STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045438	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Village Medical Center	6400 Trinity Drive Pine Bluff, AR 71603

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interviews, record reviews, and facility policy review, the facility failed to ensure Care Plans were updated for two (Resident #11 and Resident #12) of two residents reviewed for Care Plan accuracy. The findings include: Resident #11 A review of an admission Record indicated the facility admitted Resident #11 on 01/23/2017, with diagnoses which included stroke. A review of Bed Rail Assessments dated 01/21/2025 and 05/15/2025 indicated Resident #11 had expressed a desire to have siderails/assist bar for safety and/or comfort. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/15/2025, revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident had severe cognitive impairment. The MDS did not indicate the resident used side rails. A review of Resident #11’s Care Plan, revised on 02/24/2025, did not indicate the resident used bed rails. During an observation on 07/22/2025 at 10:16AM, Resident #11 was lying in bed with eyes closed. Resident #11’s bed was in lowest position with 1/4 sized rails up on both sides of the bed. During an interview on 07/23/2025 at 11:56AM, Certified Nursing Assistant (CNA) #4 stated Resident #11 used side rails for an enabler. “[Resident #11] helps us turn when we do care and feels safer with them.” During an interview on 07/24/2025 8:53AM, Licensed Practical Nurse (LPN) #5 indicated, “The Care Plan should have everything about the patient. If someone new comes in they should be able to look at the Care Plan and know everything about the resident. Code status and bed rails should be on the Care Plan.” During an interview on 07/24/2025 10:11 AM, the Director of Nursing (DON) indicated, Care Plans should have the resident’s activities of daily living (ADLS), bowel and bladder status, and anything pertinent to the resident’s specific care. Code status, fall mat, and bed rails should all be on the Care Plan. The DON stated side rail assessments are done on admission and “a lot of families ask for side rails. If families insist, the family has to sign a risk vs benefits form.” The (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DON also stated Resident #11 had side rails to help maneuver in bed for ADLs. The DON was not aware that some items were not on the Care Plan. The DON stated the Care Plans were important because they let the staff know how to care for the residents. During an interview on 07/24/2025 at 10:30 AM, the MDS Coordinator indicated, “I do the Care Plans. Care Plans should be a description of the residents and their care. The resident’s code status and side rails should be on the Care Plan. Any pertinent information about their care should be addressed. I did not know Resident #11 had side rails. Side rails should be on the Care Plan. The Care Plans tell staff how to specifically care for that resident.” Resident #12 A review of an admission Record indicated the facility admitted Resident #12 on 06/30/2025 with diagnoses which included cancer of the left lung. The admission MDS, with an ARD of 07/02/2025 revealed Resident #12 had a BIMS score of 15 which indicated Resident #12 was cognitively intact. A review of Resident #12’s Care Plan revised on 07/22/2025, did not indicate the resident smoked. During an interview on 07/23/2025 at 10:34 AM, Resident #12 indicated having smoked for 50 years. During an interview on 07/23/2025 at 1:52 PM, the Assistant Director of Nursing indicated that smoking was not on Resident #12’s Care Plan and the MDS coordinator was responsible for completing the Care Plan. During an interview on 07/24/2025 at 12:30 PM, the MDS coordinator indicated that Resident #12 stated they smoked when admitted to the facility. The MDS coordinator indicated that she forgot to put smoking on Resident #12’s Care Plan. A review of a policy titled, “Smoking Policy-Residents” revealed, “Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. The staff consults with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident’s smoking privileges based on the Safe Smoking Evaluation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure food stored in the freezer and dry storage area were covered or sealed, one of one ice scoop holder was maintained in a sanitary manner, and dietary staff washed their hands between dirty and clean tasks and before handling clean equipment for one of one meal observed. The findings include: During an observation and interview on 7/23/25 at 9:46 AM, loose coffee filters were observed on top of a bag on the tea maker, which exposed them to air and potential pests. Dietary [NAME] (DC) #8 stated they were supposed to be in a sealed bag. During an observation and interview on 7/23/25 at 9:53 AM, DC #8 was observed wearing gloves on her hands when she turned off the stove, which contaminated the gloves. Without changing gloves and washing her hands, she used her gloved hand to sprinkle shredded cheese on top of the pasta to be served to the residents for lunch. DC #8 stated that it was cross contamination, and she should have removed her gloves and washed her hands. During a concurrent observation and interview on 7/23/25 at 9:57 AM, DC #8 was wearing gloves on her hands when she pushed the blender motor to the edge of the counter, contaminating the gloves. Without changing gloves and washing her hands, she used her hand to pick up a clean blade and attached it to the base of the blender to be used in pureeing food items for the residents who required pureed diets. DC #8 stated she should have removed the gloves and washed her hands after touching dirty objects and before handling clean equipment. During a concurrent observation and interview on 7/23/25 at 10:20 AM, the ice scoop holder located on the counter by the ice machine leading to the kitchen had approximately 1/4 cup of water standing it, with yellow flaky residue floating on the water, and the ice scoop resting in it. DC #8 stated the kitchen staff were supposed to clean it every day. She also verified that the Certified Nursing Assistants used the ice in water pitchers for the residents’ rooms, and the ice was also used to fill beverages served to the residents at mealtimes. During an observation and interview on 7/23/25 at 10:24 AM, Dietary Aide #10 (DA) opened a bag of lettuce while wearing gloves. Without changing gloves and washing her hands, DA #10 used the same gloved hand to remove lettuce from the bag and placed the lettuce into a pan intended to be used for salad. DA #10 stated she should have removed the gloves and washed her hands prior to removing the lettuce from the bag. On 07/23/25 at 10:36 AM, the following observations were made on a shelf in the walk-in freezer: An opened box of broccoli was not covered or sealed, which exposed it to freezer burn. An opened box of vegetable blend was not covered or sealed, exposing it to freezer burn. DA #9 stated that it would cause freezer burn if the box was not tightly sealed. During a concurrent observation and interview on 7/23/25 at 11:53 AM, DA #11 turned off the sink faucet while wearing gloves on her hands, contaminating the gloves. Without changing gloves and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	washing her hands, DA #11 then picked up glasses with beverages in them by their rims and placed them on the trays to be served to the residents during the lunch meal. DA #11, stated she should have removed the gloves and washed her hands after touching dirty objects and before handling clean equipment. During a concurrent observation and interview on 7/23/25 at 11:54 AM, DC #8 placed the blender bowl, lid and blade on the dirty rack and pushed the rack into the dishwashing machine to wash. After the dishwashing machine stopped washing, DC #8 without washing her hands, picked up a clean blade with her bare hand and attached it to the base of the blender to be used in pureeing food items for lunch. When DC #8 was ready to use the blender, this surveyor immediately stopped DC #8. DC #8 stated she should have washed her hands after touching dirty objects and before handling clean equipment. A review of a facility policy titled “Hand Washing,” indicated kitchen staff should wash their hands when entering the kitchen at the start of a shift, during food preparation, as often as necessary to remove soil or contamination and to prevent cross contamination when changing tasks and after engaging in other activities that contaminate the hands.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record reviews, interviews, and facility policy review, the facility failed to ensure a smoking assessment was completed for one (Resident #12) of two residents reviewed for smoking safety. The findings include: A review of Resident #12’s admission Record indicated the facility admitted the resident on 06/30/2025, with diagnoses which included lung cancer. A review of Resident #12’s admission Minimum Data Set (MDS) with an Assessment Reference Date of 07/02/2025, revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. A review of Resident #12’s Care Plan, revised on 07/22/2025, indicated the resident had alteration in comfort related to lung cancer, depression, and generalized pain. The resident’s Care Plan revealed they required supervision or touching assistance to walk 10 feet. Resident #12’s Care Plan did not indicate the resident smoked tobacco products. A review of Resident #12’s Electronic Medical Record, on 07/23/2025 at 10:26 AM, revealed a smoking assessment had not been completed for the resident. During an interview on 07/23/2025 at 10:34 AM, Resident #12 stated they had smoked for 50 years and was not sure if they were going to smoke today. During an interview on 07/23/2025 at 1:52 PM, the Assistant Director of Nursing (ADON) confirmed Resident #12 smoked. She looked in the electronic health records system and verified Resident #12 did not have a smoking assessment completed. The ADON revealed the nurses that worked the halls were responsible for completing the resident’s smoking assessments. She also verified smoking was not on Resident #12’s Care Plan and revealed the MDS Coordinator was responsible for completing the Care Plans. During an interview on 07/23/2025 at 3:12 PM, Resident #12 stated the staff took them out to smoke during smoke breaks. During an interview on 07/24/2025 at 12:16 PM, the Director of Nursing (DON) indicated she did not know Resident #12 smoked, when they were admitted . The DON stated when she found out the resident smoked the staff failed to complete a smoking assessment. During an interview on 07/24/2025 at 12:30 PM, the MDS Coordinator stated Resident #12 told her that they smoked when they were admitted . The MDS Coordinator verified she forgot to put smoking on Resident #12’s Care Plan. A review of a policy titled, “Smoking Policy-Residents” documented, “Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. The staff consults with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident’s smoking privileges based on the Safe Smoking Evaluation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, interview, and facility policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were followed during high contact care to prevent the risk of cross contamination and infection for one (Resident #41) of one resident observed. Specifically, nursing staff failed to wear a gown while administering medication, feeding, and flushing a gastrostomy tube with water. The findings include: A review of a Physician Order for Resident #41, dated 03/21/2022, revealed a medication for inflammation of the stomach was to be given through [percutaneous endoscopic gastrostomy] PEG tube. A review of a Physician Order for Resident #41, dated 05/06/2022, revealed a [nothing by mouth] NPO diet. A review of a Physician Order for Resident #41, dated 07/26/2023, revealed an order for water flushes before and after medications and feedings. A review of a Physician Order for Resident #41, dated 04/15/2025, revealed Resident #41 received supplemental feedings four times a day. A review of Resident #41’s Care Plan with a revision date of 02/05/2025, revealed the resident was on EBP related to the PEG tube. A review of a Medical Diagnosis Report revealed Resident #41 had diagnoses which included brain cancer, epilepsy, and diabetes mellitus type II. A review of Resident #41’s quarterly Minimum Data Set with an Assessment Reference Date of 04/18/2025, revealed a Staff Assessment for Mental Status score of 3 which indicated the resident’s cognitive skills for daily decision making were severely impaired. The MDS also indicated that Resident #41 had a feeding tube. On 07/23/2025 at 11:47 AM, Licensed Practical Nurse (LPN) #1 was observed pulling Resident #41’s gown up revealing Resident #41’s PEG tube then aspirated to check for placement. LPN #1 was observed administering water, stomach medication in 6 ounces of water, tube feeding, and then water to Resident #41’s feeding tube without wearing a gown. LPN #3 entered the room during the medication administration and stood beside LPN #1 without wearing a gown or gloves. During an interview with LPN #1 on 07/23/2025 at 11:52 AM, LPN #1 revealed, I forgot to put the gown on, EBP are outside the door, and we know PEG tubes require a gown and gloves. We have had in-services about that.” LPN #3 said, We wear a gown and gloves when opening the PEG tube to prevent infections. During an interview with Certified Nursing Assistant (CNA) #2 on 07/03/2025 at 12:00 PM, CNA #2 stated she recognized EBP because residents “have signs up above their bed, and some have a little red stop sign outside the door.” CNA #2 revealed that residents on EBP may “have a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PEG tube, a wound, catheter, or urine infections” and staff receive “annual in-services or as needed.” A review of an in-service titled “Infection Control, EBP” revealed LPN #3 attended. A presentation titled “Infection Prevention and Control in Long Term Care” revealed goals for infection control are to protect the residents, staff and visitors. During an interview on 07/23/2025 at 12:08 PM, the Director of Nursing (DON) stated, “Nursing staff were expected to aspirate stomach contents to check placement before anything, and flush before and after medications, and EBP should be in place.” The DON confirmed staff have all been in-serviced on EBP. There would be a red stop sign outside the door and there would be personal protective equipment (PPE) inside the room. The DON stated PPE was used to protect the residents and staff from anything like wound blood or body orifice liquids coming out of a PEG tube. During an interview on 07/23/2025 at 12:15 PM, the Administrator said, “It is my understanding that staff would have to wear gloves and use universal precautions, but I am not sure staff would require a full dress out. The Administrator was asked for the last EBP in-service and policy. A review of in-serviced titled “EBP in Long Term Care,” dated 05/07/2025, revealed staff must wear gown and gloves during high contact care. Nursing will wear gown and gloves during device care including feeding tubes. Small stop signs are posted outside the door of residents identified as EBP. A flyer from the Centers for Disease Control identified EBP are required for device care including feeding tubes, central lines, catheters and tracheostomies. An article used in an in-service titled “Frequently Asked Questions about EBP in nursing homes,” revealed EBP reduce or prevent the transfer of multi drug resistant organisms and include the use of gown and gloves during high contact resident care.