STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045217	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Avalon	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49689 Based on observations, interviews, and record review the facility failed to provide a smoking apron for 3 (Resident #44, Resident #6, Resident #45) of 4 residents on the secured unit who smoked. The findings are: A review of the facility policy Smoking Policy-Resident with a revision date of July 2024, indicated 7. The staff shall consult with the attending physician and the director of nursing services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 8. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. 9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring g) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 1. A review of an Order Summary indicated the facility admitted Resident #6 with diagnoses that included dementia, type 2 diabetes, and chronic obstructive pulmonary disorder. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) on 01/11/2025 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) of 12, indicating moderate cognitive impairment. A review of Resident #6's Care Plan initiated on 11/28/2023, stated that Resident requires smoking apron while smoking. A review of the Quarterly Smoking Safety Screen revealed that Resident #6 was marked under section 7 for adaptive equipment, 7a was marked for smoking apron. 2. A review of an Order Summary indicated the facility admitted Resident #44 with diagnoses that included chronic obstructive pulmonary disorder, anxiety disorder, and depression. The admission MDS, with an ARD of 1/20/2025, revealed Resident #44 had a BIMS of 00 which indicated severe cognitive impairment. A review of Resident #44's Care Plan initiated on 01/23/2025, indicates that Resident requires supervision with smoking. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Smoking Safety Screen indicated that Resident #44 under section 7 need for adaptive equipment, 7a was marked for smoking apron. 3. A review of an Order Summary indicated the facility admitted Resident #45 with diagnoses that included anxiety disorder, dementia, and depression. The annual MDS with an ARD of 12/12/2024, revealed that Resident #45 had a BIMS of 15, which indicated cognitively intact. A review of Resident #45's Care Plan initiated on 7/10/2023 indicated that The resident needs a smoking apron while smoking. A review of the Quarterly Smoking Safety Screen indicated that Resident #45 under section 7: need for adaptive equipment; 7a was marked for smoking apron. 4. On 02/26/2025 at 10:00 AM, this surveyor observed Licensed Practical Nurse (LPN) #19 unlock the courtyard door on the secure unit for smoke break. Certified Nursing Assistant (CNA) #18 assisted four residents outside. This surveyor observed CNA #18 light cigarettes for each resident and supervise the residents while smoking. This surveyor also observed that Resident #6, Resident #44, and Resident #45 were not wearing smoking aprons while smoking. 5. During an interview on 02/26/2025 at 12:46 PM, CNA #18 stated they were familiar with the residents on 500 Hall (The secure unit in the facility where Residents #6, #44, and #45 resided). CNA #18 stated that the procedure for smoke breaks was that they go get the cigarettes, then wait for the nurse to let them out. Then they light cigarettes for the residents and ensure that everyone is in view for safety. CNA #18 stated that they use a red trash can, and a fire extinguisher was close by. CNA #18 stated they were not aware of any residents on the secure unit that need a smoking apron. CNA #18 then stated that on the halls, the smoking lockbox had a running list of residents who wear smoking aprons and that each one was labelled for the resident that needs it during break. CNA #18 stated that they were not aware that three of the four residents were supposed to wear smoking aprons on the secure unit, and without it they could get burned or hurt while smoking. 6. During an interview on 02/26/2025 at 1:15 PM, LPN #19 stated the procedure on the hallway was to have a list of residents that wore smoking aprons posted on the smoking lockbox, and to have individual smoking apron labeled with the resident ' s name. LPN #19 stated they were not aware of any residents on the secure unit that needed a smoking apron because there was not a list posted, or a smoking apron labeled for residents' use. 7. During an interview on 02/26/2025 at 1:30 PM, the Director of Nursing (DON) stated the facility ' s procedure was to label smoking aprons and to keep an updated list to make staff aware of who needed one. The DON then stated it was important to use smoking aprons to prevent burns because it was really necessary for resident safety.

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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 0761 Level of Harm - Minimal harm or potential for actual harm 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. 51477 Based on observation, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure over the counter medications in medication cart #1 were not expired. The findings include: Review of a facility policy titled, Storage of Medications, revised November 2024, indicated Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Schedule II-V controlled medications are stored in separately locked, permanently affixed compartments. Access to controlled medication is separate from access to non-controlled medications. During an interview on 02/25/2025 at 2:26 PM, the DON revealed that the facility had a book and garbage can that medications were placed in, within the medication room, for destruction of over-the-counter medication. On 02/25/25 at 3:05 PM, this surveyor observed Licensed Practical Nurse (LPN) #16 during inspection of medication cart #1, which revealed 16 medications that were expired or did not have an expiration date. Medications found that were out of date were Fish oil (no expiration date), Vitamin E 180mg (no expiration date), Bisacodyl laxative 5mg (expired 9/2024), Aspercreme (Pain reliever cream) (expired 4/2024), Preparation-H (hemorrhoidal) cream (expired 1/2025), Spiriva Respimat inhalers (nine expired 11/2024 and two expired 05/2024). During an interview with LPN #16 on 02/25/25 at 3:05 PM, she confirmed it was not appropriate to have expired medication on the medication cart. Normally we discard them. Expired medications can make residents sick. During an interview with the Assistant Director of Nursing (ADON) on 02/05/2025 at 11:37 AM, she confirmed that she handled the process of discarding expired medication. She confirmed that any expired medications, discontinued medications, or over the counter (OTC) medications from the medication carts were pulled from the carts, taken to the medication room and the pharmacist destroyed them. She confirmed the pharmacist did a match back from the medication destruction book and the medication card and then destroyed them. She confirmed if a narcotic had expired or the resident had discharged , the medication was removed, double signed in the narcotic book and removed from the medication cart. She completed a form and put the resident's name on the form along with the dosage, strength, prescriber, and how much medication was left for surrendering. She revealed two people placed the medications along with the form in a box and sent them back to the state for destruction. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DON on 02/27/25 at 2:32 PM, she confirmed medication carts were to be checked weekly for expired medication and expired medication should be removed. The process was to have reconciliation and book in place, place the number of the medication in the book, and place medications in a bag in the locked container. The DON stated the expired medications could cause side effects and harm to residents. During an interview with the Administrator on 02/27/25 at 2:34 PM, she confirmed that expired medication should be thrown away. The Administrator stated a possible outcome from expired medication could be less potent and they [residents] would not get the dose they needed. A review of the, Material Data-Aspercreme, revised 08/14/2014 revealed, Dispose in accordance with all local, state, and federal regulations. A review of the Material Data-Bisacodyl, revised 02/22/2025 revealed, The material can be disposed of by removal to a licensed chemical destruction plant or by controlled incineration with flue gas scrubbing. Do not contaminate water, foodstuffs, feed or seed by storage or disposal. Do not discharge to sewer systems. Dispose of content/container to an appropriate treatment and disposal facility in accordance with applicable law and regulations, and product characteristics at time of disposal. A review of the Material Data-Fish Oil, revised 07/15/2019 revealed, The material can be disposed of by removal to a licensed chemical destruction plant or by controlled incineration with flue gas scrubbing. Do not contaminate water, foodstuffs, feed or seed by storage or disposal. Do not discharge to sewer systems. A review of the Material Data-Preparation H, revised 12/15/2008 revealed, Dispose of in accordance with local and national regulations. A review of the Material Data-Spiriva Respimat, revised 01/2025 revealed, After assembly, the Spiriva Respimat inhaler should be discarded at the latest 3 months after first use or when the locking mechanism is engaged, whichever comes first. A review of the Material Data-Vitamin E, revised 10/28/2024 revealed, The material can be disposed of by removal to a licensed chemical destruction plant or by controlled incineration with flue gas scrubbing. Do not contaminate water, foodstuffs, feed or seed by storage or disposal. Do not discharge to sewer systems. Dispose of content/container to an appropriate treatment and disposal facility in accordance with applicable law and regulations, and product characteristics at time of disposal.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review, and interview, and facility policy review, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed. The findings are: 1. On 02/25/25, the supper meal menu revealed the residents who received pureed diets were to receive 1/2 cup of hashbrowns and 2 ounces of country gravy and residents who received regular diets were to receive 2 sausage patties. 2. On 2/25/25 at 5:03 PM, Dietary [NAME] (DC) #5 served 2 sausage patties to 10 residents who received large portion diets and gave one sausage patty to 41 residents who received regular diets, instead of giving 2 sausage patties to all residents. On 2/26/25 at 2:00 PM, DC #5 was interviewed and was asked which residents received 2 sausage patties. DC #5 stated it was the residents on large portion diets. When asked if she had reviewed the menu, DC #5 stated she had not. 3. On 2/25/25 at 5:10 PM, DC #5 used a # 10 scoop (3/8) cup to serve a single portion of pureed hashbrown to the residents on pureed diets, instead of 1/2 cup. There was no gravy served to the residents on pureed diets. On 2/26/25 at 2:00 PM, DC #5 was interviewed and was asked the reason gravy was not served to the residents on pureed diets. DC #5 stated she forgot. 4. On 2/26/25, the noon meal menu documented the residents who received pureed diets were to receive pureed chocolate cake. 5. On 02/26/25 at 12:35 PM, yellow cake was pureed and served to the residents on pureed diets, instead of chocolate cake. At 2:35 PM, during an interview, Dietary Aide (DA) #6 was asked the reason the residents on pureed diets were served yellow cake, instead of chocolate. DA #6 stated there was not enough chocolate cake to go around. We usually make 1 chocolate bag. When we used 2 bags yesterday it overflowed the pan. 6. A review of facility policy titled, Food and Nutrition Services, initiated 2017, provided by the Administrator on 2/27/25 indicated Food and Nutrition Services staff should inspect food trays and make sure the correct meal was provided to each resident. 7. A review of facility policy titled, Food and Nutrition Services Quick Recourse Tool, initiated 9/1/2021, provided by the Administrator on 2/27/25 indicated, Menus should be served as written, unless a substitution was provided in response to preference.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, facility document review, and interview, the facility failed to ensure pureed food items were blended to a smooth, lump free consistency to minimize the risk of choking or other complications for those residents who required pureed diets for 1 of 1 meal observed. The findings are: 1. On 2/25/25 5:46 PM, the following observations were made during the supper meal service: a. Residents on pureed diets were served pureed hashbrown. The consistency was lumpy, thick, and not smooth. There were still pieces of potatoes in the mixture. b. Pureed sausage. The consistency was lumpy, thick, and not smooth. There were pieces of sausage visible in the mixture. c. Pureed beets. The consistency was lumpy and not smooth. The were chunks of beets still in the mixture. 2. On 2/25/25 at 5:49 PM, Licensed Practical Nurse /[NAME] Data Set Coordinator (LPN) #7, during an interview, was asked if she could describe the consistency of the pureed food items served to the residents on pureed diets in the dining room. Pureed beets had chunks of beets in it. Pureed hashbrowns were lumpy and not smooth. Pureed sausage was thick and had pieces of meat in it. She further stated that pureed foods should be smooth like pudding and not contain lumps. 3. On 2/25/25 at 5:51 PM, during an interview with Certified Nursing Assistant (CNA) #8, she was asked if she could describe the consistency of the pureed food items served to the residents on pureed diets. She stated they were all thick and were not ground enough, that they should be a smooth consistency like pudding. 4. On 2/25/2025 at 5:52 PM, during an interview, CNA #9 was asked what the consistency of pureed food should be. She stated it should be pudding-like. 5. On 2/25/25 at 5:53 PM, during an interview with LPN #10 she was asked if she could describe the consistency of the pureed food items served to the residents for supper meal and she stated they were too thick, and the beets and sausage looked like they were not ground all the way. 6. On 2/25/25 at 6:45 PM, Dietary [NAME] (DC) #5 was interviewed and asked if she could describe the consistency of the pureed food items served to the residents for supper meal. DC #5 stated the consistencies were too thick and had solid pieces of food. They should be smooth like mashed potatoes and stated she should have used more water. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. On 2/25/25 at 6:47 PM, Dietary Manager (DM) #1, during an interview, was asked if she could describe the consistency of the pureed food given to the residents at the supper meal. She stated the beets and sausage were hard to puree, and pieces of beets and sausage were present intact. Ideally pureed should be smooth like mashed potatoes. 8. On 2/26/25 at 8:10 AM, the oatmeal served to the residents for breakfast was too thick. At 8:42 AM, during an interview with DC #5, when asked about the consistency of the oatmeal she stated that it was too thick, and she should have used more water. DM #1 confirmed the oatmeal was too thick. 9. On 2/26/25 at 8:15 AM, CNA #14 was interviewed and asked if she could describe the consistency of the oatmeal served to the residents for breakfast meal. She stated it was too thick. 10. On 2/26/25 at 8:16 AM, CNA #15 was interviewed and was asked if she could describe the consistency of the oatmeal served to the residents for breakfast meal. She stated it was dry. 11. On 2/26/25 at 8:18 AM, LPN #10 was interviewed and was asked if she could describe the consistency of the oatmeal served to the residents for breakfast meal. She stated it was too thick. 12. A review of facility Menu titled, The Springs -Week 3, initiated 9/26/2024 provided by the Dietary Manager #1 on 2/26/2025 indicated, Pureed diets should be pudding consistency and serving size listed on the menu.

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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 Surveyor: [NAME], [NAME] Based on observation, interview, and facility policy review, the facility failed to ensure ceiling tiles, dish washing machine, and door frames were free of stains, rotten and chipped wood; cold food items were maintained at 41 degrees Fahrenheit or below; dietary staff washed their hands before handling food items; foods stored in the dry storage area, refrigerator, and freezer were covered, sealed and dated; and expired food items were promptly removed from stock for 2 of 2 meals observed. The findings are: 1. On [DATE] at 10:40 AM, the following observations were made in the dry storage area: a. An opened 25-pound bag of fish breading spilled over onto the shelf, and onto the top of a 50-pound bag of sweetened cornbread mix. Dietary Manager #1confirmed that the bag was not sealed well. Dietary Manager #1 stated that items should be sealed well to prevent cross-contamination. b. Half of a 10 pound bag of penne noodles at the bottom shelf was partially sealed, exposing it to air. Dietary Manager #1 confirmed findings. c. A gallon of vinegar was on the shelf which expired on [DATE]. Dietary Manager #1 confirmed findings. d. The ceiling in the dry storage area had ceiling tiles with brown rings; all tiles looked affected. The light was dim in the storage area. The small room that held the emergency food supply before the dry storage area had ceiling tiles with brown rings and some of the tiles appeared to be bowing. 2. On [DATE] at 10:50 AM, the following were found in the three-door refrigerator: a. Two cardboard boxes of bacon were located on the second shelf, instead of the bottom. Dietary Manager #1 stated that uncooked items like bacon should be stored on the bottom to prevent dripping and any cross contamination with other food items. b. A clear bag containing 2 ,d+[DATE] blocks of cheese had no date. 3. On [DATE] at 4:38 PM, the temperatures of the cold food items in a pan of ice on the steam table when checked and read by Dietary [NAME] (DC) #5 were: a. Pureed beets were 78 degrees Fahrenheit. The consistency was lumpy and not smooth. There were chunks of beets still in the mixture. b. Regular beets were 67 degrees Fahrenheit. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On [DATE] at 4:42 PM, DC #5 dropped the temperature gauge on the floor and picked it up. Then, DC #5 turned on the faucet and rinsed off the temperature probe. After rinsing it, she turned off the faucet with her bare hand, contaminating it. Afterwards, DC #5 removed an alcohol pad from its packet, and used it to sanitize the temperature probe before checking the food temperatures. 5. [DATE] at 5:14 PM, Dietary Aide (DA) #4 who was on the tray line assisting with the supper meal service picked up condiments and spices and placed them on the trays. Without washing her hands, DA #4 picked up glasses that contained beverages by their rims and placed them on the trays. DA #4 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment. She stated she should have washed her hands. 6. On [DATE] at 5:15 PM, DA #4 was interviewed and was asked what was in the bowl that she was about to place on the tray. She stated it was yogurt. Dietary Manager #2 was asked if she could check the temperature of the yogurt. She did and stated it was 78 degrees Fahrenheit. 7. On [DATE] at 9:07 AM, upon observation of the dry food storage room with Dietary Manager#1 the following items were found: a. A 25-pound bag of flour was observed to be expired with best by date [DATE], unopened and was received [DATE]. b. A bag of sweet cornbread mix on a shelf in the storage room was torn exposing the cornbread mix to air. Dietary Manager #1stated that the cornbread mix was exposed, and she would toss it. 8. A review of facility policy titled, Hand washing /hand hygiene, initiated 2024, provided by the Dietary Manager #1 on ,d+[DATE], indicated, employees should wash their hands before and after coming on duty.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50682 Based on observation, record review, and interview, it is determined that the facility failed to ensure a resident who was on Transmission Based Precaution had a contact isolation sign in a conspicuous location outside the resident ' s room to alert and instruct staff and visitors to wear personal protective equipment (PPE) while entering the room for 1(Resident #4) of 1 sample mix resident reviewed for Transmission Based Precautions. The findings are: Review of facility policy titled Isolation - Categories of Transmission-Based Precautions dated 08/01/2024, indicated Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents and Transmission-based precautions are additional measures that protect staff, visitors and other residents from becoming infected. These measures are determined by the specific pathogen and how it is spread from person to person. The three types of transmission-based precautions are contact, droplet and airborne. The policy also indicated When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. b. Signs and notifications comply with the resident's right to confidentiality or privacy. c. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. A review of an Admission Record indicated the facility admitted Resident #4 with diagnoses that included pressure ulcers and resistance to vancomycin (VRE). The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/13/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) of 00, which indicated the resident was severely cognitively impaired. Review of Resident #4's Care Plan initiated on 02/19/2025, revealed the resident required isolation precautions to include Contact isolation for VRE in their wounds. Review of Resident #4's Order Summary Report dated 02/17/2025, specified contact isolation for VRE wound infection for 10 days. On 02/24/2025 at 10:45AM there was a sign on Resident #4's door that read see nurse before entering. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/24/2025 at 11:00 AM, the surveyor observed CNA #12 enter Resident #4's room without wearing a gown. On 02/24/2025 at 2:30PM there was a sign on Resident #4's door that read see nurse before entering. An observation on 02/25/2025 at 8:30 AM, revealed a sign on Resident #4's door that read see nurse before entering. On 02/25/2025 at 11:10AM, during interview with Registered Nurse (RN) #13 she stated Resident #4 was in isolation, but she was not sure why. During an interview, on 02/25/2025 at 11:30AM, Licensed Practical Nurse (LPN) #7 stated Resident #4 should have a sign on the door that read Contact Isolation. See nurse before entering. She stated the reason was to alert staff and visitors to wear a gown and gloves before entering the room to prevent the spread of infections. During an interview with CNA #12, on 02/25/2025 at 12:00PM, she stated that she was not aware that Resident #4 was on Contact Isolation. The Director of Nursing (DON) was interviewed on 02/26/2025 and stated that Resident #4 should have a sign on the door informing staff and visitors that the resident was on contact isolation due to contact isolation requiring a gown and gloves to be worn prior to entering the room.