

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Southern Trace Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22515 I 30 Bryant, AR 72022	

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>Provide and implement an infection prevention and control program.</p> <p>37634</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure staff wore an isolation gown when providing care for 1 (Resident #5) of 1 (Resident #5) sampled residents that were on contact isolation, and the facility failed to ensure a contact isolation sign was put outside the door of 1 (Resident #5) of 1 (Resident #5) sampled resident to alert the staff to apply PPE before providing care. This failed practice had the potential to spread infections throughout the facility.</p> <p>The findings are:</p> <p>A review of Resident #5's Order Summary Report revealed a diagnosis of elevated white blood cell count, sepsis, unspecified open wound to right lower leg, unstageable pressure ulcer of left heel, pressure ulcer of sacral region, bacteremia, and extended spectrum beta lactamase (ESBL).</p> <p>The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/18/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS indicated that Resident #5 had a wound and a blood infection.</p> <p>A review of a physician order dated 10/28/2024 indicated Resident #5 had an unstageable pressure ulcer to her sacrum, a deep tissue injury to her left heel, and a wound vac.</p> <p>A review of Resident #5's care plan initiated 10/15/2024 revealed the resident had stage 3 pressure ulcer to her left buttocks, unstageable pressure ulcers to her sacrum and right buttocks, deep tissue injury to her left heel, and a surgical wound. A care plan initiated on 10/17/2024 indicated Resident #5 had a surgical wound infection of the right thigh. Intervention was to provide isolation precautions.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Southern Trace Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22515 I 30 Bryant, AR 72022	
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>A review of a form titled, Transmission Based (Isolation) Precautions indicated Signage that includes instructions for the use of specific PPE will be placed in a conspicuous location outside the resident's room. Contact precautions are intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. The form indicated that gowns should be worn for residents on contact isolation. The form indicated that gowns should be worn whenever anticipating that clothing will have direct contact with a patient and potentially contaminated environmental surfaces or equipment near the patient. The form indicated that a gown should be applied upon entering the room.</p> <p>During an interview on 11/19/24 at 1:39 PM Resident #5 indicated having a wound vac for a long time.</p> <p>On 11/19/24/2024 at 1:55 PM Certified Nurse Aide (CNA) #1, and CNA #2 applied the straps to the mechanical lift and raised Resident #5 to the bed. CNA #1 and CNA #2 did not have on an isolation gown when Resident #5 was transferred with the mechanical lift.</p> <p>On 11/19/24 at 2:40 PM CNA#1, and CNA #2 provided incontinent care for Resident #5. There was an open area to the right side of Resident #5 buttocks. CNA #1 and CNA #2 did not have on a gown while providing incontinent care to Resident #5. There were no signs on the door indicating that Resident #5 was on precautions. There was no PPE placed near Resident #5's room. There were no trash bins in Resident #5's room to discard used isolation gowns.</p> <p>On 11/20/2024 at 8:25 AM, CNA #2 indicated she was not sure how long Resident #5 had been on precautions. She indicated no one informed her she had to wear a gown when she provided care for Resident #5. CNA #2 indicated that the isolation sign was not on the door yesterday, and today is the first day she has seen the sign on the door.</p> <p>During an interview on 11/20/2024 at 8:30 AM, the Infection Control Nurse indicated that she's been the Infection Control Nurse for 8 years. She indicated that Resident #5 was on contact isolation for ESBL in her urine. The treatment nurse indicated Resident #5 had surgical wounds, and she's not sure why the sign for contact isolation was not on the door. The Treatment Nurse indicated that Resident # 5 should not be on Enhanced Barrier Precautions because the resident was on contact isolation. The Treatment Nurse indicated she did not know when Resident #5 moved rooms, and the charge nurse that moved the resident was responsible for moving the isolation signs.</p> <p>During an interview on 11/20/2024 at 8:40 AM the Director of Nurse (DON) indicated Resident #5 moved to a different room on 11/15/2024. The DON indicated that Licensed Practical Nurse #3 was the nurse in charge of moving Resident #5. She indicated it was an oversight that the isolation sign wasn't moved to Resident #5's new room.</p> <p>During an interview on 11/20/2024 at 12:20 PM, the Treatment Nurse indicated Resident #5 had been on contact isolation since admission. The Treatment Nurse indicated that she had been going to the supply closet to get a gown when she provided wound care for Resident #5. The Treatment Nurse indicated she didn't think about the signage for contact isolation, and the PPE being nearby.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Southern Trace Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22515 I 30 Bryant, AR 72022	

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>On 11/20/2024 at 1:20 PM Resident #5 indicated today is the first day the staff have worn gowns when they provide care to her.</p> <p>During an interview on 11/20/2024 at 1:26 PM, CNA #1 indicated that the contact isolation sign was on Resident #5's door this morning. She indicated she did not see a contact isolation sign on the resident door on 11/19/2024.</p> <p>A review of an Infection Surveillance Monthly Report dated 10/16/2024 revealed Resident #5 had ESBL.</p>