STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045288	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Chenal	3115 S Bowman Road Little Rock, AR 72211

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 - Few	Provide and implement an infection prevention and control program. Based on observations, record review, interview, and facility policy review, it was determined that the facility failed to ensure that staff maintained sterility during deep tracheal suctioning and failed to ensure staff performed proper hand hygiene while providing resident care for one resident, Resident #1 reviewed for tracheal suctioning and trach care. The findings include: During an observation on 12/03/2025 at 10:06 AM, this surveyor observed Licensed Practical Nurse (LPN) #1 and LPN #2 enter Resident #1's room to provide tracheal suctioning and trach care. Both LPNs performed hand hygiene and utilized Enhanced Barrier Precautions (EBP). While setting up a sterile field on the bedside table, some supplies fell off the table and onto the floor. LPN #1 and LPN #2 agreed to start over. LPN #1 obtained new supplies, and both LPNs performed hand hygiene. At this time, no sterile drape was applied to the bedside table. LPN #2 touched the inside of the solution cup with a bare hand. During donning of sterile gloves, LPN #2 touched the outside of both gloves with her bare hands, contaminating the gloves. While donning the sterile gloves, the left glove tore. LPN #2 removed the gloves, opened the bedside table drawer and reached in the drawer to obtain another pair of sterile gloves. She did not perform hand hygiene before donning the next pair of sterile gloves. LPN #2 touched the outside of the sterile gloves with her hands again while donning the gloves. LPN #2 opened a sterile package containing a sterile tracheal suction catheter inside a paper sleeve. She placed the paper sleeve, which contained the tracheal suction catheter, on the bedside table which allowed the green attachment area of the catheter to rest on the non-sterile table. LPN #2 then performed tracheal suctioning with the catheter which had made contact with the non-sterile table, while using the gloves which were contaminated and not sterile. She reached in the bedside drawer for more gloves and to obtain the disposable inner cannula. LPN #2 did not perform hand hygiene after touching objects in the drawer, nor before donning more sterile gloves. LPN #2 picked up the sterile package which contained the new inner cannula, touched the bare table with gloved hands, and touched the resident's gown with gloved hands before placing the new inner cannula. A review of Resident #1's Medical Diagnosis indicated the facility admitted Resident #1 on 10/21/2025, with diagnoses that included tracheostomy status, non-traumatic intracerebral hemorrhage, non-traumatic intracerebral hemorrhage intraventricular, acute respiratory failure with hypoxia, pneumonia, and Parkinsonism. A review of Resident #1's comprehensive Minimum Data Set (MDS) with an assessment reference date of 10/27/2025, revealed a Brief Interview for Mental Status score of 10, which indicated the resident had moderate cognitive impairment. Resident #1's MDS also indicated the resident was dependent on staff for all self-care abilities. A review of Resident #1's Care Plan, initiated on 10/22/2025, revealed the resident had a (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tracheostomy related to respiratory failure. Resident #1's Care Plan also included interventions, initiated on 10/22/2025, that directed staff to suction as needed/per physician orders. A review of Resident #1's Physician Orders revealed the resident had an order dated 11/07/2025 for EBP for a Percutaneous Endoscopic Gastrostomy tube and a trach, an order dated 12/02/2025 to suction tracheostomy tube every dayshift for patency or to keep the airway open, and an order dated 12/02/2025 for tracheostomy care every shift and every one hours as needed for prevention, infection, and skin breakdown. A review of Resident #1's Medication Administration Record/Treatment Administration Record for December, revealed the resident had tracheostomy tube suctioning scheduled at 7:00 AM to 7:00 PM every day shift, at 7:00 PM to 7:00 AM every night shift, and every one hours as needed for patency or to keep airway open. During an interview on 12/03/2025 at 10:58 AM, LPN #2 reported sterile gloves were to be used while providing tracheal suctioning. She reported it was important to provide tracheal care and suctioning with sterile technique, to prevent infection and added, it is a portal of entry to their (resident's) lungs. LPN #2 indicated there should have been a sterile barrier on the side table and added she thought she had put a barrier down. She relayed the tracheal suction catheter should not have been able to touch the bare bedside table. She then stated that proper hand hygiene should be performed before putting on gloves, and after taking off gloves. When asked if she performed hand hygiene during the observation of Resident #1's tracheal suctioning and trach care she replied, I did most of the time. During an interview on 12/03/2025 at 11:24 AM, LPN #1 indicated it was important to maintain sterility during tracheal care and suctioning to protect the resident from infection. She reported providing tracheal care and suctioning was a sterile procedure, and that if a nurse broke the sterile field, the nurse should start over. She reported that an opened tracheal suction catheter should not be placed on a bedside table, without a sterile barrier in place. LPN #1 reported hand hygiene should be performed before gloves are put on, and after gloves are removed, every time. During an interview on 12/04/2025 at 10:14 AM, the Nurse Practitioner (NP) indicated tracheal suctioning was a sterile procedure and reported it was important to maintain sterility during tracheal suctioning and care to decrease infection. She then stated that the tracheal suction catheter should not touch a non-sterile side table. The NP indicated proper hand hygiene included washing hands before placing gloves and washing hands after removing gloves, to decrease transmission of bacteria from one patient to another patient. During an interview on 12/04/2025 at 11:49 AM, the Assistant Director of Nursing (ADON) reported handwashing was the number one way to spread infection. She reported hand hygiene should be performed before gloves were put on and after gloves were taken off. She reported tracheal suctioning is a sterile procedure and a sterile object should not be placed on a non-sterile field. The ADON indicated if a nurse broke the sterile field, the nurse should have started over. During an interview on 12/04/2025 at 12:17 PM, the Director of Nursing (DON) indicated a tracheal suction catheter should not be placed on a non-sterile bed side table. She reported it was important to perform hand hygiene for infection control and to protect the resident from infection. She then reported staff should perform hand hygiene before putting on gloves and after taking off gloves. The DON indicated tracheal suctioning was a sterile procedure, and that it was important to maintain sterility during tracheal suctioning to prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled, Tracheostomy Care indicated aseptic technique (a method that prevents contamination in a sterile environment) must be used during tracheostomy tube changes and during tracheostomy dressing changes. A review of a facility policy titled, Training for Tracheostomy and Care and Management indicated while suctioning, dominant hand remains sterile.and will be inserting the catheter. A review of a facility policy titled, Handwashing/Hand Hygiene, revised on 08/01/2019, indicated, All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Step 7 indicated staff to use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: f. before donning sterile gloves, g. before handling clean or soiled dressings, k. after handling contaminated equipment, l. after contact with objects in the immediate vicinity of the resident, m. after removing gloves.