STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045471	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hiram Shaddox Health and Rehab	1100 Pinetree Lane Mountain Home, AR 72653

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review and facility policy review, the facility failed to ensure medications were administered without errors resulting in an error rate of more than 5% for 2 (Resident #126 and Resident #227) of 7 residents who were observed during the 8:00 AM medication administration. The findings are: 1. An undated Administering Medications policy was reviewed and read in part, Medications are administered as prescribed and are administered according to prescriber orders. 2. A Medication Crushing Guidelines policy dated 2001, was reviewed and read in part Medications that should not be Crushed or Chewed B. Enteric coated medications are designed to pass through the stomach without breaking down until they reach the intestinal tract. This route may be chosen due to changes made when in contact with stomach acid, to prevent the irritation of the stomach lining and to prolong the action of the medication. Timed release tablets are designed to release their medication over a period, usually 8-24 hours. The tablets should not be crushed. 3. The Long-Term Care Survey Process was reviewed and indicated the Medication Administration error rate was 5.56%. There were 36 opportunities and 2 errors. 4. An admission Record was reviewed and read in part, Resident #126 was admitted with diagnoses that included Vitamin B 12 deficiency. a. An Order Summary Report with an active and start date of 5/14/2025, was reviewed and read in part that Resident #126 had a Physician's Order for [Vitamin B supplement] oral tablet 500 mcg [microgram] give 2 tablets by mouth one time a day. b. A Medication Administration Record was reviewed and read in part [Vitamin B supplement] Oral Tablet 500 mcg (micrograms). Give 2 tablets by mouth one time a day, order date 5/13/2025. c. On 05/14/25 at 8:14 AM during the observation of the 8:00 AM medication administration, Licensed Practical Nurse (LPN)#4 was observed administering [Vitamin B12 supplement] 1 tablet to Resident # 126. The Physician's Order dated 05/13/2025, was for 2 tablets. At the conclusion of the observation, LPN #4 confirmed that all the medications had been administered that were due for the 8:00 AM medication pass. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 5/14/2025 at 10:58 AM, LPN #4 was asked to review the Physician's Order for Resident # 126 dated 5/13/2025, for [Vitamin B 12 supplement] 500 mcg. LPN #4 confirmed that the order was written to give 2 tablets. LPN #4 confirmed only 1 tablet was administered on the 5/14/2025 8:00 AM medication administration, stating that's on me. e. On 05/14/25 at 11:59 AM, the Advance Practice Registered Nurse (APRN) did not recall the order for Resident #126, but stated Vitamin B12 was usually given for anemia, and should be administered as ordered. 5. An admission Record was reviewed and read in part that Resident #227 had diagnoses that included cerebrovascular disease (group of conditions that affect blood flow to the brain), hemiplegia/hemiparesis (a condition that causes muscle weakness or paralysis to one side of the body) and thrombophilia (a condition that causes the blood to be more likely to clot). a. An Order Summary Report with an active as date of 5/14/2025, was reviewed for Resident #227 and it read in part Resident #227 had a Physician's Order for [non-steroidal anti-inflammatory drug] oral tablet delayed release 81 mg [milligram] give 1 tablet by mouth. b. On 05/14/25 at 8:08 AM, during the observation of the 8:00 AM medication administration, LPN #4 was observed administering medications to Resident #227, LPN #4 punched out Resident #227's medications including the delayed release medication into a plastic cup then poured into an envelope. LPN #4 then crushed the medications. The crushed medications were poured into a cup with applesauce and administered to Resident #227. c. On 05/14/25 at 10:58 AM, LPN #4 confirmed that the enteric coated medication had been crushed, and that the medication should not have been crushed. d. On 05/14/25 at 11:59 AM, the Advance Practice Registered Nurse (APRN) confirmed that enteric coated and delayed release were basically the same acting medication. Their purpose was to pass through the stomach without dissolving before passing into the intestinal tract. 6. On 05/15/25 at 9:23 AM, the Director of Nursing (DON) confirmed her expectation of the nursing staff was to administer medications correctly, according to the Physician's Orders, and to follow the facilities policies. 7. On 05/15/25 at 9:41 AM, the Administrator confirmed her expectation of the nursing staff was to administer medications according to the Physician's Orders and to follow facility policies.

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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 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. Based on observation, interview, and facility policy review, it was determined that the facility failed to prepare and serve food in a safe and sanitary manner as evidenced by staff eating in the kitchen's preparation area and not performing hand hygiene after touching personal items and before serving residents. The failed practice had the potential of affecting 71 of 73 residents. On 5/12/2025 at 5:52 PM, upon entrance to the facility's kitchen, [NAME] #1 was observed eating food out of a small dish while standing on the serving line. [NAME] #1 picked up a cellphone from the top shelf of the steam table that was playing music, turned the music off, and sat the phone back down. [NAME] #1 then picked up a spoon handle and stirred the food on the steam table. On 5/13/2025 at 8:20 AM, during an interview with the Dietary Manager (DM), who had been with facility for 5 years, the DM confirmed that staff had been in-serviced on safe food handling and handwashing and hand hygiene. The DM confirmed that it was not appropriate to eat while standing at the serving line. The DM also confirmed that staff should wash their hands after touching a personal item such as a cellphone. On 5/13/2025 at 8:29 AM, [NAME] #2 confirmed that it was not appropriate to eat while serving food and hand hygiene should be done anytime you touch something dirty, before touching something clean. [NAME] #2 also confirmed they had signed in-services on hand hygiene and safe food handling. On 5/13/2025 at 8:33 AM, [NAME] #3 confirmed they had signed in-services and read policies on handwashing and safe food handling. [NAME] #3 confirmed that food should not be eaten while serving food. On 5/14/25 at 8:49 AM, [NAME] #1 confirmed eating a dessert while standing at the serving line in the kitchen and touching the cellphone. [NAME] #1 also acknowledged that it was against the facility's kitchen policy. [NAME] #1 confirmed being trained and educated on safe food handling and hand hygiene. On 05/14/25 at 4:06 PM, the Administrator stated they were responsible for the facility's kitchen operations. The Administrator stated that all kitchen staff were in-serviced and educated on handwashing and safe food handling policies. The Administrator confirmed that it was against facility policy to eat on the serving line. The DM provided a Cleanliness and Handwashing policy that indicated no staff will eat in the preparation area of the kitchen. The DM provided an in-service which indicated that hands must be washed after handling a cellphone because cellphones are considered dirty.