STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045275	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of El Dorado	1700 East Short Hillsboro El Dorado, AR 71730

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. 50580 Based on interview, record review, and facility policy review, it was determined the facility failed to notify the resident, and/or the resident's representative, in writing and provide written information regarding the facility's bed-hold policy when a resident was transferred to the hospital for three (Residents #40, #61, and #45) of four sampled residents, reviewed for hospitalization . 1. Review of Resident #40's Medicare-5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/22/2025, revealed a Brief Interview for Mental Status (BIMS) score of 10 (indicated the resident had moderate cognitive impairment). Resident #40 ' s MDS also revealed the resident had active medical diagnoses which included: diabetes mellitus, non-Alzheimer ' s dementia, and respiratory failure. a. Review of Resident #40 ' s Progress Notes on 04/30/2025 at 11:12 AM, revealed on 03/14/2025 at 10:43 PM, indicated Licensed Practical Nurse (LPN) #3 was doing rounds and noticed Resident #40 sounded very congested. LPN #3 tried to wake the resident, but the resident was unarousable. LPN #3 took the resident ' s vital signs and recorded the resident ' s oxygen saturation as 50 percent. LPN #3 notified the Advanced Practice Registered Nurse (APRN), who ordered oxygen to be delivered to the resident at 2 liters per minute by nasal cannula with an updraft treatment. Resident #40 ' s oxygen saturation rose to 98 percent, but the resident was still lethargic and unable to arouse. The APRN ordered LPN #3 to send Resident #40 to the emergency room for further evaluation. b. Review of Resident #40 ' s Progress Note, on 04/30/25 at 11:17 AM, revealed LPN #4 called the hospital for and update on Resident #40 and was informed that the resident had been admitted to the hospital with a diagnosis of acute respiratory distress. c. During an interview on 04/30/2025 at 3:01 PM, with the Director of Nursing (DON), this surveyor asked for the Notice of Transfer/Bed Hold sent for Resident #40 ' s 03/14/2025 hospitalization . d. On 04/30/2025 at 3:28 PM, the Administrator notified this surveyor that no Notice of Transfer/Bed Hold for Resident #40 ' s 03/14/2025 hospitalization had been sent. e. On 05/01/2025 at 8:45 AM, the Administrator provided a policy titled Transfer or Discharge Notice which revealed the residents and representatives were to be notified, in writing, of the following information: .reason for transfer, date of transfer, location of resident . (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. On 05/01/2025 at 8:45 AM, the Administrator provided a policy titled Bed-Holds and Returns which revealed, prior to transfer, resident representatives will be informed in writing of the bed-hold and return policy. g. During an interview on 05/01/2025 at 9:40 AM, the Business Office Manager (BOM) indicated they was responsible for sending Notices of Transfer/Bed Holds, the notice should be sent out within two days, and there was not Notice of Transfer/Bed Hold for Resident #40. h. During an interview on 05/01/2025 at 4:35 PM, Registered Nurse (RN) #2 indicated frontline staff did not have any role in initiating documentation that would contain the resident's appeal rights, the Ombudsman contact information, or the contact information for protection and advocacy agencies pertaining to nursing facility residents with intellectual/developmental/mental disabilities. RN# 2 added that the role of the Charge Nurse was to notify the DON when a resident was going to the hospital, and the DON was the one who would notify the BOM. i. During an interview on 05/01/2025 at 4:47 PM, this surveyor asked the DON how the BOM would be notified that a resident and/or resident's representative needed Notice of Transfer/Bed Hold. The DON indicated the Nurse transferring the resident out should do 3 things: 1) automatic discharge transfer (ADT) out, 2) computer generated change of condition, 3) and computer-generated transfer. When ADT was completed, a bed hold would be triggered. The nurse must click ADT and then the Notice of Transfer/Bed Hold. For the resident representatives that did not get the notices, the nurse must not have completed the ADT form. j. During an interview on 05/01/2025 at 4:47 PM, the DON indicated that when a resident was being transferred to the hospital, the Charge Nurse should have completed a document titled Automatic Discharge Transfer (ADT) form in the Electronic Health Record (EHR), which then prompted the BOM to provide the information listed above to the appropriate parties. The DON added the reason that Residents #45 and #61 did not receive the information listed above was because the nurses responsible did not select the ADT document to complete in the EHR. 2) A review of the MDS with an ARD of 03/05/2025, indicated Resident #45 had a BIMS score of 09 (indicating the resident had moderate cognitive impairment). The MDS also indicated Resident #45 had active diagnoses which included: cerebral palsy, schizophrenia, and unspecified intellectual disabilities. a. A review Resident #45's Medical Record revealed a document titled SNF/NF (Skilled Nursing Facility/Nursing Facility) to Hospital Transfer Form that indicated the resident was transferred to the hospital on 12/30/2024. b. During an interview on 05/01/2025 at 8:47AM, the Administrator indicated Resident #45 did go to the hospital on 12/30/2024. The facility could not provide evidence that Resident #45 and the resident's representative received complete information for the 12/30/2024 hospitalization . The missing information included: resident appeal rights, contact information for the Ombudsman, and the contact information of the agency responsible for the protection and advocacy of the residents with intellectual/developmental disabilities/mental disorder or related disabilities. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) A review of the MDS with an ARD of 02/10/2025, indicated Resident #61 had a BIMS score of 01 (indicating the resident was severely cognitively impaired). The MDS also indicated Resident #61 had active diagnoses, which included: stroke, hemiplegia, dysphagia, and chronic pancreatitis. a. A review of Resident #61's Medical Record revealed a document titled SNF/NF to Hospital Transfer Form indicated the resident was transferred to the hospital on 01/03/2025. b. During an interview on 05/01/2025 at 8:47 AM, the Administrator indicated Resident #61 did go to the hospital on 01/03/2025. The facility could not provide evidence that Resident #61, and the resident's representative, received complete information for the 01/03/2025 hospitalization . The missing information included: resident appeal rights, contact information for the Ombudsman, and the contact information of the agency responsible for the protection and advocacy of the residents with intellectual/developmental disabilities/mental disorder or related disabilities. 4. A review of the facility ' s Transfer Policy titled Transfer or Discharge Notice, revised March 2021, indicated that when a resident was being transferred or discharged , a written notice should have been given to the resident and representative that contained: a. Appeal rights after transfer or discharge. b. Contact information of the Ombudsman, the contact information of the agency responsible for the protection and advocacy of residents with intellectual and developmental disabilities. c. Contact information of the agency responsible for the protection and advocacy of the agency responsible for residents with a mental disorder or related disabilities. d. Contact information of the state health department agency that has been designated to handle appeals of transfers and discharge notices. 51381

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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 Based on observation, interview, record review, and facility policy review, the facility failed to ensure food items in the refrigerator, freezer and storage room were covered or sealed; one (1) of one (1) ice machine was maintained in clean and sanitary condition; dietary staff washed their hands before handling food or clean equipment; ceiling tiles, air vents, dish washer wall, kitchen door frames were free of, debris, dirt, rust, stains; baseboards were secured for one (1) of two (2) meals observed. The findings are: 1. During an observation on [DATE] at 10:22 AM, an opened box of sausage patties was on a cart in the walk-in the refrigerator. The box was not covered or sealed. 2. During an observation on [DATE] at 10:26 AM, an opened box of fish was observed on a shelf in the freezer. The box was not covered or sealed. 3. During an interview on [DATE] at 10:29 AM, with the Dietary Manager, she was asked what the concerns of not storing food in the freezer or refrigerator properly were, and she stated it could lead to freezer burn. 4. During an observation on [DATE] at 10:33 AM, one opened box of crackers was observed on a shelf in the storage room, which had a best used by date of [DATE] on it. The Dietary Manager stated it had expired, and she would go ahead and throw it away. 5. During an observation on [DATE] at 10:56 AM, one (1) opened box of salt was on a shelf, above the food preparation counter, the box was not covered. The Dietary Manager stated it was open, and she would put it in a sealed container. She was asked what could happen if food was left open, and she stated bugs could crawl in. 6. During an observation on [DATE] at 10:59 AM, the following observation was made in the kitchen area: a. The floor between the deep fryer and the oven had an accumulation of grease built up on it. 7. During an observation, on [DATE] at 11:11 AM, of the inside corners of the ice machine, in a room on the 100-hall, where ice formed before dropping into the ice collector had a wet, blackish residue on it. The areas were pointed out to the Maintenance Supervisor, with the Dietary Manager present. During an interview, the Maintenance Supervisor was asked if the residue build up could be wiped off, how often he cleaned the ice machine, and who used the ice from the machine. He used tissue papers and wiped the wet residue off. The wet residue easily transferred to the tissue. The Maintenance Director stated the area had scum from the water, which could have dripped into the ice. He stated that he had been cleaning the area once a month, but began to clean it once a week, because the dirt built up quickly. The Maintenance Director also stated he had last cleaned the area on [DATE] (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. During an observation on [DATE] at 11:38 AM, Dietary Aide (DA) #1 used a rag to wipe up food items that spilled onto the counter. She then picked up the water hose with her bare hand and used it to spray leftover food from inside of the dishes, contaminating her hands. She placed the dirty dishes in the dirty racks and pushed the racks into the dish washing machine to wash. After the dishes stopped washing, DA #1 moved to the clean side of the dishwasher area, picked up the clean blade and attached it to the base of the blender, then used a rag to dry inside of the blender bowl. As DA #1 was about to use the blender to puree food items to be served to the residents on pureed diets, this surveyor asked DA #1 what she should have done after she touched dirty objects, or before she handled clean equipment. DA #1 stated she should have washed her hands. 9. On [DATE] at 1:24 PM, the following observations were made on a shelf in the refrigerator in the Medicare wing nourishment room, on the 100 -Hall. a. One (1) unopened carton of whole milk, with an expiration date of [DATE]. b. One (1) unopened box of whole milk, with an expiration date of [DATE]. 10. A review of facility policy titled, Quick Resources Tool QRT Hand Washing indicated hands should be washed before starting work with food and before putting on gloves and as often as needed during food preparation and when changing tasks. 11. A review of facility policy titled, Quick Resources Tool QRT Food Storage reviewed indicated all foods should be stored wrapped or in covered containers and arranged in a manner to prevent cross contamination.