STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045447	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENHURST NURSING CENTER	226 SKYLER DRIVE CHARLESTON, AR 72933

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observations, record review, and interview the facility failed to ensure the 400 Hall linen cart cover and the 200 Hall linen cart were clean and maintained and in good condition as evidenced by the covers being frayed, torn, and ripped; and the facility failed to prevent the possible cross contamination and possible infections. This failed practice had the potential to affect 60 residents according to the Daily Census provided by the Administrator on 6/29/2020. The facility failed to ensure residents wheelchair cushions were clean and maintained and in good condition as evidenced by the cushion was ripped, frayed, and torn for 1 (Resident #8) of 6 (Residents #65, #63, #8, #43, #82, #14) sample residents according to a list provided by the Director of Nursing (DON) on 7/2/2020. The findings are: 1. On 06/29/2020 at 11:50 a.m., the linen cart cover on the 400 Hall hat contained clean linen was frayed and ripped. The Housekeeping Supervisor was asked, Should the linen cart cover be ripped and frayed? The Housekeeping Supervisor stated, No. a. On 07/01/2020 at 07:56 a.m., the linen cart cover on the 200 Hall was to be frayed, ripped, and had a hole that measured approximately 2 inches in diameter. b. On 07/01/2020 at 9:18 a.m., Certified Nursing Assistant (CNA) #10 was asked, Should the linen cart covers be frayed, ripped, and have holes in them? CNA #10 stated, No. c. On 07/01/2020 at 09:27 a.m., Registered Nurse (RN) #1 was asked, Should linen cart covers be frayed, ripped, and have holes in them? RN #1 stated, No. d. On 07/01/20 at 02:13 p.m., the Director of Nursing (DON) was asked, Should linen cart covers be frayed, ripped, and have holes in them? The DON, Ideally, no. e. On 07/02/20 at 12:12 p.m., the Administrator was asked, Should the linen cart covers have holes, be frayed, torn, and ripped? The Administrator stated, No. f. A policy titled Handling Clean Linen documented, It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection .Linen can become contaminated with pathogens from contact with skin or body substances, or from environmental contaminants or contaminated hands . 2. On 06/30/2020 at 11:02 a.m., Resident #8 was sitting in her wheelchair. The wheelchair cushion was cracked and frayed with the inside lining showing. a. On 07/01/2020 at 09:17 a.m., Resident #8 was sitting in her wheelchair. The wheelchair cushion was cracked and frayed with the inside lining showing. b. On 07/01/2020 at 09:18 a.m., Certified Nursing Assistant (CNA) #10 was asked, Should the residents wheelchair cushions be ripped, torn, and frayed? CNA #10 stated, They should not. c. On 07/01/2020 at 09:27 a.m., Registered Nurse (RN) #1 was asked, Should the residents wheelchair cushions be ripped, torn, and frayed? RN #1 stated, No. d. On 07/01/2020 at 02:13 p.m., the Director of Nursing (DON) was asked, Should the residents wheelchair cushions be ripped, torn, and frayed? The DON replied, No. e. On 07/02/2020 at 12:12 p.m., the Administrator was asked, Should the residents wheelchair cushions be ripped, torn, and frayed? The Administrator stated, No.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure care plans were person-centered, accurate, complete, and reflect pain management for 1 (Resident #56) of 8 (Resident #8, #33, #56, #57, #60, #67,#74 and #82) sampled residents whose medical records were reviewed. This failed practice had the potential to affect 22 residents who required routine pain medication, according to the list provided by the Director of Nursing (DON) on 7/2/2020. The findings are: Resident #56 had a [DIAGNOSES REDACTED]. a. A physicians order dated 4/23/18 documented, . [MEDICATION NAME] 50mg (milligrams) 1 tablet by mouth four times a day b. A physician order [REDACTED].[MEDICATION NAME] Capsule 300 MG give 1 capsule by mouth three times a day for chronic pain c. The Comprehensive Care Plan dated 3/7/19, and updated 5/28/2020, did not contain any documentation related to chronic pain medication, side effects, or monitoring. d. On 07/02/2020 at 11:21 a.m., Registered Nurse (RN) #3, the MDS/Care Plan Coordinator, was asked why was routine medications for pain, [MEDICATION NAME] and [MEDICATION NAME] was not addressed on the Care Plan and she stated, I'm not sure but I can add it to her Care Plan.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 observation, record review, and interview the facility failed to ensure oral care was provided for a resident who depended on staff for all Activities of Daily Living (ADL's) activities to promote dignity and prevent oral and skin irritation. This failed practice had the potential to affect 1 (Resident #14) of 5 (Residents (R) # 3, #14, #62, #63, #82) sampled residents who needed assistance and relied on staff for oral care on the 400 Hall according to a list provided by the Director of Nursing (DON) on 7/2/2020. The findings are: Resident #14 had [DIAGNOSES REDACTED]. bowel and bladder. a. The Care Plan with a revision date of 6/6/2018 documented, .The resident has an ADL self-care performance deficit r/t (related to) Limited Mobility, Limited ROM (range of motion), Musculoskeletal Impairment, [MEDICAL CONDITION]. Resident is dependent on staff for all oral care. Staff to brush his teeth, use toothette to clean mouth and tongue q2h (every two hours) and prn (as needed). Resident requires frequent oral care for secretions . b. A physician order [REDACTED]. c. On 06/29/20 at 11:44 a.m., Resident #14 was lying in his bed and had white foamy substances draining/running from both sides of his mouth. d. On 06/30/20 at 08:58 a.m., Resident #14 was lying in his bed and had white foamy substances draining/running from his mouth and down the side of his face to his chin. There were hard white patches at the end of tongue. e. On 06/30/2020 at 9:30 a.m., Certified Nursing Assistant (CNA) #2 was asked, Should R #14 have white hard crusted areas on his tongue? CNA #2 stated, No. But he drools a lot, and we have to do oral care frequently. f. On 07/01/2020 at 09:18 a.m., CNA #10 was asked, Should residents have a white, hard substance on their tongues with white foamy substances running down their face and chin? CNA #10 stated, Absolutely not. g. On 07/01/2020 at 09:27 a.m., Registered Nurse (RN) #1 was asked, Should residents have white, hard substances on their tongues with white foamy substance running down their face and chin? RN #1 stated, No. h. On 07/02/2020 at 12:12 p.m., the Administrator was asked, Should residents have white, hard substances on their tongue with white foamy substances running down their face/chin? The Administrator stated, There should be frequent oral care provided for that resident. i. A policy titled Activities of Daily Living (ADL's) documented, .The facility will ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming,

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) and personal and oral hygiene .
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review, and interview the facility failed to ensure the residents environment was free from accident hazards as evidenced by an unknown substance in a medication cup left out in the open in 1 (Resident #14) sampled resident room. This failed practice had the potential to affect 9 residents who were cognitively impaired and mobile on 400 Hall according to a list provided by the Director of Nurses (DON); The facility failed to ensure medications labeled Vics [MEDICATION NAME] and [MEDICATION NAME], were not left on 1 (Resident #3) over bed table. This failed practice had the potential to affect 5 cognitively impaired mobile residents on the 200 Hall according to a list provided by the Director of Nurses; The facility failed to ensure a can of aerosol air freshener was not left on a bedside table in 1 (Resident #43) room. This failed practice had the potential to affect 9 residents who were cognitively impaired on 400 hall according to a list provided by the Director of Nurses; The facility failed to ensure a wheelchair armrest was free of cracks and rips to prevent potential skin injuries for 1 (Resident #82) of 7 sampled residents. This failed practice had the potential to affect 19 residents on the 400 Hall who have wheelchair armrests according to a list provided by the Director of Nurses. The findings are: 1. Resident #3 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment reference Date (ARD) of 3/22/2020 documented the resident was cognitively intact a Brief interview for Mental Status (BIMS); and required extensive assistance of one person for bed mobility and toileting, limited assistance of one person for transfers, supervision and set up for mobility and eating. a. The Plan of Care with an initiated date of 1/1/2020 documented, .The resident has impaired cognitive function/dementia or impaired thought processes r/t (related to) Dementia .Cue, reorient and supervise as needed . b. The current physician orders [REDACTED]. c. On 06/30/2020 at 10:18 a.m., there was a container labeled [MEDICATION NAME] Cream 0.1% (percent) .apply to affected area twice daily-do not apply to face, armpits, or groin . dated 10/20/17 and a 6 ounce (oz) container of Vicks [MEDICATION NAME] on the resident's overbed table approximately 6 feet from the doorway visible from the hallway. A photograph of the [MEDICATION NAME] Cream and the Vicks [MEDICATION NAME] was taken at this time. d. On 06/30/2020 at 11:07 a.m., Registered Nurse (RN) #2, the nurse working the hallway, was shown the medications and asked, if she could tell me what it was. She stated, .It's a cream, he doesn't even have an order for [REDACTED]. It shouldn't. His girlfriend brings stuff to him. It is from 2017. We just haven't seen it. She always brings him snacks and things. I guess she brought it. He doesn't have and order for the Vicks, or it's not something I give him. I don't know if he has a care plan for this, we have some that are care plan. She reviewed the resident's orders and care plan and stated, It is not anything he has an order for [REDACTED]. It's not something we should have allowed. e. On 07/01/2020 at 02:03 p.m., the Director of Nursing was asked if a resident should have over the counter medications or prescribed medications in their room or on their over bed table. She stated, No. The family brought it in most likely. f. An Admission Agreement provided by the Administrator on 6/30/2020 documented, .no medications are allowed in resident rooms without doctor's orders . 2. Resident #14 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with as Assessment Reference Date (ARD) of 4/9/2020, documented the resident was severely impaired in cognitive skills for daily decision making on the Staff Assessment for Mental Status (SAMS); and required total assistance with 2 staff for bed mobility, transfer, dressing, toilet use, personal hygiene, had upper extremity impairment on both sides, and was always incontinent of bowel and bladder. a. On 06/29/2020 at 11:46 a.m., a medicine cup with 15 cc (cubic centimeters) of thick substance and unlabeled was sitting on the resident's nightstand. b. On 07/02/2020 at10:34 a.m., Certified Nursing Assistant (CNA) #5 was shown a picture of a medicine cup with 15 cc of thick substance and unlabeled and was asked, Can you tell me what is in this cup? CNA #5 stated, Looks like Vaseline. CNA #5 was asked, What would that be used for? CNA #5 stated, Sometimes on the lips. CNA#5 was asked, Is it supposed to be left out? CNA #5 stated, No. CNA #5 was asked, Could that be considered a hazard? CNA #5 stated, Yes. c. On 07/02/2020 at 10:43 a.m., Nursing Assistant (NA) #1 was shown a picture of a medicine cup with 15 cc of thick substance and unlabeled and was asked, Can you tell me what is in this cup. NA #1 stated, Looks like Vaseline. NA #1 was asked, Is it supposed to be left out? NA #1 stated, No. NA #1 was asked, Would this be considered a hazard? NA #1 stated, Yes. d. On 07/02/2020 at 10:44 a.m., CNA #4 was shown a picture of a medicine cup with 15 cc of thick substance and unlabeled and was asked, Can you tell me what is in this cup? CNA #4 stated, Barrier cream, it comes in a brown and white tub, and the nurses have it. CNA #4 was asked, Do you have to get this cream from the nurses? CNA #4 stated, Yes. CNA #4 was asked, Is it supposed to be left out? CNA #4 stated, No. CNA #4 was asked, If a cognitively impaired resident was to wander in the room and obtain this, would that be considered a hazard? CNA #4 stated, Yes. e. On 07/02/2020 at 12:32 p.m., the Administrator was asked should a medication cup with an unknown substance that staff are unable to identify be left in the resident's room. He stated, No. He was asked should any medication be left in the resident's room. He stated, No. 3. Resident #43 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/4/2020 documented the resident scored 14 (13-15 cognitively Intact) on a Brief Interview for Mental Status (BIMS); and required extensive assist of 2 for bed mobility, transfer, and toilet use, and required extensive assist of 1 for dressing, and personal hygiene, had an indwelling Foley catheter, and was occasionally incontinent of bowel. a. On 06/30/2020 at 10:33 a.m., a spray can of air freshener is on the bedside table. Resident #43 was asked do you use that air freshener. Resident #43 stated, Yes. I use it when my roommate goes to the bathroom, and the smell goes right through here to the fan. b. On 07/01/20 at 09:18 a.m., Certified Nursing Assistant (CNA) #10 was asked, Should residents have aerosol cans of air freshener in their rooms? CNA #1 stated, No. CNA #10 was asked, Would this be considered a hazard? CNA #10 stated, Yes. 4. Resident #82 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 6/8/2020 documented the resident scored 13 (13-15 cognitively intact) on a Brief Interview for Mental Status (BIMS); and required extensive assist of 2 for bed mobility, transfer, dressing, toilet use, and personal hygiene; was frequently incontinent of bowel and had a super pubic Foley catheter. a. The Care Plan with a revision date of 6/25/19 documented, . The resident has an ADL self-care performance deficit r/t [MEDICAL CONDITION], Limited Mobility, Limited ROM . Resident is able to propel self in w/c (wheelchair) but needs assistance at times. Assist as needed . b. On 06/29/20 at 12:25 p.m., Resident # 82 sitting in his wheelchair. The wheelchair arms were cracked, frayed, with hard plastic protruding out approximately 0.5 centimeters (cm). c. On 06/29/20 at 01:55 p.m., Resident # 82 wheelchairs arms were cracked, frayed, and had hard plastic protruding out that measured approximately 0.5 cm. Resident #82 was asked, Is this your wheelchair? Resident #82 stated, Yes. Resident #82 was asked, Have you ever been scratched by the arms of your wheelchair? Resident #82 shook his head up and down, in a yes motion. d. On 06/29/20 at 02:03 p.m., CNA #3 was asked to describe Resident #82's arms on wheelchair? CNA #3 stated, It's cracked apart, hard, and sticking out. CNA #3 was asked, Does that have the potential to cause a skin tear? CNA #3 stated, It could. e. On 07/1/20 at 09:18 a.m., CNA #10 was asked, Should the arms on a resident wheelchair be ripped, frayed, torn with hard vinyl protruding out? CNA #10 stated, No. They shouldn't. CNA #10 was asked, Would this be considered a hazard? CNA #10 stated, It could cause skin tears, yes. f. On 07/01/20 at 09:27 a.m., Registered Nurse (RN) #1 was asked should the arms on a resident wheelchair be ripped, frayed, torn with hard vinyl protruding out. RN #1 stated, No. RN #1 was asked, Would this be considered a hazard? RN #1 stated, Yes. g. On 07/01/2020 at 02:13 p.m., the DON was asked, Should the arms on a resident wheelchair be ripped, frayed, torn with hard vinyl protruding out? The DON stated, No. The DON was asked, Would this be considered a hazard/ The DON stated, Yes. h. On 07/02/20 at 12:12 p.m., the Administrator was asked, Should the arms on a resident wheelchair be ripped, frayed, and torn with hard vinyl protruding out? The Administrator, No. The Administrator was asked, Would this be considered a hazard? The Administrator stated, Yes. i. A policy titled Accident and Supervision documented, .Accident and Supervision. The resident environment remains as free of accident hazards as is possible .

F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, record review, and interview the facility failed to ensure food items in the dry storage and freezer

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) were properly labeled or dated to prevent food borne illnesses, failed to ensure cooking utensils were covered or inverted to prevent contamination and failed to ensure sanitary food handling practices were maintained by staff serving the lunch meal to prevent potential food borne illnesses in 1 of 1 facility kitchens. These failed practices had the potential to affect 92 residents (Total Census: 95) as documented on the Resident Listing Report provided by the Dietary Supervisor (DS) on 7/1/2020 at 11:58 a.m. The findings are: 1. On 6/29/2020 at 10:56 a.m., the kitchen dry storage area contained 1 box of Cheetos with approximately 30 bags with no open date. 2. On 6/29/2020 at 10:56 a.m., the kitchen dry storage area contained 1 box of Corn Chips with approximately 40 bags with no open date. 3. On 6/29/2020 at 10:56 a.m., the kitchen dry storage area contained 1 box of Doritos with approximately 30 bags with no open date. 4. On 6/29/2020 at 11:00 a.m., the kitchen cooler contained (1) 1/2 gallon of Cultured Buttermilk open with no date. 5. On 6/29/2020 at 11:03 a.m., the kitchen freezer contained approximately 10 patties of a potato like substance opened with no label or date. 6. On 6/29/2020 at 11:06 a.m., the kitchen freezer contained an opened clear bag of breaded okra with no label or date. 7. On 6/29/2020 at 11:06 a.m., the kitchen freezer contained an opened, clear bag of tator tots with no label or date. 8. On 6/29/2020 at 11:08 a.m., the kitchen freezer contained an opened bag of a French fries with no label or date. 9. On 6/29/2020 at 11:08 a.m., the kitchen freezer contained an opened bag of onion rings with no label or date. 10. On 6/29/2020 at 11:10 a.m., the kitchen freezer contained cooked hushpuppies with no label or date. 11. On 6/29/2020 at 11:28 a.m., in the kitchen, by the clean side of the dishwasher, contained 1 large round metal bowl, 3 medium sized metal bowls, and 2 metal, rectangle pans, not covered or inverted. 12. On 6/29/2020 at 12:28 p.m., the Dietary Supervisor (DS) was standing on the serving line and used her right hand to pick up Styrofoam trays from the left and with her right hand picked up maroon tongs from a pan of chicken tenders. She retrieved chicken tenders out of the pan with the tongs, placed the chicken tenders in the Styrofoam trays, laid the tongs on the contaminated prep area where contaminated tray cards, and a black pen laid on the counter. She picked up the black pen and marked on the tray cards, and without washing her hands, used the contaminated tongs to serve the chicken tenders into resident trays. 13. On 6/29/2020 at 12:50 p.m., Dietary Employee (DE) #1, stood at the end of the serving line, placed handled adaptive utensils, on a tray, on top of a contaminated tray card, that had been passed down the line and touched by four Dietary employees' hands. Then served the tray to a resident. 14. On 6/29/2020 at 1:04 p.m., Certified Nursing Assistant (CNA) #1 picked up a weighted spoon and fork from the left of her out of a white basket and placed the weighted spoon and fork, on a tray, on top of a contaminated tray card that had been passed down the serving line and touched by five Dietary employees, and then served the resident the tray. 15. On 6/29/2020 at 1:25 p.m., the 200 Hall nourishment room, by the nurses' station, contained a basket of approximately (8) 1.19 ounce (oz). Fudge rounds, (3) .49 Honey(NAME)cookies and (10) .67 oz Nutty Buddy with no date. 16. On 7/1/2020 at 11:33 a.m., the Dietary Supervisor was asked, Should food items be labeled/dated? She stated, Yes. She was sked, Should cooking utensils be covered/inverted? She stated, Yes. She was asked, Should kitchen utensils used to serve residents be placed on a contaminated surface from tray cards and ink pen? She stated, No. 17. On 7/1/2020 at 11:58 a.m., the facility Food Storage policy and procedure provided by the Dietary Supervisor reviewed. The policy states, .7. Hands must be washed .prior to handling food items .8.c. Food should be dated as it is placed on the shelves .16. Frozen foods: c. Foods should be covered, labeled and dated .
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 Foley catheter bags were contained and off of the floor to prevent potential cross contamination which could result in infection for 1 (Resident #82) of 2 (Residents #43 and #82) sample residents who had orders for Foley catheters according to a list provided by the Director of Nursing (DON) on 7/2/2020. The facility failed to ensure a used face mask and a used medicine cup were contained and off of the floor to prevent potential cross contamination and possible infection. These failed practice had the potential to affect 34 residents who reside on the 400 Hall according to the Daily Census provided by the Administrator on 6/29/2020. The facility failed to ensure personal cell phones and keys were contained and off the counter with clean linens and failed to ensure staff sanitized or washed hands after using a cell phone prior to handling clean linen to prevent potential cross contamination which could result in infection. This failed practice had the potential to affect 95 residents who had linens/clothes laundered by the facility according to the Census and Condition provided by the Administrator on 6/29/2020. The findings are: 1. Resident #82 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/8/2020 documented the resident scored 13 (13-15 cognitively intact) on a Brief Interview for Mental Status (BIMS); and required extensive assist of 2 for bed mobility, transfer, dressing, toilet use, and personal hygiene; was frequently incontinent of bowel and had a super pubic Foley catheter. a. A physician order [REDACTED].Suprapubic Catheter 16f/10cc (cubic centimeters) Bulb as Needed For Occluded May Change . b. The Care Plan with a revision date of 12/5/19 documented, .The resident has Suprapubic Catheter r/t (related to) neuromuscular dysfunction of bladder .Indwelling catheter care- assess for evidence of obstruction or malfunction, suspected infection, and/or compromises such as disconnections or leaks and replace as needed . c. On 06/29/2020 at 12:29 p.m., Resident #82 was in a chair in the day room. His Foley catheter was on the floor under his wheelchair (w/c). There were white substances in Foley catheter tubing. d. On 06/29/2020 at 01:46 p.m., Resident #82 was in the day room eating/self- feeding. The Foley catheter was on the floor. e. On 06/29/2020 at 01:47 p.m., Certified Nursing Aide (CNA) #4 was asked, Should Foley catheters be on the floor? CNA #4 stated, No. CNA #4 was asked, Would that be an infection control issue? CNA #4 stated, Yes. f. On 07/01/2020 at 09:18 a.m., CNA #10 was asked, Should Foley catheters bags be on the floor? CNA #10 stated, No. CNA #10 was asked, Would that be an infection control issue? CNA #10 stated, Yes. g. On 07/01/2020 at 09:27 a.m., Registered Nurse (RN) #1was asked, Should Foley catheters bags be on the floor? RN #1 stated, No. RN #1 was asked, Would that be an infection control issue? RN #1 stated, Yes. h. On 07/01/2020 at 02:13 p.m., the Director of Nursing (DON) was asked, Should Foley catheters bags be on the floor? The DON stated, No. The DON was asked, Would that be an infection control issue? The DON stated, Yes. i. On 07/02/2020 at 12:12 p.m., the Administrator was asked, Should Foley catheter bags be on the floor? The Administrator stated, No. The Administrator was asked, Would that be an infection control issue? The Administrator stated, Yes. 2. On 06/29/20 at 12:27 p.m., a used face mask and a used medicine cup was observed in the floor in the day room. a. On 06/29/2020 at 01:54 p.m., a used face mask and a used medicine cup were observed on the floor in the day room. b. On 06/29/2020 at 02:03 p.m., CNA #3 was asked, Is a used medicine cup and used face mask supposed to be on the floor? CNA #3 stated, No. CNA #3 was asked, Would that be an infection control issue? CNA #3, Yes. c. On 07/01/2020 at 09:18 a.m., CNA #10 was asked, Should used face masks and used medicine cups be in the floor? CNA #10 stated, No. CNA #10 was asked, Would this be considered an infection control? CNA #10 stated, No. d. On 07/01/2020 at 09:27 a.m., Registered Nurse (RN) #1 was asked, Should used face masks and used medicine cups be in the floor? RN #1 stated, No. RN #1 was asked, Would this be considered an infection control issue? RN #1 stated, Yes. e. On 07/01/2020 at 02:13 p.m., the Director of Nurses (DON) was asked, Should used face masks and used medicine cups be in the floor? The DON stated, No. The DON was asked, Would this be considered an infection control issue? The DON stated, It's messy, yes. f. On 07/02/2020 at 12:12 p.m., the Administrator was asked, Should there be used face mask and medicine cup in the floor, and would this be considered an infection control issue? The Administrator stated, I would like to think it was just lazy . 3. On 07/01/2020 at 12:24 p.m., rounds were made in the laundry room area. This Surveyor enter through clean side of laundry. Two phones and a set of keys were observed on the counter next to the clean linen. Laundry/Housekeeper #1 was asked, Should the phone and the keys be on the clean area counter, next to the clean linen? Laundry/Housekeeper #1 stated, No. Laundry/Housekeeper #1 was asked, What concern would there be with the keys and phones on the counter next to the clean linen? Laundry/Housekeeper #1 stated, The bacteria is getting on the clothes. a. On 07/01/2020 at 12:32 p.m., Laundry/Housekeeper #1 was observed to use a cell phone to call her supervisor, then picked up clean laundry and started to fold it. Laundry/Housekeeper #1 did not sanitize or wash hands after using the phone. Laundry/Housekeeper #1 was asked, After you used your phone, should you have sanitized your hands? Laundry/Housekeeper #1 stated, I should have sanitized my hands. b. On 07/01/2020 at 02:13 p.m., the Director of Nurses (DON) was asked, Should cell phones and keys be on the counter next to the clean linen in the laundry room? The DON stated, No. The DON was asked, Would that be considered an infection control issue? The DON stated, Yes. c. On 07/02/2020 at 12:12 p.m., the Administrator was asked, Should personal cell phones and a set of keys be on the counter with the clean linen? The Administrator stated, No. The Administrator was asked, Would a staff member using a cell phone, then picking up clean laundry and not sanitizing hands be considered an infection control issue? The Administrator stated, Yes. 4. A policy titled Infection Prevention and Control Program documented, .Infection Prevention and Control Program .This facility has established and maintains an infection prevention and control program designed to provides a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections .All

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045447	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENHURST NURSING CENTER	**226 SKYLER DRIVE CHARLESTON, AR 72933**

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	(continued... from page 3) staff have responsibilities related to the cleanliness of the facility .Linens .Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection .