

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Dardanelle Nursing and Rehabilitation Center,inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2199 State Hwy 7 North Dardanelle, AR 72834	

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 - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50505</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, the facility failed to ensure proper hand hygiene was performed and enhanced barrier precautions were followed for 2 (Residents #7 and #68) of 2 sampled residents reviewed for enhanced barrier precautions (EBP).</p> <p>Findings include:</p> <p>The Administrator provided an article from the Centers for Disease Control (CDC) titled, Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities dated 06/01/2021, which indicated residents may be placed on EBP when wounds or indwelling medical devices are present.</p> <p>A review of a policy titled Handwashing/Hand Hygiene, dated 11/22/2017, indicated the facility considers hand hygiene the primary way to prevent infections and that all personnel should follow the procedures for handwashing and hand hygiene.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #68 with diagnoses that included dementia, mild without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, retention of urine, and immunodeficiency due to conditions classified elsewhere.</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/19/2024, revealed Resident #68 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. At the time of the admission MDS, Resident #68 was frequently incontinent of urine.</p> <p>A review of Resident #68's Care Plan, initiated on 08/21/2024, revealed the resident has an indwelling catheter for urinary retention. Interventions included enhanced barrier precautions related to the indwelling catheter.</p> <p>A review of the Order Summary Report for Resident #68 revealed the Resident #68 had an order for enhanced barrier precautions with a start date of 08/16/2024 and 08/20/2024 related to indwelling urinary catheter every shift.</p> <p>(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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 08/27/2024 at 8:40 AM, the surveyor knocked on Resident #68's door, response was given resident care. Upon entering the resident's room, the privacy curtain was pulled to prevent resident from being exposed. The Director of Nursing (DON), and Certified Nursing Assistant (CNA) #5 were observed not wearing gloves or a gown while working with Resident #68. The resident was rolled to one side and CNA #5 straightened the linens under the resident, CNA #5 was on the right side of the bed and the DON was on the left side. Once CNA #5 fixed the right side of the bed, the resident was assisted to turn facing the right side, the DON then straightened the left side of the bed. The DON then moved the indwelling catheter bag, adjusted the catheter, and situated the leg band which held the catheter tubing in place. The DON then straightened Resident #68's gown and CNA #5 pulled the covers over the resident. Without sanitizing her hands, the DON then straightened items on the over-the-bed table, then moved the table closer to the resident. Once the task was completed, the DON and CNA #5 walked over to the door and sanitized their hands using the alcohol gel sanitizer dispenser prior to leaving Resident #68's room.</p> <p>During an interview on 08/27/2024 at 8:55 AM, CNA #5 was asked what should you have put on prior to providing catheter care on to Resident #68. CNA #5 responded, A gown and gloves.</p> <p>During an interview on 08/27/2024 at 8:56 AM, the DON was questioned as to what should have been done prior to providing care when dealing with an indwelling urinary catheter. The DON stated that enhanced barrier precautions should have been followed, including gowns and gloves. The DON reported that Resident #68 had recently received the indwelling urinary catheter and as soon as the catheter bag was touched, it was then she realized that enhanced barrier precautions had been forgotten. The DON confirmed that the gown signage would be on the door frame and that supplies should be within reach of those on Enhanced Barrier Precaution.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #7 with diagnoses that included: nontraumatic intracerebral hemorrhage in brain stem and gastrostomy status.</p> <p>The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/24/2024, revealed Resident #7 had a memory problem per staff interview. Section K0520 Nutritional Approaches was marked as Resident #7 having a feeding tube. Resident #7 is dependent on staff for all activities of daily living.</p> <p>A review of Resident #7's Care Plan, initiated on 09/24/2020 and revised on 05/03/2024, revealed the resident required tube feedings related to dysphagia (difficulty swallowing), vitamin deficiencies, and was obese with body mass index of 36.0-36.9. On 7/29/2021 the resident failed a swallow study. Interventions included: enhanced barrier precautions.</p> <p>A review of the Order Summary Report revealed that Resident #7 had an order for enhanced barrier precautions related to gastrostomy status every shift with a start date of 04/05/2024.</p> <p>(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 - Some</p>	<p>During an observation on 08/28/2024 at 1:40 PM, Licensed Practical Nurse (LPN) #1 was preparing to administer medications to Resident #7. LPN #1 sanitized her hands then took a bottle of Phenytoin (a seizure medication) out of the medication cart and shook the bottle to mix, she then used a syringe to draw up three milliliters (ml) of the Phenytoin solution to equal 75 milligrams (mg). LPN #1 then added the solution to a small amount of water and stirred the mixture. LPN #1 sanitized her hands with alcohol gel, LPN #1 put on an isolation gown, a pair of gloves and took a stethoscope and a towel from the top of the medication cart, knocked on Resident #7's door and entered the room. LPN #1 pulled the privacy curtain around the bed, went over to the window and closed the miniblinds with her gloves on. LPN #1 went back to Resident #7, explained what was going to be done, LPN #1 raised the resident's gown and unfastened the abdominal binder to expose the feeding tube. LPN #1 placed the towel below the tube and used a piston syringe filled with 10 ml of air, placed the tip of the syringe into the feeding tube port, placed the stethoscope on Resident #7's abdomen to auscultate/listen for the gurgle from the air being pushed into the feeding tube. Once the gurgle was heard, LPN #1 removed the syringe from the feeding tube, removed the plunger, then placed the syringe back into the feeding tube. LPN #1 flushed with 30 ml of water, once it was delivered, she added the medication mixture, then flushed with 30 ml of water after the medication was delivered. LPN #1 removed the syringe, placed it on a towel, placed the cap back on the feeding tube and placed the abdominal binder back on the resident and pulled the gown down. The syringe was then washed and left to dry. LPN #1 removed her gown and gloves and sanitized her hands before leaving the room.</p> <p>During an interview on 08/28/24 at 3:35 PM, the Director of Nursing (DON) indicated that LPN #1 should have sanitized her hands and put on new gloves after touching the privacy curtain, the mini blinds, and removing the abdominal binder prior to administering the medications through the tube.</p> <p>During an interview on 08/29/24 at 10:12 PM, LPN #1 was asked what should have been done before giving the medications through the feeding tube. LPN #1 indicated that gloves should have been changed and before putting on new gloves, her hands should have been washed or sanitized.</p>		