

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045304	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/18/2024
NAME OF PROVIDER OR SUPPLIER  Beebe Retirement Center, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE  709 McAfee Lane Beebe, AR 72012	

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 policy review, it was determined that the facility failed to ensure proper hand hygiene before, during, and after medication pass for 2 (Resident #6 and #132) residents and failed to ensure enhanced barrier precautions were being followed for a resident with a feeding tube for 1 (Resident #59) of 1 resident reviewed for enhanced barrier precautions.</p> <p>The findings are:</p> <p>1. A review of the Admission Record, indicated the facility admitted Resident #59 with gastrostomy status (placement of a feeding tube).</p> <p>a. The quarterly Minimum Data Set with an Assessment Reference Date of 06/29/2024 revealed Resident #59 had a feeding tube and received a mechanically altered diet and a therapeutic diet.</p> <p>b. A review of the Care Plan revealed Resident #59 requires enhanced barrier precautions related to peg tube status. (Initiated 04/11/2024). Interventions include: 1) Alcohol based hand-rub or wash with soap and water if visibly soiled before and after leaving the room. 2) Follow facility policies and procedures for cleaning and disinfection of medical equipment and devices. All shared equipment must be cleaned between patients. 3) Wear gloves and a gown for high-contact resident care activities.</p> <p>c. A review of Resident #59's Order Summary Report, indicated Resident #59 was on Enhanced Barrier Precautions related to peg tube status.</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>d. During an observation on 07/16/2024 at 8:47 AM, Licensed Practical Nurse (LPN) #1 was gathering supplies to start medication administration for Resident #59. LPN #1 started removing medications from the over-the-counter pill bottles without sanitizing his hands and placing them in a small plastic medicine cup. LPN #1 placed the pill cup containing the medications in the top of the medication cart, locked the cart and left to get syringes and a blood pressure cuff. At 8:51 AM, LPN #1 returned to the medication cart, and without sanitizing his hands he went into Resident #59's room without putting on a gown or gloves. LPN #1 informed the resident that the resident's blood pressure needed to be obtained. LPN #1 removed the covers off the resident to place the blood pressure cuff on the resident. LPN #1 went back to the cart, sanitized his hands and unlocked the medication cart and took out the medication cup. LPN #1 removed medications from Resident 59's pill cards and into the medication cup. LPN #1 placed the medicine cup back into the top drawer of the medication cart, locked the cart, and left to go look for the pill needed for the blood pressure. LPN #1 returned to the medication cart, sanitized his hands, applied gloves and prepared a medication in a syringe. LPN #1 returned the medication bottle to the bottom drawer of the medication cart. LPN #1 crushed the medications, gathered the medications and diabetic formula and a nine ounce drinking cup. LPN #1 walked into Resident #59's room, placed the items on the nightstand, and shut the door to the room. LPN #1 pulled the privacy curtain and went to the bathroom to get tap water, grabbed a towel, and sat down in a chair beside the bed. LPN #1 did not remove his gloves or sanitize his hands. LPN #1 did not wear an isolation gown while providing care to Resident #59. LPN #1 moved Resident #59's gown, exposed the feeding tube, placed the stethoscope on the upper abdomen to check for placement. LPN #1 placed a towel under the feeding tube, flushed the feeding tube with water, and then administered the medications and diabetic formula via the feeding tube. LPN #1 then flushed the feeding tube with water. The syringe was removed from the feeding tube, the towel was removed from under the feeding tube, the resident's gown was pulled back down and then LPN #1 covered the resident. LPN #1 gathered the used supplies and disposed of them in the bathroom trash. With the same gloves on, LPN #1 washed the syringe used for the feeding tube and placed it in the syringe bag, he then removed his gloves and washed his hands.</p> <p>2. During an observation on 07/17/2024 at 8:12 AM, Registered Nurse (RN) #2 did not sanitize hands prior to preparing to administer medications for Resident #132. After pouring a high calorie supplement into a plastic cup, RN #2 punched medications from medication cards and placed them in a small plastic medicine cup. RN #2 knocked on resident's door and entered the room. Without sanitizing her hands, she administered the medications to Resident #132.</p> <p>3. During an observation on 07/17/2024 at 8:24 AM, RN #2 did not sanitize her hands prior to preparing medications for Resident #6. Resident #6's medications were placed in a small medication cup. RN #2, placed the medication cup in the top drawer of the medication cart, locked the cart, and stated that there were no lidocaine patches on the medication cart, and she would need to go get them. RN #1 returned to the medication cart, unlocked the cart. Without sanitizing her hands, she opened the cart, put the medications back on top of the cart, grabbed tissues, started looking for gloves, and stated I thought I was prepared. RN #2 poured water into a nine ounce plastic drinking cup, gathered supplies and went into Resident #6's room, and handed the resident an inhaler. Resident #6 self-administered the inhaler then handed RN #2 the inhaler. Without sanitizing her hands, RN #2 put on gloves, and administered eye drops to both of Resident #6 's eyes. RN #2 removed her gloves and handed the resident the plastic medication cup. Resident #6 took the medications without difficulty. RN #2 then put on gloves, without sanitizing hands and administered more eye drops.</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>4. A review of a facility policy titled, Policies and Practices-Infection Control, revised October 2018, indicated The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections .</p> <p>5. A review of a facility policy titled, Handwashing/Hand Hygiene, revised October 2023, indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .</p> <p>6. During an interview on 07/18/2024 at 12:19 PM, RN #2 confirmed that hands should be washed prior to starting medication preparation, when anything dirty or soiled is touched, upon entering the resident's room, when changing gloves, after removing gloves and before leaving the resident's room.</p> <p>7. During an interview on 07/18/2024 at 11:30 AM, the Director of Nursing (DON) confirmed that enhanced barrier precautions (EBP) would be treated like other isolation precautions regarding what personal protective equipment is used. The DON confirmed a tube feeder would be on EBP, and that staff would wear gloves when taking care of the resident and the feeding tube. The DON confirmed that hand hygiene should be performed before entering or exiting a resident's room, anytime hands are soiled, before gloves are applied and after removing gloves and anytime something dirty is touched.</p> <p>8. During an interview on 07/18/2024 at 1:18 PM, Licensed Practical Nurse (LPN) #1 was asked what Enhanced Barrier Precautions meant and LPN #1 replied, I would have to put on a gown and gloves. LPN #1 also confirmed that with a tube feeder, enhanced barriers precautions should be followed. He stated I would have to put on gown and gloves, and I forgot to do that. I am still not used to doing that. LPN #1 confirmed that hands should be sanitized during medication pass or tube feeding and said anytime I have touched something dirty with my hands or my gloved hands, and before and after leaving the resident's room and after removing my gown and gloves.</p>		