STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045314	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARNES HEALTHCARE	**1010 BARNES STREET LONOKE, AR 72086**

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 -** Minimal harm or potential for actual harm **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 025) was substantiated with these findings: Based on observation, record review, and interview the facility failed to ensure supervision was provided to prevent elopement for 1 (Resident #1) of 3 (Residents #1, #2, #3) sample residents who were at risk for elopement; the facility failed to keep courtyard gate secured while not being attended. These failed practices had the potential to affect 14 other residents in the facility who were at risk for elopement and/or wandering according to a list provided by the Director of Nursing (DON) on 7/15/2020 at 10:374 a.m. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 6/18/2020 documented the resident scored 15 (13-15 indicated cognitively intact) on Brief Interview for Mental Status (BIMS); and required supervision assist with one person for bed mobility, transfer, eating and toilet use. a. Nursing progress notes documented, .5/19/2020 17:48 (5:48 p.m.) This nurse was notified at approximately that resident was seen outside the facility unattended. When this nurse last seen resident at approximately 16:45 (5:45 p.m.) she was sitting in her recliner in her room. When asked, how she got outside, resident stated, I let myself out. When asked, how she knew the code to the door resident stated, I just do. When asked who gave her the code to the door resident stated, Nobody, I just know it. Resident taken to the lockdown unit. Resident refused VS (Vital signs) .5/20/2020 13:38 DON follow up on elopement on 5/19/2020, this resident went into the courtyard and knocked out two boards of the fence and climbed through the whole, she was found close to the facility by an employee, body audit done with no injuries, when asked why she eloped the Resident stated, she was tired of electricity being put through her by our phones in the facility. Resident placed on 15-minute checks and moved to the secure unit, courtyard code changed, MD (Medical Doctor), Family, DON, Police, OLTC (Office of Long Term Care) and Administrator notified . The I & A (Incident and Accident) documented, .5/19/2020 17:40 (5:40 p.m.) incident description: This nurse was notified at approximately 1730 (5:30 p.m.) that resident was seen outside the facility unattended. When this nurse last seen at approximately1645 (4:45 p.m.) sitting in her recliner in her room . Immediate Action Taken: Resident was taken to lockdown unit. Resident refused VS. Resident q (every) 15 min. checks on the secured unit. Reported to OLTC. Notified MD, Sister, Police, DON, Administrator. No injuries . The 7734 documented, . Summary of incident: (DE) Resident eloped from the facility at approximately 1700 (5:00 p.m.) (corrected by DON), stated, Administrator did not know what time it was because he was not here. Resident returned to facility by employee at approximately 1730 .Eloped through the courtyard by pushing fencing off and climbing through the small gap she created. Resident was seen close to the facility by an employee and returned with no injuries .(Resident said eloped from the facility due to electricity from phones being used in the facility . b. On 7/13/2020 at 11:08 a.m., the Surveyor and the Assistant Director of Nurses (ADON) observed the courtyard where the resident eloped. There were 2 new boards on the fence that replaced the ones the resident had pushed out. There was a gate at the end of the sidewalk. The gate had a pad lock on the gate. It was attached to a latch to keep the gate secure. The lock was not engaged and hanging on the latch. A photograph of the lock pad on the gate and the latch was taken at this time. The gate was easily opened, and no one was on the other side of the gate. There was a clear exit with no one around the gate. The ADON was asked, Who opened the gate? He stated, He did not know. The ADON was asked, Should the gate be locked? He stated, Yes. I guess it's because they are mowing. c. On 7/13/2020 at 12:30 p.m., the DON was asked, What time did the resident get out of the facility? She stated, Approximately 1700 on 5/19/2020. The DON was asked, How long was she missing? She stated, approximately 30 minutes. The DON was asked, Did she have any injuries? She stated, No. We did a full body audit. The DON was asked, Has she tried to get any since that event? She stated, No. She is on the unit. The DON was asked, What has the facility done to prevent any further elopements? She stated, We changed all code locks and fixed the privacy fence. d. On 7/13/2020 at 12:47 p.m., the DON was asked, Should the courtyard gate be left unlocked? She stated, No. It was the boy mowing the yard. He said he saw ya'll open the gate. He was bringing in the mower. The DON was asked, How long was it left unlocked and no one there? She stated, He said he had just unlocked it. 2. The Elopement policy and procedure provided by the DON on 7/15/2020 at 11:42 a.m. documented, Record the time and date that resident was discovered missing .verify not signed out .perform census verification .Activate facility's EOP (Emergency Operations Plan) .
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 observations, record review, and interview the facility failed to ensure proper infection prevention and control practices were implemented to prevent the development and transmission of COVID-19 and other communicable diseases and infections by not wearing a face mask and wearing a face mask to cover the nose and not storing infectious waste properly. These failed practices had the potential to affect the 53 residents who resided in the facility according to the daily census provided by the Minimum Data Set Coordinator (MDSC) on 7/13/2020. The findings are: 1. On 7/13/2020 at 10:23 a.m., the Surveyor entered the facility. The Director of Nurses (DON) screened the Surveyor per the guidelines. The Surveyor observed Employee # 1 standing by the DON. The employee's mask was below the nose as he was talking to the DON. 2. On 7/13/2020 at 11:00 a.m., Employee #1 was walking through a sitting area and his mask below his nose. The mask was pushed down to the chin. There was a resident siting at the table in the sitting area. 3. On 7/13/2020 at 11:14 a.m., the Surveyor and the Assistant Director of Nurses (ADON) observed on the 500 Hall 2 red isolation containers sitting in a foyer on the hallway. There was not a door closing it off to residents. The containers were sitting next to a mechanical lift and wheelchair. There were a pair of gloves turned inside out on top of one of the containers. A photograph was taken of the 2 red isolation containers and the mechanical lift at this time. The ADON was asked, What is on top of that barrel? He stated, Gloves. The ADON was asked, Are they clean or dirty? He stated, Dirty. The ADON was asked, Should they be there? He stated, No. The ADON was asked, Where are those biohazard containers to be stored? He stated, Outside. 4. On 7/13/2020 at 11:15 a.m., Certified Nursing Assistant (CNA) #1 was walking past a resident sitting in the hallway. The CNA's mask was down below her nose. 5. On 7/13/2020 at 11:21 a.m., CNA #1 was walking past another resident sitting in the hallway. The CNA's mask was down below her nose. The CNA was asked, Have you been trained on COVID? She stated, Yes. The CNA was asked, Are you supposed to wear your mask covering your nose? She stated, Yes. 6. On 7/13/2020 at 12:29 p.m., the DON provided the Surveyor a copy of the Personal Protective Equipment-Contingency and Crisis Use of Facemasks (COVID-19 Outbreak) policy and procedure that documented, .Purpose To guide the use of personal protective equipment (PPE) through contingency and crisis capacity strategies when supply is limited . Objective To prevent transmission of infectious agents through inhalation of droplets . General Procedure for Donning and Doffing Masks . 1.b. Be sure that the face masks covers the nose and mouth while wearing . 7. On 7/13/2020 at 12:47 p.m., the DON was asked, Should staff wear their mask to cover their nose? She stated, Yes. The DON was asked, Should biohazard be stored in the hallway? She stated, No. 8. On 7/13/2020 at 5:43 p.m.,

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) the DON provided the Surveyor a copy of the Medical Waste Handling policy and procedure that documented, . Purpose, The purpose of this procedure is to provide a definition of guidelines and safe handling of medical waste .Guidelines: 1. For the purpose of this policy, medical waste includes human blood and blood-soiled articles, contaminated items, (i .e. soiled dressings) contaminated with feces from a person diagnosed as having disease that is transmitted through feces and disposable sharps .