

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045391	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Three Rivers Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 33904 Highway 63 E Marked Tree, AR 72365	

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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents who required assistance with activities of daily living were regularly provided with the necessary assistance to maintain good hygiene and grooming for two (Residents #69 and #88) of two sampled residents.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. A review of the Order Summary revealed Resident #69 had diagnoses of dementia, depressive episodes, anxiety, and chronic kidney disease. <p>A review of the quarterly Minimum Data Set (MDS) with an Assessment of Reference Date (ARD) of 06/27/2024 revealed Resident #69 scored a 3 (severe cognitive impairment) on the Brief Interview Mental Status (BIMS).</p> <p>A review of the Care Plan, initiated on 03/01/2023 revealed Resident #69 required assistance of two staff with bathing and used a shower bed.</p> <p>A review of the Bath Task revealed Resident #69 from 7/31/2024 to 8/26/2024 received a bed bath only.</p> <p>A review of the Behavior Monitoring Task sheet revealed that for Resident #69 from 07/30/2024 to 08/28/2024, no behaviors were charted.</p> <p>On 08/28/2024 at 3:05 PM, the Nurse Consultant stated the facility did not have a policy for activities of daily living.</p> <p>On 08/26/2024 at 11:23 AM, the Surveyor observed Resident #69 in bed, hair was greasy, sticking to the pillowcase and facial hair was observed to be curling on each corner of their chin.</p> <p>On 08/27/2024 at 10:00 AM, the Surveyor observed Resident #69 in bed, hair had not been washed, and resident had not been shaved.</p> <p>On 08/28/2024 at 10:45 AM, the Surveyor observed Resident #69 in bed, hair was greasy, and the resident had not been shaved.</p> <p>On 08/28/2024 at 10:45 AM, during an interview, Certified Nursing Assistant (CNA) #4 stated Resident #69's facial hair was long and needed shaved. CNA #4 stated that Hospice gave a complete bed bath yesterday and must have missed the facial hair as they usually get it. CNA #4 stated that Resident #69's hair is greasy, stringy, and long that it needs to be trimmed in the beauty shop. CNA #4 stated</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>it would not feel good to have greasy hair or long facial hair. CNA #4 stated that baths are important to ensure they get the care they need.</p> <p>On 08/28/2024 at 10:52 AM, during an interview, Licensed Practical Nurse (LPN) #6 stated Resident #69 normally gets a complete bed bath with Hospice including a shower cap. LPN #6 stated that Resident #69 needs shaved, hospice usually get its and hair is oily, stringy, and long. LPN #6 stated that nobody would want to feel unclean with greasy hair or facial hair. LPN #6 stated that baths are important to make sure they are clean and presentable and if they go without baths, they end up with skin conditions like yeast, need them to be well taken care.</p> <p>2. A review of the Order Summary revealed Resident #88 had diagnoses of type two diabetes, need for assistance with personal care, and dementia.</p> <p>A review of the Significant Change MDS with an ARD 07/29/2024 revealed Resident #88 scored a 2 (severe cognitive impairment) on the BIMS.</p> <p>A review of the Care Plan, initiated on 08/24/23 revealed Resident #88 was dependent for bathing; required assistance of two staff with bathing; and used a shower bed.</p> <p>A review of the Bathing Task sheet revealed that Resident #88 from 07/31/2024 to 08/28/2024, had only bed baths except one shower given on 08/05/2024.</p> <p>A review of the Behavior Monitoring sheets revealed that Resident #88 had no behaviors from 07/31/2024 to 08/28/2024.</p> <p>On 08/26/2024 at 11:37 AM, the Surveyor observed Resident #88 in bed, both hands had thick fingernails with a yellow brown substance around them, two of the nails on the left hand are longer and jagged.</p> <p>On 08/27/2024 at 10:05 AM, the Surveyor observed Resident #88 in bed, nails have not been trimmed or cleaned.</p> <p>On 08/28/2024 at 11:00 AM, the Surveyor observed Resident #88 in bed, nails have not been trimmed or cleaned.</p> <p>On 08/26/2024 at 12:15 PM, during an interview CNA #4 stated currently they have 13 to 14 baths to do in a day. CNA #4 then stated that usually only two CNAs work back there with all 27 residents, and some of the baths require two people to give them. CNA #4 stated that there is not a bathhouse on the unit, and they coordinate with other halls to be able to give baths, it is difficult to be able to get them done in a timely manner with the behaviors back here.</p> <p>On 08/28/2024 at 1:30 PM, during an interview with CNA #4 and CNA #5, CNA #4 stated Resident #88 had a dark substance under and around their nails and were jagged, long, and thick. CNA #4 stated that Resident #88 was diabetic, and the nurses do the nail care. CNA #5 stated that long nails can cause scratches and infections.</p> <p>On 08/28/2024 at 1:43 PM, during an interview Registered Nurse (RN) #7 stated Resident #88 's fingernails were long, dirty and jagged. RN #7 stated they need trimmed, for hygiene and bacteria and contamination, they could scratch themselves causing a sore or could put it in mouth or eyes could</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>cause infections.</p> <p>On 08/28/2024 at 2:45 PM, during an interview the Director of Nursing (DON) stated that activity of daily living is important as they should be well groomed it is their right and without baths, they can get skin issues or infections.</p>

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate foot care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents who required assistance with foot care were regularly provided with the necessary assistance to maintain good hygiene and grooming, as evidenced by failure to ensure toenails were kept clean and trimmed for one (Resident #88) of one sampled resident.</p> <p>The findings are:</p> <p>A review of the Order Summary revealed Resident #88 had diagnoses of type two diabetes, need for assistance with personal care, and dementia.</p> <p>A review of the Order Summary reveals no standing order for podiatry.</p> <p>A review of the Significant Change Minimum Data Set (MDS) with an Assessment of Reference Date (ARD) of 07/29/2024 revealed Resident #88 scored a 2 (severe cognitive impairment) on the Brief Interview Mental Status (BIMS).</p> <p>A review of the Care Plan, initiated on 08/24/23revealed Resident #88 was dependent for bathing; required assistance of two staff with bathing; and used a shower bed.</p> <p>A review of the Bathing Task sheet revealed Resident #88 from 07/31/2024 to 08/28/2024, charted only bed baths except one shower given on 08/05/2024.</p> <p>A review of the Behavior Monitoring sheet revealed Resident #88 had no behaviors from 07/31/2024 to 08/28/2024.</p> <p>On 08/28/2024 at 03:05 PM, the Nurse Consultant stated there was no foot care policy.</p> <p>On 08/26/2024 at 11:37 AM, the Surveyor observed Resident #88 was lying in bed with legs contracted, a drawsheet bunched up underneath, Resident #88 was moving their feet a lot. Surveyor observed the resident ' s toenails were long, thick, and jagged.</p> <p>On 08/27/2024 at 10:05 AM, the Surveyor observed Resident #88 in bed, toenails had not been trimmed.</p> <p>On 08/28/2024 at 11:00 AM, the Surveyor observed Resident #88 in bed, toenails had not been trimmed.</p> <p>On 08/28/2024 at 1:30 PM, during an interview with Certified Nursing Assistant (CNA) #4 and CNA #5, CNA #4 stated Resident #88's feet were dry and scaly, and the toenails were long and jagged. CNA #4 stated the nails had been reported over a month ago for podiatry. CNA #5 then stated Resident #88 was diabetic, and the nurse is supposed to do the nail care.</p> <p>On 08/28/2024 at 1:43 PM, Registered Nurse (RN) #7 stated that Resident #88's toenails are a little long and jagged, they do need trimmed for hygiene reasons and to prevent infections, normally the treatment nurse does the diabetic nail care in house, and that they can trim the resident's toenails today.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/28/2024 at 2:00 PM, during an interview Licensed Practical Nurse (LPN) #6 stated Resident #88 gets diabetic nail care in house normally and that they had been added recently to the podiatry caseload.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure an accident/hazard free environment was provided for 2 (Residents #6 and #64) of 2 sampled residents.</p> <p>The findings are:</p> <p>1. Review of a facility policy titled; Accident Hazards Prevention indicated, The environment will be free from accident hazards as is possible.</p> <p>A review of the admission Record, indicated the facility admitted Resident #6 with a diagnosis of heart disease that included dementia.</p> <p>A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/31/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) of 2, which indicated the resident had severe cognitive impairment for their daily decision making.</p> <p>Review of Resident #6's Care Plan, initiated on 02/28/2023 and revised on 06/04/2024, revealed the resident was at risk for falls. Interventions included maintaining a low bed and placing a fall mat at the bed the right side of the bed (initiated 05/30/2024).</p> <p>On 08/26/2024 at 11:10 AM, Resident #6 was observed resting in bed. The bed was in a low position without a fall mat.</p> <p>On 08/26/2024 at 2:00 PM, Resident #6 was observed receiving care by Certified Nursing Assistant (CNA) #1 and Certified Nursing Assistant #2. After the care, they left the room. Both CNAs were asked if a fall mat was beside the bed, and they said it was not.</p> <p>During an interview on 08/26/2024 at 2:15 PM, Licensed Practical Nurse (LPN) #3 stated there should be a fall mat on the right side of the bed so that if the resident rolled off the bed, they would not fall on the floor.</p> <p>During an interview on 08/26/2024 at 3:30 PM, the Director of Nursing (DON) stated Resident #6 should have a fall mat down at all times to prevent injury if they rolled out of the bed.</p> <p>2. A review of the admission Record indicated the facility admitted Resident #64 with a diagnosis of dementia that included dysuria (pain or discomfort while urinating).</p> <p>A review of the admission MDS with an ARD of 04/10/2024 revealed the resident had a BIMS score of 13, which indicated the resident was independent for their daily decision making.</p> <p>Review of Resident #64's Care Plan initiated on 03/29/2024 indicated the resident had impaired cognitive function related to dementia. Interventions included cueing, reorienting, and supervising the resident as needed.</p> <p>On 08/26/2024 at 11:30 AM, a tube of hemorrhoidal ointment was observed in Resident #64's bathroom. The instructions on the tube included to keep out of the reach of children.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/26/2024 at 3:30 PM, LPN #3 said hemorrhoidal ointment should not be left in a resident's bathroom.</p> <p>During an interview on 08/26/2024 at 4:00PM the Director of Nursing stated that Resident #64 should not have a tube of hemorrhoidal ointment in their bathroom.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observations, interview, and record review the facility failed to ensure hand hygiene was performed properly in one of one kitchen.</p> <p>The findings are:</p> <p>On 08/27/2024 at 10:45 AM, Dietary Aide #8 donned gloves to remove the middle blade of the food processor, Dietary Aide #8 then added the pureed spaghetti to a medium rectangular steam table pan with gloves still on. Dietary Aide #8 then proceeded to put the food processor back together, she took off her gloves and did not wash hands. She then added the rest of the regular spaghetti into the food processor from a medium rectangular steam table pan. Dietary Aide #8 was observed pouring the puree spaghetti into the same steam table pan with the rest of the pureed spaghetti. Dietary Aide #8 then cleaned the area up to puree green beans. The Surveyor observed Dietary Aide #8 putting the food processor back together and put on a glove on the left hand. The Surveyor then observed seven 4-ounce scoops were added in the food processor, the Dietary Aide #8 then removed the glove with no handwashing and ran the food processor. After running the food processor Dietary Aide #8 poured the pureed green beans into a medium rectangular steam table pan. Dietary Aide #8 then added the rest of the regular green beans left in the pan into the reassembled food processor. The Surveyor observed the Dietary Aide #8 run the food processor and add the puree green beans into the same steam table pan with the rest of the pureed green beans. Dietary Aide #8 then cleaned up the preparation table and the food processor and washed her hands.</p> <p>On 08/27/2024 at 12:00 PM, the Surveyor observed Dietary Aide #9 put on gloves then take off his gloves, he did not wash his hands. Dietary Aide #9 proceeded to put on oven mitts and pull-out garlic bread, he took off the oven mitts and put on gloves. He put the garlic bread in a steam table pan and covered it with cling wrap. The Surveyor observed Dietary Aide #9 add both pans to the steam table serving line, and then proceeded to wash his hands.</p> <p>On 08/28/2024 at 3:00 PM, during an interview the Dietary Manager stated that you wash hands in between tasks, changing gloves, when pureeing, you cannot wash your hands enough. The Dietary Manager stated it is important to wash hands to prevent food borne illness.</p> <p>On 08/29/2024 at 8:45 AM, during an interview Dietary Aide #8 stated that you wash hands as soon as you finish puree, when you start something again, and anytime you touch something, you wash hands. Dietary Aide #8 stated it is important to wash hands to prevent disease or infection.</p> <p>On 08/29/2024 at 8:47 AM, during an interview Dietary Aide #9 stated that you wash hands anytime you are handling food from one place to another. I always try to wash my hands. Dietary Aide #9 stated you wash your hands as you do not want to spread bacteria, infection and prevent cross contamination of food.</p> <p>A review of the facility policy, Handwashing and Glove Usage in Food Service, states that Objectives: 1. Understand the importance of handwashing in prevention of illness; 2. Identify when hands need to be washed.</p>		