STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045306	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Hillcrest	1421 West Second St North Prescott, AR 71857

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50682 Based on observation, record review and interview, the facility to ensure the dignity and privacy of 2 (Residents #187 and #438) residents. The findings are: 1. A review of the Medical Diagnosis indicated Resident #438 had diagnoses of: Urinary tract infection, heart failure, and Lymphedema (swelling in the body due to a buildup of fluid) . The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/28/2024 indicated a Brief Interview for Mental Status Score (BIMS) of 7 (0-7 suggests severe cognitive impairment) and Resident #438 was admitted with an indwelling catheter. a. On 05/20/2024 at10:31 AM, an indwelling catheter bag was hanging from the bedside with no privacy bag. b. On 05/20/2024 at 02:00 PM, an indwelling catheter bag was hanging from the bedside with no privacy bag. c. On 05/21/2024 at 9:30 AM, an indwelling catheter bag was hanging from the bedside with no privacy bag. d. On 05/22/2024 at 9:20 AM, the Surveyor asked Certified Nursing Assistant (CNA) #1 if the indwelling catheter bag should always have a privacy bag. CNA #1 stated the catheter bag should have been in a privacy bag. e. On 05/22/2024 at 9:20 AM, the Surveyor asked the Infection Preventionist (IP) if an indwelling catheter bag should always have a privacy bag. The IP stated there should always be a privacy bag to protect the resident's dignity. f. On 05/22/2024 at 11:30 AM, the Director of Nursing (DON) was interviewed, and the Surveyor asked the DON if a privacy bag should be used to cover an indwelling catheter bag and if so, why would it be needed. The DON stated a privacy bag should remain in place to cover the catheter bag while maintaining a resident's dignity. 47916 (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #187 had diagnoses of acute kidney failure, acute cystitis (an infection of the bladder), and urinary tract infection. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/14/2024 was in process. a. On 05/20/2024 at 01:30 PM, the Surveyor observed Resident 187's uncovered indwelling catheter bag draining yellow urine from the open doorway. b. On 05/20/2024 at 04:18 PM, the Surveyor observed Resident #187 resting quietly with the door open. The indwelling catheter was observed draining yellow urine facing the open doorway. c. On 05/22/2024 at 11:10 AM, a policy titled Dignity documented, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1.Residents are treated with dignity and respect at all times . d. On 05/21/2024 at 08:00 AM, the Surveyor observed Resident #187 resting quietly, with the indwelling catheter facing the wall. The Surveyor asked Registered Nurse (RN) #7 to observe Resident #187's indwelling catheter and asked what their procedure was for providing catheter care. RN #7 said that Resident #187 is new to the facility, and she (RN #7) places the catheter in a bag as soon as it is noticed. The Surveyor asked why the facilities policy was to put catheter bags in a privacy bag, and RN #7 said, It is a dignity issue. RN #7 confirmed Resident #187's indwelling catheter should be in a privacy bag. e. On 05/22/2024 at 11:30 AM, the Director of Nursing (DON) was asked what procedures were staff expected to follow when caring for a resident with a catheter. The DON told the Surveyor staff are expected to place catheters in a privacy bag to protect the dignity of the residents. f. On 05/22/2024 at 04:00 PM, the DON provided a policy titled, Catheter Care, Urinary, the policy did not address privacy bags.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 48977 Based on observation, interviews, and facility policy review, the facility failed to protect the privacy and dignity of 1 (Resident 41) sampled resident when providing wound care. The findings include: 1. Resident #60 had the diagnoses of Diabetes due to underlying condition with diabetic nephropathy (kidney damage caused by diabetes). a. Resident #60 had a Physicians Order for treatment to cleanse the left heel with wound cleanser, pat dry, apply wound gel to wound bed cover with a silicone dressing daily and as needed. b. The Quarterly Minimum Data Set with an Assessment Reference Date of 03/08/2024 documented Resident #60 scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status. c. A Care Plan, revision on: 04/18/2024 noted Resident #60 had a deep tissue injury (DTI) to the left heel. d. On 05/20/2024 at 09:21 AM, the Surveyor observed staff at the Resident #60's bedside with the left foot raised up exposing the wound to the heel, the curtain was not pulled, and the door was open. e. On 05/20/2024 at 09:23 AM, the Treatment Nurse confirmed that the resident's privacy was not maintained. f. On 05/23/2024 at 08:20 AM, the Director of Nursing (DON) voiced that to maintain a resident's privacy the door should be closed and/or curtain pulled. g. On 05/22/24 at 11:10 AM, a policy titled, Dignity documented, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. 1.Residents are treated with dignity and respect at all times .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 49413 Based on observation, record review and interviews, the facility failed to ensure the care plan included oxygen therapy and Continuous Positive Airway Pressure (CPAP) as ordered by a physician. The findings are: On 04/19/2024, Resident #8 had a diagnosis of Acute and Chronic Respiratory Failure with Hypoxia, and Dependence on Supplemental Oxygen. The Admission Minimum Data Set (MDS) with an Assessment Reference Date of 05/06/2024 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status and received Oxygen therapy and a Non-invasive Mechanical Ventilator. a. Review of the Medication Administration Record for May 2024 showed, .Oxygen every 1 hours as needed for Shortness of Breath related to Dependence on Supplemental Oxygen @ 3 Liters . -Start Date-04/19/2024 . b. Observations on 05/20/2024 at 1:02 PM; 05/21/2024 at 9:07 AM; and 05/22/2024 at 1:42 PM, noted Resident #8's oxygen concentrator was set at 3.0 liters per minute. At 1:44 PM, Licensed Practical Nurse (LPN) #6 confirmed Resident #8's oxygen concentrator was set at 3.0 liters per minute. At 3:00 PM, the MDS Coordinator LPN confirmed the care plan revision of 5/13/2024 did not contain either oxygen therapy or the use of a CPAP. c. On 05/23/2024 at 12:06 PM, the Director of Nursing (DON) provided a CPAP/BiPAP Support policy which showed, .To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen . To promote resident comfort and safety .Only a qualified and properly trained nurse or respiratory therapist should administer oxygen through a CPAP mask .Review the resident's medical record to determine his/her baseline oxygen saturation or arterial blood gases (ABGs), respiratory, circulatory, and gastrointestinal status .Review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure (CPAP, IPAP, and EPAP) for the machine .Connect supplemental oxygen . and adjust flow rate as prescribed . d. On 05/23/2024 at 12:06 PM, the DON provided an Oxygen Administration policy which showed, .Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences .Oxygen is administered under orders of a physician, except in the case of an emergency .The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: The type of oxygen delivery system .Equipment setting for the prescribed flow rates .Staff shall notify the physician of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47916 Based on observation, record review and interview, the facility failed to ensure the rear casters/wheels were kept in the unlocked position when lifting and lowering residents when using a patient lift for 3 (Residents #11, #17, and #36) residents to prevent accidental falls and injury; failed to ensure damaged, or frayed lift pads were removed from service for 1 (Resident 17) resident who had an order for mechanical lift assistance; and failed to ensure chemicals were safely stored to prevent potential harm to 8 (Residents #5, #7, #8, #20, #26, #36, #56, #58) residents who ambulated or self-propelled in the facility. The findings are: 1. Resident #11 had diagnoses of Alzheimer's disease, bipolar disorder, and urinary tract infection. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/19/2024 indicated a Brief Interview for Mental Status (BIMS) score of 03 (0-7 suggest severe cognitive impairment). a. A Care Plan (Revised, 11/17/2022) documented, [Resident #11] has an ADL [activities of daily living] self-care performance deficit related to Alzheimer's . Total 2 (two) Person Assist by Mechanical Lift .with use of Blue lift pad . b. On 05/20/2024 at 10:52 AM, the Surveyor observed Nursing Assistant (NA) #11, and Certified Nursing Assistant (CNA) #2 placed a manual lift in the open leg position around Resident #11's chair. CNA #2 placed the rear casters/wheels in the locked position and lift pad was connected to the spread bar. Resident #11 was raised up in the air while the rear casters/wheels remained locked, then the rear wheels were unlocked, and Resident #11 was rolled over to the resident's bed to be changed. c. On 05/20/2024 at 11:14 AM, with the lift pad in place, and rear casters/wheels in the locked position the Surveyor observed Resident #11 placed back into the wheelchair. NA #11 and CNA #2 were asked to provide the purpose of locking the rear casters when lifting and lowering a resident in a mechanical lift. CNA #2 told the Surveyor that the wheels were locked for safety to keep the lift from moving while lifting a resident. NA #11 was asked if she had been in-serviced on the lift and the NA #11 told the Surveyor that she had been in-serviced on the lift. The Surveyor asked her to walk the Surveyor through the process of lifting and lowering a resident. NA #11 told the Surveyor that they roll the lift to the wheelchair with the legs open for stability. The wheels are locked, and the left pad is attached to the lift. The resident is lifted, then the tires are unlocked, and the resident is rolled to their bed, the tires are locked, and they are lowered. NA #11 confirmed that the rear casters or wheels are locked when lifting or lowering a resident to keep the lift from rolling for their safety. 2. Resident #17 had diagnoses of End stage renal disease, Legal blindness, and Atrial fibrillation. The Quarterly MDS with an ARD of 03/08/2024 indicated a BIMS score of 06 (0-7 suggest severe cognitive impairment). a. On 05/20/2024 at 02:55 PM, the Surveyor observed Resident #17 sitting on a blue, fraying lift pad when the resident returned from dialysis. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 05/20/2024 at 03:45 PM, the Surveyor observed CNA #12 and CNA #13 push Resident #17's wheelchair under the lift with legs in the open position and attach the lift pad to a mechanical lift. CNA #14 locked the rear casters and began to lift Resident #17 up. The Surveyor asked what the reasoning was behind locking the rear casters/wheels on the lift. CNA #14 told the Surveyor so they will not go anywhere while lifting or lowering the resident. All three CNA's (CNAs #12, #13, and #14) confirmed it was for safety. The Surveyor asked CNA #14 to stop while using the mechanical lift and describe Resident 17's lift pad. CNA #14 said, Damaged. The Surveyor asked what the process was for removing damaged lift pads from circulation. CNA #13 said she did not know for sure. The Surveyor asked if the lift pad should be replaced or was it safe to use. CNA #13 told the Surveyor that the person who put Resident #17 in the chair to go to dialysis should not have used the lift pad, and the resident was not able to be moved in a way to replace the lift pad so they would have to use it to put Resident #17 back to bed. c. On 05/21/2024 at 09:59 AM, while interviewing Laundry the Surveyor observed a lift pad resting in a stack of clean lift pads with obvious fraying. The Surveyor asked what the process was for removing damaged or frayed lift pads from service. Laundry told the Surveyor that if lift pads have a hole or something in them, the lift pads will be shown to a supervisor and the DON would have the final say. 3. Resident #36 had diagnoses of left below the knee amputation, cerebral infarction, and end stage renal disease. The Quarterly MDS with an ARD of 03/26/2024 suggested a BIMS score of 14 (13-15 suggest cognitively intact). a. A Care Plan (Revision, 12/30/2023) documented, Resident #36 has an ADL self-care performance deficit related to decline in independence in ADLs, transfers and mobility . Resident #36 requires Mechanical Lift with 2 staff assistance for transfers . b. On 05/20/2024 at 03:28 PM, CNA #12 placed the mechanical lift around Resident #36's specialty chair while CNA #13, and CNA #14 assisted in attaching the lift pad to the mechanical lift on the first and last hooks. CNA #12 locked the rear casters/wheels, and the resident was lifted off of the chair. CNA #12 unlocked the rear casters/wheels and Resident #36 was rolled over the bed. CNA #13 lowered Resident #36 to the bed without locking the rear casters/wheels. The Surveyor asked CNA #12 about the process for lifting and lowering resident with a lift. The three CNAs confirmed that the rear wheels are locked to keep the lift from moving all over the room. CNA #14 and CNA #13 told the Surveyor that locking the rear wheels was for the resident's safety. c. On 05/22/2024 at 03:35 PM, the Surveyor asked the Director of Nursing (DON) if staff had been in-serviced on mechanical lifts, and the DON responded, Yes. The DON was asked to explain the process staff are expected to use when lifting and lowering residents with a mechanical lift. The DON explained staff would get a blue lift pad, and with the legs of the mechanical lift in the open position staff would lock the wheels to attach the lift pad and lift or lower the resident. The Consultant asked to speak with the DON and explained that the wheels on a mechanical lift should remain unlocked so the machine will move with the resident if there is any sudden movement of a resident. The DON confirmed she was not aware the wheels should be unlocked when lifting and lowering residents with a mechanical lift. The DON was asked what the process was for removing damaged lift pads from service. The DON said nurses, CNAs, or any staff that see a damaged lift pad can remove the lift pad from service for resident safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 05/22/2024 at 04:00 PM, the DON provided the signature from an in-service (dated, 02/29/2024) with the following listed to the side: i. (Brand Name) Lift ii. Workman's Comp Procedures iii. Abuse Prevention and Reporting iv. OLTC (Office of Long Term Care) Survey tips v. Smoking Policy effective 03/01/2024 48977 4. Resident #38 had diagnoses of Alzheimer's disease and dementia. a. The Quarterly MDS with an ARD of 02/28/2024 documented Resident #38 scored 09 (8-12 indicates moderate impaired cognition) on a BIMS. b. A Care Plan for Resident #38 with a revision on 07/06/2023 documented Resident #38 had impaired cognitive function related to dementia and required cues, reorientation and supervision as needed. c. On 05/21/2024 at 09:56 AM, the Surveyor observed 2 bottles of air freshener on a shelf under the television in Resident #38's room. d. On 05/21/2024 at 12:59 PM, the Surveyor observed 2 bottles of air freshener on a shelf under the television in the Resident #38's room. e. On 05/23/2024 at 02:30 PM, the Surveyor observed 2 bottles of air freshener on a shelf under the television in the Resident #38's room with a warning noted on the bottles that indicated inhaling the contents can be harmful or fatal. f. On 05/23/2024 at 02:30 PM, Licensed Practical Nurse (LPN) #6 confirmed the air freshener should not be out and visible to wondering residents. g. On 05/23/2024 at 08:20 AM, the DON confirmed the air freshener should not be out in the opening and visible to wondering residents. h. On 05/23/2024 at 10:32 AM, a policy titled, Safety and Supervision of Residents documented, .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 50682 Based on observations, interviews, and record reviews, the facility failed to ensure a leg strap was in place to prevent trauma from an indwelling catheter for 1 (Resident #438) of 8 sampled residents who were dependent on staff for indwelling catheter care. Findings include: A review of the Medical Diagnosis indicated Resident #438 had diagnoses of: Urinary tract infection, heart failure, and lymphedema (swelling in the body due to a buildup of fluid) . The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/28/2024 indicated a Brief Interview for Mental Status Score (BIMS) of 7 (0-7 suggests severe cognitive impairment) and Resident #438 was admitted with an indwelling catheter. a. A review of Physician Orders (dated 03/21/2024) documented, .[Name Brand] catheter .to aid in wound healing. Change monthly on the 15th . b. A review of Resident #438's care plan with a revision date of 4/18/2024 revealed, .The resident has . Indwelling Catheter: to aid in wound healing to unstageable Pressure Ulcer to Sacral area .Interventions include . CATHETER: The resident has . Indwelling Catheter. Position catheter bag and tubing below the level of the bladder, secure catheter tubing to leg with applicable device. c. On 05/21/2024 at 09:46 AM, Resident #438 told the Surveyor that there are times when staff are getting Resident #438 out of bed or repositioning, that the resident feels the catheter pulling. The Surveyor asked Resident #438 for permission to look at the tubing that was under the cover. The indwelling catheter was not secured to Resident #438's leg by using a leg strap or any other device. d. On 05/22/2024 at 09:20 AM, the Surveyor observed incontinent care being provided by Certified Nursing Assistant (CNA) #1, CNA #2, and the Infection Preventionist (IP). During care, the catheter tubing was unsecured to Resident #438's leg, the tubing became tight as the resident was turned. The Surveyor asked the IP if a resident was care planned to have a leg strap or something to secure the catheter tubing and should the leg strap be in place. The IP stated that the resident should have a leg strap in place to prevent the tubing from pulling, yanking, and to keep it stable. e. On 05/22/2024 11:30 AM, the Surveyor interviewed the Director of Nursing (DON). The Surveyor asked the DON to explain the process for staff to follow to make sure the catheter tubing is stable or secured. The DON stated that the catheter tubing should be held in place by placing a leg band on the resident. The Surveyor asked the DON who should be responsible for ensuring the leg strap was in place. The DON said that everyone should.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48977 Based on observation, interview, and facility policy review, the facility failed to ensure that staff displayed competency in caring for residents on Enhanced Barrier Precautions (EBP), and how to use hygiene supplies according to the manufacturer ' s directions for 1 (Resident #41) sampled resident. This failed practice had the potential to affect any resident on EBP and/or dependent on staff for baths. The findings include: 1. Resident #41 had diagnoses of Pressure ulcer of sacral region stage 4, Urinary tract infection, and Paraplegia. a. Resident #41 had the following Physician's Orders: (a) Supra pubic catheter to be changed by Urologist, (b) cleanse pressure ulcer to sacrum with wound cleanser pat dry, then apply an antibacterial wound dressing followed by a silicone dressing or abdominal dressing pad and secure with tape daily and as needed for soiled or dislodged dressing (c) Enhanced Barrier Precautions (EBP) related to sacrum wound, R heel wound and Supra pubic catheter. b. Review of the Quarterly MDS with an ARD of 03/06/2024 documented Resident #41 scored 15 (13-15 indicates cognitively intact) on a BIMS, and Resident #41 had an ostomy, indwelling catheter, and resident had one or more unhealed pressure ulcers/injuries. c. A review of Resident #41's Care Plan, (revision 05/23/2024), documented Resident #41 was on EBP related to indwelling medical devices, (suprapubic catheter), sacrum wound, and right heel wound. The Care Plan also documented staff should gown and glove during high-contact resident care activities. d. On 05/22/2024 at 09:20 AM, the Surveyor observed Licensed Practical Nurse (LPN) #3 at the bedside of a Resident #41, who was on Enhanced Barrier Precautions (EBP), providing care wearing only gloves. e. On 05/22/2024 at 09:50 AM, the Surveyor observed Certified Nursing Assistant (CNA) #4 and #5 assisting Resident #41, who was on Enhance Barrier Precautions, with a bed bath. CNA #4 applied soap to the resident body using a wet towel then CNA #5 patted the resident dry. Both CNA #4 and #5 wore only gloves while providing care. f. On 05/22/2024 at 10:05 AM, CNA #4 voiced that the soap was rinse free and that rinsing was not required. Both CNA #4 and #5 voiced that they did not know Resident #41 was on EBP and it was hard to tell if a Resident was on EBP, and the facility usually informs them or post a sign. g. On 05/22/2024 at 11:30 AM, LPN #3 stated, I know I messed up. LPN #3 voiced that when the Treatment Nurse entered the room, that is when he realized he had messed up and that it was hard to tell when a Resident is on EBP when you are in a rush. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. On 05/23/2024 at 12:16 PM, the Director of Nursing (DON) read the back of the soap used by the facility and stated what was written, apply, latter, rinse, and towel dry. The DON voiced that the residents could get skin irritation if the staff is applying soap and not rinsing the soap off the resident. i. On 05/23/2024 at 11:30 AM, the DON voiced that staff follow Enhanced Barrier Precautions when caring for a resident with an indwelling catheter and/or wound. The DON also voiced that staff had been in-serviced on EBP and were aware of the residents on EBP. j. On 05/22/2024 at 11:10 AM, a policy titled, Enhanced Barrier Precautions documented, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. 2. Initiation of Enhanced Barrier Precautions: a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO [Multidrug-Resistant Organisms] that is not currently targeted by CDC [Centers for Disease Control and Prevention]. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO .Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). PPE [Personal Protective Equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 4. High-contact resident care activities include: a. dressing, b. bathing, c. transferring, d. providing hygiene, e. changing linens, f. changing briefs or assisting with toileting, g. device care or use: central lines, urinary catheter, feeding tubes, tracheostomy/ventilator tubes, h. wound care: any skin opening requiring a dressing . k. A policy titled, Bath, Bed documented, The purposes of this procedure are to promote cleanliness, provide comfort and to observe the condition of the resident's skin .

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The Springs of Hillcrest	1421 West Second St North Prescott, AR 71857

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 Based on observation, interview, and record review, the facility failed to ensure nebulizer treatments were not left at the bedside for the resident to self-administer for 2 (Resident #8 and #188) residents who were not assessed to be safe to self-administer nebulizer treatments; an unattended medication cart on the South Hall was locked on 1 of 1 observation to prevent misappropriation of resident medications; and a narcotic box containing controlled substances was kept and maintained securely behind two locks. The findings are: 1.a. A review of Resident #188's Physicians Orders (dated 05/17/2024) documented, .Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 4 hours as needed for SOB related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE, UNSPECIFIED . b. On 05/20/2024 at 01:07 PM, Resident #188 was observed sitting on the side of the bed, and the Surveyor observed a nebulizer mouthpiece with the chamber resting in the crack in the arm of Resident #188's recliner. Resident #188 remarked that he put the nebulizer there, and he gives his own updrafts. c. On 05/20/2024 at 04:20 PM, the Surveyor observed Resident #188 sitting on the side of the bed self-administering an updraft, with vapor coming from the end of the tube. The Surveyor spoke with Licensed Practical Nurse (LPN) #9 and LPN #9 denied giving Resident #188 an updraft. LPN #9 looked at Resident #188's Medication Administration Record (MAR) and told the Surveyor that Resident #188 had an updraft at 12:00 PM given by someone else. LPN #9 stated, If they had stayed with him until it was complete he would not be able to give himself an updraft right now. The Surveyor asked what procedure is followed when administering updrafts. LPN #9 told the Surveyor the nurse should stay with the resident until the updraft is completed. d. On 05/22/2024 at 04:00 PM, the Director of Nursing (DON) provided a list of residents who self-administer their own medications, the showed no residents were assessed to self-administration medications. 2.a. On 05/22/2024 at 04:12 PM, the Surveyor observed LPN #10 go into Resident room [ROOM NUMBER] and leave the South 2 Hall medication cart unlocked. b. On 05/22/2024 04:14 PM, the Surveyor asked LPN #10 what the procedure was for leaving the cart while giving medications or checking blood sugars, and why. LPN #10 told the Surveyor that the cart should have been locked, and it was an oversite on her part. LPN #10 said the cart must be locked so residents or other staff cannot get into the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 05/23/2024 at 12:45 PM, the Surveyor asked the Director of Nursing (DON) what procedure nursing staff were expected to use when leaving a medication cart in the hallway. The DON told the Surveyor the computer screen, and the cart should be locked to prevent someone from taking something from the cart. 48977 3. Resident #8 had the diagnoses of Acute and chronic respiratory failure with hypoxia, and Chronic obstructive pulmonary disease (COPD) with acute exacerbation. a. Resident #8 had a Physician's Order for Albuterol Sulfate Inhalation Nebulization Solution 1 applicator via mask every 4 hours as needed for shortness of breath (SOB). b. Review of the Admission Minimum Data Set with the Assessment Reference Date of 05/05/2024 documented Resident #8 scored 15 (13-15 indicates cognitively intact). c. The Care Plan did not address Resident #8 had been assessed to self-administer medications. d. On 05/22/2024 at 12:12 PM, the Surveyor observed Resident #8 receiving a nebulizer treatment inside the resident's room without staff in or around the resident's room. e. On 05/22/2024 at 12:12 PM, Licensed Practical Nurse #6 confirmed that the nurse is required to remain at the resident's side during the administration of a nebulizer treatment. f. On 05/22/2024 at 12:16 PM, the DON voiced the nurse should remain with the resident during a nebulizer treatment because anything could happen, the resident could go into distress. 50682 4. On 05/21/2024 at 1:00PM, the refrigerator at Nursing Station 2, was opened and contained a locked box. The Surveyor asked Registered Nurse (RN) #7 what was in the locked box. RN #7 said it contained narcotics. RN #7 unlocked the box, and it contained two 30 milliliter bottles of Ativan. The Surveyor asked RN #7 how many locks the narcotic box should be under. She said she didn't know. a. On 05/22/2024 at 11:30 AM, the DON was interviewed by the Surveyor. The DON was asked how many locks should controlled substances be behind. She said they should be behind two locks. b. On 05/22/2024 at 04:00 PM, the DON provided a policy titled Storage of Medications which documented, . The facility stores all drugs and biological in a safe, secure, and orderly manner .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49413 Based on observation, record reviews and interviews, the facility failed to ensure serving items were properly covered; unused food items were kept away from used food items; the kitchen was free from buildup of unknown substances that had the potential to fall into food items to be served; equipment was in safe and useable condition; open food items were properly closed/sealed and had an open date; food items were not expired; food containers were put away without the contents being on the outside container; and the walls, floors, and door were in good repair without holes and or missing or chipped paint. The findings are as follows: 1. On [DATE] at 7:07 AM, the food domes (covers for transporting meals to residents eating in their rooms), were stored with the inside part that covers the food facing up. 2. On [DATE] at 7:21 AM, the used coffee filter holder containing a used coffee filter with coffee grounds, was on the counter between the coffee maker and the juice machine. An opened, unsealed package of coffee inside the filter was leaning against the used coffee filter holder. At 8:40 AM, the Surveyor asked about the unused coffee filter leaning against the used coffee filter holder. The Dietary Manager confirmed Dietary Employee #15 is not done with the coffee. 3. On [DATE] at 7:23 AM, 12 bowls, 13 desert bowls, 12 cups, and the plates in the plate warmer were not covered. There were black flies in the kitchen. The Dietary Manager confirmed that debris could fall on the items that were not properly covered. 4. On [DATE] at 7:36 AM, two air vents on the ceiling that face the food prep and cooking area had yellowish, brown, and black substances built up on the vent rails with various black and grey fuzzy objects. The wall below the air vents where the steam table is used for serving meals, had a black grimy build up with paint missing or chipping along the entire wall. The crease between the same wall and floor had a black sludgy looking substance built up in the crease. On [DATE] at 02:20 PM, the Dietary Manager confirmed Maintenance was responsible for cleaning the air vent. 5. On [DATE] at 7:43 AM, a spatula on the clean drying side of the sink had torn and missing pieces from all edges and various scratches on the flat side. The Dietary Manager confirmed the concern was food particles could still be in the torn and scratched areas of the spatula. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. On [DATE] at 8:02 AM, the freezer in the Dry Goods Storage room contained the following: 2 one gallon bags of chicken breast with ice on the chicken breast; 1 bag with skinless fish filets with ice on the fish filets; 1 bag broccoli flowerets with a hole in the bag. The bottom shelf was held up with a coffee carafe due to the plastic on the right-side wall was cracked. The inside bottom shelf contained broken ice chunks and various black and brown specks. The outside bottom of the freezer was missing a vent cover with a brownish/yellow fuzzy build up; paint chips were missing and there was a brownish build up along the seam of the vent plate and freezer bottom; inside the hole where the vent cover should be had a buildup of black, grey, and brown fuzzy substance. The Dietary Manager confirmed that the ice chunks and black specks on the bottom of the freezer was from shifting things around. [DATE] at 02:11 PM, the Dietary Manager said, I think it is something that had a blind eye to. 7. On [DATE] at 8:08 AM, the deep freezer contained the following: 25 white meat chicken patties not sealed; 1 bag hash browns not seal; 1 box of white meat chicken patties without an open date; 1 box smoked sausage without an open date. 8. On [DATE] at 8:15 AM, the Dry Goods Storage contained the following: 1 flour bin with a scoop left inside laying on top of the flour; one 4 fluid ounce bottle of liquid smoke that expired on [DATE]; 1 outlet connected to the wall was covered in a black sticky substance with whitish-gray fuzz attached to the sticky substance. The Dietary Manager confirmed the scoop should not have been left in the flour container; the expired liquid smoke should not be on the dry goods shelving for use; the outlet could use a paint job. There is concern of debris with the food being stored in the room. 9. On [DATE] at 8:28 AM, the kitchen refrigerator contained one 1 gallon creamy Caesar salad dressing that had run down on the outside of the container. The Dietary Manager confirmed the dripping on the outside could get into other food items. The inside bottom of the refrigerator had a brownish-yellow buildup of an unknown substance. The Dietary Manager confirmed today is a scheduled cleaning day for this refrigerator. 10. On [DATE] at 8:40 AM, Dietary Employee #15 served food from the steamtable after the steamtable was placed against the wall underneath the air vents and against the wall that had a black grimy build up with paint missing or chipping along the entire wall. The Dietary Manager confirmed that food is not served from that area, so this is not a concern. At 8:42 AM, after informing the Dietary Manager about the food being served from that area the Dietary Manager confirmed the concern would be that debris could get into the food. 11. On [DATE] at 8:41 AM, food domes, 3 cups with lids and re-useable straws were lying directly on the shelf and 12 cups were stored on a cart that contained a buildup of white and brownish substances on all 3 shelving tiers. The Dietary Manager confirmed the cart and shelves needed to be cleaned. 12. On [DATE] at 8:44 AM, the shelving area above the food prep counter contained one 42 ounce rolled oats without an open date; one 5 pound container of smooth peanut butter that had peanut butter smears on the rim and sides; one 8.5 fluid ounces of extra virgin olive oil without an open date. The Dietary Manager confirmed there should be an open date on the food items and the peanut butter container should not have smears. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. On [DATE] at 8:55 AM, the sand-up freezer contained the following: 1 box of 240 one ounce sugar cookies without an open date. The Dietary Manager confirmed there should have been an open date on the box. 14. On [DATE] at 9:00 AM, a piece of metal on the floor between the entrance into the kitchen work area and the uphill of the kitchen no longer had the black non-slip strip covering the metal strip that secured the metal strip to the floor. The Dietary Manager confirmed this was a safety hazard because it could cause someone to trip. The lower wall area across from the prep counter had a brownish unknown substance and the floorboard was missing, the crease between the floor and the wall had a black unknown substance build up. The Dietary Manager confirmed this is a concern mainly because of debris. It also needs a coating of paint. 15. On [DATE] at 2:55 PM, the Dietary Manager provided a policy titled, Clean and Sanitary shows .All food preparation areas, food service area, and dining area will be maintained in a clean and sanitary condition .; . 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation; 2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces . 16. On [DATE] at 2:55 PM, the Dietary Manager provided the policy for Cold Storage which shows, .All foods will be stored wrapped or in covered containers, labeled and dated, land arranged in a manner to prevent cross contamination. 17. On [DATE] at 2:55 PM, the Dietary Manager provided the policy for Safe Storage of Food shows, .All foods will be stored wrapped or uncovered containers, labeled, and dated, and arranged in a manner to prevent cross contamination . 18. On [DATE] at 9:30 AM, the Administrator provided City Termite and Pest Control service agreements and invoices. German cockroaches were contracted for [DATE], [DATE], [DATE], [DATE], and [DATE]. Flies were contracted for [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47916 Based on observation, record review and interview, the facility failed to ensure respiratory mask tubing/nasal cannula tubing was stored in a manner to prevent infection and cross contamination for 2 (Residents #50 and #17) resident; denture brush was stored in a secure and sanitary manner for 1 (Resident #438) resident to prevent infections and cross contamination; staff wore proper Personal Protective Equipment (PPE) prior to providing care for 1 (Resident #41) resident on Enhanced Barrier Precautions (EBP); hand hygiene was performed during perineal care for 2 (Residents #11 and #36) to prevent cross contamination, and the facility failed to ensure dirty laundry was bagged and returned to the laundry room in a manner to prevent the spread of germs to all 85 residents who resided in the facility. The findings are: 1. On 05/20/2024 at 09:22 AM, Resident #50 was observed resting in a recliner with a respiratory mask, not secured in a bag, and was resting on the floor between the bed and recliner. Registered Nurse (RN) #7 arrived at the bedside and told Resident #50 his mask was knocked off in the floor. RN #7 was observed picking the mask up off the floor and placing it in a blue mesh respiratory pouch dated 05/08/2024. a. On 05/21/2024 at 08:00 AM, the Surveyor interviewed RN #7 and asked how the blue pouches for storage work. RN #7 told the Surveyor the blue pouches are used to store respiratory tubing and mask, and it can be used for a month. The Surveyor asked RN #7 what process staff follow when a respiratory mask is found in the floor like Resident #50's mask was found on 05/20/2024. RN #7 told the Surveyor the respiratory mask should have been cleaned before being placed back in the bag due to risk of infection from being on the floor. RN #7 confirmed she returned the mask to the storage pouch without cleaning it first. b. On 05/22/2024 at 11:35 AM, the Surveyor asked the Director of Nursing (DON) what procedure or process staff was expected to follow if they find a respiratory mask resting on the floor. The DON told the Surveyor she would expect staff to throw away the mask and replace it with a new one to prevent infections. The DON confirmed the mesh blue respiratory pouches can store tubing and mask for 30 days. 2. Resident #17 had diagnoses of End Stage Renal Disease, Legal Blindness, and Atrial Fibrillation. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/08/2024 indicated a Brief Interview for Mental Status (BIMS) score of 06 (0-7 suggest cognitive impairment). a. A Care Plan (Revision 04/29/2024) documented, .The resident has oxygen therapy related to COPD . Oxygen via nasal cannula, as net 2 liters per minute as needed . b. On 05/20/2024 at 09:39 AM, the Surveyor entered Resident #17's room and noted the nasal tubing resting in a blue pouch dated 5/8/2024 with the cannula prongs resting outside the pouch. c. On 05/20/2024 at 02:52 PM, the Surveyor observed Resident 17's nasal cannula resting outside the blue storage bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 05/22/2024 at 08:30 AM, the Surveyor asked Registered Nurse (RN) #7 to look at the nasal cannula tubing and asked RN #7 what process was used to store oxygen tubing. RN #7 told the Surveyor that oxygen tubing should be completely placed into the blue mesh pouch. The Surveyor asked if the nasal canula hanging outside the bag was appropriate. RN #7 told the Surveyor leaving the nasal canula outside the mesh storage pouch would put the resident at risk of infection. e. On 05/22/2024 at 11:30 AM, the Surveyor asked the Director of Nursing (DON) what procedure staff are expected to follow when storing nasal canula tubing. The DON told the Surveyor that nasal canula tubing should be placed in a plastic bag or a blue mesh pouch. The DON confirmed the blue mesh pouches must be changed out every 30 days, and the plastic bags must be changed out every 7 days. The Surveyor asked if the nasal canula should be placed in the storage bag because it is the main part that goes in the resident's nose, or nares. The DON confirmed by not storing the nasal canula appropriately it would put a resident at risk of bacteria, or infection. f. On 05/22/2024 at 04:00 PM, the DON provided a policy titled, Oxygen Administration, which documented, Policy: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences . g. On 05/22/2024 at 04:00 PM, the DON provided documentation showing an Oxygen Settings in-service was done on 07/07/2023, and RN #7 was not on the list of in-serviced staff.If not in use, it is to be stored in the correct storage bag . 3. On 05/21/24 at 09:40 AM, the Surveyor observed a white laundry basket with unbagged dirty white rags and towels sitting outside the clean laundry room doors on the South Hall. The Surveyor was knocking on the laundry room door with no response when the Social Director walked up and said she had placed the dirty linens there. The Surveyor asked what the process was for bringing dirty linens to the laundry room, and should laundry be bagged when transferred to the laundry room. The Social Director told the Surveyor that she did not know what the process was, or why. She noticed there was a laundry basket of dirty linens left in the beauty shop from yesterday and she was trying to help by returning them to the laundry room. a. On 05/21/24 at 09:45 AM, the Surveyor interviewed Laundry and it was confirmed that dirty linens should be returned to the laundry room in bags to prevent the spread of germs. The halls have rolling barrels that bagged linens should be placed in. Laundry trades the barrels out with empty barrels throughout the day. b. On 05/22/2024 at 04:00 PM, while interviewing the DON the Surveyor asked about the process for returning laundry. The DON told the Surveyor that all laundry should be bagged, and there were barrels on each hall to place the bagged laundry in to prevent the spread of germs. c. The DON provided a policy titled, Infection Prevention and Control Program which documented, .12. Linens. a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection . f. Environmental services staff shall not handle soiled linens unless it is properly bagged . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #11 with diagnoses of Alzheimer's disease, Bipolar disorder, and Urinary tract infection. The Quarterly MDS with an ARD of 04/19/2024 indicates a BIMS score of 03 (0-7 suggests severe cognitive impairment). a. A Care Plan (Revision, 06/26/2023) documented, Resident has an Activity of Daily Living (ADL) self-care performance deficit related to Alzheimer's . The resident is not toileted . b. On 05/20/24 at 11:07 AM, the Surveyor observed perineal care being performed by Nursing Assistant (NA) #11 and CNA #2 for Resident #11. NA #11 did not change gloves or perform hand hygiene during the procedure. CNA #2 assisted NA #11 in pulling Resident #11's pants up and shirt down. CNA #2 and NA #11 assisted in attaching Resident #11's lift pad and transferring Resident #11 to a specialty chair while NA #11 wore the same gloves used to provide perineal care. The Surveyor asked what the procedure was for providing peri care and using a clean verses dirty technique. NA #11 confirmed that she should have used the left hand to wipe Resident #11 instead of using the same hand to wipe with to avoid contamination, and there was a risk for infection. The Surveyor asked if NA #11 had received any in-services at the facility. NA #11 confirmed she was in-serviced on properly cleaning residents, resident rights, and lifting residents. NA #1 stated, They went over everything to make sure I could properly care for residents. The Surveyor asked NA #11 if gloves should have been changed after performing perineal care for Resident #11, and before touching clean clothes and objects in the room. NA #11 said, Yes, ma'am, I believe I should have changed my gloves. 5. Resident #36 had diagnoses of left below the knee amputation, cerebral infarction, and end stage renal disease. The Quarterly MDS with an ARD of 03/26/2024 suggested a BIMS score of 14 (13-15 suggests cognitively intact). a. On 05/20/24 at 03:34 PM, Certified Nursing Assistant (CNA) #12 and CNA #13 presented to Resident 36's bedside to assist with perineal care. Privacy curtains were in place. After the perineal care was performed, without changing gloves and/or performing hand hygiene CNA #12 covered up Resident #36. After covering Resident #36, CNA #12 removed her gloves and handed Resident #36 the call light. The Surveyor asked what the process was for providing perineal care and using good hand hygiene. CNA #12 and CNA #13 both confirmed that alcohol gel is outside the room, they can go to the bathroom and wash with soap and water, none of the CNA's had hand gel on their person, and they should have done hand hygiene before touching the resident's linens, call light, or environment. CNA #13 told the Surveyor they did not go to the bathroom and wash with soap and water during peri care. b. On 05/22/2024 at 11:45 AM, the Surveyor asked the Director of Nursing (DON) what procedure staff are expected to when follow going from dirty to clean, during perineal care. The DON told the Surveyor she would expect staff to perform hand hygiene with soap and water, or alcohol gel. The Surveyor asked if hand hygiene was important. The DON told the Surveyor hand washing prevents the spread of germs. 48977 6. Resident #41 had diagnoses of Pressure ulcer of sacral region stage 4, Urinary tract infection, and Paraplegia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. Resident #41 had the following Physician's Orders: (a) Supra pubic catheter to be changed by Urologist, (b) cleanse pressure ulcer to sacrum with wound cleanser pat dry, then apply an antibacterial wound dressing followed by a silicone dressing or abdominal dressing pad and secure with tape daily and as needed for soiled or dislodged dressing (c) Enhanced Barrier Precautions (EBP) related to sacrum wound, R heel wound and Supra pubic catheter. b. Review of the Quarterly MDS with an ARD of 03/06/2024 documented Resident #41 scored 15 (13-15 indicates cognitively intact) on a BIMS, and Resident #41 had an ostomy, indwelling catheter, and resident had one or more unhealed pressure ulcers/injuries. c. A review of Resident #41's Care Plan, revision 05/23/2024, documented Resident #41 was on EBP related to indwelling medical devices, (suprapubic catheter), sacrum wound, and right heel wound. The Care Plan also documented staff should gown and glove during high-contact resident care activities. d. On 05/22/2024 at 09:20 AM, the Surveyor observed an Enhanced Barrier Precaution sign posted on the wall outside of Resident #41's door. Licensed Practical Nurse (LPN) #3 was at the bedside of Resident #41 providing care wearing only gloves. e. On 05/22/2024 at 09:50 AM, the Surveyor observed CNA #4 and CNA #5 assisting Resident #41 with a bed bath, both CNAs wore only gloves. f. On 05/22/2024 at 10:05 AM, both CNA #4 and CNA #5 voiced that they did not know Resident #41 was on EBP, and it was hard to tell if Resident #41 was on EBP that the facility usually informs them or post a sign. g. On 05/22/2024 at 11:30 AM, LPN #3 stated, I know I messed up. LPN #3 voiced that when the Treatment Nurse entered the room wearing a gown, was when he realized he had messed. h. On 05/23/2024 11:30 AM, the DON voiced staff should follow EBP when caring for a resident with an indwelling catheter and/or wound. The DON also voiced staff had been in-serviced on EBP and were aware of the residents on EBP. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045306	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Hillcrest	1421 West Second St North Prescott, AR 71857

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 - Some	i. On 05/22/2024 at 11:10 AM, a policy titled, Enhanced Barrier Precautions documented, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. 2. Initiation of Enhanced Barrier Precautions: a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO [Multidrug-Resistant Organisms] that is not currently targeted by CDC [Centers for Disease Control and Prevention]. b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO . 3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned [applied] prior to entering the resident's room . 4. High-contact resident care activities include: a. dressing, b. bathing, c. transferring, d. providing hygiene, e. changing linens, f. changing briefs or assisting with toileting, g. device care or use: central lines, urinary catheter, feeding tubes, tracheostomy/ventilator tubes, h. wound care: any skin opening requiring a dressing . 50682 7. A review of the Medical Diagnosis indicated Resident #438 had diagnoses of: Urinary tract infection, Heart failure and Lymphedema (swelling in the body due to a buildup of fluid). The Admission MDS with an ARD of 03/28/2024 indicated a BIMS score (BIMS) of 7 (0-7 suggests severe cognitive impairment). a. On 05/20/2024 at 10:31 AM, the Surveyor observed Resident #438's denture brush in the bathroom resting on its side with the bristles touching the porcelain on the right side of the faucet. b. On 05/20/2024 at 02:00 PM, the Surveyor observed Resident #438's denture brush in the bathroom resting on its side with the bristles touching the porcelain on the right side of the faucet. c. On 05/21/2024 at 02:56 PM, the Surveyor observed Resident #438's denture brush in the bathroom resting on its side with the bristles touching the porcelain on the right side of the faucet. d. On 05/22/2024 at 9:20 AM, the Surveyor observed Resident #438's denture brush in the bathroom resting on its side with the bristles touching the porcelain on the right side of the faucet. The Surveyor asked CNA #1 how the denture brush should be stored. CNA #1 said the denture brush should be stored in a plastic baggy with the resident's name on it. The Surveyor asked the reason why it should be stored in the plastic bag. CNA #1 said it should be stored in a plastic bag because the sink is where staff wash their hands, and that the denture brush would be contaminated with germs by the hand washing. e. On 05/22/2024 at 11:30 AM, the Surveyor interviewed the DON. The surveyor asked the DON how the denture brush should be stored. The DON said it should be in a plastic bag with the resident's name on it to prevent bacteria.