STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045421	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley Rehabilitation and Health Care Center	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to provide wound care in a manner to prevent infection for two (Resident #4 and Resident #5) of five residents reviewed for wound care. Specifically, staff performing wound care did not perform hand hygiene after contaminating their hands and before touching wound care supplies or applying ointments and dressings, and an impervious barrier was not used to prevent the contamination of wound care supplies. The findings include:Resident #4Review of Resident #4's Face Sheet, indicated the facility admitted Resident #4 on 03/19/2026 with diagnoses that included cellulitis, type 2 diabetes mellitus, protein-calorie malnutrition, venous insufficiency of the bilateral lower extremities, cognitive communication deficit, chronic venous hypertension with inflammation of bilateral lower extremities and candidiasis (fungal infection) of skin and nail.Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/21/2026, revealed Resident #4 had a Brief Interview of Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment. The MDS also revealed Resident #4 was admitted with a stage 2 pressure ulcer, treatments included a pressure reducing device of the chair, pressure ulcer care, application of non-surgical dressing, and application of ointments/medications.Review of Resident #4's Care Plan dated 03/20/2026 revealed the resident had a stage 2 pressure ulcer to the sacrum, bilateral lower extremity cellulitis, and candidiasis to the groin. Interventions included treatment to site per orders and monitor and record signs or symptoms of deterioration or infection.Review of Physician Orders dated 04/27/2026 revealed Resident #4 had an order to cleanse the inner gluteal fold bilaterally with wound cleanser, pat dry, apply collagen to the wound areas, and cover with hydrocolloid dressing. Change every Monday, Wednesday, and Friday and as needed due to soilage or dislodgement.During an observation on 04/27/2026 at 10:21 AM, the Infection Preventionist (IP)/Treatment Nurse (TN) performed hand hygiene, pulled keys out of her pocket to unlock the treatment cart drawer, put her keys back in her pocket then retrieved a tube of ointment from the cart. She applied a glove to her left hand, cleansed the tube off with a wipe and rolled the tube down to squeeze the contents into a medicine cup. The TN then performed hand hygiene. TN applied Personal Protective Equipment (PPE) then cleaned the bathroom counter with soap and water using a paper towel. A second paper towel was used to dry the counter off. The TN then placed a non-impervious third paper towel down as a barrier for her supplies. The wound bled during wound cleaning. The TN stopped and contacted the provider for further orders. The TN returned to the treatment cart in the hallway and used her cell phone to call the provider for new orders. The new orders were placed into the computer system. The TN then retrieved the keys out of her pocket, unlocked the cart and replaced the keys in her pocket. She retrieved a 2x2 sheet of collagen and hydrocolloid dressing still in the package, placed gauze pads into a plastic cup and sprayed them with wound cleanser. No hand hygiene was performed after touching the keys from her pocket and no gloves were applied prior to touching the gauze pads in the cup. The TN applied a PPE gown and performed hand hygiene in the resident's bathroom then applied gloves. The packaging for the 2x2 sheet of collagen and hydrocolloid dressing were opened. Resident #4 pulled self-up with grab bar in bathroom and TN cleaned the wound with the gauze pads from the cup. The TN then changed her gloves and applied the collagen (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receiving some wound care training but had not received any answers. During an interview on 04/28/2026 at 9:38 AM, referring to Resident #5 the Nurse Practitioner (NP) stated, the nurse should clean the supra pubic catheter, and the pressure ulcer wound one at a time. The NP stated, I would not want to get what could be in a wound in the supra pubic catheter. The TN stated she believed setting up wound cleaning supplies next to personal items was not a common practice since it would be an infection control issue. The NP stated she expected the TN would have completed courses in wound care but did not know what the facility required.During an interview on 04/28/2026 at 12:35 PM, the Director of Nursing (DON) stated the TN had been doing wound care since around November of 2025. She had no certification in wound care, and no specific training was provided to her by the facility. The DON's expectations for wound care were to provide quality care and follow the providers' orders. The DON stated she believed the TN was a wound care nurse at another facility before the current facility. The DON stated she was a wound care nurse years ago and that TN could come to her anytime there was a question and the NP was readily available. I have watched her provide wound care and I had no concerns. The DON stated the TN should clean her hands and change gloves when going from dirty to clean tasks during wound care. The two different areas of the supra pubic catheter and the pressure ulcer should not be treated at the same time because of the concern for potential infection. Dressings should be dated as a standard of practice with wound care. Workspace areas such as bedside tables should be clean and uncluttered with no resident items on the bedside table. The DON stated the bedside tables should be cleaned with a disinfectant, soap and water would not be the same as being cleaned with a disinfectant. The DON suggested staff should wash hands to a common song for about 90 seconds and that washing for only six seconds was probably not an appropriate amount of time. Review of an undated facility policy titled Wound Care and Treatment revealed, Clean technique is used. Sterile technique would be used with fresh surgery wounds. Care must be taken to prevent contamination of the supplies and surfaces used in wound care. Supplies should be set up on a clean surface, and the surface should be covered with an impervious barrier before putting supplies down. Hand washing must be done as outlined in the guidelines. After removing dirty dressing gloves should be removed, and hands should be washed prior to putting on clean gloves. New dressings should be labeled with the nurse's initials, date, and time.Review of an undated facility policy titled Handwashing revealed steps to handwashing but did not specify a timeframe for hand washing.Review of an article from the Centers for Disease Control (CDC) titled, About Hand Hygiene for Patients in Healthcare Settings, recommendation dated 02/27/2024, revealed Patients in healthcare settings are at risk of getting infections while receiving treatment for other conditions. Steps to washing your hands with soap and water included wet hands, apply soap, rub your hands together until soap is lathered then rub all over including between hands and under fingernails. Continue rubbing for at least 15 seconds, rinse hands well, and dry hands. Wearing gloves alone is not enough for a healthcare worker to prevent the spread of infection.