STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045419	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashton Place Health and Rehab, LLC	318 Strozier Lane Barling, AR 72923

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interview and facility policy review, the facility failed to ensure a client with a right hand contracture was receiving right hand splint treatments in line with Resident #103's physician orders and goals as outlined in the comprehensive care plan during 4 of 4 observations of 1 (Resident #103) of 1 sampled resident to prevent the risk of further reduction in range of motion. The findings include: A review of the Medical Diagnosis, revealed Resident #103 had diagnoses that included stroke, dysphasia, and aphasia. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/2024 revealed Resident #103 had short term and long term memory problems per a Staff Assessment for Mental Status (SAMS). Review of the Medication Administration Record (MAR), dated March 2025, revealed Resident #103 had an order dated 12/20/2024 for a right-hand resting splint to be worn and monitored by nursing staff daily for 6 to 8 hours. Nursing had initialed daily that splint was in place from March 1, 2025-March 26, 2025. Review of the Care Plan, initiated on 01/05/2025, revealed Resident #103 had limited mobility due to a stroke and was to wear a right-hand splint 6 to 8 hours a day, and staff to monitor for edema, discoloration, and tolerance. A review of the ICP Multidisciplinary Care Conference, dated 12/30/2024, revealed a meeting on 01/01/2025 at 08:00 AM with the family, nursing, dietary, and social services. Section E. Social Service Summary revealed goals were to maintain the current level of function (LOF). Review of the Care Area Assessment (CAA), dated 10/04/2025, revealed Resident #103 had a communication impairment, both receptive and expressive, causing an inability to speak, putting sentences together, and pronouncing words. The overall objective was to minimize risks. On 03/24/2025 at 01:39 PM, Resident #103 was observed resting in bed, eyes open, with the call light in reach. A boot splint was resting on the drawers across from the bed, no hand splint was observed on the resident or visible in the room. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/2025 at 09:55 AM, the call light was observed resting on Resident #103's chest, no right-hand splint was observed. A boot splint was resting on top of the dresser across from the resident's bed. Licensed Practical Nurse (LPN) #7 was observed conversing with Resident #103 and asked Resident #103 to blink their eyes once or twice for yes and no. LPN #7 stated Resident #103 had a limited range of motion but could lift the right contracted hand up and hit the soft call light pad. On 03/26/2025 at 10:10 AM, Resident #103 blinked their eyes twice to indicate the resident could reach their call light over the right shoulder. The boot was noted resting on the drawer across from the resident's bed, and no hand splint was observed on the resident or was visible in the room. On 03/26/2025 at 1:20 PM, Resident #103 was observed not wearing a right-hand splint. LPN #2 confirmed she was Resident #103's nurse today and was asked to show where the right-hand splint was documented on the Medication Administration Record/Treatment Administration Record (MAR/TAR) for Resident #103. When asked the process LPN #2 used when putting the splint on Resident #103, she confirmed she had not put Resident #103's hand splint on today and stated that she charted the resident was wearing it. She stated she was sorry, but it was not done. LPN #2 was asked for a copy of the MAR/TAR showing LPN #2 initialed the right-hand splint was put on Resident #103 today (03/26/2025) and was asked if the right-hand splint was care planned. LPN #2 confirmed Resident #103's right hand splint was care planned. LPN #2 then provided this surveyor with a copy of the requested MAR/TAR. LPN #2 stated she drew a line through her initials and struck it out in the computer before making the copy because she had not put the splint on Resident #103. LPN #2 wrote a note on the copy of the MAR/TAR that she changed her documentation at 03:17 PM, before making the requested copy. LPN #2 was asked the process for following the right-hand splint order. LPN #2 stated that the right-hand splint should be put on and then documented to prevent worsening of Resident #103's contracture. LPN #2 was asked if she could explain why she documented that she put the hand splint on Resident #103 when it was not done. LPN #2 did not have an answer. On 03/26/2025 at 1:32 PM, during an interview the Physical Therapy Assistant (PTA) said he was familiar with Resident #103. The PTA stated that Occupational Therapy (OT) discharged Resident #103 recently but if the resident still had an order for hand splints 6 to 8 hours a day, then (gender pronoun) should be wearing them. On 03/26/2025 at 1:46 PM, during an interview the Director of Physical Therapy/Occupational Therapy (PT/OT) was asked to explain the use of the boot splint in Resident 103's room, and a right-hand splint that had not been visualized this week. The Director of PT/OT said PT started using a non-rotation AFO (Ankle-Foot Orthoses) or boot on Resident #103's foot on 9/30/24 and ended in November 2024 when Resident #103 was discharged from services. The Director of PT/OT looked at Resident #103's computerized chart and said on 11/7/24, Resident #103 was picked up private pay and therapy did not pick up the boot as a goal. The Director of PT/OT could not recall if Resident #103 got the hand splint from them or the hospital and stated on 11/7/24 only PT was requested by private pay, then on 2/14/25 private pay started for OT as well. The Director of PT/OT stated, I cannot find anything about a hand splint being ordered or anything. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/26/2025 at 1:57 PM, during an interview the Occupational Therapist remembered the resident wearing a hand splint when (gender pronoun) first came to the facility, but since the Occupational Therapist took over Resident #103 ' s private pay services in March 2025 the resident had not worn a hand splint. The Occupational Therapist revealed the resident was evaluated again on 2/14 and discharged [DATE]. The Occupational Therapist said the evaluation did not address the hand splint, and if the doctor ordered the hand splint nursing would have just put the original hand splint on Resident #103 as ordered. On 03/26/2025 at 2:33 PM, during a phone interview, the Medical Director was asked what his expectations were for Resident #103 wearing the right-hand splint. The Medical Director stated that he placed an order on 12/20/2025 and his expectations were that nursing was placing the splint on Resident #103 daily. The concern would be that Resident #103's contracture would worsen without the splint. On 03/26/2025 at 2:53 PM, during an interview, the Administrator was asked what process staff followed to document if a resident had a hand brace and why. The Administrator said they (staff) were expected to put the hand brace on the resident and then to sign the MAR. It was not appropriate to sign the MAR as if it were placed on the resident if staff had not put the brace on the resident. This surveyor requested policies addressing splint/braces and in-service on putting the splint on residents. On 03/26/2025 at 3:45 PM, during an interview the Administrator told this surveyor that they located the right-hand splint in the top of Resident #103's closet, and they put it on (Resident #103 ' s) right hand. On 03/26/2025 at 11:19 PM, a review of page 51-52 of Resident 103's admission packet, signed on 09/27/2024, by the responsible party revealed Resident Rights which stated the resident had the right to appropriate and adequate nursing and medical care, protective and support services. On 03/27/2025 at 10:39 AM, during an interview, the Director of Nursing (DON) was asked what process nursing was expected to follow when there was an order for a hand splint on the MAR, and why. The DON stated that the nurse should review the order, place the splint on the resident and document it on the MAR. The DON said it was not appropriate to document the hand splint was placed on the resident if they did not do it because the nurse was not carrying out the physician's order and that could result in further decline of the resident. On 03/27/2025 at 11:09 AM, review of the Med Pass Checklist revealed to always read the Medication Administration Record (MAR), but did not address orders for hand splints. No other policies or in-services were provided. During an interview with Certified Nursing Assistant (CNA) #10 on 03/27/2025 at 11:13 AM, CNA #10 revealed she would not do anything if she had seen Resident #103's right-hand splint in resident's room, because she would assume it is something that physical therapy would put on and take off of Resident #103. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/27/2025 at 1:33 PM, LPN #7 stated the last time she saw Resident 103's hand splint it was resting on (gender pronoun) dresser, but she had seen it in the floor in the past. LPN #7 had charted she placed the hand splint on Resident #7 on 03/24/25 and 03/25/2025 and was asked why the hand-splint was being charted if it was not put on Resident #103. LPN #7 stated, I do not know. I just know [Resident #103] does not like them. This surveyor asked what the process for the resident wearing the splint was. LPN #7 stated, Well PT used to come and put them [the splint] on [Resident #103].

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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, record review, interview, and facility policy review, the facility failed to ensure manufacturer specifications were followed to maintain food quality; dietary staff washed their hands and changed their gloves before handling food items; hot food items were maintained at or above 135 degrees Fahrenheit on the steam table while awaiting service and cold food items were maintained at or below 41 degrees Fahrenheit for 1 of 1 meal observed. The findings are: 1. On 3/26/25 at 11:05 AM, this surveyor observed 7 bags of hamburger buns, each containing 12 buns. There was one bag that contained 5 hamburger buns. The buns had been left on the bread rack by the ice machine since they were received on 3/21/2025. The manufacturer's specification was to keep frozen when received. The Dietary Manager was interviewed and asked how long the hamburger buns had been out. The Dietary Manager stated since the time of purchase, and they have never been put in the freezer. 2. On 3/26/25 at 11:43 AM, Dietary [NAME] (DC) #3 removed a log of butter from the refrigerator and placed it on the counter. Without washing her hands, DC #3 then put on gloves, contaminating her gloves in the process. Afterwards, DC #3 touched the deep fryer basket handle and unzipped a clear bag containing slices of bread, which were to be used for making sandwiches. With her contaminated glove, DC #3 also touched the slices of bread. DC #3 was interviewed and was asked what the concerns were for not washing your hands after disposing of contaminated gloves. She stated, Cross contamination. 3. On 3/26/25 at 11:50 AM, DC #4 wore gloves on her hands when she removed breaded chicken fried steaks from the bag and placed them in the deep fryer baskets. DC #4 then picked up the baskets by their handles and lowered them into hot oil. After that, DC #4 grabbed a spray bottle and sprayed the inside of a pan. Without washing her hands, DC #4 picked up a clean blade and attached it to the base of the blender to be used in pureeing foods to be served to the residents who required mechanical soft diets and/or pureed diets. 4. On 03/26/25 at 11:53 AM, DC #4 placed 10 servings of chicken fried steaks into a blender and ground the meat. DC #4 was interviewed and asked what she should have done after touching dirty objects and before handling food or clean equipment. She stated she should have removed the gloves and washed her hands. 5. On 3/26/25 at 12:32 PM, nine bags of ham sandwiches were in a container on the counter to be served to the residents who requested a ham sandwich. The temperature of the sandwiches, when taken and read by DC #3, was 45 degrees Fahrenheit. During an interview with DC #3, she was asked what temperature cold foods should be. She stated 41 degrees Fahrenheit and below. They were supposed to be on ice. 6. On 3/26/25 at 1:12 PM, DC # 3 was asked to check the temperatures of the chef salad at the bottom of the cart ready to be served to the residents who ask for chef salad. She did and stated it was 61 degrees Fahrenheit and that it was hot. At 1:14 PM, the Dietary Manager stated anything cold should be on ice. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 3/26/25 at 1:17 PM, Dietary Aide (DA) #5, who was on the tray line assisting with the lunch meal service, picked up cartons of supplements, cans of cola, cartons of milk, ice cream cartons and placed them on the trays. Without washing her hands, she used her contaminated hands to pick up glasses by their rims and place them on the trays. DA #5 was asked what she should have done after touching dirty objects and before handling clean equipment, and she stated wash her hands. 8. The review of facility policy titled, Handwashing and Glove Usage in Food Service, not dated, and provided by the Administrator on 3/26/2025 indicated hands should be washed before starting work, after leaving and returning to the kitchen prep area, and after touching anything else such as dirty equipment and work surfaces.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, facility policy review, and facility document review, it was determined the facility failed to ensure staff performed hand hygiene while passing ice to residents to prevent the spread of infection and cross contamination. This failed practice had the potential spread of infection to all residents on the 400 Hall who received ice. The facility also failed to ensure residents were free from the risk of infection by providing a safe, sanitary environment related to flushing a feeding tube by not following enhanced barrier precautions, specifically ensuring the nurse wore a gown during 1 of 1 observation of flushing the feeding tube of 1 sampled (Resident #103) resident. The findings include: 1. A review of a facility policy titled, Ice/Scoop, Handling the, with a revision date 11/22/16, revealed staff should always wash their hands thoroughly before handling the ice scoop. a. A review of a facility policy titled, Handwashing and Glove usage in Food Service, revealed food handlers must wash their hands after touching anything else such as dirty equipment, work surfaces or clothes. b. A review of the In-service on Hand Hygiene, indicated the facility in-serviced the staff in the months of February, May and August of 2024, revealing all personnel should follow hand washing procedures to prevent the spread of infection. c. On 03/25/2025 at 10:06 AM, Certified Nursing Assistant (CNA) #1 was observed filling ice and water cups on the 400 Hall. CNA #1 walked into resident rooms [ROOM NUMBER] without using hand sanitizer. She picked up the residents ' drinking cups, opened the bathroom doors, took a step into the bathroom, put water in the cup, then came back to the ice chest. CNA #1 picked up the scoop, opened the ice chest and put ice in the cup. CNA #1 went back to the bedside and placed the cup on the bedside table. As she exited the room, she did use hand sanitizer. d. On 03/25/2025 at 10:25 AM, during an interview, CNA #1 was asked about the process of hand hygiene while passing ice and refilling cups. CNA #1 stated I use hand hygiene upon entering the room, get the cup, refill it and use hand hygiene as leaving the room. She revealed staff are in-serviced quarterly on hand hygiene. CNA #1 said after touching items in the resident environment such as doorknobs and faucet handle to refill the water cup, hand sanitizer should have been used before picking up the ice scoop and getting ice from the ice chest to prevent cross contamination, and by not using the hand sanitizer, she could spread infection to other residents. e. During an interview with the Administrator on 03/26/25 at 11:00 AM, the Administrator was asked what the hand hygiene process was that staff are expected to perform when passing ice/water. The Administrator said they were expected to use hand sanitizer before entering the room, empty the old ice and water, put new ice and water in the cup, put the cup back on the bedside table and hand sanitize again. If they go in a room and get the cup, touch things in a resident's room, door and doorknob, staff would be expected to sanitize again before getting in the ice chest and handling the scoop. She confirmed staff were in-serviced quarterly on hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. During an interview with the Minimum Data Set/Infection Preventionist (MDS/IP) Nurse on 03/27/2025 at 09:33 AM, the MDS/IP Nurse was asked what the hand hygiene process that staff were expected to follow when passing ice/water was. The MDS/IP Nurse stated to use hand sanitizer upon entering the room and when exiting the room, and after touching things in a resident's room such as the door and doorknob, to prevent cross contamination. g. During an interview with Director of Nursing (DON) on 03/27/2025 at 10:30 AM, the DON was asked what the hand hygiene process that staff were expected to follow when passing ice/water was. The DON stated to use hand sanitizer when going into a room, get the water cup, dump the old ice and water out, hand sanitize, fill the ice cup, place the cup on the bedside table, use hand sanitizer before going to the roommate, repeat steps, and sanitize hands when leaving the room. The DON stated staff would be expected to use hand sanitizer after environmental contact and before using the ice scoop. She confirmed staff would spread infection to other residents if hand sanitizer was not used 2. A review of the Medical Diagnosis, revealed Resident #103 with diagnoses that included stroke, dysphasia, and aphasia. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/2024 revealed Resident #103 had short term and long term memory loss per a Staff Assessment for Mental Status (SAMS). Section K0520 indicated Resident #103 had a feeding tube. a. Review of a policy/procedure titled, Enteral Feedings, Administration via Gastrostomy, revised 11/22/2016, revealed wearing gloves is considered part of the equipment and supplies necessary for care. The policy did not mention Enhanced Barrier Precautions (EBP) or the requirement of a gown during feeding tube care. b. Review of policy titled, Center for Clinical Standards and Quality/Quality, Safety & Oversight Group, dated 03/20/2024, revealed Enhanced Barrier Precautions (EBP) were recommended for residents with chronic wounds and indwelling devices, including feeding tubes, regardless of their multidrug resistant status. Transmission of multidrug resistant infections is common is long term care (LTC) facilities putting many residents at increased risk of developing a colonization or becoming infected with a multidrug Resistant organism (MDRO). The Center for Disease Control (CDC) recommends personal protective equipment (PPE), is considered an infection control intervention, gowning, and gloving during high contact procedures including indwelling devices such as flushing a resident's feeding tube. c. Review of an in-service titled, Enhanced Barrier Precautions, dated 03/29/2024, revealed residents with a Percutaneous Endoscopic Gastrostomy (peg tube) should be on EBP, and a gown and gloves should be worn at all times during high contact resident care. Licensed Practical Nurse (LPN)'s #7's signature was not noted on this in-service. d. Review of the Order Summary Report, dated 09/27/2024, revealed Resident #103 was on EBP related to a peg tube all day, and on night shift. Flush peg tube with 30cc of water before and after feedings related to gastrostomy and as needed according to gastrostomy status. e. Review of Care Plan Report, revised 11/14/2024, revealed Resident #103 had a feeding tube related to a stroke and head of bed should be at 30 degrees during, and 30 minutes after, tube feedings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. A review of Interdisciplinary Care Plan (ICP) Multidisciplinary Care Conference, dated 12/30/2024, revealed a meeting on 01/01/2025 at 08:00AM, the meeting noted Resident #103 was currently on a nothing by mouth (NPO) diet, and was receiving enteral nutritional formula for malnutrition 1.5 calories at 70cc/hour through a feeding tube. Resident #103's goals were to maintain the current level of function (LOF). Family, nursing, dietary, and social services were present. g. Review of Care Area Assessment (CAA), dated 03/25/2025, revealed Resident #103 had physical and mental conditions such as oral motor functions that prevented Resident #103 from swallowing, and Resident #103 required a feeding tube for nutrition. Care plan consideration was to minimize risks. h. On 03/24/2025 at 01:39 PM, this surveyor observed Resident #103 receiving nutritional formula 1.5 calories at 70cc/hour. i. On 03/25/2025 at 09:48 AM, this surveyor observed a feeding tube hanging from a feeding tube pole. Certified Nursing Assistant (CNA) #8 and CNA #9, revealed a nurse turned the feeding tube off for a shower. j. On 03/25/2025 at 10:00 AM, during a concurrent observation and interview, LPN #7 was observed at the bedside with the privacy curtain pulled, and gloves on both hands. The feeding tube was taken from where it was resting on the feeding tube pole, a sterile syringe was attached to the feeding tube and 30cc water was poured into the syringe and went down without resistance. LPN #7 was asked what the process was for staff to ensure good infection control when flushing a PEG tube. LPN #7 said staff should wash their hands and wear gloves. LPN #7 stated staff would wear a gown during perineal care for EBP. LPN #7 was asked what urinary tract infection (UTI) Resident #103 had that required EBP. LPN #7 said Resident #103 did not have a UTI. LPN #7 walked outside the door and read aloud the enhanced barrier sign and said, I made a mistake, then revealed according to the EBP sign she should have worn a gown and gloves for device care and stated signage identified a feeding tube as a device that required EBP. LPN #7 stated that she would have to find out why a feeding tube required EBP. k. On 03/25/2025 at 10:20 AM, during an interview, LPN #7 said she checked and the reason for EBP for Resident #103 was while the syringe was connected to the feeding tube gas could bring up stomach contents getting everywhere and could be an infection control issue. l. During an interview with the Administrator on 03/26/2025 at 11:13 AM, the Administrator was asked what procedure nursing was expected to follow when flushing a feeding tube and why. The Administrator said she expects staff to wear a gown and gloves before opening the PEG tube to flush or restart the feeding tube because she did not want them to introduce bacteria into the resident's stomach. The Administrator revealed nursing completed online skills for PEG tubes. The Administrator was asked to provide the policy/procedure on PEG tubes, enhanced barrier precautions, and in-services. m. On 03/26/2025 at 01:20 PM, during an interview, LPN #2 confirmed she was Resident #103's nurse on this day. LPN #2 was asked where she could find EBP interventions and what they were. LPN #2 asked another staff member for assistance in finding the care plan, then revealed that she could not find the interventions for EBP, but that would be useful for the nurses to know. n. On 03/26/2025 at 03:10 PM, during an interview, the MDS Nurse pulled up documentation on Resident #103's computerized chart showing EBP was documented on 02/07/2025 under PEG tube. A copy was not provided. (continued on next page)

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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	o. On 03/27/2025 at 09:26 AM, during an interview, the Medical Director stated that he attended QAPI (Quality Assurance and Performance Improvement) meetings and was kept informed about what was going on in the facility. EBP were in place and there were currently no concerns. p. On 03/27/2025 at 10:30 AM, during an interview, the Director of Nursing (DON) was asked the process staff were taught in order to identify residents on EBP. The DON said the facility had a list of residents on EBP and, for example, if their foley (urinary indwelling catheter) was removed they might come off the list. The facility reviewed the list daily, and there was a sign on the door that indicated the resident was on EBP. If a nurse was going to flush a feeding tube that was turned off, the process the nurse was expected to follow was to wash their hands and gown and glove before touching the resident. If they open the end of the feeding tube but are not gowned and gloved the nurse could introduce an infection to the resident, or the resident could introduce an infection to the nurse that could spread to others. q. On 03/27/2025 at 12:36 PM, during an interview, CNA #10 stated EBP could be identified by signage. CNA #10 stated he followed the directions on the signage, and as instructed by nursing and policy. r. On 03/27/2025 at 12:53 PM, the Administrator provided a printout from an online skills in-service showing LPN #7 and nursing staff were educated on PEG tubes on 11/14/2025.