STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045311	A. BUILDING _____ B. WING _____	**09/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLAGES OF GENERAL BAPTIST HEALTH CARE EAST	**6811 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 223) was substantiated, all or in part, with these findings: Based on observation, record review, and interview, the facility failed to ensure residents were properly groomed to maintain good personal hygiene / grooming for 1 (Resident #1) and facial hair was removed regularly to maintain good grooming for 1 (Resident #4) of 4 (Residents #1, #2, #3, and #4) sampled residents who were dependent or required assistance from staff for personal hygiene. This failed practice had the potential to affect 19 residents who required assistance with activities of daily living (ADLs), as documented on a list provided by the Director of Nursing (DON) on 8/20/2020. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/2020 documented the resident scored 14 (13-15 indicates cognitive intact) on a Brief Interview for Mental Status (BIMS) and required extensive one-person assistance with dressing. a. A Care Plan with dated 7/14/2020 documented, .Grooming / Hygiene . Assist of one (person) . (Resident #1) will appear neat and clean with appropriate attire through this monitoring period . (Resident #1) has orders for a life vest to be worn at all times . b. On 8/18/2020 at 1:45 p.m., Resident #1 was sitting up in bed. Her life vest was dirty and had brown and red spots all over it. c. On 8/20/2020 at 11:37 a.m., the Director of Nursing (DON) was asked, How often is (Resident #1's) life vest cleaned? She stated, She has 3 different bra things and we swap them out. 2. Resident #4 had [DIAGNOSES REDACTED]. An Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/1/2020 documented the resident scored 11 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS) and required limited one-person assistance with personal hygiene. a. A Care Plan dated 8/1/2020 documented, .(Resident #4) will appear neat and clean with appropriate attire through this monitoring period . Staff will assist (Resident #4) with hygiene . (Resident #4) is to be clean, neat, and well-groomed daily with assistance with ADLs . b. On 8/18/2020 at 1:57 p.m., Resident #4 was sitting in bed. He had a full beard and had not been shaved. He was asked if staff had offered to shave him. He stated, They're busy, but I don't mind getting shaved. He was asked if he had ever refused to be shaved. He stated, No. c. On 8/20/2020 at 11:00 a.m., Certified Nursing Assistant (CNA) #1 was asked, Why hasn't (Resident #4) been shaved? He stated, He doesn't like for anyone to touch him too much. d. On 8/20/2020 at 11:18 a.m., CNA #2 was asked, Why hasn't (Resident #4) been shaved? She stated, He likes to fight. e. On 8/20/2020 at 11:26 a.m., Licensed Practical Nurse (LPN) #1 was asked, Why hasn't (Resident #4) been shaved? She stated, He refuses a lot. f. On 8/20/2020 at 11:37 a.m., the DON was asked, Why hasn't (Resident #4) been shaved? She stated, He will not shave. We've tried since he's been here. g. On 8/20/2020 at 11:47 a.m., the Registered Nurse (RN) Supervisor was asked, Why hasn't (Resident #4) been shaved? She stated, I don't know.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure licensed nursing staff removed medications from resident's room and stored the medications in a secure area to prevent potential accidental administration by residents for 1 (Resident #1) of 3 (Residents #1, #2, and #3) sampled residents who received medications. This failed practice had the potential to affect 20 residents who received medications, as documented on a list provided by the Director of Nursing (DON) at 11:55 a.m. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS) and was independent with eating. a. A physician's orders [REDACTED].[MEDICATION NAME] Furoate-Vilanterol Inhalation Aerosol Powder Breath .1 puff into the lungs once daily at 0730 (7:30 a.m.) . b. On 8/18/2020 at 1:45 p.m., a Proair-HFA inhaler which contained 98 puffs remaining for administration was on the resident's bedside table. c. On 8/18/2020 at 2:46 p.m., Registered Nurse (RN) #1 was asked if (Resident #1) could self-medicate. She stated, No. I give it to her. She was asked, Can you tell me why she has an inhaler on her bedside table? She stated, That I don't know. d. On 8/18/2020 at 2:52 p.m., RN #1 was sitting at the Nurse's Station. She was asked if she had removed the medication from the resident's bedside table. She stated, No, but I'm going to get it now. e. On 8/20/2020 at 11:00 a.m., Certified Nursing Assistant (CNA) #1 was asked if medication should be left on the residents' bedside table? He stated, No ma'am. He was asked, Can you tell me why? He stated, You have to stand there and make sure they take it. f. On 8/20/2020 at 11:18 a.m., CNA #2 was asked if medication should be left on the residents' bedside table? She stated, No ma'am. She was asked, Can you tell me why? She stated, Because a resident could reach over and get it. g. On 8/20/2020 at 11:26 a.m., Licensed Practical Nurse (LPN) #1 was asked if medication should be left on the residents' bedside table? She stated. No. She was asked, Can you tell me why? She stated, You can't leave any medications on a bedside table unless you have an order. It could result in an overdose. h. On 8/20/2020 at 11:37 a.m., the Director of Nursing (DON) was asked if medication should be left on the residents' bedside table? She stated, No ma'am. She was asked, Can you tell me why? She stated, No residents are supposed to have medications in their room. We administer all medications. i. On 8/20/2020 at 11:47 a.m., the Registered Nurse (RN) Supervisor was asked if medication should be left on the residents' bedside table? She stated, No, ma'am. She was asked, Can you tell me why? She stated, Because they don't know, and someone happens to walk in, and it should be given by licensed personnel, and she don't leave until it's taken. j. A facility policy titled Administering Medications provided by the Director of Nursing on 8/20/2020 at 11:55 a.m. documented, .Residents may self-administer their own medications only if the attending physician, in conjunction with the Interdisciplinary Care Planning Team has determined that they have the decision-making capacity to do so safely .
F 0809 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 240) was substantiated, all or in part, with these findings: Based on observation, record review, and

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

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F 0809 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) interview, the facility failed to ensure meals were consistently served at regular, scheduled times to prevent prolonged waiting periods for meals for 2 (Residents #2 and #3) of 3 (Residents #1, #2, and #3) sampled residents who required assistance from staff with meals. The failed practice had the potential to affect 4 residents who required assistance with eating, as documented on a list provided by the Director of Nursing (DON) on 8/20/2020. The findings are: 1. A Grievance dated 4/6/2020 documented, .Concern description . Meals not being served on time . 2. Resident #2 had [DIAGNOSES REDACTED]. The resident was admitted on [DATE] and did not have a completed Minimum Data Set (MDS) assessment. a. The Care Plan dated 8/12/2020 documented Resident #2 required assistance of one staff with eating, and the Certified Nursing Assistant (CNA) will set up each meal tray. b. On 8/18/2020 at 1:35 p.m., Resident #2 was lying in bed in a fetal position. Her lunch tray was on the bedside table and was covered with aluminum foil. The resident was asked if she had eaten. She did not respond. c. On 8/18/2020 at 2:05 p.m., Resident #2's food was on the bedside table and was covered with aluminum foil. The resident's food had not been touched. d. On 8/18/2020 at 2:27 p.m., Resident #2's meal tray had been removed from the bedside table. 3. Resident #3 had [DIAGNOSES REDACTED]. An Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/31/2020 documented the resident scored 9 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status; required extensive one-person assistance with bed mobility; was totally dependent with two staff assistance for transfers; and required supervision with set-up for eating. a. The Care Plan dated 8/5/2020 documented, .CNA (Certified Nursing Assistant) will set up tray each meal . b. On 8/18/2020 at 2:03 p.m., Resident #3 was lying in bed. The resident did not have a meal tray on her bedside table. CNA #1 was asked if (Resident #3) had eaten. He stated, No. I got to feed her. c. On 8/18/2 020 at 2:28 p.m., CNA#1 was asked what time meal trays were delivered to the Unit. He stated, I'm not sure. He was asked, Can you tell me why (Resident #3) has not been fed? He stated, We were going to feed her last. d. On 8/18/2020 at 2:46 p.m., Resident #3 had not received a lunch tray. e. On 8/18/2020 at 2:33 p.m., CNA #3 was on the 200 Hall passing meal trays. She was asked if everyone on the 100 Hall had received a tray? She stated, Yes. 4. On 8/20/2020 at 11:00 a.m., Certified Nursing Assistant (CAN) #1 was asked, What time do residents receive their lunch tray? He stated, Different times because it comes from across the street. They receive it at different times every day. He was asked, Should residents that require assistance with meals be assisted with all meals in a timely manner? He stated, Yes, ma'am. He was asked, Can you tell me why (Resident #2) was not assisted with her lunch tray on Monday? He stated, I went back to assist her later. She was another one that spits her food out. He was asked, Can you tell me why (Resident #3) never received a lunch tray on Monday? He stated, They said she had to drink (supplement) because she spits her food back out. He was asked, Does she receive a (supplement) with every meal? He stated, Yes, ma'am. He was asked, If she never received a tray, how do you know she was going to spit it out? He stated, She spits it out every day. a. On 8/20/2020 at 11:18 a.m., CNA #2 was asked, What time do residents receive their lunch tray? She stated, Different times. She was asked, What's the latest trays are delivered? She stated, 12:00 (12:00 p.m.). She was asked, Should residents who require assistance with meals be assisted with all meals in a timely manner? She stated, Yes, ma'am. b. On 8/20/2020 at 11:26 a.m., Licensed Practical Nurse (LPN) #1 was asked, What time do residents receive their lunch tray? She stated, Usually between 11:30 a.m. and 12:30 p.m. She was asked, Should residents who require assistance with meals be assisted with all meals in a timely manner? She stated, Yes. c. On 8/20/2020 at 11:37 a.m., the Director of Nursing (DON) was asked, What time do residents receive their lunch tray? She stated, Anytime from 12:30 p.m. and 1:30p.m. She was asked, Should residents who require assistance with meals be assisted with all meals in a timely manner? She stated, Yes, ma'am.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure expired milk was promptly removed from stock and discarded and not served to residents to minimize the potential for food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 18 residents who received milk from the kitchen, as documented on a list provided by the Director of Nursing on [DATE]. The findings are: 1. On [DATE] at 1:45 p.m., Resident #1's breakfast tray was still on her bedside table. The tray had an 8-ounce carton of opened milk on it. The carton of milk was warm to touch and had an expiration date of [DATE]. a. On [DATE] at 1:50 p.m., Certified Nursing Assistant (CNA) #1 walked into the room and picked up the resident's breakfast tray. He was asked, What is the date on the milk on the tray? He stated, [DATE]th. He was asked, Should residents receive expired milk? He stated, No. They sent it from across the street. He was asked if the resident was able to feed herself. He stated, Every once in a while. b. On [DATE] at 2:05 p.m., Resident #1 was asked if staff assisted or fed her meals. She stated, I feed myself. c. On [DATE] at 11:00 a.m., CNA #1 was asked if residents should receive expired milk. He stated, No, ma'am. d. On [DATE] at 11:18 a.m., CNA #2 was asked if residents should receive expired milk. She stated, No, ma'am. e. On [DATE] at 11:26 a.m., Licensed Practical Nurse (LPN) #1 was asked if residents should receive expired milk. She stated, No. She was asked, Can you tell me why. She stated, It would make them sick. f. On [DATE] at 11:37 a.m., the Director of Nursing was asked if residents should receive expired milk. She stated, No, ma'am. It should be thrown in the trash if it's expired. It could make someone sick. g. A facility policy titled Food and Nutrition Services provided by the Director of Nursing on [DATE] at 12:35 p.m. documented, .Food and Nutrition Services will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature .