

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/18/2024
NAME OF PROVIDER OR SUPPLIER  The Maples at Har-Ber Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE  6456 Lynchs Prairie Cove Springdale, AR 72762	

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 0561</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 and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>42016</p> <p>Based on observations, interviews, and record review, the facility failed to provide foods preferable to a resident to meet their abilities to feed them self for 1 (Resident #83) of 1 resident reviewed for meal preferences and activities of daily living (ADL).</p> <p>Findings include:</p> <p>A review of Resident Rights, dated 07/16, 09/16, indicated, .You have the right to receive service with reasonable accommodation of your individual needs and preferences .</p> <p>A review of the Activities of Daily Living (ADLs), Supporting policy, revised March 2018, indicated, Policy Statement Residents will (sic) provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs) . 6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences .</p> <p>A review of a facility in-service titled, In-Service dated 07/01/2024, included review of the facility policy titled, Assisting the Impaired Resident with In-Room Meals revised September 2013, indicated, .Preparation . Review the resident's care plan and provide for any special needs of the resident .3. Check the tray before serving it to the resident to be sure that it is the correct diet ordered and that the consistency is appropriate .</p> <p>A review of the Admission Record indicated the facility admitted Resident #83 with diagnoses that included affective mood disorder, constipation, and depression.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/08/2024, revealed Resident #83 had a Staff Assessment of Mental Status (SAMS) score of 3 which indicated the resident had severe cognitive impairment. Resident #83 required set up and clean up assistance with meals, partial to moderate assistance with dressing, substantial to maximal assistance with personal hygiene and toileting. Resident #83 had active diagnoses of anxiety disorder, depression and psychotic disorder</p> <p>(continued on next page)</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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #83's Care Plan, revised 09/15/2023, revealed the resident required secured/special care neighborhood related to dementia diagnosis, had an activities of daily living (ADL) self-care deficit related to dementia diagnosis, and had a potential for nutritional problem related to dementia. Interventions included providing assistance setting up the meal and providing finger foods when having difficulty using utensils, Resident #83 frequently used hands to eat, initiated on 02/23/2023, and provide and serve diet as ordered, revised on 07/04/2024.</p> <p>A review of the Order Summary revealed Resident #83 had a regular diet, finger food texture, regular consistency.</p> <p>A review of the Meal Tray Card, revealed Resident #83 had standing orders for almond milk, assorted fruit juices, one each bacon, cold cereal, a hard-boiled egg, sausage patty, water, and one slice white toast.</p> <p>During an observation on 07/15/2024 at 7:54 AM, a red colored beverage in a non-spill cup was on the table in front of the resident. Resident #83 was served a meal tray by Certified Nursing Assistant (CNA) #2, containing 1 slice white toast, scrambled eggs, 1 slice bacon, and 1 sausage link. Resident #83 pushed the utensils away and began using hands to eat.</p> <p>During an interview on 07/15/2024 at 8:20 AM, CNA #3 stated the standing orders listed on resident's meal tray card are items residents should receive each meal and Resident # 83 should have received cold cereal (name brand), a hard-boiled egg, and a sausage patty. CNA #3 stated Resident #83 did not receive those food choices because the kitchen did not send them. CNA #3 stated they usually will call the kitchen and get items that are not sent but did not on this occasion.</p> <p>During an interview on 07/15/2024 at 8:22 AM, CNA #2 stated Resident #83 is ordered finger food and was unsure why the resident would receive cereal. CNA #2 stated Resident #83 did not receive the hard-boiled egg or the sausage patty, and that the food items should have been provided.</p> <p>During an interview on 07/17/2024 at 3:55 PM, the Director of Nursing (DON) stated the aides should be looking at preferences when preparing the tray and if they do not receive the items should go and collect it from the kitchen. We do ongoing training on this. The kitchen is the first line of defense and serving staff is the second line of defense to ensure residents receive the items. We do not have a policy on this.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>42016</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper nail care was provided to a resident who was dependent on nail care for one (Resident #27) resident and the facility failed to ensure a resident who required assistance with personal hygiene was regularly offered hair care to maintain good grooming and hygiene for one (Resident #96) of two sampled (Resident #27 and #96) residents reviewed for activities of daily living (ADLs).</p> <p>Findings include:</p> <p>A review of a facility policy titled, Activities of Daily Living (ADLs), Supporting, revised March 2018, indicated, Policy Statement . Residents who are unable to carry out ADLs independently will receive the services necessary to maintain .grooming and personal and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the care plan . support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) .A resident's ability to perform ADLs will be measured using clinical tools .will be evaluated in reference to the ARD . MDS definitions: .Limited Assistance .Extensive Assistance .Total Dependence - Full staff performance of an activity with no participation by resident for any aspect of the ADL activity. Resident is unwilling or unable to perform any part of the activity .</p> <p>A review of a facility In-Service, dated 05/16/2024, indicated, Ensure nail care is completed every shower day! Nail care can also be completed PRN if nails become broken or took (sic) long before next nail care time! They should be trimmed and filed to residents liking .</p> <p>A review of a facility In-Service, dated 05/28/2024, indicated, Resident's must obtain two showers (sic) weekly . If a resident wants a shower and it is not their shower day the resident can be showered .</p> <p>A review of a facility In-Service, dated 07/01/2024, indicated a review of the Activities of Daily Living (ADLs), Supporting policy revised March 2018, which included, Policy Statement .Residents who are unable to carry out ADLs independently will receive the services necessary to maintain .grooming and personal and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .in accordance with the care plan . support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care) .A resident's ability to perform ADLs will be measured using clinical tools .will be evaluated in reference to the ARD . MDS definitions: . Limited Assistance . Extensive Assistance .Total Dependence - Full staff performance of an activity with no participation by resident for any aspect of the ADL activity. Resident is unwilling or unable to perform any part of the activity .</p> <p>A review of a facility In-Service, dated 07/01/2024, indicated a review of the Brushing and Combing Hair procedure, revised February 2018, The purpose of this procedure is to provide hair and scalp care . General Guidelines 1. The resident's hair should be brushed and combed every morning before breakfast and whenever necessary throughout the day .</p> <p>A review of the Admission Record, indicated the facility admitted Resident #27 with diagnoses that included dementia, depression, trigeminal neuralgia, and hearing loss.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/20/2024 revealed Resident #27 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated the resident had severe cognitive impairment. Resident #27 required substantial/maximal assistance with personal hygiene, had diagnosis of dementia.</p> <p>A review of Resident #27's Care Plan, initiated 10/20/2023, revealed the resident lacked the capacity to understand and make decisions regarding healthcare due to the diagnosis of dementia. The resident had an ADL self-care performance deficit related to weakness, initiated 04/06/2023. Interventions included checking nail length, to trim, and clean on bath day and as necessary. To report any changes to the nurse and required extensive assistance of one (1) staff member.</p> <p>A review of Resident #27's Order Summary revealed Resident # 27 was to receive palliative care/comfort care.</p> <p>A review of a podiatry document, dated 05/29/2024, revealed Resident #27 received treatment that included debridement of two nails.</p> <p>A review of a document titled Follow Up Question Report, revealed Resident #27 received a shower on 07/11/2024.</p> <p>Review of the Grievance Tracking Log, dated 04/18/2024, revealed Resident # 27's daughter requested finger and toenails be cut.</p> <p>During an observation on 07/15/2024 at 7:00 AM Resident #27 was sitting up in bed, hair was greasy and uncombed.</p> <p>During a concurrent interview and observation on 07/15/2024 at 12:55 PM, Resident #27's Responsible Party stated staff was asked to do finger and toenails and they have not done that. Responsible Party described resident's great toes as thick and yellow, the second toe on the left foot as purple in color, and nail on right second toe was curling around end of the toe.</p> <p>During a concurrent observation and interview on 07/16/2024 at 3:16 PM, Certified Nursing Assistant (CNA) #6 stated Resident #27 received a shower today and we don't do nail care that is up to the doctor. CNA #6 did not know the reason nail care was not done for resident by staff. CNA #6 was asked to describe resident's toenails and stated the right second toenail is growing over around it. CNA #6 stated she did not know if a resident's toenail should be so long it wrapped over the resident's toe.</p> <p>During a concurrent observation and interview on 07/16/2024 at 03:22 PM, Licensed Practical Nurse (LPN) #7 stated Resident #27 received a shower earlier today and full nail care was provided if needed. Checking fingernails on both hands, LPN #7 stated it looks like this was missed. Checking toenails, LPN #7 stated they were unsure if the CNAs would feel the right second toe could be clipped because it looks like it wraps around the toe. The CNA should have notified the nurse if they were not comfortable clipping or filing a resident's nails.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/17/2024 at +3:55 PM, the Director of Nursing (DON) stated residents should receive a shower twice a week minimum on scheduled days and as needed. Some residents may request more showers. If a resident is visibly soiled, they should be offered a shower. Residents receive nail care on shower days twice a week and PRN if they are long and if they do not need to be cut, they would need to be filed. If a family requests nail care to be carried out and a resident refused, the family would be notified. The nurse should have been notified of Resident #27's toenails.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #96 with diagnoses that included cognitive communication deficit, dementia without behavioral disturbance, major depressive disorder, anxiety disorder and altered mental status.</p> <p>The admission MDS, with an ARD of 03/31/2024, revealed Resident #96 had a BIMS score of 1 which indicated the resident had severe cognitive impairment. Section F0400, Interview for daily preferences, C, indicated it was very important to choose the type of bathing. Resident required partial/moderate assistance with bathing and personal hygiene.</p> <p>A review of Resident #96's Care Plan, dated 04/04/2024, revealed the resident lacked the capacity to understand and make decisions due to dementia; has an ADL deficit related to dementia; no discharge anticipated. Interventions included honor the resident's customary routine for bathing and allow healthcare agent to review the resident current status and make healthcare decisions at least quarterly and more often as needed.</p> <p>A review of Order Summary, revealed Resident #96 had an order to admit to the Secured Neighborhood.</p> <p>A review of Individual Support Plan (ISP) for Secure Neighborhood/Alzheimer's Unit - V 1, dated 04/02/2024, revealed Resident #96 had a bathing preference of showers to be done in the morning. Resident specific interventions for bathing included, Resident is self-conscious about body odor and requests showers and clean clothes, and requires minimal assistance with bathing,</p> <p>During an observation on 07/15/2024 at 8:08 AM, CNA #2 brought Resident #96 to the dining room, hair disheveled, un-brushed, matted to sides of head, fuzzy, and bunched at the crown.</p> <p>During an interview on 07/15/2024 at 12:14 PM, Resident #96's Power of Attorney stated resident needed showers and the resident's hair was greasy.</p> <p>During a concurrent observation and interview on 07/17/2024 at 12:36 PM, CNA #3 stated Resident #96 received a shower on 07/17/2024, prefers showers on Tuesdays and Thursdays and if resident requests extra showers, is soiled, drops food on clothing additional shower would be provided. CNA #3 could not state why resident did not receive a shower on Monday when hair was greasy. Resident #96's hair was fuzzy, bunched at crown. CNA was asked to describe resident's hair. CNA #3 stated that resident did their own hair and CNA did not assist.</p> <p>During an interview on 07/17/2024 at 03:55 PM, the Director of Nursing (DON) stated residents should receive a shower twice a week minimum on scheduled days and as needed. Some residents may request more showers. If a resident is visibly soiled, they should be offered a shower. If a resident refuses a shower, they are offered a PRN shower/bath on different day, notes are made in the chart, and notification of the physician and family are done.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>42016</p> <p>Based on document review and interview, the facility failed to ensure a Registered Nurse (RN) worked at least 8 consecutive hours a day. The deficient practice had the potential to affect all residents.</p> <p>Findings include:</p> <p>A review of the Punch Date and Time, for 01/20/2024 revealed the RN punched in at 12:00 AM, out at 03:15 AM, total hours 3.25, punched in at 03:45 AM, out at 7:36 AM, total hours 3.85, punches totaling 7.10 hours. A second RN punched in at 11:34 AM, out at 5:27 PM, total hours 5.88 hours, punched in 5:57 PM, out at 7:57 PM total hours 2.00, punches totaling 7.88 hours. The RN punch in / punch out hours did not overlap.</p> <p>On 02/04/2024, an RN punched in for 7.63 total hours.</p> <p>On 02/11/2024, the RN punched in at 12:00 AM, punched out at 12:58 AM, total hours 0.97, punched in at 1:28 AM and out at 7:17 AM, total hours 5.82, punches totaling 6.79 hours. A second RN punched in at 10:03 AM, punched out at 12:44 PM, total hours 2.68, punched in 1:17 PM, punched out at 6:30 PM, total hours 5.22, total time punched 7.90 hours. The RN punch in /punch out hours did not overlap.</p> <p>On 2/17/2024, the RN punched in at 9:00 AM, out at 12:25 PM, total hours 3.42, punched in 12:57 PM, punched out 5:26 PM, total hours 4.48, punches totaling 7.90 hours.</p> <p>During an interview on 07/18/2024 at 8:31 AM, the Administrator stated that on 01/20/2024 the RN hours were reported as 7.88, on 01/27/2024 as 7.97 hours, on 02/04/2024 as 7.63 hours, 02/11/2024 as 7.9 hours, and on 02/17/2024 as 7.9 hours. The RN did not stay the full 8 hours those days, They clocked out a little early.</p> <p>During an interview on 07/18/2024 at 10:19 AM, the Administrator stated the facility has an RN every day, Pretty consistently and we just missed those and usually the RN would notify someone if not able to complete the shift.</p> <p>During an interview on 07/18/2024 at 10:04 AM, the Director of Nursing (DON) stated an RN is always on site and on 01/20/2024, 01/27/2024, 02/04/2024, 02/11/2024, and 02/17/2024 there was not an RN, and the DON was not notified. Floor staff would continue resident care as they are trained per their job title if an RN is not available to work. The DON stated notification should be made when there is no coverage. RNs are made aware of the 8-hour requirement when hired into the RN coverage pool and during orientation.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>42016</p> <p>Based on observations, document review, and interviews, the facility failed to post the nurse staffing information on a daily basis, to include the facility name, the current date, the number and actual hours worked by staff, and the resident census. The deficient practice had the potential to affect all residents.</p> <p>Findings include:</p> <p>A review on 07/15/2024 at 6:05 AM of the Direct Care Daily Staffing posted next to the time clock in the front lobby, indicated a date of 07/12/2024, listed staffing numbers and total scheduled hours for Registered Nurse (RN), Licensed Practical Nurse (LPN), Certified Nursing Assistant (CNA). The Direct Care Staffing document did not indicate the facility name, current census, or actual hours worked. There was no posting for 07/13/2024 or 07/14/2024.</p> <p>On 07/18/2024 at 10:45 AM, an observation of the posted Direct Care Daily Staffing documents dated 07/16/2024 and 07/17/2024 contained no facility name, actual hours worked or census.</p> <p>During a concurrent interview and observation with the Director of Nursing (DON) on 07/18/2024 at 1:13 PM, the posted documents did not contain the facility name, census, actual hours worked, or current daily staffing. The dates listed on the Direct Care Daily Staffing postings were 07/16/2024 and 07/17/2024. The DON stated the staffing and assignment sheets are posted daily by the on-call nurse. The weekend on-call would post staffing and assignment sheets from Friday to Monday. Licensed Practical Nurse (LPN) # 4 should have posted staffing and assignments for today and should contain the name of the facility, date, census, and staffing numbers.</p> <p>During an interview on 07/18/2024 at 1:17 PM, LPN # 4 stated sheets were posted last night, and number of staff and hours are filled in and the DON fills in the facility name and census. LPN # 4 did not do weekend staff posting.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>46723</p> <p>Based on observation, record review, and interview, the facility failed to ensure the narcotic medication for Resident # 87 was recorded correctly. This failed practice had the potential to affect 1 (Resident #87) sampled resident who had a physician order for anti-convulsant medication.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>Review of an Admission Record indicated Resident #87 had a diagnosis of polyneuropathy (nerve damage).</li> <li>The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/30/2024 documented the resident scored a 12 (8-12 indicates moderately cognitively impaired) on a Brief Interview for Mental Status (BIMS).</li> <li>The Physicians Order reads, Pregabalin Oral Capsule 75 MG (Pregabalin) *Controlled Drug* Give 1 tablet by mouth two times a day for (nerve damage).</li> <li>On 07/17/2024 at 11:13 AM, the Surveyor was checking the medication cart on Hall 500. When checking the narcotics there was a discrepancy on Pregabalin 75 mg. The narcotic book showed #34 capsules and the medication card showed #33 capsules.</li> <li>On 07/18/2024 at 12:10 PM, Licensed Practical Nurse (LPN) #4 was asked, What is the process of administering narcotics to a resident? LPN #4 said, We pull the resident up on the Electronic Medical Record (EMR), check their residents 5 medication rights, open the narcotic box with a key, find the correct medication, check for the correct count, pop the pill in a cup, give the medication to the resident, after they take the medicine, we record it in the narcotic book, and verify time given.</li> <li>On 07/18/2024 at 12:23 PM, LPN #5 was asked, What is the process of administering narcotics to a resident? LPN #5 said, Look at the Medication Administration Record (MAR), check the resident to see what is due, unlock the narcotic box with key, find the card with the residents name and medication, check the patients 5 medication rights, pop the pill in a cup, sign out medication in the narcotic book, put the medication back into the narcotic box, give the medication to the resident, and click yes, on the computer. LPN #5 was asked what you do to assure no medication error. LPN #5 said At the beginning of each shift the outgoing nurse and incoming nurse does a count and makes sure the count is correct.</li> <li>On 07/18/2024 at 12: 43 PM, the Director of Nursing (DON) was asked if when nurses are hired, they receive any training on narcotic medication administration and when. The DON stated, Yes, they receive training from the manager and nurse trainer, but [DON] will train them on this, in the future.</li> </ol> <p>(continued on next page)</p>		

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F 0755  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	7. On 07/18/2024 at 12:50 PM, the Director of Nursing (DON) provided, Medication Labeling and Storage policy. Policy heading . The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys . 7. Controlled substances (listed as Schedule II-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) and other drugs subject to abuse are separately locked into permanently affixed compartments, except when using single unit package drug distribution systems in which quantity stored is minimal and a missing dose can be readily detected .		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42016</p> <p>Based on observations, interviews and policy review, the facility failed to serve meals in accordance with professional standards for food service safety. Specifically, the facility failed to ensure staff performed hand hygiene after touching clothing and face before serving a meal tray to a resident. This failed practice had the potential to affect 11 residents residing on the secure unit.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Employee Cleanliness and Hand Washing Technique, revised March 2005, indicated, Dietary Employees will .practice good hygiene . are required to wash their hands on the occasions listed below: e. after blowing nose or touching face or hair .any other time deemed necessary .</p> <p>A review of a facility policy titled, Handwashing/Hand Hygiene, revised August 2015, indicated, This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to .residents . Use an alcohol-based hand rub .Before and after assisting a resident with meals .</p> <p>A review of a facility in-service titled, In-Service dated 07/01/2024, included review of the facility policy titled, Assisting the Impaired Resident with In-Room Meals revised September 2013, indicated, . Preparation 11. Employees must perform hand hygiene before serving food to residents . if there is contact with . clothing . the employee must perform hand hygiene before serving food .</p> <p>During an observation on 07/15/2024 at 8:11 AM, Certified Nursing Assistant (CNA) #2 used both hands and adjusted scrub jacket and wiped mouth and right cheek/face with right hand, picked up a plate, used it to cover another plate containing food, placed it on a meal tray and delivered it to a resident room. Upon entering the resident room, the meal tray was placed on a table, the cover plate, lids on beverages and a bowl were removed and the meal was served to the resident.</p> <p>During an interview on 07/15/2024 at 8:39 AM, CNA # 2 stated they should have washed their hands after straightening their jacket and touching their face to prevent transmission of communicable disease.</p> <p>During an interview PM 07/17/2024 at 3:55 PM, the Director of Nursing (DON) stated hand hygiene should be done before serving a meal tray and if someone touches their clothing or face, they should perform hand hygiene again because anything is transmissible and we need to protect our elderly population.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045407	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/18/2024
NAME OF PROVIDER OR SUPPLIER  The Maples at Har-Ber Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE  6456 Lynchs Prairie Cove Springdale, AR 72762	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42016</p> <p>Based on observations, interviews and record review, the facility failed to ensure a resident's food was not touched by another resident, prior to consumption for 1 (Resident #83) of 1 resident reviewed for infection control practices during dining observation. This failed practice had the potential to affect 11 residents residing on the secure unit.</p> <p>Findings include:</p> <p>The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/08/2024 revealed Resident #83 had a Staff Assessment of Mental Status (SAMS) score of 3 which indicated the resident had severe cognitive impairment. Resident #83 required set up and clean up assistance with meals, partial to moderate assistance with dressing, substantial to maximal assistance with personal hygiene and toileting. Resident #83 had active diagnoses of anxiety disorder, depression and psychotic disorder.</p> <p>A review of Resident #83's Care Plan revealed the resident required secured/special care neighborhood related to dementia diagnosis, had an activities of daily living (ADL) self-care deficit related to dementia diagnosis. Interventions included providing assistance setting up the meal and providing finger foods when having difficulty using utensils, and Resident #83 frequently used hands to eat, initiated on 02/23/2023.</p> <p>A review of the Order Summary, revealed Resident #83 had a regular diet, finger food texture, regular consistency.</p> <p>During an observation on 07/15/2024 at 7:54 AM, Resident #83 was served a meal tray by Certified Nursing Assistant (CNA) #2, containing 1 slice white toast, scrambled eggs, 1 slice bacon, and 1 sausage link. Resident #83 began using hands to eat the scrambled eggs.</p> <p>On 07/15/2024 at 7:55 AM, a resident seated across the table from Resident #83, placed hand on Resident #83's plate, pulling the toast and removing it from the plate. The resident then placed the palm of their right hand on the plate, placing fingers in the scrambled eggs, removed hand, placed in their mouth, removing eggs from their fingers. The resident then placed fingers on plate and attempted to pull plate away from Resident #83 and removed the sausage link from Resident #83's plate, touching the top rim of the plate. CNA #2 relocated the resident to another table. Resident #83 continued to eat eggs off the plate, using their fingers. CNA #2 did not remove or provide another plate to Resident #83.</p> <p>During an interview on 07/15/2024 at 8:22 AM, CNA #2 stated the plate should have been removed from Resident #83 when the other resident removed the food and provided a new meal due to contamination of the food by another resident.</p> <p>During an interview on 07/17/2024 at 3:55 PM, the Director of Nursing (DON) stated if a resident takes food from another resident's plate, the plate should be removed immediately and another plate should be provided. The resident should not continue to eat food, from a plate, that was touched by someone else because anything is transmissible and we need to protect our elderly population.</p>		