STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045431	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Pinnacle Mountain	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)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 49981 Based on observation, record review, and interview, it was determined the facility failed to ensure reasonable accommodation of resident needs were provided for 2 (Residents #11,and #26) of 16 sampled residents. The findings are: Resident #11 had a score of 00 on the Brief Interview for Mental Status (BIMS) per a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/22/2024. Additionally, Resident #11 was identified as being non-ambulatory, dependent on staff for all activities of daily living, and non-verbal. During an observation on 9/23/2024 at 10:20 AM, Resident #11 did not have a call light in reach. Resident was sitting in chair in front of tv and call light was on the floor behind resident's chair. During an observation on 9/25/2024 at 1:10 PM, Resident #11 and Resident #26, who were roommates, were in their room sitting in chairs with no call lights within the resident's reach. Both call lights were laying in the floor behind their chairs. On 9/25/2024 at 1:13 PM, Certified Nursing Assistant (CNA) #6 said staff should make sure residents have the call light within reach before leaving the room so residents can notify staff if they need assistance. On 9/26/2024 at 10:01 AM, the Medical Assistant-Certified (MA-C) #7 said staff should make sure the resident has the call light in reach because they may have an emergency or need something. On 9/26/2024 at 10:04 AM, Licensed Practical Nurse (LPN) #5 said staff should make sure a resident has the call light and bed remote within reach because a resident could experience choking or need assistance. On 9/26/2024 at 7:50 AM, the Administrator provided (Quality Assurance) QA meeting minutes which contained Call Light Monitoring Tool which was issued and signed by staff regarding call light placement and answering of call lights.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 37634 Based on interview and record review, it was determined the facility failed to formulate an advance directive, and document if formulation of an advanced directive was refused for 2 of 2 (Resident #13, and Resident #23) residents reviewed for advance directives. The findings are: A review of a facility policy titled, Advance Directives, revised December 2016, indicated the resident will be provided information concerning an advance directive upon admission. Information about whether the resident has executed an advance directive should be in medical records. The advance directives should be reviewed annually with the resident to ensure the directives are still the wishes of the resident. 1. A review of an Order Summary Report indicated Resident #13 had a diagnosis of Epilepsy. a. The quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 08/30/2024 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. b. On 09/24/24 at 10:00 AM, an advance directive was not available for review in Resident #13 's clinical record. c. On 09/24/24 at 10:19 AM, the Assistant Director of Nurse (ADON) indicated she could not find the advance directive in the electronic clinical record for Resident #13. d. On 09/24/24 at 11:00 AM, during interview Resident #13 could not recall being asked to formulate an advance directive. e. On 09/25/24 at 2:45 PM, the ADON indicated that Resident #13 did not have an acknowledgement of an advance directive, or an advance directive in the medical records. She indicated that an advance directive should be completed upon admission. 2. A review of an Order Summary Report indicated Resident #23 had a diagnosis of Alzheimer's disease with late onset. a. The quarterly Minimum Data (MDS) with an Assessment Reference Date (ARD) of 09/24/2024 revealed Resident #13 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident was moderate cognitive impairment. b. On 09/23/24 at 2:01 PM an advance directive was not available for review in Resident #23 's clinical record. c. On 09/24/24 at 2:20 PM, during interview Resident #23 could not recall being asked to formulate an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During an interview on 09/25/24 at 2:46 PM, the ADON indicated that Resident #23 did not have an acknowledgement of an advance directive, or an advance directive in the medical records. She indicated an advance directive should be completed upon admission. e. During an interview on 09/26/2024 at 11:22 AM, the Director of Nursing (DON) indicated that an advance directive should be formulated upon admission and documented if refused.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 37634 Based on observations, interviews, and record review, it was determined the facility failed to administer scheduled pain medication for 1 of 1 (Resident #19) reviewed for pain. The findings are: Review of a facility policy titled, Administering Medications, indicated medications are administered according with the prescriber orders. Medications are administered in accordance with prescriber's orders, and within the required time frame. Medication administration times are determined by resident need and benefit, and not for staff convenience. Medications are administered within one hour of their prescribed time. A review of an Order Summary Report indicated that Resident #19 had a diagnoses of low back pain, unspecified, and polyarthritis. Resident #19 had an order for Hydrocodone- Acetaminophen (Pain) 10-325 mg scheduled four times a day with a start date of 08/28/2024. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/14/2024, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The assessment indicated Resident #19 was on a scheduled pain medication regimen. Review of Resident #19's Care Plan revised on 06/21/2024, revealed the resident will have adequate relief of pain or ability to cope with incompletely relieved pain. Intervention included to administer scheduled pain medications as ordered. A review of Resident #19's demographic record indicated Resident #19 is scheduled to receive Hydrocodone at 9:00 AM, 1:00 PM, 5:00 PM, and at 9:00 PM. It indicated that she received Hydrocodone 10-325 mg on 09/23/2024 at 10:50 AM. On 09/23/2024 at 10:50 AM, during interview, Resident #19 indicated she's been waiting over an hour for her pain medicine. She indicated she asked the nurse for her medication, and she usually has the medication by this time. Resident #19 was observed clenching her face. On 9/23/24 at 10:52 AM, Registered Nurse #8 walked in Resident #19's room with a pill in a cup. When she walked out of the room Registered Nurse #8 confirmed it was a Hydrocodone in the cup. She indicated Resident #19's pain medication was administered late because she looked at it wrong. On 09/25/24 at 10:45 AM Resident #19 indicated she gets her pain meds on time mostly, but she does gets them late sometimes. During an interview on 09/26/2024 at 11:22 AM, the Director of Nursing (DON) indicated if a pain medication is scheduled at 9:00 AM it should be given on schedule at 9:00 AM. He indicated the medications can be given 1 hour before and 1 hour after the scheduled time. He indicated that pain medication should be given on time to regulate pain.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49981 50505 Based on observation, interview, and record review, it was determined the facility failed to ensure food preparations were separate from soiled areas of the kitchen, to ensure kitchen equipment was cleaned before storage, and that hand sanitation was performed during meal service. The findings are: On 9/25/2024 at 11:14 AM, while observing the [NAME] puree the lunch meal that consisted of chicken, broccoli, noodles, and garlic herb biscuits, the right side of a sink that was 10 inches away from food blender had several inches of brown liquid with chunks of what appeared to be noodles and broccoli floating in it. On 9/25/2024 at 11:28 AM, the [NAME] was observed draining noodles in a colander on the clean, left side of the sink prior to pureeing them. On 9/25/2024 at 11:59 AM, the [NAME] rinsed the colander out in the left side of the sink and hung it on a rack located directly above the sink, without washing and sanitizing it first. On 9/26/2024 at 8:17 AM, the surveyor asked the Dietary Manager (DM) if food preparation should be performed next to a dirty sink. The DM stated no, the facility has been having issues with the garbage disposal not working properly but maintenance made the repair yesterday evening, on 9/25/2024. The surveyor asked the DM why clean food prep area should not be next to a dirty sink and DM said it could cause cross contamination. On 9/26/2024 at 8:22 AM, during an interview the District Dietary Manager (DDM) confirmed seeing the [NAME] drain noodles in the clean (left) side of sink, rinse it out and hang it back up. On 9/26/2024 at 8:30 AM, spoke with [NAME] about pureeing foods next to dirty sink and the colander not being washed and sanitized after use. Asked [NAME] why the foods should not be prepared next to a dirty sink and why colander needed to be sanitized after use and before storage and [NAME] stated to keep from contaminating foods. On 9/26/2024 at 8:45 AM,, the policies and in-services were provided from the District Dietary Manager (DDM). The in-services were on kitchen cleaning and storing foods and food quality and puree. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/23/2024 at 1:13 PM, residents were observed being served lunch in the 300-hall dining room by the CNA. During the tray delivery and set up of the lunch tray, CNA #1, had long braids that were not tied back and kept touching the tables and chairs in the dining room while the trays were being served. The braids were touched with hands by CNA #1 to move them out of the way or head was flipped to the side to move the braids back. After serving the trays, CNA #1 sat down at a table and began to assist a resident with eating without sanitizing hands. CNA #1 touched clothing and the arms of the table, then would go back to feeding the resident without sanitizing hands. CNA #2 was observed picking up a resident's hamburger bun with un-sanitized bare hands, placed condiments and vegetables on the hamburger bun, put it back together and handed the hamburger to the resident to eat. During an interview on 09/23/2024 at 1:29 PM, CNA #1 confirmed that hands should have been sanitized before starting to serve the residents and hair should have been tied back to prevent it from touching the surrounding areas while lunch trays were being served and feeding the residents. CNA #1 also confirmed hands should have been sanitized after touching clothing or anything unclean. During an interview on 09/26/2024 at 10:07 AM . CNA #2 was asked how the hamburger should have been handled while preparing it for the resident to eat. CNA #2 confirmed eating utensils could have been used to keep the food from being touched and that hands should be sanitized after each tray was passed and before starting to assist residents to eat. A review of Handwashing/Hand Hygiene Policy indicated that the facility considers hand hygiene the primary means to prevent the spread of infections and that an alcohol-based hand rub should be used before and after handling food and before and after assisting a resident with meals.