DE #3 removed a container of slices of tomatoes from the refrigerator and placed it on the counter. He removed gloves from the glove box and placed them on his hand contaminating the gloves. He then used the same gloved hand to remove a slice of tomato from the container and placed it on top of shredded lettuce inside a bowl to be served to the resident who requested it. The Surveyor asked DE #3, What should you have done after touching dirty objects and before handling clean equipment? DE #3 stated, I should have washed my hands. 9. On 04/03/2024 at 10:56 AM, the baseboard in the janitor's closet was loose from the wall. The floor had gray stains on it. 10. The temperature of the regular vegetable on the steam table when checked and read by DE #3 was 120 degrees Fahrenheit. The above vegetable was not reheated before being served to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11. On 04/03/2024 at 12:43 PM, DE #4 removed 2 bags of bread from the bread rack and placed them on the counter. He placed gloves on his hands, contaminating the gloves. Without washing his hands, DE # 4 removed slices of bread from the bread bag and placed them on a pan liner on the counter, then slices of cheese were placed on top of a slice of bread and placed another slice of bread on top to prepare grilled chesses sandwich to be served to the resident who asked for it. The Surveyor asked DE #4, What should you have done after touching dirty objects and before handling clean equipment? DE #3 stated, I should have washed my hands. 12. A facility policy titled, Hand Hygiene technique when using soap and water documented, Wet hands with water. Avoid using hot water to prevent drying of skin. Apply to hands the amount of soap recommended by the manufacturer. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. Rinse hands with water. Dry thoroughly with a single-use towel. Use clean towel to turn off the faucet.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 48483 Based on observation, interview, and policy review, the facility failed to ensure the biohazard and oxygen rooms remained locked at all times. This failed practice had the potential to affect all 57 residents. The findings are: On 04/02/2024 at 03:09 PM, the Surveyor observed an unattended set of keys in the doorknob to the Biohazard Room on 300 Hall. The Surveyor knocked on the door with no answer. On 04/02/2024 at 03:19 PM, the Surveyor observed Maintenance walk up to the Biohazard room door and remove the keys. The Surveyor asked Maintenance to open the door and observed oxygen cylinders and biohazard boxes with full containers of syringes and needles inside. The Surveyor asked, Should the keys be left in the door? Maintenance stated, No, but I was only gone for a couple of minutes. The Surveyor asked, What time is it? Maintenance stated, It's 3:19. On 04/02/2024 at 03:33 PM, the Administrator confirmed the keys were left in the door unattended. On 04/03/2024 at 10:11 AM, the Surveyor observed a door on Hall 3 with a sign showing, .keep closed at all times . with a built-in combination lock. The door was unlocked and opened with no combination. The Surveyor observed 2 full containers with used syringes and needles, 7 oxygen cylinders, disinfecting wipes, a small refrigerator, and multiple Personal Protective Equipment (PPE) items. On 04/03/2024 at 10:15 AM, the Director of Nursing (DON) confirmed the room contained 7 oxygen cylinders, lab equipment, a biohazard refrigerator (empty), supplies of masks, disinfecting wipes, and 2 full containers holding used syringes and needles, and that the door was unlocked. On 04/03/2024 at 10:26 AM, the Administrator confirmed the door was unlocked. A document provided by the Administrator on 04/04/2024 at 09:22 a.m. titled, Incident and Accident Reporting effective 05/15/2024 with a revised date of 08/22/2017 showed, .everything possible should be done to avoid accidents or incidents involving patients .