

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER The Springs of Brinkley		STREET ADDRESS, CITY, STATE, ZIP CODE 1214 North Main Brinkley, AR 72021	

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 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>50923</p> <p>Based on interviews, record review, and facility policy review, the facility failed to ensure residents personal funds were returned within 30 days of death for 1 (Resident #207) of 3 sampled (Residents #207, #14, #6) sampled residents.</p> <p>The findings are:</p> <p>On 8/13/2024 at 11:20 AM, upon review of the facility, Progress Notes, Resident #207 passed away on 3/15/2024, and upon review of facility financial records continues to show an active balance on the account of \$94.08.</p> <p>On 8/14/2024 at 2:07 PM, interviewed Business Office Manager regarding the resident continuing to have a positive balance of \$94.08 five months following death of resident. She stated, I was waiting on the corporate office to advise me of whether or not to return the money in the account to the residents' family because the resident had an outstanding balance owed to the facility.</p> <p>Review of a facility policy titled, Management of Residents' Personal Funds, dated/revised March 2021, stated the facility they manage the resident's funds in accordance with federal/state requirements.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>47916</p> <p>Based on observation, record review, interview, and facility policy reviews, it was determined the facility failed to repair or replace a leaking water heater in a timely manner for 2 sampled (Resident #31, Resident #39) capable of ambulation or self-propelling on North Hall to ensure a sanitary, orderly, and comfortable interior.</p> <p>The findings are:</p> <p>a. On 08/12/24 at 10:28 AM, wet linens and water extending beyond a yellow caution sign were observed resting on the floor outside the soiled linen and equipment room on the North Hall.</p> <p>b. On 08/12/24 at 10:29 AM, during an interview the Floor Tech stated the hot water heater had been leaking a couple of weeks on North Hall and Housekeeping #3 stated the hot water heater had been leaking for many weeks.</p> <p>c. On 08/13/24 at 9:25 AM, a review of the maintenance log hanging up outside the Administrators office did not show documentation of a leaking hot water heater.</p> <p>d. On 08/13/2024 at 4:00 PM, the Maintenance Director stated the leaking hot water heater should have been documented on paper a long time ago.</p> <p>e. On 08/14/24 at 10:30 AM, during an interview with the Maintenance Supervisor (MS), the MS was asked how long the hot water heater has been leaking in the North Hall equipment room, and the Surveyor was referred to the Administrator.</p> <p>f. On 08/14/2024 at 10:45 AM, during an interview the Administrator was unable to confirm the exact date the North Hall water heater started leaking but was able to provide documentation of 2 plumbing estimates to replace the hot water heater, dated 06/25/2024, and 07/11/2024.</p> <p>g. Review of a facility policy titled Maintenance Service, revised 12/2024, indicated The maintenance department is responsible for maintaining the facility building in a safe and operational manner at all times.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>47916</p> <p>Based on observation, record review, interview, and facility policy review, it was determined the facility failed to provide a bed hold notice prior to discharge for 1 (Resident #11) of 2 sampled residents (Resident #11 and Resident #54) who were discharged or transferred to the hospital.</p> <p>The findings include:</p> <p>a. On 08/14/24 at 11:08 AM, the Business Office Manager (BOM) was asked to look at the last two bed holds for Resident #11. The BOM confirmed Resident #11 did not get a bed hold because the resident was not cognitive, his family member cannot be reached, and she was newly hired 11/2023 and did not know it was her job to get a bed hold.</p> <p>b. On 08/14/2024 at 11:15 AM, the BOM was asked why bed holds were given to residents. The BOM stated she did not know, and thought it was a Medicare/Medicaid requirement to ensure the safe transfer of residents.</p> <p>c. On 08/14/24 at 11:30 AM, the Administrator revealed the facility has an action plan for bed holds and was asked to provide the documentation.</p> <p>d. On 08/14/24 at 2:00 PM, the Administrator provided an action plan, dated 07/31/2024, stating the BOM/Social Designee will audit all transfers for 30 days to ensure a transfer letter is initiated and negative findings addressed. The Administrator will also complete a random audit with a target completion date of 08/16/2024.</p> <p>e. A review of the Clinical Review Profile shows Resident #11 is the responsible party and guarantor.</p> <p>f. Review of a facility policy titled, Bed Holds and Returns indicated, Residents or representatives will be informed of bed hold policies in writing prior to transfers and therapeutic leaves.</p> <p>g. On 08/15/24 at 9:00 AM, the Administrator told Surveyors the BOM did not become responsible for bed holds until 6/12/2024 after the previous business office manager left on 05/03/2024, despite Resident #11's bed hold from a transfer on 03/24/2024 being signed by the current BOM on 04/17/2024. The problem with bed holds not being completed was identified on 07/31/2024 according to an action plan started on 07/31/2024.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>47916</p> <p>Based on observation, record review, interview, and facility policy review, it was determined the facility failed to ensure a comprehensive care plan was provided for 1 (Resident #11) of 20 (Residents #1, #4, #8, #11, #12, #13, #14, #17, #19, #20, #21, #31, #32, #34, #35, #38, #39, #42, #49, #53) sampled residents requiring a comprehensive care plan to ensure residents receive appropriate care.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the Medical Diagnosis revealed Resident #11 had diagnoses of stroke, chronic obstructive respiratory failure, and acute respiratory failure. <ol style="list-style-type: none"> a. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/25/2024 suggested a Brief Interview for Mental Status score of 9 (8-12 indicates moderately cognitively impaired). Section I6300 indicated the resident had respiratory failure, Section O0110 indicated the resident was on oxygen on admission, and while a resident, and had a tracheostomy on admission and while a resident. b. On 08/14/2024 at 12:25 PM, the MDS Nurse was asked about measurable interventions on Resident #11's care plan for Respiratory failure, tracheostomy, and oxygen. The MDS Nurse said she was unable to find those areas on the care plan because the care plan was vague, and should be addressed to keep the resident well, help to assess the resident and to prevent rehospitalization s. c. During an interview with the MDS Nurse on 08/14/2024 at 12:40 PM, the MDS Nurse was asked what the process for forming a comprehensive care plan. The MDS Nurse revealed a baseline care plan is formed, and she checks what triggers after the MDS is updated using the guidance of the Resident Assessment Instrument (RAI) manual. d. Review of a facility policy titled, Care Planning-Interdisciplinary Team, indicated, Comprehensive care plans are based on resident assessments by the Interdisciplinary Team (IDT). d. Review of a facility policy titled Care Plans, Comprehensive Person-Centered, (Revised, March 2023) revealed the Interdisciplinary Team (IDT) reviews and updates care plans when a resident is readmitted from a hospital, when warranted, and with the required quarterly MDS assessment. 		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916</p> <p>Based on observation, record review, interview, and facility policy review, it was determined the facility failed to ensure care plans were revised to reflect the changing needs and preferences for 2 (Residents #11 and #35) of 20 (Residents #1, #4, #8, #11, #12, #13, #14, #17, #19, #20, #21, #31, #32, #34, #35, #38, #39, #42, #49 and #53) sampled residents reviewed for care plan revisions.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the Medical Diagnosis, revealed Resident #11 had diagnoses of stroke, chronic obstructive respiratory failure, and acute respiratory failure. <ol style="list-style-type: none"> a. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/25/2024 suggested a Brief Interview for Mental Status score of 9 (8-12 indicates moderately impaired). Section K0529 indicates the resident had a feeding tube on admission and while a resident. b. Review of Resident #11's Physician Orders, dated 05/23/2024, revealed continuous [diabetic tube feeding formula] 1.2 calorie at 65 cubic centimeters per hour. c. Review of Resident #11's Care Plan, dated 05/31/2024, revealed Resident was on a [non-diabetic tube feeding formula] 1.5 at 55 cc per hour (Revised, 02/05/2024) related to difficulty swallowing. d. On 08/14/2024 at 12:30 PM, the MDS Nurse was asked to pull up Resident #11's care plan, physician orders, and comprehensive MDS from 05/25/2024, and verify interventions implemented on the care plan for tube feeding. e. On 08/14/2024 at 12:38 PM, the MDS Nurse confirmed Resident #11 had an increase and change in tube feeding prior to the Admission MDS, dated [DATE], it was not revised on the care plan dated 05/31/2024. The Surveyor asked why is it important for the care plan to be accurate. The MDS Nurse confirmed the care plan should be revised to reflect accurate tube feeding to make sure Resident #11 gets needed nutrients. f. Review of a facility policy titled Care Planning-Interdisciplinary Team, Revised, 03/2024, did not address care plan revisions. g. On 08/15/2024 at 10:15 AM, the Administrator was asked for an MDS policy. The Chief Nursing Officer (CNO) clarified surveyor was looking at revisions, and stated they did not have a policy related to revisions. <p>37925</p> <ol style="list-style-type: none"> 2. Resident #35 had a diagnosis of seizures indicated on an, Order Summary Report, dated 08/13/2024 that was reviewed. <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. The Order Summary Report, dated 08/13/2024, was reviewed and indicated Resident #35 had a physician's order for Dilantin 100 milligrams (mg) by mouth three times a day for seizures and was ordered on 02/27/2024. Resident #35 was prescribed Levetiracetam 500 mg by mouth two times a day for seizures and was prescribed on 02/27/2024.</p> <p>b. A Care Plan, dated 08/07/2024, was reviewed and indicated Resident #35 had a seizure disorder related stroke. The interventions included seizure precautions as indicated but did not list the precautions to monitor the resident for. The interventions included giving the medications as ordered, but it did not list the medications or the side effects to monitor the resident for.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>37925</p> <p>Based on observation, interview, and record review, the facility failed to ensure fingernails were cleaned and trimmed for 1 (Resident #35) sampled resident who was reviewed for nail care.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. Resident #35 had diagnoses of muscle weakness and altered mental status as indicated on an Order Summary Report dated 08/13/2024. <ol style="list-style-type: none"> a. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/23/2024 indicated Resident #35 had a Brief Interview for Mental Status (BIMS) score of 06 indicating the resident was severely cognitively impaired. b. The Care Plan dated 08/07/2024 was reviewed and indicated Resident #35 had an activities of daily living (ADL) self-care performance deficit. The interventions for nail care indicated checking nail length and trim and clean as necessary. c. The ADL Task: Nail Care was reviewed on the electronic health record on 08/13/2024 and indicated no data found. d. On 08/12/2024 at 1:09 PM, Resident #35 was sitting up in bed awake. The fingernails on both hands were greater than a quarter (1/4) inch in length with a dark brown substance under them. Resident #35 confirmed fingernails are trimmed maybe once a year. e. On 08/13/2024 at 8:35 AM, Resident #35 was sitting up in bed finishing breakfast. The fingernails on both hands were greater than 1/4 inch in length and there was a dark substance underneath the nails on both hands. f. On 08/15/2024 at 11:46 AM, Licensed Practical Nurse (LPN) #2 looked at Resident #35's fingernails and described them as too long, and dirty. She confirmed the resident was not a diabetic and Certified Nursing Assistants (CNA) were responsible for providing nail care on the residents' bath/shower days. <p>51064</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916</p> <p>Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure the North Hall was free of water and wet linens affecting 2 (Resident #31 and #39) sampled residents when ambulating in the hallway to prevent falls, and accidents; failed to ensure the North Hall shower door tub room was locked to prevent residents from having access to open razors, and to prevent falls on wet, soapy floors; failed to ensure the tub room on the North Hall, being used to store portable oxygen tanks, was kept locked to prevent resident accidents or injuries failed to ensure 1 smoker requiring supervision (Resident #39) of 1 sampled (Resident #39) was not smoking without supervision to prevent accidents or injuries; failed to ensure the 200 Hallway was free of missing tile with an uneven surface to prevent accidents and injury; and failed to ensure an aerosol can of a name brand insect spray was not stored in a resident's room for 1 (Resident #53) of 1 sampled resident.</p> <p>The findings include:</p> <p>1a. On 08/12/2024 at 10:28 AM, soaking wet, rolled up linens were observed resting in the floor against the soiled linen and equipment room doors across the hall from 2 resident bathrooms on the North Hall.</p> <p>b. On 08/12/2024 at 10:29 AM, during an interview, the Floor Tech stated the hot water heater had been leaking for a couple of weeks and said if water stands on the floor it would cause a risk of someone falling and pointed out the resident bathrooms across the hall. Housekeeper #3 stated the linens on the floor outside the soiled linen and equipment room were changed out when they get soaked, and confirmed administration is aware of the hot water heater leaking.</p> <p>c. On 08/13/2024 at 4:49 PM, water was observed resting in the hallway floor beyond the wet rolled up linens, and a yellow wet floor sign.</p> <p>d. During an interview with the Director of Nursing (DON) on 08/14/2024 at 3:30 PM, the DON stated when staff see that something is broken or there is a problem they are expected to notify maintenance or someone to fix it and confirmed it was a risk for falls.</p> <p>e. On 08/14/24 at 4:30 PM, a large puddle of water was observed outside the baseboard of the soiled linen door on the North Hall.</p> <p>f. On 08/12/24 at 10:35 AM, the North Hall shower room was found unlocked with soapy, wet, slick floors, and open packages of razors resting on a table on the right side of the room. There was an uncapped razor in a basket on the floor, and in a bag on the table.</p> <p>g. On 08/12/24 at 11:10 AM, Certified Nursing Assistant (CNA) #4 accompanied the Surveyor to the shower room on the North Hall and confirmed the shower door was supposed to be locked, open razors could cause injury to a confused resident, and CNA #4 confirmed residents could fall on the wet, soapy floor.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>h. During an interview with the DON on 08/13/24 at 2:29 PM, the DON confirmed the shower door should be locked so residents do not have access to the razors because they could harm themselves, and the soapy floor caused a risk for falls.</p> <p>i. On 08/12/24 at 10:43 AM, the North Hall tub room was observed unlocked, and on the left side of the room were unused concentrators, 20 portable oxygen tanks in the rack, and 1 full portable tank, and 1 empty portable tank in a small cart.</p> <p>j. On 08/12/24 at 10:59 AM, during an interview, the DON was asked what the tub room is used for, and the DON confirmed the room was used to store oxygen. The Surveyor asked if the room was supposed to be locked and the DON confirmed the door should be kept locked because the tanks could fall on someone or explode.</p> <p>2. Review of Resident #39's Medical Diagnosis, revealed diagnoses of acute respiratory failure, chronic obstructive pulmonary disease, and alcohol dependence.</p> <p>a. Review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/26/2024 suggested a Brief Interview for Mental Status (BIMs) of 15 (13-15 indicates cognitively intact).</p> <p>b. Review of Resident 39's Care Plan, initiated 05/24/2024, revealed the resident required assistance and supervision when smoking.</p> <p>c. On 08/13/24 at 10:10 AM, Resident #39 was observed smoking while sitting outside alone in the smoker's area. Resident #39 said a staff member provided the cigarette, lit it, and left the resident alone in the smoking area.</p> <p>d. During an interview with Registered Nurse (RN) #5 on 08/13/24 at 10:45 AM, RN #5 confirmed Resident #39 was a supervised smoker, should not have been smoking alone outside, and could have been burned or had an accident.</p> <p>e. On 08/13/24 at 10:41 AM, the DON was asked if staff were expected to stay with residents while they smoked when they are assessed and require supervision. The DON confirmed residents are to allow staff to light their cigarettes and are not to be left alone outside smoking because they could harm themselves or start a fire.</p> <p>f. A review of Resident 39's Smoking Safety Screen, initiated 05/24/24 indicated the resident can smoke safely with supervision and cannot light residents own cigarette.</p> <p>g. Review of a facility policy titled, Smoking Policy-Residents, indicated, Residents with a smoking restriction will require supervision by a staff, or family member while smoking.</p> <p>h. On 08/12/2024 at 11:00 AM, several pieces of tile were missing, forming a large open area of uneven concrete. Resident #32 was observed walking up and down the length of the hallway, walking through the uneven area multiple times.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>37925</p> <p>Based on observation, interview, and record review, the facility failed to ensure oxygen was administered at the physician's ordered flow rate to decrease the potential for respiratory complications for 1 (Resident #38) of 2 (Residents #38 and #39) sampled residents who were reviewed for oxygen.</p> <p>The findings are:</p> <p>Resident #38 had diagnoses of heart failure and issues with the respiratory system (breathing), indicated on an Order Summary Report dated 08/13/2024 that was reviewed. There was an order for oxygen to be administered at two liters per minute (2 l/min) by way of (via) a nasal cannula as needed for shortness of breath and ordered on 07/12/2024.</p> <p>A Care Plan with a completed date of 07/25/2024 was reviewed on 08/13/2024 and indicated Resident #38 had an altered respiratory status/difficulty breathing related to heart disease and the oxygen setting was 2 liters per nasal cannula and was to be humidified.</p> <p>On 08/13/2024 at 2:49 PM, the Electronic Medication Administration Record (eMAR) was reviewed and indicated the oxygen should be at 2 liters per minute by way of a nasal cannula as needed for shortness of breath. There was no documentation in any of the boxes that the resident had oxygen in use for 08/01/2024 to 08/13/2024.</p> <p>On 08/12/2024 at 12:27 PM, Resident #38 was lying in bed, awake, with a nasal cannula in use. The oxygen concentrator was on and set at 3.5 l/min.</p> <p>On 08/13/2024 at 8:16 AM, Resident #38 was lying in bed on the right side with eyes closed. The nasal cannula was in the resident's nose and the oxygen concentrator was on and set at 3.5 l/min.</p> <p>On 08/13/2024 at 4:05 PM, Resident #38 was lying in bed on the right side awake. A nasal cannula was in the resident's nose and the oxygen concentrator was on at 4 l/min with a humidifier bottle attached to the concentrator.</p> <p>On 08/14/2024 at 4:52 PM, during an interview and concurrent observation, Registered Nurse (RN) #5 was asked to look at the oxygen concentrator and to state what the flow rate was set at. She looked at the concentrator and confirmed the resident's oxygen concentrator was set at 4 l/min. She walked to the medication cart, reviewed Resident #38's orders in the electronic health record and confirmed the resident's order was for 2 l/min. She was asked who monitors the oxygen rate. She stated, We usually glance at it and confirmed the nurses were responsible for monitoring the oxygen flow rate.</p> <p>An Oxygen Administration policy, revised 06/2024, provided by the Director of Nursing on 08/15/2024, was reviewed and indicated oxygen is administered under orders of a physician, except in cases of emergencies. It also indicated the staff would document the beginning and continued assessment of the resident's condition requiring oxygen and the response to oxygen use.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER The Springs of Brinkley		STREET ADDRESS, CITY, STATE, ZIP CODE 1214 North Main Brinkley, AR 72021	
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 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>37925</p> <p>Based on observation, interview and record review, the facility failed to ensure manufacture's guidelines found on the container were followed to prevent the potential for food spoilage and / or growth of bacteria, foods were stored properly after being opened and dietary staff washed their hands and changed gloves during the meal preparation to decrease the potential for food borne illnesses for residents who received meals from 1 of 1 kitchen. This had the potential to affect 49 residents (Census: 51), as indicated on a list provided by the District Dietary Manager on 08/15/2024.</p> <p>The findings are:</p> <p>On 08/12/2024 at 11:07 AM, initial rounds were conducted in the kitchen and the following observations were made:</p> <p>1. The Storage Room:</p> <p>a. There was a 32-ounce (oz.) bottle of [brand name] Lemon Juice Concentrate with an opened dated of 7/22/2024, observed on the shelf. There was about a fourth of the liquid left in the bottle. It was not cold and there was no condensation on the bottle. The label on the bottle indicated refrigerate after opening.</p> <p>b. There was a plastic bin observed on the bottom shelf with rice and it had a foam cup inside, directly in the rice.</p> <p>2. On 08/14/2024 at 9:17 AM, this surveyor entered the kitchen to observe the lunch meal preparation (prep). During the meal prep, Dietary Staff #6 removed a pair of gloves, washed her hands and took a red cutting board, rinsed it off in the sink. Without washing her hands, she put on a clean pair of gloves and peeled an onion and diced it with a knife. During the meal prep, she washed her hands, put on a clean pair of gloves, picked up one of two packages of tortilla shells that were placed in the work area by the Dietary Manager, opened the package with her gloved hands, reached inside and began removing the shells one at a time, placing them in a metal pan. During the meal prep, Dietary Staff #6 had on gloves and picked up a scoop to place the cooked meat mixture over the tortilla shells in the pan. With the same gloved hands, she reached in a bag of shredded cheese with her right hand, removed some of the cheese and sprinkled it over the meat mixture. She poured the remaining shredded cheese in a plastic pitcher and began shaking the pitcher so the cheese could fall over the meat mixture. During the meal prep, she used gloved hands to open the second package of tortilla shells that the Dietary Manager had placed in the work area, and she reached inside and began removing the shells one a time, placing them in two different metal pans. She did not change her gloves or wash her hands. During the meal prep, she washed her hands and picked up a pair of black oven gloves, placed them in the work area and put on a pair of clean gloves and continued with the lunch meal prep without washing her hands or changing gloves.</p> <p>3. On 08/14/2024 at 9:21 AM, there was a metal cart observed in the corner where the dietary staff prepares the pureed food. On the top shelf there was an open bag of breadcrumbs that was not properly sealed or dated and a bag with slices of bread inside that was not properly sealed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER The Springs of Brinkley		STREET ADDRESS, CITY, STATE, ZIP CODE 1214 North Main Brinkley, AR 72021	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. On 08/14/2024 at 11:03 AM, the steam table was observed and there was brown residue on the bottom of the pans.</p> <p>5. On 08/15/2024 at 9:29 AM, Dietary Staff #6 was interviewed, and she confirmed food / dry goods should be wrapped with [brand name] clear wrap, put it in a [brand name] storage bags with the opened and use by date on it. She confirmed hands should be washed in the kitchen before, during, and after, something has been touched while performing a task and before putting gloves on. She confirmed gloves should be changed before touching something. She confirmed the steam table pans are cleaned and she has scrubbed the pans, and they feel gritty. She confirmed the foam cup should not be left inside the bin of rice due to possible cross contamination.</p> <p>6. On 08/15/2024 at 9:47 AM, the Dietary Manager was interviewed and confirmed the bottle of lemon juice should have been stored in the refrigerator after it was opened. She confirmed the steam table pans were cleansed with the products recommended by the facility and pieces were coming off the bottom of the pans.</p> <p>7. A QRT Hand Washing policy dated 09/01/2021, provided by the District Dietary Manager (DDM) on 08/15/2024, was reviewed and indicated hand should be washed as often as possible and to wash hands before starting to work with food, utensils, or equipment, before putting on gloves and as often as needed during food preparation and when changing tasks.</p> <p>8. A Safe Storage of Food policy date 09/01/2021, provided by the DDM on 08/15/2024, was reviewed and indicated all foods will be wrapped or in covered containers, labeled and dated and arranged in a manner to prevent cross contamination and all perishable foods will be maintained at a temperature of 41 degrees Fahrenheit (F) or below, except during necessary periods of preparation and service.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/15/2024
NAME OF PROVIDER OR SUPPLIER The Springs of Brinkley		STREET ADDRESS, CITY, STATE, ZIP CODE 1214 North Main Brinkley, AR 72021	
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 - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37925</p> <p>Based on observation, interview, and record review, the facility failed to ensure a glucometer machine was cleansed after being used for 1 (Resident #107) of 1 sampled resident observed during a glucometer check. The findings are:</p> <p>An Order Summary Report dated 08/14/2024, was reviewed and indicated Resident #107 had a diagnosis of type 2 diabetes mellitus. There was no order for a random blood sugar check.</p> <p>On 08/13/2024 at 4:49 PM, Resident #107 was sitting in a wheelchair and asked Registered Nurse (RN) #5 for a blood sugar check. She put on gloves, held Resident #107's third (3rd) finger on the right hand, pricked it with a lancet and collected a sample of blood on the test strip. The machine's screen displayed 116 after a few seconds. RN #5 discarded her gloves and tossed the used items in the trash. She placed the glucometer machine directly in the top right drawer of the medication cart without cleaning it, closed the drawer and sanitized her hands. She opened the door of the unit to leave, and this surveyor stopped her. RN #5 was interviewed, and she confirmed she placed the glucometer back in the medication cart without cleaning it. She confirmed the glucometer was supposed to be cleansed after being used but was going to clean it later.</p> <p>A Blood Sampling-Capillary (Finger Sticks) policy, revised September 2014, provided by the Director of Nursing (DON) on 08/15/2024, was reviewed and indicated reusable equipment was to be cleansed and disinfected after each use.</p>		