

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2026
NAME OF PROVIDER OR SUPPLIER  Bailey Creek Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review, interview, facility document review, observation, and facility policy review, the facility failed to ensure that physician orders were followed for two (Resident #1 and Resident #4) of two residents reviewed for dressing changes and to ensure one resident (Resident #1) received indwelling catheter care, as ordered.</p> <p>The findings include:</p> <p>Resident #1</p> <p>A review of Resident #1's admission Record indicated the facility admitted the resident with diagnoses which included osteomyelitis (serious bone infection) of vertebra, sacral and sacrococcygeal region (base of the spine), type 2 diabetes mellitus, and pressure ulcer of unspecified site, unspecified stage.</p> <p>A review of Resident #1's Physician admission note, dated 05/13/2025, indicated the resident had been admitted with recent hospital discharge orders for antibiotics to be given until 06/13/2025, related to osteomyelitis. The Physician note also indicated that the resident did not have a Peripherally Inserted Central Catheter (PICC) in place, and the admitting physician was called. The resident's PICC line placement was scheduled for 05/13/2025.</p> <p>A review of Resident #1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/18/2025, revealed a Brief Interview Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment.</p> <p>A review of Resident #1's Order Summary Report revealed an active order dated for 05/14/2025, for the resident to have a PICC line dressing change conducted every three days.</p> <p>A review of Resident #1's TAR for June of 2025, revealed no initials or check marks were documented to indicate the resident's order change PICC line dressing every day shift every 3 days had been completed on 06/01/2025, 06/04/2025, or 06/10/2025.</p> <p>A review of Resident #1's Skin and Wound Evaluation V7.0, dated 06/02/2025, indicated the resident had an unstageable pressure ulcer which covered an area of 5.6 centimeters, with orders for generic wound cleanser and primary dressing as [Name Brand Wound Dressing]/wet to dry, with a composite secondary dressing. Additional care included, but was not limited to, incontinence management and moisture barrier.</p> <p>A review of Resident #1's Order Summary Report contained an order dated 05/21/2025, to cleanse us [unstageable pressure ulcer] right heel with wound cleaner, paint with betadine, cover with [Name (continued on next page)]</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Brand Wound Dressing] foam then wrap with [Name Brand Gauze] every day shift.</p> <p>A review of Resident #1's TAR for June of 2025, revealed no check marks or initials were documented to indicate the dressing change to the resident's right heel had been completed on 06/01/2025 or 06/10/2025.</p> <p>A review of Resident #1's Physician's admission note dated 05/13/2025, contained an order to cleanse USPU [unstageable pressure ulcer] to coccyx with wound cleaner, apply wet to dry with [Name Brand Wound Dressing], cover with island dressing every day shift.</p> <p>A review of Resident #1's TAR for June of 2025, revealed no check mark or initials were documented to indicate the cleansing and dressing of the pressure ulcer on the resident's coccyx had been completed on 06/01/2025 and 06/04/2026.</p> <p>A review of Resident #1's Order Summary Report contained an order dated 06/04/2025, to cleanse USPU to coccyx with wound cleaner, apply wet to dry with [Name Brand Wound Dressing], cover with [Name Brand Wound Dressing] foam every day shift.</p> <p>A review of Resident #1's TAR for June of 2025, revealed no check mark or initials were documented to indicate the treatment for the resident's pressure ulcer to coccyx had been completed on 06/10/2025.</p> <p>A review of Resident #1's Order Summary Report contained an order dated 05/18/2025, for cath [catheter] care q [every] shift and PRN [as needed] with soap and water or wipes every shift for wound healing.</p> <p>A review of Resident #1's TAR for June of 2025, did not have a check mark or initials documented to indicate the catheter care had been completed as ordered (on day shift) on 06/02/2025, 06/03/2025, 06/04/2025, 06/06/2025, 06/07/2025, 06/08/2025, 06/09/2025, 06/10/2025, or 06/11/2025.</p> <p>During an interview on 03/20/2026 at 1:53 PM, the Director of Nursing (DON) reviewed Resident #1's TARs for May and June of 2025 and verified that the initials documented in a block indicated that the treatment or medication was given and that an X in the box indicated the treatment was not ordered for that day and an open block would indicate the treatment was not completed. The DON verified the absence of check marks and initials on the aforementioned dates would indicate the treatments had not been completed.</p> <p>Resident #4</p> <p>A review of Resident #4's admission Record indicated the facility admitted the resident on 03/04/2026, with diagnoses which included infection and inflammatory reaction, due to internal left hip prosthesis, Methicillin-Resistant Staphylococcus Aureus (type of bacteria that has developed resistance to many antibiotics), and pain due to internal orthopedic prosthetic devices, implants and grafts.</p> <p>A review of Resident #4's Order Summary Report contained an order dated 03/05/2026, for dressing change PICC line to left upper arm every day shift every Wed.</p> <p>A review of Resident #4's TAR for March of 2026, reflected the resident had a PICC line to left arm, (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>and an order for a dressing change to the PICC line every Wednesday. A check mark and initials were documented for 03/11/2026, and for 03/18/2026. The Chart Codes/Follow Up Codes, located at the bottom of each page of the TAR, revealed a check mark indicated the treatment had been administered.</p> <p>During a medication pass observation on 03/19/2026 at 8:25 AM, Licensed Practical Nurse (LPN) #4 looked at Resident #4's PICC line dressing and stated the handwritten date on the dressing looked like the date was either 11 or 14. LPN #4 stated she was unsure when the last PICC line dressing was changed, because the PICC line dressings could only be changed by a Registered Nurse (RN). LPN #4 revealed there were no initials visible on the dressing.</p> <p>During an observation on 03/19/2026 at 9:54 AM, the Treatment Nurse (TN) was in Resident #4's room standing by the resident's bedside, when this surveyor entered the room. The TN was wearing blue gloves, the resident's PICC line site was not covered, because the dressing had been removed. LPN #4, who was also present, administered oral medications and hung an antibiotic to infuse through Resident #4's PICC line, while the TN watched. Resident #4's PICC line site was uncovered for several minutes until after the antibiotic tubing was attached to the PICC line port. The TN stated that the dressing change was due yesterday [03/18/2026], but stated the dressing was not available at the time and had to be ordered from the pharmacy. The TN stated she signed the TAR, after she completed the dressing change.</p> <p>A review of a facility document located in Resident #4's Electronic Health Record titled, Nsg [Nursing] - I &amp; A [Incident and Accident] note dated 03/19/2026 at 10:59 AM, completed by the DON, revealed the resident's PICC line dressing change was not completed on 03/18/2026, as ordered. The note also indicated the dressing was changed on 03/19/2026.</p> <p>During an interview on 03/19/2026 at 1:44 PM, LPN #4 reviewed Resident #4's TAR for 03/18/2026 and stated the initials in the box for the resident's PICC line dressing change were her initials and she revealed that she had entered them. She stated that she had not changed Resident #4's dressing but had checked with the TN and was told the dressing was within the 7-day time frame allowed for dressing changes to be performed, so LPN #4 had put her own initials in the block to indicate she had looked at the dressing. LPN #4 verified that an x in a box on the TAR indicated the treatment was not due on those days, and if the box was blank then that was where staff initials would be recorded. LPN #4 further indicated the block for 03/18/2026, where her initials were located, that if the treatment was completed the nurse who completed it would initial it, but she initialed it because she had looked at it.</p> <p>During an interview on 03/19/2026 at 2:13 PM, the TN stated she had changed Resident #4's PICC line dressing on 03/11/2026, however when she changed the dressing on 03/19/2026, the dressing had a written date of 03/14/2026. The TN reviewed Resident #4's TAR for March of 2026 and was unable to locate any documentation indicating the resident's PICC line dressing was changed on that date [03/14/2026]. The TN stated she did not know whose initials were on the dressing that she had removed on 03/19/2026. The TN then stated if she had changed the dressing, her initials would be on the TAR to indicate the dressing change had been completed, and verified her initials were documented on Resident #4's TAR for the 03/11/2026 dressing change. The TN read Resident #4's TAR order and verified that the order specified the resident's PICC line dressing was to be changed every Wednesday, and if the dressing was changed additionally between scheduled days, it would still need to be changed as ordered on Wednesday and physician orders should be followed. The TN stated that she was unsure which LPNs were allowed to change dressings and did not comment on why the (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, interview, facility document review, and facility policy review, it was determined that the facility failed to ensure hand hygiene was performed between glove changes, a Peripherally Inserted Central Catheter (PICC) access was cleaned according to industry standards, and a PICC line dressing was intact prior to accessing the hub for one (Resident #4) of one resident reviewed for infection control practices during PICC access.</p> <p>The findings include:</p> <p>A review of Resident #4's admission Record indicated the facility admitted the resident with diagnoses which included infection and inflammatory reaction due to internal left hip prosthesis, Methicillin-Resistant Staphylococcus Aureus (MRSA) [a type of bacteria that has developed resistance to many antibiotics], and pain due to internal orthopedic prosthetic devices, implants and grafts.</p> <p>A review of Resident #4's entry Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/04/2026. The Point Click Care facility database indicated the admission MDS was incomplete and in progress.</p> <p>A review of Resident #4's Care Plan Report, initiated on 03/04/2026, revealed the resident had an MRSA colonization to their left hip. Interventions included contact isolation, antibiotic therapy as ordered, wear disposable gown and gloves during physical contact with resident, discard in appropriate receptacle and wash hands before leaving room; observe standard precautions for infection control; and keep open wounds covered rather than open to air.</p> <p>A review of Resident #4's Order Summary Report revealed the resident had a PICC line in their left arm. A dressing change for the resident's PICC line was ordered on 03/05/2026, to be changed every Wednesday, and an antibiotic was ordered on 03/04/2026, to be administered intravenously (IV) once daily, for infection of the left hip.</p> <p>A review of Resident #4's Treatment Administration Record (TAR) revealed the resident had an order for a dressing change for their PICC line to their left arm for every Wednesday. A check mark and initials for the Treatment Nurse (TN) were documented for Wednesday, 03/11/2026 and a check mark and initials for Licensed Practical Nurse (LPN) #4 were documented for Wednesday, 03/18/2026. The Chart Codes/Follow Up Codes located at the bottom of each page of the TAR revealed a check mark indicated the treatment was administered.</p> <p>A review of Resident #4's Medication Administration Record (MAR) revealed the resident had an IV antibiotic once daily for infection of the resident's left hip. A check mark and initials were documented for Wednesday, 03/18/2026. The Chart Codes/Follow Up Codes located at the bottom of each page of the MAR revealed a check mark indicated the mediation was administered.</p> <p>During an observation on 03/19/2026 at 8:25 AM, Licensed Practical Nurse (LPN) #4 confirmed that Resident #4 had a PICC line, was on contact precautions related to their PICC line, and had a wound with MRSA. LPN #4 prepared to enter Resident #4's room to obtain blood pressure and administer medications obtained from the medication cart located in the doorway of Resident #4's room. LPN #4 performed hand hygiene and donned two pair of gloves and PPE that included a facemask, gown and (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>gloves. LPN #4 stated the reason for two pair of gloves was they needed to take Resident #4's blood pressure (BP), then they could remove one set of gloves, then obtain and administer Resident #4's medications. LPN #4 entered Resident #4's room a total of three times in order to obtain and administer medications from the medication cart, donning two sets of gloves each time. The third time, LPN #4 donned two pairs of gloves and stated they needed to pick up the used BP cuff from residents' and did not want to contaminate the donned gloves. LPN #4 picked up the BP cuff, reviewed reading, documented the resident's BP in the electronic health record (EHR), removed their outer gloves, opened the trash can with gloved hands, threw doffed outer gloves into trash can, then closed the trashcan lid with the second pair of gloves still in place on their hands. LPN #4 returned to the medication cart, opened the medication cart, removed medication cards and placed them on top of the medication cart. LPN #4 then removed their gloves, disposed of the gloves in the trashcan, and donned a clean pair of gloves without performing hand hygiene. LPN #4 began placing Resident #4's medication in a clear plastic medication cup, entered Resident #4's room and provided medications. LPN #4 removed their gloves and PPE, dropped the gloves and PPE into the trashcan, closed the trashcan lid with their bare hand, and then washed their hands. Next, LPN #4 donned Personal Protective Equipment (PPE) which included gloves, gown, and a mask. LPN #4 then gathered intravenous (IV) tubing, IV antibiotic, alcohol preps, and a 0.9% Sodium Chloride 10 cubic centimeter (cc) syringe. LPN #4 entered Resident #4's bathroom and obtained three paper towels, placed on Resident #4's overbed table and placed the 0.9% Sodium Chloride 10 cc syringe, the antibiotic fluid bag, and the IV tubing on the paper towels. LPN #4 removed the 0.9% Sodium Chloride 10 cc syringe from the outer packaging, removed the IV tubing from the outer packaging, removed the clear, non-disinfecting cap from the access port of the PICC line and used the alcohol prep pad to wipe twice across access port (&lt; 3 seconds). The LPN then attached and infused 0.9% Sodium Chloride into port. The IV tubing that was in LPN #4's hand touched Resident #4's bedding, then LPN #4 released the PICC line access port, which fell back onto the resident's arm. LPN #4 disposed of the IV tubing, adjusted Resident #4's arm, walked back to medication cart, obtained an unopened package of IV tubing from the medication cart, returned to Resident #4's bedside, adjusted facemask, opened IV tubing, removed medication bag access cover and inserted spiked end of the IV tubing into the IV medication bag, then primed the IV tubing. LPN #4 wiped the access port of Resident #4's PICC line with an alcohol pad for &lt; 3 seconds, attached the IV tubing to the PICC access port and started the medication flowing through the IV tubing, into Resident #4's arm. No hand hygiene or glove change was done during this process. LPN #4 stated they were unsure of when the last dressing change to Resident #4's PICC line site was done, a Registered Nurse (RN) changes the PICC dressings, LPNs cannot change them. LPN #4 stated the date on dressing is either 11 or 14. LPN #4 removed their PPE, washed their hands in Resident #4's bathroom sink, then exited Resident #4's room.</p> <p>During a concurrent observation and interview on 03/19/2026 at 9:54 AM, LPN #4 donned PPE and no hand hygiene was performed, prior to entering Resident #4's room. The Treatment Nurse (TN) was in Resident #4's room standing at the resident's bedside wearing blue gloves. Resident #4's PICC line site was not covered; the dressing had been removed. Resident #4 was not wearing a mask and was looking at their open site. LPN #4 administered Resident #4's oral medication, disconnected tubing from the resident's PICC line, wiped the access port of Resident #4's PICC line with an alcohol pad for three seconds, and flushed the access port with a 0.9% Sodium Chloride 10 cc syringe. The TN stated they were responsible for bandage changes, treatments, and PICC line dressing changes and believed Resident #4's PICC was changed Wednesday [03/11/2026] or Thursday [03/12/2026] of last week. The TN then reported the dressing removed from Resident #4's PICC line today, was marked as the 14th but did not have the dressing that was removed as it was in the trashcan. The TN reported Resident #4's dressing change was due yesterday [03/18/2026], but the dressing was not available and had to be ordered from the pharmacy and the dressing needed to be changed every seven (7) (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>days. The TN stated the TAR was signed by the nurse completing the dressing change, after dressing changes were completed.</p> <p>A review of Resident #4's Nsg [Nursing] - I&amp;A [Incident and Accident] Note, dated 03/19/2026 at 10:59 AM, signed by APN, indicated an incident description of A dressing change for a PICC line not performed on the day ordered 03/19/2026. Immediate intervention indicated the dressing was changed on 03/19/2026, with no signs or symptoms of infection observed.</p> <p>During an interview on 03/19/2026 at 1:44 PM, LPN #4 stated the process for providing medication to Resident #4 was to, knock on the door and I gown up and glove. I usually go in and do [pronoun] BP and give [pronoun] pill. LPN #4 stated, I have two pair [of gloves] on and I pull the top pair off, I clean the site, I flush it and wipe the tip [referring to the access port] off, start IV medication and when done, wipe it [access port] off again and flush. LPN #4 stated the purpose of double gloving was, So I don't have to keep changing it [gloves] and it was not the facility's policy to double glove. LPN #4 stated hand hygiene should have been performed after removing their gloves and donning new ones. LPN #4 could not respond to length of time the PICC line access should be scrubbed and stated they would obtain an answer.</p> <p>On 03/19/2026 at 2:02 PM, LPN #4 entered the conference room and stated, I should have cleaned [PICC line access port] hub with an alcohol pad for at least 15 seconds.</p> <p>During an interview on 03/19/2026 at 2:13 PM, the TN stated Resident #4's PICC dressing was removed prior to LPN #4 entering the resident room. The TNs dirty gloves and Resident #4's old PICC dressing, that had been removed by TN, were disposed of in the trash. The PICC dressing kit was opened and sterile gloves were donned. The TN pointed out the sterile gloves in an unopened PICC dressing kit and described the sterile gloves as blue in color. The TN revealed the PICC dressing kits were kept on hand in the past, and now the pharmacy would only send 2-3 kits at a time. No particular nurse or person was responsible for ordering the dressing kits, they were ordered by anyone that would be changing the dressing, and knowing this one was the last one, I ordered. The TN revealed she had changed Resident #4's PICC dressing 2-3 times, since the resident's admission on [DATE].</p> <p>During an interview on 03/19/2026 at 3:00 PM, the Advanced Practice Nurse (APN) stated she expected the nurses to keep PICC sites and access ports sterile/clean during administration of medications and flush to prevent cross contamination, and for the nurses to change gloves and wash their hands. One set of gloves should be used, removed and hands washed, then put on a new pair of gloves. Staff should not double glove.</p> <p>A review of Resident #4's Progress Notes dated 03/19/2026 at 8:14 PM, revealed an APN note assessment of Resident #4's PICC line that was done, with no evidence of improper cleansing of the resident's medication administration ports. There were also no health-related concerns with Resident #4's PICC line dressing change on 03/14/2026 or 03/19/2026, and any errors related to the dressing appears documentation related. with instruction to monitor and notify of any changes in Resident #4's condition.</p> <p>During an interview on 03/20/2026 at 9:10 AM, the Administrator provided an unlabeled package that contained a cap used for PICC lines, and stated the cap eliminated the need to sanitize the PICC line access. The Administrator also provided a file folder that contained documentation on Proper Access of Central Venous Catheter, a policy and procedure on infection control, medication administration, medication and treatment orders, donning and doffing PPE, progress note, and an In-service Education (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Report dated 03/20/2026, with a topic of Infection Control while managing PICC lines. The folder had a handwritten note indicating a one-on-one with LPN #4 was conducted, observation rounds were to be done to ensure treatments were completed per orders, nurse practitioner assessed resident, lab comparison done. The Centers for Disease Controls (CDCs) recommendation of at least 5 second scrub, Curoso product eliminates scrub, continued use of Curoso and scrub for 15 seconds per recommendation. The Administrator stated the expectation of staff was to document care, medication administration, follow physician orders, and follow infection prevention practices to prevent infections. One on one in-service education on PICC line infection control was done with LPN #4 on 03/20/2026.</p> <p>During an interview on 03/20/2026 at 1:53 PM, the Director of Nursing (DON) stated staff should wear only one set of gloves, drop things in the trash bag, remove the bag from the trash can and put in a red bag and wash their hands. Cleaning the PICC port should be done for 15 seconds with alcohol swabs, even if they have the medicated caps. Medicated caps were in a drawer, and we are looking but cannot find the box. that contained the unlabeled caps. The IV tubing should not be opened while wiping the port access, and you would want to have the dressing in place before starting the medication to prevent risk of infection.</p> <p>A review of a facility provided document titled, Inservice Education Report, dated 03/20/2026, addressing Infection Control while managing PICC lines, indicated needless access device should be disinfected using a disinfecting wipe for at least 15 seconds, allowed to air dry. Use only the [NAME] caps. These are Curoso Disinfecting Caps for Needleless Connectors that alleviate the need for vigorous scrubbing. Additional education included notification of nursing administration if PICC line dressings were changed PRN on an unscheduled day so schedule for routine changes may be adjusted as necessary, and document the change on the MAR and in the progress notes. Maintain hand hygiene to avoid potential contamination. always sanitize or wash hands after discarding items and before donning clean or sterile gloves. The in-service document was unsigned.</p> <p>A review of an undated CDC facility provided document titled, Sequence for Donning Personal Protective Equipment (PPE), instructed use of PPE varied with level of precautions required and donning PPE in order of gown, mask, goggles, gloves. To use safe work practices to protect self and limit the spread of contamination included, keep hands away from face, limit surfaces touched, change gloves when torn or heavily contaminated, preform hand hygiene.</p> <p>A review of a document titled, 3M Curoso Disinfecting Port Protectors Implementation Guide, revealed, on page 40 of 112, Page 15: A. Sequential Scrub - . has been in place for more than 1 minute., there is no need to scrub upon removal of the cap. In addition, you should scrub if any of the following conditions are present: -Scrub between sequential accesses (i.e., Between multiple medications given in one sitting, such as Saline, Medication, Saline) . Scrub if you remove the cap and set down the port before accessing, if the port becomes contaminated, or if you leave an uncapped port unattended for any length of time. B. Sequential Aseptic. has been in place for more than 1 minute. there is no need to scrub upon removal of the cap. Maintain aseptic technique between sequential accesses (i.e. between multiple medications given in one sitting such as Saline, Medication, Saline). For a sequential access, you would remove the disinfecting cap, flush, maintain aseptic technique. give your medication, maintain aseptic technique. flush and then replace with a new Curoso Disinfecting Cap.</p> <p>A review of a policy and procedure titled, Handwashing/Hand Hygiene, revised October 2023, included a policy statement, This facility considers hand hygiene the primary means to prevent the spread of (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/20/2026
NAME OF PROVIDER OR SUPPLIER  Bailey Creek Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>healthcare-associated infections. The policy interpretation indicated all personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections. Hand hygiene is indicated, a. immediately before touching a resident; b. before performing an aseptic task (for example, handling an invasive medical device), after touching a resident or their environment and immediately after glove removal. The policy revealed, 5. The use of gloves does not replace hand washing/hand hygiene, and hand hygiene should be performed prior to applying and after removing gloves.</p>		