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 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. 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. 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. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 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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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 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** 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, ½, 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.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 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. 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.

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 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** 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. 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. (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

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.