STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045241	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAILEY CREEK HEALTH AND REHAB	1621 EAST 42ND ST TEXARKANA, AR 71854

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	**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 followed universal precautions and sanitized or washed hands after soiled linen was handled, soiled linen hamper was touched and before touching clean linen cart. Failed to ensure staff washed or sanitized hands prior to the provision of care to prevent contamination of clean linens and care items for 2 (Residents #1 and #2) of 6 (Residents #1 thru #6) case mix residents who required assistance for linen change and assistance. These failed practices had the potential to affect 20 residents on the 100 Hall who required bed linen changes, 20 residents who used linen from the 100 Hall linen cart, and 20 residents who were dependent on staff for care assistance on the 100 Hall as documented on lists provided by the Director of Nursing (DON) on 6/17/20. Failure to ensure facility staff followed universal precautions and washed or sanitized their hands after adjustment of the facemask and prior to having medication administration and hand contact with the bed control for 1 (Resident #4) of 6 (Residents #1 thru #6) case mix residents who were assisted with medication administration and patient care. This failed practice had the potential to affect 18 residents who received medication assistance during the noon hour on the 300 A Hall and hand hygiene as documented on a list provided by the DON on 6/17/20. Failure to ensure disposable food containers and utensils were not removed from an isolation room, placed on the dietary food cart with non-isolation meal trays prior to the cart returned to the dietary/dining room area for 2 (Residents #4 and #5) of 6 (Residents #1 thru #6) case mix residents who were served a meal tray. This failed practice had the potential to affect 21 residents who had meal trays from the 300 A Hall cart on 6/16/20 as documented on a list provided by the DON on 6/17/20. Failure to ensure a resident on COVID-19 quarantine/isolation was instructed to wear a face mask when the resident exited their room for 1 (Resident #5) of 3 (Residents #3, #4, and #5) case mix residents who were on COVID-19 quarantine. This failed practice had the potential to affect 3 isolation residents on the 300 A Hall where the resident was quarantined/isolated as documented on a list provided by the DON on 6/16/20. 1. Resident #4 had [DIAGNOSES REDACTED]. a. A Nursing Progress Note dated 6/8/20 at 3:12 p.m. documented, Res (Resident) Rec'd (received) back to facility from hospital . b. The care plan dated 6/8/20 documented, .Contact isolation with droplet precautions for 14 days following readmission from hospital . c. On 6/16/20 at 11:15 a.m., Licensed Practical Nurse (LPN) #2 was at the medication cart. With the ungloved, bare right hand touched the N95 facemask, pulled the mask down from over the nose while talking with another staff member, then adjusted the facemask over the nose. Without having sanitized the bare hands, she picked up a plastic medication cup with a pudding-like substance and small wooden spoon, a plastic cup with approximately 4 ounces of cream colored supplement liquid, and an empty plastic cup with the medication cup in the right hand and the plastic drinking cups in the left hand, walked to outside the door labeled Unit Manager 2 and talked with a staff member in the unit manager office while having continued to hold the medication cup and 2 plastic cups with the bare, un-sanitized right hand. d. On 6/16/20 at 11:20 a.m., LPN #2 walked away from the Unit Manager 2 office into a room on the 300 hall, without having sanitized the bare hands and entered the resident's room where the door was wide opened. The LPN was asked what was in the medication cup and LPN #2 stated, I have her [MEDICATION NAME] and [MEDICATION NAME]. LPN #2 was asked what the medications were mixed in and the LPN stated, Pudding. LPN #2 went to the sink, put water into one of the plastic cups, and without having washed hands, walked to the resident's bedside and administered the medications then handed the resident the plastic cup with liquid supplement. After the resident had finished drinking the supplement, the LPN took the cup, threw the cup in the trash, gave the resident water to drink from the other plastic cup, adjusted the head of bed level with the bed control, handed the resident a box of tissues, and exited the room going to the hand sanitizer station on the hallway wall. e. On 6/16/20 at 1:00 p.m., Certified Nursing Assistant (CNA) #1 removed a brown meal tray with a divided styrofoam container, styrofoam cups, and plastic utensils from Resident #4's room and placed the tray with the disposable items onto the metal shelved dietary cart with 9 other meal trays. The door to the resident's room had a sign posted that documented, Droplet Precautions and Contact Precautions. f. On 6/17/20 at 11:46 a.m., LPN #2 was asked if someone should touch the facemask or adjust the facemask without having sanitized or washed hands afterwards and LPN #2 stated, Absolutely no. The LPN was asked if she should sanitize or wash hands before medication cups or drink cups are handled and she stated, You should do either/or, sanitize or wash. LPN #2 was asked what type of isolation the resident was on and she stated, She is contact. The LPN was asked why the resident had been placed on isolation and stated, For going out to the hospital, required 14 days . The LPN was asked if someone should touch resident or resident items without having washed or sanitized hands and she stated, Absolutely not. The LPN was then asked if she had received training on the COVID-19 protocols and procedures for hand hygiene and contact isolation and she stated, Yes, we have. g. On 6/17/20 at 11:53 a.m., CNA #1 was asked if they had received training or in-service on isolation procedures and the CNA stated, Yes. The CNA was asked if any disposable items are to be brought out of an isolation room. CNA #1 stated, Don't anything come out of the isolation room but me. The CNA was asked if there was a red trash bag kept in the isolation room and the CNA stated, They have a set up in the room, bio (biohazard) bag in the room. The CNA was asked if the resident was on isolation and the CNA stated, Yes. 2. Resident #5 had [DIAGNOSES REDACTED]. a. The care plan dated 5/26/20 documented, .Contact Isolation with droplet precautions due to recent MD (Medical Doctor) appt (appointment) for 14 days following MD appt . Instruct resident to wear a facemask when staff enters room or resident leaves room . b. A Physician order [REDACTED]. c. On 6/16/20 at 1:10 p.m., the resident propelled the wheelchair out in the hallway and held the hard-surfaced brown meal tray with styrofoam items and other disposable items. The resident did not have a mask on. The Activity Director (AD) was on the hallway near the dietary cart that was parked across from the resident's room. The AD walked to the resident and stated, (Resident #5) do you need some help? and reached to take the meal tray from the resident. The AD then turned and placed the isolation meal tray onto the dietary food cart. The AD had not redirected the resident to return to the room so staff could dispose of the isolation meal items nor had the AD reminded the resident to wear a mask when leaving the room. d. On 6/17/20 at 1:13 p.m., the AD was asked if they had been trained on COVID-19 precautions or procedures and the AD stated, Yes. The AD was asked if they had been trained on isolation procedures as well and the AD stated, Yes. The AD was asked if the resident was on any type of isolation and the AD stated, Yes. The AD was asked what type of isolation and the AD stated, Droplet and contact. The AD was asked if a resident on isolation can leave their room and the AD stated, Yes but they have to have their mask on. The AD was asked what should have been done when the resident brought the brown tray with the styrofoam containers out into the hall. The AD stated, I should have asked him to stop right there and take his tray back and someone would go into his room and throw it away. The AD was asked if the resident should have been reminded to wear a mask when out of the room. The AD stated, Yes most definitely. The AD was asked if the isolation meal tray should not go onto the dietary cart and the AD stated, No. No shape, form, or fashion. 3. On 6/16/20 at 1:25 p.m., the Certified Dietary Manager (CDM) was asked what type of food/drink dishes were used for residents in isolation or quarantine and the CDM stated, I send out 3 compartment containers, plastic utensils, foam cups and for dessert either foam platter or bowl. Sent out on regular tray. The CDM was

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 -** Some	(continued... from page 1) asked if the hard-surfaced brown tray that held the disposable items was to be taken into isolation/quarantine rooms. The CDM stated, The CNAs know the trays, just the disposable. Tray not supposed to go in the room. They are supposed to leave them out. The CDM was asked if the tray with the disposable food containers are to be brought out of isolation and placed on the dietary cart and the CDM stated, They weren't supposed to. The two I pulled off there (cart) and put them in the trash. 4. On 6/17/20 at 11:10 a.m., the Dietary Employee was asked if there had been trays with styrofoam containers that were on the dietary cart after the noon meal service on 6/16/20. The Dietary Employee stated, Yes. 5. On 6/17/20 at 12:42 p.m., LPN #3 was asked if Resident #5 was currently on isolation and the LPN stated, Yes. The LPN was asked why the resident had required isolation and the LPN stated, She was in the hospital and when she came back, we put her on isolation. The LPN was asked what type of isolation the resident was on and the LPN stated, Contact and droplet. LPN #3 was asked if hands were to be washed or sanitized before contact with the resident and the LPN stated, Yes. The LPN was asked if staff should touch or move the facemask then touch the resident. The LPN stated, No. The LPN was asked if staff should touch any item without then having sanitized hands and the LPN stated, No. LPN #3 was asked if any resident care should be given without having sanitized first and the LPN stated, No. The LPN was asked if residents on isolation/quarantine are to have a mask worn when they come out of the room into the hallway. The LPN stated, Yes. 6. The Hand Hygiene policy received on 6/16/20 at 11:42 a.m. from the Administrator, documented, . 1. All personnel shall follow our established handwashing/hand hygiene procedures to prevent the spread of infection and disease to other personnel, residents When to Use Alcohol-Based Hand Rub 3. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] for all the following situations: a. Before direct contact with residents; .d. Before preparing or handling medications; .g. After contact with resident's intact skin; h. After handling . contaminated equipment . 7. The Isolation-Categories of Transmission-Based Precautions policy received on 6/16/20 from the Administrator documented, .The three types of transmission-based precautions are contact, droplet and airborne . 4. The facility makes every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission-based precautions are used only when the spread of infection cannot be reasonably prevented by less restrictive measures . a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE (personal protective equipment), and/or instructions to see a nurse before entering the room . 5. A resident on airborne precautions will wear a mask when leaving the room or coming in contact with others . 8. On 6/16/20 at 10:53 a.m., Licensed Practical Nurse (LPN) #1 assisted Resident #1 from her wheelchair to the bed. She came out of the room with dirty laundry in her hands. She put the laundry in the soiled linen barrel in the hall, and without washing or hand sanitizing responded to a call light in another room on the 100 hall. Resident #2 requested to go to bed. Her bed had been stripped. LPN #1 came out of the room and without sanitizing her hands opened the clean linen cart, removed a sheet and returned to Resident #2's room. She then called for another staff to assist and they made the bed. After completion of this care, LPN #1 came out into the hall without washing or sanitizing her hands, went back into Resident #1's room and assisted the resident back to bed. At this point, she removed the resident's socks which were wet from the mopped floor. She came out into the hall and saw another resident in a wheelchair with fogged eyeglasses from wearing a mask. She went back into Resident #1's room and washed her hands prior to assisting the resident with the fogged eyeglasses. a. On 6/17/20 at 1:00 p.m., the Director of Nursing was asked if staff should wash or sanitize their hands after assisting one resident and before assisting another resident and she stated, Yes. She was asked should staff sanitize their hands after helping one resident to bed, and before opening the clean linen cart and handling clean linen, and she stated, Yes. When asked if staff had been trained relating to hand sanitation and cross contamination, she stated, Yes. b. The Laundry and Linens policy received from the Administrator on 6/17/20 at 1:22 p.m., documented, .Standard precautions . 2. Wash hands after handling soiled linens and before handling clean linens .