| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045170 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/01/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Green House Cottages of Belle Meade | 2200 Chateau Boulevard Paragould, AR 72450 |

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 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>Based on interview and record review, the facility failed to ensure an as needed psychotropic medication was reviewed and updated every 14 days for one (Resident #137) of five residents reviewed. The findings include: A review of Resident #137's Order Summary Report revealed the facility admitted the resident on 02/28/2024. Resident #137 had an order for an antianxiety medication to be given every 24 hours as needed for anxiety, ordered on 04/05/2024. A review of Resident #137's quarterly Minimum Data Set, with an Assessment Reference Date of 06/17/2025, revealed the resident had a Brief Interview for Mental Status score of 06, which indicated the resident had severe cognitive impairment. A review of Resident #137's Care Plan initiated 02/20/2025, indicated to administer an anti-anxiety medication as ordered by the physician. A review of Resident # 137's Medication Administration Record dated 08/01/2025 - 08/31/2025, indicated an as needed antianxiety medication was started on 04/05/2024, and discontinued 08/01/2025. A review of Resident #137's Pharmacy MRR [Medication Regimen Review], signed date 05/26/2025, indicated to continue the medication past 14 days. The medication review indicated that the resident had periods of anxiety, and it was in Resident #137's best interest to continue the medication.A review of Resident #137's Pharmacy MRR [Medication Regimen Review], dated 07/28/2025, did not indicate if the medication should be continued and was not signed by the attending physician or the DON.During an interview on 07/31/2025 at 3:43 PM, the Nurse Practitioner indicated Resident #137's as needed antianxiety medication should be reviewed every 14 days. During an interview on 07/31/2025 at 3:47 PM, the Director of Nursing indicated she did not know the order for antianxiety medication had to be rewritten every 14 days. During an interview on 08/01/2025 at 10:30 AM, Licensed Practical Nurse #3 indicated Resident #137 had an anxiety medication ordered as needed. She then indicated she was not sure when the medication should be renewed, that some medications were renewed every seven or 14 days. During an interview on 08/01/2025 at 12:01 PM, the Medical Director (MD) indicated he did not change the as needed medications when he reviewed them. He indicated he was not aware that as needed medications should be reviewed and updated every 14 days. The MD then indicated that Resident #137's as needed medication were being reviewed. If the practitioner believed the medication should extend beyond 14 days the rationale should be documented in the medical record and the duration should be documented. |

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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| | 045170 | A. Building<br>B. Wing | 08/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure hands were washed between residents while serving dinner, and to ensure utensils were not used after contamination during meal preparation for one of one puree meal observed.<br><br>The findings include:<br><br>1) During an observation on 07/28/2025 at 4:55 PM, Certified Nurse Aide (CNA) #5 and CNA #6 were observed passing trays with gloves on. CNA #5 retrieved a plate from a resident room while wearing gloves. She then took a plate to another resident room without removing gloves or performing hand hygiene. CNA #5 came out of this room, again without performing hand hygiene or removing gloves, and went to the dining room. In the dining room, CNA #5 removed her gloves and started feeding a resident without washing or sanitizing her hands.<br><br>During an observation on 07/28/2025 at 5:10 PM, CNA #4 touched a coffee cup a resident had drank from with her gloved hands. She did not remove her gloves or sanitize her hands before continuing to pass out dinner plates.<br><br>During an interview on 07/30/2025 at 4:15 PM, CNA #4 indicated she should always wash her hands and keep hand sanitizer in her pockets. CNA #4 indicated she wore gloves and was supposed to change her gloves every time she passed a plate. She stated she should have taken her gloves off and washed her hands before passing any residents their plates.<br><br>During a phone interview on 07/31/2025 at 5:19 AM, CNA #5 indicated she usually washed her hands and used hand sanitizer when she was serving meals. She stated that she used gloves to serve the dinner meal on 07/29/2025 because CNA #6 used gloves. CNA #5 indicated she should have removed her gloves after she came out of a resident's room, and before continuing to pass meal plates. She also indicated her gloves should have been removed to prevent the spread of germs since things are touched while in the resident's room.<br><br>During an interview on 07/30/2025 at 4:25 PM, CNA # 6 stated, “I should wash my hands constantly and apply sanitizer while serving the residents their meals.” She indicated she did not change gloves after passing plates to the residents on 07/29/2025, or before going to the next resident. She indicated she usually kept the same gloves on the entire time she was passing out plates.<br><br>During an interview on 07/31/2025 at 9:25 AM, Dietary Manger (DM) #7 indicated staff should wash their hands before they pass the residents plates out, and between each resident. She indicated she would start an in-service for handwashing immediately.<br><br>During an interview on 07/31/2025 at 12:52 PM, the Administrator indicated that staff should wash their hands between serving each resident. He indicated that if they touch any of the residents' items such as a cup, they should wash their hands before passing more trays.<br><br>A review of a handwashing policy indicated that handwashing was important because your hands can transfer pathogens to food. The policy indicated that your hands should be washed before putting on gloves and at the start of a new task.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Green House Cottages of Belle Meade | 2200 Chateau Boulevard Paragould, AR 72450 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 2) During an observation on 07/30/2025 at 3:04 PM, CNA #1 used a food processor to prepare food for residents on modified diets CNA #1 obtained a spatula from the drawer and mixed the puree mix with the spatula. The spatula was then placed on the counter, which had not been cleaned prior to meal service. CNA #1 added chicken broth to the blender and mixed. CNA #1 picked up the spatula and mixed the food with the spatula. CNA #1 removed the blender and poured the mixture into a bowl. CNA #1 then used the spatula to remove the mixture from the bottom of the blender.<br><br>During an observation on 07/30/2025 at 3:22 PM, CNA #1 washed, rinsed, and sanitized the spatula and a #8 scoop. CNA #1 then placed the spatula and #8 scoop on the counter next to the sink, which had not been cleaned and did not have a barrier.<br><br>During an observation on 07/30/2025 at 3:39 PM, on three separate occurrences, CNA #1 laid the spatula on the unclean counter next to the blender, mixed the meat in the blender and stirred the meat with the unclean spatula. CNA #1 completed the puree, poured the meat mixture into a warming container, and used the spatula to remove the meat from the bottom of the blender.<br><br>During an interview on 07/30/2025 at 4:22 PM, CNA #1 confirmed the counters had not been cleaned and a barrier should have been placed prior to placing the utensils on the counter. CNA #1 confirmed the utensils should not have been used after contamination.<br><br>During an interview on 07/30/2025 at 4:23 PM, Dietary Manager #7 confirmed the counters had not been cleaned and a barrier should have been placed prior to placing the utensils on the counter. DM confirmed the spatula and #8 scoop were contaminated. |

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| | 045170 | A. Building<br>B. Wing | 08/01/2025 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on record reviews, observation, interviews, and facility policy review, the facility failed to ensure personal protective equipment (PPE) was disposed of before walking out of one (Resident #4) of one resident’s room that was on Enhanced Barrier Precautions (EBP).<br><br>The findings include:<br><br>A review of Resident #4’s Order Listing Report revealed a revised order dated 07/19/2025, for an IV [intravenous] antibiotic related to a right hip incision infection.<br><br>A review of Resident #4’s admission Minimum Data Set, with an Assessment Reference Date of 07/10/2025, revealed the resident had a Brief Interview for Mental Status score of 14, which indicated Resident #4 was cognitively intact.<br><br>A review of Resident #4’s Care Plan revised 07/22/2025, indicated EBP were required related to a medical device used to drain urine directly from the kidney. The Care Plan also indicated to wear disposable gloves and gowns when providing high contact care.<br><br>During an observation on 07/30/2025 at 2:12 PM, Registered Nurse (RN) #8, and RN #9 put on gowns, sanitized their hands, and put on gloves. A bandage dated 07/29/2025 was observed to Resident #4's right hip. The bag of a medical device to drain urine directly from the kidney was observed on the bed. RN #9 looked behind the door in Resident #4's room to get supplies, and the supply organizer did not have any PPE. RN #9 left Resident #4's room with her gown and gloves on and went into the supply closet to get more gowns and gloves. She came back into the room with a box of gloves. She indicated that she threw her gown away in a garbage can in the hall.<br><br>During an interview on 07/30/2025 at 2:31 PM, RN #8 indicated that the supplies should be stored behind the door for residents on EBP. She also indicated she should not have left the room with a gown and gloves on because of transmission of different bacteria.<br><br>During an interview on 07/30/2025 at 2:43 PM, RN #9 indicated the supplies for EBP should be stored inside the room. RN #9 also indicated that PPE should always be discarded before leaving a resident’s room because used PPE could have had drainage on it, or it could have been exposed to another resident.<br><br>During an interview on 07/30/2025 at 3:00 PM, RN #9 indicated she should have taken her gown and gloves off before exiting the room.<br><br>During an interview on 07/30/2025 at 3:08 PM, RN #8 indicated RN #9 should have taken her gown and gloves off before exiting the room.<br><br>A policy titled “Infection Prevention and Control” indicate the infection control program was designed to provide a safe, sanitary, and comfortable environment to prevent transmission of diseases and infections. |