STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045275	A. BUILDING _____ B. WING _____	05/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANCED HEALTH AND REHAB OF UNION COUNTY	1700 EAST SHORT HILLSBORO EL DORADO, AR 71730

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** Based on observation, record review, and interview, the facility failed to ensure infection control measures were consistently implemented to minimize the potential for the spread of disease/COVID-19 and cross-contamination, as evidenced by: Failure to ensure staff removed Personal Protective Equipment (PPE) before exiting resident room who was on contact isolation for an infectious disease for 1 (Resident #1) of 1 case mix resident who had a diagnosed infection which required isolation. These failed practices had the potential to affect 5 residents on quarantine C Wing where an isolation resident resided per a list provided by the Administrator on 5/7/20. Failure to ensure a resident on the COVID-19 quarantine C-wing was instructed to wear a face mask when they exited their room for 1 (Resident #2) of 1 case mix resident and 3 non-case mix residents who were on the quarantine wing. This failed practice had the potential to affect 2 residents who were to wear facemask out of room on quarantine C Wing as documented on a list provided by the Administrator on 5/7/20. Failure to maintain social distancing of 6 feet between residents eating in the dining room on the secure unit and/or serve the residents in their rooms for 8 (Residents #3 - #10) of 8 residents on the secure unit. This failed practice had the potential to affect 10 residents who resided on the secured 200 Hall unit as documented on a resident census list provided by the Administrator on 5/7/20. Failure to ensure facility staff followed universal precautions and washed or sanitized their hands after having touched facemask and face prior to having touched resident care items of wheelchair for 1 (Resident #11) of 1 (Resident #11) case mix resident who was wheelchair dependent and attended an outside activity on 5/7/20. This failed practice had the potential to affect 8 residents who were wheelchair dependent who attended outside distanced activity on 5/4/20 as documented on a list provided by the Administrator. Failure to ensure laundry staff followed universal precautions and washed or sanitized hands after having touched facemask and face before the clean laundry cart and the residents' clean laundry was touched for 2 (Residents #12 and #13) of 7 (Residents #3, #6, #7, #8, #10, #12, and #13) and clean resident clothing was not in direct contact with laundry staff clothing for 1 (Resident #12) of 7 (Residents #3, #6, #7, #8, #10, #12, and #13) case mix residents who had laundry delivered on 5/7/20. This failed practice had the potential to affect 8 residents who had clean laundry delivered on the Medicare and secured 200 Hall on 5/4/20 as documented on a list provided by the Administrator. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. a. A physician's orders [REDACTED]. Give 25 ml (milliliters) q (every) 6 hr (hours) [MEDICAL CONDITIONS] until 5/6/20. b. On 5/4/20 at 12:29 PM, on the C Wing of the facility all 6 residents on this hall were in isolation. Resident #1 was in Contact Isolation per a sign posted outside of his door. All other residents were quarantined relating to COVID-19 because they had been out of the facility. Bed side tables in hallway held Personal Protective Equipment (PPE). c. On 5/4/20 at 12:43 PM, Certified Nursing Assistant (CNA) #1 entered Resident #1's room, donning yellow gown and gloves. She already had a mask on. She served Resident #1 his lunch tray in a styrofoam container. She then exited the resident's room while still wearing the yellow isolation gown, proceeded to the hand sanitizer pump located near the entry double doors and sanitized her hands. She then returned to the resident's room only to exit again to retrieve the resident's drink while still wearing the isolation gown. She re-entered the resident's room, gave him his drink, removed the PPE gown at the door's entrance and placed the gloves in the red trash bag. d. On 5/4/20 at 2:56 PM, CNA #2 was asked if it would be an acceptable practice to wear isolation gown out of the room into the hallway and she stated, No. e. A document provided by the Administrator on 5/4/20 at 5:10 PM, titled Skills Procedures documented, . r. Fold gown with contaminated side inward. Roll and deposit in laundry bag or waste container . f. On 5/5/20 at 2:02 PM, CNA #1 was contacted via telephone and was asked, Are you aware of any isolations other than those that are in their 14 day quarantine, and she stated, .one is on contact isolation . She was asked what type of PPE is required when entering a contact isolation room and she stated, Gloves, gowns, masks. She was then asked if it was okay to leave an isolation room wearing PPE and she stated, No. She was asked why it was important to remove gown prior to exiting room and she stated Infection control. Whatever you have on you you're bringing it out. She was asked if she remembered coming out of Resident #1's room wearing the yellow isolation gown and she stated, I stepped out to get help tying the gown while I held my hair up. She was asked if she remembered coming out with gown on and going to where the hand sanitizer pump was located at the double doors, and she stated, No, I don't even remember doing that. g. On 5/5/20 at 3:14 PM, Registered Nurse #1, Infection Control Nurse was contacted via telephone call and was asked what kind of isolation Resident #1 was on. She replied, He would be on contact isolation as well be on 14-day COVID quarantine. She stated that the resident had been out to hospital to have a pacemaker placed and came back with [MEDICAL CONDITION]. She was asked once in a resident's room and PPE is on, is it an acceptable practice to go out of the room with the PPE still on, and she stated, No, it is not. h. On 5/5/20 at 6:34 PM, a document entitled, Attention all Staff dated 4/17/20 and received by the Administrator via email documented, .Mask and cloth gown should be left in the room on the hanger . 2. Resident #2 had [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date of 4/21/20 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS; and received [MEDICAL TREATMENT] services. a. On 5/4/20 at 4:22 PM, Resident #2 was self-propelling out in the hallway across from the old nurse's station. She was using her mobile phone and she did not have a mask on. CNA #s 1 and 2 conversed with her but they made no mention of her not having a mask on while out of her room. b. On 5/5/20 at 9:15 AM, a record review of the electronic medical record: A nurse's note dated 5/1/20 documented the resident goes to [MEDICAL TREATMENT] MWF (Monday, Wednesday, Friday). On 4/25/20 the resident was swabbed for COVID-19 relating to possible exposure at the [MEDICAL TREATMENT] center. A 4/26/20 note documented that the test was negative. A review of Nurse's notes from 3/1/20 to present was done with no mention of resident being non-compliant. c. On 5/5/20 at 2:02 PM, CNA #1 was contacted via telephone and was asked if [MEDICAL TREATMENT] residents need to wear a mask, and she stated, Yes, when (going to) [MEDICAL TREATMENT] and back to isolation even on hall til (until) they get to (their) room. d. On 5/5/20 at 3:14 PM, RN #1 was contacted via telephone and was asked if [MEDICAL TREATMENT] resident should wear a mask if in hall, and she stated, Yes, if in hallway. We told them, I did myself that they would have to wear a mask (if they left their room). She was then asked who monitors them to ensure that they comply, and she stated, Staff. e. On 5/5/20 at 6:34 PM, a form titled, How to care for a [MEDICAL TREATMENT] during the COVID-19 pandemic dated 4/23/20 and received from the Administrator documented, .If they (the [MEDICAL TREATMENT] resident) come out of their room they need to have a mask on . f. On 5/6/20 at 3:30 PM, a review of The Arkansas Department of Health Guidance for reducing Spread on COVID-19 in Long term Care Facilities was reviewed. It documented, . 3 . Residents that regularly leave the building due to medically necessary appointments, such as [MEDICAL TREATMENT], should wear a surgical mask while they are in the building and not in their rooms . 3. Resident #3 through Resident #10 resided on the secure unit. On 5/4/20 at 12:27 p.m., in the 200 Hall secured unit there were 2 tables in the dining area that had 4 residents seated at each table. There was approximately 1.5 to 2 feet between the residents at each table. 4. Resident #11 had [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 3/20/20 documented the resident scored 12 (8-12 indicates moderately impaired), had mobility in a wheelchair, required

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) extensive assistance of 1 person with locomotion (movement) on and off the unit, and had no active infections. a. On 5/4/20 at 2:35 p.m., the resident was seated in a wheelchair in the main dining room area with the Activity Director standing behind the wheelchair. The Activity Director's nose was not covered by the facemask and stated they had just come back in from an outdoor activity. The Activity Director pulled the facemask over the nose with the right hand then without sanitizing hands, placed hands on each of the handles to the back of the resident's wheelchair. At 2:37 p.m. the Activity Director pushed the resident's wheelchair down the hallway, stopped by the nurses' station, and left the area. b. On 5/4/20 at 2:38 p.m., Certified Nursing Assistant (CNA) #4 was barehanded, placed both hands on the handles at the back of the resident's wheelchair and pushed the resident further down the hallway. At 4:24 p.m., CNA #4 was asked who the resident in the wheelchair that was pushed down the hall from the nurses' station. The CNA gave Resident #11's name. c. On 5/5/20 at 2:23 p.m., the Activity Director was asked via telephone if had been in-serviced on COVID-19 infection control procedures and the Activity Director stated, Multiple. The Activity Director was asked if there had been in-servicing on hand hygiene. The Activity Director stated, Multiple and demonstrate with check off for both (hand washing and sanitizing). The Activity Director was asked if had received instructions on wearing facemask while in the facility and how to wear the facemask. The Activity Director stated, Yes have to wear a mask at all times above nose and below mouth. The Activity Director was asked if the facemask should be touched then the resident's care items such as wheelchair should be touched. The Activity Director stated, No. The Activity Director was asked if the facemask should be touched at any time without having sanitized hands afterwards and the Activity Director stated, No. 5. Resident #12 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD 3/6/20 documented the resident scored 0 (0-7 indicates severely impaired) on the BIMS, required limited assistance from staff for activities of daily living, and had no infections. On 5/4/20 at 2:46 p.m., Laundry Worker #1 pushed a metal cart covered with a white sheet and stopped in the hallway near room [ROOM NUMBER]. The Laundry Worker touched the face near the right eye and cheek area with the right hand just above the facemask. The Laundry Worker then put the right hand onto the linen covered cart and pushed the cart down the hall to the next room without having sanitized or washed hands. At 2:48 p.m., the Laundry Worker pulled the sheet covering back from the top shelf of the cart, exposed clean clothing items, picked up a hanger of clothing, replaced the sheet covering and held the clean resident clothing against the front of the worker's clothing. The Laundry Worker entered the resident's room, went to the closet and opened the closet door, then placed the clothing items into the closet and exited the resident's room without having washed or sanitized the hands. 6. Resident #13 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 2/12/20 documented the resident scored 10 (8-12 indicates moderately impaired) on the BIMS, required limited assistance of staff for activities of daily living, and had no active infections. On 5/4/20 at 2:49 p.m., the Laundry Worker had not washed or sanitized hands and pushed the linen covered cart down the hall near room [ROOM NUMBER]. The Laundry Worker lifted the linen covering from the cart, picked up clean clothing items from the cart, entered the resident's room and placed the clothing into the closet. At 2:51 p.m., without sanitizing or washing hands, Laundry Worker then left the resident's room, went to the linen covered cart in the hallway then pushed the cart further down the hallway towards the secured unit. The Laundry Worker passed a hand sanitizer wall dispenser in the hallway that was located on the hall near rooms [ROOM NUMBERS] and had not stopped at the alcohol hand sanitizer dispenser to sanitize hands. 7. On 5/5/20 at 1:55 p.m., the Dietary Manager (DM) was asked if communal or group dining had stopped and the DM stated, Started feeding in rooms. The DM was asked how the residents on the secured unit (200 Hall) are now being fed and the DM stated, They are fed in their rooms. We feed everybody in their room. The DM was asked if any of the residents in the secured 200 Hall unit eat at the dining table. The DM stated, No, eat in their room. 8. On 5/5/20 at 4:46 p.m., the Director of Nursing (DON) was asked when communal dining was stopped approximately and the DON stated, It was March. May have been around mid- March. The DON was asked if there were still residents dining together in the dining area of the secured unit. The DON stated, In the unit there may be 1 but not everybody in the dining room. The DON was asked if the secured unit staff had been instructed about residents dining together. The DON stated, All staff have been instructed about feeding. The DON was asked if residents should be spaced apart and the DON stated, Yes. 9. On 5/6/20 at 8:31 a.m., the Administrator was asked about communal dining and stated, We had 4 people at each table. Went back there yesterday, they only had 2 tables. A table broke on Sunday. 10. On 5/6/20 at 10:24 a.m., the Housekeeping/Laundry (Hsk/Laundry) Supervisor was contacted via telephone and was asked if there had been in-servicing on COVID-19 procedures and the Hsk/Laundry Supervisor stated, Yes. The Hsk/Laundry Supervisor was asked if the laundry/housekeeping staff had been in-serviced on the COVID-19 procedures and stated, Yes. The Hsk/Laundry Supervisor was asked if the laundry staff had received training on hand hygiene. The Hsk/Laundry Supervisor stated, Yes, we have. The Hsk/Laundry Supervisor was asked if laundry staff are to wash or sanitize hands between resident rooms. The Hsk/Laundry Supervisor stated, That is something they should be doing from room to room, yes. The Hsk/Laundry Supervisor was asked if laundry staff should touch the face or facemask that is worn and the supervisor stated, No they shouldn't. The Hsk/Laundry Supervisor was asked if laundry staff should sanitize or wash hands before a resident's laundry is touched and the linen on the cart touched. The Hsk/Laundry Supervisor stated, Yes they should. The Hsk/Laundry Supervisor was asked if sanitizer was available for the housekeeping/laundry staff and the supervisor stated, Yes. 11. On 5/6/20 at 3:14 p.m., Laundry Worker #1 was contacted via telephone and was asked if had received in-services on hand hygiene of washing or sanitizing hands. The Laundry Worker stated, Yes. The Laundry Worker was asked if had received in-servicing on COVID-19 procedures and the worker stated, Yes. The Laundry Worker was asked if had received training on wearing facemask in the facility and the worker stated, Yes. The Laundry Worker was asked if the facemask should be touched then the sheet that covered the laundry cart and residents' clean clothing be touched. Laundry Worker #1 stated, No, you shouldn't. The Laundry Worker was asked if hands should be sanitized with alcohol-based hand rub or washed with soap and water after the facemask is touched. The Laundry Worker stated, Yes, it should be. The Laundry Worker was asked if hands should be sanitized or washed before clean residents' clothing are touched and the worker stated, Yes, you should. The Laundry Worker was asked if a resident's clean clothing should be held against the employee's body and clothing. The Laundry Worker stated, No. Laundry Worker #1 was asked if after touching the face, before having touched clothing covering, clothing, and going in and out of resident room should hands be sanitized. The Laundry Worker stated, Yes, I didn't sanitize. 12. The facility procedure entitled Departmental (Environmental Services)-Laundry and Linen received from the Administrator on 5/7/20 at 9:14 a.m. documented, The purpose of this procedure is to provide a process for the safe and aseptic handling . General Guidelines .2. Wash hands .before handling clean linen . 13. On 5/7/20 at 1:30 p.m., CNA #3 was contacted via telephone and was asked if they had received training/in-services on COVID-19 procedures and the CNA stated, Yes. The CNA was asked if had been instructed on residents to not dine together at the same table. CNA #3 stated, The day you (surveyor) were back there a table had broke and they have had to put the residents back like they were. The CNA was asked how many dining tables were being used on the secured unit and the CNA stated, On Monday (5/4/20) there were 2 tables with 4 residents at a table. CNA #3 was asked if residents are now to be seated next to each other at the dining table. The CNA stated, No there should have been 6 feet and the table was broke so they weren't. The CNA was asked if the residents should have been separated and distanced. The CNA stated, We knew. 14. On 5/7/20 at 1:48 p.m., Licensed Practical Nurse (LPN) #1 was asked if nursing staff had been instructed or trained that residents were not to dine together with the COVID-19 procedures and the LPN stated, Yes. The LPN was asked if had observed that the residents on the secured unit had dined together. The LPN stated, Monday for sure. The LPN was asked what had been done about the residents dining together. LPN #1 stated, When I asked CNA and they said they had a table that broke and they just sat them where they were use to. 15. On 5/7/20 at 2:35 p.m., the Administrator was asked if staff should sanitize or wash hands after the face or facemask is touched and the Administrator stated, Yes. The Administrator was asked if there should not be communal dining at this time and the Administrator stated, Yes. The Administrator was asked if residents should dine in their room or at least spaced 6 feet apart. The Administrator stated, Yes.