

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045421	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2025
NAME OF PROVIDER OR SUPPLIER Ashley Rehabilitation and Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 N 22nd Street Rogers, AR 72756	

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 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and facility document review, the facility failed to ensure the privacy and confidentiality of residents' protected health information (PHI) was maintained for 1 (200 hall) of 1 hall of the facility.</p> <p>The findings include:</p> <p>During an observation on 06/06/2025 at 8:45 AM, Registered Nurse (RN) #5 was in room [ROOM NUMBER]. An unattended medication cart was on the 200 hall. A computer was sitting on top of the medication cart with the screen open to an electronic medication administration screen for Resident #6.</p> <p>During an observation on 06/06/2025 at 8:56 AM, RN #5 prepared a medication for Resident #8, locked the medication cart, entered a resident 's room and left the computer screen open to Residents #8 's medication administration screen. During the observation, residents and staff were ambulating on the hall past the medication cart.</p> <p>During an interview on 06/06/2025 at 8:59 AM, RN # 5 stated they had been a nurse for 13 years, and began working in this facility one year ago, this July. RN #5 stated the computer screen should have been locked so the resident information was not visible to anyone walking by, because it was a HIPAA [Health Insurance Portability and Accountability Act] violation.</p> <p>During an interview on 06/06/2025 at 11:28 AM, the Director of Nursing stated all staff received training in PHI upon hire, and PHI was emphasized during trainings. Staff should have locked the computer screen when they walked away, because it was a breach of confidentiality.</p> <p>During an interview on 06/09/2025 at 10:43 AM, the Administrator stated computer screens should be locked, and not visible, to protect resident medical information.</p> <p>A review of an undated facility document titled, Resident Rights, indicated, N. Information contained in a resident's record shall be kept confidential .O. Each resident shall be treated with consideration, respect and dignity, including privacy in treatment and care of personal needs.</p> <p>A review of an undated facility document titled, Resident Rights and Responsibilities, indicated, Privacy and Confidentiality: . Resident's medical records are maintained in order and . They are available to authorized personnel only.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 045421
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<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>Based on observation, interview, and facility policy review, it was determined the facility failed to ensure staff performed hand hygiene after care of a resident and before and after medication administration for three (Resident #6, #8, and #9) of three residents observed.</p> <p>The findings include:</p> <p>During an observation on 06/06/2025 at 8:45 AM, Registered Nurse (RN) #5 was in a resident's room and placed a call light in reach of Resident #9. RN #5 exited the room, with no hand hygiene, and returned to the medication cart. RN #5 removed a medication card from the cart and placed medication into a medication cup, then provided it to Resident #6.</p> <p>During an observation on 06/06/2025 at 8:52 AM, RN #5 removed a clean medication cup, opened a bottle of vitamin D, poured one pill into the palm of their right ungloved hand, and placed the pill into the medication cup. RN #5 completed placing additional medications into the cup, then provided the medication cup to Resident #8. No hand hygiene was performed between residents.</p> <p>During an interview on 06/06/2025 at 8:59 AM, RN #5 stated they had been a nurse for 13 years and had worked for the facility for one year, in July. RN #5 stated hands should be sanitized between residents, due to the possibility of spreading germs from one resident to another. RN #5 stated the vitamin D did not have a screw top lid. RN #5 removed the vitamin D bottle from the medication cart and demonstrated the lid was a flip top. RN #5 stated the vitamin D should have been placed directly into the medication cup, and not into their ungloved hand.</p> <p>During an interview on 06/06/2025 at 11:28 AM, the Director of Nursing (DON) stated hand hygiene should be done frequently, before and after contact with residents and RN #5 should have washed their hands before walking out of a resident room, and again before dispensing medication, and before and after the next resident. The DON stated the pill and bottles become contaminated if touching the hand, and RN #5 should have worn gloves.</p> <p>During an interview on 06/09/2025 at 10:43 AM, the Administrator stated the expectation was for staff to perform hand hygiene any time it was necessary. Sanitizer should be used between residents, unless they provided direct brief care, then they should wash their hands, due to the importance of infection control purposes, there is a risk for cross contamination. The Administrator stated trainings on hand hygiene were done monthly on the 15th, unless that fell on a weekend, then would be done on the following Monday.</p> <p>During an interview on 06/09/2025 at 11:30, the Infection Preventionist/Medical Records (IP/MR) stated staff should be performing hand hygiene between residents, before and after patient care, and depending on activity. A nurse passing medications should be washing their hands before and after care, administration of insulin or checking blood sugar. Sanitizer should be used between residents when passing medications. The IP/MR stated generally, staff were taught to wash after the three uses of sanitizer. When staff are in a resident's room moving a resident table, handing the resident their call light, or resident's water, staff should be sanitizing. The nurse should have sanitized between giving residents medications and should not pour medication into their hand. Hand hygiene is important to prevent the spread of infection, protection of the residents and themselves.</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 - Few</p>	<p>A review of a facility policy titled, Medication, Administration Guidelines, revised 02/07/2013, indicated, Guidelines 1. Bring cart to resident room . 5. Wash hands.</p> <p>A review of a facility policy titled, Handwashing and Hand Hygiene, effective January 2009, indicated, Policy: This facility recognizes the importance of handwashing or use of alcohol-based rubs in controlling the spread and acquisition of nosocomial infections .Hand Hygiene: .Handwashing or use of alcohol-based hand rubs . most effective means of preventing and controlling the spread of infection .When: .1. Before and after contact with a resident .7. Before preparing medications and as appropriate throughout the medication distribution.</p> <p>A review of a facility policy titled, Hand Cleanser, Alcohol Based Hand Sanitizer, dated 2018, indicated, Purpose: Clean the hands between resident contacts Prevent spread of infection . Clean Your Hands Frequently! .Hand hygiene is the single most important step you can take to reduce transmission of infectious agents .Clean your hands before and after contact with a resident or resident's environment. This includes before and after entering a resident room .</p>