

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/07/2025
NAME OF PROVIDER OR SUPPLIER The Springs of Pinnacle Mountain		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure dietary orders were followed for one (Resident #1) of three residents. The findings include:</p> <p>A review of Resident #1's admission Record indicated the facility admitted the resident on 06/25/2025, with diagnoses which included a partial intestinal obstruction, a non-cancerous growth or tumor of the pancreas, abnormal heart rhythm, and swelling of both lower limbs.</p> <p>A review of Resident #1's 5-day Minimum Data Set (MDS) with an Assessment Reference Date of 06/27/2025, revealed the resident had a Brief Interview for Mental Status score of 15, which indicated intact cognition. The remainder of the MDS, including functional abilities, health conditions, and medications, was not completed.</p> <p>A review of Resident #1's Hospital Discharge records indicated the resident had the following procedures performed: on 06/03/2025 &ndash; Whipple Procedure (a complex abdominal surgery primarily used to treat tumors in the head of the pancreas) and a hernia repair. On 06/16/2025 &ndash; a medical procedure where a thin, flexible tube with a camera is used to examine the esophagus, stomach, and the first part of the small intestine (EGD). On 06/18/2025 -an EGD with placement of a percutaneous endoscopic gastrostomy (PEG) tube. The resident's Hospital Discharge Record also indicated Resident #1 was not to perform any heavy lifting and was to have a clear liquid diet, with sips of liquids, and tube feedings of a prescribed formula at 20 milliliters (ml) per hour and to increase the rate by 10 ml every six to eight hours, until a rate of 61 ml per hour was reached.</p> <p>A review of Resident #1's Physician Orders indicated an order for a clear liquid diet and a nausea medication to be given as needed every eight hours, dated 06/25/2025. The resident's Physician Orders revealed an enteral feed order to run at 20 ml an hour, via pump continuously with water flushes of 45 ml an hour, and to increase by 10 ml every 6 to 8 hours until a goal of 61 ml, if tolerated, dated 06/26/2025. Resident #1's Physician Orders also indicated a chest x-ray for blood in sputum, dated 06/29/2025.</p> <p>During an observation on 07/03/2025 at 3:45 PM, this surveyor observed dietary communication slips, &ldquo;Tray Card Slip&rdquo; for Resident #1, which revealed a clear liquid diet for 06/25/2025, and a clear liquid diet/texture on 06/26/2025.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 045431
		If continuation sheet Page 1 of 5

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #1's Care Plan initiated 06/27/2025, indicated the resident required extensive assistance with Activities of Daily Living, with an intervention that directed staff to encourage the resident to use their call light and request assistance. The resident's Care Plan also instructed staff to serve the residents diet as ordered by the physician. Resident #1's Care Plan did not address the resident's PEG tube status or feeding.</p> <p>A review of Resident #1's Advanced Practice Registered Nurse (APRN) Progress Notes dated 06/26/2025, indicated the resident had experienced delayed gastric emptying following their Whipple Procedure. The APRN assessment included 4+ edema to both lower extremities (A 4+ edema rating scale indicates a very deep indentation (8mm or greater) that takes 2-3 minutes to rebound after pressure is applied, according to a medical resource. This is considered the most severe grade of pitting edema), flank swelling, abdominal pain, nausea, and bloating. The APRN's physical assessment indicated Resident #1 had clear lungs, even unlabored respirations, hyperactive bowel sounds, flank swelling, rounded abdomen, and pain of abdomen with palpitation.</p> <p>A review of Resident #1's APRN Progress notes dated 06/27/2025, indicated the resident reported nausea, and the resident had accidentally been given a regular tray, with a cheeseburger and fries. Resident #1 had consumed a portion of it and appeared uncomfortable. The nausea was treated with anti-nausea medication and the resident was re-educated on following the clear liquid diet and tube feedings, as ordered.</p> <p>A review of Resident #1's Progress Notes dated 06/29/2025 at 6:43 AM, revealed Registered Nurse (RN) #3 indicated bloody vomitus was observed in a basin, in the resident's room. The APRN was notified, and a chest x-ray was ordered. The chest x-ray results revealed lungs being clear with no acute cardiopulmonary concerns.</p> <p>A review of Resident #1's Skilled Nursing Note, dated 06/29/2025 at 11:23 PM, revealed RN #3 indicated the resident was receiving nutrition via PEG tube on a feeding pump. Resident #1's Skilled Nursing Note also revealed RN #3 documented that the resident had no pain, no respiratory issues, was not receiving oxygen, and had no swelling.</p> <p>A review of Resident #1's Medication Administration Record (MAR) for June of 2025, indicated the resident's tube feeding was ordered and started on 06/26/2025 at 1:10 PM. Resident #1's MAR also revealed the resident's anti-nausea medication was given twice during their stay: on 06/27/2025 at 12:58 PM, and again on 06/30/2025 at 3:24 AM.</p> <p>A review of Resident #1's Progress Notes dated 06/30/2025, indicated that RN #3 reported the resident was found unresponsive at 5:15 AM, cardiopulmonary resuscitation was initiated, and emergency medical services were called. The paramedics pronounced Resident #1's time of death at 5:30 AM.</p> <p>During an interview on 07/03/2025 at 9:52 AM, Licensed Practical Nurse (LPN) #3 revealed nurses wrote the residents diets on a pink slip, that was then given to kitchen staff and managers. When asked if LPN #3 knew why Resident #1 received a cheeseburger and fries while being on a clear liquid diet, she stated, I believe they got that, but don't know why.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 07/03/2025 at 9:54 AM, an RN who worked under the surgeon who performed the Whipple Procedure stated Resident #1 had called on 06/26/2025 at 12:45 PM, due to not having received their tube feeding since entering the facility on 06/25/2025. RN #4 stated, I called the facility at 1:06 PM, and spoke with the nurse and was told the facility had just received the order for the tube feeding. The RN could not remember the nurse she spoke with at the facility. The RN went on to say, It's my understanding they [the facility] had given the resident a regular tray with a cheeseburger, and they [the resident] were only supposed to be getting clear liquids and their tube feeding.</p> <p>During an interview on 07/03/2025 at 12:00 PM, the Treatment Nurse revealed she did not realize the meal Resident #1 received was not part of their diet, until she investigated it. The Treatment Nurse explained the process of ensuring residents received the correct diet order was whoever placed the trays on the meal cart were supposed to double check the diet orders to ensure they matched the food. The Certified Nursing Assistants (CNAs) then compared the diet orders with the food, before the meal was given to the resident. The Treatment Nurse stated, [Resident #1] had the meal in their room and part of [Resident #1's] cheeseburger was missing when I noticed the food on tray off to the side. The resident complained of nausea, and I was going to see if we could get [Resident #1] something for nausea. The Nurse Practitioner told me the resident was on a clear liquid diet. The charge nurse and I confirmed the resident was eating a cheeseburger.</p> <p>During a telephone interview on 07/02/2025 at 3:21 PM, Resident #1's family member reported the resident called their surgeon's nurse on Friday 06/27/2025 and informed her of not being fed for two days. The family member stated the surgeon's nurse had called the facility concerning Resident #1 not being fed and that the facility had given Resident #1 a cheeseburger and fries that same day. The family member also reported Resident #1 had told the family, they had been vomiting since having received the regular tray for lunch. Per the family member, family had visited Resident #1 on Sunday 06/29/2025 and found the resident with dried blood on their face, in their nose, on their clothes, and on their bed linens. The staff had told the family the dried blood was due to oxygen the resident was receiving, which had dried out the nasal passages and caused the dried blood. The family member reported Resident #1 had bloody vomit in the trash can in their room. Resident #1 was not nauseated or vomiting during their visit, due to having received nausea medication. The family member reported the APRN informed the family that the resident had a bowel blockage.</p> <p>During a telephone interview on 07/03/2025 at 10:04 AM, RN #3 reported during the beginning of their shift on 06/29/2025, they had witnessed sputum mixed with blood in a bath basin in Resident #1's room. When asked if RN #3 had completed a Change of Condition assessment, they reported they had not and instead notified the APRN and received an order for a chest x-ray.</p> <p>During an interview on 07/03/2025 at 10:56 AM, Certified Nursing Assistant (CNA) #6 reported that on Saturday 06/28/2025, they witnessed Resident #1 vomiting and described it as being dark green and did not observe anything bright red that looked like blood. CNA #6 went on to say the CNA from the previous shift had reported to them that Resident #1 had been vomiting all day, and it continued through CNA #6's shift.</p> <p>During an interview on 07/03/2025 at 11:42 AM, RN #7 confirmed giving Resident #1 anti-nausea medication due to the resident being nauseated.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/03/2025 at 12:40 PM, the ADON reported they were notified on 06/26/2025 that Resident #1 had received and eaten a regular tray. She explained that when the facility received the referral on the resident, the diet order was correct. When the resident was admitted, the pink slip was filled out and given to dietary to make the meal cards. The meal cards were then placed on the resident's trays for mealtimes. The ADON revealed that an investigation was completed in which she checked the orders that stated, clear liquids, but dietary on their orders stated, regular but clear liquid only. The first line said regular. The ADON explained, We don't know how our orders got sent to their orders and read like that on their side. When asked if she had been aware of the resident having nausea and vomiting up blood, the ADON stated, No. I did not know that [Resident #1] was having nausea, vomiting, and bleeding for all of those days, until I came into work on Monday 06/30/2025 and [Resident #1] had passed. There was hearsay that the resident had blood in the vomit.</p> <p>During an interview on 07/03/25 at 1:58 PM, the APRN indicated they had not witnessed Resident #1 vomiting blood, but confirmed the resident had 4+ swelling to both lower extremities, and that the resident had informed her of having gained 40 pounds during their time in the hospital. The APRN stated she assumed it was improving, since the resident was taking a diuretic. The APRN went on to relate the call she received from RN #3 about having noticed a small amount of blood in Resident #1's sputum and confirmed a chest x-ray had been ordered at that time. She stated the x-ray did not indicate Resident #1 had a respiratory issue. The APRN then reported she was not notified of Resident #1 vomiting blood, and that if she had, she would have given an order for them to be transferred to the hospital. After the results of the chest x-ray, the next time the APRN was notified of any condition change was 06/30/2025, when Resident #1 had expired.</p> <p>During an interview on 07/03/2025 at 3:04 PM, the DON confirmed they had been notified of Resident #1 having eaten a regular diet, when there was a mishap with the diet order. The DON reported that the APRN assessed the resident after they ate the cheeseburger and fries. The process of ensuring the residents received the correct diet order was by the referral that came with the hospital paperwork, and the facility either continued to follow the hospital paperwork, or the provider did a medication reconciliation. The DON explained there was a discrepancy between the two systems they had, one said, clear thin and the dietary systems said, Regular clear liquids only. The DON stated they would train staff on distribution of the wrong tray and provide ongoing training. In addition, the DON said he was planning on retraining staff on assessment and documentation.</p> <p>During an interview on 07/03/2025 at 3:25 PM, the Administrator explained the diet order was what was completed first, with a diet slip for the Electronic Medical Record System and was communicated to dietary. He explained that it was a mistake that happened. The Administrator revealed the dietary system showed Resident #1 on a regular diet and clear liquid stating, They should have seen the sheet with the order, prior to giving them out.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/03/2025 at 4:15 PM, the Dietary Manager (DM) confirmed Resident #1 was given food that was not part of their diet, one time on 06/26/2025. The DM explained that the cook read on the ticket that Resident #1 had a regular diet. She explained that a nurse informed the DM that the resident was eating a cheeseburger. The DM reported that whoever touched the ticket in the beginning placed the food on the plate. Then the dietary aides placed the drinks and ice cream on the trays, filled up the hall carts, and then placed the carts on the halls. The DM explained that the CNAs ensured the food dietary placed on the trays was correct and then took it to the resident. The DM reported that in-services were completed with most of her staff and CNAs to ensure to read each part of the ticket, so the incident would not happen again.</p> <p>During an interview on 07/03/2025 at 4:50 PM, the Dietary Manager (DM) stated, I'm not allowed to change the information in the system, but I compare the information to the information on [the electronic medical record system]. The DM verified that she thought the regular option on the system was in reference to the type of diet such as no added salt, or diabetic diet, and not the consistency of the meal.</p> <p>During an interview on 07/07/2025 at 6:09 PM, [NAME] #1 revealed that the tray goes from the cook to the dietary aides in the kitchen, and then to the CNAs. She reported that if the CNAs noticed something different, they were to let dietary know. [NAME] #1 reported that Resident #1's diet information was written down and stated, I saw regular, and the aide did not see clear liquid after that and that is how it got done.</p> <p>A review of a facility policy titled, Change of residents condition, with a revision date of February 2025, indicated, The nurse will notify the residents attending physician when there has been .a significant change in the resident's condition, need to alter the resident's treatment .</p>		