STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045158	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Greers Ferry	1040 Wedding Ford Road Heber Springs, AR 72543

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview the facility failed to ensure dignity was maintained during lunch service in the dining room as evidenced by staff members not sitting with residents to help them with lunch for two sampled residents, (Resident #45 and Resident #70). These are our findings: 1. A review of the Order Summary revealed Resident #45 had diagnoses of dementia and stroke with weakness on the right dominant side. A review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/08/2024 revealed Resident #45 was given the Staff Assessment for Mental Status (SAMS) which indicated a memory problem for long term and short-term memory. A review of the Care Plan revealed Resident #45 required supervision with eating and required set-up assistance only with eating. 2. A review of the Order Summary revealed Resident #70 had a diagnosis Alzheimer's disease. A review of the Quarterly MDS with an ARD of 07/14/2024 revealed Resident #70 was given the SAMS, which indicated a memory problem for long term and short-term memory. A review of the Care Plan revealed Resident #70 required supervision with set-up assistance with meals/eating. On 08/12/2024 at 1:40 PM, the Surveyor observed Resident #45 and Resident #70 being set up with their lunch meal by Certified Nursing Assistant (CNA) #5 and CNA #6. On 08/12/2024 at 1:42 PM, the Surveyor observed CNA #5 standing next to Resident #70 encouraging the resident to eat lunch. CNA #5 proceeded to bend over and feed Resident #70 a couple bites of scalloped potatoes. CNA #6 was standing next to Resident #45 and was offering the resident verbal encouragement to eat lunch. CNA #6 proceeded to bend over and help Resident #45 with holding their fork. On 08/12/2024 at 1:45 PM, the Surveyor observed CNA #5 and CNA #6 still standing next to Resident #70 and Resident #45. CNA #5 was helping Resident #70 with lunch by offering bites of food. CNA #6 was still offering verbal encouragement to Resident #45. (continued on next page)

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/12/2024 at 1:50 PM, during an interview, CNA #5 and CNA #6 stated that when feeding a resident, you are to sit down next to them. CNA #5 stated that is to keep them from feeling intimidated by the staff members. CNA #6 asked what to do if there are no chairs available to sit next to residents during lunch. CNA #5 stated they should have gone to find chairs instead of standing next to the residents while they ate lunch. On 08/15/2024 at 8:36 AM, during an interview, the Director of Nursing (DON) stated when feeding residents, you sit down next to them to make sure a homelike environment is established. The DON stated that you would not stand over a resident as it is intimidating and not homelike. A review of the facility policy Resident Rights revealed, .Employes shall treat all residents with kindness, respect, and dignity .

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review, and interview, the facility failed to ensure the menu card was followed to accommodate one (Resident #61) sampled resident. The findings are: A review of the Order Summary, revealed Resident #61 had diagnoses of dementia, underweight, abnormal weight loss, anorexia, and malnutrition. A review of the Order Summary, revealed Resident #61 had an order for regular enhanced food, mechanical soft texture, thin consistency, with snacks three times a day in between meals, ice cream twice a day, high calorie juice every morning, and enhanced pudding three times a day with meals. A review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/2024, revealed Resident #61 scored an 11 (moderately cognitively impaired) on a Brief Interview for Mental Status (BIMS). On 08/12/2024 at 1:20 PM, the Surveyor observed Resident #61's lunch tray being set up. Chocolate ice cream, peach yogurt, and dessert were in bowls sitting on the tray around the plate that contained ground ham, cauliflower, scalloped potatoes and a slice of bread. Resident #61 immediately began to eat the container of chocolate ice cream. Resident #61 then ate the peach yogurt, and afterwards ate the dessert that was in a separate bowl. Resident #61 tried a couple bites of ground ham, cauliflower and the scalloped potatoes that were on the plate, only to grimace. Resident #61 did not touch the plate again except to pick up the bread to eat it. On 08/12/2024 at 1:50 PM, during an interview, Certified Nursing Assistant (CNA) #7 confirmed Resident #61's lunch card stated to put food in bowls. CNA #7 stated it could help the Resident #61 eat more of their lunch by picking up a bowl instead. On 08/15/2024 at 9:26 AM, during an interview, the Speech Therapist stated they had been working at the facility for a month. Then stated that the bowls were incorporated for the resident either by the previous speech therapist or nursing. The Speech Therapist stated that typically nursing or therapy would add it to make it easier for the resident to eat and hold it close to them so they will eat more. The Speech Therapist stated sometimes the resident does and sometimes the resident does not get all food in bowls at meals. On 08/15/2024 at 09:33 AM, during an interview, the Administrator stated it is important to follow menu orders on a lunch card as the doctor, or therapy has ordered it for the resident, so they will eat and get nutrition. On 08/15/2024 at 09:41 AM, during an interview, the Dietary Manager stated the process to ensure menu cards are followed is that we have somebody that is certified at the window, or I (the Dietary will watch the trays as they go out. The person at the window is supposed to follow what the menu card says. The Dietary Manager stated for Resident #61 that it is a nursing suggestion, from the staff that work on the secure unit regularly, to put the food in bowls so they will eat more at meals, as of right now the resident does not have good intake, they eat like a bird all day. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Accommodation of Needs stated, .Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed. This failed practice had the potential to affect 8 residents who received regular diets from 1 of 1 kitchen according to a list provided by the Dietary Manager on 8/12/24. The findings are: 1. On 8/12/24, a facility noon meal menu indicated all residents were to receive 3 ounces of ham. Residents on pureed diets were to receive ½ cup of pureed scalloped potatoes. 2. A facility titled recipe for baked ham initiated on 4/25/2024 indicated for 85 residents, the serving size 3 ounces. For 85 residents use a 22 1/8 pound ham, slice ham into 4 ounce slices, place the ham in a roasting pan, single stacked, add water, and cover the pan with foil. Serve: 3 ounces meat. 3. On 8/12/24 at 12:07 PM, Dietary [NAME] (DC) #1 used a #8 scoop (equivalent to 1/2 cup) to place 6 servings of scalloped potatoes into a blender and pureed, instead of total of 10 servings since 2 residents were to receive pureed doubled portions. 4. On 8/12/24 at 12:16 AM, DC #1 placed 10 small servings of sliced ham into a blender, added its juice and pureed. She poured it into a pan and placed it on the steam table. 5. On 8/12/24 at 1:53 PM, all residents were served small portions of sliced ham. 6. On 8/12/24 at1:55 PM, the Dietary Manager was informed about the portion of ham served to the residents for the noon meal and she asked for the meat to be weighed. She did, and stated, It weighed 1.5 ounces and that wasn't enough. 7. On 8/13/24 at 10:31 AM, DC #1 was asked how many pounds of ham she had prepared for the lunch meal and if she looked at the recipe to see how much to prepare for the noon meal on 8/12/2024. DC #1 confirmed, she made a 10 pound ham and did not look at the recipe. 8. On 8/13/24 at 1:30 PM, during a meeting of the Resident Council, Resident #41 reported that during the last year the portion sizes of meal items were noticeably smaller. The other 3 (Residents #53, #20, and #16) members present verbalized agreement with the assessment that the food portions served were remarkably smaller.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, and interview, the facility failed to ensure pureed food items were blended to a smooth, lump free consistency to minimize the risk of choking or other complications for those residents who required pureed diets for 2 of 2 meals observed. The failed practice had the potential to affect 8 residents who received pureed diets. The findings are. 1. On 8/12/24 at 12:16 AM, Dietary [NAME] (DC) #1 placed 10 servings of sliced ham into a blender, added its juice and pureed. She poured it into a pan. And placed it on the steam table. The consistency was thick. 2. On 8/12/24 at 12:07 PM, DC #1 used a #8 scoop (equivalent to 1/2 cup) to place 6 servings of scalloped potatoes into a blender and pureed, the consistency was runny. 3. On 8/12/24 at 1:23 PM, DC #1, who prepared the noon meal, was asked to describe the consistency of the pureed ham and pureed scalloped potatoes served to the residents on pureed diets. DC #1 stated the pureed scalloped potatoes were thin and she should have pureed the ham longer to get the right consistency. 4. On 8/13/24 at 7:35 AM, during the breakfast meal service, the following food items were served to the residents on pureed diets: a. Pureed bread. The appearance was too thick. b. The pureed grits were runny. 5. On 8/13/24 at 7:36 AM, Certified Nursing Assistant (CNA) #3 was assisting residents in the dining room with their breakfast meal. She was asked to describe the consistency of the pureed bread and pureed grits served to the residents who required pureed diets. She stated, Pureed bread was thick and pureed grits was thin. 6. On 8/13/24 at 7:40 AM, Dietary [NAME] (DC) #1, who was still serving the breakfast meal was asked to describe the appearance of the pureed bread and pureed grits served to the residents who required pureed diets. DC #1 stated, Pureed bread was thick and pureed grits were thin. 7. A facility policy titled, Pureed Diet no initiated date, provided by the Dietary Manager on 8/13/2024 indicated under how to check the texture is to make sure food is smooth with no lumps; there is no separate thin liquid; food should sit in a pile on the fork; food holds its shape on the spoon; and food is not sticky. A pureed diet is recommended to ensure residents who have problems with swallowing difficulty do not choke.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and facility policy review, the facility failed to ensure kitchen ceiling tiles were cleaned to provide a sanitary environment for food preparation; and the ice machine on the 400 Hall was maintained in a clean and sanitary condition to prevent food and beverage contamination in 1 of 1 kitchen; expired food items were promptly removed/discarded on or before the expiration or use by date to prevent the growth of bacteria; leftover food items were used in a manner to maintain food quality; and dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 82 residents who received meals from the kitchen (total census:82), as documented on a list provided by the Dietary Manager on 8/12/2024. The findings are: 1. On 8/12/24 at 10:34 AM, the following observations were made in the kitchen: a. The ceiling air vent slats between the steamtable and stove had dust on them. The ceiling tiles by the vent hood were peeling paint, exposing the cement. The area exposed had black stains on it. b. The ceiling tiles in the kitchen had dust on them. c. The ceiling air vent panels between the 2 door refrigerator had rust on them. d. The ceiling air vent panels around the food preparation counter and the stove had rust on them. 2. On 8/12/24 at 10:35 AM, the deep fryer was covered in greasy food particles. The Dietary Manager was asked when they clean the deep fryer. She stated, Every week. They used it on Friday, and it should have been cleaned. 3. On 8/12/24 at 10:36 AM, Dietary [NAME] (DC) #1 was wearing gloves on her hands when she picked up a bag of bread from the counter and untied it, contaminating the gloves. Without washing her hands and changing gloves, DC #1 used her contaminated gloved hand to remove slices of bread and place them on the pan liner on the counter. She then removed the lid from a container of peanut butter and a bottle of grape jelly that were on the counter and spread the peanut butter and jelly on the bread to be served to the residents who requested a peanut butter and jelly sandwich with their lunch. 4. On 8/12/24 at 10:54 AM, the following observations were made on a shelf in the refrigerator in the kitchen: a. Four packages of boiled eggs in an open box had an expiration date of 7/20/2024. b. A 15 pound box of bacon, the manufacturer's specification on the box indicated, Use by/freeze by 7/20/2024. There was no date indicated on the box when it was pulled out of the freezer or opened. The Dietary Manager stated they pulled it out over the weekend to be used on Monday, so it will be easy to pull apart. We have the received date on it, but no opened date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c. There were 2 opened bottles of lemon juice, the manufacturer's specification on the bottles indicated, Use by 6/7/2024. c. There were 2 opened bottles of lemon juice, the manufacturer's specification on the bottles indicated, Use by 6/7/2024. d. A zip top bag containing leftover sausages. Dietary [NAME] (DA) #1 was asked what the sausages were for. DC #1 stated, We used them the next day for the mechanical soft diets. 5. On 8/12/24 at 10:54 AM, the following observations were made on a shelf in the refrigerator in the kitchen: 6. On 8/12/24 at 11:42 AM, DC #1 removed 2 cartons of 2% milk from the milk refrigerator in the storage room and emptied them into a bowl, contaminating her hands. Without washing her hands, DC #1 picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents on pureed diets for noon meal. DC #1 was interviewed on what she should have done after touching dirty objects and before handling clean equipment, DC #1 stated, I should have washed my hands. 7. On 8/12/24 at 12:40 PM, the following observations were made on a shelf in the kitchen storage room freezer: a. An opened box of pizza. The box was not covered or sealed. b. An opened box of chicken fried steak. The box was not covered or sealed. 9. On 8/12/24 at 1:20 PM, Dietary Aide (DA) #2 turned on the hand washing sink and washed her hands. Using her bare hands to turn off the faucet, contaminating her hands, before drying her hands with tissue paper. She removed a bottle of grape jelly from the refrigerator and placed it on the counter, removed a bag of bread from the bread rack in the kitchen storage room and placed it on the counter. Without washing her hands, she removed gloves from the glove box and placed them on her hands, contaminating the gloves. She used her contaminated gloved hand to remove slices of bread from the bread bag and placed them on the pan liner on the counter. She removed the lid from a bottle of grape jelly and the lid from a container of peanut butter and spread them on the bread to be served to the residents who requested peanut butter with their lunch. DA #2 was asked what she should have done after touching dirty objects and before handling food items. DA #2 stated, I should have washed my hands. 10. On 8/12/24 at 1:49 PM, the ice machine on the 400 Hall had wet grayish residue collected on the corners and around the area where ice touched before dropping into the ice collector. It was pointed out to the Dietary Manager and asked if the residue build up could be wiped off. She used tissue paper and wiped it off. The wet grayish residue easily transferred to the tissue. The Dietary Manager was asked who used the ice from the ice machine and how often they cleaned it. She stated that it was cleaned weekly, and they use it in the kitchen to fill beverages served to the residents at mealtimes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11. A facility policy titled, Food & Nutrition Services Handwashing, initiated 9/1/2021, indicated hand washing should be done before starting to work with food, utensils, or equipment and as often as needed during food preparation and when changing tasks.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review, observations, and interviews, the facility failed to ensure infection control measures, including hand hygiene were implemented during tracheostomy care for 1 (Resident #9) of 1 sampled resident to prevent potential infection and or the spread of infections. The findings are: 1. Review of a facility policy provided by the Director of Nursing (DON) titled, Suctioning the Lower Airway (Endotracheal or Tracheostomy Tube) with a revision date of October 2010, stated that the nurse should apply sterile gloves and observe sterile technique while suctioning. A review of an admission Record indicated the facility admitted Resident #9 with a diagnosis of quadriplegia with abnormalities of breathing with a tracheostomy. On 08/13/24 at 2:04 PM, Licensed Practical Nurse (LPN) #9 was observed performing tracheostomy care on Resident #9. While performing care she washed her hands, gloved and put on her gown. Resident was on Enhanced Barrier Precautions. Before suctioning, LPN #9 started out with a sterile field, with her sterile hand she removed the resident's outer cap to the trach and placed it onto the sterile field contaminating the sterile field. With her contaminated hand, she picked up the suction catheter and inserted it into the resident's airway. After she completed suctioning, she used the same hand to replace the cap and touched the inner cannula of the trach. On 08/13/2024 at 2:25 PM, during an interview Licensed Practical Nurse (LPN) #9 stated she should not have laid the cap on the sterile field because it contaminated the sterile field, and she should have changed gloves after removing the outer cap. On 08/14/24 at 3:10 PM, during an interview the Director of Nursing (DON) stated LPN #9 should have not laid the cap on the sterile field because it contaminated the sterile field, and she should have changed gloves after removing the outer cap.