STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045454	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mitchell's Nursing Home, Inc	501 W 10th Danville, AR 72833

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 37634 Based on observation and interview, it was determined the facility failed to ensure a bed alarm was not used for 1 (Resident #3) of 1 sampled resident reviewed for restraints without a medical justification. The findings are: A review of an Order Summary Report indicated Resident #33 had a diagnosis of Unspecified Dementia. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/13/2024 revealed Resident #33 had short and long-term memory problems on a Staff Assessment for Mental Status. The MDS indicated a bed alarm and a chair alarm were being used less than daily. A review of Resident #33's Care Plan initiated on 10/26/2023 revealed the resident was at risk for falls related to impaired mobility. Interventions included sensor pad under resident when up in recliner or in bed. A review of an Incident Report dated 10/26/2023 indicated Resident #33 had a fall. The intervention was to apply a sensor pad when the resident was in bed or in a chair. On 05/28/2024 at 10:42 AM, Resident #33 was observed in bed. A bed alarm pad was observed on the bed. On 05/31/2024 at 12:30 PM, Resident #33 was observed in a recliner. A bed alarm pad was observed in the seat of the recliner. On 05/30/2024 at 3:19 PM, Licensed Practical Nurse (LPN) #3 indicated that when the alarm goes off on Resident #33's bed they can hear the alarm when it goes off. On 05/30/2024 at 3:49 PM, the Administrator indicated the facility didn't have a policy for bed alarms. On 05/31/2024 at 9:28 AM, Resident #33 was observed in bed. A bed alarm pad was observed in the bed. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/31/2024 at 9:35 AM, the Activity Director indicated that she wasn't sure the exact date Resident #33 had been using the bed alarm pad, but it's been a while. She indicated that the position change device was being used for Resident #33 because she has days where she wants to get out the bed. She indicated that Resident #33 tries to get out the doors, and she has days with lots of agitation. She indicated that the facility did lots of redirecting, and activities before the alarm was started. She indicated that she did not know of any physical or psychosocial changes that had been caused because of the device, and Resident #33 wasn't hesitant or afraid to move to avoid setting off the alarm. On 05/31/2024 at 9:49 AM, LPN #13 indicated she wasn't sure the exact date Resident #33 has been using the bed alarm pad, but Resident #33 has had it for a very long time. LPN #13 indicated that the position change device was being used for Resident #33 because of fall precautions. She indicated that she's not sure what interventions were attempted before the alarm was put in place. LPN #13 indicated that she's been here since December of 2022, and Resident #33 had the alarm when she started. She indicated that she did not know of any physical or psychosocial changes that had been caused because of the device, and the resident wasn't hesitant or afraid to move to avoid setting off the alarm. On 05/31/2024 at 10:04 AM, the Director of Nursing (DON) indicated Resident #33 had been using the bed alarm pad since October of 2023. She indicated that Resident #33 was using the position change device because the resident had a fall. She indicated that there were no other interventions put in place on that day when the resident had the fall. She indicated that she did not know of any physical or psychosocial changes that had been caused because of the device, and the resident wasn't hesitant or afraid to move to avoid setting off the alarm.

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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. 50505 Based on observation and interviews, it was determined that the facility failed to ensure over the counter medications were not expired for medication storage. Findings include: On 05/31/2024 at 10:45 AM, the Director of Nursing (DON) stated the facility did not have a policy for Medication Storage. During observation of the medication storage on 05/29/2024 at 01:30 PM the following was noted: a. 1 bottle of N-Acetyl-L-Cysteine (NAC) (an amino acid, a building block of proteins that are used throughout the body) 600 mg (milligrams) with an expiration date of April 2024. b. 1 bottle of Vitamin and Mineral Supplement (a multivitamin product used to treat or prevent vitamin deficiency due to poor diet, certain illnesses, or during pregnancy) with an expiration date of September 2023. c. 18 bottles of antiseptic skin cleanser that helps reduce bacteria that potentially can cause disease with an expiration date of April 2024. On 05/29/2024 at 01:45 PM, Licensed Practical Nurse (LPN) #3 removed the bottles of expired medications from use and stated, I will inform the Director of Nursing.

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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. 50505 Based on observations, interviews, and facility document review, it was determined the facility failed to ensure the dishwasher machine temperature gauge was in working order. Findings include: During an observation on 05/30/2024 at 08:28 AM, Dietary Aide #7 was observed spraying dishes and then pushing dishes into the dish machine for washing. Once the dish machine started the temperature gauge was not moving. The glass covering over the gauge was cracked/broken. During an observation on 05/30/2024 at 08:36 AM, Dietary Manager #6 took a manual temperature of the water inside the dish machine. Temperature readings for the dish machine were as follows: Washing cycle was 163 degrees Fahrenheit; Rinse cycle 176.9 degrees Fahrenheit. During an interview on 05/30/2024 at 08:37 AM, the Dietary Manager #6 indicated she had notified the company under contract for repair of the thermometer gauge on 05/29/2024 and that a dish rack had gotten slammed into the gauge. During an interview with Dietary Aide #7 on 05/30/2024 at 08:38 AM, the Surveyor asked how long manual temperatures had been done on the dish machine, and response was given, About a month. During an interview on 05/30/2024 at 08:45 AM, the Administrator indicated that he had not been notified of the dish machine temperature gauge not working. On 05/31/2024 at 08:32 AM, Dietary Manager #6 supplied a form titled Food Safety Best Practices: Warewashing It documented, .Machine Washing .Check the gauges and compare their readings with the minimum temperatures, chemical concentrations and pressure measurements listed on the data plate . On 05/31/2024 at 09:30 AM, Dietary Manager #6 stated the facility did not have a policy for the dish machine (washer). A review of the Dish Room Temperature Log, indicated the facility had the exact temperatures recorded for May 1,2024 through May 25, 2024, May 27,2024 through May 29, 2024.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37634 Based on observation, interview and record review, the facility failed to ensure staff washed their hands after resident care, and between feeding residents. The findings include: 1. On 05/28/2024 at 11:26 AM, Licensed Practical Nurse (LPN) #12 was observed repositioning Resident #29. LPN #12 walked out of the room without washing her hands. On 05/28/2024 at 11:28 AM, LPN #12 indicated that she forgot to wash or sanitize her hands when she finished care for Resident #29 On 05/31/2024 at 10:08 AM, the Director of Nursing (DON) indicated staff should use hand hygiene or soap and water after contact with residents. 49981 2. On 05/28/2024 at 12:41 PM, during observation of the noon meal service Certified Nursing Assistant (CNA) #2 was assisting a resident on the left with eating and switched to assisting the resident on the right with inserting a straw into a cup. CNA #2 did not sanitize hands between switching from resident to resident. a. On 05/30/2024 at 8:10 AM, CNA #9 was asked what is an important step when passing meal trays. CNA #9 said to sanitize hands in between. The Surveyor asked what is the proper way to assist with more than one resident at a time with eating their meal. CNA #9 said to be sure to sanitize hands between each resident. CNA #9 was asked what could be a possible outcome if staff failed to sanitize between trays or residents. CNA #9 said it could spread germs. b. On 05/30/2024 at 3:30 PM, CNA #10 was asked what is something important to do when passing meal trays. CNA #10 said to sanitize hands between each tray. CNA #10 was asked when feeding multiple residents, what should you do between each resident. CNA #10 stated you should sanitize your hands. CNA #10 was asked what could be a result of not sanitizing hands between trays or assisting residents to eat. CNA #10 said it could spread germs from one resident to the other. c. On 05/31/2024 at 8:20 AM, the Infection Preventionist (IP) was asked who is the person responsible for training staff on hand hygiene. The IP said she was. The IP was asked when passing meal trays in the dining room, what should staff do in between each tray. The IP stated, Sanitize hands. The IP was asked when staff are assisting with feeding multiple residents at the table, what should staff do in between assisting each resident. The IP said, Sanitize hands. d. A policy titled, Handwashing/Hand Hygiene, received from the IP on 5/30/2024 at 2:30 PM documented, Handwashing is considered the primary means to help prevent the transfer of infections. 50505 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During an observation on 05/28/2024 at 11:26 AM, the Surveyor observed CNA/Medication Assistant Certified (CNA/MAC) #1 in room [ROOM NUMBER] A walk out of the room without sanitizing her hands, holding a plastic bag, walked down the hallway and entered the soiled utility room. During an interview on 05/28/2024 at 11:30 AM, CNA/MAC #1 was asked why she did not sanitize her hands when coming out of room. CNA/MAC #1 stated she was going to the hopper room and after she emptied the bag out, then she was going to wash her hands.