STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045142	A. Building B. Wing	12/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Park Ave	1401 Park Avenue Hot Springs, AR 71901

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42965 Based on observation, interview, and record review the facility failed to report to the state survey agency when a resident, that was care planned not to leave the facility without supervision, left the facility without staff knowledge for 1 (Resident #8) of 1 sampled resident identified as an elopement risk. 1. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/2024 indicated Resident #8 had a diagnosis of non-Alzheimer's dementia, coronary artery disease, malnutrition and scored 12 (8-12 indicates moderate impairment) on the Brief Interview for Mental Status (BIMS). a. Resident #8 ' s Care Plan with an initiation date of 05/30/2024, indicated, Focus; Risk for elopement/wandering identified, Goal: The resident will not leave the facility unattended b. An Elopement assessment dated [DATE], for Resident #8 indicated, 6. Resistant to nursing home placement a) Yes 7. Expresses desire to go home a) Yes 8. Exit Seeking a) Yes 9. Evidence Sundowning behavior [increase in behaviors at the close of day] a) Yes; scored 9 [7-14 indicates moderate risk]; Conclusion: was at risk for exit seeking and wander guard was applied c. A form titled OLTC (Office of Long-Term Care) Witness Statement Form dated 10/20/2024 and signed by the Director of Nursing (DON), indicated, a wander guard was put on Resident #8 as a precaution due to Resident #8 thinking it was funny and stating next time would not tell staff when leaving. d. A form titled In-service Attendance Sheet with staff signatures attached, dated 10/20/24, with the DON listed as the signature of the presenter, indicated Topic: Wandering and Elopement; Reporting any equipment that is not functioning properly; Procedure on any alarming door. e. Resident #8 ' sCare Plan with an initiation date of 10/21/24, indicated, Focus: The resident is an elopement risk r/t [related to] history of attempts to leave the facility unattended; Goal: The resident will not leave the facility unattended through the review period; Target date 02/13/2025 f. On 10/24/24 at 11:46, a Behavior Note indicated when the nurse was passing medications Resident #8 laughed and said that they knew how to get the code to the door, and that when they left, they would leave a note by the door. The nurse documented that she notified the DON (Director of Nursing) and was instructed to place the resident on 15-minute checks. (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. On 10/30/2024 at 12:20 PM, the policy titled, Abuse, Exploitation or Misappropriation - Reporting and Investigating (revision date April 2021) indicated all reports of resident abuse (including juries of unknown origin) neglect, exploitation or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) .2. Neglect is defined as failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness . h. On 12/30/24 at 3:30 PM, Resident #8 was asked if they had ever left the facility without staff knowing. Resident #8 stated about a month ago they did leave to go and see their girlfriend and forgot to sign out. The resident stated it happened on a Sunday, they left about 2:30 PM and were gone for about four hours. i. On 12/30/2024 at 4:10PM, during an interview, Certified Nursing Assistant (CNA) #3 stated Resident #8 left the faciity on her weekend off without staff knowledge and a wander guard was immediately put on the resident. j. On 12/30/24 at 4:15 PM, during an interview, the Activity Director (AD) stated she was aware Resident #8 left the facility without supervision because the facility did Senior Alert Drills after it happened. Resident #8 had a wander guard put on and was placed on 15-minute checks. The AD stated she believed the resident was able to leave because they watched someone enter the code or heard visitors saying the code out loud to other visitors. The AD stated the door codes had to be changed all the time. The AD also stated they talked with the resident and the resident now knows to sign in and out and tell the nurse when leaving the facility. k. On 12/30/24 at 4:50 PM, the Director of Nursing (DON) was asked if Resident #8 was considered an elopement risk. She stated that Resident #8 was their own person and could come and go whenever the resident wanted to, but needed to sign out and let staff know. When asked if Resident #8 ever left without letting staff know, the DON said she was notified (possibly in October) by facility staff Resident #8 left and forgot to sign out. The DON stated when she discovered the resident was missing, she went looking for them. When she got to the facility, the resident was already back and when she asked Resident #8 where they had gone, the resident stated they had gone to see their girlfriend. The DON stated she reviewed with the resident the process for notifying staff and signing out when leaving the facility several times when the resident returned to the facility. The DON stated she thought Resident #8 got the code to the door that allowed the resident to leave by watching family members or staff enter the code. When asked why a wander guard was put on Resident #8 after the elopement assessment was done following the incident, the DON stated, it could have been done as a precaution. The DON was asked if the facility had a policy on elopement and she stated there was a binder at each nurse ' s desk and at the front of the building with a list of residents that were at risk for elopement. The DON was asked for a copy of the list of residents at risk for elopement and a copy of the policy and she stated she would get them for the surveyor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	l. On 12/31/24 at 8:50 AM, the Administrator was asked if Resident #8 was considered an elopement risk and she stated, no. The Administrator was asked if Resident #8 had ever left the facility without staff knowledge. The Administrator stated, yes, she received a call from the facility the evening it happened telling her the resident had left without signing out. The Administrator stated she called the facility to get the address of the resident ' s girlfriend, who had just recently moved out of the facilities, since she thought that was most likely where Resident #8 had gone. By the time she got to the facility Resident #8 was already back. The Administrator stated she went over signing the sign in book and location of the book with Resident #8 after the resident returned to the facility. When asked if anything else was done after Resident #8 left the facility without notifying staff, the Administrator stated they did an elopement action plan. She stated Resident #8 knew the code to the door and that was how the resident was able to get out. She stated we checked to be sure doors were functioning correctly and changed the door codes. Resident #8 acted like it was all a joke and made the comment I will leave and just leave a note at the door, so the DON put a wander guard on as a precaution. The Administrator was asked if she completed a Facility Reportable Incident to submit to the state. she stated, no, because Resident #8 did not sign out but was not lost and was capable of taking care of their self. They had never been exit seeking and were just worried about their girlfriend. The Administrator stated, Resident #8 was smart, walked around a lot and probably saw someone enter the door code, or maybe heard someone, like visitors say it. We have to change the code frequently. The Administrator was asked if she had a copy of the elopement policy, and the list of residents that are at risk for elopement that the surveyor requested yesterday from the DON, and the surveyor was given a copy of both. The Administrator was asked for a copy of the Action Plan that was developed at the time Resident #8 left the building unsupervised, and the surveyor was given a copy. m. On 10/31/24 at 9:00 AM, the list provided by the Administrator titled Residents at Risk for Elopement included Resident #8's name. n. On 10/31/24 at 9:05 AM, the policy titled Wandering and Elopement (revised March 2019) provided by the Administrator indicated, Policy heading; the facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents; Policy Interpretation and Implementation:1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety;4. When the resident returns to the facility, the director of nursing or change nurse will e. Complete and file an incident report, and f. document relevant information in the resident's medical record. o. On 12/31/2024 at 3:35 PM, during an interview the DON stated an incident report was not done when Resident #8 left the facility without staff knowledge because they just did not consider it an elopement and they told the nurse she did not need to do an incident report and that was most likely why a note was not written. When asked if they treated Resident #8 leaving the facility without notifying staff as an elopement, the DON stated in the beginning we did, but once we determined the resident was their own responsible party, we determined it was not an elopement. The DON was asked, why if it was determined it was not an elopement was an Elopement Action Plan put in place after the incident happened and she stated the plan was a preventative measure. When asked how long the resident was missing from the facility, the DON stated she believed the resident was missing from the facility for an hour, possibly less than an hour (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p. On 12/31/24 at 3:45 PM, the Administrator was informed the Surveyor had reviewed the policy she had provided on elopement and asked why an incident report was not done when Resident #8 left the facility without staff knowing. The Administrator stated Resident #8 knew what they were doing when they left, they just did not sign out. The Administrator was asked if the nurse should have written a note in the record documenting that the resident had left without staff knowing and she stated, the DON did get with the nurse and told the nurse she should have documented something. The Administrator was asked what time she become aware that the resident was not at the facility, and she stated she thought it was about 8 or 9 PM. The Administrator was asked if she thought she should have reported the incident to the state since staff were not aware of where the resident was for an unknown period of time, and she stated she did not think that was something that needed to be reported to the state.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 42965 Based on observation, record review, interview, and facility policy review, the facility failed to ensure that staff followed Enhanced Barrier Precautions (EBP) by wearing required Personal Protection Equipment (PPE), and staff failed to change their gloves during perineal care for a resident on EBP before touching resident ' s lift pad, clean brief, clothing, and linens to prevent cross contamination and the risk for infection for 1 of 1 sampled (Resident #6) resident. Findings include: 1. A review of Medical Diagnoses, revealed Resident #6 had diagnoses of chronic obstructive pulmonary disease, kidney disease, bipolar, and heart failure. 2. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/2024, indicated a Brief Interview for Mental Status score of 11 (8-12 suggest moderate cognitive impairment). Section H0300 and H0400 indicated Resident #6 was incontinent of bowel and bladder. 3. On 12/30/2024 at 11:20 AM, the surveyor observed an Enhanced Barrier Precaution (EBP) sign outside Resident #6's door, and Certified Nursing Assistant (CNA) #1 and CNA #2 were observed providing perineal care for Resident #6 without wearing protective gowns. CNA #2 used both gloved hands to roll up and remove a soiled brief with the assistance of CNA #1, place a lift pad under Resident #6, and straighten Resident #6's clothing, and surrounding linens without removing the soiled gloves or performing hand hygiene. 4. On 12/30/2024 at 11:32 AM, during an interview CNA #1 and CNA #2 were asked why Resident #6 was on EBP. CNA #1 revealed Resident #6 had a wound on the coccyx that was found a few weeks ago. When asked how staff were made aware of residents who had been placed on EBP, CNA #1 stated that nursing would communicate that to them. EBP signage was pointed out and the surveyor asked if that was a form of communication used by the facility. CNA #2 confirmed that signage could communicate precautions. The CNAs spoke to each other and agreed that PPE was in a closet across from the nurse's station. When asked the rationale for wearing PPE while providing care to residents on EBP, CNA #2 revealed if staff caught something from the resident it could be passed on to other residents. 5. On 12/31/2024 at 5:30 AM, a record review of Skin and Wound Evaluation, dated 12/30/2024, revealed Resident #6 had a stage II pressure wound that was new on the coccyx. (Stage 2 pressure injuries are open wounds. The skin breaks open, wears away, or forms an ulcer, which is usually tender and painful. The wound expands into deeper layers of the skin. It can look like a scrape (abrasion), blister, or a shallow crater in the skin.) Resident #6 was to be repositioned every two hours, and time in a specialty chair limited to 2 hours. 6. During an interview on 12/31/2024 at 10:55 AM, the Director of Nursing (DON) confirmed EBP signs should be on the outside of the resident's door, and staff should wear gowns and gloves when providing personal care. The DON confirmed staff would be expected to perform hand hygiene or change gloves when going from dirty to clean sites because it is an infection control risk. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. A policy titled perineal care, revised, February 2018, which revealed its purpose was to prevent infections and skin conditions, but did not address hand hygiene when going from a dirty to clean body site. 8. A policy titled Hand Hygiene, revised August 2019, revealed staff should be regularly in-serviced on the importance of hand hygiene, and hand hygiene should be performed when moving from a contaminated body site to a clean body site. 9. A policy provided, titled Enhanced Barrier Precautions, copyright 2024, revealing EBP are designed to reduce transmission of multi-drug-resistant organisms that target staff ' s gloves during resident contact. All staff is to be trained on EBP annually, an order should be placed by the physician, gowns and gloves should be immediately available or outside a resident's room and should be worn by staff during times of high contact including during toileting and changing briefs. 10. On 12/31/2024 at 12:51 PM, the Administrator provided in-services titled: a. Peri Care, dated 01/12/2024, which revealed staff are to make sure they are wearing clean gloves. b. Enhanced Barrier Precautions, dated 03/28/2024, and beginning on 04/01/2024, signature sheet was provided showing signage and policy, and education on multi- resistant organisms were addressed. c. Hand Hygiene, dated 08/12/2024, revealed washing hands prevents the spread of infection, and an in-service was received titled Infection Control, dated 09/06/2024, signature sheet was received, which revealed Center for Disease Control (CDC) Guidelines, OSHA, PPE Donning and Doffing, and Handwashing was addressed. d. Peri Care, dated 10/28/2024, revealed staff are to wash hands before perineal care and donning gloves and change towel between wipes.