

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2025
NAME OF PROVIDER OR SUPPLIER  The Springs of Pinnacle Mountain		STREET ADDRESS, CITY, STATE, ZIP CODE  6411 Valley Ranch Drive Little Rock, AR 72223	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review, facility document and policy review, it was determined that the facility failed to report an abuse allegation to proper authorities for 1 (Resident #1) of 5 residents, reviewed for abuse and neglect.</p> <p>The findings include:</p> <p>A review of the facility's undated policy titled Abuse, Neglect, and Misappropriation, indicated facility must notify local law enforcement agencies.</p> <p>A review of the admission Record Face Sheet, indicated Resident #1 was admitted to the facility on [DATE], with diagnoses that included type II diabetes mellitus, cognitive communication deficit, schizophrenia, and bipolar disorder.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/01/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.</p> <p>On 04/21/2025 at 12:45PM, a review of the facility's internal investigation report, involving abuse allegations from Resident #1 against Medical Assistant - Certified (MA-C) #5, revealed the facility reported the incident to law enforcement and there were no negative findings. The investigation packet did not contain the police report, so a request was made to the local police records department for the incident report on 04/21/2025 at 1:09PM.</p> <p>On 04/21/2025 at 3:38PM, an employee with the local police record department responded with an email stating that no records were found on the resident named in the allegation.</p> <p>On 04/22/2025 at 8:00AM, a copy of the police report was requested from the Administrator.</p> <p>On 04/23/2025 at 9:01AM, the Administrator confirmed that there was not a police report filed with the investigation, and when the call was initially made to the police department to report the incident, a message was left with the incident information. The Administrator went home for the day and the police had not arrived prior to the Administrator 's leaving. The internal investigation was completed, and a follow-up on the police report had not been conducted.</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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F 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	On 04/23/2025 at 9:35AM, the Director of Nursing (DON) was asked if police were notified regarding the abuse allegations. The DON stated that the Administrator had indicated that the police had been contacted. The DON confirmed that follow-up was not thought of, to ensure the report had been given to police.		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>Based on observation, record review, and interview, it was determined that the facility failed to consistently give prescription pain medication every four (4) hours, as scheduled, for one (1) (Resident #4) of five residents reviewed for medication review.</p> <p>The findings are:</p> <p>A review of an admission Record indicated Resident #4 was admitted to the facility with diagnoses that included: fracture to right ankle, chronic pain syndrome, anxiety disorder, bipolar disorder and borderline personality disorder.</p> <p>The quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/14/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact for their daily decision making.</p> <p>Review of Resident #4's Care Plan initiated 01/17/2025, revealed the resident was on pain medication therapy. Interventions included Warning: Addiction, abuse, and misuse, and to reduce the risk for respiratory depression, proper dosing and titration of [Name Brand Combination Opioid/Pain Medication], were essential.</p> <p>On 04/21/2025 at 3:30 PM, this surveyor observed Resident #4 seated at a table in the common area, with a small circulating fan blowing toward them. Resident # 4's hair was wet, and [Resident #4] was observed wiping sweat from their face. Resident #4 said, My hair is soaking wet from sweat, I am so hot, and I am hurting bad. I asked one of the nurses for my pain medication but was told that I didn't have any left.</p> <p>On 04/21/2025 at 3:45 PM, the Director of Nursing (DON), assisted by Licensed Practical Nurse (LPN) #, 1 showed this surveyor the medication card from the locked narcotic box of the nurse's medication cart. There was not any medication left on the card. The Controlled Substance Log book (page 78) for Resident # 4's [Name Brand Opioid] documented the last pill given was on 04/20/2025 at 6:07 PM, leaving an ending count of 0. LPN #1 said the pharmacy said we will need a Prior Authorization (PA) to get more.</p> <p>On 04/21/2025 at 4:09 PM, (Pharmacy Name) was called. Pharmacist #7 was asked if Resident #4's [Name Brand Opioid] would need a PA. Pharmacist #7 said, I don't know, let me check . After verifying, Pharmacist #7 said yes, it needed a PA. The facility was responsible for getting one.</p> <p>A review of Resident #4's Order Summary for the month of 04/2025, revealed an order dated 03/31/2025 [Name Brand Combination Opioid/Pain Medication] Oral Tablet 7.5-325 milligram (mg) give one (1) tablet by mouth, four (4) times a day related to chronic pain syndrome.</p> <p>A review of a Medication Administration Record (MAR), for the month of April 2025, revealed the scheduled dose for 04/20/2025 at 5:00 PM, was checked as given. The scheduled dose for 04/20/2025 at 9:00 PM, was not checked as given, by the nurse on duty.</p> <p>A review of Resident #4 ' s Medication Administration Record for the month of April 2025, revealed:</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The scheduled dose for 04/21/2025 at 9:00 AM, was not checked as given, by the nurse on duty.</p> <p>The scheduled dose for 04/21/2025 at 1:00 PM, was not checked as given, by the nurse on duty.</p> <p>The scheduled dose for 04/21/2025 at 5:00 PM, was not checked as given, by the nurse on duty.</p> <p>The scheduled dose for 04/21/2025 at 9:00 PM, was checked as given, by the nurse on duty.</p> <p>A review of the Controlled Substance Log book (page 78) for Resident #4's [Name Brand Opioid], documented on 04/21/2025, a scheduled dose of medication was given at 9:00 PM, which was over twenty-four (24) hours since the last scheduled dose was given.</p> <p>During an interview on 04/22/2025 at 8:56 AM, LPN #3 said the nurses are responsible for notifying the doctor of new prescriptions. When I get to the blue section on the card, where there are 8 pills left, I will notify the doctor for refills, or if it's controlled, I will print off a prescription and send it to the doctor for signature. I don't know who is responsible for getting a PA for medication, I guess the doctor or pharmacy would be, I've never had to do that.</p> <p>During an interview on 04/22/2025 at 09:00 AM, LPN #1 said, the last time I gave Resident #4's pain medication, there were 12 pills left. I usually order them when pills are in the blue section.</p> <p>During an interview on 04/22/2025 at 9:21 AM, the Medical Director said, the pain management doctor, the Advance Practice Registered Nurse (APRN) or I are responsible for refilling medications. Typically, we get a call from one of the nurses.</p> <p>During an interview on 04/23/2025 at 9:49 AM, the DON said Resident #4's medication was ordered two (2) days prior to running out, by one of the night nurses. The medication needed a PA, which went through yesterday, and a new prescription was obtained at that time. The reason the facility did not take some medication from the emergency box was the box did not have the correct dosage in it. The Assistant Director of Nurses who was seated in the DON 's office said, I believe Resident # 4 has a diagnosis of cirrhosis of the liver, and doubling up on the dosage would be giving too much (name brand acetaminophen).</p> <p>Review of a facility policy titled Administering Medications revised April 2019 indicated Medications are administered in accordance with prescriber orders, including any required time frame.</p>		