STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045463	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belvedere Nursing and Rehabilitation Center, LLC	2600 Park Ave Hot Springs, AR 71901

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 49596 Based on observation and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 (Resident #11) of 1 resident residing in the Memory Unit, related to identification of the medications the resident was receiving related to the Resident's medical needs. The findings are: 1. On 11/05/24 at 9:18 PM, a review of the Resident's Care Plan, Physician's Orders, and the Minimal Data Set (MDS) for Resident #111 identified Resident #111's Care Plan did not identify the following medications ordered for Resident #111: a. Risperidone oral tablet 0.25 milligram (MG), the resident was given 1 tablet by mouth two times a day for severe dementia with agitation. b. Trazodone oral tablet 150 MG, the resident was given 1 tablet by mouth at bedtime related to the resident's sleep disorder. c. Duloxetine oral capsule delayed release particles 60 MG resident was given 1 capsule by mouth two times a day related to major depressive disorder. d. Mirtazapine oral tablet 7.5 MG, resident was given 1 tablet by mouth at bedtime related to moderate protein-calorie malnutrition. e. Quetiapine Fumarate oral tablet 25 MG resident was given 1 tablet by mouth at bedtime related to dementia with agitation. f. Clonazepam oral tablet 0.5 MG a controlled drug, resident was given 1 tablet by mouth at bedtime for agitation related to Dementia with agitation. 2. Review of an admission MDS with an Assessment Reference Date (ARD) of 09/16/2024 revealed Resident #111 had a Brief Interview for Mental Status (BIMS) of 3, indicating severe cognitive impairment. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. On 11/06/24 at 10:40 AM, MDS Coordinator #1 confirmed Resident #111 was ordered Duloxetine on 9/10/24, Trazodone on 9/10/24, Risperidone on 9/10/24, Quetiapine on 10/11/24, Mirtazapine on 9/10/24, and Clonazepam on 9/10/24. MDS Coordinator #1 confirmed the resident's care plan does not address these medications. MDS Coordinator #1 said Resident #111's care plan should identify the medications the resident is prescribed so the care plan shows the most current status of the resident.

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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. 47916 Based on observation, record review, interview, and facility record review, the facility failed to ensure the central bath and soiled utility room on 300 Hall were locked to prevent resident access to dirty linens, chemicals, and wet floors to prevent accidents and injuries. The facility failed to ensure the mechanical lift was in good working order to prevent accidents and injuries to 1 (Resident #49) of 1 sampled resident reviewed for accidents and injuries. Findings include: 1. a. On 11/04/24 at 10:34 AM, the surveyor observed the central bath door on 300 hall was unlocked. A clear bottle of blue fluid labeled [named] disinfectant cleaner was observed sitting just inside the door resting on a bedside chair. The bottle says hazardous to humans and animals, avoid contact with eyes and clothes and includes an emergency toll free number to call. A blue plastic container on the bedside commode contained anti-perspirant and [named] hygiene and barrier foam. b. On 11/05/24 at 10:36 AM, a deep bathtub, moist floor, shower area with 2 [named] fragrance body spray, and shampoo were observed in the central bath. The body spray was labelled as flammable, and not for underarm use. A low hanging cabinet observed not locked containing perineal skin cleanser, shave cream, and [named] hygiene and barrier foam. c. On 11/05/24 at 10:45 AM, the door to the soiled utility room opened easily and revealed two closed laundry bags, and two open containers of soiled linens. There were 2 containers of [named] sanitizing wipes displaying on the containers to call poison control for treatment resting on the cabinet. d. On 11/05/24 at 10:46 AM, Certified Nursing Assistant (CNA) #3 presented to the soiled utility room and stated the soiled utility room is supposed to stay locked so residents can not touch the soiled linens and harm themselves. CNA #3 stated that is why we have a separate room to store dirty linens, and it has a lock. CNA #3 was asked if the central bath is supposed to be locked, and why. CNA #3 confirmed the shower room should be locked due to chemicals, wet flooring, and stated residents could fall in the shower, or into the tub. e. During an interview with Director of Nursing (DON) on 11/07/24 at 8:40 AM, the DON was asked if bathrooms, and soiled utility rooms were to be locked, and why. The DON stated the central bath and soiled utility rooms are to remain locked and that is why there is a key code on the door to prevent residents from having access to dirty linens, chemicals, and wet floors that could cause residents to slip or fall. The DON stated maintenance was responsible for making sure the battery was changed in the key code lock, so they were in good working order. The Surveyor requested any policy or procedure, and maintenance logs showing the procedure for maintaining key coded doors. f. On 11/07/24 at 9:30 AM, the DON confirmed there was no policy or procedure addressing keeping the central bath or soiled utility rooms locked, and there was no log provided showing where maintenance checked the working order of doors with a key code to prevent resident access. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Medical Diagnosis revealed Resident #49 had diagnoses of stroke, type II diabetes, and seizure disorder. a. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/06/2024 indicated Resident #49 had a Brief Interview for Mental Status (BIMS) score of 15 (13-15 indicated cognitively intact). Section GG suggest resident requires maximum assistance for bathing. b. On 11/05/24 at 2:40 PM, the surveyor observed Certified Nursing Assistant (CNA) #4 and CNA #5 removing the mechanical lift from Resident #49 with a clip missing from the right side on the 1st hook, and where the hang bar is attached to the mechanical lift there is a large piece of plastic missing at the top, exposing the metal bar. CNA #5 confirmed 3 times the lift pad is always connected to the 1st and 3rd hook and never the middle hook on the arm of the lift. CNA #5 stated she did not know what the metal clips were for, but assumed it was a safety feature to keep the lift pad from coming off the hook. CNA #4, and CNA #5 both stated they contacted maintenance, and he is coming to fix the mechanical lift, but they used it anyway because Resident #49 wanted to shower before getting a visitor. c. On 11/06/24 at 2:44 PM, Licensed Practical Nurse (LPN) #6 was asked the procedure for using a mechanical lift if a clip was missing and pointed out the broken plastic connecting the hanger bar to the mechanical lift. LPN #6 stated she would not use the lift if it was missing a clip for safety reasons. CNA #5 stated there was a risk that Resident #49 could have fallen by using a lift with a missing clip. d. On 11/05/24 at 3:45 PM, the DON provided a document from [named] Durable Medical Equipment (DME) service company showing the mechanical lift was serviced on 10/26/2024 and passed inspection. e. On 11/06/24 at 9:21 AM, Assistant Administrator provided a procedure titled Two Person Lift, revised 11-22-2016 that does not apply to the mechanical lift. e. On 11/06/24 at 9:30 AM, the Assistant Administrator provided a manual titled Hydraulic/Electric Patent Lift Warning Label Kit, revealing staff should check to see if the sling is properly attached to the hooks of the hanger bar, and if any attachments are not in place the resident should be lowered back to a stationary position. Part of maintenance is checking for missing hardware. f. On 11/07/24 at 8:35 AM, the DON was asked what process staff was expected to do before using a mechanical lift to transfer a resident. The DON revealed that durable medical equipment (DME) should be inspected to make sure everything is there or in good working condition before use. Maintenance should be notified, and the equipment removed from service, and the equipment should not return to service until it has been repaired. The DON was asked with the missing plastic and metal hook clip missing, should the mechanical lift been used. The DON stated the mechanical lift should have been pulled back and not used on Resident #49. g. On 11/07/24 at 9:30 AM, DON provided a copy of their medical equipment service agreement showing they provide service to durable medical equipment (DME) and other products.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 Based on observation, interview, record review, and facility policy review, the facility failed to ensure dietary staff washed their hands before handling clean equipment or food items when contaminated; 1 of 1 ice machines was maintained in a clean and sanitary condition, and cold dairy products were maintained at 41 degrees Fahrenheit or below for one meal observed. The findings are: 1. On 11/06/24 at 10:12 AM, Dietary Aide (DA) #7 opened the refrigerator, removed a pan of cookies, and placed it on the counter. Then DA #7 removed gloves from the glove box and placed them on her hands. Using her gloved hands, which were now contaminated, DA #7 picked up each piece of cookie from the pan placed them individually into separate bags to be served to the residents for lunch meal 2. On 11/06/24 at 10:22 AM, the following leftover dairy products were in a cooler by the steam table: a. There were 5 cartons of leftover whole milk, 2 cartons of chocolate ice cream, 4 cartons of sherbets and one carton of vanilla ice cream. The Assistant Dietary Manager was asked if she could check the temperature of the milk and check if the ice cream had thawed. She stated the milk temperature on the first carton was 43 degrees Fahrenheit and the second carton of milk temperature was 45 degrees Fahrenheit. After opening the cartons of ice cream and sherbets, the Assistant Dietary Manager confirmed the ice cream and sherberts had melted and should have been pulled from the cooler and put in the freezer at 8:50 AM, and she didn't know if staff checked the temperature on dairy products or if the ice cream had melted before putting them back in the freezer. 3. On 11/06/24 at 10:28 AM, the ice machine panel had wet black residue on it. The Surveyor asked the Assistant Dietary Manager to wipe the area, and the residue easily transferred to the tissue. The Assistant Dietary Manager stated it was dirty with black residue on the tissue, and the Certified Nursing Assistants (CNA) use it to fill beverages served to the residents at mealtimes and fill water pitchers in the resident's rooms and clean it every week. 4. On 11/06/24 at 11:05 AM, Dietary Aide (DC) #8 walked out of the restroom with tissue on his hands. Then, DA #8 picked up tray cards and placed them on the counter. Without washing his hands, he picked up napkins and placed them on the trays for the residents to use to wipe their mouths when eating. DA #8 was asked what the napkins were used for. DA #8 stated they use them to wipe their mouths while eating and he should have washed his hands. 5. A review of facility policy titled, In-Service Manual, initiated 2/92024, provided by the Assistant Dietary Manager on 11/7/2024 indicated, before, during, and after food preparation employees and after engaging in other activities that contaminate hands.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47916 Based on observation, interview, and facility policy review, it was determined that the facility failed to ensure proper hand hygiene was performed during peri care to reduce the risk of cross contamination, and the spread of infection for 1 sampled (Resident #55) resident reviewed for bowel and bladder. Findings include: Review of an in-service was provided titled Return Demonstration-Peri Care, revealing the dates of in-servicing of staff was done on 03/13/2024, 06/05/2024, and 07/01/2024, but no educational information was provided. A policy/procedure was provided titled Perineal/Catheter Care, revised 11/22/2016, revealing after perineal care gloves should be changed before placing a clean brief under resident and replacing the bedspread and giving resident the call light. On 11/04/2024 at 11:30 AM, during perineal care Certified Nursing Assistant (CNA) #2, and CNA #3 were observed cleaning Resident #55 of urine and stool without changing their gloves or washing hands prior to placing a clean brief and lift pad under the resident, pulling Resident #55's clothing up, and looking in the resident's bedside table. On 11/04/2024 at 11:40 AM, CNA #2 revealed she thought hand hygiene was supposed to be done at the beginning of perineal care, and when finished. CNA #2 confirmed hand hygiene should have been done after cleaning residents perineal area before dressing her and touching the environment. CNA #3 revealed she should have performed hand hygiene or changed her gloves after cleaning stool from resident's buttocks before dressing her and placing a clean lift pad under Resident #55 to avoid cross contamination. During an interview with Director of Nursing (DON) on 11/07/24 at 8:30 AM, the DON stated staff should wash their hands prior to beginning perineal care and should use one hand to hold the perineal area, and a clean hand should be used for wiping. The DON was asked if staff used both hands to clean a resident, if they are expected to do anything before dressing the resident. The DON stated staff should wash their hands before touching anything clean to prevent the spread of bacteria and prevent the harboring of infection.