STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045241	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bailey Creek Health and Rehab	1621 East 42nd St Texarkana, AR 71854

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure the privacy and dignity of 1 (Resident #33) sampled resident. This failed practice had the potential to affect 2 (Resident #33, Resident #49) sampled residents reviewed for privacy. Findings include: Review of a policy titled Quality of Life-Dignity, revised 08/2009, revealed every resident should always be treated with respect and dignity including their body during assistance with personal hygiene. The facility does not promote any practice that would demean, and not promote dignity to the resident. A review of Resident #33's Care Plan, dated 06/04/2024, revealed Resident #33 has increasing frequency of refusals specifically with hygiene and has identified routines that increase compliance to promote hygiene including wanting the door closed for privacy, despite a fear of being alone. A review of the Facility Assessment, revised 08/22/2024, revealed that staff competencies include caring for residents with mental and psychosocial issues without pharmacological interventions. On 09/05/2024 at 9:40 AM, Resident #33 was observed being rolled down 300 Hall in a shower chair to his/her room with buttocks exposed on both sides of the chair. On 09/05/2024 9:45 AM, Certified Nursing Assistant (CNA) #9 was asked the process for returning a resident to their room from the shower. CNA #9 said residents are placed in the shower chair and rolled back to their room, but Resident #33 refused to be covered because he/she was hot. CNA #9 confirmed Resident #33 should have been covered. On 09/05/2024 at 12:50 PM, CNA #10 confirmed that staff should make sure residents are covered when returning from the shower room, and CNA #11 said a sheet should be around the residents back and across their lap to make sure nothing is exposed to protect their dignity. CNA #9 and CNA #10 confirmed that Resident #33 was not covered when asked to assist in returning Resident #33 to resident's room. During an interview with Resident #33 on 09/05/2024 at 11:25 PM, the resident reported feeling cold rolling down the hallway when wet after a shower. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/05/2024 at 4:50 PM, the Director of Nursing (DON) confirmed staff are expected to cover residents when they are transported to resident rooms from the shower to protect the resident's dignity.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure written notification of the reason for transfer/discharge to the hospital was provided to the resident and/or resident's representative to protect the resident rights for 1 (Resident #31) of 2 sampled residents who were reviewed for hospitalization. The findings are: 1. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/29/2024 indicated Resident #31 had a diagnoses of heart failure, pneumonia, chronic obstructive pulmonary disease, and scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). a. A nurses note dated 04/18/2024 at 8 AM indicated; the Certified Nurse's Aide came to the nurse reporting Resident #31 was acting abnormally. The nurse assessed the resident and contacted the Nurse Practitioner and reported the residents change in condition. It was decided the resident should be sent to the hospital, paramedics were called, and the resident was transferred to the hospital. b. A medical provider progress note dated 04/24/2024 indicated, Resident #31 was admitted to the hospital on [DATE] to the intensive care unit for acute respiratory failure requiring the resident be placed on a mechanical respirator. c. On 09/05/2024 at 8:40 AM, the Administrator was asked for a copy of the notice of transfer given to Resident #31 and/or the resident's representative when she went to the hospital on [DATE]. d. On 09/05/2024 at 3:20 PM, the Administrator came to the Surveyor and stated when Resident #31 transferred to the hospital on 4/18/2024 a report for the notification of transfer should have been generated, but they could not find one. e. On 09/05/2024 at 4:10 PM, the Administrator was asked if they had a policy on transfer to the hospital. f. 09/05/2024 04:30 PM, the policy titled, Transfer or Discharge, Emergency did not address notification of the resident and/or the resident representative of the reason why the resident was transferred to the hospital.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #31 Hospitalization Based on record review and interview, the facility failed to ensure written notification of the bed hold policy to include the reserve bed payment was provided to the resident and/or resident's representative to protect the resident rights for 1 (Resident #31) of 2 (R#31 and R#74) sampled residents who were reviewed for hospitalization. The findings are: 1.The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/29/2024 indicated Resident #31 had a diagnoses of heart failure, pneumonia, chronic obstructive pulmonary disease, and scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). a. A nurses note dated 4/18/2024 at 8 am indicated; the Certified Nurse's Aide came to the nurse reporting Resident #31 was acting abnormally. The nurse assessed the resident and contacted the Nurse Practitioner and reported the residents change in condition. It was decided that the resident should be sent to the hospital, paramedics were called, and the resident was transferred to the hospital. b. A medical provider progress note dated 04/24/2024 indicated, Resident #31 was admitted to the hospital on [DATE] to the intensive care unit for acute respiratory failure requiring the resident be placed on a mechanical respirator. c. On 09/05/2024 at 08:40 AM, the Administrator was asked for a copy of the bed hold notification given to Resident #31 and/or her representative when she went to the hospital on 4/18/2024. d. On 09/05/2024 at 03:20 PM, the Administrator came to the Surveyor and stated when Resident #31 transferred to the hospital on 4/18/2024 a report for the bed hold notification should have been generated but they could not find one. e. On 09/05/2024 at 04:10 PM, the administrator was asked if they had a policy on transfer to the hospital. f. 09/05/2024 04:30 PM, the policy titled, Transfer or Discharge, Emergency did not address notification of the resident and/or resident representative of the bed hold policy to include the reserve bed payment when a resident is transferred to the hospital.

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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, record review, and facility policy review, the facility failed to ensure all cleaning cart doors locked to ensure residents could not access cleaning supplies and chemicals from the unlocked carts to prevent injuries. The facility failed to identify and ensure sharp, jagged plastic from a busted air conditioner frame was repaired to prevent accidents or injuries to 1 (Resident #17) sampled resident reviewed for accidents or injuries. Findings include: 1. a. On 09/03/2024 at 9:30 AM, while walking down 400 Hall in the closed unit the surveyor observed the cleaning cart door ajar revealing disinfectants and bathroom and bowl cleaners while Housekeeping #5's back was to the cleaning cart. b. During an interview with Housekeeping #5 on 09/05/2024 at 9:50 AM, the Surveyor was told there has not been a working lock on any of the cleaning carts in over a year. Housekeeper #5 stated if a resident opened the cleaning cart doors they could remove chemicals from the cart. c. On 09/05/2024 at 10:05 AM, while walking down 100 Hall, the surveyor observed Housekeeping #6's cleaning cart's door open and facing the hallway with a bottle of bathroom disinfectant visible. Housekeeper #6 confirmed the lock has not worked in at least a year and was concerned a resident could spray themselves in the face. d. During an interview with the Housekeeping Supervisor on 09/05/2024 at 10:13 AM, the Housekeeping Supervisor confirmed none of the cleaning carts have locked in the last four years. e. On 09/05/2024 at 10:50 AM, the Administrator confirmed she was not aware the cleaning carts could not be locked, and stated housekeepers are trained to leave nothing on top of the carts, keep chemicals in the closed compartment, and to always leave the door facing them so they can keep an eye on the cart and mop water to protect residents. 2. A review of Resident #17's Medical Diagnoses revealed kidney disease, chronic pressure ulcers, and anemia. a. On 09/03/2024 at 10:46 AM, the Surveyor observed sharp, jagged plastic shards sticking up from Resident #17's busted air conditioner frame, across from the right side of the resident's bed. b. During an interview with Registered Nurse (RN) #7 in Resident #17's room, on 09/04/2024 at 10:45 AM, RN #7 confirmed she did not know how or when Resident #17's air conditioner broke but confirmed if Resident #17 were to bump against the air conditioner or strike it he/she could scratch or cut him/herself on the broken plastic. Resident #17 revealed a fear of the air conditioner. c. On 09/05/2024 at 4:00 PM, Director of Nursing (DON) confirmed staff should fill out a communication sheet when broken equipment is found in a resident's room, because sharp edges on a broken air conditioner could cause harm to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. A review of a policy titled Hazardous Areas, Devices and Equipment, (Revised, July 2017) revealed hazardous areas, devices and equipment are identified by the safety committee and should be addressed appropriately to prevent accidents and protect residents. Equipment that is poorly maintained and sharp objects could affect vulnerable residents are considered hazardous. Anything in a resident's environment that could possibly cause injury is considered hazardous and should be addressed by the safety committee for recommendations and monitoring of implemented interventions.

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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 facility policy review, it was determined the facility failed to ensure medications were appropriately stored behind a lock on the treatment cart to prevent misappropriation of resident medications. The facility failed to ensure medication was stored behind a locked door, and medications were not left at the bedside for 2 (Resident #61, and Resident #375) sampled residents reviewed for medication stored at the bedside. Findings include: 1. a. A review of a policy titled Storage of Medications, revised April 2007, revealed that nursing is responsible for making sure medications are stored and locked up appropriately and not left unattended. b. On 09/03/2024 at 10:11 AM, an unlocked treatment cart was observed with the bottom drawer pulled open resting across from Nurses Station 2. The Surveyor observed betadine solution, hydrogen peroxide 3%, wound solution, Isopropyl rubbing alcohol 70%, foot peeling spray, and 2 dermal wound cleanser sprays from an open bottom drawer. Topical antifungal medication, and antifungal powder were in the second drawer from the bottom. c. On 09/03/2024 at 10:12 AM, Registered Nurse (RN) #8 returned from Unit Manager 2's office and stated she had stepped away to get something and confirmed the treatment cart should be locked when unattended, because one of the residents in the hallway could have taken medications from the cart inappropriately. 2. a. Review of a policy titled, Self-Administration of Medication, (Revised, December 2016) revealed residents have the right to self-administer medications after being assessed and found physically and mentally safe to do so if they wish. Self-administered medications must be stored in a safe place, and if staff finds medications in a resident room the medication should be turned over to the charge nurse. A resident room is not considered a safe place. b. On 09/03/2024 at 10:25 AM, the surveyor was walking down the hall and observed antimicrobial wound gel, wound solution, and ointment gel resting in Resident #61's bedroom window. c. On 09/04/2024 at 10:25 AM, Registered Nurse (RN) #7 accompanied Surveyor to Resident #61's room and identified ointment gel resting in the window. 3. a. On 09/03/2024 at 10:59 AM, Resident #375's bedside table was observed open with generic vapor rub, vitamin C 1000 milligram (mg), and two containers of menthol rub resting in the drawer. b. On 09/04/2024 at 10:30 AM, RN #7 identified a bottle of vitamin C, vapor rub, and two containers of menthol rub resting in Resident #375's bedside table. Resident #375 stated she has used the medication since a hip surgery in April. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 09/04/2024 at 10:54 AM, RN #7 confirmed medication should not have been left in resident rooms and was concerned that other residents or visitors could use the medications for wound care in an inappropriate manner, swallow pills, or use medication inappropriately causing harm. RN #7 stated she does not know of any residents with self-administration rights. d. During an interview with the Director of Nursing (DON) on 09/05/2024 at 04:35 PM, DON confirmed staff should remove medications from resident rooms or tell the nurse so they can be removed, and medications should be locked away, because there is a risk for residents to abuse medications, or other residents that wander around the building could take someone else's medication from their room.

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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 ensure nutritionally balanced meals were provided for the residents for 1 of 1 meal observed. This failed practice had the potential to affect 5 residents on pureed diets, 20 residents who received mechanical soft diets and 47 residents on regular diets from the kitchen, according to the list provided by the Registered Dietitian on 9/5/2024 (total Census 74). The findings are: 1. On 9/4/24, the lunch meal menu indicated residents on pureed diets were to receive one #6 (5.3 ounces) scoop of pureed lasagna. 2. On 9/4/24 at 3:42 PM, Dietary [NAME] (DC) #2 placed 6 slices of bread into a blender, used a 3-ounce spoon to portion 4.5 cup of meat sauce into a blender, added thickener and pureed. 3. On 9/5/24, the noon meal menu indicated, for the residents on regular diet and residents on mechanical soft diets were to receive 4 by 4 square serving of lasagna which would typically weigh around 8 ounces, and for pureed diets were to receive a #6 scoop which was equivalent to 2/3 cup. a. On 9/5/24 at 12:34 PM, DC #3 used a #10 scoop equivalent to 3/8 cup to serve a single portion of pureed lasagna to a resident on pureed diets, instead of a #6 scoop which is 2/3 cup. b. On 9/5/24 at 12:39 PM, DC #3 used a 3-ounce ladle (3/8 cup) to serve a single portion of beef lasagna to the residents on regular diets and residents on mechanical soft diets, instead of 4 by 4 square or 8 ounces which is a cup. c. On 9/6/24 at 8:27 AM, DC #3 was asked what scoop size he had used to serve beef lasagna to the residents on regular diets and residents on mechanical soft diets. DC #3 stated he used 3-ounce ladle to serve it to all residents on regular and mechanical soft diets.

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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 the ice scoop holder was maintained in clean and sanitary condition to prevent potential growth of harmful bacteria that could be transferred to the residents food, failed to ensure opened food items in the freezer were sealed to maintain freshness and prevent potential cross contamination, failed to ensure dietary staff practiced good hand washing techniques to prevent potential cross contamination of food and clean dishes for residents who received meals from 1 of 1 kitchen. The findings are: 1. On 9/4/24 at 3:20 PM, the following observations were made on the spice rack above the food preparation counter: a. A plastic container of oregano with best by date of 5/24/2024. b. A plastic container of parsley flakes with best by date of 8/5/2024. 2. On 9/4/24 at 3:37 PM, the following observations were made on a shelf in the 3- door freezer in the storage room: a. Two opened boxes of beef patties, the box was not covered or sealed. 3. On 9/4/24 at 4:13 PM, the ice scoop holder on the wall by the ice machine in the dining room had a coral-colored wet residue at the bottom of it. The substance was easily removed when wiped with a clean paper by the Registered Dietitian (RD). She stated it was wet black residue. a. On 9/06/24 at 11:15 AM, the RD was asked who used the ice from the ice machine and how often they cleaned it. She stated, The maintenance man cleans it once a month. The kitchen uses it to fill beverages served to the residents at mealtimes. They clean it daily. 4. On 9/3/24 at 4:40 PM, Dietary Aide (DA) #3 washed and dried her hands and turned off the dirty faucet with her clean hands. DC#3 then picked up clean plates and placed them on the trays with fingers inside the plates. DA#3 lifted the trash can lid and threw tissue paper into the trash can. Without washing her hands, she picked plates to be used in portioning desserts and placed them on the tray with fingers inside the plates. 5. On 9/4/24 at 5:05 PM, DC #2 picked up the blender motor from a rack by the food preparation counter and placed it on the counter, contaminating his hands. Without washing his hands, he picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents on pureed diets for supper. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. On 9/3/24 at 5:09 PM, DA #3 washed and dried her hands and turned off the dirty faucet with her clean hands. DA #3 then picked up clean plates and placed them on the trays with her fingers inside the plates. DA #3 lifted the trash can lid and threw tissue paper into the trash can. Without washing her hands, she placed new gloves on her hands, contaminating the new gloves, she used her gloved hands to pick up clean utensils close the areas that would go into the month and wrapped them in individual napkins for the residents to use at their supper meal. 7. On 9/3/24 at 5:12 PM, DC #2 removed a recipe book on the counter out of the way. Without washing his hands, he placed new gloves on his hands contaminating the gloves, DC #2 used his gloved hand to remove ham log from the bag and placed it on the cutting board and then sliced it to be used in making ham and chesses sandwiches to be served to the resident who requested it. DC #2 was asked what he should have done after touching diet objects and before handling food items. DC #1 stated, I should have washed my hands. 8. On 9/04/24 at 5:14 PM, DA #3 pushed a cart containing a pan with glasses of ice in it from the dining room into the kitchen. Without washing her hands, DA #3 picked up glasses by the rims and poured water in them to serve to residents at their supper meal. 9. On 9/5/24 at 12:12 PM, DA #4 closed the door to the janitor's closet. Without washing his hands, he picked up a clean blade and attached it to the base to be used in pureeing food items to be served to the residents for lunch meal. a. On 9/6/24 at 8:27 AM, DA #4 was asked, what he should have done after touching diet objects and before handling food items. DA #4 stated, I should have washed my hands. 10. A review of a facility policy titled, Employee cleanliness and Handwashing Technique undated provided by the Business Manager on 9/5/2024, indicated, Dietary department employees are required to wash their hands on the occasions before beginning shift, after disposing or handling of trash or food and any other time deemed necessary.

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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. FACILITY Infection Control Based on observation, record review, interviews, and facility policy review, it was determined that the facility failed to ensure staff applied appropriate personal protective equipment (PPE) such as isolation gowns when interacting with 1 (Resident #1) of 2 sampled residents reviewed for Enhanced Barrier Precautions. This deficient practice had the potential to affect all residents who are on Enhanced Barrier Precautions. 1. Quarterly Minimum Data Set (MDS) with assessment reference date (ARD) of 6/27/24 indicated Resident # 1 with diagnoses of Gastrostomy status, Hemiplegia and hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side, Aphasia. MDS indicated resident has a Gastrostomy tube and a BIMS score of 3 (0-7 suggests severe cognitive impairment) a. A physicians order dated 4/18/24 indicated - Enhanced Barrier Precautions b. On 09/04/2024 at 11:12 AM, during Gastrostomy placement check, the surveyor observed Licensed Practical Nurse (LPN) # 1 prepared to check placement of Gastrostomy tube. The surveyor observed Enhanced precautions signs outside Resident # 1 door. The surveyor observed LPN #1, without Personal Protective Equipment (PPE). LPN#1 checked tube placement. Gloves were worn. No gown was worn. c. On 9/4/2024 at 11:15 During the interview with LPN # 1 regarding not wearing isolation gown during check of gastrostomy tube. LPN # 1 stated should have worn a gown due to resident on Enhanced Barrier Precautions to help prevent infections and prevent body fluids from contaminating staff. d. On 9/5/2024 at 8:30 AM surveyor asked the administrator for Enhanced Barrier Precautions Policy. At 9:48 surveyor was provided a policy titled Enhanced Barrier Precautions indicated Policy Interpretation and Implementation: 1. Enhanced Barrier Precautions (EBP)are used as an infection prevention and control intervention to reduce spread of multi-dose resistant organisms (MDROs) to residents. 2. EBP's employ targeted gown and glove use during high contact resident care activities 3. Examples of high contact resident care activities . g Device care or use: .feeding tube

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview, record review, and facility policy review, it was determined the facility failed to ensure dementia training was provided for nursing aide staff to meet the needs of the facilities population. This failed practice had the potential to affect 18 (Residents #3, #17, #19, #21, #30, #31, #33, #40, #47, #49, #55, #60, #61, #64, #65, #176, #177, #375) sampled residents. Findings include: 1. A review of a policy titled In-Service Training Program, dated 10/2017, revealed all staff are required to attend scheduled in-services, and Certified Nursing Assistance (CNA)s must complete a performance review every 12 months. 2. The Administrator confirmed only the closed unit had a dementia in-service and provided an in-service How to Care for Residents with Behavioral Issues and Dementia, (date, 06/14/2024) revealed staff should encourage residents to do things for themselves, being consistent with care during mealtime, and prompting during mealtime and bathing to encourage resident participation. 3. During an interview with CNA #12 and CNA #13 on 09/04/2024 at 1:47 PM in the closed unit, CNA #12 revealed they have not had dementia training. 4. During an interview with the Director of Nursing (DON) on 09/05/2024 at 11:56 AM, the DON confirmed that dementia training was not provided to all staff in the past year and revealed the last time dementia training was done for staff was 06/2023. The DON stated her concern for the residents is that they are being cared for by people that may not know how to care for them, and confirmed all CNAs should have received dementia training, because dementia is not just in the closed unit.