STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045361	A. BUILDING _____ B. WING _____	**06/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PROMENADE HEALTH AND REHABILITATION	**1101 S PROMENADE BOULEVARD ROGERS, AR 72758**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 321) was substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to document, track, and trend a head lice outbreak in the facility during which a resident continued to be re-infected, to prevent the potential spread of head lice for 1 (Resident #10) of 1 case mix resident who was diagnosed with [REDACTED].#12) in Quarantine isolation pending COVID-19 test results, and 2 (Residents #11 and #14) of 10 residents who were in Quarantine isolation to prevent the potential spread of infection during a COVID-19 Pandemic, according to a list provided by the Director of Nursing on 6/1/2020 at 11:18 a.m. The facility also failed to ensure laundry staff sanitized their hands between resident's rooms, and failed to ensure contaminated hangers were not hanging with the clean laundry to prevent the potential for cross-contamination; failed to ensure appropriate notification was placed on the room entrance door, to inform the staff of the need and type of transmission-based precautions for 4 (Residents #11, #12, #14, and #16) case mix residents who were on droplet precaution quarantine isolation. These failed practices had the potential to affect 79 resident who resided in the facility, according to the list provided by the Administrator on 6/1/2020. The findings are: 1. Resident #10 was admitted on [DATE] and had a [DIAGNOSES REDACTED]. An Admission Minimum Data Set (MDS) with an Assessment Reference Date of 2/7/2020 documented the resident scored 12 (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status (BIMS); required extensive two-person assistance for bed mobility, dressing, and toilet use; required extensive one-person assistance with transfer; required limited two-person assistance with personal hygiene; required limited two-person assistance with personal hygiene; and was independent with set up only assistance for eating. a. A Progress Note dated 2/3/2020 at 4:14 p.m. documented the resident's arrival / admission to the facility and an Initial Assessment. The Progress Note also documented the resident had no complaints. b. A facility form titled Admit / Readmit Screener dated 2/3/2020 at 11:39 a.m. documented no abnormalities. c. A Progress Note dated 2/25/2020 at 11:28 a.m. documented, . complaining of her head itching . nurse examined residents (sic) hair and discovered nits (lice) . d. A physician's orders [REDACTED]. RID Aerosol ([MEDICATION NAME]) Apply to head topically one time only for itching, lice for 1 Day . e. A physician's orders [REDACTED].Contact Precautions for Two Weeks . f. A Progress Note dated 2/26/2020 at 4:48 p.m. documented, . asked the family if they knew how patient got head lice. Family said 'yes' they did, they have a family member in from out of town and she has them and unfortunately is going around the whole family now . g. A Progress Note dated 3/5/2020 at 11:00 a.m. documented, .resident is off isolation . h. A Progress Note dated 3/13/2020 at 10:27 a.m. documented, .Resident is currently on isolation for Head Lice. This is the second episode for headlice . i. A Progress Note dated 3/13/2020 at 11:07 p.m. documented, . Resident's hair combed and treated for [REDACTED]. A Progress Note dated 3/17/2020 at 5:26 p.m. documented, . resident's hair treated with mayo (mayonnaise) and tea tree oil . shampooed hair . hair combed with nit comb . a few white nits combed out . some nits still visible (sic) . remains on contact isolation at this time . k. A physician's orders [REDACTED]. Lice Killing Maximum Strength Shampoo 0.33-4 % ([MEDICATION NAME]-Piperonyl Butoxide) Apply to Scalp topically one time only for Lice . l. A Progress Note dated 3/19/2020 at 1:31 p.m. documented, . just a few live lice noted and a few nits . received order to repeat NIX . m. A Progress Note dated 3/20/20 at 10:40 a.m. documented, .Resident continues on isolation for Head Lice . n. A Progress Note dated 3/20/2020 at 10:51 a.m. documented, . hair treated with NIX yesterday . no lice or nits seen . will discontinue contact isolation . o. A Progress Note dated 3/20/2020 at 11:49 a.m. documented, . bed mattress was also changed out . p. On 4/3/2020 at 11:17 a.m., the Nurse Consultant was asked, How long have you been handling the Infection Prevention and Control Program? The Nurse Consultant stated, Since December (2019). We hired a new DON (Director of Nursing) and she will be doing it when she gets her IP (Infection Preventionist) Certification. She was asked, Have you had a lice outbreak in the facility in the last 4 months? The Nurse Consultant stated, There was one resident that admitted from the hospital with lice. She was asked, How many residents were involved? The Nurse Consultant stated, Her (Resident #10) and her roommate. I don't believe she was positive. She was asked, How do you handle isolation with a lice outbreak? The Nurse Consultant stated, We provided a bonnet for the resident and staff and they were also given gown, gloves, and shoe covers (Personal Protective Equipment). The Nurse Consultant was asked, How long is isolation for lice? The Nurse Consultant stated, I would have to look for sure at her records. She was asked, Where do you record head lice outbreaks? The Nurse Consultant stated, In the medical record. I don't believe we record that on the Infection Tracking. She was asked, Would you normally track it? The Nurse Consultant stated, Yes. She was asked, Why were they not shown on the Infection Surveillance Tracking Sheet? The Nurse Consultant stated, I don't have the tracking sheet in front of me. I can look to see if it was on there. She was asked, Please provide me with any Infection Surveillance Tracking Sheet that I do not have that shows the lice. The Nurse Consultant stated, I will, if I have it. She was asked, Are visitors allowed in when a resident is in isolation? The Nurse Consultant stated, Yes. She was asked, Are any precautions put into place? The Nurse Consultant stated, We post notice to 'Stop and See Nurse First' and we would provide them with PPE (Personal Protective Equipment) and educate them. q. On 4/3/2020 at 1:08 p.m., the Administrator was asked, Have you had any communicable disease outbreaks on any hall in the last three months? The Administrator stated, Just the flu (Influenza). We had a lady that had head lice and was in isolation on two different occasions. The Administrator was asked, How many residents were involved? The Administrator stated, The first time we treated her and the roommate, and the roommate did not have head lice and her side of the room and everything in room was treated, cleaned, stored, and waited days (I don't know how many) until we put it back in the room. The lady who had the lice had a bonnet on when she left the room to get therapy. That room was on isolation and staff wore caps and gowns as well. She was asked, Why were they (residents with head lice) not shown on the Infection Surveillance Tracking Sheet? The Administrator stated, I had a previous DON (Director of Nursing) who is no longer here. She was asked, Are visitors allowed in when a resident is in isolation? If so, are any precautions put into place? How are the visitors notified of isolation or precautions? The Administrator stated, We stopped that, sent the letters out, and no visitors on Friday night, and that was on the 10th of March (3/10/2020). She was asked, What about the head lice? The Administrator stated, They would have to don the PPE (Personal Protective Equipment). r. On 4/3/2020 at 4:53 p.m., Housekeeper #1 was asked, What is your procedure for the disinfecting of a resident's room with head lice? Housekeeper #1 stated, We put on PPE, bonnet, gown, gloves, shoe covers, enter the room, and then thoroughly disinfect the room. We take the mattress out, wrap it in plastic, and Maintenance stores it for 2 weeks. We do that with PPE for 14 days straight. 2. Resident #14, who resided in room [ROOM NUMBER], had [DIAGNOSES REDACTED]. An Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/6/2020 documented the resident scored 12 (8-12 indicates moderate cognitive impairment) on a Brief Interview for Mental Status (BIMS); required extensive assistance for bed mobility, required limited assistance for transferring, ambulation, locomotion, dressing, toilet use and personal hygiene; was independent with set-up only assistance for eating; was totally dependent for bathing, was occasionally incontinent of bladder and always incontinent of bowel; and required a walker and wheelchair for mobility. a. The Medication Administration Records (MARs) dated May 2020 and June 2020 documented, .Droplet isolation to a private room . every shift .

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

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) Order Date . 5/30/2020 . 1438 (2:38 p.m.) . b. The Care Plan with a revised date of 5/30/2020 documented, .Resident is at risk for changes in condition . Isolation Precautions related to COVID-19 circumstances . c. A Nurse's Note dated 5/30/2020 at 14:42 (2:42 p.m.) .Orders received from (Physician's Name) to place resident on Droplet ISO (isolation) pending her roommate's lab test results as a precaution . d. On 6/1/20 at 11:29 a.m., during initial rounds on the 100 Hall, room [ROOM NUMBER] had an isolation container outside the resident's room. There was a paper sign on the door frame that stated, .Stop and See Nurse . Five cloth black bags were hanging from the hallway railing outside the resident's room / door labeled with staff names. Yellow gowns, brown paper bags, and N-95 masks were protruding from the black cloth bags. e. On 6/1/20 at 11:32 a.m., outside room [ROOM NUMBER], Certified Nursing Assistant (CNA) #6 grabbed one of the black, cloth bags from the railing and set it on the Personal Protective Equipment (PPE) container. She stated to CNA #11 she needed to get a mask, left, and came back. CNA #6 placed shoe covers on, tucked in her shoelaces, sanitized her hands, and reached into the black bag. She proceeded to apply the yellow gown, N-95 mask, goggles, and then her gloves. She stated to CNA #11, Once I'm inside the resident's room, hand me the black bags. CNA #11 sanitized her hands, donned gloves, and began handing CNA #6 one bag at a time. CNA #6 was asked, What is in the cloth bags? CNA #6 stated, They are our personal PPE. We have our own bag with our name on it. She was asked, Has the PPE already been used? She stated, Yes, we are reusing our PPE. She was asked, What are you doing with the bags that (CNA #11) is handing to you? She stated, I'm hanging them behind the door with safety pins. The bags are supposed to remain in the room, not on railing in the hallway. She was asked, Why were they hanging in the hallway? She stated, I don't know. I was not here yesterday. f. On 6/2/20 at 2:27 p.m., the Director of Nursing (DON) was asked, Should contaminated / used Protective Personal Equipment (PPE) be stored in cloth bags in the hallway that is assessible to mobile residents? She stated, No. We have discussed this, and the PPE needs to be stored in the resident's room. She was asked, If a mobile resident had come into contact with, or gotten into those cloth bags, what could happen? She stated, They could get infected and / or spread the infection. She was asked for a policy on storing re-used PPE. The DON stated she did not have one. 3. On 6/1/20 at 12:11 p.m., Laundry Aid #1 was pushing the covered linen cart down the 100 Hall. Laundry Aid #1 stopped at room [ROOM NUMBER], reached in the covered cart and removed clothing on a hanger. She proceeded into the resident's room, opened the cabinet door, and hung up the clothing. She grabbed three hangers, closed the cabinet door, and exited the room. She took those hangers and hung them in the covered cart with the clean clothing. She proceeded to room [ROOM NUMBER], reached down in the covered linen cart and grabbed a clear plastic bag that contained clothing, and set the bag in the resident's chair. She exited the room and retrieved a small blanket from the clean linen cart. She reentered the resident's room, laid the blanket on the B-Bed, and exited the room. She proceeded to room [ROOM NUMBER], reached into the covered linen cart, grabbed two articles of clothing on hangers, and entered the resident's room. She opened the cabinet door, hung the resident clothes in the cabinet, and removed three hangers from the cabinet. She exited the room and hung those three hangers in the covered cart with the clean linens / clothes. a. On 6/1/20 at 12:21 p.m., Laundry Aide #1 was asked, When delivering clean clothes to a resident's rooms, should you sanitize your hands before reaching into the clean linen cart to retrieve clean linens / clothing and every time you leave a resident's room? She stated, Yes. She was asked, Did you sanitize your hands before reaching into the clean linen cart to retrieve clean linens /clothing and when leaving rooms [ROOM NUMBER]? She stated, No, I did not. She was asked, When removing hangers from the resident's room, should you hang those hangers in with the clean clothes / linens? She stated, No. She was asked, Why? She stated, They're contaminated. b. On 6/1/20 at 3:16 p.m., the Laundry Supervisor was asked, How is clean linen / clothing delivered to the residents on the hall? She stated, In a covered cart. The Laundry Aide places the clothing / linens in the resident's room. She was asked, What is the policy / procedure in placing laundry in the resident's room? She stated, If the resident is on isolation, they will hand the clean linen or clothing to a CNA that is gowned up. They will put the clothing / linen away. The linen cart is covered at all times when going room to the rooms. She was asked, What are the laundry aides supposed to do with the hangers they bring out of the resident's room? She stated, They are supposed to place the hangers in the dirty utility room? She was asked, Should those hangers be hung in with the clean linens cart? She stated, No. She was asked, Why? She stated, Cross-contamination. She was asked, Should the Laundry Aide sanitize their hands before reaching into the clean linen cart and when leaving a resident's room? She stated, Yes. The Laundry Supervisor was asked for facility policies for handling clean linens / laundry and contaminated items / hangers. She stated, I'm not sure. I will look. The Laundry Supervisor was unable to provide requested policies. 4. Resident #11 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. A Quarterly MDS with an ARD of 4/7/2020 documented the resident scored 9 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status. a. A Care Plan dated 4/21/2020 documented, .has an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) Limited Mobility . b. The Physicians' Orders Listing dated 6/1/2020 documented, .Continuous O2 (oxygen) 2 L (liters) as needed . Droplet isolation every shift . Monitor O2 q (every) shift . Vital signs every shift ., Pneumonia . c. The list titled Quarantine / Isolation Residents provided by the Director of Nursing on 6/1/2020 at 11:18 a.m. contained Resident #11's name. The room for Resident #11 contained no signage or identifier indicating Quarantine / Isolation. d. On 6/1/2020 at 11:22 a.m., CNA #10 was coming down the hall wearing a standard mask. CNA #11 was asked how the staff knew that a resident was in quarantine / isolation. She stated, When (Resident #11) came back from the hospital he had Pneumonia, and everyone had to wear a N-95 mask . She was asked, Is there usually a sign on the door? She stated, Well, I guess. She looked up and down the hall. She was asked, Where are N-95 masks located? She stated, They are here. CNA #10 reached into the room and pulled the PPE station out into the hall and moved it next to the door. There was a black bag sitting on top of it with a yellow cloth item inside the bag, two flat brown bags, and one brown paper bag sitting on top that which had something in it. CNA #10 was asked, What is in the brown paper bag? She picked it up, felt around the bag, and stated, It feels like a N-95 mask. She was asked, Do the staff re-use their masks? She stated, Yes, we store them in the bags. She pointed to the black bags and stated, We get these from (DON) . e. On 6/1/2020 at 11:26 a.m., Licensed Practical Nurse (LPN) #10 was asked to follow the surveyor to Resident #11's room. He was asked if the residents on Quarantine / isolation should have some type of signage on the door which identified them as being on Quarantine. He stated, Yes, all of the residents on Quarantine or isolation should have a sign on the door so staff know that they are on Quarantine. He was asked, This Resident doesn't have a sign? He stated, He should have one. He was asked, What type of isolation is this resident on? He stated, I'll have to check. He was asked, Since there isn't a sign, you don't know what type of isolation this resident is in, correct? He stated, I see what you mean. He needs a sign. He was asked, What kind of isolation are the residents in Quarantine under? He stated, Contact, unless they had respiratory symptoms or are on Oxygen, then it's droplet and they wear a N-95 mask. He was asked, This resident is on oxygen, so what type of isolation should he be in while he's in Quarantine? He stated, He should be in Droplet Precautions. The PPE sitting outside the resident' s room was pointed out, and LPN #10 was asked, Is the PPE re-used? He stated, Yes, we provide the PPE for each resident. They all have their own PPE for their needs. He was asked, Should ' used ' PPE be sitting out in the hallway for anyone to come into contact with for a potential contagion during the COVID-9 Pandemic? He stated, I see what you mean. No, it should be inside the room. Two black bags were sitting on top of the plastic drawers holding the PPE. LPN #10 was asked, What's in the black bags? He stated, PPE, gowns, masks, goggles. He was asked, Are they clean or used? He picked up one bag and stated, This one looks used. It's from a Contract Nurse who was here over the weekend. He was asked, So, if it's used, and the resident is in Droplet Precautions due to a recent hospitalization , this PPE has the potential to be contaminated with COVID-19? He stated, If the resident had COVID-19, then yes, there would be that potential He was asked, The potential for what? He stated, Spreading an infection. f. On 6/1/2020 at 12:10 p.m., Physical Therapy Assistant #1 was in Resident #11' s room and was wearing a standard mask. Resident #11 was in Droplet Precautions according to the list provided by the DON, and staff were instructed to wear an N-95 mask anytime they were in the room. Physical Therapy Assistant #1 was standing next to the bed talking with the resident and was pushing the call light button. Upon exiting the room, Physical Therapy Assistant #1 used alcohol-based hand sanitizer (ABHS). Physical Therapy Assistant #1 was asked if he knew what type of isolation the resident was in. He stated, He's in Quarantine, isolation. He was asked, But what type of mask are you to wear? He stated, When I'm working with him, I wear a N-95 mask. He was asked, But just now in his room, you didn't have on an N-95 mask. He stated, I know. He was asked, Are you supposed to wear an N-95 mask anytime you are in the room with the resident? He stated, I guess. 5. Resident #12 had [DIAGNOSES REDACTED]. A Quarterly MDS with an ARD of 5/11/20 documented the resident scored 4 (0-7 indicates severe impairment) on a Brief Interview for Mental Status. a. The physician's orders [REDACTED].Droplet ISO (isolation) to Private room [ROOM NUMBER] pending stool sample and COVID test results every shift for pending stool sample and COVID test results . b. A Care Plan with a revised date of 6/1/2020 documented, .Resident is at risk for psychosocial maladjustment d/t (due to) COVID-19 related restrictions such as suggested limited visitations .

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 2) Resident is at risk for changes in conditions and isolation precautions related to COVID-19 circumstances . Respiratory assessment Q (every) shift and PRN (as needed) . has an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) Confusion, Dementia, Limited Mobility . c. The list titled Quarantine / Isolation Residents provided by the Director of Nursing on 6/1/2020 at 11:18 a.m. contained Resident #12' s name. d. On 6/1/2020 at 11:20 a.m., LPN #1 was in Resident #12's room with a standard mask, gown, and gloves on while administering medications. When LPN #1's task was completed, LPN #1 came to the door of the resident's room, removed the isolation gown, rolled it in on itself and placed it in the black bag sitting outside of the room on the handrail. LPN #1 was asked, What type of isolation is this resident in? LPN #1 stated, We're waiting on her test results. She was asked, Results for what? LPN#1 stated, Her COVID-19 test. She was asked, So she's in isolation for potential COVID-19? LPN #1 stated, Yes, we should get it back sometime today. She was asked, Isn't she in Droplet Isolation / Precautions? She stated, Yes, she's in Droplet Precautions. She was asked, What type of mask should be worn for Droplet Isolation? She stated, An N-95, but I only have one and I have to use it on (Resident #11). She was asked, Can you get another one? She stated, Probably. I haven't checked. She was asked, Have you been told by anyone that you couldn't have another mask? She stated, Well, no, but I know they're trying to conserve. She was asked, If this resident was COVID-19 positive and you didn't wear the appropriate PPE, what could be a potential problem? She stated, I could spread COVID-19 to everyone on the hall. 6. Resident #16 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. An Admission MDS with an ARD of 5/19/2020 documented the resident scored 9 (8-12 indicates moderate impairment) on a Brief Interview for Mental Status. a. A Care Plan with a revised date of 5/15/2020 documented, .(Resident #16) has Oxygen Therapy prn (as needed) r/t (related to) Ineffective gas exchange . Is currently in isolation as precautionary measures to prevent risk of any exposure or transmission of [MEDICAL CONDITION] . Staff to observe handwashing per competencies and practice proper PPE while on isolation . b. The physician's orders [REDACTED].Check respiratory status q (every) shift for cough, SOB (shortness of breath), abnormal lung sounds, abnormal pulse ox . If abnormal findings found . document report to provider and DON every shift . c. The list titled Quarantine / Isolation Residents provided by the Director of Nursing on 6/1/2020 at 11:18 a.m. contained Resident #16's name. d. On 6/1/2020 at 1:26 p.m., a photograph was taken of the isolation cart sitting outside the resident's room on the 300 Hall. Two black bags were sitting on top of the cart with a rolled-up gown and a mask visible inside of the bags. e. A facility policy titled Infection Control provided by the Director of Nursing on 6/1/2020 documented, .Isolation Categories . When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution . The signage informs the staff of the type of CDC (Centers for Disease Control and Prevention) precaution(s), instructions for use of PPE, and / or instructions to see a nurse before entering the room . If re-use of items is necessary, then the items will be cleaned and disinfected according to current guidelines before use with another resident .