

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER The Springs of Avalon		STREET ADDRESS, CITY, STATE, ZIP CODE 610 South Avalon St West Memphis, AR 72301	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43409</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to initiate a care plan for elopement risk for 1 (Resident #3) of 1 resident reviewed for high risk elopement.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Wandering and Elopements, dated 03/01/2019, indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #3 on 07/08/2022, with a principal diagnosis of unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/07/2024, revealed Resident #3 had a Brief Interview for Mental Status score of 15 which indicated the resident was cognitively intact.</p> <p>A review of Resident #3's Care Plan, initiated 07/08/2022, did not address the high risk for elopement.</p> <p>A review of Resident #3's Admission assessment dated [DATE], indicated in Section 13 - Safety, that Resident #3 was at a high risk for elopement with a score of 8.</p> <p>During an interview on 05/21/2024 at 9:31 AM, the Director of Nursing (DON) confirmed the criteria for placement on the secure unit is when a resident scores greater than 1 on the elopement risk assessment, then resident is placed on the secure unit.</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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43409</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure adequate supervision was provided to prevent elopement for 1 (Resident #1) of 3 residents reviewed for elopement.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Wandering and Elopements, dated 03/01/2019, indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents .3. If a resident is missing, initiate the elopement/missing resident emergency procedure .b. If the resident was not authorized to leave, initiate a search of the building and premises; and if the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and volunteer agencies .</p> <p>A review of the Admission Record, indicated the facility admitted Resident #1 with diagnoses that included auditory hallucinations, alcohol abuse, cocaine abuse, age-related cognitive decline.</p> <p>The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/09/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment and did not exhibit any wandering behaviors.</p> <p>A review of Resident #1's Care Plan, revised on 05/15/2024, revealed Resident #1 was an elopement risk/wanderer related to cognitive decline, history of attempts to leave facility unattended and impaired safety awareness and drug seeking. Interventions included distracting Resident #1 from wandering by offering pleasant diversions, structured activities, food, conversations, television, book and be evaluated for placement on a secure unit, if indicated.</p> <p>A review of a Progress Note dated 04/12/2024, revealed Resident #1 was cursing at staff when the resident was asked to step away from the double doors trying to get off the unit.</p> <p>A review of a Progress Note dated 04/12/2024, revealed Resident #1 was observed by staff going in and out of all the rooms trying to raise the windows to get out. Redirected resident but he continues with this behavior.</p> <p>A review of a Progress Note dated 05/16/2024, revealed Resident #1 had been found in a resident's room trying to crawl out of the window.</p> <p>A review of a Progress Note dated 05/16/2024 revealed Resident #1 was continuing to get out of the doors and windows and an order was obtained for Ativan and medication was administered.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 05/20/2024 at 10:42 AM, Certified Nursing Assistant (CNA) #1 confirmed picking up Resident #1 on 05/14/2024 around 6:20 PM on the side of the street near the old library, approximately 1 mile away from the facility. CNA #1 confirmed Resident #1 was confused but not injured. CNA #1 confirmed contacting the Administrator regarding Resident #1 being on the side of the street and not at the facility.</p> <p>During an interview on 05/20/2024 at 11:39 AM, the Director of Nursing (DON) confirmed Resident #1 was able to get out of the secure unit and out of the building and go approximately 1 mile from the facility. The DON confirmed CNA #1 brought Resident #1 back to the facility.</p> <p>During an interview on 05/20/2024 at 11:53 AM, the Administrator confirmed Resident #1 was found approximately 1 mile from the facility by an employee that was off work. The Administrator confirmed when Resident #1 returned to the facility the resident was assessed and a root cause analysis was conducted.</p> <p>During an interview on 05/20/2024 at 1:27 PM, the Administrator confirmed Resident #1 was unaccounted for approximately 30 to 45 minutes.</p> <p>During an interview on 05/20/2024 at 2:25 PM, Resident #1 confirmed he walked out of the door because they don't pay attention. Resident #1 pointed to the wooden double doors which exit the secure unit. Resident #1 then stated he used a black chair to climb out the window by the television.</p> <p>During an interview on 05/21/2024 at 10:48 AM, the Administrator confirmed the facility completed head count of everyone, assessed all doors, assessed resident, verbally asked all staff members about residents, started interview process, and made sure everyone was safe and in the building.</p>		