

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Countryside Health & Rehab of Newton County		STREET ADDRESS, CITY, STATE, ZIP CODE 610 East Court Street Jasper, AR 72641	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed for 2 (Resident #33 and Resident #27) of 17 sampled residents reviewed for MDS accuracy. Specifically, the facility failed to ensure information regarding the resident's hospice care was accurately completed for Resident #33 and failed to ensure information regarding enteral feeding was accurately completed for Resident #27.</p> <p>Findings include:</p> <p>A review of the admission Record, indicated the facility admitted Resident #33 with diagnoses that included paraplegia, wedge compression fracture of vertebra, cord compression, injury to lumbar spinal cord, chronic kidney disease, and disorder of the prostate.</p> <p>The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/27/2024, revealed Resident #33 had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact, was dependent for toileting, dressing, showering/bathing, had a urinary catheter, and had active diagnoses that included paraplegia. Section O, Special Treatments, Procedures, and Programs, K1., did not indicate Hospice care was being received.</p> <p>A review of Resident #33's care plan, revised 09/11/2024, revealed the resident had a terminal prognosis of cancer and received hospice services related to end of life care. Interventions included to work cooperatively with hospice to ensure Resident #33 received maximum comfort, spiritual, emotional, intellectual, physical, social needs, and included hospice contact information.</p> <p>A review of Resident #33's Hospice IDG [Interdisciplinary Group] Comprehensive Assessment and Plan of Care Upgrade Report, dated 11/08/2024, revealed the benefit period dates were 09/21/2024 to 11/19/2024, and the purpose of the IDG meeting was Recert Order Due. The resident had a terminal diagnosis that included malignant neoplasm of vertebral column, paraplegia, and malignant neoplasm of the pelvis. Interventions included pain management, maintenance of urinary catheter, voicing coping abilities and needs for end-of-life care.</p> <p>A review of Order Summary, revealed Resident #33 had an active order for admission to hospice with a diagnosis of paraplegia with spinal cord compression, dated 10/29/2024.</p> <p>A review of hospice sign in sheet revealed Resident #33 was seen by a certified nursing assistant on 10/21/2024 and 10/26/2024, by a registered nurse on 10/24/2024, and a Chaplin on 10/24/2024.</p> <p>During an interview on 11/15/2024 at 11: 42 AM, the Assistant Director of Nursing (ADON) stated he was responsible for completing the annual MDS, for Resident #33, and the process used to complete</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>the annual MDS included review of orders and review of the hospice chart. The ADON stated the lookback period was 7 days and Resident #33 had received services from hospice since 11/02/2023, with no break in services. The ADON stated the MDS should accurately reflect Resident #33's current diagnosis, condition, and services to ensure staff providing care would know what was going on for that person. The ADON stated the Resident Assessment Manual (RAI) manual was used to complete the MDS.</p> <p>During an interview on 11/15/2024 at 12:27 PM, the Administrator stated the expectation was for staff to accurately complete the MDS, using the RAI manual, so appropriate care would be provided to residents. Resident #33 was receiving hospice services.</p> <p>A review of an admission Record indicated the facility admitted Resident #27 with diagnoses of hemiplegia (weakness of one side of the body) following cerebral infarction (stroke) and dysphagia (difficulty swallowing) following cerebral infarction. The quarterly MDS (Minimum Data Set), with an Assessment Reference Date (ARD) of 6/7/2024, revealed Resident #27's Cognitive Skills for Daily Decision Making as modified independent. The quarterly MDS, with an ARD of 9/5/2024 revealed Resident # 27's Cognitive Skills for Daily Decision Making as severely impaired. In section K, subsection k0520, part B was not marked while a Resident on both MDS. Review of Resident 27's Care Plan, with revision date of 9/10/2024, revealed that the resident had a potential nutritional problem related to dysphagia and percutaneous endoscopic gastrostomy (PEG) tube (feeding tube) use. The resident's diet is puree by mouth as tolerated. Resident intervention included providing and serving supplements as ordered, PEG tube feedings, and administering medications as ordered.</p> <p>During an interview on 11/15/2024 at 11:00 AM, Licensed Practical Nurse/Minimum Data Set /Assistance Director of Nursing (LPN/MDS/ADON) stated the importance of correctly imputing information to the MDS is that each MDS will keep track of what is coded, shows cognitive status, and (BIMS) Brief Interview for Mental Status score status. The MDS helps the facility track how the residents are doing over time.</p> <p>Review of section K, subsection K0520 on MDS with ARD dates of 6/7/2024 and 9/5/2024, showed the MDS was marked no, which indicated there was no tube feeding. The surveyor and ADON reviewed the June and September feeding on the MAR (Medication Administration Record), and Resident #27 did receive feedings and the ADON verified that section K subsection K0520 should have been marked yes. The LPN/MDS/ADON stated, I can 't argue that.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>Based on observations, interviews, and record review, it was determined the facility failed to document and complete a person-centered care plan to facilitate the ability to plan and provide necessary care and services for 1 (Resident #18) sampled resident whose care plan was reviewed.</p> <p>The findings are:</p> <p>A review of an admission Record indicated the facility admitted Resident #18 with diagnosis of pressure ulcer (injury to skin from prolonged pressure) of sacral region (portion of the lower back), stage 2.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/18/2024 revealed Resident #18 had Brief Interview Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section M part M0300 subpart B revealed one stage 2 pressure ulcer.</p> <p>Review of Resident #18's Care Plan, with revision on 9/23/2024, revealed the resident did not have pressure ulcer care planned or treatments for it.</p> <p>During an interview on 11/14/2024 at 5:00 PM, Licensed Practical Nurse/Minimal Data Set/Assistant Director of Nurse (LPN/MDS/ADON) revealed Resident #18 did not have a current pressure ulcer. Resident #18 received a medicated ointment to both buttocks as a preventative measure because of a history of pressure ulcers. There are no specific treatments on care plan. Resident #18 should have application of ointment care planned because anyone should be able to pick up the care plan to meet Resident #18's needs.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>Based on observations, interviews, record review, and facility document review, it was determined the facility failed to ensure staff performed accurate medication administration to a resident; and failed to ensure a resident's current diagnoses were documented in the medical record; and failed to ensure the Minimum Data Set (MDS) and care plan accurately reflected a residents current diagnoses and medications, and care required for 1 (Resident #20) resident; and the facility failed to ensure medication was prepared for administration in accordance with current acceptable standards of practice and facility policy for 2 (Resident #20 and Resident #21) residents; and the facility failed to ensure staff used a mechanical lift according to facility policy and manufacturing guidelines for 1 (Resident # 27) resident of 17 sampled residents.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Administering Medications, dated 11/14/2024 indicated the Director of Nursing (DON) would direct and supervise personnel administering medications and related functions. Medications must be administered in required time frames and per physician orders. Number 7. Indicated the person administering the medication must verify the five rights that included the resident, medication, dosage, time, and route by checking the label three (3) times before administering the medication. Staff shall follow facility infection control procedures when administering medications.</p> <p>A review of a patient package insert (information included with a medication with information that included uses, dosages, side effects and safety information) dated August 2005, revealed BRAND NAME indications for use included hypothyroidism (deficient or low thyroid hormone level). Precautions included a difference in dose or blood concentration of the medication could cause therapeutic failure or life-threatening adverse drug reactions, and the dose amount should be adjusted to obtain a beneficial result of treatment. Laboratory testing for diagnoses included Thyroid stimulating hormone (TSH) and thyroxine (T4) levels. The recommended frequency of TSH level testing is recommended at 6-8-week intervals until normal levels are attained and then every 8-12 weeks until optimal levels are obtained, then annual physical examination and TSH level should be performed.</p> <p>A review of a patient package insert (information included with a medication with information that included uses, dosages, side effects and safety information) dated 4/2006, revealed BRAND NAME indications for use included gastroesophageal reflux disease (GERD) with a treatment period of 4-8 weeks and treatment may be extended for an additional 4-8 week period.</p> <p>A review of a facility policy titled, Resident Rights, revised 09/19/2024 indicated the facility will ensure staff are educated on the rights of residents and facility responsibilities to properly care for residents. Residents will be provided a safe environment including receiving treatment for daily living safety.</p> <p>A review of an undated facility document titled Licensed Practical Nurse (LPN)/Registered Nurse (RN) Floor Nurse, revealed the position provides direct nursing care to the resident that included transcribing physician orders to the medical record and carrying out orders as written, preparing and administering medications per physician's orders, updates care plans as required, following appropriate safety and hygiene measures to protect residents, following infection control policies and procedures, be able to follow written instructions, and supervises day-to-day nursing activities in</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>accordance with current federal, state, and local regulations and guidelines and established facility policies and procedures, reporting to the Director of Nursing (DON), Assistant Director of Nursing (ADON), or Unit Nurse Manager.</p> <p>A review of facility documents titled, Personnel Competency Review, for medication pass, dated August 2024 revealed LPN #2 required education on fluids and foods were covered and dated; September 2024 revealed LPN #2 required education on hand hygiene prior to medication administration; and October 2024 revealed LPN #2 was reminded to wash hands prior to medication administration.</p> <p>A review of the admission Record, indicated the facility admitted Resident #20 with diagnoses that included abdominal pain, hernia, heart disease, and pulmonary disease.</p> <p>A review of the annual visit dated 07/11/2024, revealed Resident #20 was receiving an anti-ulcer 20 milligram (mg) capsule daily and a hypothyroid 50 microgram (mcg) tablet daily.</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/13/2024, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment and required set up/clean up assistance with eating, oral hygiene and was independent with personal hygiene. Active diagnoses did not include gastrointestinal or metabolic diagnoses.</p> <p>A review of Resident #20's care plan, revised, revealed that the resident had an Activity of Daily Living (ADL) self-care performance deficit related to muscle weakness and had a nutritional problem related to poor appetite. Interventions included providing medication in the dining room, and administering medications as ordered. The care plan did not include care related to gastrointestinal disorder or hypothyroidism.</p> <p>A review of Order Summary, revealed Resident #20 had an antiulcer (treats and prevents development of ulcerations in the stomach and upper intestine) medication, 20 mg one tablet by mouth in the morning for gastroesophageal (tube connecting the mouth to the stomach)reflux disease (GERD) (acid from the stomach rising into the esophagus); and thyroid hormone replacement, 50 micrograms (mcg) one tablet in the morning for hypothyroidism.</p> <p>A review of Medication Administration Record [MAR], revealed Resident #20 had an antiulcer medication 20 mg one tablet by mouth in the morning for GERD, scheduled for 6:00 AM, with a checkmark and initials of LPN #2 administering the medication on 11/13/2024.</p> <p>A review of MAR, revealed Resident #20 had a thyroid hormone replacement, 50 mcg, one tablet in the morning for hypothyroidism, scheduled for 6:00 AM, with a checkmark and initials of LPN #2 administering the medication on 11/13/2024.</p> <p>During an observation on 11/13/2024 at 5:36 AM, LPN #2 removed two medication cards from the medication cart, the first card, with a pharmacy label that indicated the medication was for Resident #20, and contained a delayed release antiulcer medication 40 mg, one tablet. The second card, with a pharmacy label that indicated the medication was for Resident #20, and contained a thyroid hormone replacement medication, 25 mcg, one tablet. LPN #2 placed one pill from each card into a medication cup. The surveyor asked LPN #2 how many tablets were in the cup and LPN #2 looked in the medication cup and responded, two. LPN #2 entered Resident #20's room and provided Resident #20 with the medication cup and water. Resident #20 swallowed the medications.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/15/2024 at 11:52 AM, the Assistant Director of Nursing (ADON) stated medication orders indicated that Resident #20 should be receiving one 20 mg antilulcer tablet every morning and one 50 mcg hypothyroid tablet every morning. The ADON stated for new admissions, or new orders for a current resident, the nurse receiving the order would enter the order into the electronic health record, verify the instructions, sign and date that the order had been entered. If an order for medication changes, the receiving nurse would enter the information in a progress note as to who made the order and what the order was, write the new medication order on the new order sheet and it would be faxed to the pharmacy. The ADON stated he was responsible for entering the admission medications for Resident #20, the medications were correct per the annual visit dated 07/11/2024. The ADON stated Resident #20's antilulcer and hypothyroid medication was started on admission, and Resident #20 did not receive the correct dose of the antilulcer or hypothyroid medication from 07/21/2024 through 11/15/2024, and no thyroid hormone testing was done to monitor thyroid levels of TSH, T3 or T4 since admission.</p> <p>During an interview on 11/15/2024 at 12:27 PM, the Administrator stated staff should be checking each medication against the MAR, it was the physician order, prior to administering to the resident.</p> <p>A review of the admission Record, indicated the facility admitted Resident #21 with diagnoses that included thyroid disease and diabetes mellitus (blood sugar concentration above the normal level) a chronic disease, causing high sugar levels in the blood.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/03/2024, revealed Resident #21 had a Brief Interview for Mental Status score of 6 which indicated the resident had severe cognitive impairment. Active diagnoses included diabetes mellitus and hypothyroidism. Medications included hypoglycemic (medication used to lower blood sugar concentration).</p> <p>A review of Resident #21's care plan, revised, revealed the resident had type 2 diabetes mellitus. Interventions included diabetes medication as ordered by doctor.</p> <p>A review of Order Summary, revealed Resident #21 had an order for a long-acting insulin glargine, inject 42 units subcutaneously (beneath the skin) in the morning for diabetes.</p> <p>A review of MAR, revealed Resident #21 had a long-acting insulin glargine, 42 units to be administered at 06:00 AM, for diabetes, with a checkmark and initials of LPN #2 administering the medication on 11/13/2024.</p> <p>During an observation on 11/13/2024 at 5:40 AM, LPN #2 cleaned Resident #21's finger, used a lancet to pierce the skin and placed blood on a testing strip inserted into a testing device, and obtained a blood sugar level of 140. LPN #2 stated if a reading was less than or equal to 110, the insulin would not be given until later because Resident #21 did not eat breakfast.</p> <p>LPN #2 cleaned the top of the insulin vial using an alcohol prep pad, opened a 100-unit insulin syringe, removed the cap from the needle, pulled back on plunger, holding vial sideways, inserted the needle into the rubber stopper, inserted air into the vial by pushing plunger, pulled plunger back obtaining insulin and air bubbles. LPN #2 pulled the needle guard, handed the syringe to surveyor. The surveyor asked LPN #2 what was in the syringe with the insulin. LPN #2 stated, air bubbles. LPN #2 took syringe and banged the shaft of the syringe against the top edge of the medication cart. LPN #2 used fingers to flick the syringe and was unable to release the bubbles. LPN #2, while holding the insulin vial sideways, used the same syringe and needle and pierced the rubber stopper on the</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of an admission Record indicated the facility admitted Resident #27 with diagnosis of hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following cerebral infarction (stroke) and dysphagia following cerebral infarction (difficulty swallowing after a stroke).</p> <p>The quarterly MDS with an ARD of 9/5/2024 revealed Resident # 27 had a Staff Assessment for Mental Status (SAMS) score of 3, indicating the resident's cognitive skills for daily decision making was severely Impaired. Section GG, Subsection GG 0170-part E on MDS was charted 01 (dependent) with chair/bed-to-chair transfers.</p> <p>Review of Resident #27 Care Plan, revision on 9/10/2024, revealed the resident has an ADL self-care performance deficit related to hemiplegia. Resident was totally dependent of 2 staff for transferring with mechanical lift.</p> <p>During observation on 11/15/2024 1:20 PM, observed CNA #7 and Restorative Certified Nursing Assistant (RCNA) #8 with mechanical lift transfer. During observation, RCNA #8 did not lock lift during transfer of resident from Geri-chair (Geriatric Chair) to bed. RCNA #8 did not lock lift when lowering resident to bed.</p> <p>During interview 11/15/2024 1:31 PM, RCNA #8 regarding mechanical lift transfer. RCNA #8 stated, That was part of my training with named lift to lock the wheels, so it is stable when lifting the resident.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to ensure its medication error rate was not 5% or greater. There were three errors out of 36 opportunities for 2 (Resident #20 and Resident #21) of 6 residents, which resulted in a medication error rate of 8.33%.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Administering Medications, dated 11/14/2024 indicated, The Director of Nursing (DON) would direct and supervise personnel administering medications and related functions. Medications must be administered in required time frames and per physician orders. Number 7. Indicated the person administering the medication must verify the five rights that included the resident, medication, dosage, time, and route by checking the label THREE (3) times before administering the medication. Staff shall follow facility infection control procedures when administering medications.</p> <p>A review of the admission Record, indicated the facility admitted Resident #20 with diagnoses that included abdominal pain, hernia, heart disease, and pulmonary disease.</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/13/2024, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment and required set up/clean up assistance with eating, oral hygiene and was independent with personal hygiene. Active diagnoses did not include gastrointestinal or metabolic diagnoses.</p> <p>A review of Resident #20's care plan, revised 9/20/2024, revealed that the resident had an ADL self-care performance deficit related to muscle weakness and had a nutritional problem related to poor appetite. Interventions included providing medication in the dining room, and administering medications as ordered.</p> <p>A review of the Order Summary, revealed Resident #20 had an antiulcer medication, 20 milligrams (mg) one tablet by mouth in the morning for gastroesophageal (tube connecting the mouth to the stomach) reflux disease (GERD) (acid from the stomach rising into the esophagus); and thyroid hormone replacement, 50 micrograms (mcg) one tablet in the morning for hypothyroidism (deficient or low thyroid hormone).</p> <p>A review of Medication Administration Record [MAR], revealed Resident #20 had an antiulcer medication 20 mg one tablet by mouth in the morning for GERD, scheduled for 6:00 AM, with a checkmark and initials of LPN #2 administering the medication on 11/13/2024.</p> <p>A review of MAR, revealed Resident #20 had a thyroid hormone replacement, 50 mcg, one tablet in the morning for hypothyroidism, scheduled for 6:00 AM, with a checkmark and initials of LPN #2 administering the medication on 11/13/2024.</p> <p>During an observation on 11/13/2024 at 5:36 AM, LPN #2 removed two medication cards from the medication cart, the first card, with a pharmacy label that indicated the medication was for Resident #20, and contained a delayed release antiulcer medication 40 mg, one tablet. The second card, with a pharmacy label that indicated the medication was for Resident #20, and contained a thyroid hormone</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Countryside Health & Rehab of Newton County		STREET ADDRESS, CITY, STATE, ZIP CODE 610 East Court Street Jasper, AR 72641	

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>replacement medication, 25 mcg, one tablet. LPN #2 placed one pill from each card into a medication cup. The surveyor asked LPN #2 how many tablets were in the cup and LPN #2 looked in the medication cup and responded, Two. LPN #2 entered Resident #20's room and provided Resident #20 with the medication cup and water. Resident #20 swallowed the medications.</p> <p>During an interview on 11/15/2024 at 11:52 AM, the Assistant Director of Nursing (ADON) stated medication orders indicated that Resident #20 should be receiving one 20 mg antilucer (treats and prevents development of ulcerations in the stomach and upper intestine) tablet every morning and one 50 mcg hypothyroid tablet every morning.</p> <p>During an interview on 11/15/2024 at 12:27 PM, the Administrator stated staff should be checking each medication against the MAR, it was the physician order, prior to administering to the resident.</p> <p>A review of the admission Record, indicated the facility admitted Resident #21 with diagnoses that included thyroid disease and diabetes mellitus, a chronic disease-causing high sugar levels in the blood.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/03/2024, revealed Resident #21 had a Brief Interview for Mental Status score of 6 which indicated the resident had severe cognitive impairment. Active diagnoses included diabetes mellitus and hypothyroidism. Medications included hypoglycemic (medication used to lower blood sugar concentrations).</p> <p>A review of Resident #21's care plan, revised, revealed the resident had type 2 diabetes mellitus. Interventions included diabetes medication as ordered by doctor.</p> <p>A review of Order Summary, revealed Resident #21 had an order for a long-acting insulin glargine, inject 42 units subcutaneously (beneath the skin) in the morning for diabetes.</p> <p>A review of MAR, revealed Resident #21 had a long-acting insulin glargine, 42 units to be administered at 6:00 AM, for diabetes, with a checkmark and initials of LPN #2 administering the medication on 11/13/2024.</p> <p>During an observation on 11/13/2024 at 5:40 AM, LPN #2 cleaned Resident #21's finger, used a lancet to pierce the skin and placed blood on a testing strip inserted into a testing device, and obtained a blood sugar level of 140. LPN #2 stated if a reading was less than or equal to 110, the insulin would not be given until later because Resident #21 did not eat breakfast. LPN #2 cleaned the top of the insulin vial using an alcohol prep pad, opened a 100-unit insulin syringe, removed the cap from the needle, pulled back on plunger, holding vial sideways, inserted the needle into the rubber stopper, inserted air into the vial by pushing plunger, pulled plunger back obtaining insulin and air bubbles. LPN #2 pulled the needle guard, handed the syringe to surveyor. The surveyor asked LPN #2 what was in the syringe with the insulin. LPN #2 stated, air bubbles. LPN #2 took syringe and banged the shaft of the syringe against the top edge of the medication cart. LPN #2 used fingers to flick the syringe and was unable to release the bubbles. LPN #2, while holding the insulin vial sideways, used the same syringe and needle and pierced the rubber stopper on the insulin vial three additional times, without disinfecting the rubber stopper. LPN #2 continued to use their fingers to flick the syringe mid shaft and bang the syringe on the top edge of the medication cart. LPN #2 asked the surveyor what should be done to remove the bubbles.</p> <p>During observation at 5:54 AM LPN #2 telephoned the Administrator. LPN #2 was told to discard</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>syringe and start again. LPN #2 discarded syringe containing insulin, opened a new 100-unit insulin syringe, used an alcohol pad to clean the rubber stopper on the insulin vial, held the vial sideways, pulled back plunger, injected air into the vial, pulled back on the plunger and withdrew insulin.</p> <p>At 6:03 AM, LPN #2 turned head toward the left and verbally called out for assistance down hallway, toward the nurse station. Registered Nurse #1 took syringe and tried flicking syringe midshaft, handed syringe back to LPN #2 and told LPN #2 to discard the syringe, start again, and draw slowly.</p> <p>At 6:06 AM, LPN #2 obtained a new 100-unit insulin syringe, turned vial sideways, disinfected rubber stopper with alcohol prep pad, pulled back plunger on syringe, inserted needle into rubber stopper, pushed plunger inserting air into the vial, pulled plunger back slowly, obtained insulin to 42-unit mark, entered Resident #21's room and injected insulin into resident's left upper arm.</p> <p>During an interview on 11/13/2024 at 6:49 AM, RN #1 stated no bubbles should be in the insulin syringe and needed to be removed. RN #1 stated training for nurses was done by the DON and Administrator.</p> <p>During an interview on 11/13/24 at 07:00 AM, the Administrator stated LPN #2 called regarding bubbles in the syringe and was told to discard the syringe and start again due to the bubbles making the dose inaccurate. The Administrator stated she was not aware the vial had been accessed more than one time and should not have been because the insulin syringe needles cannot be changed and there was an increased risk of germs.</p> <p>During an interview on 11/15/2024 at 11:52 AM, the ADON stated the proper procedure used to obtain insulin from a multi-dose vial, for administration to a resident, would include hand hygiene, verifying the dates, the medication was correct, the order and name of resident. An alcohol swab should be used to clean the rubber stopper at the top of the vial, obtain syringe, turn the vial upside down, insert the needle, push air into the vial, draw up the ordered dose, verify the amount of insulin in the syringe, inspect for bubbles, and ensure bubbles are out in order to have the right amount of insulin. If the syringe had air it would rise to the top and push the insulin down and the reading could be short by a unit or two, depending on amount of air in syringe. The vial should never be accessed with the needle more than once because the needle will dull and there was a higher risk of contamination the more times the vial was accessed with the same needle. If air remains in the syringe and air gets into the bloodstream from entering a vein, it could affect a resident's health. If air was pushed into the skin it could be painful.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were free from significant medication errors related to hypothyroid (replacement for deficient or low thyroid hormone level) medication, antiulcer (to prevent development of ulcerations in the stomach and upper small intestine) medication, and insulin administration, for 2 (Resident #20 and Resident #21) of 6 residents reviewed for medication administration. This failed practice resulted in Resident #20 receiving an inaccurate dose of hypothyroid and antiulcer medication from 07/21/2024 through 11/15/2024.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Administering Medications, dated 11/14/2024 indicated the Director of Nursing (DON) would direct and supervise personnel administering medications and related functions. Medications must be administered in required time frames and per physician orders. Number 7. Indicated the person administering the medication must verify the five rights that included the resident, medication, dosage, time, and route by checking the label THREE (3) times before administering the medication. Staff shall follow facility infection control procedures when administering medications.</p> <p>A review of a patient package insert (information included with a medication with information that included uses, dosages, side effects and safety information) dated August 2005, revealed BRAND NAME indications for use included hypothyroidism. Precautions included a difference in dose or blood concentration of the medication could cause therapeutic failure or life-threatening adverse drug reactions, and the dose amount should be adjusted to obtain a beneficial result of treatment. Laboratory testing for diagnoses included Thyroid stimulating hormone (TSH) and thyroxine (T4) levels. The recommended frequency of TSH level testing is recommended at 6-8-week intervals until normal levels are attained and then every 8-12 weeks until optimal levels are obtained, then annual physical examination and TSH level should be performed.</p> <p>A review of a patient package insert (information included with a medication with information that included uses, dosages, side effects and safety information) dated 4/2006, revealed BRAND NAME indications for use included gastroesophageal reflux disease (GERD) with a treatment period of 4-8 weeks and treatment may be extended for an additional 4-8 week period.</p> <p>A review of the admission Record, indicated the facility admitted Resident #20 on 07/21/2024, with diagnoses that included abdominal pain, hernia, heart disease and pulmonary disease.</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/13/2024, revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment and required set up/clean up assistance with eating, oral hygiene and was independent with personal hygiene. Active diagnoses did not include gastrointestinal or metabolic diagnoses.</p> <p>A review of Resident #20's care plan, revised, revealed that the resident had an ADL self-care performance deficit related to muscle weakness and had a nutritional problem related to poor appetite. Interventions included providing medication in the dining room, and administering medications as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Order Summary, revealed Resident #20 had an antiulcer medication, 20 milligrams (mg) one tablet by mouth in the morning for GERD; and thyroid hormone replacement, 50 micrograms (mcg) one tablet in the morning for hypothyroidism.</p> <p>A review of Medication Administration Record [MAR], revealed Resident #20 had an antiulcer medication 20 mg one tablet by mouth in the morning for GERD, scheduled for 06:00 AM, with a checkmark and initials of LPN #2 administering the medication on 11/13/2024.</p> <p>A review of MAR, revealed Resident #20 had a thyroid hormone replacement, 50 mcg, one tablet in the morning for hypothyroidism, scheduled for 06:00 AM, with a checkmark and initials of LPN #2 administering the medication on 11/13/2024.</p> <p>During an observation on 11/13/2024 at 5:36 AM, LPN #2 removed two medication cards from the medication cart, the first card, with a pharmacy label that indicated the medication was for Resident #20, and contained a delayed release anti-ulcer medication 40 mg, one tablet. The second card, with a pharmacy label that indicated the medication was for Resident #20, and contained a thyroid hormone replacement medication, 25 mcg, one tablet. LPN #2 placed one pill from each card into a medication cup. The surveyor asked LPN #2 how many tablets were in the cup and LPN #2 looked in the medication cup and responded, two. LPN #2 entered Resident #20's room and provided Resident #20 with the medication cup and water. Resident #20 swallowed the medications.</p> <p>During an interview on 11/15/2024 at 11:52 AM, the Assistant Director of Nursing (ADON) stated medication orders indicated that Resident #20 should be receiving one 20 mg antiulcer tablet every morning and one 50 mcg hypothyroid tablet every morning.</p> <p>The ADON stated for new admissions, or new orders for a current resident, the nurse receiving the order would enter the order into the electronic health record, verify the instructions, sign and date that the order had been entered. If an order for medication changes, the receiving nurse would enter the information in a progress note as to who made the order and what the order was, write the new medication order on the new order sheet and it would be faxed to the pharmacy.</p> <p>The ADON stated Resident #20's antiulcer and hypothyroid medication was started on admission.</p> <p>A review of the annual visit dated 07/11/2024, revealed Resident #20 was receiving an antiulcer 20 mg capsule daily and a hypothyroid 50 mcg tablet daily, prior to admission.</p> <p>During an interview on 11/15/2024 at 12:27 PM, the Administrator stated staff should be checking each medication against the MAR, it was the physician order, prior to administering it to the resident.</p> <p>A review of the admission Record, indicated the facility admitted Resident #21 with diagnoses that included thyroid disease and diabetes mellitus, a chronic disease, causing high sugar levels in the blood.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/03/2024, revealed Resident #21 had a Brief Interview for Mental Status score of 6, which indicated the resident had severe cognitive impairment. Active diagnoses included diabetes mellitus and hypothyroidism. Medications included hypoglycemic.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #21's care plan, revised 9/20/2024, revealed the resident had type 2 diabetes mellitus. Interventions included diabetes medication as ordered by doctor.</p> <p>A review of an Order Summary, revealed Resident #21 had an order for a long-acting insulin glargine, inject 42 units subcutaneously in the morning for diabetes.</p> <p>A review of MAR, revealed Resident #21 had a long-acting insulin glargine, 42 units to be administered at 6:00 AM, for diabetes, with a checkmark and initials of LPN #2 administering the medication on 11/13/2024.</p> <p>During an observation on 11/13/2024 at 5:40 AM, LPN #2 cleaned Resident #21's finger, used a lancet to pierce the skin and placed blood on a testing strip inserted into a testing device, and obtained a blood sugar level of 140. LPN #2 stated if a reading was less than or equal to 110, the insulin would not be given until later because Resident #21 did not eat breakfast. LPN #2 cleaned the top of the insulin vial using an alcohol prep pad, opened a 100-unit insulin syringe, removed the cap from the needle, pulled back on plunger, holding vial sideways, inserted the needle into the rubber stopper, inserted air into the vial by pushing plunger, pulled plunger back obtaining insulin and air bubbles. LPN #2 pulled the needle guard, handed the syringe to surveyor. The surveyor asked LPN #2 what was in the syringe with the insulin. LPN #2 stated, air bubbles. LPN #2 took syringe and banged the shaft of the syringe against the top edge of the medication cart. LPN #2 used fingers to flick the syringe and was unable to release the bubbles. LPN #2, while holding the insulin vial sideways, used the same syringe and needle and pierced the rubber stopper on the insulin vial three additional times, without disinfecting the rubber stopper. LPN #2 continued to use their fingers to flick the syringe mid shaft and bang the syringe on the top edge of the medication cart. LPN #2 asked the surveyor what should be done to remove the bubbles.</p> <p>During observation at 5:54 AM, LPN #2 telephoned the Administrator. LPN #2 was told to discard syringe and start again. LPN #2 discarded the syringe containing insulin, opened a new 100-unit insulin syringe, used an alcohol pad to clean the rubber stopper on the insulin vial, held the vial sideways, pulled back plunger, injected air into the vial, pulled back on the plunger and withdrew insulin. At 6:00 AM, LPN #2 turned head toward the left and verbally called out for assistance down hallway, toward the nurse station. Registered Nurse (RN) #1 took syringe and tried flicking syringe midshaft, handed syringe back to LPN #2 and told LPN #2 to discard the syringe, start again, and draw slowly. At 6:06 AM, LPN #2 obtained a new 100-unit insulin syringe, turned vial sideways, disinfected rubber stopper with alcohol prep pad, pulled back plunger on syringe, inserted needle into rubber stopper, pushed plunger inserting air into the vial, pulled plunger back slowly, obtained insulin to 42-unit mark, entered Resident #21's room and injected insulin into resident's left upper arm.</p> <p>During an interview on 11/13/2024 at 6:49 AM, RN #1 stated no bubbles should be in the insulin syringe and needed to be removed.</p> <p>During an interview on 11/13/24 at 7:00 AM, the Administrator stated LPN #2 called regarding bubbles in the syringe and was told to discard the syringe and start again due to the bubbles making the dose inaccurate.</p> <p>During an interview on 11/15/2024 at 11:52 AM, the ADON stated an alcohol swab should be used to clean the rubber stopper at the top of the vial, obtain syringe, turn the vial upside down, insert the needle, push air into the vial, draw up the ordered dose, verify the amount of insulin in the syringe, inspect for bubbles, and ensure bubbles are out in order to have the right amount of insulin. If</p> <p>(continued on next page)</p>		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the syringe had air it would rise to the top and push the insulin down and the reading could be short by a unit or two, depending on amount of air in syringe.		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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 observation, interview, and review of facility's policy, the facility failed to ensure staff completed proper handwashing during food preparation and food was prepared safely and properly. The failed practices had the potential to affect all forty-four residents.</p> <p>The findings are:</p> <p>On 11/14/2024 at 10:30 AM, Dietary [NAME] #8 was observed preparing lunch. Dietary [NAME] #8 washed hands turned off the faucet touching the faucet, and dried hands. Dietary [NAME] #8 was observed with long hair, on both the left and right side, hanging out of the hairnet. Surveyor asked Dietary [NAME] #8 to look in the mirror. After noticing the hair in the mirror, Dietary [NAME] #8 secured hair under the hairnet. Dietary [NAME] #8 touched their face after washing hands. Dietary [NAME] #8 touched several dirty surfaces, such as opening drawers, touching clothing, and dishwashing area and then went to preparing food at least three times. Dietary [NAME] #8 donned gloves five times during preparing pureed foods and obtaining temperatures of the prepared foods without washing hands in between each glove change. Prior to obtaining temperatures for the foods, Dietary [NAME] #8 placed an unopened alcohol pad in her mouth while washing hands, then opened the same alcohol pad to clean the thermometer. After these observations, Dietary [NAME] #8 confirmed she should have had her hair up completely under the hairnet to prevent possible contamination of hair into the food and followed her training on washing her hands properly. She also confirmed safe food preparation, proper hand hygiene, and proper donning of gloves is important to reduce the risk of food-borne illness and cross contamination.</p> <p>During an interview on 11/15/2024 at 8:30 AM, Dietary Manager confirmed staff initially trained on proper hand hygiene, and safe food handling, and staff are offered refresher training as needed. Dietary Manager stated, I know she (Dietary [NAME] #8) was very nervous and made mistakes she normally doesn't make. I assure you; we will be having an in-depth in-service to address what we talked about.</p> <p>Upon review of the facility's policy titled Hand Hygiene revised on 01/30/2024, it stated under section number 5. Hand hygiene technique when using soap and water: a. Wet hands with water. Avoid using hot water to prevent drying of skin. b. Apply to hands the amount of soap recommended by the manufacturer. c. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. d. Rinse hands with water. e. Dry thoroughly with a single-use towel. f. Use a clean towel to turn off the faucet.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, it was determined the facility failed to ensure staff performed hand hygiene during meal service; failed to ensure insulated meal cart door remained closed when not accessing meal trays; failed to ensure proper infection control practices were performed during medication pass for 1 (Resident #21) failed to ensure measures were taken to prevent resident's from using bathroom sink water in oral care for 1 (Resident #22) resident of 17 sampled residents, and water fountains were marked/labeled/taken out of service from use by residents, staff and visitors.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Hand Hygiene, dated 01/30/2024, indicated, performing proper hand hygiene procedures prevented the spread of infection and should be performed as outlined in the attached table. No table was attached.</p> <p>During an observation on 100 hall on 11/12/2024 at 12:25 PM, an insulated meal cart was on 200 hall, Certified Nursing Assistant (CNA) opened the cart and removed meal tray from cart, served room [ROOM NUMBER], door was not closed. At 12:27 PM the meal cart door was closed and moved to 100 hall, door was opened and tray removed for room [ROOM NUMBER]-B. The last tray was served at 12:33 PM and the cart door was closed.</p> <p>During an observation on 11/12/2024 at 12:31 PM, CNA #9 sanitized hands, removed meal tray from insulated cart, rubbed nose with right hand, and entered room [ROOM NUMBER] and served the meal tray to a resident.</p> <p>During an interview on 11/12/2024 at 12:35 PM CNA #9 stated the door on insulated cart should be kept closed to keep the food hot and air from getting to the food. CNA #9 stated hands should have been sanitized after touching their face and prior to serving the tray in 110 to keep from spreading germs to the resident because it could cause them to become very ill.</p> <p>During an interview on 11/14/2024 at 5:36 PM, the Administrator stated the expectation of staff when serving residents meals residents in their rooms, was performing hand hygiene between residents, because of infection control, to protect the residents and staff from spreading germs. If staff touch anything before serving a resident, they should wash their hands. The insulated meal cart door should be closed between each tray.</p> <p>A review of a facility policy titled, Administering Medications, dated 11/14/2024 indicated, the Director of Nursing (DON) would direct and supervise personnel administering medications and related functions. Medications must be administered in required time frames and per physician orders. Staff shall follow facility infection control procedures when administering medications.</p> <p>A review of the admission Record, indicated the facility admitted Resident #21 with diagnoses that included thyroid disease and diabetes mellitus, a chronic disease, causing high sugar levels in the blood.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/03/2024, revealed Resident #21 had a Brief Interview for Mental Status score of 6 which indicated the resident had</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Countryside Health & Rehab of Newton County		STREET ADDRESS, CITY, STATE, ZIP CODE 610 East Court Street Jasper, AR 72641	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>severe cognitive impairment. Active diagnoses included diabetes mellitus and hypothyroidism. Medications included hypoglycemic.</p> <p>A review of Resident #21's care plan revealed the resident had type 2 diabetes mellitus. Interventions included diabetes medication as ordered by doctor.</p> <p>A review of Order Summary, revealed Resident #21 had an order for a long-acting insulin glargine, inject 42 units subcutaneously in the morning for diabetes.</p> <p>A review of MAR, revealed Resident #21 had a long-acting insulin glargine, 42 units to be administered at 6:00 AM, for diabetes, with a checkmark and initials of LPN #2 administering the medication on 11/13/2024.</p> <p>LPN #2 cleaned the top of the insulin vial using an alcohol prep pad, opened a 100-unit insulin syringe, removed the cap from the needle, pulled back on plunger, holding vial sideways, inserted the needle into the rubber stopper, inserted air into the vial by pushing plunger, pulled plunger back obtaining insulin and air bubbles. LPN #2 banged the shaft of the syringe against the top edge of the medication cart attempting to release air bubbles. LPN #2 used fingers to flick the syringe and was unable to release the bubbles. LPN #2, while holding the insulin vial sideways, used the same syringe and needle and pierced the rubber stopper on the insulin vial three additional times, without disinfecting the rubber stopper. LPN #2 continued to use their fingers to flick the syringe mid shaft and bang the syringe on the top edge of the medication cart.</p> <p>During an interview on 11/13/2024 at 7:00 AM, the Administrator stated she was not aware the vial had been accessed more than one time and should not have been because the insulin syringe needles cannot be changed and there was an increased risk of germs.</p> <p>During an interview on 11/15/2024 at 11:52 AM, the LPN/MDS/ADON stated insulin vials should never be accessed with the needle more than once because the needle will dull and there was a higher risk of contamination the more times the vial was accessed with the same needle.</p> <p>A review of City of (named city) News Release, dated 11/06/2024 revealed a precautionary bowl water notice was issued due to a main water break and indicated water should be boiled as water may be unsafe for human consumption, and included drinking water, cooking, making ice, brushing teeth or washing dishes. The notice would remain in effect until the break was corrected and a bacteriological survey indicated the water was safe to drink.</p> <p>A review of the admission Record, indicated the facility admitted Resident #22 with diagnoses that included dementia, psychosis, lung disease, fecal abnormalities and urinary elimination problems.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/17/2024, revealed Resident #22 had a Brief Interview for Mental Status score of 15 which indicated the resident was cognitively intact and was independent with oral care.</p> <p>A review of Resident #22's care plan revised 09/11/2024, revealed the resident had an ADL (Activities of Daily Living) self-care performance deficit related to dementia, and impaired cognitive function / dementia or impaired thought processes related to vascular dementia. Interventions included cue, reorient, supervise as needed, and keep routine consistent to decrease confusion.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Countryside Health & Rehab of Newton County		STREET ADDRESS, CITY, STATE, ZIP CODE 610 East Court Street Jasper, AR 72641	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 11/12/2024 at 3:52 PM, Resident #22 stated I brush my teeth in the sink in the bathroom. They do not provide bottled water or any water to me.</p> <p>During an observation on 11/14/2024 8:27 AM, the water fountains located on the wall between the male and female visitor and staff bathrooms across from the dining room, accessible to ambulatory residents, had a pink/red/brown, irregular semitransparent, gel like substance partially covering the silver drain cover, brown/black debris was located at the back left side of the basin, and the water bubbler (part that expels water into the air for consumption) was covered with a green and white gritty layer.</p> <p>During an interview on 11/14/2024 at 5:36 PM, the Administrator stated residents and staff were verbally notified of the boil water order, when the pipe was broken. The city called and brought over a notice. Emergency water was used, and the information was passed on from shift to shift. The Administrator stated the steps taken to ensure residents knew not to use the water in their bathrooms for brushing teeth, rinsing their mouth or drinking was by the CNAs monitoring residents, passing ice and water and checking 7 am and 3 pm to ensure their carts are stocked with bagged ice and water. CNAs reminded residents not to drink the water or use the water in the bathrooms. No signs or warnings were posted in bathrooms on faucets or on drinking fountains.</p>		