| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045142 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/08/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER The Springs of Park Ave | | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 Park Avenue Hot Springs, AR 71901 | |

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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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925<br><br>Based on record review and interview, the facility failed to ensure an advanced directive was readily accessible in the electronic health record for 1 (Resident #24) of 1 sampled resident whose electronic health record (EHR) was reviewed for an advanced directive.<br><br>The findings are:<br><br>1. Resident #24 had diagnoses of dementia and type 2 diabetes mellitus as documented on an order summary.<br><br>a. A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented a Brief Interview of Mental Status (BIMS) score of 03 (,d+[DATE] indicates severely impaired)<br><br>b. A Care Plan dated [DATE] documented the residents did not want cardiopulmonary resuscitation (CPR) and to follow the do not resuscitate (DNR) instructions as detailed inside the Advance Directive and/or Living Will.<br><br>c. On [DATE] at 11:03 AM, Resident #24's electronic health record (EHR) was reviewed and a resuscitation designation order dated [DATE] documented the resident had an advance directive but this surveyor did not locate it in the EHR.<br><br>d. On [DATE] at 12:33 PM, the Administrator brought a copy of an advanced directive acknowledgement form dated [DATE] and stated, Some of the older ones were in the Social Services Office and I didn't know that they weren't scanning them in. The form documented, .I have been informed of my rights to formulate Advanced Directives .I Have not executed an Advance Directive . She also provided a copy of a General Durable Power of Attorney of [Resident #24] that she stated was also in the Social Services Office in a binder and was dated [DATE]. It documented on page 15 and 16, .Section 4.01 Power to Provide for My Support .My agent may do anything reasonably necessary to maintain my customary standard of living, including .Make all necessary arrangements, contractual or otherwise, for my care at any hospital, hospice, nursing home .should I desire it .<br><br>e. On [DATE] at 04:43 PM, Licensed Practical Nurse (LPN) #4 was asked how she knew if a resident had or did not have an Advanced Directive in place and she confirmed that she looked at their chart. |

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 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925<br><br>Based on observation, record review, and interview, the facility failed to ensure a baseline care was completed within 48 hours of a residents admission to address activities of daily living, to promote continuity of care and communication among nursing home staff for 1 (Resident #123) of 1 sampled resident whose electronic health record (EHR) was reviewed for a 48 hour baseline care plan.<br><br>The findings are:<br><br>1. Resident #123 had diagnoses of full incontinence of feces (unable to control bowel movements) and adult failure to thrive, as documented on an Order Summary.<br><br>a. An entry Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/03/2024 documented Resident #123's most recent admission/entry or reentry to the facility was 05/03/2024.<br><br>b. A care plan dated 05/05/2024 did not address Resident #123's activities of daily living (ADLs) for bathing, personal hygiene, oral hygiene, mobility, dressing, grooming or toileting for bowel incontinence.<br><br>c. An admission assessment dated [DATE] on pages 20 through 38 contained questions for the Care Plan and all the sections were left blank.<br><br>d. On 05/05/2024 at 11:47 AM, Resident #123 was lying in bed in a gown with the head of bed up about 30 degrees. Resident #123 asked this surveyor for something for Resident #123's lips which were visibly dry and cracked.<br><br>e. On 05/07/2024 at 08:36 AM, Resident #123 was lying in bed in a gown, awake, with the head of bed up about 30 degrees. Resident #123's lips were visibly dry and cracked.<br><br>f. On 05/08/2024 at 04:43 PM, Licensed Practical Nurse (LPN) #4 was interviewed and confirmed that the nurses do admit residents but did not do the 48 hour baseline care plan. She added they only answer questions such as how the residents transfer, their diet, can they ambulate independently, do they have any broken teeth, things like that. She confirmed there is a template in the residents' EHR and an admission assessment is filled out. She was asked if answering those questions triggered a care plan for the residents and she stated, As far as I know it doesn't.<br><br>g. On 05/09/2024 at 05:20 PM, the Director of Nursing was interviewed and confirmed the nurses were able to do a baseline care plan on the admission assessment. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925<br><br>Based on record review and interview, the facility failed to ensure care plans were reviewed and revised at least annually, or when the residents care needs changed, as evidenced by failure to revise the plan of care to address the use of insulin, a high risk medication, to ensure staff were made aware of the necessary care, assessments and services required for insulin for 1 (Resident #39) of 1 sampled residents who were reviewed for care plan revisions for insulin.<br><br>The findings are:<br><br>1. Resident #39 had a diagnosis of type 2 diabetes mellitus with hyperglycemia as documented on the medical diagnosis section of the electronic health record (EHR).<br><br>a. An order summary documented a physician's order for insulin glargine .Inject 30 unit subcutaneously two times a day for diabetes which was ordered 03/26/2024.<br><br>b. An annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/18/2024 documented Resident #39 had a Brief Interview for Mental Status (BIMS) score of received 7 (0-7 indicates severe cognitive impairment) and received insulin injections during the last 7 days or since admission/entry or reentry if less than 7 days.<br><br>c. A care plan dated 02/08/2024 documented Resident #39 had diabetes mellitus and to observe the resident for side effects and effectiveness. The care plan did not list any signs/symptoms or side effects to monitor Resident #39 for regarding insulin use, which is a high risk medication.<br><br>d. On 05/08/2024 at 04:18 PM, the MDS Coordinator was interviewed and she confirmed that she was familiar with the Resident Assessment Instrument (RAI) manual. She was asked to look at Resident #39's annual MDS regarding insulin injections and she confirmed it documented insulin injections were administered for 7 days in the look back period. She confirmed that insulin should be added to the resident's care plan. When she was asked why this was not added to Resident #39's care plan after the annual MDS dated [DATE] reflected the use of insulin injections, she looked at the resident's care plan in the EHR and stated, I'm not seeing it on there. It was an oversight. She confirmed that insulin should be added to the care plan so the nursing staff could see what [Resident #39] took for diabetes. When she was asked if there were any other reasons, she added, For complications. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>37925<br><br>Based on observation, interview, and record review, the facility failed to ensure enteral feeding and flush bags were properly labeled with the necessary information to promote continuity of care and decrease the potential for complications for 1 (Resident #123) of 1 sampled resident who had a percutaneous endoscopic gastrostomy (PEG) tube (tube that goes through the skin into the stomach).<br><br>The findings are:<br><br>1. Resident #123 had a diagnosis of gastrostomy status as documented on an order summary.<br><br>a. An order summary documented a physician's order of, .[named a 2.0 Cal/ml formula] continuous feed- 80 cc/hr (cubic centimeters per hour).<br><br>b. An electronic Medication Administration Record (eMAR) documented, .[named a 2.0 Cal/ml formula] continuous feed- 80 cc/hr with flush 100 cc/2 hr (2 hours) every shift -Start Date 05/03/2024 2300 (11:00 PM) . There were initials in the boxes on 05/03/24 for night, 05/04/24-05/06/24 had initials in boxes for day, evening, and night and 05/07/24 initials in the box for day. That order was stopped on 05/05/24 at 9:47 AM and a new order to decrease the feeding rate to 50 cc/hr start 05/07/24 at 3:00 PM and there were initials in the evening box for this date.<br><br>c. A care plan dated 05/05/24 documented the resident required tube feeding related to dysphagia (difficulty swallowing) and was dependent with tube feeding and water flushes and to see the MD (Medical Doctor) orders for the current feeding orders.<br><br>d. On 05/05/24 at 11:47 AM, Resident #123 was lying in bed and an empty enteral feeding bag with a small amount of tan colored liquid in the tubing was hanging and was not connected to the resident and was not labeled. A flush bag with clear liquid had the following written on it in black H20 [water]100 cc/24 hrs). The feeding pump was off.<br><br>e. On 05/06/24 at 08:21 AM, Resident #123 was lying in bed with the head of bed (HOB) elevated 30 degrees. The enteral feeding bag was labeled but the flush bag had about 950 ml of clear liquid in it and it was not labeled.<br><br>f. On 05/07/24 at 08:36 AM , Resident #123 was lying in bed with the HOB elevated 30 degrees. The feeding bag was labeled and there was a flush bag with clear liquid inside hanging but not labeled.<br><br>g. On 05/08/24 at 04:43 PM, Licensed Practical Nurse (LPN) was interviewed and confirmed that she was familiar with performing enteral feedings to residents. She confirmed that the date, milliliters per hour, name, room number should be on the enteral feeding bag and the water bag should have the flush amount, date, name, room number and time started. She stated they should be labeled in case someone comes in and doesn't know what to set it at and to make sure it's being ran correctly.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | h. An Enteral Nutrition policy provided by the Administrator on 05/07/24 documented, .The recommendation to initiate the use of enteral nutrition is based on the results of the comprehensive nutritional assessment, and is consistent with current standards of practice, the resident's advance directives, treatment goals and facility policies . |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>46868<br><br>Based on observation, record review and interview, the facility failed to ensure the medication error rate was less than 5%. An observation of a medication pass performed on 08/16/23 at 7:53 AM resulted in the identification of 3 errors in 25 opportunities, resulting in a medication error rate of 12.00 %.<br><br>The findings are:<br><br>1. Resident #176 had a physician's order for Aspirin Oral Capsule 81 MG (milligram) Give 1 tablet by mouth one time a day for blood thinner.<br><br>a. On 05/06/24 at 08:10 AM, Licensed Practical Nurse (LPN) #3 gave Aspirin enteric coated 81 MG (Enteric-coated aspirin is designed to resist dissolving and being absorbed in the stomach. the purpose of taking low-dose aspirin is to help prevent the development of harmful artery-blocking blood clots. However, with enteric-coated aspirin, research indicates that bloodstream absorption may be delayed and reduced, compared to regular aspirin absorption).<br><br>2. Resident #176 had a physician's order for B Complex-C Oral Tablet (B Complex w/ C) Give 1 tablet by mouth one-time a day for supplement (Vitamin B with vitamin C added).<br><br>a. On 05/06/24 at 8:10 AM, Licensed Practical Nurse (LPN) #3 gave B complex with vitamin B.<br><br>3. Resident #176 had a Physicians order for Multivitamin Oral Tablet (Multiple Vitamin) Give 1 tablet by mouth one time a day for supplement.<br><br>a. On 05/06/24 at 8:10 AM, LPN #3 gave Multi-Vitamin with Minerals 1 tablet.<br><br>4. On 05/07/24 at 9:10 AM, LPN #3 was asked to look at all medications she gave Resident #176 on 05/06/24 at 8:10 AM. LPN #3 got all the medications out of the cart and placed them on the top. The Surveyor asked LPN #3 if she was certain that these medications were the same medications that she gave. LPN #3 checked again and stated yes. The Surveyor asked LPN #3 to read the order for the aspirin on the medication administration record (MAR) and compare it to what she gave. LPN #3 stated, I shouldn't have given enteric coated because it says plain aspirin. The Surveyor asked LPN #3 to repeat this process with the bottles of B Complex and Multi vitamin with Minerals. LPN #3 read the Medication record for the B complex and stated, Oh it says with vitamin C; I gave with vitamin B. LPN #3 stated, The order for multivitamin was plain and I gave the multivitamin with minerals.<br><br>On 05/08/24 at 10:30 AM, the Director of Nurses (DON) was asked if nurses were expected to follow the physicians orders while administering medications. The DON stated, Yes. The DON was asked what could happen when a nurse does not follow physician orders. The DON stated, Medication Errors. The DON was asked to explain how she expected the nurses to do the medication pass accurately. The DON stated, Have everything ready and in date then use the 5 (Five) rights and compare the MAR and meds.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 05/07/24 at 3:32 PM, the Administrator provided a form titled Administering Medications which documented, Medications administered .as prescribed . Medications are administered in accordance with prescribed orders .The Individual administering the medication checks the label THREE (3) times to verify the .right medication, right dosage .As required or indicated for a medication, the individual administering the medication records in the residents medical record: b the dosage . |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49688<br><br>46868<br><br>Based on observation, record review, interview, it was determined that the facility failed to store controlled medications in a permanently affixed container, and to ensure medications were not left at the bedside.<br><br>Findings include:<br><br>1. On [DATE] at 01:30 PM, the surveyor asked Licensed Practical Nurse (LPN) #1 what the procedure was to dispose of medications if a resident discharges or passes away in the facility. She stated the take the narcotics and the narcotic book to the Director of Nursing's (DON) office, count the medications, and then sign them over for her to send them out of facility.<br><br>a. On [DATE] at 01:50 PM, LPN #2 was asked what the procedure was to dispose of medications if a resident discharges or passes away in the facility. She stated they take the narcotics and the narcotic book to the DON's office, count, and sign them over for her to send them out of facility. A<br><br>b. On [DATE] at 01:50 PM, the surveyor observed the container used to store controlled medications in the medication room on Hall C was not permanently affixed inside the refrigerator. LPN #2 was asked to open the container, but reported she did not have a key to open box.<br><br>c. On [DATE] at 02:25 PM, the DON reported the Maintenance Director was coming to unlock the container used to store controlled medications because no one has a key. The surveyor asked if the Maintenance Director had a key to this container. The DON stated, No, he will have to break the lock as I didn't think we were using this anymore. There is nothing in there no there shouldn't be maybe it's just an expired wrapper I already sent back we are not supposed to use this at this time because it's not fixed to the refrigerator.<br><br>d. On [DATE] at 03:05 PM, the Maintenance Director and DON remove the lock from the container. Inside was Ativan 2 MG/ML, expiration [DATE], belonging to a non-sample resident.<br><br>2. Per a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], Resident #16 scored 10 (,d+[DATE] indicates moderately impaired) on the Brief Interview for Mental Status (BIMS).<br><br>a. On [DATE] at 11:59 AM, in the room of Resident #16 an inhaler was lying on the bed side table, and a nebulizer was present with clear liquid in the chamber. The door was open and the medication was visible from the doorway.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | b. On [DATE] at 12:59 AM, LPN #4 was asked to accompany the Surveyor to Resident #16's room. The Surveyor asked if any resident on the hall was assessed for self-administration of medications. LPN#4 stated, No. LPN #4 was asked if there should be any medications left at bedside. LPN #4 stated, No, it can cause respiratory failure. LPN #4 picked up the Inhaler from the bedside table and stated, Yes that's her inhaler, I must have left it here, but I gave her medication this morning in the dining room. LPN #4 picked up the chamber of the Updraft. LPN #4 stated, That's her updraft medication; they gave that at 6 this morning.<br><br>c. On [DATE] at 10:20 AM, the Director of Nurses (DON) was asked if the facility had anyone who is assessed for self-administration of medications. The DON stated, No. The DON was asked to explain what she expected the nurses to do with medications received. The Don stated, Stay with them till all meds are taken. The DON was asked if the medication should ever be left at bedside. The DON stated, No; someone one else could go in and take them and have a bad reaction, hurt themselves or others.<br><br>d. On [DATE] at 3:32 PM, the Administrator provided a Policy titled, Storage of Medications which documented, The facility stores all drugs and biologicals in a safe, secure, and orderly manner .Drugs and biologicals used in the facility are stored in locked compartments . |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>49413<br><br>Through observation, record review, and interviews, the facility failed to ensure open food packages were properly closed, ensure walls and floors were in sanitary condition, canned goods were dent free, dietary staff washed their hands between dirty and clean tasks, chemicals were kept away from serving items, food on the steam table was properly covered, and proper serving sizes were provided.<br><br>The findings are as follows:<br><br>1) On 05/05/24 at 10:45 AM, two trash cans were not covered by the hand washing sink and the reach in refrigerator in the main kitchen prep area. The Registered Dietician stated trash cans should not be opened if not being used to prevent cross-contamination.<br><br>2) On 05/05/24 at 10:46 AM, a coffee filter containing coffee and one pitcher container were uncovered and sat next to the hand washing sink. The Dietary Supervisor confirmed the coffee in the coffee filter and pitcher not being covered could cause cross-contamination because something could land on them.<br><br>3) On 05/05/24 at 10:47 AM a plate warmer contained plates with serving side face up and uncovered. The Dietary Supervisor confirmed something could land on the plates that were not covered.<br><br>4) On 05/05/24 at 10:48 AM, a cart stored food warmer covers where the inside was not covered. The Dietary Supervisor confirmed something could land on the food domes that are not covered.<br><br>5) On 05/05/24 at 10:49 AM, in the dry goods storage room one 111 ounces can (name) pinto beans that had a dent on the top seal. The Registered Dietician confirmed the dent could cause a broken seal or the contents to be bad.<br><br>6) On 05/05/24 at 10:50 AM, in the dishwasher room a metal shelving unit contained clean dishes, cups, bowls, and dishes serving side up and 2 - 1 quart spray bottles of Mold & Mildew Stain remover on the third shelf were hanging by the trigger. The label on the spray bottles contained the warning, Keep out of reach of children and pets and Harmful if Swallowed. For emergency medical assistance, call your local poison control center. Each bottle was half full. The Registered Dietician confirmed that chemicals are to be stored in a separate area because the chemicals could make someone sick.<br><br>7) On 05/05/24 at 10:51 AM, a water bottle belonging to staff was stored on clean silverware shelving unit in the dishwasher room. The Registered Dietitian confirmed that personal bottles and foods are not to be near anything and to be kept in a specific area.<br><br>8) On 05/05/24 at 10:52 AM, greyish brown stagnant water was pooled under the dishwasher and the 3 compartment sinks. The Registered Dietitian confirmed this could cause cross-contamination, make people sick because clean dishes are stored and dried there, and could cause someone to fall.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 9) On 05/05/24 at 10:56 AM, a chest freezer held 4 pitchers that did not have the open top covered and 4 pitcher lids inside facing up not covered. The Registered Dietitian confirmed the pitchers uncovered could cause cross-contamination.<br><br>10) On 05/05/24 at 10:57 AM, 1 spray bottle of glass and hard surface cleaner had the spray nozzle touching napkins on a shelf next to the chest freezer that held the 4 pitchers. The label of the spray bottle documented, DO NOT DRINK; WARNING! Causes skin and eye irritation. Harmful if swallowed or in contact with skin. The Registered Dietitian confirmed that chemicals are to be stored in a separate area, and the chemical touching the napkin or food could cause someone to get sick.<br><br>11) On 05/05/24 at 11:00 AM, 2 plastic storage containers in the main kitchen area holding various serving scoops were not covered.<br><br>12) On 05/07/24 at 6:39 AM, 1 pitcher of orange juice and 2 pitchers of iced tea were on the counter by the handwashing sink not covered.<br><br>13) On 05/07/24 at 6:40 AM, the light switch and plug outlet on the located on the right-side wall above the ice machine had a brown fuzzy substance on the top, the light switch cover left an opening on the upper right corner. The Dietary Supervisor confirmed that the fuzzy substance felt like wall insulation and could be a concern because there is a possibility the stuff could get into the ice that is used for residents' consumption. On 05/07/24 at 9:09 AM the Registered Dietitian confirmed the light switch near the ice machine had a hole in the facing and the stuff on top could cause cross contamination.<br><br>14) On 05/07/24 at 6:41 AM, the hall door that led to an outside alcove had black and brown smudges. The alcove contained 7 milk crates, 1- 30-gallon trash can, 1 ice chest, 1 water cooler, 1 chair, 3 bun racks 3 metal serving pans and 1 cart with wheels, 2 mops, 1 mop bucket and various unknown items in a pile. At 8:47 AM, the Maintenance Director confirmed the outside alcove was a safety issue that could possibly draw bugs and pest that like to live in trash. At 9:11 AM, the Registered Dietitian confirmed the stuff probably needed to be picked up, the concern would be bugs could come through the door.<br><br>15) On 05/07/24 at 6:43 AM, the wall on the right in the walkway from the main kitchen to the dishwasher room contained 2 dustpans with various particles and substances adhered to the dustpan, 4 different brooms that contained various brown and black fuzzy items on the bristles, and 1 squeegee. At 8:48 AM, the Registered Dietitian confirmed the brooms, dustpans, and squeegee on the wall are a cross-contamination concern with the clean dishes being transported from the dishwasher room to the kitchen area.<br><br>16) On 05/07/24 at 6:50 AM, the shelving unit against the back wall in the dishwasher room on the bottom shelf a container with pitcher lids was uncovered and the second shelf held 2 dessert bowls with serving side up and uncovered. At 8:48 AM, the Dietary Supervisor confirmed the serving items not covered is a concern due to stuff getting on them.<br><br>17) On 05/07/24 at 6:51 AM, the corner shelving unit bottom shelf held 9 desert bowls and 5 regular bowls serving side up uncovered.<br><br>(continued on next page) |

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 18) On 05/07/24 at 6:59 AM, the freezer by the 3 compartments sink in the food prep area contained the following open food items that were not properly closed: 1- 10-pound box of breakfast turkey skinless link sausages the following open items that were not and 1 - 10-pound box of 4-ounce 80/20 individual pure ground beef patties<br><br>19) On 05/07/24 at 8:04 AM, a serving cart used to store clean serving trays had black smudges with unknown substance particles with yellowish and brown sludge built up on bottom tier and around the bolts. On 05/07/24, the Registered Dietitian confirmed the cart was dirty and needed to be cleaned.<br><br>20) On 05/07/24 at 8:16 AM, a kitchen puree prep table had a container of thickener lying on top. The lid has black smudges and white granules substance with scoop with brown substance adhered laying on top of the container lid. The Dietary Supervisor confirmed the lid had powder on top of it.<br><br>21) On 05/07/24 at 8:20 AM, the spice shelf above the microwave contained 1 - 7-ounce container of thyme leaves not properly sealed. The Dietary Supervisor confirmed the lid was not properly closed.<br><br>22) On 05/07/24 at 8:27 AM, a plug outlet over the clean dish dry counter contained a brownish grimy substance. The Dietary Supervisor confirmed the clean serving items drying under the outlet did have some debris that could get onto the clean serving items.<br><br>23) On 05/07/24 at 8:30 AM, ceiling tiling in various areas or the kitchen had yellow - brownish stains; the Chef confirmed the ceiling tiles were old. On 05/07/24 at 9:12 AM, the Registered Dietitian confirmed the tiles need replaced.<br><br>24) On 05/07/24 at 12:27 AM, food placed on the steam table at 11:45 AM remained uncovered for 32 minutes. The Registered Dietitian confirmed the food should have been covered.<br><br>25) On 05/07/24 at 12:46 PM, Dietary Aide #2 failed to provide a full serving scoop of turkey pot pie for a resident that received a room tray. The Registered Dietitian confirmed the serving scoop should be full.<br><br>26) On 05/07/24 at 12:53 PM, Dietary Aide #2 accepted scissors from staff that were in the dining room, then proceeded to serve food without washing hands. The Registered Dietitian confirmed Dietary Aide #2 should have washed her hands between touching the scissors and serving food.<br><br>27) On 05/07/24 at 1:10 PM, Dietary Aide #3 had prepared a mechanical soft cheeseburger. After the hamburger was at the mechanical soft stage, Dietary Aide #3 threw away a hamburger bun in paper then returned to the food prep area and ripped a piece of wrapping paper from the roll, placed the paper on the counter. The Registered Dietitian confirmed that Dietary Aide #3 should have washed hands before returning to the food prep area.<br><br>28) On 05/07/24 at 3:10 PM, the Administrator provided the Hand Washing Policy which documented, Standard: Do not block the area around hand washing sinks or stack items, such as soiled utensils, in them. Do not use hand washing sinks for any other purpose .Guidelines: Wash your hands as often as possible. It is important to wash your hands: Before starting to work with food utensils, or equipment Before putting on gloves; After handling soiled utensils and equipment AS often as needed during food preparation and when changing tasks .<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 29) On 05/07/24 at 3:10 PM, the Administrator provided a document titled, Cleaning and Sanitizing and Proper Hair Restraints which documented, Standard: Non-food contact surfaces are cleaned per individual facility cleaning schedule to maintain optimal cleanliness of kitchen equipment .Guidelines: Non-food contact surfaces are washed with soapy water per frequency identified on the facility cleaning schedule - or as visually necessary. These are then wiped down with sanitizer solution .<br><br>30) On 05/07/24 at 3:10 PM, the Administrator provided the Material Safety Data Sheet for Glass and Hard Surface Cleaner that documented, Hazards Identification .Harmful if swallowed; Harmful in contact with skin; Causes skin irritation; Causes eye irritation . First Aid Measures Ingestion: If swallowed, call a poison center if you feel unwell. Rinse mouth. Skin contact: If on skin, wash with plenty of water. If skin irritation occurs, get medical advice. Take off contaminated clothing and wash it before reuse. Eye Contact: If in eyes, rinse cautiously with water for several minutes .If eye irritation persists, get medical advice. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>49413<br><br>46868<br><br>37925<br><br>Based on observation, interview, and record review, the facility failed to ensure a linen cart was covered while on a resident hall, failed to ensure hand hygiene was performed and proper protective equipment (PPE) was used when caring for 1 (Resident #44) of 1 sampled resident with Clostridium Difficile (C-Diff) and failed to ensure Enhanced Barrier Precautions were consistently implemented for 1 (Resident #39) of 1 sampled resident who was reviewed for EBP.<br><br>The findings are:<br><br>1. On 05/05/24 at 10:35 AM, the clean linen cart was uncovered and unsupervised by staff.<br><br>a) 05/07/24 at 11:19 AM, Laundry Personnel #1 confirmed clean laundry is to be distributed through the facility by placing the clean linen on the linen cart. Linen that hangs is placed on the metal rack in front of the wall with a sign that says Hall B. A brown cover is then placed on the linen cart then it goes out. The cover is only removed to take items from the cart that need to be taken to residents' room.<br><br>2. Resident #44 was n transmission based precaution for C-diff.<br><br>a. On 05/05/24 at 12:59 PM, a 3 drawer cart was outside Resident #44's room. A sign titled, Contact Isolation Precautions, was affixed to the door of the room and documented, Please see nurse before entering room. Remove all PPE Before leaving the room. There were no masks in the cart and none on the hall.<br><br>b. On 05/05/24 at 11:10 AM, Certified Nursing Assistant (CNA) #1 entered Resident #44's room with a gown and mask. Inside the door on a wall was a dispenser for gloves. CNA #1 did not wash her hands before she went to the room and got the breakfast tray and moved the items on the over bed table. CNA #1 then removed her gloves and gown and exited the room. CNA #1 did not remove her mask or wash her hands.<br><br>c. On 05/05/24 at 11:16, CNA #1 was asked what she should do prior to entering a room with under contact isolation precautions. CNA #1 stated, Sanitize my hands. CNA #1 was asked if she washed her hands and stated, No I sanitized. CNA #1 was asked if hand sanitizer was enough to clean C-diff from her hands. CNA #1 stated, Yes. CNA #1 wore the same mask in and out of all rooms on the hall.<br><br>d. On 05/06/22 at 1:33 PM, CNA #3 entered Resident #4's room with a gown on then put on her gloves. Her hands were not washed. Upon coming out of the room CNA #3 removed her gloves and gown. The Surveyor asked CNA #3 to explain what staff should do prior to entering an isolation room with the diagnosis of C-Diff. CNA#2 stated, Put on gloves, gown, and shoe covers. Maybe a mask; I'm not sure. CNA#3 was asked what should be done after giving care to a resident on C-Diff. CNA #3 stated, Remove my PPE.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | e. On 05/06/24 at 1:40 PM, Licensed Practical Nurse (LPN) # 1 was asked, What should you do prior to entering a residents room who is diagnosed with C-Diff? LPN #1 stated, Gloves, gown and shoe covers. LPN #1 was asked what should be done after caring for a resident and exiting the room. LPN #1 stated, Remove all PPE.<br><br>f. On 05/07/24 at 2:11 PM, CNA #2 was asked to explain what is done prior to entering a residents room with C-Diff, while providing care, then when exiting the room. CNA #2 stated, I put on gloves, gown and shoe covers and I keep my mask on at all times; I never take it off. I sanitize while in the room and when I leave the room I remove my gown, and gloves. I leave my mask on. CNA #3 was asked to explain when hands are to be washed. CNA stated, I sanitize while in the room then wash my hands after I leave the room.<br><br>3. Resident #39 had diagnoses of type 2 diabetes mellitus with hyperglycemia and protein-calorie malnutrition as documented on an order summary.<br><br>a. A physician's order dated 04/01/24 documented Resident #39 was on enhanced barrier precautions for chronic wounds.<br><br>b. An annual Minimum Data Set (MDS) with as Assessment Reference Date (ARD) of 04/18/24 documented Resident #39 had a Brief Interview for Mental Status (BIMS) score of 13 (13-15 indicates cognitively intact) and had an unhealed pressure ulcer / injury.<br><br>c. A Care Plan dated 02/08/24 documented Resident #39 was on enhanced barrier precautions related to a wound and staff were to put on a gown and gloves during high-contact resident care activities.<br><br>d. An in-service on Enhanced Barrier Precautions dated 04/01/24 and provided by the Director of Nursing (DON) on 05/07/24 documented, .Wear gloves and a gown for the following High-Contact Resident Care Activities .Changing briefs or assisting with toileting .<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | e. On 05/05/24 at 12:27 PM, this surveyor approached Resident #39's door and there was an enhanced barrier precaution sign on the door. CNA #4 was in Resident #39's room and took a pair of gloves to the bathroom where the resident was sitting on the toilet. This surveyor asked CNA #4 what she was about to do and she stated, I'm about to get [Resident #39] cleaned up and she walked in the resident's bathroom not wearing an isolation gown. This surveyor remained in the room and waited until CNA #4 was done in the bathroom. At 12:36 PM, CNA #4 opened the door and propelled Resident #39 out of the bathroom by wheelchair (w/c) to the side of the bed. CNA #4 had gloves on but no gown. CNA #4 attempted to close the blinds with the gloves on but was unsuccessful. CNA #4 then assisted Resident #39 to bed. This surveyor stepped in the bathroom and there was a brown substance on the outer part of the toilet bowl. Resident #39 stated, I got a sick stomach. CNA #4 removed her gloves and without sanitizing hands, pushed a bedside table near the resident. She touched the w/c handles and pushed the w/c away from Resident #39's bed. At 12:40 PM, CNA #4 put on a pair of clean gloves and did not sanitize her hands. She went in the bathroom and removed paper towels from the dispenser and began cleaning a brown substance from the outer toilet bowl with no gown on. At 2:38 PM CNA #4 confirmed that she was familiar with Resident #39's care. She was asked if knew if Resident #39 was on Enhanced Barrier Precautions and she replied, I don't at this moment. CNA #4 was asked if she knew what Enhanced Barrier Precautions were for and she stated, Well, I'm assuming it's something to help them not fall or it could be something for acid reflux. After surveyor asked if she again knew what EBP was for, CNA #4 said that she thought it could have been something to do with safety. CNA #4 was asked if she had any in-services on Enhanced Barrier Precautions and she stated she was not recalling it at that time. This surveyor asked the CNA to walked to Resident #39's door and asked her if she was familiar with the enhanced barrier precautions signage on the door and she did not answer. She was asked, Were you aware that there was a sign there? and she stated, Yes, I was aware that's there. She was asked what she was supposed to put on before caring for the resident and she stated, Gloves. When she was asked if there was anything else, she looked at the enhanced barrier precautions signage on Resident #39's door and stated, I see the gown, yeah. She confirmed that she was not wearing a gown when she went into Resident #39's bathroom. She confirmed that she was supposed to wash her hands when she changed gloves. She admitted the reason for washing her hands was to keep the germs away.<br><br>f. On 05/05/24 at 2:47 PM, this surveyor and CNA #4 entered Resident #39's room and CNA #4 was asked to show the surveyor any gowns in the room or bathroom. She checked Resident #39's closets, drawers and bathroom and she stated, There are no gowns anywhere in here.<br><br>g. On 05/07/24 at 12:24 PM, the Infection Preventionist was asked to state what her understanding of enhanced barrier precautions was and she stated, The way I understand it, for anybody that comes in with an open wound that has drainage and that's not healing, feeding tubes, catheters and any type of device that would not normally be there . anything that has an open area that they could transmit to us or us to them we are putting up an enhanced barrier precautions [sign] . She was asked where the PPE was located and she stated it was in the supply closets or on the carts on the halls. She was asked, On whose carts? She stated, Their linen carts. She was asked, Is the new staff being trained on enhanced barrier precautions? She stated, They get orientation. We're still working on it. She was asked, Is enhanced barrier precautions a part of their [new employees] training? She stated, Honestly, I couldn't tell you right now if it is. This surveyor then stated, To be clear, you are saying that the new employees are being trained in orientation on EBP? She stated, Well I'll have to say not at this time but we're working on getting something together because it's so new. |