STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045211	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Texarkana	2107 Dudley Street Texarkana, AR 71854

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 47916 Based on observation, record review, interview, and facility policy review, it was determined the facility failed to ensure a resident's personal and medical information was protected from potential unauthorized persons for 1 (Resident #306) sampled resident. Findings include: 1. A review of Medical Diagnosis, revealed Resident #306 had diagnoses of a brain bleed, respiratory failure, and type II diabetes a. Review of the discharge assessment-return anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/14/2024, and a Staff Assessment for Mental Status (SAMS) indicated Resident #306 had severe cognitive impairment. b. A review of a policy titled Confidentiality of Information and Personal Privacy, revised October 2017, revealed the facility will safeguard residents personal and medical records, and medical records will be limited to authorized staff. Computer stored information is protected according to resident rights, and privacy policies. c. On 10/07/24 at 10:44 AM, Licensed Practical Nurse (LPN) #1 went to Resident #306's room and left the computer screen open revealing Resident #306's name, room number, weight, vitals, allergies, and medications visible to anyone passing down the hall. d. On 10/07/2024 at 11:14 AM, LPN #1 told the Surveyor that the process for leaving the cart in the hall is to lock the medication cart and computer screen, so nobody has access to the resident information. It is the Health Insurance Portability and Accountability Act (HIPAA). e. A review of the Resident Rights, revealed that the information in a Resident's clinical record is confidential and requires a Resident's written consent to be disclosed. f. During an interview with the Director of Nursing (DON) on 10/09/24 at 04:19 PM, the DON stated there is a button on the computer screen the nurses are expected to push to lock the screen when they walk away from the computer. The DON confirmed that if the screen displays a resident's face, demographics, and medications then it is considered an invasion of privacy and a HIPAA violation. The Surveyor asked for any in-services, policy or procedures addressing privacy.

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47916 Based on observation, record review, interview, and facility policy review, it was determined the facility failed to ensure lift pads were in appropriate working order, free of fraying and loose strings to prevent potential accidents or injury for 1 sampled (Resident #10) resident; aerosol disinfectant was not stored at the bedside to prevent accidents or injury for 1 sampled (Resident #84); and failed to ensure the resident's environment remained free of accidents as possible and each resident received adequate supervision to prevent accidents for 1 sampled (Resident #69). Findings include: 1. A review of Medical Diagnoses revealed Resident #10 had diagnoses of stroke, heart failure, and diabetes type II. a. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/21/2024 suggested a Brief Interview for Mental Status (BIMS) score of 05 (0-7 indicates severe cognitive impairment). Section GG0139 indicated Resident #10 was totally dependent in all areas. b. A review of a policy titled, Lifting Machine, using a Mechanical, revised July 2017, revealed staff were to ensure all necessary equipment was in good working condition before use. c. A review of an in-service training dated 06/26/2024, revealed staff were trained on the safe transfer of residents, and the mechanical lift policy. d. Review of Resident #10's Care Plan revised 06/15/2023, revealed Resident #10 required assistance of 2 staff members with a mechanical lift transfers. e. On 10/07/24 at 10:00 AM, Certified Nursing Assistant (CNA) #9 was observed pushing the lift away from Resident #10's adjustable chair at Resident #10's bedside. The Surveyor observed the lift pad placed under Resident #10 had fraying and loose strings around the lift pad edges. f. On 10/07/24 at 10:05 AM, CNA #9 was asked to look at Resident #10's lift pad and CNA #9 pointed out frayed areas, and loose strings. CNA #9 stated it is tearing, and the thread is coming out. When asked if staff would want to use lift pads that are frayed and tearing, CNA #9 stated the resident could be dropped, and there was a possibility of the lift pad ripping while being used with a resident and the resident could be dropped in the air. g. During an interview the Director of Nursing (DON) on 10/09/2024 at 04:12 PM, the DON stated that the CNA supervisor is responsible for inspecting lift pads and confirmed that any lift pad with fraying or loose strings should be thrown away and reported to the DON for replacement. Please summarize/paraphrase your interview. The DON stated that using lift pads that are damaged could rip when being used with a resident and cause them to fall. 2. A review of Medical Diagnoses revealed Resident #84 had diagnoses of brain injury, anxiety, and depression. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/20/2024 suggested a Brief Mental Status (BIMS) of 09 (8-12 indicates moderate cognitive impairment). b. On 10/07/24 at 10:24 AM, a can of disinfectant spray was observed at Resident #84's bedside. c. On 10/09/24 at 03:44 PM, Resident #84 was observed sitting in a wheelchair to the left of a bedside table with a can of disinfectant spray resting nearby. Resident #84 stated a relative brings the disinfectant spray for the bathroom. Certified Nursing Assistant (CNA) #10 stated that staff are not allowed to have a disinfectant spray but did not see a problem with family bringing it in for their use. d. During an interview with the Director of Nursing (DON) on 10/09/2024 at 04:12 PM, the DON confirmed residents were not allowed to have disinfectant spray at the bedside, and stated a confused person could spray it in their face. The DON stated there were no in-services or a policy or procedure addressing aerosol disinfectants at the bedside. 3. On 10/07/24 at 12:26 PM, during an interview, Resident #69 informed the surveyor that the resident took pain medications and was waiting on the nurse to bring the medications just anytime. LPN #1 knocked on Resident #69's door and partially opened it. Resident #69 greeted LPN #1 by her name. The surveyor was standing behind the partially opened door. The surveyor observed someone reach into the room and hand a clear medicine cup, with a white pill in it, to Resident #69. LPN #1 immediately shut the door without watching Resident #69 take the pill. Resident #69 reached for a cup of water, from her over the bed table, as she held the medicine cup with the white pill inside in her right hand. The surveyor asked Resident #69 if she could look at the pill. The surveyor noted it was a white round tablet with a 3 on the side facing up. The surveyor asked Resident #69 who had handed Resident #69 the medicine cup with the white pill. Resident #69 said [LPN #1] handed me my Acetaminophen-Codeine #3, my pain pill. Resident #69 then took the pill. Resident #69 then told the surveyor LPN #1 brought them Albuterol (a vial of medication) for their breathing machine and told Resident #69 to put it in their purse until they got ready to use it, and that LPN#1 told them not to tell anyone. So, I put it beside me in my chair until I was ready to use it. Resident #69 reported doing their own breathing treatments every day. Resident #69 said when they were administering their breathing treatment when the Infection Nurse saw them and informed the resident they wasn't supposed to be doing that by themselves. Resident #69 then asked why not. Resident #69 then said the Infection Nurse stood there and watched them until they finished the breathing treatment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 10/07/24 at 12:43 PM, the Surveyor interviewed LPN#1. LPN#1 explained the process for administering medication, stating LPN#1 follows the 5-Rs (rights) of medication administration: right patient, right medicine, right time, right route, and right date. The surveyor asked LPN #1 if residents here administer their own breathing treatments or give their own medications. LPN #1 told the surveyor some residents hold their own tubing after we put the medication in the machine, and then we watch them to make sure they take all the medication correctly. No resident gives themselves their medication because we need to know they take it, and the right amount is taken at the right time. The surveyor asked LPN #1 if they had left Albuterol with a resident today and left the room before administering it. LPN #1 said, Yes, with [Resident #69], because [Resident #69] asked us to leave it. The surveyor asked if she saw Resident #69 administer the Albuterol. LPN #1 said No. The surveyor asked what the risk was of leaving the Albuterol with the resident. LPN #1 said, The resident could overuse it or not use all of it. The surveyor asked if she knew if Resident #69 still had the Albuterol in Resident #69's room. LPN #1 said, No, I don't know. The surveyor asked if she had handed a medicine cup with an Acetaminophen-Codeine to Resident #69 and shut the door without seeing Resident #69 take the Acetaminophen-Codeine. LPN #1 said, Yes, I was interrupting Resident #69, so I left it, but that is not a reason to leave a resident with their medication because a resident might not take it. The surveyor asked if she knew if Resident #69 took the medication. LPN #1 said, Yes because she always takes her pain medicine. The surveyor asked if she had seen Resident #69 take the medication. LPN #1 said No. b. On 10/07/24 at 1:00 PM, the surveyor informed the Director of Nursing (DON) and the Administrator of Acetaminophen-Codeine being left with Resident #69 to self-administer. c. On 10/07/24 at 1:15 PM, the Surveyor interviewed the Infection Preventionist (IP) Registered Nurse (RN) #5. The IP said she had not actually witnessed LPN #1 leave the Albuterol with the resident but that she had witnessed the resident administering the treatment without supervision, so she stayed and supervised the resident while the resident received the medication. d. A review of Resident #69's Order Summary Report, revealed Resident #69 takes 1 tablet of Acetaminophen-Codeine by mouth every six hours for pain; and Albuterol Sulfate Inhalation Nebulization Solution three milliliters via nebulizer two times a day due to chronic obstructive pulmonary disease (COPD). e. A review of Resident #69's care plan revealed Resident #69 takes Acetaminophen-Codeine with instructions to ensure accuracy when prescribing, dispensing, and administering acetaminophen/codeine oral solution or suspension. Dosing errors due to confusion between mg and mL and other codeine-containing oral products of different concentrations can result in accidental overdose and death. f. On 10/10/24 at 9:14 AM, Care Consultant #7 provided a policy titled, Administering Oral Medications. Item 21 instructs staff to remain with the resident until all medications have been taken. g. On 10/10/24 at 9:45 AM, the Director of Nursing informed the surveyor that a Self-Administration Assessment was completed for Resident #69 to self-administer Albuterol on 10/7/24 at 2:30 PM. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. On 10/10/24 at 11:45 AM, an interview was conducted with the Director of Nursing (DON). The DON said new Licensed Practical Nurses (LPNs) are provided three days of orientation unless they request more, then more is provided. The DON said she, and other nurses, provide on-going training for Medication Administration, and the Pharmacy Consultant along with other nurses, conduct medication pass observations with the nurses. A previous staff conducted the medication pass observation with LPN #1. The DON said LPN #1 should not have left the narcotic or the Albuterol with Resident #69 because Resident #69 had not been assessed to self-administrator medication. The DON provided the surveyor with in-service training dated 8/16/24 and 9/12/24 on Medication Administration in which LPN #1 was in attendance. The in-services dated 8/16/24 and 9/12/24 instructed the nurse to remain with the residents until medications are swallowed. In-service dated 9/12/24 gives a second instruction stating Please note the nurse must remain in the resident's room while medication is administered for nebulizer (Albuterol updrafts) setting up the medication and leaving the room will be considered a medication error unless the resident has an order to self-administer their medication. 49596

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 Based on observation, record review, interview, and facility policy review, it was determined the facility failed to ensure medication carts were locked when left unattended to prevent accidents, or the misappropriation of medications on the 600 Hall; doctor ' s orders were followed; and a feeding tube was flushed before and after giving medications through a feeding tube for 1 sampled (Resident #306) resident of 3 sampled (Resident #76, #101, #306) residents reviewed for tube feeding. Findings include: 1. A review of a policy titled Storage of Medications, revised November2020, revealed compartments containing drugs or biologicals, including carts, are expected to be locked when they are not in use. a. A review of an in-service titled, Medication Pass Tip Sheet, dated 04/30/2024, revealed the medication cart should be locked when unattended, unless the cart is pulled up to the resident's door with the drawers opening into the room. b. On 10/07/24 at 10:44 AM, Licensed Practical Nurse (LPN) #1 was observed leaving the medication cart unlocked on 600 Hall when entering room [ROOM NUMBER]A and closing the door. c. On 10/07/24 at 10:56 AM, the Administrator walked down the hall and was observed locking the medication cart. d. On 10/07/24 at 11:12 AM, LPN #1 was asked the process for leaving the medication cart when going into a resident room. LPN #1 told the Surveyor that the medication cart should have been locked so nobody would have access to medications in the cart. e. During an interview with the Director of Nursing (DON) on 10/09/2024 at 04:20 PM, the DON stated the medication cart should be locked when left unattended to prevent residents from having access and taking medications from the cart. 2. A review of Medical Diagnosis, revealed Resident #306 had diagnoses of a brain bleed, respiratory failure, and type II diabetes. a. Review of the discharge assessment-return anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/14/2024, and a Staff Assessment for Mental Status (SAMS) indicated Resident #306 had severe cognitive impairment. b. Review of a policy titled, Administering Medications through an Enteral Tube, revised November 2018, revealed staff should verify there is a physician's order, administer the medication between flushes, stop feeding and flush with at least 15 milliliters of warm purified water, and administer medication to gravity. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. A review of the Physician Orders, dated 07/17/2024, revealed medications can be crushed and mixed together with a flush of 60 milliliters of water before and after. d. A review of the Physician Orders, dated 09/27/2024, revealed an order for an anti-nausea medication every 8 hours as needed for nausea and vomiting via feeding tube. e. On 10/07/24 at 10:44 AM, Licensed Practical Nurse (LPN) #1 was observed crushing an anti-nausea medication and mixing it in 6 to 8 ounces of water. f. On 10/07/24 at 12:29 PM, LPN #1 was observed unhooking the feeding tube from Resident #306 and then she placed a syringe into the feeding tube and without checking placement or flushing, the anti-nausea medication in the water mixture was poured into the syringe. LPN #1 used the syringe plunger to get the mixture to go into the tube. LPN #1 did not flush behind the anti-nausea medication. g. On 10/07/2024 at 11:14 AM, during an interview the Surveyor asked LPN #1 the process for flushing and giving medications with a feeding tube. LPN #1 stated it was not necessary to flush before and after giving medication and confirmed there are orders to flush the feeding tube twice a day, but I just add a little more water to the crushed pills when I am giving them. h. On 10/10/24 at 09:40 AM, the Director of Nursing confirmed a nurse should flush the feeding tube before and after giving medications to make sure any medication is cleared from the tube.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03508 Based on observation, interview, and facility policy review, the facility failed to ensure dietary staff washed their hands before handling clean equipment when contaminated; the ice machine was maintained in clean and sanitary condition, and cold food items were maintained at 41 degrees Fahrenheit or below. The findings are: 1. On 10/9/24 at 1:19 PM, Dietary Aide (DA) #2 picked up tray cards and placed them on the trays located on the food carts. Without washing her hands, he picked up plates from the clean rack and placed them on the plate warmer with her hands inside of them. DA #2 stated he should have washed his hands. 2. On 10/9/24 at 1:24 PM, the top panel of the ice machine in the nourishment room on the 400 Hall had a wet reddish pink slimy residue on it. It was pointed out to the Dietary Manager, and the Dietary Manager was asked if the residue build up could be wiped off. She used a tissue and wiped it off. The pinkish residue easily transferred to the tissue. At 1:25 PM, during an interview the Dietary Manager stated that the residue was slimy, wet, and reddish pink, and the ice was being used by the Certified Nursing Assistants (CNAs) to fill the water pitchers in the residents' rooms and they cleaned it every month. 3. On 10/9/24 at 4:35 PM, the temperatures of the cold food items on pans of ice on the counter by the steam table were checked by Dietary [NAME] (DC) #4 were: a. Pimento cheese sandwich - 50.4 degrees Fahrenheit. b. Pureed pimentos cheese - 44.1 degrees Fahrenheit. c. Three bean salad - 53.2 degrees Fahrenheit. d. On 10/10/24 at 11:33 AM, during an interview DC #4 was asked about the process of keeping cold food items cold before being served. DC #4 stated she should have kept it on ice when she first put it in the refrigerator. 4. On 10/10/24 at 9:40 AM, DA #3 turned on the two compartment sink faucet and obtained water in a pitcher and then turned off the faucet. Without washing his hands, he picked up glasses by the rims and placed them on the trays to be used in portioning food items to be served to the residents for the lunch meal. 5. A review of a facility policy titled, QRT [Quick Reference Tool] Hand Washing, initiated on 9/1/2021 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.