STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045189	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Camden	900 Magnolia Road Camden, AR 71701

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. 48390 Based on interview, record review, and policy review, the facility failed to ensure that interest was paid on a resident trust account. This failed practice affected one (Resident #3) of three sampled residents, for whom the facility maintained trust accounts, per a list provided by the Business Office Manager (BOM) on 05/07/2025. The findings are: A review of Resident Statement Landscape, for Resident #3 on 01/03/2025, revealed a balance of $2,025. 36, prior to the withdrawal on 01/28/2025. A review of Trial Balance dated 05/07/2025, provided by the Business Office Manager (BOM) on 05/07/2025, revealed a balance for Resident #3 of $1,141.17. A review of Resident Statement Landscape , for Resident #3 provided by the BOM on 05/07/2025, revealed that on 01/28/2025, a withdrawal was made in the amount of $1,025.00 for personal needs. During an interview on 05/08/2025 at 12:13 PM, the Business Office Manager (BOM) was asked how much money she withdrew from Resident #3 ' s account? The BOM indicated $1,025.00 was withdrawn from Resident #3 ' s account on 01/28/2025. The BOM indicated she had spoken with Resident #3 ' s Power of Attorney (POA) and asked them to come pick up the money and go spend it on Resident #3. The BOM was unable to provide proof that she had tried to contact the family after she withdrew the money. The BOM said the reason she withdrew the money was to make sure Resident #3 would be under the $2,000 limit and not lose [pronoun] Medicaid funding. Resident #3 ' s money ($1,025.00) sat in the safe at the nursing home from 01/28/2025 until 05/08/2025. The BOM was asked what amount must be deposited in an interest-bearing account for a resident on Medicaid? The BOM indicated $40.00. This surveyor then asked who had access to the safe that had Resident #3 ' s money ($1,025.00). The BOM indicated the Social Services Director and herself. The BOM indicated she did not know if the Administrator was aware that Resident #3 ' s money was in the safe. During an attempt to interview Resident #3 ' s POA, the phone number provided by the facility was found to not be a working number. (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/2025 at 12:20 PM, the BOM was asked if the money ($1,025.00) out of Resident #3 account, that was in the safe, had been drawing interest since it had been withdrawn from the bank on 01/28/2025. The BOM indicated no. This surveyor asked the BOM what she should have done with the money once the POA did not pick the money up at the facility, in a timely manner? The BOM said she should have deposited it back into Resident #3 account at the bank. During an interview on 05/08/2025 at 12:25 PM, the BOM was asked, when the last quarterly statement for Resident #3 was sent out, if the $1,025.00 was included on Resident #3 balance. The BOM indicated no, because it was in the safe. During an interview on 05/08/2025 at 12:41 PM, the Administrator was asked if he knew about Resident #3 ' s money ($1,025.00) in the safe. The Administrator said, yes and no. The Administrator indicated that he had become aware of the situation, and it was getting deposited back into Resident #3 ' s bank account today. The Administrator was asked if the money ($1,025.00) in the safe was drawing interest while it was in the safe? The Administrator indicated no. The Administrator was asked what the resource limit was when the amount in the account reached $200 of the resource limit. The Administrator indicated $2,000. This surveyor asked what amount must be deposited in an interest-bearing account for a resident on Medicaid. The Administrator indicated $50.00. This surveyor then asked who all had access to the safe where Resident #3 ' s money had been kept. The Administrator indicated the BOM, the Social Services Director, and himself (Administrator). A review of Policy titled Accounting and Records of Resident Funds , provided by the Administrator on 05/08/25, indicate, Individual accounting records are made available to the resident through quarterly statements and upon request. Quarterly statements include the following information: The resident ' s balance at the beginning and ending of the statement period; The total of deposits and withdrawals by the resident for the quarter; Interest earned on the resident ' s funds .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 48977 Based on record review and interview, it was determined that the facility failed to ensure the comprehensive assessment for the current and previous year accurately reflected the Pre-admission Screening and Resident Review (PASRR) status of one (Resident #4) of two sampled residents reviewed for comprehensive assessments. The findings include: A review of the annual Minimum Data Set (MDS) with the Assessment Reference Date (ARD) of 03/13/2025, revealed Resident #4 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS revealed Resident #4 had active diagnoses, which included: psychotic disorder, anxiety, and depression. According to the MDS, Resident #4 was not considered by the state, level II PASRR process, to have serious mental illness and/or intellectual disability or a related condition. A review of the annual MDS with the ARD of 03/21/2024, revealed Resident #4 had a BIMS score of 15, which indicated the resident was cognitively intact. The MDS revealed Resident #4 had diagnoses, which included: psychotic disorder and depression. According to the MDS, Resident #4 was not considered by the state, level II PASRR process, to have serious mental illness and/or intellectual disability or a related condition. A review of the Care Plan Report, with a revision date of 01/31/2025, revealed Resident #4 was PASRR level II. During an interview on 05/06/2025 at 3:18 PM, the MDS Coordinator stated Resident #4 was considered by the state as PASARR level II process, to have serious mental illness and/or intellectual disability or a related condition. The MDS Coordinator stated that neither the annual MDS with the ARD of 03/13/2025, nor the annual MDS, ARD of 03/21/2024, noted Resident #4 was considered by the state as PASRR level II, which was completed 09/08/2023. The MDS Coordinator stated both comprehensive MDS assessments were inaccurate. During an interview on 05/08/2025 at 1:39 PM, the Director of Nursing (DON) stated the most recent comprehensive MDS, and the comprehensive assessment from the past year, were inaccurate.

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F 0804 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 03508 Based on observations and interviews, the facility failed to ensure hot foods were served hot and cold foods/beverages were served cold to maintain palatability and encourage adequate nutritional intake for two meals at which food temperatures were checked. The findings are: On 05/05/2025 at 12:12 PM, the first lunch meal tray for the female unit was placed on a shelf inside the food cart, by License Practical Nurse (LPN) #1. The food cart was located by the kitchen door in the dining room. On 05/05/2025 at 12:25 PM, a cart that contained 16 lunch trays was delivered to the [NAME] Hall (Female unit) by Certified Nursing Assistant (CNA) #2. At 12:37 PM, immediately after the last resident was served in the [NAME] Hall (Female Unit) dining room, the temperatures of the food items from the test trays on the cart were checked by CNA #2, with the following results: a) Pudding: 59 degrees Fahrenheit b) Purred vegetables: 113 degrees Fahrenheit c) Pureed chicken tender: 105.2 degrees Fahrenheit d) Ground chicken tender: 98 degrees Fahrenheit e) Cut green beans: 103.8 degrees Fahrenheit During the noon service observation on 05/05/2025 at 12:53 PM, the first food tray was placed on a shelf in the food cart, for the East 1 Hall by LPN #1. On 05/05/2025 at 1:03 PM, a cart that contained 14 lunch trays was delivered to East 1 Hall, by CNA #3. At 1:12 PM, immediately after the last resident was served in their room on East 1 Hall, the temperatures of the food items from the test trays on the cart were checked by CNA #3, with the following results: a) Milk: 44 degrees Fahrenheit b) Chicken tenders: 114 degrees Fahrenheit c) Purred vegetables: 113 degrees Fahrenheit d) Mashed potatoes: 111 degrees Fahrenheit e) Pureed chicken tender: 114 degrees Fahrenheit f) Ground chicken tender: 104 degrees Fahrenheit (continued on next page)

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F 0804 Level of Harm - Potential for minimal harm Residents Affected - Some	g) Cut green beans: 107 degrees Fahrenheit On 05/05/2025 at 1:16 PM, the District Dietary Manager (DDM) stated hall-trays food temperatures should be 120 degrees Fahrenheit when they reach the residents. She explained how long the trays sat from the time they been loaded into food cart, until they were delivered to the halls, could affect the temperature. She also explained that if the plates were not heated, it would affect the temperature further. She then felt the plates with her hands and stated the plates were not warm. On 05/06/2025 at 7:34 AM, the first breakfast tray was placed on a shelf, in an unheated food cart by LPN #7, while the door remained open. The food cart stayed open as she continued loading the remaining meal trays. After placing 14 meal trays inside, she closed the food cart door. On 05/06/2025 at 7:43 AM, CNA #4 then delivered the food cart to the [NAME] Hall (Male unit). At 7:52 AM, immediately after the last resident was served in the [NAME] Hall (Male Unit) dining room, the temperatures of the food items from the test trays on the cart were checked by CNA # 4, with the following results: a) Milk: 55.9 degrees Fahrenheit b) Sausage links: 94.8 degrees Fahrenheit c) Pureed sausage: 102.8 degrees Fahrenheit. d) Pureed chicken tender: 105.2 degrees Fahrenheit e) Ground sausage with gravy: 102.2 degrees Fahrenheit f) Scrambled eggs: 107.7 degrees Fahrenheit Immediately following the temperature checks, CNA #4 stated the food should have been reheated. During an observation of the breakfast meal service on 05/06/2025 at 7:44 AM, the first breakfast meal tray for East 1 Hall was placed on a shelf, in an unheated food cart by LPN #7, while the door remained open. The food cart stayed open as she continued loading the remaining meal trays. On 05/06/2025 at 7:53 AM, an unheated food cart, that contained 14 breakfast meals, was delivered to East 1 Hall by CNA #3. On 5/06/2025 at 8:04 AM, immediately after the last resident was served in their room on East 1 Hall, the temperatures of the food items from the test trays on the cart were checked by CNA #3, with the following results: a) Milk: 45 degrees Fahrenheit b) Scrambled eggs: 113 degrees Fahrenheit Immediately following the temperature checks, CNA #3 stated the food should have been reheated. (continued on next page)

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F 0804 Level of Harm - Potential for minimal harm Residents Affected - Some	On 05/06/2025 at 8:03 AM, the first breakfast meal tray for East 2 Hall was placed on a shelf, in an unheated food cart by LPN #7, while the door remained open. The food cart stayed open as she continued loading the remaining meal trays. On 05/06/2025 at 8:11 AM, a cart that contained 13 breakfast meals was delivered to East 2 Hall by CNA #5. At 8:19 PM, immediately after the last resident was served in their room on East 2 Hall, the temperatures of the food items from the test trays on the cart were checked by CNA #8, with the following results: a) Milk: 43.7 degrees Fahrenheit b) Pureed sausage: 104.7 degrees Fahrenheit c) Pureed bread and milk: 113.6 degrees Fahrenheit d) Ground sausage with gravy: 102.2 degrees Fahrenheit e) Pureed eggs: 100.4 degrees Fahrenheit Immediately following the temperature checks, CNA #5 stated the food should have been reheated. During an interview on 05/05/2025 at 11:46 AM, Resident #15 stated the soup provided by the facility, as an option on the alternative menu, was always cold. During an interview on 05/05/2025 at 3:10 PM, Resident #1 was asked if the temperatures of their hot foods and cold foods were appropriate. Resident #1 stated the food was usually cold. The resident stated they usually ate in their room. On 05/06/2025 at 10:33 AM, two alert and oriented residents, who were present during the resident group meeting, were asked if the temperatures of the hot foods and cold foods were appropriate. Two of the five residents, who ate meals in their rooms, agreed with the following statements: a) Resident #49 indicated that their breakfast was cold sometimes. b) Resident #66 indicated that sometimes their food was cold. During an interview on 05/06/2025 at 1:44 PM, LPN #7 stated she did not know the food cart should remain closed while loading meal trays, until the Dietary Manager (DM) informed her. She stated that she had not considered that leaving the door open would cause the food temperatures to drop. During an interview with the Dietary Manager on 05/06/2025 at 1:46 PM, she stated the food cart door should be kept closed each time a meal tray was placed inside, to retain the proper temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, record review, interview, and facility policy review, the facility failed to ensure foods stored in the dry storage area were covered and sealed; expired food items were promptly removed / discarded, on or before the expiration or use by date; dietary staff washed their hands between dirty and clean tasks and before handling clean equipment; and the ice machine was maintained in a clean sanitary condition for one of one meal observed. The findings are: On [DATE] at 10:09 AM, the following observations were made on a shelf above the food preparation counter: a. An opened bag of grits, the bag was not sealed. b. An open box of salt, the box was not covered. On [DATE] at 10:12 AM, this surveyor observed a box of baking soda, on a shelf in the storage room, that had an expiration date of [DATE]. On [DATE] at 10:35 AM, Dietary [NAME] (DC) #6 turned the water on and washed her hands. After washing her hands, she turned off the faucet with her hands, contaminating her clean hands. Without washing her hands again, she removed 20 slices of bread from a bread bag and broke the bread into pieces into the blender. She then added warm milk to be pureed and served to the residents on pureed diets for lunch meal. During an observation on [DATE] at 10:40 AM, the ice machine panel in the kitchen, where ice formed before dropping into the ice collector, had a wet yellowish residue on it. The areas were pointed out to the Maintenance Supervisor, with the Dietary Manager present. During an interview, the Maintenance Supervisor was asked if the residue build up could be wiped off, how often he cleaned the ice machine, and who used the ice from the machine. The Dietary Manager used tissue papers and wiped the wet residue off. The wet residue easily transferred to the tissue, and she (Dietary Manager) stated the area had a dirty, rusty color from the water. The Dietary Manager stated the Certified Nursing Assistants (CNAs) used the ice machine for the water pitchers in the residents' rooms, for the beverages served to the residents, and the kitchen staff used it to fill beverages served to the residents at mealtimes. The Maintenance Supervisor stated that he cleaned the ice machine at the end of each month, and it currently had dirty yellowish residue on it. On [DATE] at 10:58 AM, this surveyor observed a box that contained 14 strawberry banana yogurts on a shelf in the refrigerator, with an expiration date of [DATE]. The DM stated the yogurts had expired. She then removed the box of yogurts from the refrigerator and threw them away. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:33 AM, DC #6 removed bags of chicken tenders from the freezer and placed them on the counter by the deep fryer. DC #6 opened a bag of chicken tenders, contaminating her hands. Without washing her hands, she removed chicken tenders from the bag and placed them in a deep fryer to be cooked and served to the residents during the lunch meal. On [DATE] at 11:40 AM, DC #6 washed her hands and then turned off the faucet with her clean hands. DC #6 picked up a clean blade and attached it to the base of the blender. She then placed eight chicken tenders into the blender to grind and be served to the residents on mechanical soft diets for the lunch meal. This surveyor asked DC #6 what she should have done after she touched dirty objects, or before she handled clean equipment, and she stated she should have washed her hands. A review of facility policy titled, Quick Resources Tool, QRT Handwashing, initiated [DATE], provided by the Administrator on [DATE], indicated hands should be washed before starting to work with food and equipment and as often as needed, during food preparation and when changing tasks. A review of facility policy titled, Quick Resources Tool, QRT Safe storage of Food initiated [DATE], provided by the Administrator on [DATE], indicated, all foods will be stored wrapped or in covered containers, and arranged in a manner to prevent cross contamination . A review of facility policy titled, Ice machine and ice storage chests, initiated [DATE], provided by the Administrator on [DATE], indicated to flush and clean the ice machine and dispenser after lengthy water disruptions.