

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045455	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/03/2024
NAME OF PROVIDER OR SUPPLIER  Hickory Heights Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  #3 Chenal Heights Drive Little Rock, AR 72223	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>37925</p> <p>Based on observation, interview and record review, the facility failed to ensure dignity was maintained for 2 (Residents #10 and #90) and privacy was maintained for 1 Resident #90 when caring for the Residents. The findings are:</p> <p>Resident #10 had a diagnosis of Spastic Quadriplegic Cerebral Palsy as documented on an Order Summary.</p> <p>An Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/24 documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 (13-15= cognitively intact), had functional limitation in range of motion on both sides in upper and lower extremities and was dependent for upper and lower body dressing.</p> <p>A Care Plan, last dated 4/25/24, documented Resident #10 had an Activities of Daily Living (ADL) self-care performance deficit related to diagnosis process and contractures and was dependent on staff for personal hygiene.</p> <p>On 04/30/24 at 12:07 PM, Certified Nursing Assistant (CNA) #3 was in Resident #10's room and Resident had been put back to bed after receiving a shower. Resident #10 was in bed, awake and the privacy curtain was positioned behind the head of the bed and the privacy curtain of the roommate was pulled closed. At 12:11 PM, CNA #3 removed the top sheet from the Resident, exposing the entire front side of the Resident's body. CNA #3 placed a white substance on her gloved hands and rubbed in on the Resident's chest area and legs. She rolled Resident #10 on the left side and removed a blue lift pad. Resident #10's back, buttocks and legs were exposed. At 12:14 PM, CNA #3 pulled the sheet down completely, and exposed Resident #10's back, bottom, and legs. CNA #3 said she was applying lotion to Resident. Without changing gloves, she applied a white cream to Resident #10's left and right buttocks. CNA #3 said it was barrier cream. She rolled the sheets under the Resident, towards the left side and then rolled Resident on Resident's back. Resident #10's front body was naked and exposed to both surveyors. At 12:18 PM, CNA #3 applied a condom catheter to Resident #10 and the Resident's chest, private area, and legs were exposed. At 12:21 PM, she tied the strings on a gown and placed the gown over the Resident's head and pulled the top sheet off the Resident, exposing the Resident's private area and legs and then she pulled the gown down over the Resident. She pulled the top flat sheet over the Resident and began cleaning up the area.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/02/24 at 2:29 PM, CNA #3 was interviewed, and she had Resident #10's front body exposed while she was placing cream on the Resident's body. When CNA #3 was asked how she should have applied the cream to the Resident, she confirmed she should have placed the bath blanket on and rolled it down as she was working, to only expose the portion of the body that needed cream to provide privacy.</p> <p>Resident #90 has a medical diagnosis of Hemiplegia, Affecting Right Dominant Side, Personal History of Transient Ischemic Attack (TIA), and Cerebral Infarction Without Residual Deficits, Chronic Systolic (congestive) Heart Failure, Cerebral Infarction, Frontal Lobe and Executive Function Deficit Following Nontraumatic Intracerebral Hemorrhage, Shortness of Breath. A Quarterly Minimum Data Set [MDS] with an Assessment Reference Date [ARD] of 11/02/2023 documented a Brief Interview Mental Status [BIMS] of 00, (unable to complete screening).</p> <p>On 4/30/2024 at 10:33 AM, the surveyor observed Registered Nurse (RN) #1, administering a tube feeding to Resident #90. The surveyor walked past Resident #90's room with the door open and observed Resident's abdomen exposed.</p> <p>On 5/02/2024 at 9:52 AM, the surveyor asked RN #1 what is important when providing personal care, tube feeding, etc. to protect a Resident's privacy and promote dignity? RN #1 stated to be sure to close the door and pull the privacy curtain. RN was asked what the outcome could be if the door was left open or curtain was not pulled. RN stated that people passing by in the hallway could see the resident.</p> <p>On 5/02/2024 at 9:57 AM, the Director of Nursing (DON), was asked what is important to do when providing personal care, tube feedings, etc. to protect a resident's privacy and promote dignity? DON said staff need to close the resident's door and pull the privacy curtain. The surveyor asked the DON what the outcome could be if the door was left open or the curtain was not pulled? DON said people passing by in the hallway would be able to see the resident.</p> <p>On 5/03/24 at 12:40 PM the Administrator said the facility does not have a policy on dignity when he was asked to provide one.</p> <p>49981</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49596</p> <p>49071</p> <p>Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure personal hygiene as related to proper nail care was provided for 3 of 3 Residents (Resident #2, #42, #73) reviewed for activities of daily living.</p> <p>A. Resident #2's Care Plan identifies Resident #2 to have an ADL (Activity of Daily Living) self-care performance deficit r/t Dementia, Limited Mobility, weakness Date Initiated: 03/13/2023. Intervention/task: Personal Hygiene: substantial/max. Date Initiated: 12/07/2023.</p> <p>B. Resident #2 has impaired cognitive function BIMS (Brief Interview for Mental Status) score related to dementia. Date Initiated: 03/13/2023.</p> <p>C. MDS (Minimum Data Set) dated March 07, 2024, reflects Resident's has a BIMS of 3. BIM scores of 00 - 07 Severely Impaired.</p> <p>The findings are:</p> <p>1. On 04/30/24 at 02:20 PM, Resident #2's fingernails were partially painted, long, chipped, with dark brown substance under the nails, and brown substances smeared over and around the fingernails.</p> <p>On 05/01/24 at 08:36 AM, Resident #2's fingernails were partially painted, long, chipped, with dark brown substance under the nails, and brown substances smeared over and around the fingernails.</p> <p>On 05/01/24 at 08:43 AM, Resident #2's fingernails were partially painted, long with dark brown substance under the nails, and brown substances smeared over and around the fingernails.</p> <p>On 5/2/24 at 1:23 PM, Resident #2's fingernails were partially painted, long, chipped, with dark brown substance under the nails, and brown substances smeared over and around the fingernails.</p> <p>On 4/30/24 at 9:43 AM, observed Resident #42's nails with jagged edges and brown substance under nails on both hands. Resident had 1/2 inch nails on some fingers with chipped polish.</p> <p>On 4/30/24 at 3:47 PM, observed Resident #42 with 1/2 inch nails with chipped polish and jagged edges with brown substance under nails.</p> <p>On 5/1/24 at 12:07 PM, observed Resident #42 with 1/2 inch nails with chipped polish and jagged edges with brown substance under nails.</p> <p>Resident #42's Care Plan identifies Resident #42 to have an ADL self-care performance deficit related to dementia, Schizophrenia, wandering, behaviors Date Initiated: 08/11/2021.</p> <p>Resident #2 has impaired cognitive function with a BIMS score related to dementia. Date Initiated: 04/26/2024.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>MDS dated [DATE], reflects resident has a BIMS of 03. BIM scores of 00 - 07 Severely Impaired.</p> <p>On 4/30/24 at 9:05 AM, observed Resident #73 lying on bed with 1/2 inch thumb nails and brown substance under nails on both hands and chipped polish on thumb nails.</p> <p>On 4/30/24 at 11:13 AM, observed Resident #73 in chair in dining room after receiving her shower with 1/2 inch thumb nails with chipped nail polish and brown substance under nails on both hands.</p> <p>On 4/30/24 at 2:1, observed Resident #73 up in dining area with 1/2 inch thumb nails with chipped nail polish and brown substance under nails on both hands.</p> <p>On 5/1/24 at 11:06 AM, observed Resident #73 sitting on side of bed with 1/2 inch thumb nails with chipped polish and brown substance under nails on both hands.</p> <p>Resident #73's Care Plan identifies Resident #73 to have an ADL self-care performance deficit related to cognitive status/ limited mobility Date Initiated: 12/01/2021. Intervention/tasks: praise all self-care revised: 2/23/24.</p> <p>Resident #73 has impaired cognitive function AEB BIMs score r/t dementia. Date Initiated: 02/20/2024.</p> <p>MDS dated [DATE], reflects resident has a BIMS of 03. BIMS scores of 00 - 07 Severely Impaired.</p> <p>C. On 5/2/24 at 11:07 AM, certified nursing assistant (CNA) #2 was asked, who is responsible for making sure nails are trimmed, and cleaned. CNA#2 confirmed, the CNA's are unless they are diabetic then the nurses do them. When do you provide nail care. CNA#2 confirmed on resident shower days and if we notice them dirty we do them as needed. What can occur from nails being left jagged. CNA#2 confirmed, they can cut themselves with them. What can occur from brown substance being left under their nails. CNA#2 confirmed, infection.</p> <p>D. On 5/2/24 at 11:11 AM,, Licensed Practical Nurse (LPN)#4 was asked, who is responsible for making sure nails are trimmed, and cleaned. LPN#4 confirmed, the CNA's are unless they are diabetic then the nurses do them. When is nail care provided. LPN#4 confirmed, as needed. What can occur from nails being left long and jagged. LPN #4 confirmed, skin tears. What can occur from nails being left with brown substance under them. LPN #4 confirmed, it can cause an infection.</p> <p>E. On 5/2/24 at 11:17 AM, Director of Nursing (DON) was asked who is responsible for making sure residents nails are trimmed and cleaned. DON confirmed, the CNAs are. When is nail care provided. DON confirmed on bath days. What can occur from nails being left long and jagged. DON confirmed, skin tears. What can occur from brown substance being left under nails. DON confirmed infection. Who should be monitoring the nails to assure these tasks are being performed. The DON confirmed the nurses and myself.</p> <p>On 5/2/24 at 12:56 PM, nurse consultant was asked for policy for nail care, nurse consultant confirmed the facility does not have a policy for nail care.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>49071</p> <p>Based on observations, interviews, and record review the facility failed to ensure resident with limited range of motion (ROM) received care and services to prevent any further decrease in ROM for one (Resident #19) who was reviewed for position/mobility. The findings are:</p> <p>On 4/30/24 at 9:56 AM, observed Resident #19 lying in bed with left hand contracted and no device in place.</p> <p>On 4/30/24 at 3:10 PM, observed Resident #19 up in chair with contracted left hand and no device in place.</p> <p>On 5/1/24 at 12:34 PM, observed Resident #19 up in dining room in chair with left hand contracted and no device in place.</p> <p>Resident #19's Care Plan identifies Resident #19 to have an ADL (Activity Daily Living) self-care performance deficit related to cardiovascular accident with hemiplegia Date Initiated: 12/23/2019.</p> <p>Resident #19 has impaired cognitive function BIMS (Brief Mental Status Score) score related to cardiovascular accident and schizophrenia. Date Initiated: 03/28/2024.</p> <p>MDS (Minimum Data Set) dated March 28, 2024, reflects Resident has a BIMS of 03. BIM scores of 00 - 07 Severely Impaired.</p> <p>During an interview on 5/1/24 at 12:37 PM, the Director of Physical Therapy said no I am not aware Resident #19 has a hand contracture. The surveyor asked can you look and see if there are any notes for Resident #19 regarding a hand splint or device. The Director of Physical Therapy looked and informed the surveyor that there were no notes for Resident #19. The surveyor asked should a resident with a hand contracture have a device or a hand roll in place. The Director of Physical Therapy said ideally yes, they should.</p> <p>On 5/1/24 at 2:04 PM, surveyor asked the Director of Nursing (DON), where you aware that Resident #19 had a contracted left hand. The DON said, yes I am. The surveyor asked should there be something in the Resident's left hand to help with the mobility of the left hand. The DON said yes, a hand roll. The DON placed a dry cotton tip applicator in Resident #19's contracted hand and twisted it and then pulled it out. The surveyor asked can you describe what the cotton tip applicator smells like? The DON said foul smelling nasty, and white with some tan on it.</p> <p>During an interview on 5/2/24 at 11:10 AM, License Practical Nurse (LPN)#4 confirmed, everyone who takes care of the Resident can place a hand roll in their hand. The surveyor asked who is responsible for making sure the contracted hand is cleaned. LPN #4 confirmed, the CNAs are. The surveyor asked why is it important to assure a roll/splint is applied. LPN #4 confirmed to combat constriction.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/2/24 at 11:14 AM, surveyor asked the DON who is responsible for making sure that a hand roll/splint is placed. The DON said nurses or restorative is. Why is it important to have a hand roll/splint in place. The DON confirmed, to help with mobility of hand.</p> <p>On 5/2/24 at 11:56 AM, Restorative Aide (RA) was asked, are you aware of Resident #19, RA confirmed, yes, I am. Are you aware that Resident #19 has a left contracted hand. RA confirmed, yes, I am. Last week the restorative nurse and the MDS nurse and I all met to go over all contractures. The surveyor ask, did you discuss Resident #19, the RA confirmed, yes, we did. The surveyor asked what was the outcome of the discussion. RA said nothing, I guess. The surveyor asked was Resident #19 placed on restorative, RA said no. The surveyor asked was Resident #19 referred to therapy for a splint. RA said I don't know. The restorative nurse handles that.</p> <p>On 5/2/24 at 12:01 PM, surveyor asked Restorative Nurse, RN (RN#2), are you familiar with Resident #19.? RN #2 said yes, I am. Are you aware that Resident #19 has a contracted left hand. Yes, I am. The surveyor asked are you aware Resident #19 does not have a hand roll/or splint in place. RN #2 said yes, we used to attempt to place a hand roll in the hand but Resident #19 often wouldn't allow us to place it in the hand because it hurt. Are you still attempting to place it in the Resident's hand. RN #2 said no I guess we just quit trying. Has the resident been referred to therapy for the contracture. RN #2 said, I just got permission to get referral for therapy to evaluate.</p> <p>On 5/2/24 at 12:56 PM, a nurse consultant was asked for contracture policy. The nurse consultant confirmed, facility does not have a policy for contractures.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>37925</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Observations revealed there were 5 of 26 medications not administered in accordance with physician's orders for 3 (Residents #3, #10 and #35) of 4 residents, resulting in a medication error rate of 19.23%. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #10 had a diagnosis of Spastic Quadriplegic Cerebral Palsy. <ol style="list-style-type: none"> <li>a. An Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/24 documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 (13-15= cognitively intact) and had functional limitation in range of motion on both sides in upper and lower extremities.</li> <li>b. An Order Summary documented resident #10 had the following medication orders: 1. 1. Polyethylene Glycol Powder 34 gram by mouth one time a day</li> <li>2. Senna Tablet 8.6 mg (milligrams) give 2 tablets by mouth one time a day.</li> <li>c. On 5/2/24 at 09:07 AM, Licensed Practical Nurse (LPN) #2 was at the 300-hall medication cart and was observed preparing medications for Resident #10. She took out a bottle of Polyethylene Glycol) and poured 17 grams of powder into the top and then poured the powder in a cup, poured about 6 ounces of water in the cup with the powder and mixed them together. She opened a bottle of Senna-Plus and poured 1 capsule in the top and then placed it in the cup with other medications she was preparing. At 9:15 AM, she poured the pills in Resident #10's mouth and then administered the cup of water mixed with Clear-lax and to the Resident.</li> <li>d. An electronic Medication Administration Record (MAR) documented on 5/2/24 at 0800 (8:00 AM) resident #10 was administered Polyethylene Glycol Powder 34 grams by mouth and Senna Tablet 8.6 MG 2 tablets by mouth.</li> <li>e. On 5/2/24 at 11:26 AM LPN #3 was interviewed, and she confirmed she only poured one cap (1 cap = 17 gm) of Clear Lax and administered it to Resident #10 during the morning medication pass. She then confirmed that she only administered one capsule of the Senna-Plus to Resident. She was asked to look at the medication administration record to state what the orders were for Clear Lax and Senna. At 11:27 AM LPN #3 looked at the MAR for Resident #10 and she stated, The Senna is to give two tablets, but [Resident #10] doesn't want two, [resident #10] wants one. This surveyor stated, The order shows 2 tablets, and you signed off that two tablets were given. She was asked if the order should have been called to the doctor for clarification and she stated, I guess. She confirmed that the MAR documented 2 tablets given. She confirmed the Clear Lax dose ordered was 34 grams. She confirmed she should have read the order before she prepared Resident #10's medication and she stated the reason was, Just in case something changes.</li> </ol> </li> <li>On 5/2/24 at 08:25 AM, surveyor observed LPN #1 administer a 1000 mg tablet of Omega 3 fish oil tablet to Resident #35. The order reads, Fish Oil 2000 mg by mouth related to vitamin deficiency.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/2/24 at 8:32 AM, LPN #1 confirmed there were 7 pills in the medication cup and 2 sets of eye drops to be given.</p> <p>On 5/2/24 at 8:32 AM, surveyor observed order for Vitamin D3 25 mg (1000out) give 2 tablets daily related to vitamin deficiency. These tablets were not given to Resident #35.</p> <p>On 5/2/24 at 8:40 AM, surveyor observed LPN #1 administer medication to Resident #3. LPN #1 confirmed there were 5 tablets in the medication cup.</p> <p>On 5/2/24 at 8:40 AM, surveyor observed order for Loratadline 10mg oral tablet, 1 tablet by mouth daily for allergies that LPN #1 did not administer to Resident #3.</p> <p>On 5/2/24 at 10:10 AM, surveyor asked LPN #1, when administering medication what should the nurse do to assure that all the medication is given, and the right amount is given. LPN#1 confirmed, look at your MAR and compare your medication to the order and the Resident. Can you look at your orders for the 0800 AM medication pass and tell me how many of the fish oil tablets the order states to give. LPN #1 confirmed, it says 2, but I only gave 1. Do you remember us counting the pills to confirm how many were in the cup? LPN #1 confirmed, yes there were 7 for this Resident. Can you look at your orders and tell me how many pills you should have given at your 0800 AM medication pass. LPN #1 confirmed looks like 10. Do you see which medication you did not give. LPN #1 confirmed, I only gave 1 fish oil, but I am still missing 2 tablets. Do you remember giving Vitamin D3, 2 tablets. LPN confirmed, no I forgot to give those.</p> <p>On 5/2/24 at 10:18 AM, surveyor asked LPN #1, when administering medication to Resident #3 do you remember how many pills we confirmed were in the cup. LPN #1 confirmed yes 5. Can you count your pills to be given at 0800 for Resident #3 and tell me how many should have been given. LPN #1 confirmed, it should have been 6. Can you look at your orders and confirm what medication you missed. LPN #1 confirmed, yes, the brand antihistamine, I forgot to give it. Can you tell me why it is important for a resident to get the medication that is ordered for them. LPN #1 confirmed, it is important because they need them for their diagnosis and the doctor ordered them, so I am responsible for giving them. They will get sicker if they are not given.</p> <p>On 5/2/24 at 11:13 AM, the nurse consultant informed surveyor they did not have a policy for medication administration.</p> <p>49071</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure that meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed. This failed practice had the potential to affect 9 residents who received pureed diets from 1 of 1 kitchen, according to a list provided by the Administrator on 04/30/2024 at 11:05 AM The findings are:</p> <ol style="list-style-type: none"> <li>1. The menu for lunch documented that the residents who received pureed diets were to receive 2 #8 scoops (1 cup) of spaghetti with meat sauce, a #16 scoop (1/4 cup) of pureed bread, and a #8 scoop (1/2 cup) of pureed vegetable blend.</li> <li>2. On 04/30 /2024 at 012:43 PM, the following observations were made during the noon meal service. a. On 04/30/24 at 12:43 PM Dietary Employee (DE) #3 used a #8 scoop (1/2 cup) to serve a single portion of pureed spaghetti to 5 residents who are on a regular puree diet, instead of 2 #8 scoops (1 cup) and served 2#8 scoops of pureed spaghetti to 4 residents who are on double portion diets, instead of 4#8 scoops (2 cups) for being on double portion diets.</li> <li>c. On 04/30/24 at 01:31 PM 6 residents who required pureed diets did not receive pureed bread with their lunch meal. All residents on pureed diets were served pureed cut green beans, instead of pureed vegetables blend per the written menu. Vegetable blend consisted of other vegetables. On 05/01/24 at 11:08 AM The surveyor asked the Dietary supervisor the reason pureed cut green beans was used for the pureed vegetable, instead of vegetable blend. He stated, They should have use vegetable blend as stated on the menu because vegetable blend is a mixture of other vegetables.</li> <li>d. On 04/30/23 at 01:35 PM 6 bowls of pureed bread were on the counter in the kitchen. The surveyor asked the Dietary Employee (DE) #3 the reason pureed bread was not served to other residents. DE #3 stated, I forgot. The surveyor asked Dietary Employee (DE) #3 how many servings of pureed spaghetti she gave to each resident on pureed diets and what scoop size was used. (DE) #3 stated, I used #8 scoop (1/2 cup) and I gave one serving each to 7 residents on a regular pureed diets, and gave a serving of 2#8 scoops each to 2 residents on double portion. The surveyor asked the Dietary Employee (DE) #3 if she read the menu. DE #3 stated, I looked at it, I should have given 2#8 scoops to the ones on regular puree diets 4 #8 scoops the ones on double portion.</li> <li>3. On 05/01/24 at 11:08 AM The surveyor asked the Dietary supervisor the reason the cut green beans were used for the pureed vegetable, instead of vegetable blend. He stated, They should have use vegetable blend as stated on the menu because vegetable blend is a mixture of other vegetables.</li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  Hickory Heights Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  #3 Chenal Heights Drive Little Rock, AR 72223	
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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>03508</p> <p>Based on observation and interview, the facility failed to ensure that pureed food items were blended to a smooth, lump free consistency to minimize the risk of choking or other complications for those residents who required pureed diets for 2 of 2 meals observed. The failed practice had the potential to affect 9 residents who received pureed diets, as documented on the list provided by the Administrator on 05/01/2024 at 11:05 AM The findings are:</p> <ol style="list-style-type: none"> <li>On 04/30/24 11:46 AM Dietary Employee (DE) #3 used #8 scoop to place 13 servings of cut green beans into a blender and pureed. At 11:49 AM Dietary Employee (DE) #3 poured the pureed cut green beans into a pan, added thickener, and stirred it with a spoon. The consistency was thick.</li> <li>On 04/30/24 at 12:26 PM Dietary Employee (DE) #3 used #6 scoop to place 10 servings spaghetti with meat sauce into a blender and pureed. At 12:29 AM Dietary Employee (DE) #3 poured the pureed spaghetti with meat sauce into a pan and placed it on the steam table. The consistency was chunky. There were pieces of noodles and meat visible in the mixture.</li> <li>On 04/30/24 at 12:33 PM Dietary Employee (DE) #4 placed 13 servings of bread sticks into a blender, added 3 cartons of whole milk and pureed. Dietary Employee (DE) #4 used a #16 scoop to portion pureed bread sticks into 9 individual bowls. The consistency was lumpy and thick.</li> <li>On 04/30/24 at 01:45 PM The surveyor asked the Dietary Employee (DE) #4 to describe the consistency of the pureed food items served to the residents on pureed diets. (DE) #4 stated, Pureed spaghetti was more of mechanical soft, it was thick. You are seeing noodles and meat. It was supposed to be pudding consistency. Pureed bread was thick and had lumps in it. I should have added more milk to make it smoother. Pureed cut green beans were thick.</li> <li>On 04/30/24 at 02:05 PM The surveyor asked the Certified Nursing Assistant #1 to describe the consistency of the pureed spaghetti served to the residents on pureed diets. She stated, It was more of mechanical soft.</li> <li>On 04/30/24 at 02:06 PM The surveyor asked the license Practical nurse #2 to describe the consistency of the pureed spaghetti served to the residents on pureed diets. She stated, It has lumps.</li> <li>On 04/30/24 at 08:10 AM during the breakfast meal service. Pureed sausage was served to the residents on pureed diets from a pan of pureed sausage located on the steam table. The consistency of the pureed sausage was gritty. The surveyor asked the Dietary Employee (DE) #6 to describe the consistency of the pureed sausage prepared and served to the residents on pureed diets. DE #6 stated, It was gritty.</li> </ol>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure opened food items in the walk-in refrigerator and walk-in freezer were covered, sealed, and dated to maintain freshness and prevent potential cross-contamination, and lemon juice was stored in the dry storage area in accordance with the manufacturer's instructions for residents who receive meal from 1 of 1 kitchen, failed to ensure dietary staff practiced good and washing techniques to prevent potential cross-contamination of food and clean dishes, failed to ensure hot food items were maintained at the required temperatures on the steam table while awaiting service to prevent potential food borne illness for the residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 103 residents who received meals from the Kitchen. The findings are:</p> <p>1. On 04/30/24 at 08:46 AM, the following observations were made in the walk-in refrigerator.</p> <p>a. The temperature of the walk-in refrigerator was 55 degrees Fahrenheit. The surveyor asked the Dietary Supervisor to check the temperature of the milk in a gallon on a shelf and temperature of milk in a carton. The temperature of each milk was 53 degrees Fahrenheit. The Dietary Supervisor stated, They have been going in and out of the refrigerator.</p> <p>b. There were opened boxes of sausage stored on a shelf in the refrigerator. The boxes were not covered or sealed.</p> <p>2. On 04/30/24 at 08:50 AM, the following boxes of food items stored on a shelf in the walk-in freezer were not covered or sealed.</p> <p>a. An opened box of hoagie buns. The box was not covered or sealed.</p> <p>b. An opened box of cod fish. The box was not covered or sealed.</p> <p>c. An opened box of chicken tender. The box was not covered or sealed.</p> <p>d. An opened box of turkey patties.</p> <p>e. An opened box pork chop. The box was not covered or sealed.</p> <p>f. An open box of bread sticks. The box was not covered or sealed.</p> <p>g. An opened box of biscuits. The box was not covered or sealed.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>3. 04/30/24 09:13 AM, Dietary Employee (DE) #1 picked up the water hose with his bare hand, used it to spray leftover food from inside of the dishes, contaminating his hands. DE #1 placed the dirty dishes in the dirty racks and pushed the racks into the dish washing machine to wash. After the dishes stopped washing, he moved to the clean side of the dishwasher area and picked up clean dishes and placed them on the clean rack to be used in serving lunch meal to the residents. The Surveyor asked DE #1 immediately what should you have done after touching dirty objects or before handling clean equipment? DE #1, stated, I should have washed my hands.</p> <p>On 04/30/24 at 09: 23 AM, an opened bottle of lemon juice was on a shelf in the storage room. Some of the juice has been used. The manufacturer's specification documented, Refrigerate after opening. At 03:40 PM The surveyor asked DE #5 what was lemon juice used for. DE #5 stated, They used it to make icing for cake. On 05/01/24 at 08:30 AM, the surveyor asked Dietary Supervisor what you use lemon juice for. He stated, They will use it on salad. He was asked how you store an opened lemon juice. He stated, It is supposed to be refrigerated once open.</p> <p>4. On 04/30/24 at 09:46 AM, Dietary Employee (DE) #2 wiped his hands on his shirt. Without washing his hands, he picked up clean eating utensils, by the end of the utensils that would go into the mouth and wrapped them in individual napkins for the residents to use at their lunch meal. The Surveyor asked him immediately what should you have done after touching dirty objects or before handling clean equipment? DE #2 stated, I should have washed my hands.</p> <p>5. On 04/30/24 at 11:19 AM, DE #3 was wearing gloves on her hands when she turned off the food preparation sink faucet. Without changing gloves and washing her hands, she picked up a clean blade, and attached it to the base of the blender to be used in pureeing food items to be served to the residents on pureed diets for their lunch meal. As she was about to scoop vegetables to puree, the surveyor immediately stopped and asked DE #3 what should you have done after touching dirty objects or before handling clean equipment? DE #3 stated, Removed the gloves and wash my hands.</p> <p>6. On 04/30/24 at 11:33 PM, DE #2 turned on the hand washing sink faucet, washed his hands. After washing his hands, he turned off the faucet with his bare hands, contaminating his hands. Then used his contaminated hands to pick up cups by their rims and placed them on the counter by the steam table to be used in serving beverages to the residents with their lunch meal. The Surveyor asked DE #2 what should you have done after touching dirty objects or before handling clean equipment? DE #2, stated, Washed my hands.</p> <p>7. On 04/30/24 at 12:23 PM, DE #4 made grilled cheese sandwiches for the residents who requested a [NAME] cheese sandwich with their lunch meal by taking slices of bread from the original bag, using her gloved hand that she had turned the stove on with. She placed slices of cheese on the slices of bread using her contaminated gloved hand to touch the bread and cheese. The surveyor immediately asked the (DE) #4 what should you have done after touching dirty objects and before handling clean equipment? (DE) #4 stated, I should have removed the gloves and wash my hands.</p> <p>8. On 04/30/24 at 12:31 PM Dietary Employee (DE) #2 picked the tray cards and cartons of beverages and placed them on the trays. Without washing his hands, he began picking up plates for the residents' lunch, with his fingers touching the interior surfaces of the plates.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>9. On 04/30/24 at 12:49 PM The Dietary Supervisor checked the temperatures of the hot food items that had been placed on the serving line on the steam table in preparation for the lunch meal service. The temperatures were:</p> <p>a. Pureed cut green beans 123 degrees Fahrenheit.</p> <p>b. Mashed potatoes 132.3 degrees Fahrenheit. The above food items were not reheated before being served to the resident for lunch meal. At 01:55 PM The surveyor asked the Dietary Employee what should you do when hot food items are not at the required temperature before serving them to the residents? He stated, Immediately reheat it.</p> <p>10. On 04/30/24 at 12:59 PM, DE #1 took a food cart to the dining room, walked back into the kitchen. Without washing his hands, he picked up cups by the rims and poured tea to be served to the residents with their lunch meal. The surveyor immediately asked DE #1 what should you have done after touching dirty objects and before handling clean equipment? DE #1 stated, I should have washed my hands.</p> <p>11. A facility policy titled . Hand Washing/ staff will wash hands and expose portions of their arms provided by the Dietary Supervisor on 05/01/2024 at 07:50 AM documented, To remove contamination after entering the kitchen handling soiled utensils or equipment during food preparation, before donning gloves for working with food, and after engaging in other activities that contaminate the hands.</p> <p>12. On 05/01/24 01:55 PM. the surveyor asked the Dietary Manager what should you do when hot food items are not at the required temperature before serving them to the residents? He stated, Immediately reheat it.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37925</p> <p>Based on observation, interview and record review, the facility failed to ensure staff performed hand hygiene between changing gloves and before leaving a room after assisting with care for 1 (Resident #10) of 1 sampled resident who was reviewed for infection control; failed to ensure staff performed hand hygiene before and between passing meal trays to residents and before and between administering medications to residents. The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #10 had a diagnosis of Spastic Quadriplegic Cerebral Palsy as documented on an Order Summary. <ol style="list-style-type: none"> <li>a. An Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/19/24 documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 (13-15 cognitively intact), had functional limitation in range of motion on both sides in upper and lower extremities and was dependent for upper and lower body dressing.</li> <li>b. A Care Plan, last dated 4/25/24, documented Resident #10 had an Activities of Daily Living (ADL) self-care performance deficit related to diagnosis process and contractures and was dependent on staff for personal hygiene.</li> <li>c. On 04/30/24 at 12:07 PM, Certified Nursing Assistant (CNA) #3 was in Resident #10's room and resident had been put back to bed after receiving a shower. With bare hands, CNA #3 opened the plastic and removed the catheter bag. She hooked the bag to the right side of the bed and placed the tubing on the bed. CNA #3 opened the Resident's top drawer, took out a pair of gloves and without sanitizing her hands, she put on the gloves and used a large white towel to remove the excess water from Resident #3's hair and then placed the towel in a clear plastic bag that was sitting on top of the bedside table. At 12:11 PM, CNA #3 placed a white substance on her gloved hands and rubbed the Resident's chest area and legs. She rolled Resident #10 on the left side and removed a blue lift pad. Without changing gloves, CNA #3 placed a white substance on her gloved hands and rubbed the Resident's back and then pulled the sheet over the Resident. At 12:14 PM, she pulled the sheet down completely and applied lotion to the Resident. Without changing gloves, she applied a white cream to Resident #10's left and right buttocks and she stated it was barrier cream. She rolled the sheets under the Resident, towards the left side and rolled Resident #10 on Resident's back. She picked up the end of the catheter tubing and connected a condom catheter to the end, as she held the bag and tubing next to her clothing. At 12:18 PM, CNA #3 applied the condom catheter to Resident #10. CNA #3 opened the top drawer on the nightstand with the same gloved hands, removed deodorant, removed the top and placed deodorant under Resident #10's arms. She removed her gloves and left the room without sanitizing her hands. She returned to the room with a gown. She reached into the top drawer of the chest of drawers, retrieved a new pair of gloves and put them on without sanitizing her hands. After she placed the gown on the Resident, she placed the top sheet over the Resident and began cleaning up the area.</li> <li>d. On 5/02/24 at 2:29 PM, CNA #3 was interviewed, and she said she had only been working at the facility for 4 months. She confirmed she should have washed or sanitized her hands when she changed gloves and before she left the room.</li> </ol> </li> </ol> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. On 4/30/24 at 1:24 PM, observed Licensed Practical Nurse (LPN) go to tray cart and remove tray and take to a resident. Assisted with her food items and open condiments and then returned to food cart to remove another tray without sanitizing hands. After passing and assisting the resident with food items, condiments, and utensils nurse then returned to food cart to remove another tray and take to another resident without sanitizing hands.</p> <p>a. On 4/30/24 at 1:46 PM, LPN#1, was asked, what should you do before starting to serve resident trays. LPN#1 said, sanitize my hands. What should you do after serving a resident tray before you remove another tray from the cart. LPN#1 confirmed, sanitize my hands. What can occur from not sanitizing hands in between passing trays to residents. LPN#1 confirmed, cross contamination.</p> <p>b. On 5/2/24 at 11:21 AM, the Director of Nursing (DON) was asked what should occur before starting to pass trays. Don confirmed, sanitize hands. What should occur after passing a tray and before passing another tray. Don confirmed, sanitize hands. Why is it important to sanitize your hands in between passing resident trays. Don confirmed, to prevent contamination.</p> <p>3. On 5/2/24 at 08:26 AM, LPN#1 administered medication to a resident without sanitizing hands before beginning to do medication pass.</p> <p>4. On 5/2/24 at 08:40 AM, LPN#1 administered medication to another resident without sanitizing hands after administering medication to another resident previously.</p> <p>a. On 5/2/24 at 8:52 AM, LPN#1 was asked, what should you do before administering medication. LPN#1 said, sanitize my hands. What should you do after giving medication to a resident and before giving medication to another resident. DON#1 said, sanitize my hands. Why is it important to sanitize your hands before and after giving medication to another resident. LPN#1 said, to prevent cross contamination.</p> <p>b. On 5/2/24 at 11:11:18 AM, the DON was asked what should a nurse do before passing medication. The DON said, sanitize their hands. What should a nurse do after administering medication to a resident. DON said, sanitize their hands. Why is it important to sanitize hands in between passing medication to residents. The DON said, to prevent spread of infections.</p> <p>c. A Handwashing / Hand Hygiene policy provided by the Administrator on 5/1/24 documented, . This facility considers hand hygiene the primary means to prevent the spread of infection. 1. All personnel shall follow the handwashing / hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 4. An alcohol-based hand rub may be used if no visible soiling. 5. Hand hygiene is the final step after removing and disposing of personal protective equipment. 6. The use of gloves does not replace hand washing / hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .</p> <p>49071</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>49596</p> <p>Based on observations and record review the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.</p> <p>The findings are:</p> <p>On 04/30/24 at 10:01 PM, observation rounds were made on the men's secured unit. The entire length of the wall, 15 feet, has peeling paint and gouged areas of drywall approximately 7 from the floor. The walls of the dining room, of the men's secured unit, has several areas with the paint chipping off and holes in the drywall of the walls. A large hole is in the drywall near the window where a resident dining table sits and where residents eat their meals. This hole measures 4 1/2 X 2; there is a second large hole beside a second dining table where the residents eat their meals which measures 6 X 4; on the wall where the med-room window is located is a large area of peeling paint just under the med-room window. This is a central area where the residents gather and sit for activities and meals. This area measures 23 X 17 in diameter; another area of dry wall has been gashed out measuring 2X 1.25 which is hanging from the wall, this is within reach of all residents.</p> <p>On 05/02/24 at 02:14 PM, the surveyor and Maintenance Director made observations in the Men's secured unit. The Maintenance Director measured the areas and stated The wall looks awful and needs to be painted. It has been this way since I started two months ago. We are doing a total repaint of the walls. The surveyor asked the maintenance director if he had a work order book. The Maintenance Director stated yes and pulled a 3- ring binder from the wall pocket near the Med-room window. The surveyor asked the Maintenance Director if he had work orders on any of the areas identified in the dining room. The Maintenance Director stated, No. The surveyor asked the Maintenance Director what caused these problems. The Maintenance Director stated, The residents peel the paint off the walls and the wheelchairs.</p>