

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045476	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Hampton Place Healthcare, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2029 South Hampton Place Rogers, AR 72758	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49866</p> <p>50923</p> <p>Based on observation, interviews, record review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed for 2 (Resident #56 and Resident #61) of 2 residents reviewed for MDS accuracy. Specifically, the facility failed to ensure information regarding the resident's hearing was accurately completed for Resident #56, and Resident # 61 was inaccurately coded for hospice services.</p> <p>The findings are:</p> <p>A review of the Order Summary dated December 2024, indicated the facility admitted Resident #56 with diagnoses of fracture of left femur, urinary tract infection (UTI), and history of falls.</p> <p>The admission Minimal Data Set (MDS), with Assessment Reference Date (ARD) of 10-31-2024, revealed that Resident #56 ' s hearing was adequate. Resident #56 ' s Brief Interview for Mental Status (BIMS) was a 9 and indicated moderately impaired cognitive impairment.</p> <p>A review of Resident #56 ' s care plan, with initiation date of 10-28-2024, did not reveal that Resident #56 was hard of hearing or required use of a hearing aid.</p> <p>A review of the Admission Record indicated that Resident #56 was hard of hearing and had a left hearing aid in ear.</p> <p>On 12/11/24 at 04:02 PM, the surveyor visited Resident #56. The resident was unable to hear the surveyor. A Certified Nursing Assistant (CNA) in the room leaned into resident ' s ear and spoke loudly. The resident heard and responded to the surveyor. The surveyor observed Resident #56 wearing a hearing aid in the left ear.</p> <p>During an interview with Restorative Nursing Aide (RNA) #5, on 12/11/24 at 04:04 PM, she stated that resident was hard of hearing. She was unsure if the resident had hearing aids or not. RNA #5 reviewed the closet care plan and verified that hard of hearing and hearing aid neither one was on there for review.</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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with the MDS Coordinator, it was revealed that Resident #56 was hard of hearing. She had no knowledge that Resident #56 had a hearing aid. It was also revealed that hearing was coded as adequate on the MDS and in fact it was coded incorrectly.</p> <p>Review of the Admission Record revealed Resident #61 was admitted on [DATE] with a diagnosis of type II diabetes mellitus with diabetic polyneuropathy.</p> <p>Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/2024, revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of 11 (8-12 suggest moderate cognitive impairment). Per section GG of the MDS, Resident #61 required partial to moderate assistance with Activities of Daily Living (ADLs) and ambulated with the assistance of a walker or manual wheelchair. In section O, sub-section K1, it was noted that Resident #61 was under hospice care.</p> <p>During an interview on 12/09/2024 at 1:30 PM, Resident #61 confirmed the resident did not receive hospice care.</p> <p>Upon review of the physician orders, Resident #61 did not have an order for hospice care.</p> <p>During an interview on 12/09/2024 at 1:45 PM, Licensed Practical Nurse (LPN) # 6 confirmed Resident #61 was not ordered or received hospice care.</p> <p>During an interview on 12/12/2024 at 9:30 AM, the MDS Coordinator-LTC confirmed Resident #61 was not receiving hospice care and confirmed hospice was selected in section O, sub-section K1. The MDS Coordinator -LTC was asked why it was important to have accurate assessments of the residents within the MDS. The MDS Coordinator -LTC stated, Because the MDS is what helps create the care plan. The care plan is what the staff use to care for the residents.</p> <p>A facility policy titled Resident Assessment with no date was reviewed. The review revealed that comprehensive assessments will describe significant impairment in functional capacity. Therefore, to develop a care plan to be able to provide appropriate care and services for the resident.</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>49866</p> <p>Based on facility policy review, record review, and interviews, the facility failed to develop a person centered, comprehensive care plan for hearing loss or use of hearing aid for 1 (Resident #56) of 1 sampled resident reviewed for hearing loss.</p> <p>The findings are:</p> <p>A review of the facility policy titled Resident Assessment revealed that comprehensive assessments will describe significant impairment in functional capacity. Therefore, to develop a care plan to be able to provide appropriate care and services for the resident.</p> <p>A review of the December 2024 order summary indicated the facility admitted Resident #56 with diagnoses of fracture of left femur, urinary tract infection (UTI), and history of falls.</p> <p>The admission Minimal Data Set (MDS), with Assessment Reference Date (ARD) of 10-31-2024, revealed Resident #56 ' s hearing was adequate. Resident #56 ' s Brief Interview for Mental Status (BIMS) was a 9 and indicated moderately impaired cognitive impairment.</p> <p>A review of Resident #56 ' s care plan, with initiation date of 10-28-2024, did not reveal that Resident #56 was hard of hearing and required use of a hearing aid.</p> <p>A review of previous Admission Record, dated 8-7-2024, indicated that Resident #56 was hard of hearing and had a left hearing aid in ear.</p> <p>On 12/11/24 at 04:02 PM, the surveyor visited Resident #56, and the resident was unable to hear the surveyor. A Certified Nursing Assistant (CNA) in room leaned into resident ' s ear and spoke loudly. The resident heard and responded to the surveyor. The Surveyor observed the resident wearing a hearing aid in the left ear.</p> <p>During an interview with Restorative Nursing Aide (RNA) #5, on 12/11/24 at 04:04 PM, she revealed that the resident was hard of hearing. RNA #5 was unsure if the resident had hearing aids or not. She reviewed the closet care plan and stated hard of hearing and hearing aid neither one was on there for review.</p> <p>During an interview with the MDS Coordinator-Skilled it was revealed that Resident #56 was hard of hearing. The MDS Coordinator-Skilled had no knowledge that Resident #56 had a hearing aid. The MDS Coordinator-Skilled stated she did not add hearing loss or hearing aid usage to the care plan. The MDS Coordinator-Skilled revealed it was important to add these types of things to care plan because it was the guidance of how care was given to the resident.</p>

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508</p> <p>Based on observation, interview, and record review, the facility failed to ensure foods stored in the freezer were covered and sealed; 1 of 2 ice machines were maintained in clean and sanitary condition; expired food items were promptly removed, and dietary staff washed their hands before handling clean equipment or food items for 2 of 2 meals observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. On [DATE] at 1:22 PM, the following observations were made in the walk-in freezer. <ol style="list-style-type: none"> a. An opened box of fish. The box was not covered or sealed. b. An opened box of breaded chicken. The box was not cover or sealed. 2. On [DATE] at 1:27 PM, the following observations were made in the kitchen area. <ol style="list-style-type: none"> a. An opened bottle of lemon juice was on a shelf above the food preparation counter with an expiration date of [DATE]. The Dietary Manager (DM) was interviewed and was asked what she used lemon juice for. The DM stated the staff used it when they had a recipe that called for it, but they have not used it to bake anything in a long time. b. A bottle of lemon juice was on a shelf in the storage room with an expiration date of [DATE]. 3. On [DATE] at 1:49 PM, inside the back wall of the ice machine in a hall opposite the kitchen had buildup of wet black residue on it. This surveyor asked the DM if she could wipe the area where the wet black residue was observed. She did. Solid black residue easily transferred to the tissue. This surveyor asked the DM if she could describe what she saw on the back wall of the ice machine, where ice cubes were resting. She stated it was wet black residue. The DM was interviewed and was asked how often the ice machine was cleaned and who used the ice from the ice machine. She stated it was cleaned once a week, then sanitized every six (6) months. The kitchen staff used it to fill beverages served to the residents at mealtimes, and the Certified Nursing Assistants (CNA) also used it for the water pitchers in the residents' rooms. 4. On [DATE] at 1:52 PM, the scoop holder attached to the body of the ice machine had wet brown residue at the bottom of it and the ice scoop was resting directly on it. This surveyor asked the DM if she could wipe the wet brown residue. She did so, and the wet brown residue easily transferred to the tissue. This surveyor asked the DM if she could describe what she saw at the bottom of the scoop holder and how often the scoop holder got cleaned. She stated it was cleaned every week, and there was a brown residue. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. On [DATE] at 2:03 PM, Dietary Aide (DA) #1 pushed a cart with an empty glass toward the refrigerator. DA #1 opened the refrigerator, removed pitchers of tea, punch, orange juice, and cartons of milk and placed them on the counter. DA #1 did not wash her hands when she picked up glasses by their rims and poured beverages to be served to the residents who requested juice with their supper meal. DA #1 was interviewed and was asked what she should have done after touching and before handling food items. DA #1 confirmed she should have washed her hands.</p> <p>6. On [DATE] 02:12 PM, Dietary [NAME] (DC) #2 turned on the sink faucet and washed his hands. He used his bare hands to turn off the faucet, contaminating his hands. DC #2 picked up scissors from the counter and placed in a cup on a shelf above the food preparation counter. DC #2 did not wash his hands when he removed the gloves from the glove box and put them on, contaminating the gloves. DC #2 then used his contaminated gloved hand to remove slices of bread from the bread bag and placed them on a pan liner to be used for making pimento cheese sandwiches for the supper meal. DC #2 was interviewed, and based on current observations, he was asked what he should have done after touching dirty objects and before handling food items. He stated he should have washed his hands before putting on gloves and handling food.</p> <p>7. On [DATE] at 2:15 PM, DA #3 turned the sink on and washed her hands. She used her bare hands to turn off the faucet, contaminating her hands. Without washing her hands, she picked up plates and placed them on a clean cart to be used in portioning food items to the residents for the supper meal with her fingers inside of the plates. DA#3 was interviewed and was asked what she should have done after touching and before handling food items. DA #3 confirmed she should have washed her hands.</p> <p>8. On [DATE] at 4:00 PM, DA #1 turned on the hand washing sink and washed her hands. She turned off the faucet with her bare hands, contaminating her hands. Without washing her hands, she picked up glasses by their rims and placed them on a cart to be used in serving beverages to the residents for the supper meal. On [DATE] at 04:02 PM, DA #1 opened the refrigerator, removed a carton of silk milk, a pitcher tomato juice, and orange juice. Without washing her hands, DA #1 picked up glasses by their rims and poured beverages to be served to the resident for the supper meal.</p> <p>9. On [DATE] at 4:14 PM, DA #1 pulled her blouse down, then pushed her sleeves back, contaminating her hands. Without washing her hands, DA #1 picked up glasses that contained beverages from the cart by their rims and placed them in the cooler by the steam table to be served to the residents for the supper meal.</p> <p>10. On [DATE] at 7:34 AM, DC #4 was on the tray line serving the breakfast meal. She picked up tray cards and placed them on the trays. Without washing her hands, DC #4 picked up plates and placed them on the trays to be used in portioning food items to be served to the residents for lunch with her fingers inside the plates. DC #4 was interviewed and was asked what she should have done after touching and before handling food items. DC #4 stated she should have washed her hands,</p> <p>11. A review of facility policy titled, Food Safety-Infection Control and Hand washing initiated [DATE] and provided by the DM indicated hands should be washed entering the kitchen and before, during and after food preparation.</p>		