STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195304	A. BUILDING _____ B. WING _____	**07/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHATEAU ST. JAMES REHAB AND RETIREMENT	**1980 JEFFERSON HWY LUTCHER, LA 70071**

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews, the facility failed to ensure adequate staffing to meet residents' needs as evidenced by failing to ensure residents were bathed and/or showered on their scheduled days. This deficient practice was identified for 2 (Resident #1 and Resident #3) of 5 sampled residents, and had the potential to affect any of the 87 residents who resided in the facility as documented on facility's Resident Census List. Findings: Resident #1 Review of Resident #1's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/07/2020 revealed, in part, a Brief Interview for Mental Status (BIMS) score of 12 (score of 8-12 indicated moderate cognitive impairment). Further review of the MDS revealed Resident #1 required total dependence of 1 person with bathing and was always incontinent of bowel and bladder. Review of Resident #1's Care Plan revealed, in part, the resident required assistance with Activities of Daily Living (ADLs) and staff was to provide a shower 3 times per week. In an interview on 06/30/2020 at 10:00am, Resident #1 stated she did not always get a shower as she was scheduled to have a bath. In an interview on 06/30/2020 at 2:40pm, Resident #1 stated she could not recall the last time she had a bath. Resident #1 further stated this made her feel as if she stinks and upset her. Review of Resident #1's completed care documentation for June 2020 revealed the only dates Resident #1 was recorded as having any type of bath, shower, or bed-bath were: 06/02/2020 at 11:19am complete bed bath; 06/04/2020 at 1:57pm complete bed bath; 06/11/2020 at 3:42pm complete bed bath; and 06/13/2020 at 2:27pm complete bed bath. In an interview on 06/30/2020 at 11:00am, S3Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Nurse stated bathing should be documented in completed care and per review of the documentation in the record she stated it appeared bathing was done in the month of June 2020, June 2, 2020, June 4, 2020, June 11, 2020 and June 13, 2020. In an interview on 06/29/2020 at 10:35am, S4TreatmentNucrse stated the facility has had an increase in wounds related to Covid19 pandemic. S4TreatmentNurse stated the facility does not have adequate numbers of staff to implement preventative measures. In an interview on 06/29/2020 at 10:43am, S5CertifiedNursingAssistant (CNA) stated when the facility does not staff a shower aide, the floor aide was expected to complete showers or bed baths. S5CNA stated she does not always have time to give the residents a shower or bed bath; therefore, she often skips the bath. In an interview on 06/29/2020 at 11:04am, S14LicensedPracticalNurse (LPN) stated the facility does not always staff enough aides and the rooms are re-assigned for the numbers of staff available. S10LPN stated the residents are not bathed as scheduled, and stated residents have complained about the lack of bathing. In an interview on 06/29/2020 at 12:00pm, S15CNA stated a shower aide was scheduled daily; however, the shower CNA was often pulled to work the floor. S15CNA stated the residents have suffered due to the lack of staff. S15CNA further stated the floor aides should bathe residents; however, they are assigned too many residents and they were not able to bathe the residents as scheduled. S15CNA confirmed the concerns had been brought to the attention of administration. In an interview on 06/29/2020 at 12:40pm, S1Administrator stated the facility had staffing issues and it had been discussed with S2NurseConsultant. In an interview on 06/29/2020 at 12:45pm, S2Nurse Consultant stated she had discussed staffing with S1Administrator and identified that staff were not allocated in a correct manner. S2NurseConsultant stated staffing had become an issue in the last 2 weeks and have had 4 CNA staff resign. Resident #3 Review of the record revealed Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's MDS with an ARD of 05/08/2020 revealed he had a BIMS score of 15 (score of 13-15 indicated cognitively intact). Resident #3 was totally dependent with bathing, and was always incontinent of bowel and bladder. Review of Resident #3's record revealed a care plan was developed which identified Resident #3 as requiring assistance with personal hygiene as needed, and was to have a shower/bath/whirlpool/bed-bath per his choice 3 times a week. Review of Resident #3's completed care for 06/19/2020 through 06/26/2020 revealed no documentation of bathing and/or showering having been completed. Review of Resident #3's nurse's notes from 06/22/2020 to 07/01/2020 revealed no documentation of the resident's having refused care. In an interview on 06/29/2020 at 1:00pm, S12CNA stated the facility was very short staffed, and some residents have not been bathed in weeks. S12CNA stated the staff was exhausted, and even though the facility hired agency staff, they are virtually no help because they don't do anything. S12CNA stated the residents are suffering. When asked how they were managing with turning and repositioning residents every 2 hours, S12CNA stated it wasn't being done like it was supposed to. In an interview on 06/29/2020 at 1:15pm, Resident #3 stated he has gone up to 9 days without a shower. Resident #3 stated residents were sitting in their own filth for hours, and nobody was doing anything about it. Resident #3 stated his shower days were Monday, Wednesday, and Friday. Resident #3 stated he had a shower on 06/19/2020, and was not showered again until 06/26/2020 because the shower aides were being pulled from their jobs to work the floor, and the residents were not getting showered according to their scheduled shower days. Resident #3 stated the facility hired agency staff, but all they did was sit on their phones all day, and were not performing their job duties. Resident #3 stated it was miserable and degrading. Resident #3 stated he spoke to the administrator about the lack of staff, and was told that they were using agency staff, and were trying to hire more facility staff. In an interview on 06/30/2020 at 11:51am S13CNA stated she had found residents soiled and wet when she arrived at work. S13CNA stated they were working very short staffed, and residents were not getting turned every 2 hours, not getting showered or bathed when they were supposed to, and were not being fed as needed. S13CNA confirmed the facility was using agency staff, but they were not performing their work duties as needed. S13CNA stated she reported this to administration. In an interview on 06/30/2020 at 2:30pm, S2Nurse Consultant confirmed the facility was having a staffing problem and had pulled shower aides to work the floor. S2Nurse Consultant further confirmed some of the residents had been without full showers. In an interview on 07/01/2020 at 11:19am, S6CNA confirmed the facility was short staffed. S6CNA stated one agency CNA was observed sitting in her car smoking during her shift, and was not providing care to her assigned residents. S6CNA stated this CNA walked off the job, and did not shower Resident #3 on 06/17/2020. In an interview on 07/01/2020 at 11:47am, S1Administrator confirmed the agency staff was not doing their work, and not completing their shifts. S1Administrator confirmed he never called the agency office to report this, but rather left that up to S10Director of Nursing (DON) and S11Assistant Director of Nursing (ADON). In an interview on 07/01/2020 at 12:25pm, S10DON stated facility staff have asked for help because they are tired and exhausted. S10DON confirmed she contacted the contract agency, and those CNAs were no longer allowed in the building. In an interview on 07/01/2020 at 12:28pm, S11ADON stated the CNAs have picked up extra shifts. Extra shifts lead to exhaustion.
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 and interview the facility failed to screen a vendor prior to admittance to the facility and a staff

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) member failed to wear a face covering correctly. This deficient practice had the potential to affect any of the 87 residents who resided in the facility as identified on the facility's census list. Findings: Observation on 06/30/2020 at 8:35am revealed a vendor in the facility lobby stocking a vending machine. Further observation revealed the vendor did not have a face covering over the nose and mouth. In an interview on 06/30/2020 at 8:40am, the surveyor approached the vendor and asked the vendor who granted him access to the facility. He further stated a staff member opened the doors to allow him into the building. The vendor stated he was not screened upon entry and he was not provided a mask. The vendor stated he entered the building at least weekly and stated he did not always wear a mask and he was not always screened by staff. Observation on 06/30/2020 at 8:53am revealed the vendor remained in the facility lobby and continued to stock the vending machine without a face covering. In an interview on 06/30/2020 at 8:56am, S1Administrator stated the vendor should not have been allowed entrance to the facility through the front door. S1Adminstrator further stated the vendor should have been screened prior to admittance and a mask should have been provided and worn over the nose and mouth while in the facility. In an interview on 06/30/2020 at 10:00am S1Administrator stated everyone who entered the facility required their temperature taken and a health questionnaire completed. S1Adminstrator further stated everyone should wear a mask and confirmed the facility had mask to provide. In an interview on 06/30/2020 at 10:15am, S9WardClerk stated she allowed the vendor into the building through the front door. S9WardClerk stated she assumed he had been screened at the side door. S9WardClerk further stated she did not screen the vendor nor did she provide a mask to the vendor. Observation on 06/30/2020 at 9:24am revealed S8CertifiedNursingAssistant (CNA) in the hallway with a face covering worn under the chin. S8CNA's nose and mouth were not covered. This surveyor observed S8CNA enter a resident room and remove a breakfast tray from approximately 4 feet away from the resident. S8CNA left the room with the tray and with the face covering worn under the chin. S8CNA was observed as she emptied the food tray into the garbage and walked to the food cart in the hallway. In an interview on 06/30/2020 at 9:29am, S8CNA confirmed the face covering was worn under the chin and did not cover her nose and mouth. In an interview on 07/01/2020 at 12:30pm, S1Administrator confirmed face covering should be worn to cover the nose and the mouth.