STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045197	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Harrison	115 Orendorff Avenue Harrison, AR 72601

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016 Based on observations, interviews, records review, and facility policy review, the facility failed to ensure residents, or their representatives were notified of the high concentrations of [NAME] gas in the facility, depriving them of the right to choose to remain in the facility or move to another facility. This failed practice had the potential to affect all residents residing in the facility. Findings include: A review of Resident #6's electronic health records, reviewed on 08/26/2024 at 1:45 PM, revealed no documentation of [an electronic system for email, text or phone call messaging] to residents or their representatives regarding [NAME] gas exposure. No scanned paper notification was contained in the electronic health record. A review of Resident #6's Medical Diagnosis sheet included post Covid-19 condition. A review of a quarterly Minimum Data Set (MDS) with an assessment references date (ARD) of 07/24/2024, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. A review of a Progress Note dated 05/21/2024 at 02:24 PM indicated Resident #6 was administered an updraft treatment for a productive cough with thick, yellow sputum A review of a Progress Note dated 05/22/2024 at 3:41 PM indicated Resident #6 was started on antibiotics for an upper respiratory infection. A review of Resident #8's electronic health records, on 08/26/2024, at 2:00 PM, revealed no documentation of [an electronic system for email, text or phone call messaging] to residents or their representatives regarding [NAME] gas exposure. No scanned paper notification was contained in the electronic health record. A review of the Medical Diagnosis portion of Resident #8's electronic health record revealed a diagnosis of chronic obstructive pulmonary disease (COPD). (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of an admission MDS with an ARD of 07/21/2024 revealed Resident #8 had a BIMS score of 5, which indicated the resident had severe cognitive impairment. Resident #8 was not receiving oxygen therapy. A review of the Order Summary Report indicated Resident #8 was receiving two oral inhalers daily for COPD. A review of the Care Plan, with a revised date of 07/26/2024, indicated Resident #8 had impaired cognitive function related to a stroke and indicated the resident was able to make simple decisions with yes/no questions. A review of Resident #9's electronic health records on 08/26/2024 at 2:00 PM revealed no documentation of [an electronic system for email, text or phone call messaging] to residents or their representatives regarding [NAME] gas exposure. No scanned paper notification was contained in the electronic health record. A review of the Medical Diagnosis portion of Resident #9's electronic health record revealed diagnoses of allergic rhinitis and persistent asthma. A review of the admission MDS with an ARD of 07/19/2024 revealed Resident #9 had a BIMS score of 11, indicating resident had moderate cognitive impairment. Resident #9 was not receiving oxygen therapy. A review of the [NAME] Measurement Report dated 03/27/2023 indicated conditions were required for testing that included all occupants of the building were to receive notices no less than 24 hours prior to testing. A review of a list provided on 08/26/2024 at 07:56 AM and identified by the Maintenance Director as locations of [NAME] mitigation equipment revealed equipment was placed in the areas of the facility that included resident room numbers 102, 110, 117, 120, 121, 126, 134, 146, and the North Hall dining room. A review of the [NAME] Measurement Report, prepared by[named company providing testing services], dated 03/27/2023, indicated the report was done in accordance with the ANSI-AARST [American National Standards Institute-American Association of [NAME] Scientists and Technologists] protocol [specifies practices and minimum requirements for reducing soil gas entry into existing structures to mitigate exposure to hazardous gases, including [NAME], by occupants] used in schools and large buildings for[commercial real estate company]. The report summary revealed testing was done in 39 residential locations and sent out to [company providing analysis services] for analysis. Results returned included elevated results (concentrations that meet or exceed EPA [Environmental Protection Agency] action level of 4.0 pCi/L [picocuries per liter]) of the following rooms/areas: 100, 102, 104, 115, 116, 117, 118, 119, 121, 122, 123, 124, 125, 126, 127, 130, 134, 135, 136, 138, 140, 142, 144, 145, 146, 147, 148, 149, 150, 151, 152, small dining, living room, nurse station, main dining room, main dining room addition, living room, main lobby, and west nurse station. Recommendations included mitigation in 16 locations, must be completed as quickly as possible but no later than 12 months after closing per HUD [Housing and [NAME] Development] loan requirements. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Section 2.2 of the [NAME] Measurement Report dated 03/27/2023, indicated the purpose for testing is [NAME] occurs due to decay of uranium in soil, water and rocks releasing an odorless, colorless, radioactive gas which may become trapped in structures, causing high concentrations of [NAME]. [NAME] is the second-leading cause of lung cancer in the United States and the leading cause of lung cancer among non-smokers. The report noted no notification from the facility was given and no observations were made of mitigations systems present during testing. A review of [testing laboratory] report dated 08/21/2024, with testing dates of 08/16/2024 to 08/19/2024, indicated results obtained in different areas and had an estimated margin error rate of +/- 5%. Results dependent on using according to directions. Highest levels in room [ROOM NUMBER] at 2.3% with an error documented as 10 grams of water absorbed in test and high humidity indicative of lower test accuracy and room [ROOM NUMBER] at 2.1 %. A review of the Resident Room Roster with a printed on date of 08/26/2024 revealed residents occupancy of the following rooms: 100 - 2 residents, 102 - 2 residents, 104 - 2 residents, 115 - 2 residents, 116 - 2 residents, 117 - 2 residents, 118 - 2 residents, 119 - 2 residents, 121 - 2 residents, 122 - 1 resident, 123- 2 residents, 124 - 2 residents, 125 - 2 residents, 126 - 1 residents, 127 - 1 resident, 130 - 1 resident, 134 - 2 residents, 135 - 2 residents, 136 - 2 residents, 138 - 2 residents, 140 - 2 residents, 142 - 2 residents, 144 - 2 residents, 145 - 2 residents, 146 - 2 residents, 147 - 2 residents, 148 - 2 residents, 149 - 2 residents, 150 - 2 residents, 151 - 2 residents, and 152 - 2 residents. A review of the policy and procedure titled Hazardous Areas, Devices and Equipment, with a revised date of 07/2021, included a policy statement that indicated for the safety of the residents, all hazardous areas in the facility would be identified and mitigated to the extent possible. The interpretation and implementation of the policy included hazardous areas would be identified and addressed. Hazards were defined as, .anything in the environment that has the potential to cause injury or illness . This included, .but are not limited to, access to toxic chemicals and unsafe exposure . Assessment and Analysis included, 2. Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous. During an interview on 08/27/2024 at 10:35 AM, the Administrator stated the testing was done in March of 2023 and the facility was given about a week's notice prior to testing, no special instruction was given for occupants or the building itself. The Administrator stated the results required an intervention of the [NAME] Mitigation System because they rose to the yellow area. No notice was ever given to the resident or their representative prior to the testing, during the testing process, or after the testing was completed with the known results of high [NAME] levels in the yellow area. The Administrator stated they were not even sure [NAME] was a real thing and they did not follow up with [NAME] information. During an interview on 8/27/2024 at 11:30 AM, Resident #6's family member stated no communication was provided from the facility regarding [NAME] testing, results of elevated [NAME] levels, or the [NAME] Mitigation System at the time of admission in February 2024. The family member was aware a pipe had been installed somewhere recently and assumed the electric cord ran to it. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 08/27/2024 at 12:50 PM, Resident #9 acknowledged awareness of the electric cord running out of the window and the installation of the pipe in the room. Resident #9 was unaware of its purpose and denied any information from the facility regarding elevated [NAME] levels or a [NAME] Mitigation System. During an interview on 08/27/2024 at 1:00 PM, Resident #8's family member stated there was no information given at admission regarding elevated [NAME] levels in the facility, no information was given when the pipe was installed in the room, nor was the purpose was explained for the extension cord running out the window. During a follow-up interview on 08/27/2024 at 1:58 PM, the Administrator did not answer when asked if the resident's rights had been deprived because of noncommunication between the facility and the residents/representatives about the high concentrations of [NAME]. The Administrator again stated they did not believe [NAME] was even a real thing. When asked if the residents had the right to also formulate an opinion and make informed decisions for themselves, the Administrator became emotional and left the room.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016 Based on observations, interviews, record review, and facility document review, the facility failed to provide a safe environment, specifically the facility did not address [NAME] gas found in the facility one year ago, to protect residents residing in the facility. Findings include: During an observation and interview on 08/26/2024 at 4:54 AM of room [ROOM NUMBER], an orange electric cord was observed plugged into an outlet by bed B and running out the window. The window had the screen removed and was open about two inches allowing the cool night air and moths inside. CNA (Certified Nursing Assistant) #7 stated the electric cord was new and was unaware what the cord ran to. During a concurrent observation and interview on 08/26/2024 at 6:10 AM of room [ROOM NUMBER], the Maintenance Director stated the orange electric cord was running outside to the [NAME] Mitigation System. The Maintenance Director reported installation was completed sometime last week and was used to lower the elevated [NAME] levels in the facility, and there were eleven systems so far in the facility with plans to install more, some were in resident rooms, one in the dining room, one in the skilled therapy room, and the others in offices. The electric cords were the facilities practice for supplying power to the systems because it was not hardwired in. During an observation on 08/26/2024 at 07:15 AM of room [ROOM NUMBER], bed B, an orange electrical cord was plugged in above the resident's headboard, draped in front of the headboard and over to and out of the window. A second orange electrical cord was plugged into an outlet near the closet, over to and out the window. The windows were closed over top of electrical cords. A white PVC (polyvinyl chloride) straight pipe was attached to the floor near the resident's bed at one end, extending vertically upward and curved horizontally, using a PVC elbow attachment and another straight PVC pipe, toward the wall and attached to the wall to the left of the window. The device was in an upside-down L shape. The residents in the room stated they do not know what the cords or the pipes are for but were recently installed. During an observation and interview of room [ROOM NUMBER] on 08/26/2024 at 08:16 AM, there was an orange electrical cord laid across windowsill, under the bottom of the window, and through a hole in the screen to the outside. The window was closed pinning the cord in the groove of the window casing. CNA #2 stated the orange electrical cords are connected to [NAME] pumps installed in the room and did not know exactly what they did. A review of a list provided on 08/26/2024 at 07:56 AM and identified by the Maintenance Director as locations of [NAME] mitigation equipment, revealed equipment was placed in the areas of the facility that included, resident room numbers 102, 110, 117, 120, 121, 126, 134, 146, and the North Hall dining room. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	A review of the [NAME] Measurement Report, prepared by[named environmental reporting company], dated 03/27/2023, indicated the report was done in accordance with the ANSI-AARST [American National Standards Institute-American Association of [NAME] Scientists and Technologists] protocol [specifies practices and minimum requirements for reducing soil gas entry into existing structures to mitigate exposure to hazardous gases, including [NAME], by occupants] used in schools and large buildings for[named commercial real estate company]. The report summary revealed testing was done in 39 residential locations and sent out to [company providing analysis services] for analysis. Results returned included elevated results (concentrations that meet or exceed EPA [Environmental Protection Agency] action level of 4.0 pCi/L [picocuries per liter]) of the following rooms/areas: 100, 102, 104, 115, 116, 117, 118, 119, 121, 122, 123, 124, 125, 126, 127, 130, 134, 135, 136, 138, 140, 142, 144, 145, 146, 147, 148, 149, 150, 151, 152, small dining, living room, nurse station, main dining room, main dining room addition, living room, main lobby, and west nurse station. Recommendations included mitigation in 16 locations, must be completed as quickly as possible but no later than 12 months after closing per HUD [Housing and [NAME] Development] loan requirements. Review of Section 2.2 of the [NAME] Measurement Report dated 03/27/2023, indicated the purpose for testing was, [NAME] occurs due to decay of uranium in soil, water and rocks releasing an odorless, colorless, radioactive gas which may become trapped in structures, causing high concentrations of [NAME]. [NAME] is the second-leading cause of lung cancer in the United States and the leading cause of lung cancer among non-smokers. The report noted no notification from the facility was given and no observations were made of mitigations systems present during testing. A review of the Resident Room Roster with a printed on date of 08/26/2024 revealed residents occupancy of the following rooms: 100 - 2 residents, 102 - 2 residents, 104 - 2 residents, 115 - 2 residents, 116 - 2 residents, 117 - 2 residents, 118 - 2 residents, 119 - 2 residents, 121 - 2 residents, 122 - 1 resident, 123- 2 residents, 124 - 2 residents, 125 - 2 residents, 126 - 1 residents, 127 - 1 resident, 130 - 1 resident, 134 - 2 residents, 135 - 2 residents, 136 - 2 residents, 138 - 2 residents, 140 - 2 residents, 142 - 2 residents, 144 - 2 residents, 145 - 2 residents, 146 - 2 residents, 147 - 2 residents, 148 - 2 residents, 149 - 2 residents, 150 - 2 residents, 151 - 2 residents, and 152 - 2 residents. A review of the policy and procedure titled Hazardous Areas, Devices and Equipment, with a revised date of 07/2021, included a policy statement that indicated for the safety of the residents, all hazardous areas in the facility would be identified and mitigated to the extent possible. The interpretation and implementation of the policy included hazardous areas would be identified and addressed. Hazards were defined as, . anything in the environment that has the potential to cause injury or illness . This included, .but are not limited to, access to toxic chemicals and unsafe exposure . Assessment and Analysis included, 2. Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous. During an interview on 08/26/2024 at 1:45 PM, the Infection Control Nurse stated there was a spike in respiratory infections during April of 2024 that could not be attributed to any known pathogens such as influenza, covid, or pneumonia, only stating there were just more upper respiratory cases that month. During an interview on 08/27/2024 at 7:45 AM, the Maintenance Director stated their cooperate office gave about one-week prior notice to the [NAME] testing process. This did not include any special instructions for the occupants or the building itself and lasted over four days. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	During an interview on 08/27/2024 at 10:35 AM the Administrator stated the testing was done in March of 2023 and the facility was given about a week's notice prior to testing, no special instruction was given for occupants or the building itself. The administrator stated the results required an intervention of the [NAME] Mitigation System because they rose to the yellow area of the results chart. No notice was ever given to the resident or their representative prior to the testing, during the testing process, or after the testing was completed with the known results of elevated [NAME] levels in the yellow area. The Administrator failed to follow up with [NAME] information and had formed the opinion it wasn't even a real thing. During an interview on 08/27/2024 at 12:42 PM, Advanced Practice Registered Nurse (APRN) stated no information was provided by the administrator or the Medical Director about [NAME] testing or results prior to the last couple of weeks when the installation process started for the [NAME] Mitigation System. The APRN stated no changes in respiratory assessments had been necessary to make related to [NAME] exposure, only as part of normal assessments with residents' respiratory needs. During an interview on 08/27/2024 at 1:15 PM, the Maintenance Director stated he believed the space in resident rooms was sufficient for the resident to carry out activities and instillation of the devices had not particularly changed the ability to use the space, although beds could not be placed against the wall, it helped with lighting because the beds had to be centered under the light affixed to another wall. The Maintenance Director stated the pipe is out of the way to allow staff and residents to do what I have seen them do and the pipe is not in their way. The Maintenance Director was not sure if installation of the devices affected the residents and stated the doors were closed and the room was not occupied during installation, so nothing clouded out. When asked the meaning of clouded out, the Maintenance Director stated a dust cloud did not come into the hallway. The Maintenance Director and surveyor entered resident room [ROOM NUMBER], with the residents' permission. Measurements of the device taken by the Maintenance Director were 26.5 inches high (vertically from floor to top of the horizontal pipe), 9.0 inches from wall at the head of the bed [HOB] to the outside edge of the device, and 11.5 inches from outside edge of vertical pipe to area where horizontal pipe exits through wall near the window. During a concurrent observation and interview on 08/27/2024 at 1:30 PM, the Maintenance Director entered room [ROOM NUMBER], listed as a room having a [NAME] mitigation device, and did not have a device located in the room. The Maintenance Director stated there was not a device in room [ROOM NUMBER], that it was a mistake, and was in another room. During a concurrent observation and interview on 08/27/2024 at 1:35 PM, the Maintenance Director entered room [ROOM NUMBER], not on the list provided to surveyors, located a [NAME] mitigation device, and took measurements of the device per surveyor request. The Maintenance Director stated the measurements were 25 inches high (vertically from floor to top of the horizontal pipe), 9.5 inches from wall at the head of the bed [HOB] to the outside edge of the device, and 11.5 inches from outside edge of vertical pipe to area where horizontal pipe exits through wall near the window. The Maintenance Director then entered the following rooms sequentially, obtained measurements and stated: room [ROOM NUMBER] was 26 inches high (vertically from floor to top of the horizontal pipe), 9.5 inches from wall at the HOB to the outside edge of the device, and 11.5 inches from outside edge of vertical pipe to area where horizontal pipe exits through wall. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	room [ROOM NUMBER] was 22.25 inches high (vertically from floor to top of the horizontal pipe), 46 inches from bathroom door jamb, 9.25 inches from edge of the open bathroom door, at the foot of the resident's bed which was located against the outside wall, and 11.5 inches from outside edge of vertical pipe to area where horizontal pipe exits through wall. room [ROOM NUMBER] was 26 inches high (vertically from floor to top of the horizontal pipe), 8 inches from HOB to the outside edge of the device, and 11.5 inches from outside edge of vertical pipe to area where horizontal pipe exits through wall. room [ROOM NUMBER] was 26 inches high (vertically from floor to top of the horizontal pipe); 8.5 inches from wall at HOB to the outside edge of the device, and 11 inches from outside edge of vertical pipe to area where horizontal pipe exits through wall. room [ROOM NUMBER] was 26 inches high, (vertically from floor to top of the horizontal pipe), 12 inches from wall at HOB to the outside edge of the device, and 9 inches from outside edge of vertical pipe to area where horizontal pipe exits through wall. room [ROOM NUMBER] was 22.25 inches high, (vertically from floor to top of the horizontal pipe), 20 inches from wall at HOB to the outside edge of the device, and 17 inches from outside edge of vertical pipe to area where horizontal pipe exits through wall. During a follow-up interview on 08/27/2024 at 1:58 PM, the Administrator was of the opinion sufficient space existed for resident activities and staff performance of resident care. The Administrator stated the facility was looking into modifications around the newly installed pipes to allow for usable space for the residents, but no actual plan or time frame was known.