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)

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 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 50505 Based on observations, interviews, record reviews, and facility policy review, it was determined the facility failed to administer oxygen at the physician ordered rate for 1 (Resident #47) of 1 sampled resident. Findings include: A review of a facility policy titled, Oxygen Administration dated 03/22/2024 indicated, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. 1. Oxygen is administered under orders of a physician, except in the case of an emergency. 4. The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders such as, but not limited to: a. The type of oxygen delivery system. b. When to administer, such as continuous or intermittent and/or when to discontinue. c. Equipment setting for the prescribed flow rates. d. Monitoring of oxygen saturation levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen. A review of the Medical Diagnosis, indicated the facility admitted Resident #47 with diagnoses that included chronic obstructive pulmonary disease (COPD), pulmonary embolism, and lobar pneumonia. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/26/2024, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) of 13, which indicated the resident was cognitively intact. Resident #47's MDS was marked in the following sections as: 1. Section I6200 as having Asthma, chronic obstructive pulmonary disease, or chronic lung disease. 2. Section J1100 was marked a) shortness of breath or trouble breathing with exertion; b) shortness of breath or trouble breathing when sitting at rest; and c) shortness of breath or trouble breathing when lying flat. 3. Section O-0110: C1 oxygen therapy. A review of Resident #47's Care Plan initiated 02/02/2024, revealed the resident has chronic obstructive pulmonary disease and is at risk for shortness of breath. Intervention: Oxygen at two liters per minute via nasal cannula as needed for shortness of breath or decrease in oxygen saturation. A review of the Physician Orders revealed Resident #47 had an order updated on 02/12/2024 for oxygen at two liters per minute via nasal cannula as needed for shortness of breath or decrease oxygen saturation. A review of the Treatment Administration Record (TAR) for Resident #47 revealed oxygen two liters per minute via nasal cannula as needed for shortness of breath or decreased oxygen saturation every day and night shift and had been marked as being administered at the correct rate from July 1, 2024, through July 10, 2024. During an observation on 07/08/2024 at 11:42 AM, Resident #47 had an oxygen concentrator delivering oxygen at 1.5 liters per minute via a nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 07/10/2024 at 8:46 AM, Resident #47 was lying in bed with the head of bed slightly elevated. Oxygen via nasal cannula in place. The oxygen concentrator rate was set and running at four liters per minute. During an interview on 07/10/2024 at 8:45 AM, with Licensed Practical Nurse (LPN) #12, the surveyor asked for LPN #12 to look up Resident #47's physician's orders for oxygen and to tell the surveyor what the oxygen concentrator should be set at. LPN #12 confirmed the order should be at two liters per minute. During a concurrent observation and interview on 07/10/2024 at 8:57 AM, with the Director of Nursing (DON) and LPN #12, both the DON and LPN #12 entered Resident #47's room. The DON was asked to check the oxygen concentrator and to tell the surveyor what rate the concentrator was set on. She confirmed that it was set on four liters per minute. LPN #12 also confirmed that the concentrator was set to four liters per minute. LPN #12 then stated, I will correct the rate, and then adjusted the oxygen concentrator setting to two liters per minute. The DON stated, I just completed rounds earlier and I checked the oxygen in the rooms.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 03508 Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 3 of 3 meals observed. This failed practice had the potential to affect 4 residents who received pureed diets, as documented on the List provided by the Dietary Manager on 07/09/2024 at 1:45 PM. The findings are: 1. On 07/08/2024 at 1:29 PM, the pureed English peas and pureed cake served to the residents on pureed diets was thin and not formed. At 1:30 PM, the surveyor asked the Dietary Manager to describe the consistency of the pureed English peas and pureed cake served to the residents on pureed diets. She stated, Pureed peas and pureed cake were thin. 2. On 07/08/2024 at 4:50 PM, Dietary [NAME] (DC) #5 used an 8-ounce spoon to place 6 servings of pizza casserole into a blender, added beef broth and pureed. At 4:58 PM, DC #5 poured the pureed pizza casserole consisting of pasta, ground beef, pepperoni and cheese and placed it on the steam table. The consistency of the pureed pizza casserole was thick, lumpy, and not smooth. There were pieces of pasta visible in the mixture. 3. On 07/08/2024 at 5:03 PM, Dietary Aide #4 placed 6 bread sticks into a blender, added chicken broth and pureed. She portioned pureed bread sticks into 6 bowls. The consistency of the pureed bread was thick, lumpy, and not smooth. At 5:15 PM, the surveyor asked the Dietary Manager to describe the consistency of the pureed pizza casserole and pureed bread. She stated, Pureed pizza could have been pureed a little longer. It still had pieces of noodles in it. Pureed bread sticks were thick and had lumps.