STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045254	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Springs Health and Rehab of Hot Springs	1208 North Highway 7 Hot Springs, AR 71909

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. 50505 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to assess for, obtain physician's order for, and care plan for self-administration of medications for 2 (Resident #41 and Resident #73) of 2 residents reviewed for self-administration of medications. Findings include: 1. A review of a facility policy titled, Medication, Self-Administration of Policy and Procedure, provided 08/15/2024 indicated, the purpose is to provide patient with right to self-administer medication when deemed safe and In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. 2. Review of the Admission Record indicated the facility admitted Resident #73 on 08/31/2023 with diagnoses that included dementia, age-related physical debility, and glaucoma. a. The signification change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/29/2024, revealed Resident #73 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. b. A review of Resident #73's Care Plan, initiated on 05/20/2024, revealed the resident has a terminal prognosis related to Alzheimer's disease and has was admitted to hospice. Interventions included: observe patient closely for signs of pain, administer pain medications as ordered, and notify physician immediately if there is breakthrough pain and work with nursing staff to provide maximum comfort for the resident. No care plan was located to indicate self-administration of medication. c. An Order Summary Report that listed orders active as of 08/15/2024 revealed Resident #73 did not have an order for any type of eye medication/drops and had no order to self-administer medications. d. A review of the Assessments portion of Resident #73's electronic health records revealed that no self-administration of medications assessment was completed. e. During an observation on 08/12/2024 at 10:05 AM, a bottle of artificial tears was noted on the nightstand beside Resident #73's bed. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. During an observation on 08/13/2024 at 8:04 AM, a bottle of artificial tears was noted on top of the nightstand beside Resident #73's bed. g. During an interview on 08/13/24 at 8:26 AM, Medication Assistant Certified (MA-C) #4 confirmed there was a bottle of artificial tears that was on the nightstand of Resident #73. MA-C #4 picked up the bottle of artificial tears and reported that the resident's family member brought the medication into the facility and leaves the medication at bedside. MA-C #4 then confirmed that the back of the bottle stated, Keep out of reach of children. 2. A review of the Admission Record indicated the facility admitted Resident #41 on 07/29/2024 with diagnoses that included vascular dementia with agitation, chronic obstructive pulmonary disease and allergic rhinitis. a. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/01/2024, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident is cognitively intact. b. A review of Resident #41's Care Plan, initiated 08/05/2024, revealed the resident has a behavior problem: refuses medication. Intervention included explaining all procedures to the resident before starting and allowing the resident to adjust to changes. No care plan was located to indicate self-administration of medication. c. An Order Summary Report that listed orders active as of 08/14/2024 revealed Resident #41 had orders for ipratropium/albuterol inhaler 20-100 microgram/actuation (mcg/ACT) one puff orally two times a day and fluticasone propionate nasal suspension 50 mcg/ACT two sprays in both nostrils two times a day. d. A review of the Assessments portion of Resident #41's electronic health records revealed that no self-administration of medications assessment was completed. e. During an observation on 08/14/2024 at 7:31 AM, Medication Assistant-Certified #4 (MA-C), went into Resident #41's room to administer medications. The ipratropium/albuterol inhaler and fluticasone propionate nasal suspension were sitting on the bedside table in front of the resident. Once pill form medications were administered, Resident #41 picked up the fluticasone propionate nasal suspension and inserted into right nostril and squirted spray two times without waiting between sprays, then moved to left nostril and squirted spray two times without waiting between sprays. Resident #41 placed the cap on the fluticasone and then picked up the ipratropium/albuterol inhaler. One puff was administered by the resident with no issues. Resident #41 then put the inhaler back in her mouth and took a second puff. f. During an interview on 08/14/2024 at 7:35 AM, MA-C #4 confirmed that Resident #41 did administer inhaler and spray and that no instructions were given to the resident prior to resident self-administering the medication. g. During an interview on 08/14/2024 at 12:00 PM, the Assistant Director of Nursing (ADON) confirmed before a resident self-administers medications, the physician must evaluate and give orders, an assessment must be completed, and the resident is care planned for self-administration of medications.

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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. 48977 Based on observations and interviews, the facility failed to ensure an unattended medication cart was not left unlocked and keys unattended. The findings include: On 08/15/24 at 9:35 AM, the Surveyor observed an unattended medication cart in the hallway on the secured unit unlocked with the keys in the lock. On 08/15/24 at 9:41 AM, Licensed Practical Nurse (LPN) #9 confirmed the unattended medication cart was unlocked with keys inside lock. LPN #9 stated anyone could have gotten anything, any of the drugs or narcotics, and a resident could get a medication that could harm or kill them. On 08/15/24 at 10:54 AM, the Administrator confirmed an unattended medication cart should not be unlocked with the keys in the lock. The Administrator stated there was access to the medications, the residents can take the medications, and/or harm themselves. On 08/15/24 at 12:22 PM, the Surveyor was informed there was not a policy on accidents and hazards.

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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** 49413 Through observation, interview, and policy review, the facility failed to ensure food brought in for residents was properly labeled, food items received had both open and expiration dates, and food serving items were properly stored. The findings are as follows: 1. On [DATE] at 5:46 AM, three drink pitchers were laying on their side with the opening not properly covered to prevent foreign substances from entering the pitchers used for resident's drinks. 2. On [DATE] at 5:47 AM, four cups were laying on their side with the opening not properly stored to prevent foreign substances from entering the cups used for resident's drinks. 3.On [DATE] at 5:51 AM, four food dome covers were sitting on the counter, by the serving window, with the inside facing the ceiling, not covered. 4. On [DATE] at 5:57 AM, a container with pureed breadcrumbs was not completely sealed. 5. On [DATE] at 7:29 AM, the nourishment room refrigerator contained the following items: a. one plastic bag that contained one open bottle of thousand island dressing, one open bag of yellow cheese squares, one open bag of ham circles, one unopened bag of imitation crab meat, and one bag of [brand] string cheese sticks without residents' name, date of purchase, or and open date b. One 2-quart 100% vegetable juice did not have a resident's name or open date on the container. c. One 8-ounce medium cheddar shredded cheese without a resident's name or a received date. d. The Dietetic Technician inferred the refrigerator was for resident use only, and the residents name should have been on the items. 6. On [DATE] at 7:44 AM, one brownie mix package had an expiration date of [DATE]. The Dietetic Technician confirmed the product had expired and needed to be thrown away. 7. On [DATE] at 7:50 AM five 14.75 ounce cans of classic pink salmon did not have a received date. The Dietetic Technician confirmed the product was missed when the other cans had been dated. 8. On [DATE], Dietetic Technician confirmed the pureed breadcrumbs were not completely sealed. Dietetic Technician then properly sealed the container without stating why the container should have been properly covered. 9. On [DATE], a document titled Storage of Resident Food: Policy and Procedure (undated) showed, Family and resident will be encouraged to date items (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On [DATE] at 3:10 PM, a Food Storage Areas Policy and Procedure (undated) showed, Refrigerated and frozen foods are dated upon delivery. Canned goods should be dated. 11. On [DATE] at 9:40 AM, the Dietetic Technician stated that something could get in the opened pureed bread container. 12. On [DATE] at 11:00 AM, a Handling Clean Equipment and Utensils Policy and Procedure (undated) showed, Clean equipment will be stored in a clean, dry location in a way that protects them from splashes, dust, or other contamination. Glasses and cups will be stored on a clean sanitary surface.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50505 Based on observations, interviews, record review, facility document review, and facility policy review, the facility failed to ensure hand hygiene was performed during medication administration, failed to ensure drinking cups did not become contaminated while preparing for medication administration, and failed to follow procedures for Enhanced Barrier Precautions for a resident with a feeding tube for 2 (Resident #92 and Resident #67) of 2 residents reviewed for infection prevention and control and hand hygiene; and failed to provide proper storage for oxygen tubing and updraft tubing and apparatus at bedside for 1 (Resident #7) of 1 reviewed for infection prevention and control measures. Findings include: A review of an undated facility policy titled, Hand Hygiene Policy and Procedure, supplied 08/14/2024, indicated the process and purpose was to cleanse the hands between resident direct contact and to prevent spread of infection. 1(e) before and after entering isolation precaution settings. 1(j) before and after handling peripheral vascular catheters and other invasive devices. A review of an undated facility policy titled, Isolation Policy and Procedure supplied 08/15/2024 indicated that the purpose was to prevent the spread of infection. To be utilized on all residents in isolation: a) isolation and precaution categories include a) Isolation and Precaution Categories include: (i)Enhanced Barrier Precautions (EBP). Enhanced Barrier Precautions (EBP): 1. EBP precautions are utilized for residents that have wounds and/or indwelling medical devices (central line, catheter, feeding tube, tracheostomy) and has a multi-drug resistant organism. An undated facility policy titled, Oxygen Administration Policy and Procedure supplied 08/15/2024 offered no relevant information in regard to how oxygen tubing and updraft tubing and apparatus should be stored at bedside. A review of the Admission Record, indicated the facility admitted Resident #7 with diagnoses of chronic obstructive pulmonary disease and atherosclerotic heart disease of native coronary artery without chest pain. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/01/2024 revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident has moderate cognitive impairment. Resident was not marked as having oxygen in special treatments, procedures, and programs. A review of Resident #7's Care Plan, initiated on 09/28/2022, revealed that Resident#7 has 1) altered respiratory status/difficulty breathing related to chronic obstructive pulmonary disease with shortness of breath. Interventions include oxygen per medical doctor's orders and administer medication/puffers as ordered. Monitor for effectiveness and side effects. 2) Resident #7 has oxygen therapy related to chronic obstructive pulmonary disease. Interventions include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitor/document side effects and effectiveness and give medications as ordered by physician. 3) Resident #7 has a behavior problem-at times resident takes her oxygen bag and puts trash in it and throws it away. Intervention includes: if reasonable, discuss the resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. A review of Order Summary Report, revealed Resident #7 has the following orders: 1) change oxygen tubing, humidifier water (if applicable), bag and date every Wednesday night shift for oxygen use. 2) Change updraft mask and tubing weekly, bag and date every Wednesday night shift for updraft use. 3) Oxygen at two liters per minute via nasal cannula as needed for shortness of breath. During an observation on 08/12/24 at 10:19 AM, Resident # 7 was lying in bed. Oxygen was being administered via nasal cannula at 2 liters per minute. No date seen on tubing. No humidifier bottle. The updraft machine at bedside had the tubing and apparatus (mask) lying on the nightstand without proper storage. During an observation on 08/13/24 at 8:39 AM, Resident # 7's oxygen concentrator was not in use and the oxygen tubing was draped across the nightstand and concentrator without proper storage. The updraft mask was lying on top of the nightstand without proper storage. During an interview on 08/13/24 at 8:45 AM, Certified Nursing Assistant #7 confirmed the tubing for the updraft machine and the oxygen tubing was not properly stored. During an interview on 08/13/24 at 8:50 AM Licensed Practical Nurse (LPN) #8 confirmed the oxygen tubing was lying across the nightstand and not being properly stored. LPN #8 confirmed the updraft tubing was not properly stored. When LPN #8 was asked what the importance was of keeping them properly stored, she stated, To keep from giving them more germs. During an interview on 08/15/24 at 12:00 PM, the Assistant Director of Nursing stated, Oxygen and updraft tubing should be in plastic bags with their names and date on them. They should not be left out lying around. A review of the Admission Record, indicated the facility admitted Resident #67 with diagnoses of schizophrenia and dysphagia (difficulty swallowing). The quarterly MDS, with an ARD of 06/04/2024 revealed Resident #67 had a BIMS score of 6, which indicated the resident had severe cognitive impairment. During an observation on 08/14/2024 at 8:00 AM, LPN #3 was at a medication cart. LPN#3 removed gloves from prior medication administration and without sanitizing hands picked up two plastic drinking cups which were stuck together. LPN #3, with fingers inside the cup, separated the two plastic cups and placed the one the fingers had been inside of on top of the medication cart and filled the cup with water. Medications were then prepared for Resident #67. Medications were then delivered to the resident, and Resident #67 consumed the water inside the drinking cup. LPN #3 confirmed that cups were pulled apart with fingers being placed inside of the cups. Confirmation was given by LPN #3 that gloves were removed and hands were not sanitized before medication administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record, indicated the facility admitted Resident #92 with diagnoses that included: encounter for attention to gastrostomy, dysphagia, pharyngeal phase, and moderate protein-calorie malnutrition. The quarterly Minimum Data Set (MDS), with an ARD of 07/18/2024, revealed Resident #92 had BIMS score of 13 which indicated the resident is cognitively intact and Nutritional Approaches marked as feeding tube while a resident. A review of Resident #92's Care Plan, initiated on 04/15/2024, revealed the resident requires tube feeding related to dysphagia due to osteophyte protrusion and moderate protein-calorie malnutrition. Interventions included all medications may be given simultaneously through feeding tube, flush feeding tube per facility protocol before and after medication administration. A review of Order Summary Report revealed Resident #92 had an order for nothing by mouth and tube feeding formula 1.5 at 70 cubic centimeter (cc)/hour via pump continuously with water flushes of 35 milliliters (ml)/hour. May disconnect as needed for activities of daily living, medications, and flushes. May mix medication with up to 60 ml of water prior to medication administration. Flush feeding tube with 60 ml of water before and after medication administration. During an observation on 08/14/2024 at 3:30 PM, LPN #3 did not sanitize hands prior to medications being set up for administration to Resident #92. After medications were placed in plastic medication cup, without sanitizing hands, placed medications in a pill crushing pouch and crushed the medications. The medications were then placed in a plastic drinking cup. After placing stethoscope and a pair of gloves in scrub pocket, LPN #3 entered Resident #92's room. LPN #3 did not put on a gown or gloves prior to entering the resident's room. After entering, LPN #3 went into the bathroom to obtain tap water from the sink, returned to the bedside of Resident #92 and placed the water and medication glass on the bedside table. LPN #3 left the bedside and went back to the medication cart, outside of the resident's room door and picked up a plastic spoon, applied gloves, added water to the medication glass and stirred with the plastic spoon. LPN #3 went over to the resident, explained medications were going to be administered and lifted the covers from the abdominal area to access the feeding tube. LPN #3 adjusted the feeding tube, disconnected the feeding tube and draped the tubing over the feeding pump pole. Using the same gloves without sanitizing hands, removed the stethoscope from scrub pocket, placed a piston syringe in the feeding tube port and auscultated and aspirated feeding tube to verify placement. Once placement was confirmed, the piston syringe was removed from the port, the plunger was removed and then piston syringe was placed back into the port. The feeding tube was flushed with 60 milliliters (ml) of water, medication mixture was added, after medications passed through the feeding tube, tube was flushed with 60 ml of water. LPN #3 reconnected the feeding to the feeding tube, straightened Resident 92's gown, placed trash in trash can, adjusted the covers over the resident, moved the bedside table and wheelchair closer to the bed, removed the gloves, left the room, went to the medication cart and sanitized hands. LPN #3 confirmed hand hygiene and glove changes had not occurred during the process of administering medications through the feeding tube.