STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045359	A. BUILDING _____ B. WING _____	**06/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE WATERS OF CUMBERLAND, LLC	**1516 CUMBERLAND ST LITTLE ROCK, AR 72202**

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.** Based on observation, record review, and interview, the facility failed to ensure proper infection prevention and control practices were maintained to prevent the development and transmission of COVID-19 and other communicable diseases and infections by wearing a face mask and wearing a face mask appropriately. These failed practices had the potential to affect 68 residents who resided in the facility, according to the Resident Census List provided by the Director of Nursing on 6/15/2020. The findings are: a. On 6/15/2020 at 1:38 p.m., Office Personnel #1 was in her office and did not have a mask on. She was asked, Where's your mask? She stated, I was wearing one earlier, but it was dirty. I was going to get one. b. On 6/15/2020 at 1:46 p.m., Dietary Employee #1 was at the Nurse's Station and his below-the-nose mustache was visible. He was asked, Do you have your mask on correctly? He stated, Yes, I do. He pulled the mask up over his nose. c. The facility policy titled COVID-19 provided by the Director of Nursing on 6/15/2020 documented, .PPE (Person Protective Equipment) Clinical Competency . Donning and doffing return demonstration tool . Don mask . Fit flexible band to nose bridge . Fit snug to face and below the chin . Green Zone requires surgical mask and gloves . The yellow zone Prevention / Readmission requires surgical mask, gown, and gloves .

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.