

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  The Springs of Harrison		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39316</p> <p>Based on observation, interview, and record review, the facility failed to maintain a safe, functional, sanitary, and homelike environment for the residents to promote dignity and prevent the potential injury or spread of disease. The findings are:</p> <p>On 04/01/2024 at 02:13 PM, observed Resident #28 sitting in a wheelchair in the resident's room. The left and right wheelchair arm rests were wrapped in bubble plastic and black duct tape. Resident #28 was asked, Is this your wheelchair? Resident #28 stated, No, my [family member] brought mine from home, but it was too wide, so [the family member] took it home, and fixed this wheelchair so the arms would stay on.</p> <p>On 04/02/2024 at 08:31 AM, the right arm rest on Resident #25's wheelchair had the vinyl torn with foam exposed. Resident #25 stated, It's not my chair, it's theirs, [facility], it's been like that since I've been here.</p> <p>On 04/01/2024 at 11:24 AM, observed Resident #23 sitting in a geriatric chair. The plastic end of the left arm rest was missing and wrapped in black duct tape. The left arm rest of the geriatric chair had a dried white substance on it.</p> <p>On 04/04/2024 at 09:48 AM, observed Resident #23 sitting in a geriatric chair in the dayroom. The plastic end of the left arm rest was missing and wrapped in black duct tape. The left arm rest had a dried white substance on it. Maintenance #1 was asked to describe the left arm rest. Maintenance #1 stated, It's dirty, heavily stained, the arm rest is duct taped and the end of the arm rest is missing. It needs to be replaced.</p> <p>On 04/01/2024 at 02:17 PM, observation of room [ROOM NUMBER], the bathroom's metal door frame was rusted, with metal exposed and protruding 0.5 inches on both sides of the door frame near the floor.</p> <p>On 04/01/2024 at 02:19 PM, observed the bottom of a metal door frame in the shower room on Hall ACU (Acute Care Unit)/North Wing was rusted, with metal exposed and protruding outward 0.5 inches on both side of the door frame.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/04/2024 at 09:15 AM, Certified Nursing Assistant (CNA) #6 was asked, What is the process for reporting things in the facility that need to be repaired? CNA #6 stated, Write it on the board/book for maintenance. CNA #6 was asked, What are some things that would be reported? CNA #6 stated, Beds not working, television's not working, or if there are some wires showing.</p> <p>On 04/04/2024 at 09:18 AM, Registered Nurse (RN) #1 was asked, What is the process for reporting things in the facility that need to be repaired? RN #1 stated, There is a log by the time clock, and we fill out the paper for maintenance. RN #1 was asked, What are some things that would be reported? RN #1 stated, Beds, door handles, wheelchairs, medication carts, any kind of maintenance.</p> <p>On 04/04/2024 at 09:32 AM, Maintenance #1 was asked, What is the process for reporting things in the facility that need to be repaired? Maintenance #1 stated, There is a maintenance work request by the time clock. They fill it out and leave it for me. I check it every morning and throughout the day. Maintenance #1 was asked, What are some things that would be reported? Maintenance #1 stated, Any type of malfunctions, tv's, wheelchair malfunctions. Maintenance #1 was asked if any resident's wheelchair/geriatric arm rests had been reported for repair. Maintenance #1 stated, No. Maintenance #1 was asked to assess environmental issues with Surveyors.</p> <p>On 04/04/2024 at 09:40 AM, observed the lower door frame on the ACU/North Hall shower room was rusted, with metal protruding outward 0.5 inches. Maintenance #1 was asked if it had been reported. Maintenance #1 stated, It had been reported last week, it needs bracket support, but they haven't been ordered yet. Maintenance #1 was asked, What has been done to protect the residents from possible skin injury when entering and exiting the shower room? Maintenance #1 stated, Nothing.</p> <p>On 04/04/2024 at 09:43 AM, Maintenance #1 was asked to describe the lower metal doorframe in the bathroom of room [ROOM NUMBER]. Maintenance #1 stated, It's rough and it could cause an injury. Maintenance #1 was asked if it had been reported. Maintenance #1 stated, No.</p> <p>On 04/04/2024 at 09:45 AM, Maintenance #1 was asked about Resident #25's right wheelchair arm rest. Maintenance #1 stated, It needs to be replaced.</p> <p>On 04/04/2024 at 09:47 AM, Maintenance #1 was asked about Resident #47's bilateral wheelchair arm rests. Maintenance #1 stated, They are loose and need new arms.</p> <p>The Maintenance Work Requests on 11/15/2023 to 03/18/2024 did not include any work orders for the findings on [NAME] Hall. Maintenance #1 stated that none of these issues had been reported.</p> <p>On 04/04/2024 at 09:50 AM, the following observations were made with Maintenance #1 on [NAME] Hall:</p> <p>room [ROOM NUMBER]: The baseboard was pushed down on the wall next to the closet. Maintenance #1 felt of the area, then replied that it's a bit rough. The door facings in the bathroom were rusted. Maintenance #1 felt of the area and replied that is rough could cause injury.</p> <p>room [ROOM NUMBER]: The wall next to the closet had yellow paint peeling and protruding from the wall exposing sheet rock. Maintenance #1 replied that it needed to be painted, and it had crumbling dry wall. Bed B did not have a footboard or headboard on it. Maintenance #1 replied that needs to be fixed, I will definitely be putting those back on this bed.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER]: All four bottom door frames in the bathroom were rusted with protruding metal. The baseboard for the room was completely missing, and a strong smell pervaded the air. Maintenance said the room was not reported to him and that the door facings needed to be repaired.</p> <p>room [ROOM NUMBER]: The bottom of the door frame in the bathroom was rusted with metal exposed. The Surveyor asked Maintenance #1 about the door frame. Maintenance #1 answered that it was not as sharp as some of the others, but it is getting there to cause an injury. On the right-hand side of the door half of the door facing was missing with wood exposed and protruding. The Surveyor asked Maintenance #1 to feel the door facing. Maintenance #1 answered that the silicone area was not bad but the areas with wood were sharp and could cause injury.</p> <p>room [ROOM NUMBER]: The entrance door facing was chipped with metal protruding. Under the sink the baseboard on the right-hand side was coming off the wall and the tile was discolored and raised. The Surveyor explained the issues with Maintenance #1. Maintenance said that they will be starting with room [ROOM NUMBER] and will do a round of the building to begin fixing these issues.</p> <p>room [ROOM NUMBER]: Behind Bed B's headboard, paint had been scrapped off the wall. Maintenance #1 was asked the approximate size of the area. Maintenance #1 answered, The longest scrape is approximately ten and one half inches and its approximately the width of the bed, maybe twenty three inches across, needs to be painted.</p> <p>room [ROOM NUMBER]: A cable was hanging from the ceiling tile above Bed B. Maintenance #1 said that the cable was long and could be pulled on.</p> <p>room [ROOM NUMBER]: There was a missing baseboard on a wall by the sink and under the vent area. Maintenance #1 said the areas needed to be repaired.</p> <p>On 04/01/24 at 11:58 AM, on Bed B there was a red comforter with a larger darkened area that had a white substance on top of it.</p> <p>On 04/02/24 at 3:00 PM, the red comforter had not been changed.</p> <p>On 04/03/24 at 11:53 AM, the red comforter had not been changed.</p> <p>On 04/03/24 at 12:48 PM, the Surveyor asked CNA #2 if the bed needed changed. CNA #2 confirmed it did. The Surveyor asked what was wrong with the bedding. CNA #2 said we don't know what is on the bedspread, could be anything. The Surveyor asked when the beds were supposed to be changed. CNA #2 said that they get changed as needed and with showers twice a week.</p> <p>A review of the facilities, Maintenance Work Request, dated 11/15/2023 through 03/18/2024, did not document any work order requests for Residents #23, #25, and #28 arm rests to be replaced. There were no work order requests for door frames in room [ROOM NUMBER] or for the shower room door frame on the ACU/North Wing.</p> <p>On 04/03/2024 at 04:07 P.M., the Director of Nursing (DON) provided the Resident's [NAME] of Rights, which documented, This facility must ensure and protect the human rights of every resident and will provide a clean, healthy, attractive environment .</p> <p>(continued on next page)</p>		

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F 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	49689		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>39316</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers received care and treatment to prevent potential infection or deterioration and promote healing for 1 (Resident #29) of 1 sampled resident. The findings are:</p> <p>A review of the Medical Diagnosis Record indicated the facility admitted Resident #29 with a diagnosis of Alzheimer's disease.</p> <p>The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/18/2024, revealed Resident #29 had a Staff Assessment for Mental Status (SAMS) score of 3, which indicated the resident was severely impaired for daily decision making. The resident was dependent on staff for Activities of Daily Living (ADL) and was always incontinent of bowel and bladder; had one Stage IV pressure ulcer (Full-thickness skin loss extends through the fascia with considerable tissue loss. There may be muscle, bone, tendon, or joint involvement); and skin and ulcer/injury treatments included, pressure reducing device for chair and application or nonsurgical dressings (with or without topical medications) other than to feet.</p> <p>A review of Resident #29's Physician Orders, for the month of April 2024, revealed an order, dated 12/29/2023 which noted Resident #29 was to have an unstageable pressure ulcer (PU) to right buttock cleansed with antimicrobial wound cleanser, pack wound with calcium alginate rope, and cover with a foam dressing every day shift for wound healing; and as needed for missing or soiled dressing.</p> <p>Review of Resident #29's Care Plan, revised on 07/17/2023, revealed the resident was at risk for impaired skin integrity and UTI (urinary tract infection) r/t (related to) decreased mobility and bowel and bladder (b/b) incontinence. Interventions included provide pressure reducing cushion to wheelchair; initiated on 07/06/2023. A revision on 04/01/2024 revealed the resident had a one (1) stage four (4) pressure ulcer to the left (L) gluteus (glute) related to (r/t) immobility. Interventions included administering treatments as ordered and observing for effectiveness.</p> <p>On 04/01/2024 at 12:09 PM, observed Resident #29 in a geriatric chair in the dining room. A mechanical lift pad was in the chair under the resident. There was no pressure relieving device/cushion under Resident #29.</p> <p>On 04/01/2024 at 02:16 PM, observed Resident #29 in a geriatric chair sitting in the resident's room. A mechanical lift pad was under the resident. There was no pressure relieving device/cushion under Resident #29.</p> <p>On 04/02/2024 at 12:10 PM, observed Resident #29 in a geriatric chair in the resident's room. A mechanical lift pad was under the resident. There was no pressure relieving device/cushion under Resident #29.</p> <p>On 04/03/2024 at 09:42 AM, observed Resident #29 sitting up in a geriatric chair in the hallway across from the resident's room. A mechanical lift pad was observed under Resident #29.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/03/2024 at 09:45 AM, Certified Nursing Assistant (CNA) #3 was asked if Resident #29 was supposed to have heels off loaded. CNA #3 stated, [The resident] had heel protectors or boots, but I don't know what happened to them, [the resident] was up when we got here. CNA #3 was asked what time did you get here this morning. CNA #3 stated, Six fifty AM. I should have made sure they were floated. CNA #3 was asked if Resident #29 had a cushion in [the resident's] chair. CNA #3 stated, They do not have a cushion in their chair. CNA #3 was asked why doesn't the resident have a cushion in the chair? CNA #3 stated, Therapy gives out the cushions. CNA #3 was asked if Resident #29 had a sore on [the resident's] bottom. CNA #3 stated, Yes. CNA #3 was asked how do you know how to take care of a resident? CNA #3 stated, They have a care plan that's in the computer that we have access to.</p> <p>On 04/03/2024 at 09:50 AM, CNA #3 and CNA #4 were to use a mechanical lift to lift Resident #29 out of the geriatric chair to be laid down in bed. The CNAs connected the lift pad to the mechanical lift and began to raise Resident #29 up in the air. Resident #29 had no chair cushion in the chair.</p> <p>On 04/03/2024 at 11:25 AM, Licensed Practical Nurse (LPN) #1 was asked what interventions the facility uses for residents with pressure ulcers. LPN #1 stated, Turn every two hours, cushions in chairs. LPN #1 was asked who was responsible for ensuring residents have cushions in their chairs. LPN #1 stated, Basically, everybody. I wasn't aware [Resident #29] didn't have a cushion in her chair until the girls said something.</p> <p>On 04/04/2024 at 08:36 AM, the Director of Nursing (DON) was asked when were chair cushions utilized and why. The DON stated, Utilized to prevent pressure ulcers.</p> <p>On 04/04/2024 at 08:39 AM, the Infection Control Preventionist (ICP) was asked when chair cushions were utilized and why. The ICP stated, Utilized for residents that need extra cushion to prevent pressure sores.</p> <p>A facility policy titled, Prevention of Pressure Injuries, dated April 2020, specified, The purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. Review the interventions and strategies for effectiveness on an ongoing basis.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>49689</p> <p>Based on observation, interview, and record review, the facility failed to ensure interventions were in place for a contracture for 1 (Resident #20) of 1 sampled resident.</p> <p>The findings include:</p> <p>Resident #20 had diagnoses that included Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.</p> <p>The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/21/2024 revealed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 15 (13-15 indicates cognitively intact) and had limited range of motion on one side both upper and lower extremity.</p> <p>A review of Resident #20's Care Plan, dated 04/03/2024, revealed the resident had an ADL (Activities of Daily Living) self-care deficit related to left side hemiplegia due to Cerebral Vascular Accident (CVA), and a contracture to the left hand.</p> <p>During an observation on 04/01/2024 at 12:20 PM, Resident #20 's left hand was contracted (A contracture is a fixed tightening of muscle, tendons, ligaments, or skin. It prevents normal movement of the associated body part). Resident #20 said that the resident had a splint apparatus on their chair, but it was broken, and foot pedals, but they were missing. Resident #20 said that the resident worries about their left hand getting worse and had tried an intervention with a washcloth, but it fell out. Resident #20 showed the Surveyor how the resident performs passive range of motion by using their right hand to open up their left hand.</p> <p>During an observation on 04/02/2024 at 09:50 AM, Resident #20 was up in a wheelchair, using their right foot to hold up their left foot. Resident #20 would stop at intervals and drag the affected left foot. Resident #20 said that the resident gets tired sometimes moving around and sometimes the resident doesn't like to get up because of it. No intervention for the contracted left hand was noted.</p> <p>During an observation on 04/03/2024 at 10:15 AM, Resident #20 was moving around the resident's room with the left foot dragging and no intervention in place for the left hand.</p> <p>During an interview on 04/03/2024 at 10:30 AM, Certified Nursing Assistant (CNA #1) was asked if Resident #20 had any interventions for the affected left foot while in the wheelchair. CNA #1 said he doesn't know why the resident doesn't have a foot pedal. The Surveyor asked what the issue could be for the resident. CNA #1 said that Resident #20 could have break down of the skin from the skin dragging and possible skin tears from it dragging around. The Surveyor asked if the resident had any interventions for left hand or left foot. CNA #1 said I have been here only six months but not that I know of. The Surveyor asked what could be the issue for Resident #20's left hand. CNA #1 said that nails could dig into the skin and cause infection. CNA #1 said that they were going to alert their nurse to the issues.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 04/03/2024 at 03:20 PM, the Surveyor asked Licensed Practical Nurse (LPN) #2 what could happen with Resident #20 being up in a wheelchair and their left foot dragging. LPN #2 said that the foot could get run over. The Surveyor asked what interventions could be put into place to prevent injury. LPN 2 said a foot pedal possibly. The Surveyor asked what the issue could be with no interventions for the contracted left hand? LPN #2 said nails could grow in or the contracture could get worse. The Surveyor asked what interventions could be put into place to prevent worsening of contracture. LPN #2 said that a hand roll or wash cloth could help.</p> <p>A review of a facility policy titled, Assistive Devices and Equipment, dated 04/04/2024, indicated, Our facility maintains and supervises the use of assistive devices and equipment for the resident.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49689</p> <p>According to observation, interview, and record review, the facility failed to ensure food was stored properly, kitchen equipment was maintained properly, and disinfectant was in use for the dishwasher.</p> <p>The findings are:</p> <p>On [DATE] at 11:15 AM, a container containing powdered milk had no date. The Dietary Manager said that it is a 5-gallon bucket.</p> <p>On [DATE] at 11:17 AM, the following observations were made in the walk-in freezer:</p> <ul style="list-style-type: none"> <li>a. Twenty-four 4-ounce bowls of ice cream were on trays on the bottom left shelf with no date.</li> <li>b. Two bags of frozen coconut, one with a date of ,d+[DATE] and the other had no date with frost on the bags. The Dietary Manager said that they were clumpy and hard, possibly frost bitten.</li> <li>c. A plastic 2 pound container of salami was not dated. The Dietary Manager said that the salami was discolored and frost bitten.</li> <li>d. A 2 quart plastic container of lemonade was not dated and expired [DATE].</li> </ul> <p>On [DATE] at 11:27 AM, on the bread rack were flour tortillas with an expiration date of [DATE].</p> <p>On [DATE] at 11:30 AM, the following observations were made in the walk-in refrigerator:</p> <ul style="list-style-type: none"> <li>a. Cabbage Salad Mix three full bags, with an expiration date of [DATE].</li> <li>b. Salad Mix one bag with an expiration date of [DATE].</li> <li>c. Two Lemon Juice 32 fluid ounces, and the other about 16 fluid ounces with an expiration date of [DATE]. The lemon juice was cloudy. The Dietary Manager described them as cloudy and threw them away.</li> <li>d. Six boxes of 2 pie crust with no date and an expiration date of [DATE].</li> </ul> <p>On [DATE] at 11:45 AM, the following observations were made in the deep freezer:</p> <ul style="list-style-type: none"> <li>a. ,d+[DATE] bag of tator tots with no date.</li> <li>b. ,d+[DATE] bag of fries with no date.</li> </ul> <p>During an observation on [DATE] at 11:50 AM, a staff member got ice with the large scoop and then laid the scoop down on the stainless-steel table to the right of the ice machine.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on [DATE] at 11:52 AM, a towel dripping with water was tied around a pipe, with a medium sized gray plastic bin under it. To the right of the pipe was the garbage disposal, the nozzle for the sprayer was leaking continuously. The Dietary Manager stated it was their understand it had been like this for a while and Maintenance was coming to fix it.</p> <p>During an observation on [DATE] at 11:57 AM, the grease in the fryer was cloudy with a thin film of light brown breading. The metal area around the fryer was coated in a layer of light brown breading. The inside of the fryer was coated in a thick layer of yellowish-brown grime. The Dietary Manager said the oil was supposed to be cleaned out every Saturday, but they have been out of oil and just got some in on the truck.</p> <p>During an observation on [DATE] at 11:58 AM, the outer edges of the vent in the left-hand corner above the dishwashing area were discolored.</p> <p>During an observation on [DATE] at 10:01 AM, the Surveyor entered the kitchen and observed the low temp (temperature) dishwasher thermometer was at 130 degrees. The Dietary Manager tested the chemical solution and said it's at 10 ppm (parts per million) and it should be higher. The sanitizing solution was empty. The Dietary Manager said they had another container in the closet but was not sure who was supposed to change out the disinfectant. The dietary employees thought the company did that.</p> <p>On [DATE] at 12:39 PM, the Dietary District Manager provided the Manufacturer guidelines are on the dishwasher. The guidelines noted the Dishwasher Operating Requirements were Water Temperature - 120 degrees Fahrenheit minimum; Chlorine Residual - 50 ppm minimum, Minimum Wash 56 seconds and Rinse 24 seconds.</p> <p>During an interview on [DATE] at 12:40 PM, the Surveyor asked for the temperature/chemical log for the dishwasher. The Dietary Manager said this is the one for March. The surveyor asked about April's log. The Dietary Manager said it was not put out yesterday. I don't have one currently. Then the Dietary Manager stated that as of [DATE]st after dinner the sanitization could have been out. The Dietary District Manager agreed with the statement.</p> <p>During an interview on [DATE] at 02:25 PM, the Surveyor asked the Dietary Manager, Were you in-serviced on dishwasher temperature and chemical test strip usage? The Dietary Manager stated No, I just started two weeks ago. The District Manager said they did it roughly six months ago, but the forms keep disappearing.</p> <p>During an interview on [DATE] at 02:34 PM, the Surveyor asked the Administrator, Do you communicate with the district manager about any issues in the kitchen? The Administrator said yes. The Surveyor asked if she was aware of any issues in the kitchen? The Administrator said there was a little problem with dates and expired food. The Surveyor asked if she was aware of any issues with the dishwasher? The Administrator said no. The Surveyor asked, who was responsible for ensuring maintenance and chemicals be provided on site? The Administrator said she would get an answer for the surveyor. The Surveyor asked, who was allowed to change the chemicals? The Administrator said she would get an answer for the surveyor.</p> <p>During an interview on [DATE] at 02:42 PM, the Surveyor was informed by the Administrator that the Dietary Manager is responsible for ordering the disinfectant and that the dishwashers are responsible for taking temperatures and testing the disinfectant level.</p> <p>(continued on next page)</p>		

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

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on [DATE] at 10:45 AM, there was a puddle of water spanning from under the sink to the end of the steam table. The Surveyor asked the Dietary Manager what it was from. The Dietary Manager said that Maintenance tried to fix that pipe next to the garbage disposal, but it is leaking again.</p> <p>On [DATE] at 11:30 AM, during observation of the food temperatures, Dietary Employee #4 did not clean the thermometer in between the regular chicken strips and the French fries.</p> <p>During an interview on [DATE] at 09:30 AM, the Surveyor asked Maintenance #1 about the ongoing repairs with the pipe next to the garbage disposal. Maintenance #1 said that it has been ongoing for a couple months, and that they have tried different repairs which help for a bit, but then it starts back up again. Maintenance #1 then said this next repair was to replace an inner ring inside the pipe area.</p> <p>On [DATE] at 1:30 PM, an in-service titled, Dietary In-services that indicated it was completed on [DATE] documented, .label and date everything going into refrigerator .make sure dates are checked every day .</p> <p>On [DATE] at 09:18 AM, the Administrator provided a kitchen cleaning list that noted the deep fryer was to be cleaned every 2nd Saturday by the A.M. cook and every 4th Saturday by the P.M. cook.</p> <p>On [DATE] at 9:18 AM, the Administrator provided a document titled, Night Shift Close Down Check Off that detailed, .Fryer is off and check to see if it needs cleaned .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39316</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control measures, including hand hygiene, were implemented during wound care for 1 (Resident #29) of 1 sampled resident; and failed to ensure hand hygiene was performed during meal service to prevent potential infection and or the spread of infections. The findings are:</p> <p>A review of the Medical Diagnosis Record indicated the facility admitted Resident #29 with a diagnosis of Alzheimer's disease.</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #29 had a Staff Assessment for Mental Status (SAMS) score of 3, which indicated the resident was severely impaired for daily decision making. The resident was dependent on staff for activities of daily living (ADL's) and was always incontinent of bowel and bladder; had one stage IV pressure ulcer (Full-thickness skin loss extends through the fascia with considerable tissue loss. There may be muscle, bone, tendon, or joint involvement); and skin and ulcer/injury treatments included: pressure reducing device for chair and application or nonsurgical dressings (with or without topical medications) other than to feet.</p> <p>A review of Resident #29's Physician Orders, for the month of April 2024, revealed an order dated 12/29/2023 documenting, cleanse unstageable pressure ulcer (PU) to right buttock with [name brand of antimicrobial wound cleanser]; pack wound with calcium alginate rope; cover with foam dressing; every day shift for wound healing; and as needed for missing or soiled dressing.</p> <p>Review of Resident #29's Care Plan, revised on 07/17/2023, revealed the resident was at risk for impaired skin integrity and UTI (urinary tract infection) r/t (related to) decreased mobility and bowel and bladder (b/b) incontinence. Interventions included provide pressure reducing cushion to wheelchair; initiated on 07/06/2023. A revision on 04/01/2024 revealed the resident had a one (1) stage four (4) pressure ulcer to the left (L) gluteus (glute) related to (r/t) immobility. Interventions included: administer treatments as ordered and observe for effectiveness.</p> <p>On 04/03/2024 at 11:34 AM, observed Certified Nursing Assistant (CNA) #3 and Licensed Practical Nurse (LPN) #1 washed hands, applied personal protective equipment, including gloves. Resident #29 was lying in bed. CNA #3 was standing on the side of Resident #29's bed near the window. LPN #1 was standing on the side of Resident #29's bed near the door. CNA #3 and LPN #1 pulled Resident #29 blanket/sheets down toward the resident's feet. A pillow was observed under Resident #29's left hip/back. With gloved hands, LPN #1 unfastened Resident #29's brief from the left side and tucked it under the resident. LPN #1 pulled the pillow out from under/behind the resident's left hip/back and placed it on the bedside table near the head of the bed. LPN #1 did not change gloves or perform hand hygiene. Using gloved hands, LPN #1 removed the dirty 4 x 4 bordered foam dressing from the upper mid area of Resident #29's right buttock and placed it in a biohazard bag taped at the end of the bedside table. LPN #1 did not change gloves or perform hand hygiene. Using contaminated gloves, LPN #1 picked up the clean plastic cup containing cleanser soaked gauze pads and removed a gauze pad. LPN#1 placed the clean cup on the bedside table. LPN #1 used the cleanser soaked gauze pad and wiped around the wound and discarded it into a biohazard bag. LPN #1 removed a clean cleanser soaked gauze pad and wiped around the wound and discarded it into a biohazard bag.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/03/2024 at 11:40 AM, observed LPN #1 removed gloves and washed hands. LPN #1 measured Resident #29's wound. LPN #1 changed gloves after measuring Resident #29's wound. LPN #1 used one skin prep and wiped around the wound then discarded. Using a cotton tipped applicator, LPN #1 packed the wound with 5 calcium alginate strips, touching the outer edges of the wound with gloved hands. LPN #1 then disposed of the cup in a biohazard bag. LPN #1 did not change gloves and did not perform hand hygiene.</p> <p>On 04/03/2024 at 11:49 AM, observed LPN #1, with contaminated gloves, remove a dry gauze pad from a plastic cup resting on the bedside table and placed the gauze pad over the calcium alginate packed wound. LPN #1 did not change gloves or perform hand hygiene. LPN #1 then applied a 4 x 4 bordered foam dressing over the wound and secured it. LPN #1 did not change gloves or perform hand hygiene. LPN #1 used one skin prep pad and wiped in a circular motion around the edge of the bordered 4 x 4 foam dressing then discarded it.</p> <p>On 04/03/2024 at 11:57 AM, LPN #1 was asked when gloves should be changed while performing wound care. LPN #1 stated, When dirty, after cleaning the wound you change them, and after I'm done cleaning the wound. LPN #1 was asked why should contaminated gloves be changed before going to a clean area during wound care. LPN #1 stated, To prevent infections.</p> <p>On 04/04/2024 at 08:36 AM, the Director of Nursing (DON) was asked, when are gloves changed during wound care and why? The DON stated, Between clean and dirty and to prevent infection.</p> <p>On 04/04/2024 at 08:39 AM, the Infection Control Preventionist (ICP) was asked, when are gloves changed during wound care and why? The ICP stated, When removing the bandage and putting new gloves on when cleaning, change after cleaning to prevent infection.</p> <p>On 04/01/2024 at 12:45 PM, during the lunch meal a CNA was observed feeding two residents with no hand hygiene between the two. The CNA got up to help a third resident in the dining room who was asking for a drink and the CNA provided an 8 ounce cup to the resident without any hand hygiene.</p> <p>On 04/01/2024 at 12:50 PM, observed two staff members feeding two residents apiece with no hand hygiene in between feeding the residents. One resident asked for sweetener in their tea. The staff member left to go get sweetener and upon returning did not perform hand hygiene. The staff member then added the sweetener to the drink and continued to feed the two residents.</p> <p>On 04/04/2024 at 08:40 AM, the Surveyor asked CNA #5, When feeding two residents or in general when providing meal service what should you do? CNA #5 said, wash hands in between the residents or when switching tasks. The Surveyor asked why that could be an issue. CNA #5 said it could spread germs.</p> <p>On 04/04/2024 at 08:45 AM, the Surveyor asked the Infection Preventionist, When feeding two residents or in general when providing meal service what should you do? The Infection Preventionist stated, Sanitize in between. The Surveyor asked why this could be an issue. The Infection Preventionist stated, Spread germs, infection control.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A facility policy titled, Handwashing/Hand Hygiene, dated August 2019, specified, This facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-amicrobial) and water for the following situations: before handling clean or soiled dressings, gauze pads, etc.; before moving from a contaminated body site during resident care; after contact with blood or bodily fluids; after handling used dressings, contaminated equipment, etc.; after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; after removing gloves. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.</p> <p>49689</p>		