STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045432	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Barrow	2600 John Barrow Road Little Rock, AR 72204

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37925 Based on interview, record review and facility policy review, the facility failed to ensure a resident's emergency contact was notified of a change in a resident's plan of care for 1 (Resident #5) of 1 sampled resident reviewed for plan of care changes. The findings are: On 01/07/2024, Resident #5's emergency contact was exiting the resident's room. This surveyor asked her about the resident's care at the facility and she stated she had called the facility earlier and was told there was a fall mat in place. She asked this surveyor to look in the room and see if a fall mat was in place. This surveyor entered the resident's room and there was no fall mat in place. Resident #5's Medical Diagnosis Screen was reviewed and indicated the resident had a fracture of the neck of the right femur (a break in the thigh bone) and a brain condition with causes the progressive decline in memory, thinking, learning and organizing skills (Alzheimer's disease). A quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/05/2025 was reviewed and indicated Resident #5 had a Staff Assessment for Mental Status (SAMS) score of 3, which indicated severe cognitive impairment. A Plan of Care, dated 11/04/2024, was reviewed and indicated Resident #5 had an actual fall with an intervention for staff to check range of motion and scheduled pain medication. An established patient visit note, dated 12/20/2024 at 23:59 (11:59 PM), was reviewed and indicated Resident #5 was seen due to readmission. The fall risk section of the note indicated a plan of treatment which included implementation of safety measures with a low bed and a floor mat. A Nursing Incident and Accident follow up note, dated 12/31/2024 at 11:51 AM, was reviewed and indicated a fall mat was initially placed as an intervention to prevent injury, but after therapy evaluation the mat was removed. Resident #5's Progress Notes were reviewed from 12/30/2024 through 01/07/2025, and there was no documentation which revealed Resident #5's emergency contact, or any other person was notified of a decision to remove the resident's fall mat. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/08/2025 at 3:43 PM, the Director of Nursing (DON) was interviewed and stated after Resident #5 returned to the facility the immediate intervention was to put a fall mat bedside the resident's bed. She stated the facility held weekly interdisciplinary team (IDT) fall meetings and per her note dated 12/31/2024, the fall mat was not appropriate because Resident #5 was mobile and there was a concern the resident would trip over the fall mat. She stated the emergency contact should have been notified of the change by someone from the interdisciplinary team. A Change in a resident's condition or status policy, dated as revised February 2021, was reviewed and indicated the facility promptly notifies the resident, attending physician and the resident representative of changes in the resident's medical/mental condition and/or status such as changes in level of care and resident rights.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51381 Based on interviews, record review, and facility document review, it was determined the facility failed to provide needed care or services resulting in an actual decline in one resident's physical well-being (Resident #1) of 3 sampled residents reviewed for Quality of Care. Findings include: Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2024, revealed Resident #1 had Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. Other diagnoses on the MDS included hypertension (high blood pressure), end-stage renal disease (kidney disease) and hemiplegia (not being able to move one side of the body). Resident #1 ' s medical record was reviewed for accuracy of medications. 1)A review of Resident #1's hospital and facility records revealed the following. a. 11/04/2024 - The Discharge (DC) Summary from the hospital stay ending on 11/04/2024, for admission to the Nursing facility has this medication listed - [Name brand angiotensin-converting enzyme inhibitor] 40 milligrams (mg) tab take one tablet by mouth every day for high blood pressure. [Name brand angiotensin-converting enzyme inhibitor] was one medication in a list of medications recommended for Resident #1 to continue by the discharging hospital. b. 11/08/2024 - The DC Summary from a hospital procedure, admitted [DATE], and discharge date [DATE], had a note Medication(s) stopped/held - [Name brand angiotensin-converting enzyme inhibitor] (this medicine is to be resumed upon discharge). c. 11/12/2024 - The Medication Reconciliation Report from a procedure performed on 11/12/2024, has listed [name brand angiotensin-converting enzyme inhibitor] 40mg tab - take one tablet by mouth every day for high blood pressure. d. A review of the November 2024 Administration Record, and the December 2024 Administration Record, demonstrated that Resident #1 did not receive [name brand angiotensin-converting enzyme inhibitor] from 11/04/2024 (admission to facility) through 12/23/2024, when Resident #1 was being admitted to the hospital for a hypertensive (high blood pressure) emergency. e. A review of the [name brand angiotensin-converting enzyme inhibitor] order report demonstrated Resident #1 did not have [name brand angiotensin-converting enzyme inhibitor] ordered from the time of admission to the facility (11/4/2024) until 12/23/2024, when Resident #1 was being admitted to the hospital for hypertensive (high blood pressure) emergency. f. A review of the hospital History and Physical (H&P) from 12/24/2024, revealed the following information from the hospital provider. Within the Assessment and Plan of Care, it states the resident told the provider that they used to take [name brand angiotensin-converting enzyme inhibitor] but had not gotten any at the nursing home. Also, it stated Resident #1 would be started on [name brand angiotensin-converting enzyme inhibitor] moving forward. The first issue on the H&P problem list was hypertensive emergency, requiring an Intensive Care Unit (ICU) admission. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2)On 01/07/2025 at 2:16 PM, the Admission Nurse and LPN #1 were interviewed regarding the process for 1) determining what medications residents are to receive and 2) determining who reviews for medication accuracy. Both nurses responded the process for residents coming to a facility was as follows. a. Facility receives the Discharge (DC) medication list b. Nurse managers put the medication list into the queue which is the electronic platform where orders wait to be reviewed by the floor nurse c. Floor nurse double checks and confirms each medication is in the queue. d. Admission nurse does the match back process to confirm the correct medications are on the Medication Administration Record (MAR). This process is where the discharge medications/orders are resubmitted by the Admission Nurse to ensure it matches the original order. The Admission Nurse also stated this process provided a third set of eyes on the orders. Both nurses stated that they started the last step because a medication got missed about a month ago. 3) On 01/08/2025 at 10:15 AM, the Admission Nurse and LPN #1 were interviewed regarding the process for orders and document review after someone has gone to the hospital/doctor appointment/dental visit, etc. The Admission Nurse stated that it was their responsibility (Admission Nurse) to review the documents and then follow up with any orders. 4) On 01/08/2025 at 1:50 PM, an interview with the Director of Nursing (DON) was conducted, included, but not limited to, acquiring orders for a new resident and verification of the orders. a. What is the process regarding orders for a new resident? The Discharge (DC) orders come with the resident, and one nurse puts admission orders in. The orders are reviewed with the provider within 24 hours. The floor nurse reviews, and another nurse reviews for a double check. The admissions nurse receives the admission orders and checks the orders again, against the paperwork provided. b. What is the process regarding documents and/or orders for a resident that has gone to the hospital, doctor appointment, dental appointment, etc.? If someone goes to an appointment, the transport personnel give the papers to a nurse or department head for processing. c. Who communicates with the provider if there is an order that is recommended for the resident? Prior to December 2024, the Medical Director would be contacted by the nurse or Department Heads. A Nurse Practitioner (NP) was hired in the early part of December. Since the early part of December 2024, the NP is notified by the nurse and/or department heads. With the addition of the NP, Clinical meetings are now conducted daily, and any new orders can be reviewed at that time for accuracy/resolution. 5) On 01/08/2025 at 2:20PM, the Administrator provided a procedure document titled Reconciliation of Medications on Admission. The body of the document listed the steps in the procedure, which include: 1) Listing all medications from the discharge summary and 2) Reviewing the list carefully to determine if there are discrepancies/conflicts. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6) On 01/08/2025 at 3:15 PM, the DON was interviewed again and stated there was not an additional policy to address orders/medication orders when a resident returns to the facility. The DON was asked why it is important for Medication Reconciliation be completed accurately. The DON answered for the health and safety of the resident and that incorrect medications and/or missing medications are not good.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37925 Based on observation, interview, record review, and facility policy review, the facility failed to ensure enhanced barrier precautions (EBP) were consistently implemented during resident care activities for 1 (Resident #4) of 1 sampled resident reviewed for enhanced barrier precautions. The findings are: On 01/07/2024 at 12:15 PM, Certified Nursing Assistant (CNA) #2 and CNA #3 were in Resident #4's room to provide incontinence care. Both CNAs put on gloves prior to the start of the high-contact care activity but did not put on a gown. There was a sign on the wall outside the Resident #4's room under the resident's name which was reviewed and indicated the resident was on EBP and staff must wear gloves and a gown for high-contact resident care activities and changing briefs was included on the list. Resident #4 was incontinent of bowel and CNA #2 and CNA #3 completed this high contact care activity and only used gloves. Both CNAs were interviewed and asked if the resident was on EBP. CNA #3 stated she was sure Resident #4 was, and CNA #2 indicated he did not know. CNA #3 confirmed neither she nor CNA #2 wore a gown while providing incontinent care to Resident #4. Resident #4's Medical Diagnosis Screen was reviewed and indicated a diagnosis of gastrostomy status (a surgical opening into the stomach for nutritional support). A review of Resident #4's Order Summary Report indicated the resident received continuous enteral (a form of nutrition delivered into the digestive system as a liquid) feeding and was on EBP related to a percutaneous endoscopic gastrostomy (PEG) tube. A review of Resident #4's Plan of Care dated 11/27/2024, indicated Resident #4 had a self-care performance deficit in activities of daily living (ADL) and required total assistance with bathing/showers, extensive to total assistance of one staff member with toilet use and was at risk for skin breakdown due to incontinence of bowel and bladder. An Enhanced Barrier Precautions policy, copyright 2024, The Compliance Store, LLC (limited liability company), was reviewed and indicated EBP referred to an infection control intervention to reduce transmission of multidrug-resistant organisms in which employees use gown and gloves during high contact resident care activities. The policy indicated an order for EBP would be obtained for residents with wounds and/or medical devices such as a feeding tube.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925 Based on observations, interviews, and facility policy review, the facility failed to ensure a trash can was cleansed and had a liner inside and the inside of a resident's toilet bowl was clean for 1 (Resident #4) of 3 whose rooms were reviewed for cleanliness; failed to ensure walls and baseboards were cleansed in the hallways of the facility; failed to ensure cigarette butts were removed from the grounds of a smoking area and shower rooms were maintained in a clean and sanitary condition for 3 of 4 showers in the facility. The findings are: On 01/06/2024, initial rounds were conducted at the facility and the following observations were made: 1. At the end of hall 100, the base boards and lower walls to the right of the doorway upon entrance had brown stains and a brown unknown substance on the floor. 2. Resident #4's trash can had no liner and there were gloves, debris and stains in the bottom of the trash can. There was a brown ring inside the toilet bowl in the Resident #4's bathroom. 3. On hall 400, between rooms [ROOM NUMBERS], there was a How to view resident care plan in [program name] sign on the wall with brown stains on and around the sign. 4. The baseboards between rooms [ROOM NUMBERS] had brown stains on it. 5. The female shower room, for halls 100 and 200, had black stains on the grout between the tiles on the floor, and the lower walls of two shower stalls and a trash can with no liner half full of a discolored liquid with dark sediment in the bottom. 6. The male shower room, for halls 100 and 200, had black stains on the grout lines between the tiles on the floor, and walls of the two shower stalls. One shower stall had a pair of black boots with debris on them and a dustpan with brown, black and white stains on it on the floor of the shower stall. On 01/07/2025 at 12:05 PM, the smoking area for the secured unit was observed and there were several used cigarette butts and ashes on the concrete slab. On 01/07/2025 at 1:00 PM, the toilet bowl in Resident #4's bathroom continued to have a brown ring inside and toilet paper. On 01/08/2025 at 1:47 PM, the trash can in Resident #4's room did not have a liner and there was a brown stain and debris in the bottom of the trash can. Certified Nursing Assistant (CNA) #4 placed a clean trash liner in the trash can without cleaning the inside first. He was interviewed and stated housekeeping was responsible for cleaning the inside of the trash can. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/08/2025 at 2:52 PM, the Laundry/Housekeeping Supervisor (LHS) was interviewed and stated he was responsible for cleaning the shower rooms every day. He stated he used a disinfectant [brand name]. He stated Maintenance swept the [cigarette] butts early each morning and before he (Maintenance) left for the day. He stated housekeeping cleaned the walls and railings in the hallways every other day. He stated housekeeping was responsible for cleaning the resident's rooms, including the floor, toilet, sink, trash can and putting a liner in the resident's trash can every day. On 01/08/2025 at 3:04 PM, LHS was asked to remove the liner from Resident #4's trash can and describe what he observed. He stated there was old trash and dirt on the bottom of the trash can and there were brown and black discolorations inside the trash can. On 01/08/2025 at 3:06 PM, LHS entered the men's shower room on the locked unit and described the smell upon entrance as old water. He described the color between the tiles on the floor as black. He stated there was dirt on the lower tiles of the shower wall and described the color as black. On 01/08/2025 at 3:11 PM, LHS opened the janitor's closet leading to Hall 100 and there was a cleaning system set up on the wall with a brand name one step disinfectant solution inside. LHS stated a bottle could be placed under the spout of the cleaning system and filled with the cleaning solution. He stated the cleaning solution was diluted and ready to use and required a 3-second sit, which he explained as once the solution was sprayed on something, it would sit for 3 seconds before being removed. He stated the disinfectant was supposed to work on mold and mildew. On 01/08/2025 at 4:04 PM, the Maintenance Director (MD) was interviewed, and stated staff were expected to pick up after themselves in the smoking area and staff with the residents in the smoking were expected to pick up after the residents. He stated the responsibility of removing cigarette butts from the grounds was a shared duty, which he did rounds once a day, but he did not indicate who else shared the responsibility. He stated cigarette butts should be removed from the grounds because it gave a bad appearance. A Daily cleaning procedures (DCP) policy, not dated, provided by the Administrator on 01/08/2025, was reviewed and indicated the waste basket should be disinfected and a can liner inserted. The restroom required supplies such as toilet paper, paper towels and soap be restocked, trash emptied, toilet area disinfected. The policy did not specify cleaning of the walls or baseboards in the hallways outside resident rooms. The [name brand] One-Step Disinfectant manufacture's guidelines, not dated and provided by the Administrator on 01/08/2025, was reviewed and indicated this product is a concentrated hospital use disinfectant cleaner which it's uses include inhibiting the growth of mold and mildew and odors when used as directed. The directions indicated the original container label should be referred to for use directions. For Fungi, the contact time indicated 3 minutes, but did not specify mold or mildew contact time.