STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045314	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49413 Based on observation, interviews, record review, and policy the facility failed to ensure bed linens were maintained in clean condition for two (Resident #28 and #36) of seven residents sampled for safe, clean, and comfortable homelike environment. The findings are: A review of Resident #28 ' s admission report showed Resident #28 had diagnoses of bipolar, depressive episodes, stroke, and psychosis. A review of Resident #36 ' s admission report showed Resident #36 had diagnoses of Alzheimer's disease, dementia, and schizophrenia. During observations on 1/6/2025 at 10:37AM and 2:45PM, Resident #36 ' s bed on the right side of the room was covered with a blue bed spread that had white unknown substance scattered on top of the cover. The folded blue blanket at the head of the bed had an unknown dried smeared white stain on the top right corner. The side of the bed cover that hung towards the floor had unknown brownish stains along the middle third of the linen. During observations on 1/6/2025 at 10:38AM and 2:46PM, on the left side of Resident #36 ' s room, a second bed contained unknown substances of black and brown specks grouped together on the bottom right corner with unknown black spots scattered along the left side length of the bed. During observations on 1/6/2025 at 10:40AM and 2:48PM a bed on the right side of Resident #28 ' s room against the wall, in the center of the bed linen was a dried yellowish-brown stain. Certified Nursing Aide (CNA) #8 was interviewed in person on 1/9/2025 at 7:05AM. CNA #8 stated residents will get their bed linens changed after showers or accidents. Some of the residents prefer to change their own sheets and will ask for clean bed linens. When linens are dirty on non-shower days the linens are to be changed. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045314	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Barnes Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Barnes Street Lonoke, AR 72086	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA #7 was interviewed in person on 1/9/2025 at 7:15AM. CNA #7 stated, bed linens are changed as needed, after showers or if residents ask for clean linens on non-shower days. Residents with their own bed linens will ask for their linens to be changed. Laundry will return linens to resident's room. When laundry is unable to have linens back the same day it is explained to residents that laundry still has the linens and facility linens are provided. Licensed Practical Nurse (LPN) #5 was interviewed in person on 1/9/2025 at 7:20AM. LPN #5 stated, residents have their sheets changed on shower days and as needed. Registered Nurse (RN) #6 was interviewed in person on 1/9/2025 at 7:30AM. RN #6 confirmed bed linens are changed on shower days, or any time linens are soiled. Residents that had soiled their bed will ask me for clean linens due to not wanting others to know. The clean linens are provided. Residents with personal bed linens are changed the same way as facility linens. Residents with personal linens are provided facility linens if laundry was unable to return them the same day. The Director of Nursing (DON) was interviewed in person on 1/9/2025 at 7:48AM. The DON confirmed staff should have changed the bed linens in [resident ' s room number] due to linens had been soiled. The bed on the other side of the room was also dirty. The DON was interviewed in person on 1/9/2025 at 7:51AM and stated, the bed in [resident ' s room number] did need to be changed. The Administrator was interviewed in person on 1/9/2025 at 7:55AM and confirmed that both beds in Resident #36 ' s room looked dirty and needed to be changed. The Administrator was interviewed in person on 1/9/2025 at 7:57AM and confirmed the bed on the right side of Resident #28 ' s room against the wall, should be changed. A review of facility policy titled Policy and Practices for Infection Control showed: 1. The facility's infection control policies and practices apply equal to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public alike, regardless of race, color, creed, national origin, religion, age, sex, handicap, marital or veteran status or payor source. 2. The objective of our infection control policies and practices are to: a. Prevent, detect, investigate and control infections in the facility b. Maintain a safe, sanitary, and comfortable environment for personnel, residents. Visitors and the general public f. Provide guidelines for the safe cleaning ad reprocessing of reusable resident-care equipment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 50505 Based on record review, interviews, and facility document review, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS) for 7 (Residents #5, # 25, #16, #27, #41, #14, #22) of 11 sample mix residents. The findings are: Review of Resident #5's Admission Record noted the resident was admitted on [DATE] with diagnoses of peripheral vascular disease (PVD) (slow and progressive disorder of the blood vessels), cerebral infarction(stroke) and presence of cardiac pacemaker. Review of Resident #5's Order Summary Report dated 1/8/2024 noted [anti-platelet medication name] Tablet 75 milligrams (MG) give 1 tablet by mouth one time a day for blood clot prevention; [nonsteroidal anti-inflammatory (NSAID) medication name] enteric coated (EC) tablet delayed release 81 MG give 1 tablet by mouth one time a day for prophylactic. Review of Resident #5's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/2024 noted in section N0415. High Risk Drug Classes: Use and Indication E. Anticoagulant Yes. Review of Resident #25's Admission Record noted the resident was admitted on [DATE] with a diagnosis of pleural effusion (a collection of fluid around the lungs). Review of Resident #25's Order Summary Report dated 1/8/2025 noted [NSAID medication name] 81 oral tablet chewable give 1 tablet through gastrostomy tube (G-Tube) one time a day for pain. Review of Resident #25's annual MDS with an ARD of 12/11/2024 noted Section N0415. High Risk Drug Classes: Use and Indication E. Anticoagulant Yes. Review of Resident #16's Admission Record noted the resident was admitted on [DATE] with a diagnosis of stroke (cerebral infarction). Review of Resident #16's Order Summary Report dated 1/6/2025 noted [NSAID medication name] oral tablet give 325 milligrams (mg) by mouth one time a day for blood thinner. Review of Resident #16's quarterly MDS with an ARD of 11/26/2024 noted in section N0415. High Risk Drug Classes: Use and Indication E. Anticoagulant yes. Review of the Admission Record indicated the facility admitted Resident #27 with diagnoses that included atherosclerotic heart disease, cerebral infarction, peripheral vascular disease and insomnia. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/01/2024, revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident had severe cognitive impairment. The MDS was marked for anticoagulant and hypnotic use. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #27's Care Plan, initiated on 05/21/2020, revealed the resident had a potential for pressure ulcers status post cerebral infarction with left hemiparesis; makes only slight changes in body positioning; incontinent of bowel and bladder, during a move, skin probably slides to some extent against the sheets; thin fragile skin, taking routine full strength aspirin due to her history of cerebral infarction and myocardial infarction, with potential for easily tearing and/or bleeding. Resident #27's skin bruises easily related to [NSAID medication name therapy. Interventions included: to assist with showers/baths 3 times per week and prn. Observe for and report to nurses of any changes in skin integrity and ensure that Resident #27's skin is thoroughly clean and dry. Insomnia and the use of [over the counter (OTC) supplement name] were not included in the care plan A review of the Order Summary Report, revealed Resident #27 had orders for [NSAID medication name] 325 mg, give 1 tablet by mouth one time a day for cerebral infarction and [OTC supplement name] 3 mg, give 3 tablets by mouth in the evening for insomnia. A review of the Medication Administration Record (MAR) revealed Resident #27 was receiving [NSAID medication name] 325 mg 1 tablet every day for cerebral infarction and [OTC supplement name] 3 mg, 3 tablets every evening for insomnia. A review of the Admission Record indicated the facility admitted Resident #41 with diagnoses that included paranoid schizophrenia, mild dementia with behavioral symptoms, and essential hypertension. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/19/2024, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. The MDS was marked for anticoagulant use and weight loss of 5% or more in the last month or loss of 10% or more in the last six months. A review of Resident #41's Care Plan, initiated on 01/23/2024, revealed the resident had a significant weight loss. Interventions included: obtain weights as indicated/as ordered and inform MD of significant weight loss, offer snacks as ordered/per resident's request and assist resident to eat, provide diet as ordered, and refer to dietician for possible diet modification(s). No care plan was noted for aspirin use of deep vein thrombosis (DVT) prophylaxis. A review of the Order Summary Report revealed Resident #41 had orders for enteric coated [NSAID medication name] 81 mg delayed release, give 1 tablet by mouth one time a day for DVT prophylaxis. A review of the Medication Administration Record (MAR), revealed Resident #41 was receiving enteric coated [NSAID medication name] 81 mg delayed release, give 1 tablet by mouth one time a day for DVT prophylaxis. A review of weight list, indicated Resident #41 had a weight gain. Resident #41's previous month weight was taken on 12/05/2024 with a weight of 149.2. Weight on 06/03/2024 was 140. During an observation of the resident smoke break on 1/7/2025 at 1:31 PM, the surveyor observed Resident #14 did not have on a smoking apron. Two staff were present during the smoke break. Staff had residents ' cigarettes and a lighter. Smoking ashtray was present along with a fire extinguisher. Review of Resident #14's Assessments did not note the resident was assessed for smoking. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's Admission Record noted the resident was admitted on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). Review of Resident #14's Care Plan with a date of 7/16/2024 noted Resident #14 was a risk for potential injuries and health complications related to history of smoking. Cigarettes and lighters to be kept at the nurses station and given to resident upon request. Complete smoking assessment quarterly to assess safety of smoking outside. Provide resident with assistance needed. Provide resident/ family with education regarding proper places to smoke and provide education regarding risk of smoking and benefits of quitting. Provide resident/ family with education regarding risks of smoking. Review of Resident #14's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/1/2025 did not note in section J tobacco use. Review of Resident #22's Admission Record noted the resident was admitted on [DATE] with a diagnosis of schizoaffective disorder. Review of Resident #22's Annual MDS with an ARD of 11/10/2024 noted Psychiatric/ Mood Disorder I5950. Psychotic disorder (other than schizophrenia) Yes; 16000. Schizophrenia Yes. During an interview with the Director of Nursing (DON) on 1/7/2025 at 1:34 PM, she confirmed no smoking assessment was completed, and the resident should have had one completed prior to smoking. The DON confirmed that the resident should have been assessed for smoking for safety purposes. During an interview with the MDS Coordinator on 1/9/2025 at 9:00 AM, she confirmed Resident #14's MDS did not indicate the resident was a tobacco user and it should. During an interview with the Director of Nursing (DON) on 1/9/2025 at 9:24 AM, she confirmed Resident #14's MDS should indicate the resident is a smoker. During an interview with the MDS Coordinator on 1/9/2025 at 9:14 AM she confirmed Resident #22 does not have a diagnosis of Schizophrenia and that the resident has a diagnosis of schizoaffective disorder. The MDS Coordinator confirmed the MDS with an ARD of 11/10/2024 should have indicated Schizoaffective not Schizophrenia as the resident is not Schizophrenic. During an interview on 01/09/2025 at 9:29 AM, the MDS Coordinator explained that the importance of coding the MDS accurately was to ensure medications were administered correctly and that errors could be made and that it was for the residents' well-being and that weights should be accurately recorded in the MDS. The MDS coordinator confirmed that the [NSAID medication name] was coded as an anticoagulant and the [OTC supplement name] was coded as a hypnotic for Resident #27 and that Resident #41 did not have a weight loss but a weight gain and was coded incorrectly and the [NSAID medication name] was coded as an anticoagulant. During an interview with the Director of Nursing (DON) on 1/9/2025 at 9:37 AM, she confirmed Resident #22 does not have a diagnosis of Schizophrenia and that the resident has a diagnosis of other schizoaffective disorders. She confirmed the MDS with an ARD of 11/10/2024 should not have indicated Schizophrenia because the resident does not have a diagnosis of Schizophrenia. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Barnes Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 1010 Barnes Street Lonoke, AR 72086	

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/2025 at 10:00 AM, the Director of Nursing (DON) confirmed medications were coded incorrectly on the MDS and that the MDS Coordinator was responsible for ensuring accuracy of the MDS. The DON confirmed that Resident #27's MDS had been coded incorrectly for the [NSAID medication name] use, that it should have been marked as an antiplatelet and that [OTC supplement] was not a hypnotic medication as marked on the MDS. The DON confirmed that Resident #41's MDS was coded incorrectly for [NSAID medication name] use as an anticoagulant and that the resident had a weight gain, not a weight loss. During an interview with the MDS Coordinator on 1/9/2025 at 10:25 AM, she confirmed Residents #5, #25, #16, #41 and #27 should not have had [NSAID mediation name] coded on the MDS as an anticoagulant and that it should have been coded as an antiplatelet.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 50505 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure preadmission screening and resident review (PASRR) was completed for 1 (Resident #32) of 1 resident reviewed for preadmission screening due to diagnosis. Findings include: On 01/08/2025 at 9:30 AM, the Director of Nursing (DON), stated the facility did not have a policy for Preadmission Screening and Resident Review. A review of the Admission Record, indicated the facility admitted Resident #32 with diagnoses that included schizophrenia, vascular dementia, mood disorder, anxiety disorder, and psychosis. Resident #32's actual admitted to the facility was 07/13/2020. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/2024, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. Active diagnoses were marked for mood disorder, anxiety disorder, psychotic disorder, schizophrenia. The admission 5-day MDS with an ARD of 07/20/2020 did not have schizophrenia marked. A review of Resident #32's Care Plan, initiated on 05/21/2024, revealed the resident had a risk for adverse reactions from behavior disturbances as related to vascular dementia with behavioral disturbance, schizophrenia, psychosis and mood disorder. Interventions included: administer and monitor effectiveness of medications as prescribed by physician; anticipate needs and provide them before the resident becomes overly stressed; educate resident on other effective coping skills for dealing with feelings; explain care in advance to resident; intervene during behavioral outbursts to protect the safety of the resident and others; investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by the physician; monitor and document any non-pharmacological interventions used to deter behavior prior to as needed medication administration; observe and record changes in behavioral symptoms; provide resident with diversional activities when behavioral symptoms arise; provide resident with one-on-one attention as needed; and reinforce positive behavior. Preadmission screening and resident review were not mentioned in the care plan. A review of the PASRR, a letter dated 05/19/2020 from [company name] stated it was determined Resident #32 was a non-PASRR client. Upon reviewing the entire information sent in for the PASRR, only one diagnosis was given: mild neurocognitive disorder and was marked no for having a diagnosis or history of mental illness (schizophrenia). During an interview on 01/08/2025 at 8:44 AM, the Director of Nursing (DON) confirmed there had been no PASRR completed after the 05/19/2020 PASRR and confirmed that Resident #32 entered the facility on 07/13/2020.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 50505 Based on record review, interview, and facility document review, it was determined that the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) was completed prior to admission to ensure the resident received the needed care and services in the most appropriate setting for 3 (Residents #16, #22,#32) of 4 sampled residents whose records were reviewed for PASRR screening information. The findings are: Review of Resident #16's [company name] letter, submitted by another facility, dated 5/14/2018, for a Level I application and the resident was considered a change of condition. Review of Resident #16's Division of Medical Services (DMS) 787 dated 6/11/2018 noted in Section II the resident had a diagnosis of Mental Retardation (MR)/ Intellectual Development disorder (IDD). Mental Retardation developed before the resident reached age 18, and the resident had a Developmental Disability before reaching the age of 22. Mental Illness section noted Resident #16 has a diagnosis of schizophrenia has received treatment within the last two years at a mental hospital. The DMS 787 also documented that the resident has a diagnosis of dementia. Review of Resident #16's DMS-780 dated 6/11/2018 noted the Diagnostic and Statistical Manual of Mental Disorders- Fourth Edition- (DSM-IV) was utilized to substantiate the following diagnosis of dementia (including Alzheimer's, cognitive disorder, alcohol/ drug and other related disorders). Major neurocognitive disorder, IDD list for dementia diagnosis. The diagnosis was made on the basis of a mental status examination. Behavior, history or physical findings that lead to the dementia diagnosis: Refusing meds, mood lability, psychosis, poor safety awareness. Diagnosis of dementia first made in 2015. Section II B. note the resident has a diagnosis of Schizophrenia, is the primary diagnosis and existed prior to the onset of dementia. Review of Resident #16's Arkansas Department of Health and Human Services Evaluation of Medical Need Criteria (DHHS-703) dated 6/11/2018 noted the resident has a diagnosis of schizophrenia and IDD Mental disorder. The document noted it was electronically processed on 6/12/2018 and emailed to medical needs. Review of Resident #16's Division of Provider Services and Quality Assurance (DPSQA) Office of Long Term Care (OLTC) letter dated June 15,2018 noted they were unable to process the application for nursing home care due to lack of information in following area(s) and or additional information is needed to accurately review the application: Licensed Practical Nurse (LPN) signature missing and completed Minimum Data Set (MDS). Because of these items, the processing of the application was being delayed and to avoid further delay resubmit by 6/28/2018. Review of Resident #16's Admission Record with an admitted [DATE] noted diagnoses of schizophrenia and a mental disorder. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #16's Update Diagnosis with a date of 3/8/2022 noted a diagnosis of schizophrenia as a primary admitting diagnosis. Review of Resident #16's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/26/2024 noted the resident had a score of 9 (08-13 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS). Section I. Active Diagnosis Psychiatric/ Mood Disorder I6000. Schizophrenia yes. Review of Resident #16's electronic chart documented no PASRR II, or exemption located on the electronic chart. During an interview with the MDS Coordinator on 1/7/2025 at 2:59 PM, this surveyor requested Resident #16's Pre-Admission Screening documents and [company name] letter that would indicate either a Level II or exempt from a Level II PASRR. The MDS Coordinator revealed 2018 was the last time Resident #16 was seen for [company name]/ Med Needs and that she did not have a copy of the paperwork that indicated whether or not the resident had a Level II PASRR for diagnoses of schizophrenia and intellectual or developmental disability (IDD) Disorder and that there was no Level II exempt or instructions for specialized services. During an interview with the Director of Nursing (DON) on 1/9/2025 at 9:31 PM, she confirmed a PASSR should have been submitted for Resident #16 to the Office of Long-Term Care (OLTC) for the resident to receive a Level II for schizophrenia diagnosis. Review of Resident #22's [company name] letter submitted by another facility dated 6/28/2018 for a Level I application and the resident was considered a change of condition. Review of Resident #22's Admission Record noted the resident was admitted on [DATE] with a diagnosis of schizoaffective disorder. Review of Resident #22's Division of Medical Services (DMS) 787 dated 11/8/2022 noted in Mental Illness section noted Resident #22 had a diagnosis of schizoaffective and there was presenting evidence of disturbance in orientation, affect, mood or behavior that suggested mental illness. The DMS 787 also documented the resident had no diagnosis of dementia. Review of Resident #22's DMS-780 dated 11/13/2022 was not completed. Review of Resident #22's Arkansas Department of Health and Human Services Evaluation of Medical Need Criteria (DHHS-703) dated 10/28/2022 noted the resident had a diagnosis of schizoaffective disorder. Review of Resident #22's annual MDS with an ARD of 11/10/2024 noted a score of 11 (8-12 indicates moderate cognitive impairment) on the BIMS. Section I. Active Diagnosis Psychiatric/ Mood Disorder I5950. Psychotic disorder (other than schizophrenia) Yes; 16000. schizophrenia Yes. Review of Resident #22's electronic chart documented no PASRR II, or exemption located on the electronic chart. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the MDS Coordinator on 1/7/25 at 2:59 PM, this surveyor requested Resident #22's Pre-Admission Screening documents and [company name] letter that would indicate either a Level II or exempt from a Level II PASRR. The MDS Coordinator revealed 2018 was the last time Resident #22 was seen for [company name]/ Med Needs and that she did not have a copy of the paperwork the indicated whether or not the resident had a Level II PASRR for a diagnosis of schizoaffective disorder and that there was no Level II exempt or instructions for specialized services. During an interview with the Director of Nursing (DON) on 1/9/2025 at 9:37 PM, she confirmed a PASSR should have been submitted to the Office of Long-Term Care (OLTC) for Resident #22 to receive a Level II for a schizoaffective diagnosis. A review of the Admission Record, indicated the facility admitted Resident #32 with diagnoses that included schizophrenia, vascular dementia, mood disorder, anxiety disorder, and psychosis. Resident #32's actual admitted to the facility was 07/13/2020. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/2024, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had severe cognitive impairment. Active diagnoses were marked for mood disorder, anxiety disorder, psychotic disorder, schizophrenia. The admission 5-day MDS with an ARD of 07/20/2020 did not have schizophrenia marked. A review of Resident #32's Care Plan, initiated on 05/21/2024, revealed the resident had a risk for adverse reactions from behavior disturbances as related to vascular dementia with behavioral disturbance, schizophrenia, psychosis and mood disorder. Interventions included: administer and monitor effectiveness of medications as prescribed by physician; anticipate needs and provide them before the resident becomes overly stressed; educate resident on other effective coping skills for dealing with feelings; explain care in advance to resident; intervene during behavioral outbursts to protect the safety of the resident and others; investigate/monitor the need for psychological/psychiatric support. Provide services if desired by the resident/family and ordered by the physician; monitor and document any non-pharmacological interventions used to deter behavior prior to as needed medication administration; observe and record changes in behavioral symptoms; provide resident with diversional activities when behavioral symptoms arise; provide resident with one-on-one attention as needed; and reinforce positive behavior. Preadmission screening and resident review were not mentioned in the care plan. A review of a Physician's Progress Note, dated 08/13/2020, revealed the resident had a past medical history of major neurocognitive disorder with behaviors, schizophrenia, hypothyroidism, hypertension, mood lability, and anxiety. A review of Medical Diagnosis on 01/07/2025, revealed that Resident #32 had the primary diagnosis of schizophrenia added on 06/03/2022. A review of the PASRR, a letter dated 05/19/2020 from [company name] stated it was determined Resident #32 was a non-PASRR client. Upon reviewing the entire information sent in for the PASRR, only one diagnosis was given: mild neurocognitive disorder and was marked no for having a diagnosis or history of mental illness (schizophrenia). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045314	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barnes Healthcare	1010 Barnes Street Lonoke, AR 72086

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/2025 at 8:44 AM, the Director of Nursing (DON) confirmed there had been no PASRR completed after the 05/19/2020 PASRR and confirmed that Resident #32 entered the facility on 07/13/2020.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 50505 Based on observations, interviews, and record review, it was determined the facility failed to document and complete a person-centered care plan to facilitate the ability to plan and provide necessary care and services for 6 (Residents #32, 22, 27, 3, 7, 14) of 19 sampled residents whose Care Plans were reviewed. The findings include: A review of the Admission Record, indicated the facility admitted Resident #32 with diagnoses that included schizophrenia, vascular dementia with behavior disturbance, psychosis, mood disorder, convulsions, anxiety disorder, and abnormal weight loss. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/2024, revealed Resident #32 had a Brief Interview for Mental Status (BIMS) score of 0 which indicated the resident had severe cognitive impairment. Resident #32 was marked as having 2 or more falls since admit or prior assessment. A review of Resident #32's Care Plan, initiated on 06/22/2023, revealed the resident had a high potential for fall and/or fall-related injuries due to strong history of falling, (intermittently causing hematoma's to forehead), and diagnosis of dementia with behavior disturbances, decreased safety awareness, routine psychotropic medications per physician orders, Vitamin D deficiency with potential for bone demineralization an or pathological fractures. Falls listed on care plan for Resident #32: 04/24/2024; 06/20/2024; 07/22/2024; 09/03/2024; 10/01/2024 and 01/02/2025. Interventions included: anticipate and meet Resident #32's needs; encourage Resident #32 to sit on the side of the bed for a few moments prior to rising and assist as indicated; frequent observation by staff due to resident's inability to use call light, but keep call light within reach in room to encourage resident to press for assistance, staff to respond in a timely manner; resident assessed with no injury apparent, no pain indicated, assisted to couch to rest; keep pathways clean and free of clutter; labs per physician orders; bed needs to be in lowest position while resident is in it for safety and comfort, pharmacy to review medications monthly with recommendations to the physician as indicated (these interventions were added in 2023). Intervention added 01/31/2024: the resident was assessed for injuries, none found. Resident redirected to another activity; non-skid socks placed on resident's feet. Maintenance requested to secure mini refrigerator. Most recent fall was recorded on 01/02/2025 with no interventions in place. A review of the Order Summary Report, revealed Resident #32 had been admitted to Hospice; Receiving [antiparkinson medication name] 25/100 milligrams (mg), 1 tablet by mouth 3 times a day; [anticonvulsant medication name] 125 mg, 4 capsules by mouth 3 times a day; [antidepressant medication name] 50 mg, 1 tablet one time a day; [antipsychotic medication name] 0.5 mg, 1 tablet by mouth every 12 hours and [opioid pan relieving medication name] 20 milligrams(mg)/milliliter(ml), 0.25 ml by mouth every 4 hours as needed for pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an Activity of Daily living task list revealed Resident #32 had no tasks developed for interventions for falls. The Director of Nursing (DON) was asked to review the incident reports for falls for Resident #32 on 07/22/2024; 09/03/2024; 10/01/2024, and 01/02/2025. After reviewing, the DON confirmed there were no immediate action interventions on the incident reports except for 07/22/2024, nor were there interventions placed on the care plans for any of the incidents. Review of Resident #22's Admission Record dated 10/28/2022 note a diagnosis of swelling (edema), and schizoaffective disorder. Review of Resident #22's Order Summary Reported dated 12/6/2025 noted [diuretic medication name] oral tablet 20 Milligrams (Mg) give 1 tablet by mouth two times a day for edema. Review of Resident #22's Care Plan with a revision date of 11/29/2024 did not note medication or black box warning for [diuretic medication name], diagnosis of edema, and Resident #22's diagnosis of schizoaffective disorder. A review of the Admission Record, indicated the facility admitted Resident #27 with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, vascular dementia, anxiety disorder, psychosis, major depressive disorder, and insomnia. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/01/2024, revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated the resident had severe cognitive impairment. Resident #27 was marked as receiving an antipsychotic, antianxiety, antidepressant, hypnotic, and anticoagulant. A review of Resident #27's Care Plan, initiated on 03/07/2023, revealed the resident had an alteration in behavioral status following cerebral infarction as evidenced by refusals of care and has impulsiveness with little or no safety awareness placing Resident #27 at risk for further falls; yells out loudly, potentially disturbing others and when approached and questioned, will state that nothing is needed; and frequently kicks right lower extremity against the bed/specialized geriatric chair or the wall with risk for injury. Interventions included: administer and monitor effectiveness of medications as prescribed by physician, intervene during behavioral outbursts to protect the safety of the resident and others. No black box warnings were noted. Resident #27's care plan revealed the resident had potential for impaired skin integrity/pressure ulcers status post cerebral infarction with left hemiparesis; makes only slight changes in body positioning, decreased physical mobility, risk for nutritional deficit and frequently kicks the right lower extremity against bed/specialized geriatric chair or the wall with risk for injury. Interventions included: assess and record changes in skin status. Report pertinent changes to the physician, complete skin risk assessment quarterly; provide diet as ordered and monitor nutritional status and dietary needs, and standard pressure reducing mattress to bed. Contracture and contracture management was not included in care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Order Summary Report, revealed Resident #27 had [NSAID medication name] 325 mg, 1 tablet by mouth one time a day; [benzodiazepine medication name]1 mg, 1 tablet by mouth every 12 hours; [anti-Parkinson ' s and anticholinergic agent name] 0.5 mg, 1 tablet by mouth two times a day; [anticonvulsant medication name] 125 mg, 2 capsules by mouth two times a day; [antidepressant medication name] 10 mg, 1 tablet by mouth one time a day; [over the counter supplement name] 3 mg, 3 tablets by mouth in the evening; and [antipsychotic medication name] 2 mg, 1 tablet by mouth two times a day. A review of Medication Administration Record (MAR), revealed Resident #27 had been receiving [NSAID medication name], [antidepressant medication name], [over the counter supplement name], [benzodiazepine medication name], [anti-Parkinson ' s and anticholinergic medication name], and [anticonvulsant medication name]. A review of an Activity of Daily living task Clean left hand and between fingers. Passive Range of Motion (PROM) to left elbow, wrist, and fingers. Place hand roll in left hand, ensuring all fingers are open around the roll, revealed Resident #27 had a contracture to the left hand. During an observation on 01/06/2025 at 10:50 AM, Resident #27 had no handroll observed, no device observed in left hand, obvious contracture noted. During an observation on 01/08/2025 at 10:30 AM, Resident #27 had no hand roll or device to the left hand. No device or handroll was noted to in or on the bed or on the tabletops in the room. During an interview on 01/08/2025 at 11:19 AM, the Certified Nursing Assistant (CNA) #11 stated that Resident #27 has a hand roll, but that the resident refuses to use at times. CNA #11 stated, I don't document the refusals, and the nurses document the refusals. When asked if refusals are reported to the nurse, CNA #11 stated, I don't report it to the nurse. CNA #11 was asked where the hand roll was in the room and CNA #11 searched the room, closet, drawers, and bed of resident and the hand roll was not located in Resident #27's room. When asked how CNAs knew what care needed to be provided to the residents', CNA #11, reported, I ask the nurse what needs to be done. The DON reviewed the care plan for Resident #27 and confirmed there were no black box warnings listed in the care plan and that the MDS Coordinator was responsible for care planning black box warnings. When asked what the importance of documenting the black box warnings, the DON stated, to know what adverse reactions to watch for. Review of Resident #3's Admission Record dated 6/7/2019 noted diagnoses of major depressive disorder, anxiety, asthma, chronic obstructive pulmonary disease (COPD), atrial fibrillation (A-Fib), irritable bowel syndrome with constipation, chronic pain. Review of Resident #3's Order Summary Report dated 1/8/2025 noted (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[diuretic medication name] oral tablet 20 milligrams (Mg) give 1 tablet by mouth one time a day every Monday, Wednesday, Friday, Sunday for swelling (edema); [anticoagulant medication name] oral tablet 2.5 Mg give 1 tablet by mouth two times a day for A-fib; [opioid agonist medication name] oral tablet 50 Mg give 1 tablet by mouth three times a day for chronic pain; [benzodiazepine medication name] tablet 1 Mg give 1 tablet by mouth two times a day for anxiety; [irritable bowel syndrome agent medication name] capsule 290 microgram (mcg) give 1 capsule by mouth one time a day for Irritable Bowel Syndrome (IBS); [antidepressant medication name] oral tablet Extended Release 24 Hour 300 Mg give 1 tablet by mouth one time a day for depression/anxiety Do not crush; [leukotriene modifier medication name] Tablet 10 Mg Give 1 tablet by mouth one time a day. Review of Resident #3's Care plan dated 12/31/2019 does not note medications or black box warnings for [diuretic medication name], [anticoagulant medication name], [opioid agonist medication name], [benzodiazepine medication name], [irritable bowel syndrome agent medication name], [antidepressant medication name], and [leukotriene modifier medication name]. The Care plan noted the resident is taking psychotropic medications that have been discontinued. A review of an Admission Record indicated the facility admitted Resident #7 with chronic kidney disease stage 3 (kidneys have mild to moderate damage and has difficulty filtering waste and excess fluid from the blood). The quarterly Minimum Date Set (MDS), with an Assessment Reference Date (ARD) of 10/20/2024, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Review of Resident #7 ' s Care Plan, revealed that multiple areas in intervention where black box warnings did not reveal details to monitor. Black box warning and medication were not reference in Care Plan. No warnings for symptoms to monitor. Review of Resident #14's Admission Record noted the resident was admitted on [DATE] with a diagnosis of repeated falls. Review of Resident #14's Care Plan dated 7/16/2024 noted Resident #14 is at high risk for falls/injuries related to previous history of falls, unsteady gait, obesity, osteoarthritis, and chronic pain. The care plan noted falls on: 7/15/24 Actual fall without injury 8/13/24 Actual fall with injury to right hand 9/15/24 Actual fall with minor injury 9/18/24 Actual fall without injury 9/26/24 Actual fall without injury 9/27/24 Actual fall without injury (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/3/24 Found on floor 11/20/24 Witnessed fall 11/23/24 Witnessed fall 12/1/24 Unwitnessed fall 12/4/24 Fall with no injury 12/6/24 Witnessed fall-skin tear 12/22/24 Fall with no injury x 2 12/26/24 Fall with no injury 12/31/24 Found on floor, no injury 1/1/25 Found on floor, no injury Care plan interventions include: Assess for and record any additional fall risk factors Date Initiated: 7/16/2024 Frequent monitoring and anticipation of needs if resident is unable to or forgets to use call light Date Initiated: 7/16/2024 Instruct resident to move or change positions slowly Date Initiated: 7/16/2024 Interventions: Resident to have low bed with floor mats Date Initiated: 7/16/2024 Resident has a cane/walker and uses it when he has strength to ambulate without falling. Date Initiated: 12/13/2024 Review of Resident #14's Progress Notes dated 8/13/2024 at 9:54 AM, noted Resident #14 fell into dresser. No injuries noted. Staff discussed with the resident sitting up on side of bed for a few minutes before attempting to ambulate. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's Progress Notes dated 9/15/2024 at 8:50 AM, noted Resident #14 reported fell in the morning and stated right hand was hurting. Right hand noted to be swollen and some bruising around knuckles. The resident reported it hurt to try to bend fingers. New order received for right hand x-ray. Review of Resident #14's Progress Notes dated 9/26/2024 at 10:56 AM, noted Resident #14 had fallen in the bathroom across the hallway from Resident 14's room. Review of Resident #14's Progress Notes dated 9/27/2024 at 8:24 AM, noted Resident #14 was found on the floor in the bedroom. Review of Resident #14's Progress Notes dated 11/3/2024 at 3:03 PM, noted Resident #14 slid out of wheelchair. Resident #14 was observed to have 2 skin tears to left forearm. The resident instructed to lock wheelchair, do not overreach or call for help. Review of Resident #14's Progress Notes dated 11/20/2024 at 11:06 AM, noted Resident #14 slipped and fell in shower. No injuries noted. Educated resident to ask for assist while transferring in shower room. Review of Resident #14's Progress Notes dated 11/24/2024 at 3:57 PM, noted Resident #14 denies pain, no bruising or skin tears. No change in mobility related to fall on 11/23. Review of Resident #14's Progress Notes dated 12/6/2024 at 6:38 PM, noted Resident #14 was observed hitting the floor and rolled to side just inside the doorway. Resident #14 revealed sliding into the floor. Small skin tear to right forearm noted. Resident #14 was instructed to use cane or walker when going to the bathroom. Review of Resident #14's Progress Notes dated 12/9/2024 at 8:47 PM noted Resident #14 had no injuries noted from previous fall on 12/6/24. Encouraged to use call light for transfers. Review of Resident #14's Progress Notes dated 12/22/2024 at 3:36 PM noted Resident #14 was using the commode and attempted to get up and slid off the commode to the floor between commode and sink. No injuries noted. Commode Rails requested for safety. Review of Resident #14's Progress Notes dated 12/26/2024 at 1:01 PM noted the resident was found on the floor with arms and head on the floor sticking out of room in hallway. Resident #14 was assessed for injury and skin tears noted to back of right forearm. Resident encouraged to use call light and ask for assist from staff for transfer needs Review of Resident #14's Progress Notes dated 12/26/2024 at 1:07 PM Noted Resident #14 was found on stomach in room. Review of Resident #14's Progress Notes dated 12/26/2024 at 7:18 PM noted staff will continue to monitor the resident and instructed to use call light and ask for help if feeling week to help prevent falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #14's Progress Notes dated 1/1/2025 at 7:34 PM noted the resident slid out of bed. No injuries noted. No interventions listed. Review of Resident #14's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/1/2025 noted section J1800. Has the resident had any falls since admission/ entry or reentry or Prior Assessment (OBRA or Scheduled PPS), which ever is more recent? Yes. During an interview with Resident #14 on 1/7/2025 at 9:08 AM, Resident #14 confirmed they had multiple falls recently. Resident #14 confirmed no injuries were sustained. This surveyor did not observe any fall interventions in the residents room. During an interview on 01/08/2025 at 8:44 AM, the Director of Nursing (DON) stated the fall process was as follows: investigate to find out what the resident was trying to do, assess the resident, if needed provide first aid or medical care or send to hospital, provide interventions. Confirmed that this information would be documented in the incident record as well as a progress note and the care plan. During an interview with the MDS Coordinator on 1/9/2025 at 9:00 AM, she confirmed Resident #14 did not have fall interventions listed on the care plan for falls that occurred on 8/13/2024; 9/15/2024; 9/18/2024; 9/20/2024; 9/26/2024; 9/27/2024; 11/03/2024; 11/20/2024; 11/23/2024; 12/1/2024; 12/14/2024; 12/22/2024; 12/26/2024; 12/31/2024 and 1/1/2025. She confirmed there should be interventions on the care plan for each fall so if one intervention does not work they could try something else to prevent falls. During an interview with the MDS Coordinator on 1/9/2025 at 9:04 PM, she confirmed medications that require black box warnings were not listed on the residents care plans for medications that have black box warnings. She confirmed the medications with black box warnings should be on the care plans, and the purpose of the warning is due to possible drug interactions. During an interview with the DON on 1/9/2025 at 9:24 AM, she confirmed Resident #14 did not have fall interventions listed on the care plan for falls that occurred on 8/13/2024; 9/15/2024; 9/18/2024; 9/20/2024; 9/26/2024; 9/27/2024; 11/03/2024; 11/20/2024; 11/23/2024; 12/1/2024; 12/14/2024; 12/22/2024; 12/26/2024; 12/31/2024 and 1/1/2025. She confirmed there should be fall interventions on the care plan, so staff were aware of what needed to be done to prevent additional falls. During an interview on 01/09/2025 at 9:29 AM, the MDS Coordinator confirmed that the MDS Coordinator was responsible for the comprehensive care plan and that fall interventions should be added to the care plan soon after the fall occurs. The MDS Coordinator was unaware that black box warnings needed to be included in the comprehensive care plan and agreed that contractures should be care planned with interventions to prevent worsening. During an interview on 01/09/2025 at 10:00 AM, the DON confirmed that the MDS Coordinator was responsible for care planning the black box warnings to the care plan. During an interview with the DON on 1/9/2025 at 9:33 AM, she confirmed medications that require a black box warning were not listed on the residents care plans for medications that have black box warnings. She confirmed the medications with black box warnings should be on the care plans, so staff was aware of what side effects to watch for. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the MDS Coordinator on 1/9/2025 at 10:25 AM, she confirmed Resident #22 was not care planned for edema or schizoaffective disorder and that the resident was care planned for schizophrenia. 51477

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50505 Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure family/responsible party and resident were included in the care plan process for 1 (Resident #47) of 1 resident reviewed for care plan meetings. The findings include: A review of the Admission Record, indicated the facility admitted Resident #47 with diagnoses that included down syndrome, abnormal weight loss, seizures, dysphagia, anxiety disorder, and insomnia. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2024, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) score of 00 which indicated the resident had severe cognitive impairment. The MDS was marked resident and family participation in assessment and goal setting. A review of Resident #47's Care Plan, initiated on 07/03/2023, revealed the resident/family or physician had determined the resident had a need for long term care. Interventions included: educate resident/family of benefits of nursing home care. A review of Progress Notes on 01/08/2025, from 01/01/2024 through 05/29/24, revealed no care plan meeting notes in the medical record for Resident #47. A review of Miscellaneous Paperwork scanned into the electronic medical record for Resident #47 revealed no care plan meeting information. During an interview on 01/09/2025 at 09:29 AM, the MDS Coordinator stated that the care plan meetings were set up by the Social Director (SD) and that assistance was now being provided in the process by the MDS coordinator. When asked who should be included in the invitation, the MDS coordinator confirmed that it should include the families, social, assistant director of nursing or director of nursing, dietary, MDS coordinator and the resident. During an interview on 01/09/2025 at 10:00 AM, the Director of Nursing (DON) stated that care plan meetings were set up by the MDS Coordinator and the SD. During an interview on 01/09/2025 at 10:40 AM, the SD was unable to locate any documentation, notes, or verification for family invitations being sent for Resident #47. No records were found prior to June 2024. The SD stated that letters were sent out to the family and if the resident was cognitive, they were given a letter as well and that a copy of the letter was kept with memos written on the copied letter if no one was going to attend or any other note that needed to be kept. The SD confirmed that the actual care plan meeting, with signatures included, was now being kept and was scanned into the electronic medical record. No policy was provided for the care planning process during the survey.

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Barnes Healthcare	1010 Barnes Street Lonoke, AR 72086

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 Based on observation, interview, record review, and facility document review, it was determined the facility failed to ensure that residents who smoke have a smoking assessment for 2 (Resident #14, #41) of 2 sample mix residents reviewed for smoking and to ensure hand rolls were used for residents with contractures for 1 (Resident #27) of 1 sample mix residents reviewed for contractures and to ensure specialized shampoo was used during showers as ordered by physician instead of regular body wash for 1 (Resident #47) of 1 resident reviewed for ADL (activities of daily living) care for dependent residents. The finding are: During an interview with Resident #14 on 1/7/2025 9:11 AM, the resident stated there are smoking times and confirmed staff keep cigarettes and lighters. Resident #14 confirmed that they don't wear an apron when smoking. Review of Resident #14's Admission Record noted the resident was admitted on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). Review of Resident #14's Care Plan with a date of 7/16/2024 noted Resident #14 was a risk for potential injuries and health complications related to history of smoking. Cigarettes and lighters to be kept at the nurses ' station and given to resident upon request. Complete smoking assessment quarterly to assess safety of smoking outside. Provide resident with assistance needed. Provide resident/ family with education regarding proper places to smoke and provide education regarding risk of smoking and benefits of quitting. Provide resident/ family with education regarding risks of smoking. Review of Resident #14's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/1/2025 does not note in section J. Tobacco use. During an observation of Resident #14 during smoke break on 1/7/2025 at 1:31 PM, this surveyor observed Resident #14 did not have on a smoking apron while smoking. Review of Resident #14's Assessments does not note the resident was assessed for smoking. A review of the Admission Record, indicated the facility admitted Resident #41 with diagnoses that included paranoid schizophrenia, mild dementia with behavioral disturbance, and depression. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/19/2024, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. A review of Resident #41's Care Plan, initiated on 05/15/2024, revealed the resident had a risk for potential injuries and health complications related to resident is a recent smoker with a history of smoking inside the building at previous facility and being caught outside in the smoke area after smoke break again smoking. Interventions included provide resident with assistance needed to smoke outside of facility and complete smoking assessment quarterly to assess safety of smoking outside. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 01/07/2025 at 1:15 PM, Resident #41 was outside with staff assistance. Staff lit Resident #41's cigarette, and no smoking apron was used. Resident #41 was supervised by staff. A review of the Admission Record, indicated the facility admitted Resident #27 with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, anxiety disorder, psychosis, cerebral infarction (CVA), peripheral vascular disease and myocardial infarction. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/01/2024, revealed Resident #27 had a BIMS score of 5. which indicated the resident had severe cognitive impairment. The MDS was marked for Resident #27 as having impairment to upper and lower extremity and requiring passive range of motion (ROM). A review of Resident #27's Care Plan, initiated 05/21/2020, revealed the resident had a potential for pressure ulcers status post CVA with left hemiparesis, makes only slight changes in body positioning. Interventions included: assist with showers/baths three times per week and as needed. Observe for and report to nurses any changes in skin integrity and ensure skin is thoroughly clean and dry. A review of the Order Summary Report revealed Resident #27 had an order for weekly skin assessment on Wednesdays. A review of the Activities of Daily Living (ADL) Task Record, revealed Resident #27 had the task: Clean left hand and between fingers. Passive Range of Motion (PROM) to left elbow, wrist, and fingers. Place hand roll in left hand, ensuring all fingers are open around the roll. Documentation reviewed from 12/08/2024 through 01/06/2025. During these times, 7 times were documented as not applicable, with 7 times applied and 14 times being refused and 1 time with no documentation available. During an observation on 01/06/2025 at 10:50 AM, Resident #27 was noted to have contracture of the left hand. No handroll or device was observed in the resident's left hand. During an observation on 01/08/2025 at 10:30 AM, Resident #27 had no handroll or device in left hand. No device or handroll was observed on the bed or on the table or on top of the cabinet in the resident's room. A review of a facility policy titled, Medication Policy, revised in April 2007 stated, all the resident's clinical record must have an order for over-the-counter medications and if ordered will be supported by the appropriate care processes and practices. A review of the Admission Record, indicated the facility admitted Resident #47 with diagnoses that included down syndrome, seizures, abnormal weight loss and dysphagia. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2024, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) of 0 and no staff assessment for mental status had been completed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #47's Care Plan, revised on 10/09/2023, revealed the resident had a slight risk for impaired skin integrity/pressure ulcers, related to incontinent episodes, risk for nutritional deficit. Intervention included: assess and record changes in skin status and to assist resident with showers twice weekly, PRN and upon request. Intervention was added on 12/18/2023 which included medicated external shampoo (ketoconazole topical 1%, apply to affected areas topically as needed for every shower use in place of body wash. A review of the Order Summary Report, revealed Resident #47 had an order dated 12/11/2023, Ketoconazole 1% topical shampoo, apply to affected areas topically as needed for every shower, use in place of body wash. A review of Treatment Administration Record (TAR), revealed Resident #47 had Ketoconazole 1% topical shampoo, apply to affected areas topically as needed every shower, use in place of body wash. TARs were reviewed from 12/11/2023 until May 29,2024 with no signatures present to show the medicated shampoo had ever been used. A review of an Activity of Daily living task Bathing, May 2024, revealed Resident #47 had the intervention/task of Bathing on Tuesday, Thursday, Saturday and PRN. Baths were documented as being given on 5/2, 5/4, 5/7, 5/11, 5/14, 5/16, 5/21, 5/25, 5/28. Documentation was not provided for 5/18 and 5/23, and the resident was unavailable per documentation for 5/9. A review of Progress Notes revealed no documentation written regarding the medicated shampoo being ordered. A review of the skin observation tool for the following dates in 2024, 1/2, 2/7, 3/2, 4/5, 5/3, 5/10, 5/18, 5/24, and 5/29 indicated that the resident had psoriasis patches present. During an interview with the Director of Nursing (DON) on 1/7/2025 at 1:34 PM, she confirmed no smoking assessment had been completed for Resident #14 and the resident should have had one completed prior to smoking. The DON confirmed the resident should have been assessed for smoking for safety purposes. The DON also reviewed the last smoking evaluation completed on Resident #41 and confirmed that no smoking evaluation had been completed since 12/01/2023. DON was unsure as to how often the evaluation was to be completed. After reviewing the care plan, DON confirmed that the smoking evaluation should be completed quarterly. During an interview on 01/08/2025 at 11:19 AM, the certified nursing assistant (CNA) #11 stated that Resident #27 had a hand roll, but that the resident refuses to use it at times. CNA. #11 stated, I don't document the resident's refusals, the nurses document it. I don't report it to the nurse. CNA #11 confirmed the hand roll was not in Resident #27's room. During an interview on 01/09/2025 at 08:45, the Treatment Nurse stated that the medicated shampoo is on the nurse's medication carts and certified nursing assistants (C.N.A.) use during showers. Treatment nurse confirmed the medicated shampoo should be signed out on the TAR when used. During an interview on 01/09/2025 at 08:45, the Director of Nursing (DON) agreed with the Treatment nurse on the medicated shampoo being on the medication carts and that the C.N.A.'s use during showers. DON confirmed that the medicated shampoo should be signed out on the TAR when used. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/09/25 at 9:29 AM, the MDS Coordinator confirmed that contractures should be included on the care plan with interventions to prevent worsening and agreed that quarterly smoking assessments should be completed on any resident that smokes. A policy for positioning was not provided during the survey. 50505

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 50505 Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure treatment was provided for the left foot for 1 (Resident #47) of 1 resident reviewed for skin and wound treatments and care. Findings include: A review of a facility policy titled, Medication Policy, revised in April 2007 stated, all the resident's clinical record must have an order for over-the-counter medications and if ordered will be supported by the appropriate care processes and practices. A review of the Admission Record, indicated the facility admitted Resident #47 with diagnoses that included down syndrome, seizures, abnormal weight loss and dysphagia. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2024, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) of 0 and no staff assessment for mental status had been completed. No area was marked for issues with the feet. A review of Resident #47's Care Plan, revised on 10/09/2023, revealed the resident had a slight risk for impaired skin integrity/pressure ulcers, related to incontinent episodes, risk for nutritional deficit. Interventions included: assess and record changes in skin status and assist resident with showers twice weekly, PRN and upon request. Intervention for treatment to the left foot, first and 2nd toenail was not included in the care plan. A review of the Order Summary Report, revealed Resident #47 had an order from 01/25/2024, for Povidone-Iodine external solution, apply to nailbed, topically every 24 hours as needed for left foot, 1st and 2nd toenail until healed. A review of Treatment Administration Record (TAR), revealed Resident #47 had a treatment order in place for Povidone-Iodine external solution, apply to nailbed, topically every 24 hours as needed for left foot, 1st and 2nd toenail until healed. TARs from January 2024-May 2024 indicated the treatment was only provided once on 01/25/2024. A review of Progress Notes indicated Resident #47 had documentation on 01/25/2024, First and 2nd left (L) toenail not connected to nail bed. Nails removed. Beds cleaned with povidone-iodine per physician orders. No redness, swelling, pain, or drainage at sites. Tolerated without difficulty. No other documentation regarding left foot was found from February-May 2024. A review of the skin observation tool for the following dates in 2024, 1/2, 2/7, 3/2, 4/5, 5/3, 5/10, 5/18, 5/24, and 5/29 indicated that the resident had psoriasis patches present. No mention of toenails of left foot mentioned on the skin observation tool. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/09/2025 at 8:49 AM, the Director of Nursing (DON) was unable to state the reason as to why the Povidone-Iodine was not documented on the TAR. The DON stated that the treatment nurse was not working at the facility at the time the resident resided in the facility. The DON confirmed that the nurses should have signed the TAR off if the treatment was provided.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50505 Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure adequate nutrition and hydration was provided for dependent residents for 1 (Resident #47) of 1 resident reviewed for nutrition and hydration status and weight loss. Findings include: A review of the facility policy titled, Assistance with Meals, revised in September 2013, indicated that residents would receive assistance with meals to meet the individual needs of the resident and that resident who could not feed themselves would be fed with attention to safety, comfort, and dignity. A review of the Admission Record indicated the facility admitted Resident #47 with diagnoses that included down syndrome, seizures, abnormal weight loss, and dysphagia. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/18/2024, revealed Resident #47 had a Brief Interview for Mental Status (BIMS) of 0 and no staff assessment for mental status (SAMS) had been completed. Resident #47 was coded as having a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. A review of weights revealed Resident #47 admitted to the facility on [DATE] and discharged [DATE]. Resident #47 weighed 170.4 on 06/26/2023 and on 04/17/2024 weighed 124.8. A review of Resident #47's Care Plan, initiated on 07/03/2023, revealed the resident was at risk for decline in nutrition/hydration status related to new admission to facility, medications that have the potential to alter appetite, and body mass index (BMI). Interventions included: assist resident as needed with eating, monitor oral intake and weigh routinely per facility policy, notify physician and family/responsible party of significant weight changes, and dietary recommendations as needed. A review of the Order Summary Report revealed Resident #47 was on a regular diet, regular consistency with a dietary supplement drink with breakfast and dinner, a fortified donut with breakfast, and a strawberry dietary supplement drink as a snack before dinner. Resident #47 was also taking a multivitamin with minerals once a day. A review of the Medication Administration Record (MAR), revealed Resident #47 was receiving a multivitamin with minerals daily and was documented. A review of an activities of daily living (ADL) task for May 2024 Nutrition: Eating, revealed Resident #47 had the task for 3 times per day with 18 times not being documented. A review of an ADL task for May 2024 Nutrition: Fluids, revealed Resident #47 had the task for 3 times per day with 17 times not being documented. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an ADL task for May 2024 Nutrition: Supplements, revealed Resident #47 had the task 2 times per day with 15 times not being documented. A review of an ADL task for May 2024 Nutrition: Snacks, revealed that Resident #47 had only been offered snacks 6 times and was documented. During an interview on 01/09/2025 at 9:54 AM, Licensed Practical Nurse (LPN) #5 stated that the Certified Nursing Assistants (CNA)s document nutrition and hydration and that the nurses do not have access to see the CNA charting. LPN #5 stated that if an alert was triggered on the computer for the residents consuming less than 25% of a meal, documentation would be done at that time. LPN #5 stated the CNAs were asked to offer snacks, different food, and fluids if the resident was not eating and I make notes in the computer. During an interview on 01/09/2025 at 9:58 AM, CNA #10 stated it was important to document nutrition and hydration so that the nurse can see if the resident was not eating or drinking and alert the nurse to see if something is wrong. CNA #10 confirmed that water should be offered every time someone goes into the resident's room. During an interview on 01/09/2025 at 10:05 AM, the Director of Nursing (DON) reviewed the ADL record for May 2024. When asked what the importance was for accurate nutrition and hydration documentation, the DON responded, It would be important for health and general well-being, and it would show the care that was actually provided. The DON agreed there were many missing areas of documentation on the ADL record for Resident #47. The DON stated that Resident #47 liked snack food and not actual food from the kitchen and that Resident #47 had stopped eating prior to discharge.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 51477 Based on observation, interviews, record review, and facility policy review, it was determined that the facility failed to ensure the medication regimen was free from unnecessary medications without adequate indications for its use for 1(Resident #7) of 1 resident reviewed for unnecessary medications. Findings Included: Review of a facility policy titled, Medication Therapy Policy, no date indicated Medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to such treatments. A review of an Admission Record indicated the facility admitted Resident #7 with chronic kidney disease stage 3 (kidneys have mild to moderate damage and have difficulty filtering waste and excess fluid from the blood) The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/20/2024, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. During a record review, Resident #7 ' s order summary, revealed three medications without proper indications for their use. Orders read as follows: [Antidepressant medication name] 12.5mg give 12.5mg by mouth at bedtime [Thyroid hormone medication name] 175mcg give 1 tablet by mouth one time a day [Antidiabetic medication name] 500mg give 1 tablet by mouth 2 times a day No indications for use we present on the orders. During an interview on 01/09/25 09:22 AM the MDS Coordinator revealed the importance of ensuring the diagnosis for each resident is linked to the medication in the orders so the medication can reveal what it is used for. The MDS Coordinator also revealed that not having a diagnosis properly linked to medication could affect the care of the resident and all medications such be linked appropriately.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review and interview, the facility failed to ensure meals were prepared and served in accordance with the planned, written menu to meet the nutritional needs of the residents for 1 of 2 meals observed. The findings are: 1. On 1/6 /25 at 12:35 PM, a #12 (3 ounces) scoop was used by Dietary [NAME] (DC) #4 in the mechanical soft yogurt baked chicken for serving. The menu for the 01/06/25 lunch meal indicated 4 ounces per serving, a difference of 1 ounce. 2. On 1/6/25 at 12:37 PM, the menu for the lunch meal indicated 4 ounces for pureed yogurt baked chicken and 1 pureed wheat dinner roll. A #12 scoop (3 ounces) was used in the pureed yogurt baked chicken for meal service, a difference of 1 ounce. No pureed dinner roll was served to pureed diets. There were no substitutions served to the residents in place of a dinner roll. 3. On 1/6/25 At 1:03 PM, DC #1 was interviewed and was asked why no dinner roll was served to the residents on pureed diets. DC #1 stated she was told by the previous Dietary Manager not to serve bread to the residents on pureed diets. DC #1 was asked if substitutions were given in place of dinner rolls. DC #1 confirmed that she did not give extra food items in place of dinner rolls. 4. On 1/6/25 at 1:09 PM, DC #4 was asked what scoop size she had used to serve ground meat and pureed meat. DC #4 stated she used a #12 scoop. When asked if she had reviewed the menu beforehand to ensure she was using the correct serving scoop and to confirm how many servings she gave to each resident, DC #1 stated she had not reviewed the menu and that she gave one serving to each resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 Based on observation, interview, record review, and facility policy review, the facility failed to ensure food items stored in the freezer were covered, sealed, dated; manufacturer specification was followed; kitchen ceiling tiles were replaced, cleaned to provide a sanitary environment for food preparation; floors, dish washer, kitchen walls, were free of chipped and stains and dietary staff washed their hands before they handled clean equipment or food for 1 of 1 meal observed. The findings are: 1. On 1/6/25 at 10:01 AM, the following observations were made on a rack above the food preparation counter: a. An opened bag of cornmeal. The bag was not sealed. b. An opened box of baking soda. c. An opened bottle of dill weed. 2. On 1/06/25 at 10:11 AM, the following observations were made on a shelf in the 2-door freezer: a. An opened box of hamburger patties. The bag was not covered or sealed. b. An opened box of catfish. The box was not covered or sealed. c. An opened box of cod fish. The box was not covered or sealed. d. An opened box of veggie sausage. The box was not sealed or covered. e. An opened box of black bean burgers. The box was not sealed or covered. 3. On 1/06/25 at 10:17 AM, the following observations were made on a shelf in the 2nd freezer: a. An opened box of biscuits. The box was not covered or sealed. b. An opened box of dinner rolls. The box was not covered or sealed. c. An opened box of vegetable blend. The box was not covered or sealed. 4. On 1/6/25 at 10:22 AM, an opened gallon of soy sauce was on a shelf in the storage room. The manufacturer's specifications on the gallon indicated to refrigerate after opening. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Barnes Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 1/6/25 at 10:39 AM, Dietary [NAME] (DC) #1 opened the oven door and looked at the food items inside the oven, contaminating her hands. Without washing hands, DC #1 picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents on pureed diets. DC #1 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment she stated she should have washed her hands. 6. On 1/6/25 at 10:51 AM, the following observations were made in the kitchen areas: a. The wall in the dishwashing machine had sage color on it. b. The wall below the dish washing room was chipped, exposing the cement. c. The ceiling tiles throughout the kitchen had brown stains on it. d. The floors in several areas of the kitchen were chipped, exposing the cement. e. The floor in front of the oven was warped and had black stains on it. f. The ceiling tiles were loose in some areas. g. A floor tile was missing around the area leading to the dishwashing machine. 7. On 1/6/25 1 at1:18 AM, DC #2 removed a carton of drinks from the refrigerator and placed it on the counter, contaminating his hands. Without washing his hands, he picked up glasses by their rims and placed them on the trays to be used portioning beverages to be served to the residents for lunch. DC #2 interviewed and was asked what he should have done after touching dirty objects and before handling clean equipment he stated he should have washed his hands. 8. On 1/6/25 at 12:15 PM, Dietary Aide (DA) #3 who was on the tray line assisting with noon meal was observed to pick up cartons of supplements and placed them on the trays, contaminating his hands. Without washing his hands, DA #3 was interviewed and was asked what he should have done after touching dirty objects and before handling clean equipment he stated he should have washed his hands. 9. On 1/6/25 at 12:36 PM, the following observations were made on a shelf in the refrigerator: and freezer in the breakroom on 300- hall: a. A glass of milk. There was no date when it was stored. b. A glass of apple juice. There was no date to indicate when it was stored. c. An opened box of butter pecan ice cream on a shelf in the freezer has freezer burn. The Dietary Manager was interviewed and was asked if she can describe the appearance of the ice cream, and she confirmed ice cream has freezer burn. It looked like it had melted and then refrozen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045314	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Barnes Healthcare	1010 Barnes Street Lonoke, AR 72086

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On 1/6/25 at 12:40 PM, the metal area above the ice machine panel located in the breakroom in the business hallway where ice forms before dropping into the ice collect had a layer of a black and gray residue that had settled on it. The Dietary Manager was asked if she could wipe the area. She did so, and the black and gray residue easily transferred to the tissue. The Dietary Manager was interviewed and was asked if she can describe what was observed, she stated it was dirty and yucky. The Dietary Manager was interviewed and was asked who used the ice from the machine located in the break room on 300-hall and how often the ice machine was cleaned. She stated the CNAs (Certified Nursing Assistants) used it to fill water pitchers in the residents ' rooms. The kitchen staff also used it to fill beverages served to the residents at meals and she cleans the ice machine once a month 11. A review of facility policy titled, Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices, initiated 2017, provided by the Dietary Manager on 1/6/2025 indicated, employees should wash their hands whenever entering or re-entering the kitchen, before coming in contact any food surfaces and after engaging in other activities that contaminate the hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045314	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Barnes Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38200 Based on observation, interview, and facility policy review, it was determined that the facility failed to ensure staff did not place dirty meal trays on the meal transport cart while clean trays were still on the metal transport cart being served to residents to avoid cross-contamination. The findings are: During an observation of the lunch meal on 1/6/2025 at 12:54 PM, this surveyor observed Certified Nursing Assistant (CNA) #9 placed lunch meal trays that were dirty, due to the residents already consuming the meal, on the meal transport cart with four (4) resident meal trays that still needed to be served to the residents. During an interview with CNA #9 on 1/6/2025 at 12:54 PM, he confirmed that he should not place dirty meal trays on the meal cart with meal trays that had not been served to the residents. During an interview with the Director of Nursing (DON) on 1/9/2025 at 9:43 AM, the DON confirmed that staff should not place dirty meal trays on the meal cart with meal trays that had not been served to the residents due to it being an infection control issue. Review of the facility policy titled, Policies and Practices- Infection Control, with a revision date of July 2014 noted Policy Statement This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation 1. This facility's infection control policies and practices apply equally to all personnel. 2. The objective of our infection control policies and practices are to: a. Prevent, detect, investigate, and control infections in the facility; b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public. 4. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter.