

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/25/2024
NAME OF PROVIDER OR SUPPLIER  The Springs of Chenal		STREET ADDRESS, CITY, STATE, ZIP CODE  3115 S Bowman Road Little Rock, AR 72211	

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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42965</p> <p>Based on record review and interview, the facility failed to ensure the residents' decisions as to whether they desired to have, or not have, an advanced directive, were documented in a prominent part of the clinical record to ensure their wishes were known regarding acceptance or rejection of any life-sustaining treatments in the event of their incapacitation for 1 (Resident #154) of 1 sampled resident whose clinical records were reviewed for advanced directive information.</p> <p>The findings are:</p> <p>1. Review of the July Order Summary Report noted Resident #154 was admitted on [DATE] with diagnoses of diabetes mellitus, heart failure, and peripheral vascular disease.</p> <p>a. On 07/23/2024 at 8:03 AM, the Surveyor reviewed Resident #154's electronic record and was unable to locate any information for the resident on whether the resident had formulated an advanced directive or not.</p> <p>b. On 07/23/2024 at 12:55 PM, the Director of Nursing (DON) was asked for a copy of Resident #154's advanced directive information.</p> <p>c. On 07/23/2024 at 1:15 PM, the Director of Nursing (DON) came to the surveyor and stated, I cannot find any advanced directive information on this resident. I talked with admissions, and (Resident #154) has been gone from the facility over 30 days, so we are going to get one (new advanced directive information) done now. The DON was asked, Should the advance directive information be gotten when the resident is first admitted ? The DON stated, Yes. The DON was asked, Why is it important that the advanced directive information is gotten when the resident is first admitted ? The DON stated, It is part of the admission paperwork and consent to treat and code status is all vital information we should get when the resident is first admitted .</p> <p>d. On 07/23/2024 at 3:55 PM, the policy titled Advance Directives provided by the Director of Nursing (DON) indicated, Policy Statement: Advanced directives will be respected in accordance with state law and facility policy .Policy Interpretation and Implementation: 6. Prior to or on admission of a resident, the social services director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advanced directive .7. Information about whether or not the resident has executed an advanced directive shall be displayed prominently in the medical record .</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 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>49596</p> <p>Based on interview, and record review, the facility failed to ensure an Advanced Beneficiary Notice (ABN) was provided, as required, to allow the resident and/or the resident representative family, decide if the resident wishes to continue receiving skilled services that may not be paid for by Medicare; and of their financial liability for care and services after the Medicare coverage was discontinued for 1 (Resident #3) sampled resident.</p> <p>The findings are:</p> <p>1. Review of Resident #3's PPS (Prospective Payment System) Part A Discharge (End of Stay) Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/02/2024, indicated Resident #3 scored 12 (8-12 indicates moderately cognitively impaired) on the Brief Interview for Mental Status (BIMS).</p> <p>a. A review of the Physician Order Summary Report indicated Resident #3 had diagnoses of pneumonitis, acute kidney failure, hypertension, major depressive disorder, anoxic brain damage, type II diabetes mellitus, and dysphagia following cerebral infarction.</p> <p>b. Resident #3 Care Plan with a revision date of 06/13/2024 noted Resident #3 had an alteration in neurological status related to disease process anoxic brain damage, with a goal for the resident to show improvement to maximum potential with mobility and cognition.</p> <p>c. On 07/23/2024 at 10:29 AM, the Administrative Consultant (AC) returned the completed SNF (Skilled Nursing Facility) Beneficiary Notification Review forms to the surveyor. The AC stated, We did not send the Advanced Beneficiary Notice (ABN) to Resident #3, or Resident #3's care conference person. We should have, but we didn't.</p> <p>d. On 07/23/2024 at 1:20 PM, the surveyor conducted an interview with the Social Director (SD). The SD was asked who sends out the Advanced Beneficiary Notice (ABN) when a residents Medicare days are ending. The SD stated, I do. The surveyor asked if an ABN was sent out to Resident #3 and Resident #3's designated care conference person. The SD stated, No, The Interdisciplinary Team (IDT) did not notify me that I needed to send it. The surveyor asked the SD how she is notified. The SD stated, During the Medicare, or IDT meeting on Tuesday, they notify me who is coming off Medicare or who isn't skill-able anymore. I found out he was going to long-term care, but I wasn't given a date as to when. On 07/02/2024, the IDT said Resident #3 wasn't skill-able but nothing about sending an ABN. The surveyor asked the SD why it is important to send the ABN to a resident. The SD stated, It lets them know the last covered day of Medicare so the resident can file an appeal to stop the discharge. We set up a Care Plan meeting and Resident #3 went Long-Term Care. The surveyor asked if the family and resident attended. The SD stated, No, the meeting was held on a phone call to the care conference person. The resident was not on the call. This phone meeting took place on 07/03/2024. Resident #3 was already on Medicaid, and we informed the resident's care conference person of the change from Medicare to Medicaid payment for Resident #3's stay. The surveyor asked why Resident #3 was discharged from Part A Medicare services. The SD stated, The IDT team said they did not have any skill-able need.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written quantified recipe and menu to meet the nutritional needs of the residents for 2 of 2 meals observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>On 07/24/2024 at 7:40 AM, the surveyor asked Dietary [NAME] #1, who was on the tray line serving the breakfast meal, how he prepared the fortified cereal for the residents receiving fortified foods, he stated, I added about one fourth quart of butter and two cups of brown sugar.</li> <li>On 07/25/2024 at 8:50 AM, the District Dietary Manager, Food Supervisor #2, and Dietary [NAME] #4 were interviewed by the surveyor. When asked what foods were served to the residents on fortified oatmeal on 07/24/2024 for breakfast they indicated they were served oatmeal prepared by Dietary [NAME] #1. When shown the recipe for fortified oatmeal provided by the facility that documented for 6 servings: whole milk 1 quart 2 cups, cereal 2 cups, margarine 1/4 lb., brown sugar 1/2 cup, granulated sugar 1/2 cup, whole milk 1/2 cup. The District Dietary Manager, Food Supervisor #2, and Dietary [NAME] #4 confirmed that the recipe for fortified oatmeal was not followed.</li> <li>On 07/25/2024 at 9:00 AM, District Dietary Manager, Food Supervisor #2, and Dietary [NAME] #4 were interviewed by Surveyor. When asked what fortified foods were provided to the residents on a fortified diet for lunch on 07/24/2024. Dietary [NAME] #4 stated, We normally provide fortified potatoes, but yesterday we didn't. I put two sugar packs on the trays for the residents on the fortified diet. When asked why fortified foods were not provided to the residents on fortified diets, she stated, I didn't even think about it. Food Supervisor #2 stated, We usually always have fortified potatoes. The Menu provided by Food Supervisor #2 documented fortified cheesy noodles for residents on fortified diet for lunch on 07/24/2024.</li> </ol>		

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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> 03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure foods in the freezer and storage room were covered, sealed and dated to maintain freshness and prevent potential cross contamination; and expired food items were promptly removed from stock to maintain freshness and prevent potential cross contamination; dietary staff practiced good hand washing techniques to prevent potential cross contamination of food and clean dishes.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. On [DATE] at 7:41 AM, Dietary [NAME] #1, on the tray line serving the breakfast meal, picked up tray cards and placed them on a tray. Without washing his hands, he picked up the breakfast plates, and with his fingers inside the plate he placed breakfast food on the plate.</li> <li>2. On [DATE] at 7:50 AM, the following observations were made on the spice rack:             <ol style="list-style-type: none"> <li>a. Rubbed sage with an expiration date of [DATE].</li> <li>b. Ground cayenne pepper with an expiration date of [DATE].</li> </ol> </li> <li>3. On [DATE] at 8:00 AM, on a stand in the walk in freezer, the following observations were observed:             <ol style="list-style-type: none"> <li>a. An opened bag of mixed vegetables with no open date.</li> <li>b. An opened bag of chicken fingers with no open date.</li> </ol> </li> <li>4. On [DATE] at 8:04 AM, the following observations were made on bread rack:             <ol style="list-style-type: none"> <li>a. A bag that contained one hot dog bun with received date of [DATE], did not have opened date.</li> <li>b. A bag that contained two hamburger buns with a received date of [DATE], with no opened date.</li> </ol> </li> <li>5. [DATE] at 8:07 AM, the following observations were made on storage area:             <ol style="list-style-type: none"> <li>a. opened gallon container of soy sauce; the manufacturer specification noted, refrigerate after opening.</li> </ol> </li> <li>6. On [DATE] at 8:25 AM, an unidentified gray item was observed in a sugar container. The surveyor showed the item to Food Supervisor #2 who used a spoon to scoop it out.</li> <li>7. On [DATE] at 9:27 AM, Dietary Aid #3 lifted the plate warmer and placed clean plates on it, then pushed the lid down. Without washing her hands, she cleaned up clean plates with her fingers inside of them and placed them in the plate warmer.</li> </ol> <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>8. On [DATE] at 9:32 AM, the following observations were made on a shelf in the refrigerator locked in the Med Room:</p> <ul style="list-style-type: none"> <li>a. A bottle of vanilla protein drink. There was no name on the bottle to identify who it belonged to and no received by date.</li> <li>b. Two cartons of fruit yogurt smoothie had no name or received by date.</li> <li>c. A peach sports drink had no name or received by date on it.</li> <li>d. A bottle of thickened water with no name or no received by date.</li> <li>e. Two cans of prune juice with no name or received by date.</li> <li>f. One bottle of fruit punch with no name or no received by date.</li> </ul> <p>Licensed Practical Nurse (LPN) #5 said all the food items in the Med (Medication) Room refrigerator belonged to residents.</p> <p>9. On [DATE] at 9:38 AM, the following items were observed in the freezer located in the Medication Room:</p> <ul style="list-style-type: none"> <li>a. There was no temperature gauge in the Medication Room freezer.</li> <li>b. All frozen food items in the freezer were frozen solid.</li> <li>c. Two boxes of chicken broccoli alfredo meals with no name or received by date.</li> <li>d. Three boxes of chocolate ice cream with no name or no received by date.</li> <li>e. One bag of microwaveable turnovers with noted freezer burns. The surveyor asked the Food Supervisor to describe the appearance of the food item, he stated It is freezer burnt.</li> <li>f. Two cartons of cherry and lemon Italian ice with no name or received by date.</li> </ul> <p>10. On [DATE] at 9:48 AM, Dietary [NAME] #4 while wearing gloves, picked up a pan of cake and placed the pan on the counter. Without changing gloves, she began removing cake from the pan and placed the cake on a tray, before icing to serve to the residents for lunch.</p> <p>11. On [DATE] at 11:04 AM, Dietary [NAME] #1 opened the refrigerator door and took out a bottle of 1% milk and placed it on food preparation counter contaminating his hands. Without washing his hands, he removed two slices of bread and placed them in a blender. Then he unzipped a zip top bag that contained loose gloves, he removed gloves and placed them on his contaminated hands, contaminating the gloves. Without replacing his gloves or washing his hands he added two more slices of bread to the blender and added 1% milk to puree.</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>12. On [DATE] at 11:12 AM, Dietary [NAME] #1 used a rag to wipe up spilled bread puree from the food preparation area. Without washing his hands, he attached the blade to the base of the blender to be used to puree food for the residents who require puree diet. As he was ready to pour food into the blender, the surveyor immediately stopped Dietary [NAME] #1 and asked what he should have done before handling food items. He stated, Wash my hands and rewash the blender. He then removed the blender and rewash the blender and washed his hands.</p> <p>13. On [DATE] at 11:30 AM, Dietary [NAME] #1 used his bare hands to pick up bowls to be used in portioning pureed desert, with his fingers inside of the bowls.</p> <p>14. On [DATE] at 8:08 AM, Food Supervisor #2, and the District Dietary Manager, called Dietary [NAME] #1 for an interview conducted by the surveyor. The surveyor asked Dietary [NAME] #1 what the steps to hand hygiene were after washing one's hands. He stated, I wash them to get the soap off, then dry them, and turn off the faucet with the paper towel. When asked if it was appropriate to dry hands with a paper towel, turn off the faucet with paper towel, and use same paper towel to again dry hands before throwing the paper towel away, he stated, no.</p> <p>15. On [DATE] at 8:15 AM, review of the facility provided hand washing policy titled, Hand Washing stated, . 2. How to wash your hands: -Wet your hands, -Apply soap, -Rub your hands for 10 seconds, -Rinse your hands for 10 seconds, -Turn off water with clean paper towels, -Dry your hands, -Keep your hands clean.</p> <p>Food Supervisor #2 and the District Dietary Manager stated that the hand washing policy is contradictory in nature and will be revised.</p> <p>16. On [DATE] at 8:33 AM, the District Dietary Manager provided the Surveyor with a revised facility hand washing policy and stated that will replace the previous hand washing policy.</p>		