STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045430	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Brinkley	1214 North Main Brinkley, AR 72021

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 - Few	Provide and implement an infection prevention and control program. 46724 Based on observation, interview, record review, and policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented and hand hygiene was performed to prevent the possible spread of infection for 1 (Resident #5) of 1 resident sampled for infection prevention and control. The findings are: Per a Centers for Medicare and Medicaid Services (CMS) memorandum titled, Enhanced Barrier Precautions in Nursing Homes and dated 03/20/2024, EBP refers to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. It stipulated EBP are indicated for residents with wounds and/or indwelling medical devices, even if the resident is not known to be infected or colonized with an MDRO and indicated EBP be employed when performing high-contact resident care activities, including wound care: any skin opening requiring a dressing. Review of Resident #5's diagnosis sheet indicated diagnoses of pressure ulcer of unspecified heel and skin graft infection. Resident #5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/26/2024 indicated a Brief Interview for Mental Status (BIMS) of 03, indicating the resident's cognitive status was severely impaired. The MDS indicated that the resident was dependent on staff for activities of daily living (bathing, dressing, grooming, toileting) as well as transfers and bed mobility and that the resident had one stage 3 pressure ulcer and one unstageable deep tissue injury. Resident #5's Care Plan with a revision date of 12/23/2024 indicated the resident was on EBP related to wounds, and indicated staff were to wear a gown and gloves during high contact care activities. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER The Springs of Brinkley		STREET ADDRESS, CITY, STATE, ZIP CODE 1214 North Main Brinkley, AR 72021	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/04/2025 at 11:20 AM, prior to the treatment being performed, a one inch circle of a bright red substance, resembling blood, was noted to the bottom fitted sheet at the foot of Resident #5's bed, in the area the resident's heel would rest. Licensed Practical Nurse (LPN) #6, accompanied by the Director of Nursing (DON), entered Resident #5's room and was observed providing wound care to Resident #5's right heel. LPN #6 washed her hands and entered the resident's room and began treatment without donning a gown. The front of LPN #6's scrubs repeatedly came into contact with the sheets on Resident #5's bed during the treatment. LPN #6 removed the soiled dressing from the heel of Resident #5, then removed her gloves. Without performing hand hygiene, LPN #6 applied a new pair of gloves and cleaned the wound on the resident's heel. With soiled gloves the LPN opened a clean dressing package. LPN #6 removed the soiled gloves, and without performing hand hygiene applied a new pair of gloves. LPN #6 then applied the dressing to the wound. On 02/04/2025 at 11:45 AM, LPN #6 confirmed she should have performed hand hygiene with each glove change. She said she normally would have washed her hands between glove changes, but the resident's room did not have a sink. When asked what she could have done without soap and water, LPN #6 stated, I could have used alcohol hand sanitizer, but I didn't have it. On 02/04/2024 at 11:50 AM, LPN #6 and the DON acknowledged EBP, which included gowns and gloves, were required to be utilized when performing high contact activities with residents that have an indwelling device such as a catheter or feeding tube or that have a wound. On 02/04/2025 at 3:10 PM, LPN #7 related all residents on EBP were identified by a sign on the door of their room, so staff knew gloves and gowns were required prior to providing care to those residents. LPN #7 related PPE (Personal Protective Equipment) supplies were kept in a supply room beside hall 200's nurses' station, to which she had the key, and she would put supplies out at the nurses' station for use by staff. On 02/04/2025 at 3:14 PM, CNA #8 confirmed residents with EBP were identified by signage on the door of their room and required staff to wear gowns and gloves and masks at times. CNA #8 stated the staff got PPE supplies from the linen closet but most of the time they were unable to locate supplies there and must go to the brief room which was located on the 100 Hall. On 02/04/2025 at 2:20 PM, the DON stated residents on EBP were identified by signage on the door to their rooms, and it was in their electronic health record. The DON reported PPE was kept in a drawer in each resident's room. The DON then accompanied this surveyor to 4 different resident rooms, who were identified by the DON as being on EBP and was unable to locate PPE in the rooms. On 02/04/2025 at 2:33 PM, the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) stated that residents on EBP were identified by signage by their bed, and they included gowns, gloves and goggles if required. She reported the supplies were kept locked in her office but now they were located in the central supply closet, so staff had access to it. On 02/04/2025 at 2:45PM the DON came to this surveyor and stated the ADON/IP had just informed her that the EBP supplies had been moved under the sink in the room of each resident with EBP last week. A list of residents on EBP obtained from the DON included 5 residents who had indwelling devices on the 200 Hall, but did not include any residents identified as having a wound, including Resident #5. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy for Infection and Prevention Control indicated, it is designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Review of the facility policy for Enhanced Barrier Precautions with no indication or revision date, showed enhanced barrier precautions would be provided for residents with wounds and/or indwelling medical devices. The policy also indicated the facility would make gowns and gloves available immediately near or outside of the resident's room.