STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045451	A. BUILDING _____ B. WING _____	**03/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COMMUNITY COMPASSION CENTER OF YELLVILLE	**620 NORTH PANTHER AVENUE YELLVILLE, AR 72687**

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 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 record review and interview, the facility failed to ensure staff assisted a residents with the necessary care needs for her Activities of Daily Living for 1 (Residents (R) of 7 (R 1, R 2, R 3, R 4, R 5, R 6, and R 7) sampled residents, who had require assistance with their Activities of Daily Living (ADL's). The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. A Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BI[CONDITION]), was totally dependent upon staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. Required limited one-person assistance with locomotion on and off the unit and utilized an electric wheelchair for mobility. Resident required set up assistance only with eating. a. A Care Plan dated 12/21/2018, documented, .Requires assistance with all ADL's (Activities of Daily Living) . Resident is extensive assist of two people for bed mobility, transfers, ambulation, dressing, and toileting. b. On 0[DATE]20 at 12:48 PM, Certified Nursing Assistant (CNA) #2 entered R #1 room and served R #1 a lunch tray. R #1 right arm was hanging over the upper right bed rail. CNA #2 asked resident to Move over so your arm isn't there. R #1 attempted to move self and was unable to reposition. c. On 0[DATE]20 at 3:57 PM, the Social Services Director (SSD) was asked, Where can I find the MDS/Care Plan Coordinator? The SSD stated, They left last week. We have a new one starting soon. d. On 0[DATE]20 at 4:01 PM, the Director of Nursing (DON) was asked, Do you currently have an MDS/Care Plan Coordinator? The DON stated, We have hired one, she just finished orientation and is giving a 2 week notice then should start on the 9th. We have had people filling in and the ADON (Assistant Director of Nursing) and I are working on them. The DON was asked, Is the care plan used to direct resident care? The DON stated, Yes. The DON was asked, Is the care plan used by staff to provide care to the residents? The DON stated, Yes. They have access on the kiosk and desktop. e. On [DATE]20 at 11:25 AM, the Physical Therapy Assistant (PTA) was asked, Can you tell me what you are working with R #1 on? The PTA stated, I am trying to get back to one person assist for transfers, bed mobility to get to the edge of the bed, elbow prop/push. Right now, R #1 is experiencing difficulty maintaining balance and I am working on that so when R #1 sits on the edge of the bed balance is maintained. The PTA was asked, Is resident able to position in the bed without assistance? The PTA stated, Yes. The PTA was asked, Can R #1 eat while in the bed? The PTA stated, Yes. (R #1) would need assistance to position upright but cannot sit on the side of the bed to eat due to inability to balance. The PTA was asked, Should staff properly position resident prior to serving a meal? The PTA stated, Yes. The PTA was asked, Should the bedside table be over the bed with the head of bed (HOB) be raised to 90 degrees? The PTA stated, Yes. The resident should be positioned upright with the meal tray in front.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure staff washed hands prior to handling food for 1 (Resident #1) who required assistance with meal set up. This failed practice had the potential to affect 13 residents who received assistance with meal set up on the Blue Hall according to a list provided by the Assistant Director of Nursing (ADON) on [DATE] at 01:12 PM. The facility failed to ensure staff provided a clean surface for wound treatment supplies and washed hands and changed gloves during wound treatment to prevent potential infection from contamination for 1 (Resident #7) who required wound treatments. This failed practice had the potential to affect 5 residents who were received wound care on Rose Hall, according to a list provided by the Assistant Director of Nursing (ADON) on [DATE] at 12:25 PM. The facility failed to ensure staff were trained in the maintenance and care of central intravenous lines to prevent the potential development infection for 1of 1 (Resident #1) who had a intravenous (IV) catheter inserted in the upper arm. This failed practice had the potential to affect 1 resident who resided in the facility who received intravenous (IV) therapy according to the Resident Census and Conditions of Resident for, dated [DATE]20. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. A Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/30/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BI[CONDITION]), required set up assistance only with eating. a. On 0[DATE]20 at 12:48 PM, Certified Nursing Assistant (CNA) #2 entered R #1 room and served R #1 a lunch tray. CNA #2 placed the lunch tray on the overbed table. CNA #2 asked R #1 about raising the head of the bed (HOB). R #1 agreed and CNA #2 began raising the HOB. R #1 stopped CNA when the HOB was at approximately 35-40 degrees. Without sanitizing or washing her hands, CNA #2 removed the lid from a plate located on the tray. A bowl was in the middle of the plate with 8 packages of saltine crackers surrounding the bowl. CNA #2 removed the lid from the bowl of soup and removed the lid from a dessert cup. CNA #2 asked resident, Do you want me to open your crackers for you? R #1 stated, Yes. CNA #2 opened 4 packages of crackers, each time tearing the cellophane wrapping, using index finger and thumb of right hand, to remove crackers and place them on the plate. CNA #2 asked resident, Do you want me to open all of them? R #1 stated, No, that is enough. CNA #2 left the room. b. On [DATE] at 08:19 AM, CNA #2 was asked, Yesterday, while you were assisting R #1, you were opening the crackers and you touched the crackers with your bare hands. Did you sanitize or wash your hands prior to entering the room and touching the crackers? CNA #2 stated, No, I did not sanitize my hands. 2. Resident #7 had [DIAGNOSES REDACTED]. A Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/11/2019 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BI[CONDITION]). a. A physician's orders [REDACTED].Cleanse stage 2 pressure area to left buttock with w/c (wound cleaner). b. A care plan, with a revision date of 03/29/2019 documented, . has potential/actual impairment to skin integrity. Interventions. Facility protocol for assessments and treatment of [REDACTED]. On [DATE] at 09:15 AM, Registered Nurse (RN) #1 pushed treatment cart onto Rose Hall. RN #1 began to gather supplies for dressing change for R #7. RN #1 stated, We had a treatment nurse until recently, so I am having a hard time finding this stuff. RN #1 was observed opening the drawers and looking for various items. Supplies were placed on top of the treatment cart. RN #1 did not perform hand hygiene and did not clean the top of the treatment cart. RN #1 gloved her hands and squeezed less than 10 cc (cubic centimeters) Anased gel into a clear, plastic medication (med) cup. Gentell collagen powder was added to the med cup and stirred with a cotton tip applicator (stick end). RN #1 threw the cotton tip applicator into the trash and removed her gloves. RN #1 moved the treatment cart down the hallway. RN #1 was asked, Why is resident on isolation? RN #1 stated, She [MEDICAL CONDITION] ([MEDICAL CONDITION] Resistant Staph Aureus) in her urine. RN #1 donned a gown and gathered supplies from the treatment cart. d. At 09:25 AM, CNA #3 donned a gown and entered R #7's room. RN #1 placed supplies on the over bed table that held R #7's personal items and food stuff. The over bed table was not cleared or cleaned and no barrier was placed on the table. Photograph taken of resident's over bed table with Curad dressing on table, showing soiled table, resident milk, chocolate milk, and napkin containing flatware. Both RN and CNA performed hand hygiene at the sink in

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** - Few	(continued... from page 1) the resident's room, and donned gloves. CNA #3 closed the door to resident's room and assisted the resident with positioning onto the left side. e. At 09:28 AM, RN #1 removed the dressing from the resident's left buttock area, removed gloves, disposed in trash and donned new gloves. No hand hygiene was performed. RN #1 cleaned area with 4 x (by) 4's sprayed with wound cleanser by wiping wound from outer area to inner area and disposed of 4 x 4's in trash. RN #1 removed gloves and donned new gloves. No hand hygiene was performed. RN #1 used gloved index finger of right hand to apply gel from med cup to wound. RN #1 removed right glove and disposed of in the trash. RN #1 donned a new right glove without performing washing or sanitizing her hands. Exuderm dressing was applied to left buttock. RN #1 lowered the bed into the low position and moved the bed away from the wall. The over bed table was moved to the left side of the resident's bed. RN #1 removed her gloves and donned new gloves without performing washing or sanitizing her hands. The resident was positioned to right side with assistance of CNA #3. The dressing was removed from the left side skin fold. RN #1 removed gloves and donned new gloves without performing washing or sanitizing her hands. The area was cleaned 3 times with wound cleanser sprayed 4 x 4s. RN #1 removed her gloves and donned new gloves without performing washing or sanitizing her hands. RN #1 applied Curad dressing and Cool Gel dressing. The bedside table was placed to the right of the resident, a box of gloves were removed from the table and placed on the counter to the right of the sink by RN #1. CNA #3 removed personal protective equipment (PPE), performed hand hygiene and exited the room. RN #1 removed PPE and performed hand hygiene prior to exiting room. f. At 9:45 AM, RN #1 was asked, Do you have hand sanitizer in the room? RN #1 stated, Guess I could get some, but I don't want to take my personal one in there because of the isolation. g. On [DATE] at 9:48 AM the ADON was asked, Should gloves be changed and hands sanitized when moving from dirty to clean during a wound dressing change? The ADON stated, Yes. You need to change gloves and I would sanitize with each glove change. 3. On [DATE] at 12:01 PM, the ADON provided a policy and procedure titled, Hand Hygiene, dated 6/19 documented, .Procedure. Staff implement standard precautions (e.g., hand hygiene. Appropriate hand hygiene practices are followed: . Alcohol-based hand rub (ABHR) is readily accessible. at the bedside. Staff perform hand hygiene (even if gloves are used). Before and after contact with the resident. 4. On [DATE] at 12:01 PM, the ADON provided a policy and procedure titled, Infection Control Program, with a created date of 06-19 documented, .designed to provide a safe, sanitary. to help prevent the development and transmission of communicable diseases and infections. following accepted national standards. Procedure/Protocol: . 6. The hand hygiene procedures to be followed by staff involved in direct resident contact . 5. Resident #1 had [DIAGNOSES REDACTED]. The Medicare 5-day Minimum Data Set with an Assessment Reference Date of [DATE]20 documented the resident scored 13 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status. a. A physician order [REDACTED]. b. A physician's orders [REDACTED].Flush PICC line before and after each medication administration using SASH (Saline, Administer infusion, Saline, [MEDICATION NAME]) method 10 cc (cubic centimeters) NS (Normal Saline) aspirate for blood, 10 cc NS, 10 cc [MEDICATION NAME]. c. The February 2020 Medication Administration Record [REDACTED]. using 10 cc NS, 10 cc [MEDICATION NAME] using push pause method. d. The Hospital Discharge Instructions dated 3/18/2020 documented, .Discharge Diagnosis.2. Bacteremia likely secondary to PICC that was present on admission. this was discontinued and he will continue IV antibiotics as listed below. Powerwand (IV catheter inserted in the upper arm) may be left in place up to 29 days however this can be removed after antibiotics are completed. e. On 3/31/2020 at 10:49 a.m.; Licensed Practical Nurse (LPN #1) was asked how long she had worked as a LPN at the facility. LPN #1 stated, Since, January of this year. LPN #1 was asked if she received any training involving Central Lines at the facility. LPN #1 stated, No, but I did with my LPN training. LPN #1 was asked if she got any training regarding PICC lines. LPN #1 stated, I wasn't trained on PICC lines. I didn't work with (Resident #1) when he had a PICC line. LPN #1 was asked if she received any training regarding the Powerwand. LPN #2 stated, Just verbally. I look at the MAR for instructions. I know his Powerwand does not get [MEDICATION NAME]. f. On 3/31/2020 at 11:03 a.m., LPN #2 was asked how long she had worked at the facility. LPN #2 stated, Three weeks, total. LPN #2 was asked how long she had worked with Resident #1. LPN #2 stated, Just a few weeks. LPN #2 was asked if had any training at the facility regarding Central Lines. LPN #2 stated, Not here, but at the previous facility I worked at. I worked as a travel nurse. LPN #2 was asked what type of training she had at this facility. LPN #2 stated, I had orientation where I followed another nurse around for two days. LPN #2 was asked if she had any training regarding Resident #1's Powerwand. LPN #2 stated, I have worked with them before. They are like a heavy duty IV. I look at the Standing Orders. The treatment nurse does the dressing changes. g. On 3/31/2020 at 11:30 a.m.; the Assistant Director of Nurses (ADON) was asked if the facility had any recent training or inservices regarding Central Lines or Powerwands. The ADON stated, No. The ADON was asked if the facility provided any competency check offs or Central Line training with newly employed licensed staff. The ADON stated, No, not that I am aware of. The ADON was asked if the facility admitted many residents with Central Lines? The ADON stated, Not, very often. We have had a several in the last year.