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 _____	08/28/2020

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 0658 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to ensure the Comprehensive Care Plan documented the method in which the resident was to be fed with use of hands and not to use silverware due to resident clamps down on the spoon for 1 (Resident #10) of 1 case mix resident that had to be fed in an alternative method by using gloved hand. This failed practice had the potential to affect 1 resident in the facility that had to be fed in an alternative method by using gloved hand according to the Director of Nurses (DON). The findings are: Resident #10 had [DIAGNOSES REDACTED]. The Quarterly MDS with an Assessment Reference Date 06/25/2020 documented the resident was severely impaired in Cognitive Skills for Daily Decision Making (SAMS) and required limited assistance of one person for bed mobility, extensive assistance of one person for transfer and eating, total dependency of one person for dressing, toilet use, personal hygiene and bathing. a. The Care Plan, updated on 07/01/2020 documented, Ensure nutrition and hydration daily, assist with meals. Set up help. Assist with meals per adl (activities of daily living) needs . Encourage to eat where most comfortable . There was no documentation the resident was to be fed with use of hands and not to use silverware due to resident clamps down on the spoon. b. On 08/26/2020 at 8:29 a.m., Resident #10 received her breakfast tray. Certified Nursing Assistant (CNA) #3 set up the tray and put on gloves. CNA #3 fed the resident her lunch of Lasagna, Salad, Roll and Pudding with her gloved hand. CNA #3 would put the food into the resident's mouth and tell the resident to take a bite. The resident was given a drink in a styrofoam cup and the resident bit down on the cup. CNA #3 transferred the drink to plastic cup. c. On 08/27/2020 at 8:27 a.m., Resident #10's breakfast tray was taken into the resident's room by CNA #4. The CNA #4 set up the tray of Scrambled Eggs, Ground Sausage, Toast, Ensure, Milk and Orange Juice. CNA #4 put on gloves and fed the resident with gloved hands, putting the food to the resident's mouth and telling the resident to take a bite. CNA #3 came in and took over feeding the resident her breakfast with gloved hands. d. On 8/27/2020 at 9:42 a.m., CNA #3 was asked, How long has (Resident #10) been fed by using hands instead of silverware? CNA #3 stated, For some time now. When the family could come and visit, they said she did better if the food touched her mouth. She will open her mouth. I had an issue when I put the spoon in her mouth, she will bite down and it hard to get the spoon out. To me it is safer to feed her with our hands. She will eat better, at least she does for me. I feed her most of the time. CNA #3 was asked, Who made the decision not to use the silverware? CNA #3 stated We did let them know, but since she bit down on the spoon, it is just safer to me to feed her with our gloved hands. CNA #3 was asked, How long has the resident been fed by the method of using a gloved hand? CNA #3 stated, Ever since she has been here. She's been here for a while. e. On 08/27/2020 at 10:10 a.m., Registered Nurse (RN) #2 was asked if she was aware of the method that they were feeding (Resident #10). The staff have been feeding the resident by using hands instead of silverware. RN #2 stated, I knew that they were feeding her that way. RN #2 was asked, Should this be care planned? RN #2 stated, Yes. f. On 08/27/2020 at 11:40 a.m., the Director of Nurses (DON) was asked, When were you aware of the method that (Resident #10) was being fed? The DON replied, They told me a yesterday. The DON was asked if this should have been care planned. The DON stated. Yes. The DON was asked if she knew how long the resident had been fed by this method of gloved hand. The DON stated, No. g. On 08/28/2020 at 12:15 p.m., the Dietary Manager (DM) was asked, Who does the Dietary Assessment? She replied, Myself or the Dietician. The DM was asked, How often are the assessments done? The DM stated, Quarterly or as needed. The DM was asked, When were you made aware of how they are feeding (Resident #10)? She replied, They told me last night, I put it in the care plan. The DM was asked, This was put in the care plan last night? The DM stated, Yes, I put it in the care plan last night. That this needed to be known. The DM was asked if she had visited the halls during meal service. The DM stated, No.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The Complaint (AR 294) and Complaint (AR 367) was substantiated, all or in part, in these findings: Based on observation, record review and interview the facility failed to ensure the plan of care was followed for turning, repositioning and incontinent care was provided every 2 hours and the dressing was in place to promote healing and prevent an infection for 1 (Resident #4) of 2 (Resident #4 and #9) case mix residents that were dependent with turning, repositioning and incontinent care and had a pressure ulcer. This failed practice had the potential to affect 19 residents that were dependent with turning, repositioning and incontinent care on the 400 Hall according to a list received from the Director of Nursing (DON) on 08/21/2020. The findings are: 1. Resident #4 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with Assessment Reference Date of 05/28/2020 documented the resident was severely impaired in cognitive skills for daily decision making; required total dependency of 2 person for transfer; totally dependent of 1 person for bed mobility, dressing, eating, toilet use and personal hygiene; had an indwelling catheter and was always incontinent of bowel; and had one Stage IV Pressure Ulcer. a. The Comprehensive Care Plan documented, Focus (Resident #4) has a history of skin breakdown. She remains at Potential for alteration in skin integrity related incontinent of bowel . (Resident #4) has a sacral wound - Onset 05/28/2020. Focus ADL (Activity of Daily Living) deficit unable to perform adl's, requires (total) assistance per 1 - 2 staff. . Approaches: .Turned and repositioned q (every) 2 hrs (hours) and prn (as needed). (Entered 05/11/2009 Edited 06/21/2019). b. The Braden Scale for Predicting Pressure Sore Risk dated 03/22/2020 documented the resident scored 14 (13 to 14 indicates moderate risk). The Sensory Perception Ability to respond meaningfully to pressure-related discomfort: Is Very Limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness or has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body . Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. [DIAGNOSES REDACTED], contractures or agitation leads to almost constant friction. c. On 08/19/2020 at 7:20 a.m., Resident #4 was kept in the surveyor's line of sight. The resident was lying in bed on her back with the head of the bed elevated approximately 30 degrees. At 10:30 a.m., Certified Nursing Assistants (CNA) #1 and #2 entered the resident's room. The CNA's preformed incontinent care and turned the resident on her left side. There was no dressing on the Stage IV pressure Ulcer on the coccyx. The resident had been incontinent of bowel and bladder. CNA #1 was asked, When did the dressing come off? CNA #1 stated, The dressing must have come off last night. d. The Weekly Wound Report provided by the Treatment Nurse on 08/21/2020 documented the measurements for Residents #4's pressure ulcer on 08/05/2020 was Length 0.6 cm (centimeters) x (times) Width 0.3 cm x Depth 0.2 cm. The Treatment Nurse stated, The bottom portion of the area, the whitish-yellowish area. The Wound Clinic Physician stated that this was scar tissue. The only area measured in Pressure Ulcer is the top of the wound bed. e. On 08/21/2020 at 9:26 a.m., the DON was asked, How often are residents to be turned and repositioned? The DON stated, Every 2 hours. The DON was asked, Who is responsible for ensuring that the residents are turned in a timely manner? The DON stated, The CNA's are supposed to turn them and the Nurse is responsible for monitoring to ensure that they are turned. The DON was asked, When (Resident #4) was observed from 7:20 a.m. to 10:30 a.m. the resident had not been turned or repositioned for approximately 3 hours and 10 minutes. When the incontinent care was provided there was no

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 -** Few	(continued... from page 1) dressing on the stage IV coccyx area. Who is responsible for ensuring that the dressing remains intact? The DON stated, The Nurse. The DON was asked, Should the CNA's report to the nurse if the dressing is off during care? The DON stated, Yes. f. On 08/21/2020 at 9:45 a.m., the Treatment Nurse was asked, Regarding (Resident #4), the dressing was off, and the resident had been incontinent of bowel and bladder. Can that cause harm to the wound? The Treatment Nurse stated, It could and possibly cause infection of the wound. The Treatment Nurse was asked, If the dressing comes off who is responsible for replacing the dressing? The Treatment Nurse stated, The Nurse or should report that the dressing is off. The Treatment Nurse was asked, Were you aware that the dressing was off? The Treatment Nurse stated, No I was not aware that the dressing was off. The Treatment Nurse was asked, How often should the resident be turned and repositioned? The Treatment Nurse stated. Every 2 hours or more often.