STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A158	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Craighead Nursing Center	5101 Harrisburg Rd Jonesboro, AR 72404

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50505 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure care plan interventions were added to the care plan for elopement monitoring device for 1 (Resident #21). Findings include: A review of a facility policy titled, Care Plan Revisions Upon Status Change dated 03/25/2024, indicated the comprehensive care plan will be reviewed and revised as necessary, when a resident experiences a status change. A review of the Medical Diagnosis indicated the facility admitted Resident #21 with diagnosis of unspecified dementia. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/15/2024 revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was moderately cognitively impaired. A review of an Incident and Accident (I&A), Follow Up note dated 02/14/2024 at 12:37 PM, indicated the long-term intervention was an elopement monitoring device applied to the right ankle due to wandering and increased confusion. The I &A note stated that intervention was added to the care plan. A review of Resident #21's Care Plan updated 02/13/2024, revealed the resident was at risk for falls related to confusion, deconditioning and gait balance problems, and Resident #21 had had a fall with a hematoma. No new interventions were added. During an observation on 07/10/2024 at 8:36 AM, upon entering Resident #21's room, Resident #21 was sitting in a wheelchair. No elopement monitoring device could be seen on the right or left ankle of the resident. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation on 07/10/2024 at 8:39 AM, Certified Nursing Assistant (CNA) #8 and CNA #13 were asked by the surveyor to check Resident #21 for an electronic monitoring device. C.N.A. #8 and C.N.A. #13 confirmed there was no device on the resident. C.N.A. #13 informed the surveyor that some people on the 300 Hall have the elopement monitoring device and some do not. When asked if the resident was supposed to have an elopement monitoring device, CNA #8 and CNA #13 said let us go look. Both CNAs went to the nurse's desk to check to see if the resident had on an elopement the device. After returning to Resident #21's room, the surveyor was informed by C.N.A. #13 that the resident was supposed to have one on. During an observation on 07/10/2024 at 8:49 AM, the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #12 went into Resident #21's room with the surveyor. The DON was asked to see if she could locate Resident #21's elopement monitoring device. The DON assessed both of Resident #21's arms and legs for the elopement monitoring device. The DON confirmed no device was located. During an interview on 07/11/2024 at 8:45 AM the DON was asked who revises and changes the care plans when changes need to be made. The DON replied that she was the one who initiates the care plans when an incident and accident (I&A) occurs and includes the intervention(s). Care plan revisions and resolving are made by the interdisciplinary team. When asked how the front-line staff knows when new interventions have been put into place, the DON stated meetings are held with the restorative aides and folders that contain information on the residents are updated at the nurse's desk and if the staff need to know immediately of an intervention, in-services are provided at that time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50505 Based on observations, interviews, record reviews, facility document review, and facility policy review, it was determined the facility failed to ensure interventions to prevent falls were implemented for 1 (Resident #21) resident and the sharps container (a container to dispose of used needles and other sharp objects) in the shower room was not overfilled to prevent access/injury. Findings include: 1. A review of a facility policy titled Accidents and Supervision signed and dated by the Administrator on 07/11/2024 indicated, The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1) identifying hazard(s) and risk(s); 2) evaluating and analyzing hazard(s) and risk(s); 3) implementing interventions to reduce hazard(s) and risk(s); 4) monitoring for effectiveness and modifying interventions when necessary . A review of the Medical Diagnoses indicated Resident #21 had diagnoses that included unspecified dementia; fracture of unspecified part of neck of right femur; atrial fibrillation; Parkinson's disease; hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side; epilepsy; muscle wasting and atrophy; difficulty walking; unspecified abnormalities of gait and mobility; fibromyalgia; and age-related osteoporosis. A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/15/2024, revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated Resident #21 was moderately cognitively impaired. A review of Resident #21's Care Plan, updated 07/03/2024 revealed the resident had a risk for falls related to confusion, deconditioning, and gait balance problems. Interventions included on 06/27/2024 anti-rollbacks were placed on the wheelchair. During an observation on 07/10/2024 at 8:36 AM, Resident #21 was sitting in the resident's room in a wheelchair. The fall mat was beside the bed. Anti-rollbacks were not on the rear of the wheelchair. During an observation and concurrent interview on 07/10/2024 at 8:38 AM with Certified Nursing Assistant (CNA) #8, and CNA #13, both CNA #8 and CNA #13 informed the surveyor that anti-rollbacks had never been seen on Resident #21's wheelchair. CNA #8 was asked how staff were to know what kind of assistance and interventions were needed with the resident. CNA #13 stated the information was on the task section of the electronic charting system used by the CNAs and the assistance required was on the back of the nurse's station door. During an observation and concurrent interview on 07/10/2024 at 8:49 AM, the Director of Nursing (DON) and Licensed Practical Nurse (LPN) #12 entered Resident #21's room. The DON was asked to look at Resident #21's wheelchair for anti-rollbacks. The DON stated, They are not on the chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 07/11/2024 at 10:30 AM, the DON was asked who was responsible for carrying out interventions and making sure that those interventions were put into place. The DON stated that maintenance would add the anti-rollback brakes and that she and the restorative aides would meet to discuss and decide if interventions were effective or if the intervention needed to be changed. During an interview with the Maintenance Director on 07/10/2024 at 4:30 PM, regarding any maintenance requests for Resident #21 and anti-rollbacks. The maintenance request was in the maintenance request logbook and was dated 07/09/2024, the request had been made by the Director of Nursing. 2. During an observation on 07/09/2024 at 9:35 AM, Shower room [ROOM NUMBER] was inspected for cleanliness. The sharps container on the wall was overflowing, a bottle of aftershave, gloves and a bottle of lotion were sitting on top of the sharps container. During an interview and concurrent observation on 07/09/2024 at 2:14 PM, the surveyor and the Maintenance Supervisor were walking on the 300 Hall. The door to the shower room was noted to be slightly open. After knocking on the door, no one was observed in the shower room. The sharps container was still overflowing. According to the Maintenance Supervisor, no requests had been made for the sharps container to be changed out or picked up. When asked how the sharps, once full, should be handled, the Maintenance Supervisor explained that the Certified Nursing Assistants (C.N.A.) and the nurses communicate the sharps need to be changed and picked up. The Maintenance Supervisor then picks the sharps containers up and places them in biohazard bags/boxes and the boxes are then stored in the shed for biohazard waste until picked up by the medical waste company. During an observation on 07/09/2024 at 2:16 PM, a CNA entered the Shower room [ROOM NUMBER] and then exited the shower room and pulled the door closed and the door remained slightly open. The Surveyor walked over to the door and pushed on the door and the door opened. During an observation on 07/09/2024 at 2:30 PM, a CNA walked into the shower room and walked back out and left the door open. It was within sight of the CNAs that were in the hall. A CNA walked over and shut the door to Shower room [ROOM NUMBER]. During an interview and concurrent observation on 07/09/2024 at 2:40 pm, the Administrator was asked to come to Shower room [ROOM NUMBER]. Upon arriving to the shower room, the door was pulled to with the privacy curtain hanging outside the door. The Administrator knocked on the door. At that time a CNA was finishing with a resident. As the CNA exited the room, the surveyor asked the CNA to pull the door to so that the Administrator could see the door closing. The door was pulled to and let go. The door did not close completely. The Administrator then looked at the sharps container and made the comment, Oh my, that is a little full. The Administrator confirmed that it was possible for alert and ambulatory residents to get into the shower room since the door was not shutting completely. During an interview on 07/09/2024 at 2:45 PM, the DON walked up to Shower room [ROOM NUMBER] and was shown the sharps container and was informed by the Administrator that the door was not being shut completely and that residents that were alert and ambulatory could enter the shower room. The DON concurred that it could happen with the door not shutting completely.

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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 and interview, the facility failed to ensure dietary staff washed their hands between dirty and clean tasks and before handling clean equipment or food items to prevent potential for cross contamination and food borne illness for residents who received meals from 1 of 1 kitchen; leftover food items were not used for residents who received meals from 1 of 1 kitchen to maintain food quality and prevent the growth of bacteria; and failed to ensure dietary staff secured facial hair in a hairnet when preparing food. The failed practices had the potential to affect 87 residents who received their meals from one of one kitchen according to a list provided by the Dietary Manager on 07/09/2024 at 9:12 AM. The findings are: 1. On 07/08/2024 at 11:29 AM, Dietary Aide #2 picked up a box of gloves and placed it on the counter, then removed gloves and placed them on her hands, contaminating the gloves, she untied the bread bag and used her contaminated gloved hand to remove slices of bread and placed them on a pan liner on the counter. She removed a lid from a container of chicken salad, she scooped chicken salad out of the container and placed it on each slice of bread to be used in making chicken salad to be served to the residents who asked for a chicken salad sandwich with their meal. The Surveyor asked Dietary Aide #2 what she should have done after touching dirty objects and before handling clean equipment. She stated, I should have removed the gloves and washed my hands. 2. On 07/08/2024 at 11:33 AM, Dietary Aide #3 walked out of the walk-in freezer with a box of sugar cookies and placed it on the counter. She opened the box, contaminating her hands. Without washing her hands, she unwrapped the bag inside the box that held the cookies, removed cookies with contaminated gloved hand and placed them on a pan to be baked and served to the residents who asked for sugar cookies with their lunch meal. At 12:17 PM, the Surveyor asked Dietary Aide #3 what she should have done after touching dirty objects and before handling clean equipment. She stated, I should have hands washed before putting the gloves on. 3. On 07/08/2024 at 11:34 AM, Dietary Aide #2 picked up a can of thickener from the cabinet and placed it on the counter. Without washing her hands, she picked glasses by their rims and poured beverages to be served to the residents with their lunch meal. 4. On 07/08/2024 at 12:04 PM, Dietary Aide #4 placed a piece of paper and a marker on the counter, contaminating her hands. Without washing her hands, she picked up clean bowls with her fingers inside the bowls and placed them on the trays to be used in portioning desserts to be served to the residents for lunch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 07/08/2024 at 3:48 PM, Dietary Aide #4 opened the refrigerator and removed a can of diced pears and placed it on a cart and pushed it towards a can opener attached at the end of the counter. After opening the can of diced pears with the can opener, she poured it into a bowl, contaminating her hands. Without washing her hands, she picked up clean bowls from the tray on the counter and placed them on the food preparation counter with her fingers inside them. Just as she was about to place diced pears into individual bowls to be served to the residents for supper meal. The surveyor immediately stopped her and asked Dietary Aide #4, What should you have done after touching dirty objects and before handling clean equipment? She stated, I should have washed my hands. I will rewash the bowls. She removed the bowls and rewashed them. 6. On 07/08/2024 at 4:26 PM, Dietary Aide #4 turned on the food preparation sink and rinsed tomatoes. She turned off the faucet with her bare hand. She picked up a cutting board and a knife and placed them on the counter. She removed gloves and placed them on her hands, contaminating the gloves. Without washing her hands and changing gloves, she diced tomatoes and placed them into a bowl. The surveyor asked Dietary Aide #4 what are the tomatoes for? She stated, There are for the mechanical soft salad. The surveyor asked Dietary Aide #4 What should you have done after touching dirty objects and before handling clean equipment? She stated, I should have washed my hands. 7. On 07/08/2024 at 4:38 PM, Dietary Aide #2 picked up a non-stick spray bottle and sprayed the pan liner inside the pans. Next, she removed gloves from the glove box and placed them on her hands, contaminating the gloves. Without changing gloves and washing her hands, she removed bread sticks from the original box, placed them on the pan liners in the pans, and put them in the oven to heat up and be served to the residents for the supper meal. The surveyor asked, What should you have done after touching dirty objects and before handling clean equipment? She stated, I should have washed my hands. 8. The facility policy titled, Handwashing provided by the Dietary Manager on 07/09/2024 at 9:12 AM documented, HANDS MUST BE WASHED. 1. When employee reports to work . 4. After handling anything considered dirty (example: cans from the storeroom soiled dishes.) 5. After leaving the kitchen for any reason . 7. Hands should be wash after any probable contamination. 9. On 07/08/2024 at 12:38 PM, Certified Nursing Assistant (CNA) #7 had Resident #81's tray on the counter in the dining room. Resident #24 reached for Resident #81's tray. CNA #7 touched Resident #24's hand and moved it away from the tray. She removed the bread from the parchment paper on Resident #81's tray and broke the bread into pieces without washing her hands. 10. On 07/10/2024 at 10:05 AM, CNA #7 was asked what should she have done after touching Resident #24's hand, and before touching the bread on Resident #81's tray? She stated, I forgot to sanitize. After I cut up his bread, I thought about it. I should have used the paper the bread came in to cut it up. 37634