STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045357	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier at the Springs	3600 Richards Road North Little Rock, AR 72117

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to accurately develop and implement a baseline Care Plan for one (Resident #1) of one resident reviewed for baseline care planning. Specifically, the facility failed to include minimum healthcare information such as, administration of an anticoagulant and the resident being at risk for falls, necessary to ensure the facility staff provided continuity of care, staff communication, resident safety, and prevention of adverse events for Resident #1. The findings included: Review of Resident #1's Medical Diagnoses Report revealed Resident #1 had diagnoses that included a history of respiratory failure with hypoxia (low oxygen levels), atrial fibrillation (irregular heart rhythm), unspecified fall subsequent encounter (frequent falls), spinal stenosis lumbar region with neurogenic claudication (the lower spinal canal is narrowed, compressing nerves and causing weakness/numbness/pain in the legs), and other abnormalities of gait and mobility. Review of Resident #1's admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact. The MDS revealed Resident #1 required partial to moderate assistance for chair/bed to chair transfers, and substantial to moderate assistance for toileting hygiene, to shower/bathe self, lower body dressing and putting on/taking off footwear. The MDS also revealed Resident #1 had a diagnosis of falls. Review of Resident #1's Care Plan initiated on [DATE], revealed the care plan did not indicate Resident #1 was on an anticoagulant and did not include interventions for facility staff to provide resident safety or monitor for fall risk while taking an anticoagulant. Review of facility document titled, Fall Risk Assessment Criteria, dated [DATE], revealed a score of 12, which indicated the resident should be considered high risk for potential falls and a prevention protocol should be initiated and care planned. The Fall Risk Assessment also revealed Resident #1 had a history of falls with an occurrence of 1-2 in the past 3 months. The Fall Risk Assessment Criteria also revealed Resident #1 had a balance problem while standing/walking, decreased muscular coordination/jerking movements, and required the use of assistive devices. Review of Resident #1's Order Summary dated [DATE], revealed Resident #1 was ordered an anticoagulant that was to be taken two times a day related to atrial fibrillation. Review of the facility's Medication Administration Record (MAR) dated [DATE], revealed Resident #1 (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was administered an anticoagulant that started on [DATE], twice a day through the morning dose on [DATE]. Review of a Skilled Charting Assessment narrative note dated [DATE] at 2:16 PM, revealed Resident #1 was newly admitted , used a wheelchair for mobility, was weak in extremities, and needed assistance of one staff for the bathroom. Review of a Hospital Referral dated [DATE], revealed that Resident #1 had gone to the hospital post fall with weakness and numbness to right lower extremity (RLE) and increasing pain status post-surgery. Resident #1 had a right iliofemoral thromboendoarterectomy with stent explant, thrombectomy with fasciotomies (removal of a blood clot from the femoral artery) on [DATE].The Hospital Referral listed Resident #1's treatment plan as discharge to skilled therapy. Review of Resident #1's Progress Notes dated [DATE], revealed staff were called to Resident #1's room. Upon entering, Resident #1 was lying on the floor on the left side with blood under the head from a laceration. Resident did not respond verbally. The resident responded to painful stimuli, had shallow and slow respirations. Facility staff called 911. Emergency Medical Services (EMS) transferred the resident to the ambulance where the resident expired. Resident #1 was listed as Do Not Resuscitate (DNR). EMS brought the resident back into the facility and family was notified. During an interview on [DATE] at 6:21 PM, a family member of Resident #1 stated the resident walked with their back bent over due to spine surgery. The family member stated the resident did not like to have people help them and wanted to do things themselves. The family member asked the facility staff about a fall mat and the use of bed alarm. The family member stated the staff had informed them, they don't use bed alarms here. The family member stated the resident was admitted at the facility on [DATE], passed away on [DATE] and was to be discharged from skilled therapy on [DATE]. During an interview on [DATE] at 4:18 PM, Certified Nursing Assistant (CNA) #1 stated, I know how to take care of a resident by looking at their care plan in the kiosk. If there is something that is not on the care plan, I don't know how to take care of that resident. If a resident is a fall risk and it is not on the care plan, I don't know to be more cautious of that resident. During an interview on [DATE] at 4:30 PM, CNA #2 stated, to take care of a resident, you have to look at their care plan. Each resident is different. If there is something that is not on the care plan, we do not know they need it to be done, unless we are told verbally. If a resident is a fall risk, we don't know they need the interventions for falls [without it being on the care plan]. During an interview on [DATE] at 4:40 PM, Licensed Practical Nurse (LPN) #3 stated she always refers to care plans to know how to care for a resident. I always observe the residents to see how they are doing but, if it is not on the care plan, I really wouldn't know what exactly was needed for that specific resident. During an interview on [DATE] at 12:07 PM, LPN #4 stated she knew how to take care of a resident by referring to their care plan and talking with the resident and family. I believe if a fall risk assessment is done and they have had falls; it is put on the care plan at that time. LPN #4 stated, No one knows what to do for a resident if the care plan is not right. During an interview on [DATE] at 12:54 PM, Director of Nursing (DON) #2 stated he remembered (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 being admitted to the facility and knew the resident had falls prior to being admitted . He indicated that is why the resident came was for skilled therapy from falls and was known for jumping up and trying to go. The DON #2 stated they had startup meetings every morning Monday through Friday where things were discussed. He stated there were multiple people that should have caught that the care plan for Resident #1 was not accurately filled out. The DON #2 stated we have to manually enter falls on the care plan after the MDS admission is filled out. But the admission nurse should have placed the anticoagulant and at risk for falls on the baseline care plan. During an interview on [DATE] at 1:48 PM, the Long-Term Care (LTC) MDS Coordinator stated, when a resident was admitted , a baseline care plan was done by the admission assessment nurse. She stated, if a resident is admitted late in the afternoon on a Friday, we will review the information on Monday morning but a baseline care plan with the basics is done upon admission, and it is posted immediately. She stated the following should be included in the basic care plan: pain, activities of daily living (ADLS), falls, skin conditions, isolations, code status and discharge plan. The LTC MDS Coordinator stated, If a resident was admitted with a history of falls and it is not put on the basic care plan (indicating the baseline care plan), it placed the resident at a higher risk of falls and injury. During an interview on [DATE] 2:13 PM, The Skilled Therapy (ST) MDS Coordinator stated, all care plan items are manually put in the care plan. The nurse's admission assessment does trigger over to the basic care plan starting day one. He stated the admission nurse performed a fall risk assessment and she should have put it on the basic care plan if there was a history of falls. The ST MDS Coordinator stated if falls were not included on the basic care plan, it could increase risk of additional falls. He stated, if the admission nurse did not include it on the basic care plan and did not tell the facility staff, the facility staff would not know the resident was at risk for falls. During an interview on [DATE] at 2:27 PM, DON #1 stated that if a resident had a history of falls prior to being admitted to the facility, it should be reflected on the MDS and it had to manually be entered on the care plan. The DON #1 stated if a resident was at risk for falls, interventions were automatically implemented such as bed in lowest position, non-skid socks, fall mat, and all the standard interventions. She stated, if it was not included on the baseline care plan, the staff would not know. During an interview on [DATE] at 2:45 PM, the Administrator stated that if a resident was admitted to the facility with a history of falls, it should have been on the baseline care plan. He stated if the nursing admission assessment indicated a resident had a history of falls 1-2 in the past 2-3 months prior to admission, it should be added to the care plan. He also stated, that is how the care plan is built, by the assessments. The Administrator indicated staff would not know a resident was at risk of falls if it was not on the baseline care plan. He stated, but it will for sure be added from now on.Review of a facility policy titled Care Plans-Baseline, revised in [DATE], revealed the baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: initial goals based on admission orders and discussion with the resident/representative; physician orders; therapy services; and social services.