STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045396	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JOHNS PLACE OF ARKANSAS, LLC	**1400 HWY 79/167 BYPASS FORDYCE, AR 71742**

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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** Complaint # (AR 056) was substantiated, all or in part, with these findings: Based on record review and interview, the facility failed to ensure adequate supervision was provided to prevent elopement by failure to ensure windows on the Secured Hall were secured for 1 (Resident #1) case mix resident who was at risk for elopement. This failed practice resulted in past non-compliance at the level of Immediate Jeopardy, which caused or could have caused serious harm, injury, or death to Resident #1, who had been assessed for being at risk for elopement, and eloped from the facility unnoticed by the staff, and was found approximately 15 minutes later at the convenience store across the road from the facility, and had the potential to cause more than minimal harm to 4 residents who were at risk for elopement, according to the list provided by the Administrator on 7/22/2020. The facility removed the Immediate Jeopardy and corrected the failed practice on 7/3/2020 prior to the survey. The Administrator was informed of the Past Immediate Jeopardy condition on 7/17/2020 at 3:04 p.m. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 5/1/2020 documented the resident scored 5 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS), exhibited wandering behavior one to three days out of the last 7 days; required supervision with transfer, walking in room and in corridor; and required a wander / elopement alarm daily. a. A physician's orders [REDACTED].Wander Guard bracelet in place to left ankle QS (every shift) every shift for Elopement Risk . b. A facility Incident and Accident form dated 2/24/2020 documented, .Elopement Date . 2/24/2020 (at) 17:50 (5:50 p.m.) . Resident . (Resident #1) . Incident Location . Outside . Incident Description . Another resident's son who was visiting told nurse at front desk that resident was outside of facility. Nurse (Nurse's first name) immediately headed out of front door to assist resident back into facility. Resident had made it across one side of two-lane highway and median to the other side of highway. (Nurse's first name) reached resident and was able to persuade resident to come back into facility. Resident and (Nurse first name) ambulated into front door of facility. Body audit performed and no apparent injury noted .No injuries observed at time of incident . Mobility . Ambulatory without assistance . Notes . 2/25/2020 Administrator came to facility to investigate. Statements were taken from staff who were aware of this incident. (LPN #3) stated she had seen resident in front lobby at 17:45 p.m. (5:45 p.m.) and several visitors had been in the facility this evening. She had gone to 300 Hall and then at 17:58 (5:58 p.m.) she saw (LPN #4) with resident . 2/25/2020 Care Planned elopement risk, Wander Guard in place . c. A Nursing Progress Note dated 2/24/2020 at 9:20 p.m. and signed by LPN #3 documented, .Incident Note . Nature / Description of Incident . Another resident's son who was visiting told Nurse (Nurse's first name) at front desk that resident was outside of facility. Nurse (Nurse's name) immediately headed out of front door to assist resident back into facility. Resident had made it across one side of two-lane highway and median to the other side of highway. Nurse (Nurse's first name) reached resident and was able to persuade resident to come back into facility. Resident and nurse ambulated into front door of facility. Body audit performed. No apparent injury noted. Description of Injuries . Body audit performed. Medical Professional Notified (Who / When) . (Physician) 2/24/2020 . Resident Representative Notified (Who / When) . (Resident spouse) 2/24/2020 . d. An Elopement Risk assessment dated [DATE] at 5:50 p.m. documented, .Score: 9.0 . Elopement Risk Assessment . b. Scoring: A score of less than 5 (equals) Low Risk for Elopement. Score of 5 or greater (equals) High Risk for Elopement . Checklist . 1. Cognition / Mental Status / Memory . b) Moderately impaired . 2. Dependent on staff for ADLs (activities of daily living) . b) 3. Ambulation . a) Able to ambulate independently . a) Yes . 4. Able to transfer independently . a) Yes . 5. History of wandering prior to nursing home placement . a) Yes . 6. Resistant to nursing home placement . a) Yes . 7. Expresses desire to go home . a) Yes . 8. Exit Seeking . a) Yes . The Elopement Risk Assessment score indicated the resident was at risk for elopement. e. An Elopement Risk assessment dated [DATE] at 3:50 p.m. documented, .Score: 12 .Elopement Risk Assessment . b. Scoring: A score of less than 5 (equals) Low Risk for Elopement . Score of 5 or greater (equals) High Risk for Elopement . Checklist . 1. Cognition / Mental Status / Memory . b) Moderately impaired . 2. Dependent on staff for ADLs (activities of daily living) . b) No 3. Ambulation . a) Able to ambulate independently . a) Yes . 4. Able to transfer independently . a) Yes . 5. History of wandering prior to nursing home placement . a) Yes . 6. Resistant to nursing home placement . a) Yes . 7. Expresses desire to go home . a) Yes . 8. Exit Seeking . a) Yes . Comments Wander Guard bracelet intact per MD (Medical Doctor) orders . The assessment score indicated the resident was at risk for elopement, and also indicated an increased score in the Elopement Risk Assessment from the assessment dated [DATE] due to the addition of medications. f. The Care Plan dated 7/3/2020 documented, .(Resident) is an elopement risk r/t (related to) hx (history) at home and Dx (diagnosis) (of) [MEDICAL CONDITION] . 7/3/2020 . Windows on the hall were secured so that they don't go up more than 6 (inches) Psych (Psychiatric) consult ordered . Resident eloped out of window in the Day Area on 7/3/ 0 . All windows were secured in Secured Unit . Distract (Resident) from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers . color, draw, listening to music . (Doctorate of Nursing Dementia Consultant) contacted by nursing, medication review completed . Resident taken off a medication that doctor thought was making resident (sic) . Ordered labs (laboratory tests) and UA (urinalysis) . Resident placed on one-on-one until windows were secured on Secured Unit . Wander Alert . Wander Guard anklet . g. A Nursing Progress Note dated 7/3/2020 at 6:00 a.m. and signed by Licensed Practical Nurse (LPN) #1 documented, .This nurse was walking down hallway on 100 (Hall) when she heard a noise on 200 hallway. (Certified Nursing Assistant (CNA) #2) and (CNA #3) stated resident has started kicking on double door. Both CNAs stated they went around doors to enter hallway from another direction when they noticed resident was no longer at double doors. CNAs stated they both went to (the) resident room and resident was not in room so they proceeded to go through all rooms to look for resident, and that when they came and told this nurse, they searched all rooms and they could not locate resident. This nurse went to 200 Hall and helped both CNAs search all rooms, closets, and bathrooms for resident. When this nurse could not locate resident, this nurse began walking toward front door and noticed shades on the window in TV (Television) lobby was slightly pulled up. When this nurse approached the window, she noticed that window up and the screen pushed away from the window. This nurse immediately looked out window to pitch black darkness and could not see anything. So, she summoned CNA and herself to go outside with flashlights to look around back of facility where window is located. Resident was nowhere to be found. This nurse and CNA walked all around facility to search for resident. When this nurse came back in facility, the front door screener (Screener name) asked if we were looking for someone. When this nurse stated, 'Yes', he stated, 'I think I seen her at the (gas) station down the road' . h. A Nursing Progress Note dated 7/3/2020 at 7:21 a.m. and signed by LPN #1 documented, .Incident Note . Nature / Description of Incident . This nurse was walking down hallway on 100 (Hall) when she heard a noise on 200 Hallway. (CNA #2) and (CNA #3) stated, 'Resident has started kicking on double door.' Both CNAs stated they went around doors to enter hallway from another direction. When they noticed resident was no longer at double doors,

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) CNAs stated they both went to resident room and resident was not in room so they proceeded to go through all rooms to look for resident; and that when they came and told this nurse they searched all rooms and they could not locate resident. This nurse began walking toward front door and noticed shades on the window in TV (Television) Lobby was slightly pulled up. When this nurse approached window, she noticed that window (was) up and the screen pushed away from the window. This nurse immediately looked out window to pitch black darkness and could not see anything. So, she summoned CNAs and herself to go outside with flashlights to look around back of facility where window is located. Resident was nowhere to be found. This nurse and CNAs walked all around facility to search for resident. When this nurse came back in facility, the front door screener (Screener name) asked if we were looking for someone. When this nurse stated, 'Yes', he stated, 'I think I seen her at the (gas) station down the road. Description of Injuries . No injuries noted at this time . Immediate Actions Taken . Supervised by staff one-on-one . Medical Professional Notified (Who / When) . (Advanced Practice Registered Nurse #1) APRN, (Director of Nursing), Resident Representative Notified (Who / When) . (Resident spouse) . i. A Nursing Progress Note dated 7/3/2020 at 7:27 a.m. and signed by LPN #1 documented, .This nurse contacted (Advanced Practice Registered Nurse (APRN) #1). Resident down hallway, agitated, kicking, grabbing, punching at staff. Stating she is getting the hell out of here. Staff try to redirect resident with no success. (APRN #1) ordered 2 mg (milligrams) [MEDICATION NAME] IM (intramuscular). Resident's husband was present at back door and is aware of (APRN #1) orders . j. A Nursing Progress Note dated 7/3/2020 at 10:56 a.m. and signed by the Director of Nursing (DON) documented, .06:45 (6:45 a.m.) Noted Resident sitting up in chair in hallway of 200 Hall. Calm at this time. CNA continues with 1:1 (one-on-one). 0700 (7:00 a.m.) b'fast (breakfast) served. Remains calm. 0830 (8:30 a.m.) called (Physician); notified of Resident leaving building this a.m.; that 1:1 is being continued at this time; and that we are awaiting results from COVID-19 testing done yesterday before BHU (Behavioral Health Unit) will accept her. 0920 (9:20 a.m.) phone call with (Doctor of Nursing Dementia Consultant), per (APRN #2), APN (Advanced Practice Nurse) with SAS (Behavioral Health Unit) re: (regarding) resident's behaviors and leaving building. Advised us to speak further with husband to find out if Resident ever was seen by psychiatrist prior to being diagnosed with [REDACTED]. That it appears that her behaviors have been ramping up in the last 2 weeks and this is possibly a form of [MEDICAL CONDITION] .0955 (9:55 a.m.) husband called while on conference call with (DNP (Doctor of Nursing Dementia Consultant), GNP (General Nurse Practitioner)). Advised that we are doing phone conference with (DNP, GNP) and resident was calm a little while ago, would call him back after conference. 1020 (10:20 a.m.) blood spec (specimen) obtained without incident from left a/c (antecubital) (times) 1 stick for CBC (complete blood count), CMP (comprehensive metabolic profile), TSH ([MEDICAL CONDITION] stimulating hormone) and urine obtained per voiding spec for UA. Spec's couriered to lab (laboratory) for stat (immediate) analysis at (Hospital #1). 1040 (10:40 a.m.) called and spoke to (resident's spouse). Res's (Resident's) husband and RP (responsible party) .Explained to him that we had spoken to (DNP-GNP) who is an expert on staff for Dementia residents having behavioral issues and that she has recommended stopping some of her med (medications), but that (Physician) would have to approve this and that we are getting labs (laboratory tests). Will call him back after labs back and Plan of Care discussed. Verbalizes understanding . 1120 (11:20 a.m.) Rec'd (received) results of lab . Spoke with (DNP-GNP) and rev'd (reviewed) labs and information gleaned from husband. States if (Physician) agrees, she will be glad to consult on Resident this weekend and provide orders to help manage her while here. 1210 (12:10 p.m.) attempted to reach (Physician) by phone. Left message. 1220 (12:20 p.m.) (Physician) returned call, notified of lab results, of (DNP-GNP) offer to consult and recommendations. New orders rec'd (received) and noted. Will discontinue the [MEDICATION NAME], Oxybutin, and Donepezil. (DNP-GNP) will be on call thru the weekend for further orders if needed . k. A report to the State Agency Office of Long Term Care (OLTC), Division of Medical Services (DMS) form 7734 received from the Administrator on 7/15/2020 documented, .OLTC Incident and Accident Report (I&A) . Date and Time Submitted (if known) . 7/3/2020 (at) 0800 (8:00 a.m.) Date and Time of Discovery . 07/03/2020 (at) 0545 (5:45 a.m.) . Staff Reporting I & A . (Administrator's Name) .Title . Administrator . Date of I & A . 07/03/2020 . Time . 0600 AM (6:00 a.m.) . Name of Resident . (Resident #1) .Summary of Incident . At approximately 5:45 a.m., Administrator was notified that resident (Resident #1) had eloped by opening a window and removing a screen. Charge Nurse (LPN #1), LPN reported to Administrator that the resident had crossed the road and was inside the convenience store there. Charge Nurse talked the resident into getting in her car and returned with her to the facility where she was placed under 1:1 (one-on-one) supervision. Resident was absent from facility approximately 15 minutes. Physician, Administrator, and family were notified. Steps Taken to Prevent Continued Abuse or Neglect During the Investigation . Resident was placed on 1:1 supervision until other interventions could be initiated. At the time of this report, (Resident #1) is residing in her room under supervision. All windows that the resident had access to in the facility were secured so that they cannot be raised more than 6 (inches) to prevent further incidents. Staff interviews and witness statements were begun. An in-service on facility policy/procedures for elopement was initiated for all staff. The investigation is continuing . l. An Office of Long Term Care (OLTC) Division of Medical Services (DMS) form 762 report form to the State Agency received from the Administrator on 7/15/2020 documented, .Complete Description of Incident . At approximately 5 a.m. (5:00 a.m.) Friday, July 3, 2020, LPN (LPN #1) was conducting her Medication Pass on 100 Hall when she heard a banging noise from 200 Hall. CNAs informed LPN that resident (Resident #1) was banging on the entry doors to 200 Hall. CNAs went around to the other end of the hall and entered, and (Resident #1) was no longer at the other end of the hall. Staff initiated a search on the hall for her, and when she could not be located, notified the LPN. LPN initiated a thorough room-to-room search and did not locate the resident. LPN then went to alert all staff of missing resident, and when she walked by the lounge area, she noticed the blinds on the window were slightly open LPN opened the shade to discover the window open about 12 to 15 inches and the screen pushed approximately halfway out. LPN directed CNAs (CNA #2) and (CNA #3) to do a ground search around the facility with a flashlight while she alerted other staff of the suspected elopement. LPN (LPN #1) then walked to the road to see if she could see the resident. She was unable to see the resident at that time. Upon her return to the building, COVID-19 screener (Screener #1) was coming in and he asked if they were 'looking for someone' and when LPN said, 'Yes', (Screener #1) said he had seen her 'going into (gas station)', a convenience store nearby. LPN contacted the Administrator with details and said she was 'on my way to (gas station)'. LPN immediately got in her car with CNA (CNA #2) and drove to the (gas station), approximately one-tenth (1/10) of a mile from the facility, where she observed (Resident #1) sitting in a chair inside the (Name) Restaurant which is inside the convenience store. LPN states that she calmly approached the resident, telling her they had come to take her home. Resident refused several times, stating she was 'not going back to that cage' and 'no way was she taking her back to that hell hole.' LPN says she then told the resident, 'let's go home so we could call (spouse) (resident's husband) and talk to him.' (Resident #1) then agreed to go with them. LPN says that resident stated that 'if I was lying, she was going to kick my (expletive).' LPN reassured the resident that they would call her husband. Upon return to the facility, (Resident #1) refused to get out of the car. LPN contacted the Administrator who gave permission to call (Resident #1) husband. The resident then went into the facility and down to the end of the hall where she could visit with her husband through the glass doors, as in-person visits are not allowed during the COVID-19 Public Health Emergency. While talking to her husband through the door, resident started banging on the door and yelling because her husband would not take her home. APN notified of incident and resident's subsequent actions. APN ordered 2mg (milligrams of) [MEDICATION NAME] injection. (Resident #1 spouse) was made aware of the order, and he left the facility grounds. He later told the Administrator, 'I hoped that if I left, she'd settle down after they gave her a shot.' The resident was placed on 1:1 (one-on-one) monitoring with staff until the windows could be secured. She remained on 1:1 monitoring until 2 p.m. (2:00 p.m.) A Nurses Note dated 7/3/2020 stated that at 0645 (6:45 a.m.), the resident was seated calmly in a chair in the hallway . Findings and Actions Taken . Family, Administrator, Physician all notified and aware. Administrator came to the facility and observed and was updated on the situation with (Resident #1). DON (Director of Nursing) (DON name), RN (Registered Nurse) and Nurse Consultant (APRN #2) began working on a Psychiatric Consult with (DNP-GNP), D.N.P., Director of the Centers on Aging at the (Hospital) to determine appropriate interventions. The consult was approved by the PCP (Primary Care Physician). After reviewing the case, (DNP-GNP) issued orders to discontinue three medications, [MEDICATION NAME], Oxybutin, and Doneprizil, as these can trigger agitation. Administrator secured all windows on 200 Hall so that they would not open more than 6 inches. This was completed at noon. Administrator observed resident to be asleep in her bed at this time. .At this writing, there have been no further outbursts or attempts to elope from (Resident #1) and she remains under the care of (DNP-GNP). (Resident #1) sustained no injuries during her absence from the facility. An in-service on elopement policies and procedures was immediately initiated for all staff. No abuse or neglect is suspected in this incident, and the investigation is concluded. (Resident #1) is a [AGE] year old female who is ambulatory and functionally independent. She is only oriented to person and place. She has [DIAGNOSES REDACTED]. m. A Witness Statement form dated

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) 7/3/2020 which was included with the State Agency Report dated 7/3/2020 and signed by LPN #1 documented, . Walking down 100 Hall passing my 5 am (5:00 a.m.) meds (medications), I heard a noise down on 200 Hall. CNAs, (CNA #2) and (CNA #3) approaching the door stated (Resident) was at the door kicking it when (CNAs) (CNA #2) (and) (CNA #3) noticed (resident) not to be on hall. They approached this nurse stating they had looked all over 200 Hall and could not locate (Resident), so this nurse went to 200 Hall (with) both CNAs to look in rooms. I myself could not locate (Resident). As this nurse was walking out of 200 Hall to alert other staff of missing (Resident), I noticed that the blinds on the window in TV (Television) Lobby on 200 Hall slightly open on Secure Unit. All doors locked, no alarms had gone off, so I pulled up the shade, and window was up, and screen was halfway out. This nurse then instructed CNAs (CNA #2) and (CNA #3) outside and do ground search around facility. This nurse then notified the other on-duty nurse, (LPN #2), and CNA that (resident) is not on 200 Hall and I proceeded to go outside. (LPN #2) and (CNA #4) continued to search in facility for (Resident) while CNAs (CNA #2) (and) (CNA #3) continued to look outside. This nurse then walked up to highway (with) flashlight to see if I could see (Resident). This nurse did not see (Resident), so as this nurse returned back into facility to make proper phone calls. (Screener) front door screener coming into facility asked if we were looking for someone and this nurse stated, 'Yes.' He then stated, 'I seen her going in (Name) gas station down the road. This nurse immediately drove down to (Name) gas station (with) CNAs (CNA #2), and this nurse pulled up and noticed (Resident) sitting in a chair inside the store. This nurse calmly approached res (Resident) and stated to (Resident) that we came to pick her up and take her back home. (Resident) refused several times, stating she was not going back to that cage no one was taking her back to that hell hole. This nurse then stated to res (Resident), 'Let's go home so we could call (Resident #1's husband) and talk to him.' (Resident) then agreed, and stated, 'If I was lying, she was going to kick my (expletive).' Reassured (Resident) we would call husband. (Resident) then got back to facility went down on 200 Hall and talk to husband and started banging on back door . n. A Witness Statement form dated 7/3/2020 included with the Report to the State Agency which was dated 7/3/2020 and signed by CNA #2 documented, .Around 5 (5:00 a.m.) something in the morning I heard (Resident) kicking on door 200 Hall. (CNA #3) and I walked around to another entry to keep resident from busting door. Upon entering, (Resident) was no longer at door. We proceeded to walk down to her room. She was not there. I opened the bathroom door; she was not there either. We then proceeded to go room-to-room on 200 Hall searching each bathroom and closet. She was not there so we went and got (LPN #1) and said we could not find resident. (LPN #1) came down. Then we all three searched every room and bathroom. (Resident) was not on hall. (LPN #1) noticed window was open in TV (Television) Room on 200 Hall. She instructed us to look around building. We proceeded to walk around the building with our phone flashlights on due to being dark outside. We walked around the perimeter on building with no sighting of (Resident) . o. A facility form titled Inservice Education Report dated 7/3/2020 and received from the Administrator on 7/15/20, documented, .Date . July 3, 2020 In-service Conducted by (Administrator's Name) . Elopement . Review and understand the attached Elopement Policy and Procedure. Familiarize yourself with all aspects and be able to explain it when asked. Know your role! Sign the In-service sign-in sheet attached. All staff must sign this in-service . The attached form documented, .Elopement . It is the intent of this facility to provide for the safety of all residents. This is the responsibility of the Registered Nurses, LPNs, CNAs, and Department Heads. Monitoring Compliance . The following elements are in place for the facility to demonstrate satisfactory compliance with the guide . Evaluate Risk of elopement at admission, readmission, and quarterly, a change of condition, and on occurrence, using the elopement assessment in (facility Medical Records Computer system). Resident identified as 'at risk' have a picture in the Elopement Book, Care Plan for elopement in place, and interventions are individualized. Staff able to verbalize knowledge of elopement procedure. Door alarms are checked weekly and documented. Resident wander guards are checked daily and documented. Elopement Review Report is completed at least quarterly by QA&A (Quality Assessment and Assurance) Committee . Definition . Elopement is defined as that situation where a resident with impaired decision-making ability, oblivious to his / her own safety and needs outside the confines of the facility has left the facility without the knowledge of staff. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e. (for example) an order for [REDACTED]. All new employees are in-serviced on elopement guidelines during orientation. All employees will be in-serviced on elopement procedures annually . A staffing sign-in sheet attached to the in-service included signatures of staff from all departments / areas who were in attendance. p. A facility procedure / protocol form attached to the in-service dated 7/3/2020 and received from the Administrator on 7/15/2020 documented, .Missing Resident Event . When a door alarm sounds, the source of the alarm must be identified immediately. Do not turn the alarm off until you have checked both the inside and outside areas . If the cause of the alarm cannot be identified, the facility elopement protocol must be initiated, and staff assume that a resident has eloped . When notified, Charge Nurses must immediately huddle at Nurse's Station and page for all staff to report to the Nurse's Station immediately. This will be called as a CODE SILVER on overhead paging system . The Charge Nurse will initiate a perimeter search and send 1 person immediately to Hwy 79 / 167 to search that area, working back to facility. He / she will send 2 people to the rear exit and instruct 1 to go right around building, and 1 to go left . Charge Nurse will initiate a head count of the facility to identify missing resident. A Daily Census Report can be printed from (Clinical Record Computer System) . Once missing resident has been identified, Charge Nurse will initiate a full search of the facility, including all rooms and common areas . If the resident cannot be located in the facility or on the grounds, the facility shall . A. Notify the resident's family or responsible party . B. Notify (local) Police Department (number) . C. Notify resident's attending physician . Maintain correct time specific documentation including date and time resident was last seen, all actions taken to find the resident, and all parties notified . Post Elopement Actions . Assess the resident and document findings . Notify MD (Medical Doctor) and family / responsible party of assessment and determine appropriate action as needed . Update resident Plan of Care to include visual checks, transfer to hospital, etc. (et cetera) . Complete I and A (Incident and Accident Report) . Monitoring . Elopement events will be reviewed, analyzed, summarized, and any significant trends will be reviewed by the facility QA & A (Quality Assessment and Assurance) Committee, to ensure the appropriate process improvement actions have been taken . q. An Elopement Risk assessment dated [DATE] at 8:24 a.m. documented, .Score . 12 . Elopement Risk Assessment . b. Scoring . A score of less than 5 (equals) Low Risk for Elopement . Score of 5 or greater (equals) High Risk for Elopement . Checklist . 1. Cognition / Mental Status / Memory . c) Severely Impaired . 2. Dependent on staff for ADLs (activities of daily living) . a) Yes . 3. Ambulation . a) Able to ambulate independently . a) Yes . 4. Able to transfer independently . a) Yes . 5. History of wandering prior to nursing home placement . a) Yes . 6. Resistant to nursing home placement . a) Yes . 7. Expresses desire to go home . a) Yes . 8. Exit Seeking . a) Yes . r. The Medication Administration Record [REDACTED].Wander Guard Bracelet In Place To Left Ankle QS (every shift) for Elopement Risk . Start Date .01/23/2020 . The MAR indicated [REDACTED]. s. On 7/15/2020 at 1:00 p.m., the 200 Hall door was locked and secured with a coded keypad. On 7/15/2020 at 3:00 p.m., the 2 doors on the odd numbered side of the hall each had a keypad below the door handle and the doors would not open. APRN #2 entered numbers into the keypad before the doors opened. t. On 7/15/2020 at 2:30 p.m., Resident #1 resided on the Secured Unit, 200 Hall. The resident opened the door to the room and a Wander Guard bracelet was visible on the resident's lower left ankle. u. On 7/15/2020 at 3:40 p.m., the Director of Nursing (DON) accompanied the Surveyor on the outside of the building's 200 Hall. At the end of the wing, there was a wooden fence that surrounded the outside yard area with a padlocked gate. The rooms on the even number side of the hall windows were checked for screws in the window frame that prevented the windows from being raised. The window in the lobby area of the 200 Hall had screws placed on each side of the upper window metal frame approximately 6 to 7 inches from the lower window. Each of the windows for the resident rooms on the even side of the building were then viewed and screws were intact in the upper window metal frame that were approximately 6 inches above the lower window for a total of 8 windows. The upper window for each unit was fixed and did not raise or lower. Screws were seen in the metal upper window frame to the room where Resident #1 resided. v. On 7/15/2020 at 5:50 p.m., the Administrator accompanied the surveyor to the outside of the facility to the enclosed fenced area of the 200 Hall on the odd numbered side of rooms. Each window had screws intact to the upper window metal frame approximately 6 inches above the lower window. The enclosed area had a high metal fence with a padlocked metal gate. w. On 7/15/2020 at 6:15 p.m., APRN #2 accompanied the surveyor to the window in the Day Room / Lobby Area and attempted to pull the window up. The window raised only approximately 6 to 7 inches and the APRN stated that the window would not raise higher due to screws. A random check of room [ROOM NUMBER] also had a window with screws intact in the metal frame that prohibited the APRN from being able to raise the window more than approximately 6 inches. At 6:55 p.m., the Main Front Door was locked with a key code required. x. On 7/17/2020 at 6:27 a.m., LPN #1 was asked what had occurred when the resident had eloped on 7/3/2020. LPN #1 stated, I was going down 100 Hall. I came to the desk to get some straws, and she (Resident #1) was kicking doors on the 200 Hall. CNAs said they went to see about her kicking. I guess they were looking for her. I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045396	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST JOHNS PLACE OF ARKANSAS, LLC	**1400 HWY 79/167 BYPASS FORDYCE, AR 71742**

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 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) locked Med (Medication) Cart, went to the 200 Hall, and the CNAs had looked for her. That's when I saw the window blind. It was not closed all the way. I moved the blind. The window was opened, and the screen was pushed out. (LPN #2) and (CNA #4) told them she was gone. Our phones were out, due to the storm, went to my car, got my cell phone to call the Administrator and DON, and as I was coming back in, the one who does the screening (COVID) was coming in to work and asked if we were looking for someone. He said he saw her going in the (gas station) convenience station down the road. I Called the Administrator and DON and we went and got her, me and (CNA #2). She was sitting in there in (restaurant part of gas station). LPN #1 was asked if the resident was cooperative in leaving the store. LPN #1 stated, At first, then I told her we would call her husband when we got back, and s
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 infection control measures were consistently implemented and direct care staff wore face masks while assisting residents with eating in the Main Dining Room for 1 (Resident #2) of 1 case mix resident, to minimize the potential for the spread of disease and infection, and failed to ensure direct care staff followed universal precautions and washed or sanitized their hands after having touched their facemask before resident and Dietary Department environmental contact, to prevent potential cross-contamination during the provision of direct care for meal assistance for 1 (Resident #3) of 1 case mix resident who was assisted with delivering of their meal and with eating. These failed practices had the potential to affect 5 residents who received meals in the Main Dining Room, documented on a list provided by the Administrator on 7/22/2020. The findings are: 1. Resident #3 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/30/2020 documented the resident scored 3 (0-7 indicates severely impaired) on a Brief Interview for Mental Status and required extensive assistance for eating. a. The Care Plan with a revised date of 3/15/2020 documented, .I am at risk for signs / symptoms of COVID-19 . Please educate the staff providing my care . of COVID-19 signs and symptoms and precautions . Eating . (Resident #3) requires extensive assistance (times) 1 (person) with meals / eating . b. On 7/15/20 at 5:32 p.m., Certified Nursing Assistant (CNA) #1 was seated in the Main Dining Room next to the resident and assisting the resident with eating by holding a spoon. The CNA had a facemask down around her neck and the facemask was not covering the entire area of the nose and mouth. At 5:35 p.m. the CNA pulled the facemask up over her nose and mouth and without having sanitized hands, went to the Dietary Department window, placed both hands on the metal frame on the right side of the window, and placed her hands on the metal frame. CNA #1 picked up a plate containing a chef's salad at the Dietary window and carried the plate back to the table where the resident was seated. At 5:36 p.m., the CNA sat the plate on the table in front of the resident. CNA #1 picked up a spoon and fork from the other plate, placed the utensils on the plate of salad, and began feeding the resident with the spoon without having sanitized her hands. CNA #1 was asked if a facemask should be covering the entire nose and mouth on the face. CNA #1 stated, Yes. c. On 7/22/2020 at 5:35 p.m., the Administrator was asked if staff members are to wear a facemask at all times while on duty in the facility. The Administrator stated, Yes. The Administrator was asked if staff's hands should be sanitized after having touched the face or facemask. The Administrator stated, Yes. The Administrator was asked if hands should be sanitized by staff before a resident is assisted with eating. The Administrator stated, Yes. 2. The facility policy titled Hand Hygiene provided by the Administrator on 7/15/2020 documented, .Hand Hygiene is any method that removes or destroys microorganisms on hands that includes Handwashing and Alcohol Based Hand Rubs . Perform Hand Hygiene when . 1. Before having direct contact with patients . 4. If hands will be moving from a contaminated body site to clean body site during patient care . 5. After contact with inanimate objects in immediate vicinity of the patient . Wash hands when . hands are visibly dirty, contaminated with proteinaceous material . Alcohol-based Hand Rub . is the preferred method of decontamination if hands are not visibly dirty, contaminated with proteinaceous material .