STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045196	A. BUILDING _____ B. WING _____	**07/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHRIDGE VILLAGE NURSING AND REHAB	**400 SOUTHRIDGE PARKWAY HEBER SPRINGS, AR 72543**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure Personal Protective Equipment (PPE) for re-use was properly removed and replaced for 1 (Resident #1) of 5 (Resident #1, #2, #3, #4, and #5) sampled residents who were on isolation and failed to ensure staff sanitized their hands after contact with contaminated objects and before and after assisting residents with a meal to prevent the spread of infections to others and the residents during a COVID-19 Pandemic. These failed practices had the potential to affect 13 residents on isolation according to the list provided by the Assistant Administrator on 07/31/2020 and 84 residents who resided in the facility, according to the Resident Matrix, provided by the Administrator on 07/29/2020. The findings are: 1. Resident #1 had a [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/13/2020 documented the resident scored 4 (0-7 indicates severely impaired) per a Brief Interview for Mental Status (BIMS), and required extensive assistance with one person assist for bed mobility, transfer and bathing, limited assistance with one person assist for dressing, toilet use and personal hygiene, and supervision with one person assist for locomotion and was independent with set up for eating and was always incontinent of bowel and bladder. a. The July 2020 Physician orders [REDACTED]. b. The updated Care Plan documented, Psychosocial: The resident is at risk for alteration in psychosocial functioning due to requiring medically imposed isolation r/t COVID 19 precautions after hospital stay. Date Initialed: 07/29/2020 .provide activity: 1:1 visits to ensure socialization . c. On 7/29/2020 at 11:03 a.m., Nursing Assistant (NA) #1 and Registered Nurse (RN) #2 were standing outside of Resident #1's room. NA #1 was wearing a yellow surgical mask and the bottom half of the mask was torn and missing the outer layer with the white layer exposed. She donned PPE (blue plastic gown, gloves, N-95 mask) outside of Resident #1's door. The student entered the room, assisted the resident then began donning her PPE. When she donned her blue plastic gown, she grabbed the outside of the sleeves, removed her arms then pulled the gown over her head, with her arms from underneath. She grabbed the gown and folded it, with the contaminated side on the outside, then rolled the gown up against her uniform before placing it in a personal plastic bag. After she exited the room, she removed her N-95 and placed her yellow mask back on. d. On 07/29/2020 at 11:14 a.m., NA #1 was asked, When should you replace your surgical mask? She stated, When its soiled or torn. She was asked, Should you replace your mask since half of it is torn and missing a layer of the outer material? She stated, Yes, I didn't notice that had happened, I was giving a resident a shower and she grabbed at my mask. She was asked, Have you been trained to don PPE? She stated, Yes, I'm learning. She was asked, Should you fold your gown with the contaminated side out? She stated, No. She was asked, When rolling up your gown with the contaminated side out, should the gown touch your uniform? She stated, No. e. On 07/29/2020 at 11:17 a.m., RN #2 was asked, When should you or staff replace a surgical mask? She stated, When it becomes soiled, torn or contaminated. She was asked, Has the student been trained on donning PPE? She stated, Yes, she is still learning. She was asked, Did she properly don her gown? She stated, No, she should of pulled the gown off so the contaminated side was on the inside, and fold it away from her uniform, instead of the contaminated side on the outside, and she shouldn't have rolled the gown up against her uniform. 2. On 07/29/2020 at 11:36 a.m., CNA #1, entered Resident room [ROOM NUMBER] carrying a walker. She placed the walker on the floor and knocked on the bathroom door. She entered the bathroom with the walker and after a few minutes she exited the bathroom carrying the walker. She closed the bathroom door then exited the resident's room. She then entered Resident room [ROOM NUMBER], she opened a resident's closet and placed the walker inside and closed the closet door then exited the room. She walked down the hall and sanitized her hands with the wall sanitizer. a. On 07/29/2020 at 11:42 a.m., CNA #1 was asked, When should you sanitize your hands? She stated, Before and after when assisting a resident, before and after resident care, and before entering and after leaving a resident's room. She was asked, When you brought the wheeled walker into room [ROOM NUMBER], is it sanitary to take the walker and place it in another resident's room? She stated, No, I should have wiped the wheeled walker down, before I placed it in the resident's closet. 3. On 07/29/2020 at 12:17 p.m., 4 residents were sitting at separate tables in the main dining room. RN #1 came into the dining room and spoke in general to the 3 CNA's that were present, including CNA #1, and stated, Be sure you have alcohol gel in your pocket, you need to use it between residents . a. At 12:35 p.m., CNA #1 was assisting Resident #6 with lunch and was asked by another CNA to assist with positioning Resident #7's chair. CNA #1 walked over and pushed on the foot of Resident #7's Geri Chair making contact with her chair, feet and blanket. CNA #1 walked back to Resident #6, picked up her spoon and offered her a bite of food. CNA #1 went to the kitchen serving door, came back to Resident #6 with 2 straws, opened one and placed it in one of her drinks and began to feed her again. CNA #1 was asked if she should have sanitized her hands after assisting with Resident #7's chair. CNA #1 stated, I should be sanitizing my hands between residents, I've got it right here in my pocket, I have no excuse. 4. On 07/30/2020 at 10:20 a.m., the DON was asked, When should staff wash or sanitize their hands? She stated, Sanitize their hands between every resident, anytime they touch anything that could be contaminated, and after every three residents wash their hands. She was asked, When should a surgical mask be replaced for a new surgical mask. She stated, If the mask is torn, soiled or not tight fitting to the face. She was asked, When donning a blue plastic gown for re-use, what is the proper way to remove for storage? She stated, It should be taken off with the contaminated side, inside, fold up away from the body and place in personal bag. She was asked, Should the gown be rolled up with the contaminated side on the outside? She stated, No. She was asked, Should the contaminated side of the gown be rolled up against the staff's uniform? The DON stated, No. She was asked, If a CNA entered a resident's room and brought a wheeled walker into this room and placed it on the floor, is it permitted for the CNA to take the same wheeled walker and place it in another's resident's room, in their closet? She stated, Absolutely not. She was asked, When a CNA enters a resident's room after knocking on the door, opening up the bathroom door by the doorknob, should the CNA sanitize their hands before entering another's resident's room and touching or opening their closet door? She stated, Yes. 5. On 07/29/2020 at 2:58 p.m., the Putting On and Taking Off PPE Policy provided by the Infection Prevention and Control Program (IPCP) documented, .Gown: unfasten gown ties, pull gown away from neck and shoulders, touching inside of gown only, turn gown inside out, fold or roll into a bundle. . 6. On 07/29/2020 at 2:58 p.m., the Handwashing/Hand Hygiene Policy provided by the IPCP documented, This facility considers hand hygiene the primary means to prevent the spread of infections to other personnel, residents and visitors. .Use an alcohol-based hand rub .or alternatively, soap .water for the following situations. .After handling used .contaminated equipment .After contact with objects .in the immediate vicinity of the resident .Before and after assisting a resident with a meal .

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.