STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045379	A. BUILDING _____ B. WING _____	07/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLAGES OF GENERAL BAPTIST HEALTH CARE WEST	6810 SOUTH HAZEL STREET 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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 769), (AR 77), (AR 098) and (AR 978) were substantiated all or in part in these findings. Based on observation, record review and interview the facility failed to ensure the same surface of the cleansing wipe was not used more than once, cleansing was not done in a back and forth motion and/or circular motion, the labia was separated during incontinent care for 3 (Residents #3, #7 and #9), and all surfaces of the skin were cleansed during incontinent care to promote good hygiene and prevent odors for 1 (Resident #7) of 3 (Residents #3, #6 and #7) case mix residents that were dependent for incontinent care. The findings are: 1. Resident #3 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) with Assessment Reference Date (ARD) 03/18/2020, documented the resident scored 9 (08-12 indicates moderately impaired) per a Brief Interview for Mental Status (BIMS), required total dependency of 2 person for transfers, total dependency of 1 person for bed mobility, dressing and personal hygiene and was always incontinent of bowel and bladder. a. The Comprehensive Care Plan documented, Problem Potential for alteration in skin integrity r/t incontinent of bowel and bladder. History of irritation to the breast skin folds abdomen folds and bilaterally hip and buttocks area. (Resident #3) will maintain skin integrity and be clean and dry thru this quarter - (Entered 02/09/2016 Edited . 07/3/2019). Approaches; Assist/ (and or) check with incontinence every 2 hours and prn (as needed) .Turn and repositioning q (every) 2 hrs (hours) and prn .Incontinent care with each episode, skin barrier after each episode . b. On 07/15/2020 at 10:40 a.m., Certified Nursing Assistants (CNA's) #1 and #2 entered the room and told the resident that they were going to check her for incontinence. The resident's pants were removed, and the incontinent brief was soiled with urine. CNA #1 stated We don't have any small cloths so we will have to use a towel. CNA #1 wet the towel on both ends and put soap on one end of the towel. She folded the incontinent brief down between the resident's legs and wiped the peri area in a back and forth and circular motion with the same surface of the towel. CNA #1 did not separate and cleanse the labia area. The resident was turned on the side and CNA #1 wiped the outer buttocks in a back and forth motion and the rectal area front to back with the same surface of the towel. With the same gloves she applied a clean incontinent brief. 2. Resident #7 had [DIAGNOSES REDACTED]. The MDS with ARD of 04/28/2020 moderately impaired in cognitive skills for daily decision making per the Staff Assessment for Mental Status, was risk for pressure ulcers and has one Stage II pressure ulcer and was always incontinent of bowel and bladder. a. The Comprehensive Care Plan documented, Problem; ADL (Activities of Daily Living) deficit unable to perform adl's, require (limited, extensive, total) assistance per 1-2 staff. Approaches, Apply skin barrier after each incontinent episode .Turn and reposition q 2 hrs and prn . b. On 07/15/2020 at 11:45 a.m., CNA's #1 and #2 entered the Resident #7's room. CNA #1 wet a towel then put the resident's Body Wash on one end of the towel. She unfastened the resident's incontinent brief and rolled the brief between the resident's legs. CNA #1 wiped twice across the lower abdominal area and then wiped the vaginal area in a back and forth motion four times with the same surface of the towel. She flipped the towel and dried the area. She did not separate and cleanse the labia area. CNA #1 and #2 turned the resident. The resident was incontinent of bowel, CNA #1 wiped excess feces with the soiled incontinent brief and with the same contaminated gloves wiped the rectal area from front to back twice with the same surface of the towel. She rotated the towel and wiped twice in a back and forth motion over the rectal area with the same surface of the towel. She rotated the towel again and wiped the outer left buttock and the right buttocks with the same surface of the towel. She then flipped the towel and dried the area. With the same contaminated gloves, she applied the clean incontinent brief. CNA #1 did not apply the skin barrier cream that was on the overbed table. c. On 07/15/2020 at 4:32 p.m., the Treatment Nurse and CNA #9 performed wound care. When the resident was turned, the resident had been incontinent of urine. CNA #9 performed incontinent care on the peri-area, changed the resident's sheets, positioned the resident on her back and covered the resident up. The areas of the bilateral buttocks, upper thighs and rectal area that had come in contact with the urine were not cleaned. 3. Resident #9 had [DIAGNOSES REDACTED]. The Annual MDS with ARD 07/09/2020, documented the resident scored 7 (08-12 indicates moderately impaired) per a BIMS, required total dependence of 2 person for dressing, toilet use, personal hygiene and extensive assistance of 1 person for bed mobility, was always incontinent of bladder, frequently incontinent of bowel, and was at risk for skin breakdown. a. The Comprehensive Care Plan documented, Problem; Potential for alteration in skin integrity r/t (related to) fragile skin, decreased mobility. Frequently incontinent episodes of bowel and bladder . Goal (Resident #9) will maintain skin integrity and be clean and dry thru this quarter. Approaches, . Assist/check with incontinence every 2 hours and prn . Incontinent care with each episode, skin barrier after each episode . b. On 07/15/2020 at 1:30 p.m., CNA's #1 and #2 entered the resident's room. CNA #2 wet a towel on both ends and put shampoo/ (and or) body wash on the towel. She rolled the incontinent brief between the resident's legs and wiped across the lower abdominal area three times and then wiped the left groin area, the right groin area and down the peri area with the same surface of the towel in a back and forth motion. She did not separate and cleanse the labia area. With the same gloves she applied Vaseline on the front peri area. The CNA's turned the resident and CNA #2 cleansed the rectal area wiping in a back and forth motion with the same surface of the towel she wiped the outer right and left buttocks. She then applied Vaseline on bilateral buttocks without changing her gloves. 4. On 07/17/2020 at 12:58 p.m., CNA #2 was asked, How often are the residents to be turned, repositioned and checked for incontinence? She stated, Every 2 hours. CNA #2 was asked, Have you had training on incontinent care? She stated, Yes. CNA #2 was asked if you should wipe with the same surface of the towel. CNA #2 stated, No. CNA #2 was asked, Should the soap be rinsed from the resident's skin? She stated, Yes, I thought I did. 5. On 07/17/2020 at 2:28 p.m., CNA #9 was asked if she was the trainer for the CNA's. CNA #9 stated, Yes. She was asked, How often should the residents be turned, repositioned and checked for incontinence? CNA #9 stated, Every 2 hours. She was asked if all surfaces of the skin should be cleansed after exposure to urine. She stated, I know I messed up. 6. On 07/20/2020 at 10:34 a.m., the Assistant Director of Nurses (ADON) was asked, Who was the trainer for the staff for incontinent care? The ADON stated, (CNA #9). The ADON was asked, Who monitors to ensure that the incontinent care is provided in a timely manner? The ADON stated, The Nurses. The ADON was asked, Should the staff wipe in a back and forth motion during incontinent care? The ADON stated. No. The ADON was asked, How often should a resident be checked for incontinence and repositioning? The ADON stated Every 2 hours. 7. The Facility Policy and Procedure for Incontinence-Peri-Care provided by the Treatment Nurse on 07/17/2020 at 3:45 p.m. documented, Purpose, 1. To keep skin clean . 3. To prevent skin breakdown. 4. To prevent infection .Procedure: . 3. wash all soiled skin areas and dry very well, especially between skin folds, above and below peri area. 4. Apply protective skin lubricant and rub well into skin . 11. For female: Use a separate portion of the washcloth for each stroke. Change washcloths as necessary. Separate the labia and cleanse in a downward motion from the pubis to anal area. Wash between the labia including the urethral meatus and vaginal area. Rinse well and pat dry.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 098) was substantiated, all or in part in these findings. Based on observation, record review and interview the facility failed to ensure the Comprehensive Care Plan was followed for repositioning and providing incontinent care every 2 hours and failed to rinse the skin of soap to maintain the resident's skin integrity for 2 (Resident #7 and #9) of 3 (Resident #3, #7 and #9) case mix residents on the 200 Hall that required turning, repositioning and incontinent care every 2 hours as documented on the Comprehensive Care Plan. The findings are: 1. Resident #7 had [DIAGNOSES REDACTED]. and has one Stage II pressure ulcer and was always incontinent of bowel and bladder. a. The Comprehensive Care plan documented, Problem; ADL (Activity of Daily Living) deficit unable to perform ADL's, require (limited, extensive, total) assistance per 1-2 staff. Approaches, Apply skin barrier after each incontinent episode .Turn and reposition q (every) 2 hrs and prn . b. On 07/15/2020 at 11:45 a.m., Certified Nursing Assistant (CNA's) #1 and #2 entered the resident's room. Resident #7 had remained lying in bed mainly on her back with a device under her legs with the left heel lying flat on the mattress from 9:10 a.m. to 11:45 a.m. (surveyor kept resident in line of sight for 2 hours and 35 minutes.) CNA #1 wet a towel then put the resident's Body Wash on one end of the towel. She unfastened the resident's incontinent brief and rolled the brief between the resident's legs. CNA #1 wiped twice across the lower abdominal area and then wiped the vaginal area in a back and forth motion four times with the same surface of the towel. She flipped the towel and dried the area. CNA's #1 and #2 turned the resident, a dressing was on the coccyx dated 07/13/2020. The resident was incontinent of bowel. CNA #1 wiped excess feces with the soiled incontinent brief then wiped the rectal area from front to back twice with the same surface of the towel, she then rotated the towel again and wiped the outer left buttock and the right buttocks with the same surface of the towel. The soap was not rinsed off the resident's skin. With the same contaminated gloves, she applied the clean incontinent brief. CNA #1 did not apply the skin barrier cream that was on the overbed table, CNA #1 did not apply skin barrier cream to the resident's skin. 2. Resident #9 had [DIAGNOSES REDACTED]. The Annual MDS with ARD 07/09/2020, documented the resident scored 7 (08-12 indicates moderately impaired) per a BIMS, required total dependence of 2 person for dressing, toilet use, personal hygiene and extensive assistance of 1 person for bed mobility. The resident was always incontinent of bladder, and frequently incontinent of bowel. The resident is at risk for skin breakdown. a. The Comprehensive Care Plan documented, Problem; Potential for alteration in skin integrity r/t (related to) fragile skin, decreased mobility. Frequently incontinent episodes of bowel and bladder . Goal (Resident's name) will maintain skin integrity and be clean and dry thru this quarter . Approaches, .Assist/check with incontinence every 2 hours and prn .Incontinent care with each episode, skin barrier after each episode . b. On 07/15/2020 at 1:30 p.m., CNA's #1 and #2 entered the resident's room. The resident was sitting up in the wheelchair with lift pad under her from 9:10 a.m. to 1:30 p.m., (the surveyor had Resident #9 in her line of sight for approximately 4 hours and 20 minutes). CNA #2 wet a towel on both ends and put shampoo/ (and or) body wash on the towel. She rolled the incontinent brief between the resident's legs and wiped across the lower abdominal area three times and then wiped the left groin area, the right groin area and down the peri area with the same surface of the towel in a back and forth motion. She did not separate and cleanse the labia area. With the same gloves she applied Vaseline on the front peri area. The CNA's turned the resident and CNA #2 cleansed the rectal area wiping in a back and forth motion with the same surface of the towel she wiped the outer right and left buttocks. She then applied Vaseline on bilateral buttocks without changing her gloves. The shampoo/body wash was not rinsed off the resident's skin. The instructions documented Wash and rinse the skin. 4. On 07/17/2020 at 12:58 p.m., CNA #2 was asked, How often are the residents to be turned, repositioned and checked for incontinence? She stated, Every 2 hours. CNA #2 was asked, Have you had training on incontinent care? She stated, Yes. CNA #2 was asked if you should wipe with the same surface of the towel. CNA #2 stated, No. CNA #2 was asked, Should the soap be rinsed from the resident's skin? She stated, Yes, I thought I did. CNA #2 was asked, Should the resident heels be off loaded. She stated, Yes, there's the pad that we put under her legs. CNA #2 was asked, Should you ensure that the heel is not touching the mattress. She stated. Yes. 6. On 07/17/2020 at 1:52 p.m., Licensed Practical Nurse (LPN) #1 was asked, Who monitors to ensure that the residents are turned, repositioned and changed in a timely manner? LPN #1 stated, The Nurses, we make rounds on the halls. LPN #1 was asked, Is Resident #7 heels to be off loaded? LPN #1 stated Yes, she has a brace under her legs and the heel is to be off loaded. LPN #1 was asked, Who trains the CNA's on incontinent care? LPN #1 stated, (CNA #9) 7. On 07/20/2020 at 10:34 a.m., the Assistant Director of Nursing (ADON) was asked, Who's the trainer for the staff for incontinent care? The ADON stated,(CNA #9). The ADON was asked, Who monitors to ensure that the incontinent care is provided in a timely manner? The ADON stated, The Nurses. The ADON was asked, Should the staff wipe in a back and forth motion during incontinent care? The ADON stated. No. The ADON was asked, How often should resident be checked for incontinence and repositioned? The ADON stated Every 2 hours.
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 observation, record review and interview, the facility failed to ensure implementation of proper infection prevention and control practices to prevent the development and transmission of Covid -19 and other communicable diseases and infections by not wearing a face mask to cover the nose for 18 Nursing Staff, 2 Housekeeping/Laundry staff and 4 Dietary Staff. This failed practice had the potential to affect 131 residents in the facility according to the facility census received from the Administrator on 07/13/2020. The findings are: The following staff were wearing the face mask with their nose exposed or not on as follows: a. On 07/13/2020 at 12:10 p.m., Housekeeping Staff #1 was passing out resident laundry on the 500 Hall with mask on with nose exposed. b. On 07/13/2020 at 12:22 p.m., Certified Nursing Assistant (CNA) #3 was wearing mask on the 300 Hall with the nose exposed. c. On 07/15/2020 at 8:10 a.m., CNA #9 was at the front entrance screening staff into the facility with the mask on with the nose exposed. d. On 07/15/2020 at 8:57 a.m., Registered Nurse #1 was at the medication cart with mask on with her nose exposed and CNA #6 was on the 500 Hall with her mask on with the nose exposed. e. On 07/15/2020 at 8:58 a.m., CNA #8 was on the 500 Hall with her mask on with the nose exposed. f. On 07/15/2020 at 9:03 a.m., CNA #7 was on the 500 Hall picking up trays with her mask on with the nose exposed. g. On 07/15/2020 at 11:18 a.m., CNA #5 and #6 were at the Nurses Station with the mask on with the nose exposed. h. On 07/15/2020 at 12:35 p.m., CNA #13 was at the Nurses Station with her mask off. i. On 07/15/2020 at 12:40 p.m., CNA #13 and #14 were at the Nurses Station with their mask on with the nose exposed. j. On 07/15/2020 at 3:42 p.m., Licensed Practical Nurse #2 was sitting at the Nurses station with 2 other staff members within 6 feet with her mask off and tucked under her chin. k. On 07/16/2020 at 8:24 a.m., CNA #10 was passing trays on the 200 Hall was passing trays. l. On 07/16/2020 at 11:45 a.m., Dietary Aide (DA) #1 was preparing salads the mask was sitting under her nose with her nose exposed. m. On 07/16/2020 at 11:47 a.m., DA#2's mask was sitting below her nose with her nose exposed., DA #3 was unloading boxes to the freezer and his nose was exposed and Dietary staff #4 had her mask with the nose exposed while walking through the kitchen area. n. On 07/16/2020 at 11:52 a.m., Dietary staff #4 while speaking to the surveyor and while taking temperatures on the 1st steam table o. On 07/16/2020 at 11:56 p.m., DA #1 was serving trays from the first steam table with the mask on with the nose exposed. p. On 07/16/2020 at 12:28 p.m., DA#2's mask was sitting below her nose with her nose exposed when putting health shakes into cups. q. On 07/16/2020 at 12:29 p.m., DA #3 was carrying a tray of uncovered desserts with his mask on with the nose exposed. r. On 07/16/2020 at 12:35 p.m., Dietary staff #4 was serving the 2nd steam table with the mask on with the nose exposed s. On 07/16/2020 at 2:22 p.m., CNA #12 was in the Administrator Office with her mask pulled down with the nose exposed. t. On 07/16/2020 at 2:23 p.m., Housekeeper #2 was at the dryer folding clothes with the mask on with her nose exposed. u. On 07/17/2020 at 12:51 p.m., LPN #1 was at the Nurses Station with her mask on with her nose exposed. v. On 07/17/2020 at 1:54 p.m., CNA #11 was standing in the hall with the Administrator with her mask off her nose. 2. On 07/16/2020 at 3:04 p.m., the Housekeeping Supervisor was asked, Are the staff to wear mask covering the mouth and nose at all times in the laundry area when folding the laundry? She replied, Yes. She was asked, When the Housekeeping staff are passing out resident's laundry, should they have mask on covering mouth and nose? She replied, Yes. 3. On 07/17/2020 at 1:52 p.m., Licensed Practical Nurse #1 (LPN) was asked How should the staff be wearing their mask? She replied, They should be covering the mouth and nose. 4. On 07/17/2020 at 3:07 p.m., the Dietary Manager (DM) was asked, Should the staff be wearing the mask covering the mouth and nose while preparing food? She replied, Yes. 5. On 07/20/2020 at 1:28 p.m., The Administrator was informed that there was a concern with the staff not wearing mask correctly. The Administrator replied, Yes, I understand that is an issue. She was informed the Nurses, CNA's, Dietary and Laundry staff were wearing the mask with the nose exposed. Surveyor stated, This is very important that the staff wear the mask appropriately. The Administrator replied, Yes I'm am aware. She was asked if the mask should cover the staff's mouth and nose at all times. She stated, Yes. 6. On 07/20/2020 at 2:28 p.m., CNA #9 was asked, How should the mask be worn? She replied, Covering the

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) nose and mouth. She was asked, Should the mask be worn the entire time you are in the facility? She replied, Yes. 7. On 7;20/2020 at 10:34 a.m., the Assistant Director of Nurses (ADON) was asked, Have you noticed that staff are not wearing their mask correctly? She replied, Yes, She was asked, Should they be wearing their mask below their nose? The ADON replied, No. The ADON was asked, Have you addressed this issue? She replied, Yes. I told them to pull it up. 8. The Centers for Disease Control and Prevention. Coronavirus Disease 2019 (Covid 19) documented, Background Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens. . Preparing for COVID-19 in Nursing Homes. Updated June 25, 2020 added guidance about new requirements for nursing homes to report to the National Healthcare Safety Network (NHSN). Implement Source Control Measures. Healthcare Personnel (HCP) should wear a facemask at all times while they are in the facility. When available, face masks are generally preferred over cloth face coverings for HCP as face masks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemask's is available.