STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045134	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Jonesboro	1705 Latourette Drive Jonesboro, AR 72404

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 Note: The nursing home is disputing this citation.	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. 37634 Based on observation, and interview, the facility failed to ensure 1 (Resident #83) of 1 sampled resident had a pillowcase on their pillow. The findings are: A review of Resident #83's medical records revealed a diagnosis of pressure-induced deep tissue damage of unspecified site. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 06/11/2024 indicated the resident scored 15 (cognitively intact) on a Brief Interview for Mental Status (BIMS). A review of the Care plan with a revision date of 04/11/2024 indicated Resident #83 was at risk for impaired skin integrity related to restricted mobility. On 07/22/2024 at 11:45 AM, Resident #83 was in bed. There was not a pillowcase on their pillow. Resident #83 indicated that the facility doesn't have any pillowcases, and the resident hasn't had a pillowcase on the pillow in months. On 07/22/2024 at 1:33 PM, there was no pillowcase on Resident #83's pillow. On 07/22/2024 at 2:25 PM, there was no pillowcase on Resident #83's pillow. On 07/22/2024 at 2:32 PM, during an interview, Certified Nursing Assistant (CNA) #1 indicated she didn't know why Resident #83 didn't have a pillowcase on her pillow. On 07/25/2024 at 9:30 AM, during an interview, the Director of Nursing (DON) indicated the facility did not have a policy related to bed linen.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 37634 Based on observations, interviews, and record review, the facility failed to follow physician orders for wound care for 1 (Resident # 88) of 3 (Residents #42, #88, and #96) sampled residents reviewed for pressure ulcers. The findings are: A review of the Physicians Orders indicated Resident #88 had diagnoses of pressure ulcer of sacral region, stage 4, pressure ulcer of left heel, unstageable, pressure-induced deep tissue damage of right heel, pressure ulcer of right hip, unstageable, pressure ulcer of other site, unstageable, pressure-induced deep tissue damage of unspecified heel. A review of a Physicians Order with a start date of 07/19/2024 revealed, Gentamicin Sulfate External Ointment 0.1 % .Apply to stage IV (4) sacrum topically every day shift related to pressure ulcer of sacral region, stage 4 Cleanse with wound cleanser, apply, cover with scored PolyMem [a soft dressing that soaks up liquid easily] and foam bordered dressing .; Gentamicin Sulfate External Ointment 0.1 % .Apply to unstageable L (left) ischium topically every day shift related to pressure ulcer of other site, unstageable. Cleanse with wound cleanser, apply, cover with scored PolyMem [a soft dressing that soaks up liquid easily] and foam bordered dressing . A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/05/2024 revealed Resident #88 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A review of Resident #88 ' s Care Plan, revised on 6/06/2024, revealed Resident #88 had stage 4 pressure ulcers. Interventions included, wound nurse to assess wounds and notify physician of decline or no progress in 2 weeks. On 07/24/2024 at 2:55 PM, during observation of wound care, the Treatment Nurse washed her hands, applied gloves, and put on an isolation gown. Certified Nursing Assistant (CNA) #6 held Resident #88 over on the resident ' s left side. The wound to Resident #88's right hip was open, and red around the edges. The Treatment Nurse cleansed the right hip with a 4x4 and wound cleanser. She applied Gentamicin Ointment to the inside of the wound and applied a foam dressing border. On 07/24/2024 at 3:09 PM, during observation of wound care, the Treatment Nurse washed her hands, applied gloves, and put on an isolation gown. Certified Nursing Assistant (CNA) #6 held Resident #88 over on the resident ' s left side. The wound to the top center of Resident #88's buttocks was open and red around the edges. The Treatment Nurse cleansed the wound to the top center of the buttocks with a 4x4 and wound cleanser. She applied Gentamicin Ointment to the inside of the wound and applied a foam dressing border. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 07/24/2024 at 3:21 PM, during observation of wound care, the Treatment Nurse washed her hands, applied gloves, and put on an isolation gown. Certified Nursing Assistant (CNA) #6 held Resident #88 over on the resident ' s left side. The wound to the bottom right of Resident #88's buttocks was open, and red around the edges. The Treatment Nurse cleansed the bottom right buttocks with a 4x4 and wound cleanser. She applied Gentamicin Ointment to the inside of the wound and applied a foam dressing border. On 07/24/2024 at 3:32 PM, during observation of wound care, the Treatment Nurse washed her hands, applied gloves, and put on an isolation gown. Certified Nursing Assistant (CNA) #6 held Resident #88 over on the resident ' s left side. The wound to the left bottom of Resident #88's buttocks was open, and red around the edges. The Treatment Nurse cleansed the left buttocks with a 4x4 and wound cleanser. She applied Gentamicin Ointment to the inside of the wound and applied a foam dressing border. On 07/24/2024 at 3:49 PM during observation of wound care, the Treatment Nurse washed her hands, applied gloves, and put on an isolation gown. Certified Nursing Assistant (CNA) #6 held Resident #88 over on the resident ' s left side. The wound to Resident #88's right heel was open. The Treatment Nurse cleansed the right heel with a 4x4 and wound cleanser. She applied Gentamicin Ointment to the inside of the wound and applied a foam dressing border. On 07/25/2024 at 8:44 AM, during an interview, the Treatment Nurse was asked, How do you ensure that you are providing the correct treatment when providing wound care? She stated, Reading the treatment record. The Treatment Nurse indicated that Resident #88 had 5 wounds, and the treatment was the same for all 5 wounds. She was asked the reason why PolyMem wasn't applied to Resident #88's wounds. She stated, I went right over it, nervous, and didn't see it. She indicated that it has been a week since the PolyMem was ordered for Resident #88. A review of a facility policy titled, Wound Care, received 07/25/2024 indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Verify that there is a physician's order for this procedure. On 07/25/2024 at 9:25 AM, the Director of Nursing (DON) indicated the Medication Administration Record (MAR), and the physician orders should be reviewed prior to administering wound care treatment to prevent treatment errors.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44852 Based on observation, interview, record review and policy review, the facility failed to ensure hands were washed between clean and dirty tasks; hair covering was worn at all times; and meals were served, and food was stored in a manner as to prevent cross contamination for the 113 residents who received their meals from one of one kitchen. The findings are: On 07/22/2024 at 10:18 AM, upon attempting to determine the internal temperature of the two-door refrigerator the Dietary Manager (DM) reported there was no thermometer located inside the machine. The shelves inside the two door refrigerator were observed to have areas of rust. On 07/22/2024 at 10:20 AM, upon entering the walk-in refrigerator the plastic sheeting covering of the door was observed to have a red substance which was spilled and had congealed and stuck to the plastic. The walk-in freezer was observed to have a red liquid substance which had spilled on the floor and left to freeze. Two steam table pans (2 inches deep) of gelatin were observed to be located on the middle shelf of the walk-in freezer. The plastic wrap had been removed from the corner of the pan exposing the mixture to air and contaminants. On 07/22/2024 at 10:21 AM, three large garbage cans were observed in front of the door to the walk-in freezer. One of the cans had no lid. The lids on top of the other two cans were ajar. On 07/22/2024 at 10:23 AM, a large plastic tub (18 gallon) labeled flour was observed to contain a foam cup which was laying on top of the flour. The large plastic tub labeled cornmeal had a foam cup laying on top of the cornmeal. The lid of the container of cornmeal had not been properly sealed leaving the contents open to air and contaminants. The large plastic container labeled thickener was observed to have a piece of blue plastic protruding from the dry ingredient. The Dietary Manager observed that the container was missing a closure which was the blue plastic piece which was half submerged into the thickener. The absence of the closure prevented the container from maintaining a proper seal, leaving the contents open to air and contaminants. On 07/22/2024 at 11:36 AM, a 21 ounce container of garlic powder was observed on a shelf above the counter in the kitchen. The lid of the container was open exposing the contents to air and contaminants. On 07/22/2024 at 11:40 AM, three large trays of dinner rolls were removed from the oven. The trays were placed on a rack to cool and were left uncovered. On 07/22/2024 at 11:45 AM, the Dietary Manager was observed with the bottom half of her hair uncovered. The hairnet was observed to cover the large top knot of hair, however leaving the bottom half of the head exposed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 07/22/2024 at 11:47 AM, Dietary Aide #4 was observed carrying clean pitchers to the shelf for storage. Dietary Aide #4 placed her fingers inside the containers. Dietary Aide #4 was then observed to raise her shirt exposing her midriff to pull up her pants. She then lowered her shirt and wiped her hands down the front of her shirt to smooth. Dietary Aide #4 continued to the clean dish area of the dish-room and retrieved more clean dishes. Hands were not washed after touching her person or clothing and prior to touching the clean dishes. Dietary Aide #4 was observed multiple times bringing her shirt up to wipe her face. On 07/22/2024 at 11:49 AM, Dietary Aide #3 was observed to carry multiple large plastic containers to the sink to make powdered drinks. Fingers were placed inside the containers. On 07/22/2024 at 12:15 PM, Dietary Aide #2 was observed to enter the kitchen and proceed to the office prior to putting on a hair covering. A sign located at the entrance to the kitchen instructs employees to apply hair covering prior to entering the kitchen. On 07/22/2024 at 12:17 PM, Dietary Aide #3 was observed to dry his hands on his pants, adjust his face covering, and obtain a cart. Hands were not washed prior to continuing with meal service or providing coffee to a resident through the window. On 07/22/2024 at 12:20 PM, Dietary Aide #1 was observed to place her thumb on each plate prior to filling the plate for the noon meal. Dietary Aide #1 was observed to have fingernails which extend approximately one inch over the end of the finger and into the plate. On 07/22/2024 at 12:24 PM, Dietary Aide #4 was observed to place contaminated hands into each insulated dome prior when placing the dome over the plate of food. On 07/22/2024 at12:35 PM, a meal cart was observed to leave the kitchen to be delivered to the unit. The Dietary Consultant was asked if it was customary for the temperature to be taken of the food prior to serving the meal. The Dietary Consultant described that she did not take the temperature and that the new Dietary Manager forgot to do it. On 07/24/2024 at 7:35 AM, Dietary Aide #1 was observed to place her hand on her hip contaminating her hand just prior to picking up a plate. Dietary Aide #1's thumb went into each plate as it was picked up and placed on the tray. The hand to hip motion was observed between the placement of every plate served on the 300 Hall. On 07/24/2024 at 7:38 AM, Dietary Aide #1 was observed to drop an insulated base into the steam table pan containing French toast. The base encountered three slices of toast. The base was removed, and the French toast was served to the residents. On 07/24/2024 at 7:40 AM, the Dietary Manager was observed to place her fingers inside the insulated dome each time just prior to placing the dome over the hot food. On 07/24/2024 at 1:43 PM, review of a policy provided by the Administrator titled, Preventing Foodborne Illness - Food Handling revealed, the policy statement reflected food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a second policy titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, addressed the prevention of food borne illness through employee hygiene and sanitary procedures. Employees must wash hands before coming into contact with any food surfaces; when changing tasks or after engaging in other activities that contaminate the hands; fingernails shall be kept clean and trimmed; hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food. On 07/25/2024 at 8:25 AM, the Dietary Consultant reported that dietary employees should be washing their hands, every two seconds. He continued to identify after you touch your person, move from one task to the next, move from one area to the next. Concerning hair coverings, he reported that a hair covering should be applied before entering the kitchen. The nails of a dietary employee should not extend over the end of the finger. Fingers should not extend into the inside of containers, or the surface of plates or inside the domes which cover the plates. Dry ingredients should be stored in air-tight containers and should not have scoops or other items left inside.