STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045366	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE SQUARE HEALTHCARE CENTER	**710 NO RUDDLE ROAD BLYTHEVILLE, AR 72316**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a physician order [REDACTED].#1) of 2 (Residents #1 and #3) sampled residents with indwelling catheters. This failed practice had the potential to affect 3 residents with indwelling catheters, according to the Roster Matrix provided by the Administrator on 8/12/2020. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set with an Assessment Reference Date of 8/4/2020, documented the resident scored 15 (13-15 cognitively intact) on the Brief Interview for Mental Status (BIMS), required limited assist of 1 person for bed mobility, transfer, and dressing, had an indwelling catheter and was always continent of bowel. a. A physician order [REDACTED].DC (discontinue) Foley Catheter and monitor voiding . b. On 8/12/2020 at 02:42 pm, Resident #1 was in bed. The Foley catheter bag was attached to the nightstand drawer handle with the indwelling Foley catheter drainage spout resting on a pair of black shoes in the floor. Photo taken at this time. c. The Care Plan history dated 8/12/2020 documented, Resident will move catheter drain bag out of holder and put in chair, on bed or on floor, she has been educated many times by multiple staff to not do this for her safety of back flow from Catheter and Infection control . d. On 8/14/2020 at 08:29 am, the Administrator was asked about the Care Plan notes above. The Administrator replied, Yes, we talked about it, and we did revise the care plan that day because the resident does do that, and it needed to be care planned. The Administrator was asked, do you have a physician order [REDACTED]. The Administrator was asked to provide a copy of Resident #1's physician order [REDACTED].
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, record review, and interview, the facility failed to ensure a indwelling catheter drainage spout was not in direct contact with the resident's shoes for 1 (Resident #1) of 3 (Residents #1 and #3) sampled residents with a indwelling catheter; failed to ensure trash and debris were contained in a closed trash/linen cart and failed to ensure residents clothing and linen were secured off the floor to prevent potential infection/contamination in 1 of 1 facility. These failed practices had the potential to affect 3 residents with catheter and 62 residents in the facility. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set with an Assessment Reference Date of 8/4/2020, documented the resident scored 15 (13-15 indicated cognitively intact) on the Brief Interview for Mental Status, required limited assist of 1 person for bed mobility, transfer, and dressing, had an indwelling Foley catheter and was always continent of bowel. On 8/12/2020 at 02:42 pm, Resident (R) #1's indwelling Foley catheter drainage spout was resting on a pair of black shoes on the floor. Photo taken at this time. 2. On 8/12/2020 at 02:09 pm, a bag of linens was on the floor in room [ROOM NUMBER]. Photo taken. At 02:10 pm, a bag of linens and a bag of clothes were on the floor in room [ROOM NUMBER]. Photo taken. At 02:12 pm, a bag of linens and a bag of clothes/personal items were on the floor. Photo taken. 3. On 8/12/2020 at 2:38 pm, a linen/trash cart on West Hall was opened with trash overflowing. Laundry Aid #1 was asked, should the trash be overflowing. Laundry Aid #1 replied, No. Laundry Aid #1 was asked, Would that be considered an infection control issue? Laundry Aid #1 replied, Yes. Laundry Aid #1 was asked, Can you smell that? Laundry Aid #1 replied, Eeewee, you don't want to know. Photo was taken. 4. On 8/12/2020 at 03:06 pm, Certified Nursing Assistant (CNA) #1 was asked, Should bags of residents' clothes and linens be on the floor? CNA #1 replied, No. CNA #1 was asked, Would that be considered an infection control issue? CNA #1 replied, Yes. CNA #1 was asked, Should a Foley catheter drainage spout be touching residents' shoes? CNA #1 replied, No, the catheter should be in a bag. CNA #1 was asked, Would that be considered an infection control issue? CNA #1 replied, Yes, it could cause an infection. 5. On 8/13/2020 at 11:25 am, the Administrator was asked, Should bags of linens and residents' clothes be on the floor?' The Administrator replied, No. The Administrator was asked, Should the linen/trash container in the halls be overflowing with trash? The Administrator replied, No. The Administrator was asked, Should foley catheter drainage spouts be touching resident's shoes? The Administrator replied, No. The Administrator was asked, Would all these issues be considered an infection control issue? The Administrator replied, It could be.

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.