STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045464	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amberwood Health and Rehabilitation	6420 Alcoa Road Benton, AR 72015

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48977 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure staff followed basic competencies and nursing skills when administering medication for 3 (Residents #14, #244, #245) residences observed during medication administration. The findings include: 1. A review of the quarterly Minimum Date Set (MDS) with Assessment Reference Date of [DATE] revealed Resident #14 had a Brief Interview of Mental Status score of 15 indicating the resident was cognitively intact and received scheduled pain medication regimen. a. A plan of care for Resident #14 (revision on [DATE]) revealed Resident #14 had chronic pain related knee pain, back pain, age related decline, muscle wasting and shrinkage of muscle mass, and muscle spasms. b. According to the Medication Administration Record (MAR) Resident #14 had a physician's order for lidocaine External Cream 4% apply to both knees and shoulders. c. On [DATE] at 12:05 PM, the Surveyor observed Licensed Practical Nurse (LPN) #2 apply lidocaine cream to Resident # 14's lower back and knees. 2. Resident #244 was admitted on [DATE] and did not have a completed Admission MDS. a. A plan of care for Resident #244 (date initiated [DATE]) revealed Resident #244 had a nutritional problem or potential nutritional problem related to inflammation of the throat and difficulty swallowing. b. According to Medication Administration Record (MAR) Resident #244 had a physician's order for Sucralfate Suspension 1 gram (GM)/10 milliliter (ML) give 1 gram by mouth before meals and at bedtime for gastric protection. c. On [DATE] at 4:06 PM, the Surveyor observed LPN #3 add 5 ml of diphenhydramine viscous lidocaine added to water and administer to Resident #244. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On [DATE] at 9:30 AM, the Surveyor reviewed the medication that was administered and noted the medication was expired and there was no physician's order to administer. e. On [DATE] at 9:35 AM, the Assistant Director of Nursing (ADON) stated Resident #244 brought the medication in the facility when admitted and she should have removed it. The ADON stated Resident #244 did not have a physician's order and confirmed the medication was expired. 3. Resident #245 was admitted on [DATE] and did not have a completed Admission MDS. a. A plan of care for Resident #245 (date Initiated: [DATE]) revealed Resident #245 had a nutritional problem or potential nutritional problem related to type II diabetes mellites (T2DM), hypertension (HTN), gastroesophageal reflux disease (GERD), hyperlipidemia (HPLD), gout, chronic kidney disease (CKD) stage 4, chronic obstructive pulmonary disease (COPD), and irritable bowel syndrome (IBS). b. According to Medication Administration Record (MAR) Resident #245 did not have a physician's order for polyethylene glycol 17 grams (g), atorvastatin 5 milligram (mg), or metoclopramide 5 mg. Resident #245 had a physician's order for amlodipine 10 mg daily was taken at 8:00 AM, Carvedilol 12.5 mg twice daily was taken at 8:00 AM, and gabapentin 600 mg three time daily was taken at 8:00 AM and 12:00 PM. c. On [DATE] at 4:15 PM, the Surveyor observed LPN #3 administer Resident #245 atorvastatin 40 mg, amlodipine 5 mg, carvedilol 3.125 mg, polyethylene glycol 17 g added to water, gabapentin 400 mg, and metoclopramide 5 mg. d. On [DATE] at 4:20 PM, after exiting the room the Surveyor asked LPN #3 to see her MAR and noted the name on the MAR was not Resident #245. The Surveyor then stated to LPN #3 the name on the MAR does not match the name on the door. LPN #3 stated That's why I don't like to be watched I knew I was going to make a mistake. LPN #3 locked her cart and walked off. e. On [DATE] at 2:39 PM, the Director of Nursing (DON) stated a nurse should ensure he/she has the right resident, right medication, it is the right time to administer the medication, the dose is correct, and the medication is given the right route prior to administering the medication. The DON stated if these 5 things are not done a resident could get the wrong medication. The DON stated the resident's name and picture are on the MAR to further prevent an adverse outcome. f. A review of policy titled Competency of Nursing Staff noted competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in basis nursing skill.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48977 Based on observation, interviews, record reviews, and facility policy review, the facility failed to ensure the medication error rate was not greater than 5%. The medication errors occurred with 3 (Resident #14, #244, #245) sampled residents observed during medication administration. The finding include: 1. A review of the quarterly Minimum Date Set (MDS) with Assessment Reference Date (ARD) of [DATE] revealed Resident #14 had a Brief Interview of Mental Status score of 15 indicating cognitively intact, and received a scheduled pain medication regimen. a. A plan of care for Resident #14 (revision on [DATE]) revealed Resident #14 had chronic pain related to r knee pain, back pain, age related decline, muscle wasting or thinning of the muscle mass, and muscle spasms. b. According to Medication Administration Record (MAR) Resident #14 had a physician's order for lidocaine External Cream 4 % apply to both knees and shoulders. c. On [DATE] at 12:05 PM, the Surveyor observed Licensed Practical Nurse (LPN) #2 apply lidocaine cream to Resident # 14's lower back and knees. 2. Resident #244 was admitted on [DATE] and did not have a completed Admission MDS. a. A plan of care for Resident #244 (date initiated [DATE]) revealed Resident #244 had a nutritional problem or potential nutritional problem related to inflammation in the throat and difficulty swallowing. b. According to Medication Administration Record (MAR) Resident #244 had a physician's order for Sucralfate Suspension 1 gram (GM)/10 milliliter (ML) give 1 gram by mouth before meals and at bedtime for gastric protection. On [DATE] at 4:06 PM, the Surveyor observed LPN #3 add 5 ml of diphenhydramine viscous lidocaine added to water and administer to Resident #244. c. On [DATE] at 9:30 AM, the Surveyor reviewed the medication that was administered and noted the medication was expired and there was no physician's order to administer. d. On [DATE] at 9:35 AM, the Assistant Director of Nursing (ADON) stated Resident #244 brought the medication in the facility when admitted and she should have removed it. The ADON stated Resident #244 did not have a physician's order and confirmed the medication was expired. 3. Resident #245 was admitted on [DATE] and did not have a completed Admission MDS. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. A plan of care for Resident #245 (date Initiated: [DATE]) revealed Resident #245 had a nutritional problem or potential nutritional problem related to type II diabetes mellites (T2DM), hypertension (HTN), gastroesophageal reflux disease (GERD), hyperlipidemia (HPLD), gout, chronic kidney disease (CKD) stage 4, chronic obstructive pulmonary disease (COPD) and irritable bowel syndrome (IBS). b. According to Medication Administration Record (MAR) Resident #245 did not have a physician's order for polyethylene glycol 17 grams (g), atorvastatin 5 milligram (mg), or metoclopramide 5 mg. Resident #245 had a physician's order for amlodipine 10 mg daily was taken at 8:00 AM, carvedilol 12.5 mg twice daily was taken at 8:00 AM, and gabapentin 600 mg three time daily was taken at 8 AM and 12 PM. c. On [DATE] at 4:15 PM, the Surveyor observed LPN #3 administer Resident #245 atorvastatin 40 mg, amlodipine 5 mg, Carvedilol 3.125 mg, polyethylene glycol 7 g added to water, Gabapentin 400 mg, and Metoclopramide 5 mg. d. On [DATE] at 4:20 PM, after exiting the room the Surveyor asked LPN #3 to see her MAR and noted the name on the MAR was not Resident #245. The Surveyor then stated to LPN #245 the name on the MAR does not match the name on the door. LPN #3 stated That's why I don't like to be watch I knew I was going to make a mistake. LPN #3 locked her cart and walked off. e. On [DATE] at 6:30 PM, the Surveyor was informed by the Director of Nursing (DON) the Physician was notified that Resident #245 was given the wrong medication. f. On [DATE] at 2:39 PM, the Director of Nursing (DON) stated a nurse should ensure he/she has the right resident, right medication, it is the right time to administer the medication, the dose is correct, and the medication is given the right route prior to administering the medication. The DON stated if these 5 things are not done a resident could get the wrong medication. The DON stated the resident's name and picture are on the MAR to further prevent an adverse outcome. g. A review of the policy titled Administering Medication noted Medication shall be administered in a safe and timely manner, and as prescribed. 6. The individual administering the medication must verify the resident's identity before giving the resident his/her medication. 7. The individual administering the must check the label 3 times to verify the right resident, right medication, right dose, right time and method (route) of administration before giving the medication.

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	045464	A. Building B. Wing	11/14/2024

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48977 Based on observations, interviews, record reviews, and facility policy review the facility failed to ensure the facility was free from significant medication error for 2 (Resident #244, #245) sampled residents who were administered the wrong medication during observed medication administration. The findings include: 1. Resident #244 was admitted on [DATE] and did not have a completed Admission Minimum Data Set (MDS). a. A plan of care for Resident #244 (date initiated [DATE]) revealed Resident #244 had a nutritional problem or potential nutritional problem related to throat and difficulty swallowing. b. According to Medication Administration Record (MAR) Resident #244 had a physician's order for Sucralfate Suspension 1 gram (GM)/10 milliliter (ML) give 1 gram by mouth before meals and at bedtime for gastric protection. c. On [DATE] at 4:06 PM, the Surveyor observed LPN #3 add 5 ml of diphenhydramine viscous lidocaine added to water and administered to Resident #244. d. On [DATE] at 9:30 AM, the Surveyor reviewed the medication that was administered and noted the medication was expired and there was no physician's order to administer. e. On [DATE] at 9:35 AM, the Assistant Director of Nursing (ADON) stated Resident #244 brought the medication in the facility when admitted and she should have removed it. The ADON stated Resident #244 did not have a physician's order and confirmed the medication was expired. 2. Resident #245 was admitted on [DATE] and did not have a completed Admission MDS. a. A plan of care for Resident #245 (date initiated: [DATE]) revealed Resident #245 had a nutritional problem or potential nutritional problem related to type II diabetes mellites (T2DM), hypertension (HTN), gastroesophageal reflux disease (GERD), hyperlipidemia (HPLD), gout, chronic kidney disease (CKD) stage 4, chronic obstructive pulmonary disease (COPD) and irritable bowel syndrome (IBS). b. According to Medication Administration Record (MAR) Resident #245 did not have a physician's order for polyethylene glycol 17 grams (g), atorvastatin 5 milligram (mg), or metoclopramide 5 mg. Resident #245 had a physician's order for amlodipine 10 mg daily was taken at 8:00 AM, Carvedilol 12.5 mg twice daily was taken at 8:00 AM, and gabapentin 600 mg three time daily was taken at 8 AM and 12 PM. c. On [DATE] at 4:15 PM, the Surveyor observed LPN #3 administer Resident #245 atorvastatin 40 mg, amlodipine 5 mg, Carvedilol 3.125 mg, polyethylene glycol 17 g added to water, Gabapentin 400 mg, and Metoclopramide 5 mg. (continued on next page)

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	045464	A. Building B. Wing	11/14/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On [DATE] at 4:20 PM, after exiting the room the Surveyor asked LPN #3 to see her MAR and noted the name on the MAR was not Resident #245. The Surveyor then stated to LPN #245 the name on the MAR does not match the name on the door. LPN #3 stated That's why I don't like to be watch I knew I was going to make a mistake. LPN #3 locked her cart and walked off. On [DATE] at 6:30 PM, the Director of Nursing (DON) informed the Surveyor the Physician was notified that Resident #245 was given the wrong medication and LPN #3 was sent home until Monday. e. On [DATE] at 2:39 PM, the Director of Nursing (DON) stated a nurse should ensure he/she has the right resident, right medication, it is the right time to administer the medication, the dose is correct, and the medication is given the right route prior to administering the medication. The DON stated if these 5 things are not done a resident could get the wrong medication. The DON stated the resident's name and picture are on the MAR to further prevent an adverse outcome. f. A review of policy titled Administering Medication noted Medication shall be administered in a safe and timely manner, and as prescribed. The individual administering the medication must verify the resident's identity before giving the resident his/her medication. The individual administering the must check the label 3 times to verify the right resident, right medication, right dose, right time and method (route) of administration before giving the medication.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, record review, interview, and facility policy review, the facility failed to ensure food items expired food items were promptly removed/discard by the expiration or use by dates as when it was delivered, staff washed their hands, and dietary staff washed their hands and between clean tasks when contaminated. The findings are: 1. On [DATE] at 10:13 AM, the following observations were made in the refrigerator in the activity lounge. a. There was an opened bottle of tomatoes juice on a shelf with no received date on it. b. One turkey sandwich was inside a container on a shelf with an expiration date of [DATE]. 2. On [DATE] at 10:49 AM, Dietary Aide (DA) #1 picked up the water hose with her bare hand, used it to spray off leftover food items from the dishes, contaminating her hands. She placed dishes in the dirty racks and pushed them into the dish washing machine to wash. After the dishes stopped washing, the Dietary Aide #1 turned on the hand washing sink faucet and washed her hands. She turned off the faucet with her bare hands. Her hands contaminated and without washing his hands, she picked up clean plates with his fingers inside the plates and placed them on top of the cart to be used in serving food items to the residents for lunch 3. On [DATE] at 10:53 AM, DA #1 picked up the water hose with her bare hand, used it to spray off leftover food items from the dishes, contaminating her hands. She placed dishes in the dirty racks and pushed them into the dish washing machine to wash. After the dishes stopped washing, DA #1 turned on the hand washing sink faucet and washed her hands. She turned off the faucet with her bare hands her hands. With her hands contaminated and without washing her hands, she picked up clean plates with her fingers inside the plates and placed them on top of the cart to be used in serving food items to the residents for lunch. DA #1 was asked what she should you have done after touching dirty objects and before handling clean equipment she stated she should have washed her hands. 4. On [DATE] at 12:32 PM, Dietary Aide #1 turned on the hand washing sink and washed her hands, she removed tissue from the tissue dispenser and dried her hands. DA #1 turned off the faucet with the same tissue, contaminated the tissue papers. DA #1 then used the same tissue papers to dry her hands and without re-washing her hands, picked up clean plates and stacked the on a cart to be used in portioning food items to the residents for lunch with fingers inside the plates. 5. On [DATE] at 7:58 AM, DA #1 turned on the hand washing sink and washed her hands, she removed tissue from the tissue dispenser and dried her hands. DA #1 turned off the faucet with the same tissue, contaminated the tissue papers. She then, used the same tissue papers to dry her hands and without re washing her hands, DA #1 picked up clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents for breakfast and/or lunch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. A review of facility policy titled, Employee Cleanliness and Hand washing Technique, not dated, provided by the Food Service Director on [DATE] indicated hands should be washed before beginning and any other time deemed necessary.