STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045183	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Place Nursing and Rehabilitation Center, Inc	2401 Christina Lane Conway, AR 72034

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to notify the ombudsman of a hospital transfer for 1 (Resident #95) of 1 resident reviewed for hospitalization. Findings include: A review of Progress Notes revealed Resident #95 had been sent to the hospital for low blood pressure and abdominal cramping on 6/12/2024. A review of Emergency Transfers from the Facility document sent to the ombudsman provided by the Business Office Manager revealed Resident #95 had not been included on the list. During an interview on 08/15/2024 at 8:57 AM, the Business Office Manager confirmed by reviewing the list with the surveyor that Resident #95 was not included and should have been to reflect the hospital transfer and the ombudsman should have been notified. During an interview on 08/15/2024 at 9:05 AM, the Administrator confirmed the hospital transfer and reviewed the provided list with the surveyor and stated Resident #95 should have been included on the list sent to the ombudsman to notify of the hospital transfer. On 08/15/2024 at 9:05 AM, the Administrator stated the facility did not have a policy for ombudsman notification of hospital transfers.

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, it was determined the facility failed to ensure a discharge Minimum Data Set (MDS) assessment to accurately reflect the residents discharge status for 1 (Resident #13) sampled resident. The findings are: Facility provided the Resident Assessment Instrument (RAI) assessment for discharge instructions on 8/15/2024 and was reviewed. The instructions indicated a discharge assessment must be completed when a resident is discharged from the facility and the resident is not expected to return to the facility within 30 days; must be completed within 14 days after discharge date , must be submitted within 14 days after the MDS completion date, and for unplanned discharges. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/19/2024 indicated Resident #13 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. During a closed record review, the surveyor was unable to locate an MDS Discharge Summary for Resident #13. In an interview on 8/15/2024 at 8:38 AM, the Administrator stated the MDS Coordinator was responsible for the MDS discharge assessments, and that medical records staff fill in when needed. She also stated a discharge could have been overlooked when the MDS Coordinator was previously out on leave. In an interview on 8/15/24 at 10:09 AM, MDS Coordinator #9 said a notification appears in the system to indicate that an MDS discharge is overdue, and that medical records staff fill in when the MDS Coordinator is out of the office.

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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. Based on observation, interview, and record review, the facility failed to ensure hazards were removed from resident areas as evidenced by medications left at the bedside for 1 (Resident #64) of 1 resident; and a handrail on the Rehab hallway had an end-cap cover on the end of the handrail to prevent exposure of rough edges. Findings include: 1. A review of the facility's undated policy titled, Medications, Oral, indicated staff were to remain at the bedside until all medications are swallowed. A review of the admission Record, indicated the facility admitted Resident #64 with diagnosis that included fracture around internal prosthetic joint. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/04/2024, revealed Resident #64 had a Brief Interview of Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. During an observation on 08/12/2024 at 10:46 AM, Resident #46 had a medication cup with one green pill and one yellow pill located on the resident's overbed table. During a concurrent observation and interview on 08/12/2024 at 11:24 AM, Licensed Practical Nurse (LPN) #2 stated she administered the resident's medications this morning and did not observe the resident take them. LPN #2 confirmed there was a medicine cup with two pills present on the resident's bedside table. LPN #2 stated that during medication administration the staff are supposed to observe the resident take the prescribed medication to ensure it is taken as prescribed. During an interview on 08/15/2024 at 10:48 AM, the Assistant Director of Nursing (ADON) stated that the nurse administering the resident's medications should ensure the medications are swallowed prior to leaving room, and medications should never be left at the bedside because another resident could take the medication and the nurse needs to ensure the medications are taken. 2. During an observation on 08/13/24 at 10:38 AM, a handrail on the left side of the Rehab Hallway near the therapy room was missing the end-cap. The exposed end of the rail had the potential to cause skin tears if a resident were to use this area to hold the handrail for balancing or to hold themselves up. On 08/14/2024 at 8:30 AM, the same observation was made of the missing end cap of the handrail. During an interview on 8/15/24 at 8:55 AM, the Maintenance Supervisor stated he checks the handrails once a month. The Maintenance Supervisor s they do not keep a maintenance log or work orders for the handrails, he just walks around each month and checks and repairs any issues. The Maintenance Supervisor stated the facility checks to ensure the handrails are in good working condition and tight in case a resident grabs a handrail. At 9:05 AM, The Maintenance Supervisor and the surveyor walked over to the handrail with the missing endcap. The Maintenance Supervisor observed the handrail with the missing cap and stated, Oh no, that is not good, it is sharp and could cause a skin tear or a bruise.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure all medications were safely stored and secured in to prevent accidental ingestion and or injury, as evidenced by a tube of anti-fungal medication left at Resident #15's bedside. The findings are: 1. Resident #15 had a diagnosis of brain bleed, heart failure and stroke, as indicated in the Physician's Orders dated August 12, 2024. a. Review of the Care Plan dated 07/23/24, Resident #15 had impaired cognitive function/dementia or impaired thought processes with a Brief Interview for Mental Status (BIMS) score of 6 severely impaired. b. On 08/13/24 at 9:33 AM, the surveyor observed a tube of anti-fungal medication lying on the residents over bed table. A review of the information located on the back of the tube indicated the active ingredient was Miconazole Nitrate 2% (antifungal medication). On the back of the tube was warnings for external use only; keep out of reach of children; and if swallowed, get medical help or contact a Poison Control Center right away. c. On 08/14/24 at 8:20 AM, the surveyor observed a tube of anti-fungal medication lying on the Resident #15's over bed table. 2. On 08/14/24 at 10:31 AM, the surveyor conducted an interview with Registered Nurse (RN) #4 and asked why Resident #15 used the anti-fungal cream. RN #4 stated Resident #15 used the anti-fungal cream as a lotion due to redness around the groin area and that Resident #15 did not have an order for the anti-fungal cream. 3. On 8/14/24 at 11:19 AM, the surveyor interviewed the Assistant Director of Nursing (ADON). The ADON confirmed that the anti-fungal cream used at the facility had medication in it and should be stored in the treatment cart and a physician ' s order is required and it should not be left at Resident #15's bedside to prevent other residents from getting into it. 4. Review of the facility policy titled, Medication Storage in the Facility indicated under Storage of Medications that medications and biologicals are to be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier and is only accessible to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 5. On 08/14/24 at 12:58 PM, the Assistant Director of Nursing (ADON) provided the surveyor with a Safety Data Sheet (SDS) for Clinical Antifungal Ointment. Review of the SDS sheet indicated the ointment can cause eye irritation and to get medical advice/attention. The eyes should be rinsed cautiously with water for several minutes. The skin should be washed with water and get medical attention if it persists. If inhaled one should get fresh air. If ingested consult a physician.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, record review, and interview, the facility failed to ensure 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 8 affect residents who received regular diets from 1 of 1 kitchen according to a list provided by the Dietary Manager on 8/15/2024. The findings are: 1. On 8/13/24, a facility supper meal menu indicated residents on mechanical soft diets were to receive 3 ounces of chicken with bun and 1/2 cup of chopped lettuce with tomatoes. Residents on pureed diets were to receive two #8 scoops (#8 scoop is 1/2 cup) of pureed breaded chicken with bun. 2. On 8/13/24 at 5:51 PM, the following observations were made during supper meal service: a. Dietary [NAME] (DC) #5 used a #16 scoop (1/4 cup or 2 ounces) to serve a single portion of ground breaded chicken to the residents on mechanical soft diets, instead of 3 ounces. b. Used a 2-ounce spoon to serve a single portion of chopped lettuce with tomatoes to the residents on mechanical soft diets, instead of 4 ounces c. DC #5 used a #8 scoop (1/2 cup) to serve a single portion of pureed breaded chicken with bun, instead of two #8 scoops. At 5:53 PM, DC #5 was asked what scoop size he had used to serve pureed burger and ground meat and how many servings he gave to each resident. DC #5 confirmed that he had used #16 scoop (1/4 cup) to serve a single portion to the residents on mechanical soft and used a #8 scoop (1/2 cup) to serve a single serving each to the residents on a puree diet. Dietary [NAME] #5 was asked if he looked at the menu before serving supper meal and stated, NO. 3. On 8/14/24 at 11:22 AM, Dietary [NAME] (DC) #7 used a 4 -ounce spoon to place 6 servings of brussels sprouts into a blender and pureed, instead of 7 servings. At 11:25 AM, DC #2 poured the pureed vegetables into a pan and placed it into the warmer. 4. On 8/14/24 at 11:34 AM, DC #7 used a 4-ounce spoon to place 6 servings of candy yam into a blender, added melted butter and pureed. At 11:37 AM, DC #2 poured the pureed candy yam into a pan and placed it in the warmer to serve it to 7 residents who required pureed diets. 5. On 8/14/24 at 11:42 AM, DC #7 placed 6 slices of bread into a blender, added a little water, thickener and pureed, instead of 7 servings. 6. On 8/14/24 at 11:44 AM DC #7 poured the pureed bread into a pan, covered the pan with foil and placed it in the warmer. The DC #7 stated, I just added a little water.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interview, the facility failed to ensure meals were served in a method that maintained nutritive value and taste that were acceptable to the residents to improve palatability and encourage good nutritional intake during 1 of 1 meal observed. This failed practice had the potential to affect 7 residents who receive their meal from 1 of 1 kitchen, as documented. on a list provided by Dietary Manager on 8/15/2024 at 8:30 AM. The findings are: 1. Review of a facility titled recipe for pureed herbed pork loin initiated on 2/20/2024, indicated for 10 residents to use ten 3 ounce herbed pork loins and add 1.25 cups of water or stock. 2. On 8/14/2024 at 10:58 AM, Dietary [NAME] (DC) #7 placed 6 thick slices of pork lion into a blender, added 2 cups of water, instead of 1.25 cup, and pureed. At 11:01 AM, DC #7 poured the pureed meat into a pan and placed it in the oven. 3. Review of a facility titled recipe for pureed brussels sprouts initiated on 2/20/2024, indicated for 10 residents use 10.5 cups of brussels sprouts, three tablespoons plus 2 teaspoons of food thickener. Process until smooth using 1 teaspoon food thickener per serving. A note at the bottom stated the amount of thickener may vary relative to liquid content of cooked vegetable. On 8/14/24 at 11:22 AM, DC #7 used a 4 ounce spoon to place 6 servings of brussels sprouts into a blender, added 2 cups of water and pureed, instead of no fluids. 4. On 8/14/24 at 12:31 PM, during an interview DC #7 was asked how much water she had used in the pureed pork lion, pureed brussels sprouts, and pureed bread. DC #7 stated, I used 2 cups water for both pureed meat and pureed vegetables. I just put a little water in the pureed bread. 5. On 8/15/24 at 8:08 AM, during an interview DC #7 was asked to describe how food items pureed with water would taste. DC #7 stated, Both pureed meat and pureed vegetables would taste nasty, and pureed bread would be bland.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure dietary staff practiced good hand washing to prevent potential cross contamination, Dairy products were maintained frozen to prevent the growth of bacteria, and hot food items were maintained at above 135 degrees Fahrenheit on the steam table while awaiting service to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 84 residents who received meals from 1 of 1 kitchen, as indicated by a list provided by the Dietary Manager on 8/15/2024 at 8:30 AM. The findings are: 1. On 8/13/24 at 5:16 PM, Dietary [NAME] (DC) #5 was wearing gloves on his hands when he pulled his pants up, contaminating the gloves. Without changing gloves and washing his hands, he picked up chicken patties, buns, lettuce, tomatoes, and tarter tots, and placed them on the plates to be served to the residents for supper meal. DC #5 was asked what he should have done after touching dirty objects and before handling food items. DC #5 stated, I should have changed gloves and washed my hands. 2. On 8/13/24 at 5:29 PM, after the lunch meal service Dietary Aide (DA) #6 was pushing a cart that contained a deep bowl with 4 cartons of vanilla ice cream, 3 cartons of strawberry ice cream, 2 cartons of chocolate ice cream, one carton of whole milk, and one cartoon of 2% milk to the walk-in freezer. DA #6 was asked to check to see if the ice cream was frozen. DA #6 opened one carton of vanilla ice cream, and stated, No, they are melted. DA #6 was asked to check the temperature of the milk. She did, and stated, It was 50 degrees Fahrenheit. DA #6 was asked if thawed ice cream should be refrozen. DA #6 stated, No. 3. On 8/13/24 at 5:41 PM, the following observations were made on a shelf in the storage room: a. An opened gallon of soy sauce, the manufacture's speciation on the gallon specified to refrigerator after opening. b. There were 6 bags of coffee in a pan with an expiration date of 1/20/2024. 4. On 8/14/24 at 10:59 AM, Dietary [NAME] (DC) #7 lifted the trash can lid and threw away an empty glove box into the trash, contaminating the gloves. Without washing her hands, DC #7 picked up strawberries that had been rinsed with water and placed them on the cutting board. DC #7 then sliced the strawberries and placed them in individual bowls. She then removed rinsed fresh grapes from a deep bowl and placed them in individual bowls to be served to the residents for a noon meal. DC #7 was about to cover the bowls of fruits with lids, when she was stopped. DC #7 was asked what she should have done after touching dirty objects and before handing fruits. DC #7 stated, I should have removed the gloves and washed my hands. 4. On 8/14/24 at 12:02 PM, Dietary Aide #8 checked the temperatures of the hot food items that had been placed on the serving line on the steam table in preparation for the noon meal service. The temperatures were: a. Pureed yams - 100 degree Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Pureed bread with a little water - 100 degree Fahrenheit, c. Hamburger - 100 degree Fahrenheit. d. Plain pork lion - 125 degree Fahrenheit. The above food items were not reheated before being served to the residents. 5. A facility policy titled, Hand Washing, initiated 3/27/2012 indicated hands should be washed before and after putting gloves on and after touching dirty objects.

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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. Based on observations, interviews, and facility policy review, the facility failed to ensure a laundry linen delivery cart on W Hall was covered during delivery of clean personal laundry to prevent the possible spread of harmful bacteria. Findings include: On 08/14/2024 at 2:47 PM, during an interview, the Laundry and Housekeeping Supervisor stated the facility did not have a policy for the delivery of clean resident laundry. During an observation on 08/12/2024 at 12:14 PM, a linen cart was parked against the wall on W Hall with the cover open and laid on top of the cart. Laundry Employee #11 was going in and out of resident rooms delivering laundry from the opened linen delivery cart. During an observation on 08/12/2024 at 12:16 PM, Laundry Employee #11 was observed pushing the linen cart down the W Hallway with the front cover open and continued to pass out resident's laundry. During an observation on 08/12/2024 at 12:33 PM, there was a clean linen laundry cart on the other end of W Hall with the front cover open, exposing the resident's clean laundry as Laundry Employee #11 continued to take laundry to each resident's room. During an interview on 08/14/2024 at 2:41 PM, Laundry Employee #3 stated they had been trained to deliver laundry in a covered transport cart or a rolling basket with a cover placed over the top to prevent germs, bacteria, and particles from landing on the resident's clean clothing. During an interview on 08/14/2024 at 2:38 PM, the Housekeeping and Laundry Supervisor stated when delivering laundry, the cart should always be covered. When removing laundry from the cart, the cover should be opened and closed to protect the remaining clothes on the cart from germs, bacteria, and particles in the air. Also, by closing the cart it prevents non-staffed individuals and residents from accessing the linen cart.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interview, the facility failed to ensure the influenza and/or pneumococcal immunizations were administered and/or offered and documented for 4 (Resident #18, Resident #19, Resident #60, and Resident #64) of 5 (Resident #18, Resident #19, Resident #60, Resident #64, and Resident #92) sampled residents reviewed for the compliance of immunizations. The findings are: On 8/14/24 at 3:09 PM, the Administrator provided a form titled, Immunizations, Influenza, Pneumococcal and Covid 19. It indicated that the influenza, pneumococcal, and the Covid 19 immunizations will be administered unless medically contraindicated. The immunization policy indicated that the immunizations will be documented in the medical record when administered or refused. On 8/14/24 at 10:47 AM, review of Resident #64's Physician Orders indicated Resident #64 was admitted on [DATE]. There was no documentation that Resident #64 received the pneumonia or influenza immunization. The immunizations were reviewed in the immunization tab on the electronic record. There was no documentation that the resident's representative, or the resident consented or declined the immunization. On 8/14/24 at 10:49 AM, review of Resident #18's Physician Orders indicated Resident #18 was admitted on [DATE]. There was no documentation Resident #18 received the influenza immunization. The immunizations were reviewed in the immunization tab on the electronic record. There was no documentation that the resident's representative, or the resident consented or declined the immunization. On 8/14/24 at 10:52 AM, review of Resident #60's Physician Orders indicated Resident #60 was admitted on [DATE]. There was no documentation Resident #60 had received the pneumonia, or influenza immunization. The immunizations were reviewed in the immunization tab on the electronic record. There was no documentation that the resident's representative, or the resident consented or declined the immunization. On 8/14/23 at 10:58 AM, review of Resident #19's Physician Orders indicated Resident #19 was admitted on [DATE]. There was no documentation indicating the resident had received the influenza immunization. The immunizations were reviewed in the immunization tab on the electronic record. There was no documentation that the resident's representative, or the resident consented or declined the immunization. On 8/15/24 at 9:30 AM, during an interview, Resident #18 did not remember if the influenza or the pneumococcal immunizations were offered when the resident was admitted . Resident #18 did not remember taking the influenza or the pneumococcal immunizations. On 8/15/24 at 9:35 AM, during an interview, Resident #60 did not remember if the influenza or the pneumococcal immunizations were offered when the resident was admitted . Resident #18 did not remember ever taking the influenza or the pneumococcal immunizations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/15/24 at 9:53 AM, Licensed Practical Nurse (LPN) #10 indicated the department head nurses administer the influenza or the pneumococcal immunizations to the residents, documents the results on a form, and gives the results to the Director of Nursing (DON). She indicated that she doesn't know when the influenza or the pneumococcal immunizations were offered. She indicated that the immunizations should be documented in the electronic record if a resident refuses. On 8/15/24 at 10:05 AM, Certified Medication Technician (CMT) #1 indicated the DON usually administers the influenza or the pneumococcal immunizations. She indicated that the DON has the form with the immunizations documented. She indicated that it should be documented if a resident refuses a vaccine. On 8/15/24 at 10:13 AM, Registered Nurse (RN) #4 indicated the floor nurse or any department head nurse administers the influenza or the pneumococcal immunizations. She indicated the immunizations are documented on a piece of paper and given to medical records. She indicated the Influenza Vaccine is offered in September and October, and the Pneumococcal Vaccine is offered on admission. She indicated that the residents are educated if they refuse to take the vaccine, and the refusal is documented. On 8/15/24 at 10:29 AM, the Administrator indicated the nursing staff is responsible for administering the influenza and the pneumococcal immunizations. She indicated the immunizations should be documented under the immunization tab in the electronic record. The Administrator indicated the Influenza vaccine is offered during the flu season, and the Pneumococcal vaccine is offered on admission. She was asked the reason Resident #60, Resident #64, Resident #18, and Resident #19, did not have the influenza, and/or the pneumococcal immunization documented in the clinical records. She stated, To be completely honest I'm not sure where the ball got dropped. I don't know if a pass employee took it.