

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER The Springs of Barrow		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 John Barrow Road Little Rock, AR 72204	

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 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>49596</p> <p>Based on observations, record review, and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for 5 (Residents #2, #13, #14, #33, and #65) of 5 sampled residents residing on the 300 Hall.</p> <p>The findings are:</p> <p>1. On 9/09/24 at 10:40 AM, the Surveyor observed:</p> <p>a) Resident #2's bathroom floor was dirty and sticky, causing the surveyor's shoes to stick to the floor.</p> <p>b) The bathroom door had several brown smears on the inside and outside of the door.</p> <p>c) Resident #2's feeding pole had a brownish-white hard-dried substance dried to the pole, the pole's electrical cord, and the base of pole.</p> <p>d) Several areas of the resident's wardrobe had the finish missing and the rough particle board was exposed.</p> <p>e) The over the bed table had a large chunk out of the top right corner, leaving rough particle board exposed.</p> <p>2. On 9/9/24 at 1:00 PM, the Surveyor observed:</p> <p>a) Resident #2's bathroom floor was dirty and sticky; causing the surveyor's shoes to stick to the floor.</p> <p>b) Resident #2's bathroom door was sticky to touch and had several brown smears on the door.</p> <p>c) Resident #2's bathroom floor had black, yellow, and orange stains on the floor under the sink and around the toilet.</p> <p>d) Resident #2's feeding pole had a thick dried brownish-white substance on the pole, the pole's electrical cord, and on the base of the pole.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a) Resident #13's bedroom had a strong, nauseating odor in the room.</p> <p>b) The trim atop the wainscoting was missing along the wall where the headboards of the beds were located, leaving a rough edge exposed.</p> <p>c) The bedroom floors were dirty with a black substance around the baseboards.</p> <p>7. On 9/10/24 at 1:02 PM, the Surveyor observed:</p> <p>a) Resident #13's bathroom had a large area of black substance on the center of the floor.</p> <p>b) Resident #13's room had a musty odor.</p> <p>c) The trim atop the wainscoting was missing along the wall where the headboards of the beds were positioned, leaving a rough edge exposed.</p> <p>d) The bedroom floors were dirty with a black substance around the baseboards in the room.</p> <p>8. On 9/11/24 at 12:17 PM, the Surveyor observed:</p> <p>a) Resident #13's room had a strong urine odor in the room.</p> <p>b) The bedroom floors were dirty with a black substance around the baseboards in the room.</p> <p>c) Resident #13's bathroom had a large area of black substance on the center of the floor.</p> <p>9. On 9/11/2024 at 3:30 PM, while making rounds with the Administrator the Surveyor observed the Administrator attempt to open the Resident #13's bathroom door. The door stuck and the Administrator had to jerk the door open. The Administrator said the door would need to be sanded down at the top.</p> <p>10. On 9/09/24 at 10:50 AM, the Surveyor observed:</p> <p>a) Resident #14's bathroom door was difficult to open. The roommate yelled out that the door sticks and is hard to open sometimes, just pull it hard.</p> <p>11. On 9/09/24 at 10:59 AM, the Surveyor observed:</p> <p>a) Resident #14's bedroom had a strong odor of feces in the room.</p> <p>b) Resident #14's footboard had a large hole in the fiberglass facing covering the outside of the footboard. The Surveyor could put her open hand over the hole, and it did not cover the hole.</p> <p>c) Resident #14's bathroom had a toilet plunger sitting inside a clear plastic bag. The contents inside the bag were visible. The handle of the plunger and the suction cup had a dark brown clumpy substance on them. The plunger was sitting to the left side of the toilet under the toilet tissue roll and a clear plastic bag with a urinal inside was hanging from the handrail.</p> <p>12. On 9/09/24 at 1:01 PM, the Surveyor observed:</p> <p>(continued on next page)</p>		

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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>25. On 9/11/2024 at 3:33 PM, the Administrator and the Surveyor were walking down the hallway and observed the plunger in the clear plastic bag with dark brown clumps and yellowish liquid on the handle and on the suction cup of the plunger sitting in Resident #14's bedroom beside the wardrobe. The Administrator informed the Surveyor he knew he needed to replace some wardrobes but wasn't sure exactly when they would be replaced. The Administrator identified the orange spots on the floors to be rust.</p> <p>26. On 9/11/2024 at 3:38 PM, the Assistant Director of Nursing (ADON) gave the Survey Team a Floors policy. The policy was dated 2001 Med-Pass with a revised date of December 2009. The Policy Statement indicates the floors should be maintained in a clean, safe, and sanitary manner. Item 1. Indicates all floors shall be mopped/cleaned/vacuumed daily in accordance with our established procedures.</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>47916</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure the storage closet and the janitor's closet near the dining area, and the water heater closet off the 100 Hall were locked to ensure residents did not have access to equipment that could result in accidents or injuries.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A review of a policy titled, Maintenance Service, dated December 2009, revealed maintenance was responsible for the safe maintenance of the facility and keeping it free of hazards. 2. On 09/09/2024 at 09:48 AM, the Surveyor opened a set of white double doors revealing the heating and cooling equipment. 3. On 09/09/2024 at 09:49 AM, the Storage Closet was opened revealing a large metal cabinet with coiling wires hanging down on the right-hand side, and on the left side was a bucket with 4 inches of gray fluid resting under a humidifier. 4. On 09/09/2024 at 09:51 AM, the Surveyor observed a slightly opened door marked, water heater, located off the 100 Hall, the doors were opened revealing the hot water system. 5. During an interview with the Maintenance Supervisor on 09/09/2024 at 02:15 PM, the Maintenance Supervisor stated the batteries in the keypad locks were dead, and the doors should require a key to be unlocked. He confirmed residents should not have access to the hot water heaters, electrical, and equipment, because they could get hurt. 		

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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>47916</p> <p>Based on observation, interview, and facility policy review, it was determined the facility failed to ensure refrigerated narcotic were documented appropriately to ensure accurate reconciliation of medications, and nursing staff counted the refrigerated narcotics every shift to reconcile medications, prevent medication errors, and to prevent the misappropriation of resident owned narcotics.</p> <p>Findings include:</p> <p>1. On 09/10/24 at 01:00 PM, Licensed Practical Nurse (LPN) #3 stated refrigerated narcotics from the 100/200 Hall Medication Room were not documented in the new narcotic book dated 08/20/2024, and LPN #3 stated she could not find a narcotic page for Resident #61, or the other 2 non-sampled residents.</p> <p>a. On 09/10/24 at 01:30 PM, Registered Nurse (RN) #4 told LPN #3 that the narcotic pages had been documented in the back of the narcotic book and showed LPN #3 where the refrigerated narcotics were documented. The Nurse Consultant was questioning staff as to why narcotics would be placed in the back of the narcotic book, and no response was noted.</p> <p>2. On 09/10/24 at 01:15 PM, Licensed Practical Nurse (LPN) #3 stated that the refrigerated narcotics were not being counted every shift, and confirmed the narcotics could disappear and they would not know when it happened. LPN #3 verified the process for nursing was to count all narcotics at the beginnings of each shift, and RN #4 confirmed this is the correct process.</p> <p>a. During an interview with the Assistant Director of Nursing (ADON) on 09/11/2024 at 02:10 PM, the ADON stated that narcotics should be documented on the next corresponding page and not written in the back of the narcotic book to ensure narcotic pages are not overlooked, and nursing staff are expected to count all narcotics at the beginning of each shift to prevent medications from being taken.</p> <p>b. A review of an in-service provided by the ADON addressing Controlled Substances, dated, 09/10/2024 revealed all controlled substances are to be counted by nursing during each shift, and both responsible parties should look at the medication card, and narcotic page to verify accuracy.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47916</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure clear, legible medication labels were on narcotics to prevent medication errors, and misappropriation of resident medications in the 100 Hall/200 Hall Medication Room.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A review of a policy titled, Storage of Medications, revised November 2020, revealed nursing staff are responsible for the medication storage area. Medications are stored separately from food and are labeled accordingly. 2. On 09/10/24 at 01:00 PM, Licensed Practical Nurse (LPN) #3 opened the refrigerated narcotic box and verified there were four bottles of anti-anxiety medication belonging to Resident #61 and three belonging to three non-sampled residents, and one unidentified bottle of medication in a plastic bag marked 102, with a completely faded out label and a red C. LPN #3 confirmed that she was not sure of the process, but the unidentified medication should be given to the Director of Nursing (DON), because it could disappear, and nobody would know where it was. 3. On 09/10/2024 at 01:30 PM, Registered Nurse (RN) #4 located narcotic page 102, and verified the unidentified bottle of medication was an anti-anxiety medication belonging to a non-sampled resident. 4. On 09/10/24 at 01:35 PM, RN #4 stated another nurse was asked to contact the pharmacy for a new label about 2 weeks ago. The pharmacy verified they had not sent out a replacement label. RN #4 confirmed that when a label is faded nursing is supposed to have the pharmacy print a label, because there was a risk the faded label could have resulted in someone getting the wrong medication. 5. During an interview with the Assistant Director of Nursing (ADON) on 09/11/24 at 02:15 PM, the ADON stated that if a medication label is worn and cannot be read, staff are expected to notify the DON or the ADON, and to call the pharmacy to request a new label, because someone could be given the wrong medication, or the medication could be taken. 		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508</p> <p>Based on observation, interview, and faculty policy review, the facility failed to ensure dietary staff washed their hands and changed gloves when contaminated; the ice machine was maintained in a clean and sanitary condition; opened food items in the refrigerator and freezer were sealed or covered to maintain freshness and prevent potential cross-contamination; expired dressing products were promptly removed/discarded on or before the expiration or use by date to prevent the growth of bacteria; cold beverages were held at 41 degrees Fahrenheit to maintain the quality of food items and beverages.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. On [DATE] at 9:28 AM, Dietary Aide (DA) #1 picked up his phone and placed it in his pocket, contaminating his hands. Without washing his hands, DA #1 picked up clean plates from the dish racks and placed them on the plate warmer to be used in portioning food items for lunch. 2. On [DATE] at 9:53 AM, the ice machine in the kitchen had a wet, pink, and slimy residue on the panel. It was pointed out to the Dietary District Manager and asked if the residue build up could be wiped off. She used tissue paper and wiped it off. The pink slimy residue easily transferred to the tissue. DA #1 was asked who used the ice from the ice machine and how often they cleaned it. DA #1 stated, CNAs (Certified Nursing Assistants) use it to fill beverages served to the residents at mealtimes and they use it for the water pitchers in the residents' rooms. I don't know how they clean it. On [DATE] at 10:09 AM, Dietary [NAME] (DC) #2 was asked how often they cleaned the ice machine. DC #2 stated, Once a every week. 3. On [DATE] 10:09 AM, DA #1 turned on the hand washing sink, washed his hands, turned off the hand washing faucet with his bare hands, contaminating his hands, and then used his contaminated hands to pick up clean plates and place them on the plate warmer to be used in portioning food items to be served to the residents for supper. 4. On [DATE] at 10:15 AM, an opened box of sausage was on a shelf in the refrigerator. The box was not covered or sealed. 5. On [DATE] at 10:18 AM, the following observations were made on a shelf in the freezer: <ol style="list-style-type: none"> a. An opened box of steak fritters. The box was not covered or sealed. b. An opened box of corndogs. The box was not covered or sealed. 6. On [DATE] at 10:45 AM, the following observations were on a shelf in the - Medication Room between the 100 Hall and the 200 Hall: <ol style="list-style-type: none"> a. Two bags of potato chips with an expiration date of [DATE]. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER The Springs of Barrow		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 John Barrow Road Little Rock, AR 72204	
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 - Many</p>	<p>b. An opened bottle of tea. The manufacturer specification on the bottle indicated to keep refrigerated.</p> <p>7. On [DATE] at 11:09 AM, DA #1 removed a carton of milk from the refrigerator and gave it to a staff member, contaminating his hands. Without washing his hands, DA #1 then picked up utensils from the area and wrapped them in napkins for the supper meal. DA #1 was asked what he should have done after touching dirty objects and before handling clean equipment? DA #1 stated, I should have washed my hands.</p> <p>8. On [DATE] at 11:54 AM, DA #1 walked into the kitchen and placed a bag that contained packages of cream cheese on the counter. Without washing his hands, DA #1 picked up clean eating utensils by the tip of the utensils and wrapped them in individual napkins for the residents to use at their noon meal. Dietary Aide DA #1 stated he should have washed his hands.</p> <p>9. On [DATE] at 1:00 PM, Dietary [NAME] (DC) #2 wore gloves when he opened two bags of shredded cabbage and emptied them into a pan. Then, using his gloved hands, he smoothed the shredded cabbage, shredded carrots and shredded red cabbage evenly in the pan. DC #2 poured dressing over the slaw, mixed it with a spoon, covered the pan with saran wrap and placed it on a shelf in the walk-in refrigerator to be served to the residents at their supper meal. DC #2 was asked what she should have done after touching dirty objects and before handling food items. DC #2 stated she should have washed her hands.</p> <p>10. On [DATE] at 8:05 AM, the Dietary Manager was asked to check the temperature of the leftover cartons of strawberry shake and cartons of apple juice that she was about to put in the refrigerator. DC #2 did and stated the apple juice was 51 degrees, and the strawberry shake was 50 degrees. They are supposed to be 41 degrees. The manufacturers specification on the cartons of strawberry indicated, store frozen, thaw under refrigerator. After thawing keep refrigerated and use within 14 days.</p> <p>11. A review of a facility policy titled, QRT (Quick Reference Tool) Hand Washing, initiated on [DATE] indicated, wash your hands as often as possible. Before starting to work with food utensils or equipment, and as often as needed during food preparation and when changing tasks.</p>		