STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045155	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASH FLAT HEALTHCARE AND REHABILITATION CENTER	**66 OZBIRN LANE ASH FLAT, AR 72513**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that a comprehensive care plan addressed frequent pain for 1 (Resident #23) of 9 (Residents #3, #15, #16, #17, #18, #30, #41, #47, and #48) sampled residents who had a [DIAGNOSES REDACTED].#12) of 4 (Residents #12, #18, #35, and #40) sampled residents who smoked. Failed to ensure a comprehensive care plan was developed regarding refusal of enteral nutrition for 1 (Resident #33) of 1 sampled resident who had a PEG (percutaneous endoscopic gastrostomy) tube and failed to ensure the use of a hot pack was included for 1 (Resident #48) of 1 sampled residents who used a hot pack. These failed practices had the potential to affect 23 residents who had a [DIAGNOSES REDACTED].M., 18 residents who smoke based on a list provided by the Administrator on 07/13/2020 at 12:17 P.M., 1 resident who had a feeding tube and 1 resident who used a hot pack based on a list provided by the DON on 07/17/2020 at 11:00 A.M. The findings are: 1. Resident #23 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set Assessment (MDS) with an Assessment Reference Date (ARD) of 05/07/2020 documented the resident scored 09 (08-12 indicates moderately impaired) per a Brief Interview of Mental Status (BIMS), required limited assistance of one person for Activities of Daily Living and had frequent pain with a pain level of 06 of 10. a. The July 2020 physician's orders [REDACTED]. The Medication Administration Record [REDACTED]. b. On 07/15/2020 at 8:35 P.M., frequent pain was not documented or addressed on Resident #23's comprehensive care plan. c. On 07/16/2020 at 8:00 A.M., the DON was asked if Resident #23's MDS documented frequent pain and should it be addressed on the care plan. She replied, Yes, it should. She was asked to review Resident #23's care plan and show where it is addressed. She replied, I don't see it. d. On 07/16/2020 at 8:10 A.M., the MDS and Care Plan Coordinator was asked, If the MDS documents frequent pain should it be addressed on the care plan? She replied, Yes. She was asked to review the care plan and show me where it has been addressed. She replied, Oops, I missed that one. 2. Resident #12 had a [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 01/13/2020 documented the resident scored 10 (08-12 indicates moderately impaired) per a BIMS, required supervision and set up help only for all activities of daily living except for personal hygiene which required supervision and assistance of 1 person, and had current tobacco use. a. On 07/16/2020 at 9:19 A.M., the Assistant DON was asked if a resident smokes should it be addressed on the care plan. She replied, Yes. She was asked to review Resident 12's care plan and show where smoking is addressed. She replied, It's not. b. On 07/16/2020 at 9:25 A.M., the MDS and Care Plan Coordinator was asked if a resident smokes should it be addressed on the care plan. She replied, Yes. She was asked to review Resident 12's care plan and show where it addressed smoking. She replied, No, it's not there. c. A Safety Smoking Screening dated 06/24/2020 documented, .Resident has been assessed safe to smoke unsupervised . Smoking was not addressed in the resident's care plan. 3. Resident #33 had [DIAGNOSES REDACTED]. a. On 07/14/2020 at 10:28 A.M., the DON stated the resident has a PEG tube, but doesn't use it. b. On 07/16/20 at 09:49 A.M., the Care Plan documented. .I returned from the hospital and required bolus peg tube feedings twice daily (Osmolyte 1.5 cal (calorie)/237 ml (milliliter)) because I have difficulty swallowing at times secondary to stroke. Date Initiated: 02/08/2020 . c. On 07/16/20 at 09:51A.M., the DON stated, He does have BID (twice a day) feedings, but often refuses, that's why I was thinking he didn't have a feeding any longer. She was asked, Should it be care planned if he refuses? She stated, Yes, it should. 4. Resident #48 had [DIAGNOSES REDACTED]. a. The July physician's orders [REDACTED]. I have my own personal bean bag that I heat up to my own preference to place under my suprapubic catheter or groin area to help with pain. I have been instructed by the nurse to place bean bag in a towel or some kind of protector before applying to my skin. I am in the process of making a pouch to place it in. . c. On 7/16/2020 at 9:28 A.M., the DON was asked was asked, Should a hot pack be care planned? She stated, Yes, it should be care planned. She was asked, This resident's care plan mentions a Bean Bag hot pack, is that the same as the gel pack that the resident had in his room and was using? She stated, No, they are not the same.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents' fingernails were cleaned and trimmed to promote good personal hygiene and grooming for 1 (Residents #51) of 6 (Residents #47, #30, #41, #16, #53 and #51) sampled residents who were dependent for nail care. This failed practice had the potential to affect all 56 residents who required assistance with nail care as documented on a list provided by the Assistant Director of Nursing on 07/17/20. The findings are: Resident #51 had a [DIAGNOSES REDACTED]. a. The Care Plan documented, The resident has an ADL self-care performance deficit r/t (related to) effects of impaired mobility and impaired cognitive functioning associated with effects of Dementia. 06/17/20 Significant functional status change: Weakness, Increase ADL assistance, . Staff to trim and file nails weekly and prn (as needed) . b. On 7/13/20 at 9:39 A.M., the resident's fingernails had a yellowish stain, with brown substance under the nail tips. Her fingernails were approximately inch long from her fingertip and were jagged. (Photo taken.) c. On 7/15/20 at 8:28 AM, the residents' fingernails had yellowish stain, with brown substance under the nail tips. Her fingernails were approximately inch long from her fingertip and were jagged. (Photo taken.) d. On 07/15/20 at 8:37 A.M., Licensed Practical Nurse (LPN) #1 was asked, Who is responsible for performing nail care on the residents? She stated, For diabetics the nurses, the Certified Nursing Assistants (CNAs) if nondiabetics? The LPN then accompanied the surveyor to the resident's room and she was asked, What is that substance under the resident's nails? She stated, It looks like food to me, not dirt, she has calluses under her nails. The LPN was asked, How often is nail care provided? She stated, Weekly and prn. The LPN was asked, Does her nails need to be cleaned, trimmed and filed? She stated, Yes. The LPN was asked, When was the last time she had her nails clean, trimmed and filed? She stated, I don't know, but I'll have it done and do the nail care. The LPN was asked, Who is responsible to ensure the CNAs provide nail care weekly and prn? The LPN stated, The floor nurses. e. On 07/17/20 at 9:05 A.M., the ADON stated, We do not have a policy for nail care.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Based on observation, interview and record review the facility failed to ensure licensed staff monitored and provided treatment using a Hot Gel Pack for 1 (Resident #48) of 1 sampled resident who used a hot back. This failed practice had the potential to effect one resident who used Hot Packs as a treatment according to a list provided by the Director of Nursing (DON) on 07/17/2020 at 11:00 A.M. The findings are: Resident #48 had [DIAGNOSES REDACTED]. a. The July 2020 physician's orders [REDACTED]. I have my own personal bean bag that I heat up to my own preference to place under my suprapubic catheter or groin area to help with pain. I have been instructed by the nurse to place bean bag in a towel or some kind of protector before applying to my skin. I am in the process of making a pouch to place it in. . c. On 07/13/20 at 11:39 A.M., Resident #48 asked this surveyor to get (CNA (Certified Nursing Assistant) #1), I need my hot pack heated up CNA #1 was identified and given the residents message. CNA #1 was observed going into resident's room, exiting with the gel pack, going into the break room, a minute later returned to resident's room with the gel pack. CNA #1 was asked how she heated the pack up. She stated, .in the microwave, in the breakroom .She was asked, Were you trained to heat the pack up? She stated, . yes, in CNA classes . She was asked, How often do you heat it up for the resident? She stated, .about 2 times a shift . She was asked, How long do you set the microwave for? She stated, .around 45 seconds . She was asked, Do you know how hot it gets? She stated, .no, not really, it's pretty warm . She was asked, But, you don't know the temperature? She stated, .no . d. On 07/13/2020 the resident was asked how warm the pack was. He stated, .it's hot! Showing a washcloth on the outside of the pack that was being held in place on resident's lower abdomen, he stated, .that's why I got it wrapped up . Resident #48 was asked if this surveyor could feel the heat of the pack and he placed it on the overbed table. The pack was very hot to the touch, not so hot as it couldn't be handled by this surveyor, but very warm. e. On 07/13/2020 at 11:47 A.M., CNA #2 was asked to check the temperature of the pack with a temperature gun and it read Hi. (Photo taken.) She was asked, How high does the thermometer read? CNA #2 stated, . I don't know, but it's warm . f. On 07/16/2020 at 8:52 A.M., LPN #1 was asked if Resident #48 had a physician's orders [REDACTED]. After checking her computer LPN #1 stated, no, he doesn't have a physician's orders [REDACTED]. She was asked, Should he have a physician's orders [REDACTED].? LPN #1 stated, .yes, he should have an order . She was asked, If he had a physician's orders [REDACTED].? LPN #1 stated, .no, it should be the nurses who give it to him . She was asked, Would that be to ensure that it wouldn't burn him? LPN #1 stated, .yes . g. On 7/16/2020 at 9:28 A.M., the DON was asked if the resident should have an order for [REDACTED]. yes, there should be an order . She was asked, Should a hot pack be heated and provided to the resident by a CNA? She stated, .no, a CNA isn't trained to provide treatments. That's out of their scope of practice . She was asked, Have the CNA's working in this facility been given direction or authority to heat these packs and provide them to the resident? She stated, .not as long as I've been here . She was asked, If a Hot Pack was too hot, could that harm the resident? She stated, . potentially, yes, if it was too warm . She was asked, Should a hot pack be care planned? She stated, . yes, it should be care planned . She was asked, This resident's care plan mentions a Bean Bag hot pack, is that the same as the gel pack that the resident had in his room and was using? She stated, . no, they are not the same .
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure an updraft mask / (and/or) tubing was stored in a bag or other closed container when not in use to prevent potential contamination or infection for 1 (Resident # 51) of 1 case mix resident and failed to ensure oxygen was administered only when ordered by a physician to prevent potential complications for 1 (Resident #51) of 2 (Residents #51 and #53) case mix residents. This failed practice had the potential to affect 1 resident who had physician's orders [REDACTED]. The findings are: Resident #51 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set with an Assessment Reference Date of 6/17/2020 documented the resident scored 4 (0-7 indicates severely impaired) on a Brief Interview for Mental Status, required extensive assistance for eating and dressing and was totally dependent on staff for bed mobility, transfers, personal hygiene, toilet use and bathing, locomotion on and off the unit. a. The July 2020 Physicians Orders, active as of July 14, 2020 documented, [MEDICATION NAME] Nebulization Solution 0.63 MG/3ML (milligrams/milliliters) 3 ml inhale orally via (by) nebulizer every 4 hours for shortness of breath 07/15/2020 . There were no orders for oxygen. b. A nurses note dated 07/13/2020 at 02:27 (A.M.) documented, .O2 (oxygen) Sats (Saturations): O2 95.0 % - 07/13/2020 00:46 (12:46 A.M.) Method: Oxygen via Nasal Cannula .resident resting quietly in bed without distress noted O2 in place via NC updrafts administered as ordered . c. On 07/13/2020 at 9:39 A.M., the resident was in her room receiving oxygen at 3 liters (L) via nasal cannula (NC). An updraft machine along with the tubing and mask were laying on top of the wall air conditioner unit. (Photo taken) d. On 07/13/2020 at 9:51 A.M., Licensed Practical Nurse (LPN) #1 accompanied the surveyor to the resident's room and was asked, What is the proper way to store an updraft tubing / mask when not in use? She stated, A plastic bag, which is changed out every Wednesday. The LPN was asked, Is laying the updraft tubing / mask on the wall air conditioner unit the proper way to store it when not in use? She stated, No, the CNAs (Certified Nursing Assistants) must have moved it off her bedside table and laid it there. LPN #1 then placed the updraft mask and tubing in the bag and walked away. She was asked, Is the mask and tubing contaminated since it was laying on the wall unit? She stated, No it was sitting on top of the updraft machine. LPN#1 was shown the photo taken of the tubing and mask laying directly on the wall unit. She stated, Yes, I'll get a new mask, tubing and bag. e. On 07/15/2020 at 8:28 A.M., the resident was sitting in a chair receiving oxygen at 3 liters via nasal cannula. f. On 07/16/2020 at 08:16 A.M., the ADON was asked, Does the resident have an order for [REDACTED]. A copy of the standing orders was requested. g. On 7/16/2020 at 10:20 A.M., the Director of Nursing (DON) stated, The resident had standing orders on 07/16/15 but it's only good for 60 days. She was asked, To use standing orders should the July's Physician order [REDACTED].? The DON stated, Yes, the nurses have 24 hours to get a physician's orders [REDACTED]. h. On 07/16/20 at 10:20 A.M., the DON was asked, Is oxygen a medication? She stated, Yes. She was asked, When administering oxygen do you need a physician's orders [REDACTED]. She was asked, Should oxygen be monitored for the ordered liters and oxygen saturation by the nurses and documented on the MAR? She stated, Yes. She was asked, Is the oxygen and oxygen saturation being monitored and documented? She stated, No. i. On 07/16/20 at 11:59 A.M., the Administrator stated they did not have a policy on storage for oxygen or updrafts. j. A copy of the Oxygen Administration (Company) provided by the ADON documented, A patient will need oxygen therapy when [MEDICAL CONDITION] results from a respiratory or cardiac emergency or an increase in metabolic function. .Implementation: Verify the practitioner's order for oxygen therapy because oxygen is considered a medication or therapy and should be prescribed. .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an antipsychotic medication, [MEDICATION NAME]/ (and/or) Quentiapine, was prescribed with an appropriate [DIAGNOSES REDACTED].#12 and #17) of 3 (Residents #12, #16, and #17) sampled residents who had a physician order [REDACTED]. Resident #17 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/01/2020 documented the resident scored 00 (0-7 indicates severely impaired) per a Brief Interview of Mental Status (BIMS), and documented wandering and verbal behavior symptoms for 1-3 days on the behaviors section. a. The July 2020 physician's orders [REDACTED]. [MEDICATION NAME] Tablet 50 MG (QUEtiapine [MEDICATION NAME]) Give 50 mg by mouth one time a day related to Major [MEDICAL CONDITION], Recurrent, Unspecified . b. On 7/15/2020 at 1:30 P.M., the Director of Nursing (DON) provided a copy of the recommendation from the pharmacist sent to the physician for May 2020 which documented . (Resident) . Is currently prescribed the following medication . [MEDICATION NAME] 25 mg q (every) am (morning) and 50 mg q hs (evening) DX (diagnosis) [MEDICAL CONDITION] SINCE 05/27/20 . [MEDICATION NAME] is not approved for the treatment of [REDACTED]. PLEASE REDUCE TO 25 MG BID (twice a day) . The Disagree box was checked, the Nurse Practitioner signed and dated the document on 06/10/2020. 2. Resident #12 had a [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 01/13/2020 documented the resident scored a 10 (8-12 indicates moderately impaired) on a BIMS, required supervision and set up help only for all activities of daily living tasks except for personal hygiene which required supervision and assistance of 1 person. a. The July 2020 physician's orders [REDACTED].

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) Give 1 tablet by mouth in the evening for mood related to Major [MEDICAL CONDITION], Single Episode, Unspecified . b. On 07/15/2020 at 1:30 P.M., the recommendation from the pharmacist addressing the use and [DIAGNOSES REDACTED].DATE: JANUARY 2020 .Resident: (Resident # 12) . Is currently prescribed the following medication . Quentiapine 25 mg bid dx mood since 01/03/20 .[MEDICATION NAME] Generic Name: Quentiapine [MEDICATION NAME] . [MEDICATION NAME] is not approved for the treatment of [REDACTED].please reduce am dose to 12.5 mg and change to a CMS (Centers for Medicare & Medicaid Services) APPROVED DX . The box marked Agree was checked, the Nurse Practitioner signed and dated the document on 02/14/2020. c. The Pharmacy Consultant documented the following: 04/30/2020 . Quetiapine dx still depression . please change to CMS approved diagnosis . On 05/30/2020 the reports documented . please address Quetiapine and [MEDICATION NAME] . On 06/30/2020 it documented . Quetiapine and [MEDICATION NAME] . There was no documentation that the doctor addressed the recommendation from the Pharmacy Consultant. d. On 7/16/2020 at 2:45 P.M., the DON was asked why the medication does not have an approved diagnosis. She stated, I've tried to get the doctor to change it, but he hasn't addressed it yet. She was asked if she was aware that the pharmacist had addressed it in April, May and again in June and she said Yes.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** a Based on observation, interview and record review, the facility failed to ensure that the injectable diabetic medication [MEDICATION NAME] was given according to the manufacturer's instructions to assist with blood glucose level regulation for 1 (Resident #43) who had an order for [REDACTED]. The findings are: Resident #43 had a [DIAGNOSES REDACTED]. a. The July 2020 physician orders [REDACTED]. b. On 07/16/2020 at 7:29 A.M., Licensed Practical Nurse (LPN) #1 was administering [MEDICATION NAME] injectable to Resident #43. The accurate prescribed dose was dialed to set, the left lower quadrant intended area was cleaned with an alcohol swab and the LPN inserted the pen with the needle attached into the intended area, depressed the pen plunger and immediately withdrew the injection from the resident's abdomen. c. On 7/16/2020 at 10:30 A.M., LPN #1 was asked if there was anything, she should have done differently with the [MEDICATION NAME] injection. She replied, Not that I can think of. She was asked if she had ever had any training on the use of the [MEDICATION NAME] Pen. She replied, No. She was asked if she had ever been instructed that the injection pen plunger should be kept depressed for a certain number of seconds before removing it from the resident. She replied, No. d. On 07/16/2020 at 10:40 A.M., the DON was asked if her staff had ever had any training on the use of diabetic injectable pens and she said No. e. The [MEDICATION NAME] Injection package insert provided by the DON on 7/16/2020 at 12:28 P.M., documented . Keep the dose button pressed down and make sure that you keep the needle under the skin for a full count of 6 seconds to make sure the full dose is injected . f. This was a significant medication error due to the type of medication (diabetic).
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation and interview, the facility failed to ensure dietary staff washed their hands or changed gloves before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. Failed to ensure an ice machine was maintained in clean sanitary condition to prevent the potential of bacteria growth and contamination for residents who received ice from 1 of 1 ice machine. These failed practices had the potential to affect 56 residents who received meals from the kitchen (Total Census :56), as documented on a list provided by the Administrator on 07/30/2020. The findings are: 1. On 07/13/20 at 11:22 a.m., Dietary Employee #1 turned the faucet of the hand washing sink on and washed her hands. After washing her hands, she pulled a paper towel from the dispenser and used it to dry her hands and to turn the sink faucet off, she then used the same paper towel to dry spilled water around the sink contaminating her hands. She picked up a clean blade and attached it on the base of the blender, which was used to puree food to be served to the residents on pureed diets for the noon meal. Dietary Employee #1 was asked, What should you have done after touching dirty objects before handling clean equipment? She stated, Washed my hands. 2. On 07/13/20 at 11:32 a.m., Dietary Employee #1 adjusted the oven knob with her bare hand. She picked up a potholder used by Employee #3 to pick up a pan of tomato with zucchini and placed it in the oven. Without washing her hands, she picked up a clean blade and attached it on the base of the blender to be used in pureeing food items to be served to the residents on pureed diets. 3. On 07/13/20 at 12:12 p.m., there was reddish slimy residue on the ice machine panel. The Food Service Supervisor was asked to wipe the reddish slimy residue on the panel of the ice machine. She did and the reddish-residue easily transferred to the paper towel. The Food Service Supervisor was asked to describe the appearance of the ice machine panel. She stated, It's a reddish slimy colored residue. 4. On 7/13/20 at 1:34 p.m., Dietary Employee #1 used a rag to wipe off spilled liquids on the counter around the steam table. She then used the same rag to wipe off lids that are used to cover the food pans on the steam table. 5. On 7/13/20 at 1:47 p.m., Dietary Employee #2 turned on the hand washing sink faucet and washed her hands. After washing her hands, she pulled a paper towel from the dispenser and used it to dry her hands, she then wiped around the sink with the same paper towel contaminating her hands. Without properly sanitizing her hands, she picked up clean dishes stacked them on the plate warmer with her fingers inside the dishes. Dietary Employee #2 was asked, What should you have done after touching dirty objects before handling clean equipment? She stated, I should have picked up the dishes in a different way. 6. On 07/13/20 at 2:16 p.m., Dietary Employee #3 turned on the hand washing sink faucet and washed her hands. After washing her hands, she pulled a paper towel from the dispenser and used it to dry her hands, she then wiped around the sink with the same paper towel contaminating her hands. Without properly sanitizing her hands, she picked up clean bowls and placed them on the trays with her fingers inside the dishes. Dietary Employee #3 was asked, What should you have done after touching dirty objects before handling clean equipment? She stated, Washed my hands, after cleaning around the sink. 7. On 7/14/20 at 7:40 a.m., Dietary Employee #4 was on the tray line assisting with meal service. She picked up cartons of health shakes, milk and condiments and placed them on trays. Dietary Employee #4 did not wash her hands after placing the cartons of beverages and condiments on the meal trays. She then used her contaminated hands and picked up glasses by their rims and placed them on trays to be served to the residents for breakfast. 8. On 7/14/20 at 9:56 a.m., Dietary Employee #4 turned the faucet of the sink on and washed her hands. She removed a paper towel from the dispenser and used it dry her hands and to turn the sink faucet off, then used it to wipe spilled water around the sink contaminating her hands. She then picked up clean utensils and wrapped them in individual napkins.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure staff wore appropriate Personal Protective Equipment (PPE) when entering resident rooms whom were on Contact / Droplet Isolation for 2 (Resident #206 and #16) of 5 (Residents #48, #206, #16, #53 and #45) sampled residents. These failed practices had the potential to affect 3 residents on 400 and 4 residents on the 600 hall according to lists of residents on isolation provided by the Director of Nursing (DON) on 7/15/2020. The findings are: 1. The Resident #16 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/21/20 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS), required extensive two-plus person assistance with transfers and toilet use and was always incontinent of bowel and bladder. a. The July 2020 Physicians Orders documented, .Contact Isolation related to [MEDICAL CONDITIONS], must have 48 hours of solid stools to remove from isolation. b. An updated Care Plan documented, . I have [DIAGNOSES REDACTED]icile infection .Maintain Isolation Precautions as ordered . c. On 07/13/20 at 1:07 P.M., a PPE container was located outside the resident's room, a Droplet / Contact Precaution sign was posted on the door. Certified Nursing Assistant (CNA) #3 was in the resident's room performing meal set up for the resident. She had a mask on, but no gloves or a gown. d. On 07/13/20 at 1:09 P.M., CNA #3 was asked, Is the resident on isolation? She stated, Yes. She was asked, What kind of isolation? She stated, Contact for [MEDICAL CONDITION] and droplet. She was asked, When entering a room for Droplet and / or Contact Isolation, should you don gown and gloves? CNA #3 stated, Yes. 2. Resident #206 had [DIAGNOSES REDACTED]. An Admission MDS had not been completed, resident admitted [DATE]. a. The July 2020 Physicians Orders documented, . Droplet Isolation Precautions for COVID-19 every shift for 14 Days Order date 07/02/2020 . b. On 07/14/2020 at 09:18 A.M., the Housekeeping Supervisor entered the resident's room to deliver a cup of coffee. She did not stop to don appropriate PPE prior to entering the resident's room. On exit she was asked if the resident was in isolation. She stated, Oh yes, I forgot. She was asked, What type of PPE are you supposed to be wearing? She stated, I was just getting him coffee, I forgot to put the PPE on, I should have put on gown and gloves. c. On 7/16/2020 at 9:28 A.M., the DON was asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045155	A. BUILDING _____ B. WING _____	**07/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ASH FLAT HEALTHCARE AND REHABILITATION CENTER	**66 OZBIRN LANE ASH FLAT, AR 72513**

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 -** Some	(continued... from page 3) if any staff entering an isolation room should don PPE. She stated, Yes, they should have donned gown and gloves along with a mask that they should already be wearing. She was asked, Do you expect staff to follow the policies of the facility? She stated, Yes. d. The Infection Control Policy and Procedure received on 07/13/20 documented, . Transmission Based Precautions . To prevent transmission of infections or colonized microorganisms . Contact Precautions: a. Personal Protective Equipment: Gloves and Gown. b. Wear PPE for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. c. Donning PPE upon entry and discarding before exiting the patient room is done to contain pathogens. . Droplet Precautions: PPE: Mask .