STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045367	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windcrest Health and Rehab Inc	2455 Lowell Road Springdale, AR 72764

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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to shave, clean the hands and face, and change clothing for 1 (Resident #2) of 1 resident reviewed for dignity. Findings include: A review of a facility policy titled, Resident Rights, revised on 12/01/2016, indicated residents would have their existence dignified and would be treated with respect kindness and dignity. A review of Resident #2 ' s admission Record, indicated the facility admitted Resident #2 with diagnoses that included Parkinsonism, dementia, chronic pain, and muscle weakness. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2024, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact; needed supervision or touching assistance with personal hygiene; and partial to moderate assistance with upper body dressing. A review of Resident #2 ' s Care Plan, initiated on 12/26/2023, revealed the resident had an ADL deficit. Interventions included extensive assistance by one staff for personal hygiene and oral care and extensive assistance by one staff for dressing. A review of an Activity of Daily living task listed in the Documentation Survey Report, Personal Hygiene, revealed Resident #2 had personal hygiene every shift and staff were to layer clothing instead of applying loose articles such as a lap blanket to accommodate feeling cold when up to wheelchair related to mental awareness. A review of the MDS [NAME] Report, printed on 06/21/2024, indicated Resident #2 needed extensive assistance with personal hygiene and dressing. During an observation on 10/28/2024 at 1:28 PM, Resident #2 returned to room after noon meal in the dining room, the area around the mouth, chin and hands were covered in orangish-red sauce from meal and the tee shirt that was worn was stained with droppings from the noon meal. Resident #2 had the appearance of not being shaved for several days, as indicated by the hair growth on the cheeks and chin. (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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(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 - Few	During an observation on 10/29/2024 at 8:14 AM, Resident #2 ' s room was darkened due to the light being off. Resident #2 was sitting in wheelchair waiting to go to bed. Resident #2 in need of a shave due to facial hair growth on chin and cheeks. Droppings of food were noted on the shirt being worn at that time. During an observation on 10/29/2024 at 12:30 PM, Resident #2 was sitting at the dining room table eating lunch and was noted with long facial hair on chin and cheeks and the same shirt that Resident #2 was wearing at breakfast was still being worn with the same stains visible. During a concurrent interview and observation on 10/29/2024 at 1:47 PM, Resident #2 was made aware of the facial hair growth and the stains of food on the face, and beard and that the shirt had not been changed since breakfast and was still soiled with droppings of food from breakfast and lunch, and a large coffee stain around the neck of the shirt. When asked Resident #2 stated a preference to be clean and did not want to be dirty. During an interview on 10/30/2024 at 8:55 AM, the Certified Nursing Assistant (CNA) #4 stated Resident #2 did like to be shaved and that with dressing, it was extensive assistance that was needed. CNA #4 confirmed CNAs provide showers and sometimes Resident #2 will refuse to be shaved, only when not feeling good, but most of the time will allow staff to shave when it is needed. CNA #4 confirmed Resident #2 ' s face and hands should have been cleaned prior to leaving the dining room and the shirt should have been changed if Resident #2 agreed, and it should have been offered. During an interview on 10/30/2024 at 12:39 PM, Director of Nursing (DON) confirmed Resident #2 should have had his face and hands cleaned prior to leaving the dining room, and staff should have offered to change the soiled shirt.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, it was determined that the facility failed to ensure that residents had a clean, safe, homelike environment by not repairing water damaged ceiling, walls, light fixtures, and not keeping furniture and linens clean. The findings are: 1. On 10/28/2024 at 11:55AM, Resident #11's bedsheets were observed to have a brown, wet substance on them. Resident #11 confirmed she had an accident and needed assistance. A Certified Nursing Assistant (CNA) was called into the room to assist resident. a. On 10/29/2024 at 8:27AM, observed Resident #11 having the same bedsheets as the day before, and brown substance appeared to be dried on the sheets. 2. On 10/29/2024 at 8:31AM, in the hall of the secure unit, two ceiling tiles and a light covering appeared to have been wet by the appearance of brown ring stains, and a spot in the light covering that looked like liquid. 3. On 10/29/2024 at 8:48AM, rubber stripping that connects the floor with the wall in the dining room was peeled back and a hole was exposed in the wall. a. On 10/29/2024 at 8:49AM, in the dining room, above the exit sign, the ceiling tile was brown, as though it had been wet. b. On 10/29/2024 at 8:49AM, in the dining room, the wall had a lump in it and was spongy to touch. The rubber stripping that attaches the wall to the floor was not attached to the floor. The stripping was pulled up, and what appeared to be a wooden or cement wall was exposed, that looked like it had been wet. The wooden or cement surface had black and gray substance, and the bottom looked to be eroding and crumbling. 4. On 10/29/2024 at 8:59Am, in the secure unit of the facility, there was a chair in the dayroom that was observed to have several stains. The chair was a greenish gray color, and the stains were darker in color, as though there had been spills on it. 5. On 10/29/2024 at 11:44AM, an air conditioner was observed in a resident's room, that had a metal casing that attached it to the wall along with a puffy yellow substance around the edges where the air unit met the wall. 6. On 10/30/2024 at 8:45AM, a picture of the chair with stains, from the unit in the facility, was shown to the Administrator. The Administrator was asked if he would sit in the chair or have it in his home. The Administrator confirmed that the chair should not have been in the building, and it would be removed promptly. (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 10/30/2024 at 8:47AM, a picture of Resident #11's bedsheets was shown to Administrator. Administrator was asked if the bedsheets needed to be changed. Administrator confirmed the bedsheets should not have been left on resident's bed in that condition. 7. On 10/30/2024 at 2:11PM, the surveyor observed in the secure unit of the facility, that the dirty chair with stains had been removed from the unit. Surveyor asked CNA #1 where the chair went and CNA #1 stated the chair was not even supposed to be in there, somebody came and took it out. 8. On 10/30/2024 at 2:13PM, Resident #11's bedsheets had been changed and resident was in bed taking a nap. 9. On 10/30/2024 at 2:15PM, Licensed Practical Nurse (LPN) #9 confirmed that resident's sheets are changed on bath day. LPN #9 confirmed CNAs are to change the bedsheets if needed or resident gets a bath. LPN #9 stated CNAs are assigned to residents, and it changes daily. There are no housekeeping chore assignments for the CNA's. 10. On 10/30/2024 at 2:45PM, the Administrator provided a copy of the Quality of Life-Homelike Environment Policy for the facility. The policy indicates that the residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 11. On 10/31/2024 at 7:30AM, upon entering facility the surveyor noticed several places in the dining room ceiling leaking a liquid onto the floor. Housekeeper #2 confirmed this happens often. Housekeeper #8 confirmed it happens every time it rains. a. On 10/31/2024 at 7:59AM, the Administrator confirmed the facility's roof leaks when it rains, and they have quotes to have the roof fixed and waiting for approval from owners. b. On 10/31/2024 at 9:52AM, the Maintenance Director (MD) confirmed the floors, walls, and rubber stripping were worn badly and needing repair. The MD said that new tile is on its way and when the new floor was laid, the walls and rubber stripping would be replaced. The MD also confirmed the roof leaks when it rains, and it was hard to seal the leaks when the roof was flat and stays wet from holding water. 12. On 10/28/2024 at 12:11PM, the air conditioning unit in room [ROOM NUMBER] had a yellowish tinge to the upper section where the cold air was dispersed. The same vent area showed a blackish brown substance adhered to the inside of the upper section and the vent fins. The vent joints contained a greyish-white, fuzzy substance. The wall directly to the left side of the window, behind the headboard and the wall to the right, where a resident ' s bed was pushed up against it, had gouges of paint missing. 13. On 10/28/2024 at 12:14PM, the 300-hall dayroom air conditioning unit, showed an approximate two-inch vertical accumulation of a dark brown, fuzzy-like unknown substance that clogged the right vent screen. The bottom screen near first vertical plastic stabilizer on the left side was approximately one and a half inches. The bottom screen, near the first vertical plastic stabilizer on the right side, had approximately one-third of the middle section clogged with a similar unknown dark brown, fuzzy-like substance. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. On 10/28/2024 at 12:25PM, in room [ROOM NUMBER] the ceiling air vent near the window, directly above a resident's bed, contained several brown fuzzy objects hanging from the grating of the air vent. The wall air vent located by the door, where another resident ' s bed was pushed directly underneath the vent, contained a black grimy substance adhered to the air vent grid. 15. On 10/30/2024 at 7:33AM, a hallway 300 ceiling light cover contained what appeared to be various insect and spider carcasses, along with various black or brown specks. 16. On 10/31/2024 at 9:50AM, Maintenance Director, stated the air conditioning units were unable to be cleaned, but the facility was in the process of replacing them. The wall and ceiling air vents were maintenance responsibility to clean. The ceiling light covers were maintenance responsibility to clean. 17. On 10/31/2024 at 10:17AM, during an interview the Director of Nursing (DON) stated air filtration was a problem. Residents should not be exposed to the air coming out of dirty vents. It can exacerbate a lung diagnosis or increase a need for O2. All departments should be involved in observing and notifying maintenance or housekeeping to help keep air vents clean. 18. On 10/31/2024 at 10:23AM, during an interview Administrator stated, I need to get the housekeepers on deep cleaning ceiling vents and cleaning the air conditioning unit vent areas. The facility has been trying to replace the air conditioning units. 19. On 10/31/2024 at 10:30AM, the Nurse Consultant stated the facility does not have a housekeeping policy. 20. Review of a facility document, October 2024 housekeeping deep clean schedule showed October 1, 2024, room [ROOM NUMBER] and October 11, 2024, room [ROOM NUMBER] had been deep cleaned.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility document review, and facility policy review it was determined that the facility failed to ensure accuracy of the assessments required for the Minimum Data Set (MDS) for 1 (Resident #2) of 2 residents reviewed for accuracy and assessment completion of the MDS. Findings include: A review of a facility policy titled, Certifying Accuracy of the Resident Assessment, revised on December 2009 indicated, any personnel completing any section of the MDS must sign and certify accuracy of that assessment portion. A review of the admission Record, indicated the facility admitted Resident #2 with diagnoses that included Parkinsonism, dementia, chronic pain and muscle weakness. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2024, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact; needed set up or clean up assistance with eating and oral care, supervision or touching assistance with personal hygiene; partial to moderate assistance with upper body dressing, toileting, bed mobility which included sit to lying, lying to sitting on the side of the bed, sit to stand position, and chair to bed transfer, toilet transfer and tub/shower transfer. A review of Resident #2 ' s Care Plan, dated on 12/26/2023, revealed the resident had an Activities of Daily Living (ADL) self-performance deficit. Statement in the care plan: the assistance needed for self-care performance fluctuates and Resident #2 may require more or less assistance, therefore the staff will provide the needed assistance at the time based on the circumstances. Interventions included being able to feed self after setting up, extensive assistance with oral care, personal hygiene, dressing, bed mobility, and transfers needed. A review of Resident #2 ' s MDS [NAME] Report printed on 06/21/2024, indicated Resident #2 needed extensive assistance with personal hygiene and dressing. A review of an activity of daily living task in the Documentation Survey Report, bed mobility, revealed Resident #2 required partial to moderate assistance 3 out of 7 days and substantial to maximal assistance on 3 out of 7 days and total dependency on 1 out of 7 days. For the task of toileting, required substantial to maximal assistance 4 out of 7 days, 2 out of 7 days of total dependence and 2 out of 7 days for partial to moderate assistance. The task of transferring, 4 out of 7 days required substantial or maximal assistance, 3 out of 7 days required partial to moderate assistance and 1 day Resident #2 was independent with transfer. During an observation on 10/28/2024 at 1:28 PM, Resident #2 returned to room after noon meal in the dining room, the area around the mouth, chin and hands were covered in orangish-red sauce from meal and the tee shirt that was worn was stained with droppings from the noon meal. Resident #2 had the appearance of not being shaved for several days as indicated by the hair growth on the cheeks and chin. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/29/2024 at 8:14 AM, Resident #2 ' s room was darkened due to the light being off. Resident #2 was sitting in wheelchair waiting to go to bed. Resident #2 in need of a shave due to facial hair growth on chin and cheeks. Droppings of food were noted on the shirt that was being worn at that time. During an observation on 10/29/2024 at 12:30 PM, Resident #2 was sitting at the dining room table eating lunch and was noted with long facial hair on chin and cheeks and the same shirt that Resident #2 was wearing at breakfast was still being worn with the same stains visible. During a concurrent interview and observation on 10/29/2024 at 1:47 PM, Resident #2 was made aware of the facial hair growth and the stains of food on the face and beard and that the shirt had not been changed since breakfast and was still soiled with droppings of food from breakfast and lunch and a large coffee stain around the neck of the shirt. When asked, Resident #2 stated a preference to be clean and did not want to be dirty. During an observation on 10/30/2024, CNA#4 and CNA#5 transferred Resident #2 to bed after breakfast. A gait belt was placed around Resident #2 ' s waist, the wheelchair was placed beside the resident's bed on the left side. The resident ' s jacket was removed. CNAs were on either side of Resident #2 and resident was asked to lean forward, with the use gait belt, Resident #2 was brought to a standing position with body bent forward, scooted feet to pivot and was placed in a seated position on the side of the bed with CNA#4 and CNA #5 providing maximal support for Resident #2. Once on the side of the bed, both CNAs had to assist Resident #2 to scoot further up to the head of the bed, CNA#5 turned the top half of the body while CNA #4 brought Resident #2's legs up and placed on the bed. During an interview on 10/30/2024 at 12:14 PM, CNA #4 stated the closet care plan was used to determine what type of assistance was needed with care provided to Resident #2. CNA #4 confirmed Resident #2 needed assistance with cleaning up, shaving and changing clothing. Confirmation was given by CNA #4, that Resident #2 was an extensive transfer of 2 staff members. During an interview on 10/30/2024 at 12:14 PM, MDS Coordinator stated to complete the MDS, observations were made, staff and residents were interviewed, and the chart was reviewed. The MDS coordinator confirmed the care plan was updated once the MDS had been completed. The MDS coordinator stated Resident #2 must have had a significant change, and the resident would be reevaluated. The MDS coordinator gave confirmation that the MDS and the Care Plan did not match on Resident #2. During an interview on 10/30/2024 at 3:00 PM, DON stated the inaccuracy of MDS ' had been identified and were brought to the attention of the Quality Assessment and Assurance Committee in June 2024. An action plan was put into place which included 1) Interdisciplinary team members were in-serviced to make sure information was entered correctly on the MDS the first time, 2) MDS coordinator and DON/Assistant Director of Nursing (ADON) in-serviced to ensure accuracy prior to signing and/or submitting the MDS, 3) The MDS coordinator will ensure the care plan was updated when completing the MDS, 4) MDS sections will be audited weekly to ensure all sections were being completed timely and accurately by the DON or designee, 5) hire new MDS coordinator, and 6) sign MDS coordinator up for training. DON stated the issue of MDS ' was discussed in the morning meetings and t the Administrator would have the minutes. When asked how the staff would know what plan to follow when caring for the residents, since the care plan, the closet care plan and the MDS did not match; DON stated the staff had a fall binder which would tell the staff what interventions had been put into place and what assistance would be required. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 3:10 PM, Administrator was asked to review the morning meeting minutes to see if there was any information regarding MDS inaccuracy issues. From June 2024 to October 2024, the Administrator confirmed there was no mention of MDS inaccuracy or care plan issues. Administrator confirmed there was a mention of the MDS inaccuracy in the July 2024 Quality Assurance meeting, but no further follow-up was documented in the following months. Administrator stated the DON had sent an email, titled Corrections/Plans from Mock Survey, dated 09/11/24 at 3:55 PM, stating five care plans would be reviewed in the morning start up. During an interview on 10/30/24 at 3:52 PM, DON provided paperwork showing care plan reviews but described no issues or how those issues were corrected. Most of the pages had no dates, no last names of residents and only 100 hall were provided. No other forms were provided to support any evidence that ongoing reviews for MDS and care plan inaccuracies were being completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility document review, facility policy review, it was determined that the facility failed to ensure care plans were updated with accurate information and failed to resolve care plans that were no longer needed for 1 (Resident #2) of 3 residents reviewed for Care Plans. The findings are: 1. A review of a facility policy titled, Resident Rights, revised December 2016, indicated residents have the right to be informed of and participate in care planning and treatment. 2. A review of Resident #2 ' s admission Record, indicated the facility admitted Resident #2 with diagnoses that included Parkinsonism, dementia, chronic pain and muscle weakness. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2024, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact; needed set up or clean up assistance with eating and oral care, supervision or touching assistance with personal hygiene; partial to moderate assistance with upper body dressing, toileting, and bed mobility which included: sit to lying, lying to sitting on the side of the bed, sit to stand position, and chair to bed transfer, toilet transfer and tub/shower transfer. A review of Resident #2 ' s Care Plan, dated on 12/26/2023, revealed resident had an Activities of Daily Living (ADL) self-performance deficit. Statement in the care plan: the assistance needed for self-care performance fluctuates and Resident #2 may require more or less assistance, therefore staff will provide the needed assistance at the time based on the circumstances. Interventions include being able to feed self after setting up, and extensive assistance with oral care, personal hygiene, dressing, bed mobility, and transfers. A review of Resident #2 ' s MDS [NAME] Report printed on 06/21/2024, indicated Resident #2 needed extensive assistance with personal hygiene and dressing. A review of an activity of daily living task in the Documentation Survey Report, titled bed mobility, revealed Resident #2 required partial to moderate assistance 3 out of 7 days and substantial to maximal assistance on 3 out of 7 days and total dependency on 1 out of 7 days. For the task of toileting, required substantial to maximal assistance 4 out of 7 days, 2 out of 7 days of total dependence and 2 out of 7 days for partial to moderate assistance. The task of transferring, 4 out of 7 days required substantial or maximal assistance, 3 out of 7 days required partial to moderate assistance and 1 day Resident #2 was independent with transfer. During an observation on 10/28/2024 at 1:28 PM, Resident #2 returned to room after noon meal in the dining room, the area around the mouth, chin and hands were covered in orangish-red sauce from meal and the tee shirt that was worn was stained with droppings from the noon meal. Resident #2 had the appearance of not being shaved for several days as indicated by the hair growth on the cheeks and chin. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/29/2024 at 8:14 AM, Resident #2 ' s room was darkened due to the light being off. Resident #2 was sitting in wheelchair waiting to go to bed. Resident #2 in need of a shave due to facial hair growth on chin and cheeks. Droppings of food were noted on the shirt being worn at that time. During an observation on 10/29/2024 at 12:30 PM, Resident #2 was sitting at the dining room table eating lunch and was noted with long facial hair on chin and cheeks and the same shirt that Resident #2 was wearing at breakfast was still being worn with the same stains visible. During a concurrent interview and observation on 10/29/2024 at 1:47 PM, Resident #2 was made aware of the facial hair growth and the stains of food on the face and beard and that the shirt had not been changed since breakfast and was still soiled with droppings of food from breakfast and lunch, and a large coffee stain around the neck of the shirt. When asked, Resident #2 stated a preference to be clean and did not want to be dirty. During an observation on 10/30/2024, CNA#4 and CNA#5 transferred Resident #2 to bed after breakfast. A gait belt was placed around Resident #2 ' s waist, the wheelchair was placed beside the resident ' s bed on the left side. The resident ' s jacket was removed. CNAs were on either side of Resident #2 and resident was asked to lean forward, with the gait belt, Resident #2 was brought to a standing position with body bent forward, scooted feet to pivot and was placed in a seated position on the side of the bed with CNA#4 and CNA #5 providing maximal support for Resident #2. Once on the side of the bed, both CNAs had to assist Resident #2 to scoot further up to the head of the bed, CNA#5 turned the top half of the body while CNA #4 brought Resident #2 ' s legs up and placed on the bed. During an interview on 10/30/2024 at 12:14 PM, CNA #4 stated the closet care plan was used to determine what type of assistance was needed with care provided to Resident #2. CNA #4 confirmed that Resident #2 needed assistance with cleaning up, shaving and changing clothing. Confirmation was given that Resident #2 was an extensive transfer of 2 staff members. During an interview on 10/30/2024 at 12:09 PM, the MDS Coordinator stated the treatment nurse and dietary are responsible for reviewing and updating care plans for their areas. The MDS Coordinator confirmed that the care plan was updated once the MDS has been completed. The MDS Coordinator stated Resident #2 must have had a significant change, and that resident would be reevaluated. Confirmation from the MDS coordinator was given that the MDS and Care Plan did not match on Resident #2. During an interview on 10/30/2024 at 3:00 PM, the Director of Nursing (DON) stated the inaccuracy of MDS ' had been identified and were brought to the attention of the Quality Assessment and Assurance Committee in June 2024. An action plan was put into place which included 1) Interdisciplinary team members were in-serviced to make sure information was entered correctly on the MDS the first time, 2) MDS coordinator and DON/Assistant Director of Nursing (ADON) in-serviced to ensure accuracy prior to signing and/or submitting the MDS, 3) MDS coordinator will ensure care plan is updated when completing the MDS, 4) MDS sections will be audited weekly to ensure all sections are being completed timely and accurately by the DON or designee, 5) hire new MDS coordinator, and 6) sign MDS coordinator up for training. DON stated the issue of MDS ' was discussed in the morning meetings and the administrator would have the minutes. When asked how the staff would know what plan to follow when caring for residents, since care plan, closet care plan and MDS did not match, DON stated staff had a fall binder which would tell what interventions had been put into place and what assistance would be required. (continued on next page)

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	045367	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windcrest Health and Rehab Inc	2455 Lowell Road Springdale, AR 72764

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/24 at 3:10 PM, the Administrator was asked to review the morning meeting minutes to see if there was any information regarding MDS inaccuracy issues. From June 2024 to October 2024, Administrator confirmed there was no mention of MDS inaccuracy or care plan issues. Administrator confirmed there was a mention of the MDS inaccuracy in the July 2024 Quality Assurance meeting, but no further follow-up was documented in the following months. The Administrator stated the DON had sent an email titled, Corrections/Plans from Mock Survey, dated 09/11/24 at 3:55 PM, stating five care plans would be reviewed in the morning start up. During an interview on 10/30/24 at 3:52 PM, the DON provided paperwork showing care plan reviews, but no issues were described and no details on how those issues would have been corrected. Most of the pages had no dates, no last names of residents and only 100 hall was provided. No other forms were provided to support any evidence that ongoing reviews for MDS and care plan inaccuracies were being completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility document review, facility policy review, it was determined that the facility failed to ensure the care plans were updated within the appropriate time frame with accurate information and failed to resolve care plans that were no longer needed for 3 (Resident #2, #14, and #23) of 3 residents reviewed for Care Plans. The findings are: 1. A review of a facility policy titled, Resident Rights, revised December 2016, indicated, residents have the right to be informed of and participate in care planning and treatment. 2. A review of Resident #2 ' s admission Record, indicated the facility admitted Resident #2 with diagnoses that included Parkinsonism, dementia, chronic pain, and muscle weakness. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2024, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact; needed set up or clean up assistance with eating and oral care, supervision or touching assistance with personal hygiene; partial to moderate assistance with upper body dressing, toileting, and bed mobility which included: sit to lying, lying to sitting on the side of the bed, sit to stand position, and chair to bed transfer, toilet transfer and tub/shower transfer. A review of Resident #2 ' s Care Plan, dated on 12/26/2023, revealed the resident had an Activities of Daily Living (ADL) self-performance deficit. Statement in Resident #2 ' s care plan: assistance needed for self-care performance fluctuates and Resident #2 may require more or less assistance, therefore staff will provide the needed assistance at the time based on the circumstances. Interventions include being able to feed self after setting up, and extensive assistance with oral care, personal hygiene, dressing, bed mobility, and transfers. A review of Resident #2 ' s MDS [NAME] Report printed on 06/21/2024, indicated Resident #2 needed extensive assistance with personal hygiene and dressing. A review of an intervention/task, in the Documentation Survey Report, titled, bed mobility, revealed Resident #2 required partial to moderate assistance 3 out of 7 days and substantial to maximal assistance on 3 out of 7 days and total dependency on 1 out of 7 days. For the task of toileting, Resident #2 required substantial to maximal assistance 4 out of 7 days, 2 out of 7 days of total dependence and 2 out of 7 days for partial to moderate assistance. The task of transferring, 4 out of 7 days required substantial or maximal assistance, 3 out of 7 days required partial to moderate assistance and 1 day Resident #2 was independent with transfer. During an observation on 10/28/2024 at 1:28 PM, Resident #2 returned to room after noon meal in the dining room, the area around the mouth, chin and hands were covered in orangish-red sauce from meal and the tee shirt that was worn was stained with droppings from the noon meal. Resident #2 had the appearance of not being shaved for several days as indicated by the hair growth on the cheeks and chin. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/29/2024 at 8:14 AM, Resident #2 ' s room was darkened due to the light being off. Resident #2 was sitting in wheelchair waiting to go to bed. Resident #2 in need of a shave due to facial hair growth on chin and cheeks. Droppings of food were noted on the shirt being worn at that time. During an observation on 10/29/2024 at 12:30 PM, Resident #2 was sitting at the dining room table eating lunch and was noted with long facial hair on chin and cheeks and the same shirt that Resident #2 was wearing at breakfast was still being worn with the same stains visible. During a concurrent interview and observation on 10/29/2024 at 1:47 PM, Resident #2 was made aware of the facial hair growth and the stains of food on the face and beard and that the shirt had not been changed since breakfast and was still soiled with droppings of food from breakfast and lunch, and a large coffee stain around the neck of the shirt. When asked, Resident #2 stated a preference to be clean and did not want to be dirty when asked. During an observation on 10/30/2024, Certified Nursing Assistant (CNA) #4 and CNA #5 transferred Resident #2 to bed after breakfast. A gait belt was placed around Resident #2 ' s waist, the wheelchair was placed beside the resident ' s bed on the left side. The resident ' s jacket was removed. CNAs were on either side of Resident #2 and resident was asked to lean forward, with the gait belt, Resident #2 was brought to a standing position with body bent forward, scooted feet to pivot and was placed in a seated position on the side of the bed with CNA #4 and CNA #5 providing maximal support for Resident #2. Once on the side of the bed, both CNAs had to assist Resident #2 to scoot further up to the head of the bed, CNA #5 turned the top half of the body while CNA #4 brought Resident #2 ' s legs up and placed on the bed. During an interview on 10/30/2024 at 12:14 PM CNA #4 stated the closet care plan was used to determine what type of assistance was needed with care provided to Resident #2. CNA #4 confirmed Resident #2 needed assistance with cleaning up, shaving and changing clothing. Confirmation was given that Resident #2 was an extensive transfer of 2 staff members. 3. A review of Resident #14 ' s admission Record, indicated the facility admitted Resident #14 with diagnoses that included cerebral infarction, cerebellar stroke syndrome, dementia, pain, and seizures. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/09/2024, revealed Resident #14 had BIMS score of 7 which indicated the resident had moderate cognitive impairment. Resident #14 required set up or clean up assistance with eating, supervision or touching assistance with oral care, upper and lower body dressing, required substantial or maximal assistance with showering/bathing and applying or removing footwear, partial to moderate assistance with bed mobility and personal hygiene. Resident #14 was dependent with toileting hygiene and transferring from one surface to another. A review of Resident #14 ' s Care Plan, initiated on 02/16/2018, indicated total dependence on staff for bathing and showering and transferring required 2 staff with the use of a mechanical lift. Resident #14 was able to feed self after setting up, and extensive assistance was required with bed mobility, personal hygiene and dressing. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #14 ' s MDS [NAME] Report, printed 06/20/2024, indicated Resident #14 required extensive assistance with bed mobility, dressing, toilet use, personal hygiene and total dependence for transferring. A review of an Activity of Daily living task in, the Documentation Survey Report, bed mobility for August 2024 revealed Resident #14 required total assistance with bed mobility 5 out of 7 days and partial to moderate assistance 2 out of 7 days. Toileting: 4 out of 7 days required total assistance, substantial to maximal assist for 1 out of 7 days and 2 days with partial to moderate assistance were required. During an observation on 10/28/2024 at 1:31 PM, Resident #14 was assisted to room by staff and 1 staff member was noted to be taking a mechanical lift into the room to assist the resident to bed. During an observation on 10/29/24 at 8:07 AM, Resident #14 was eating breakfast in the dining room without assistance. During an interview on 10/30/2024 at 4:10 PM, CNA #7 confirmed Resident #14 was unable to dress self, was transferred with a mechanical lift, and could not position self in bed. 4. A review of Resident 23 ' s admission Record, indicated the facility admitted Resident #23 with diagnoses that included encephalopathy (fluid on the brain), dependence on renal dialysis, chronic kidney disease, Stage 4 (severe), and acute metabolic acidosis. Review of 5-day Medicare Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/15/2024, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. Resident #23 was not marked for taking a high-risk drug, a diuretic. A review of Resident #23 ' s Care Plan, initiated 12/09/2022 revealed Resident #23 was on diuretic therapy related to hypertension. Interventions included administering the diuretic medication and monitoring for side effects and effectiveness, monitoring dose; and to monitor, document and report as needed any adverse reactions to the diuretic therapy. A review of the Order Summary Report, revealed Resident #23 did not have an order for any type of diuretic. During an observation on 10/28/24 at 1:00 PM, Resident # 23 was lying in bed on right side eating lunch and watching television. During an observation on 10/29/24 at 8:11 AM, Resident #23 was lying in bed, watching television and voiced no concerns. MDS coordinator confirmed Resident #23 was no longer on a diuretic and the care plan was last updated on 12/09/2022. MDS Coordinator stated according to the discontinued physician orders, the diuretic had been discontinued on 04/12/2023. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/30/2024 at 12:09 PM, MDS Coordinator stated, the treatment nurse and dietary are responsible for, reviewing and updating care plans for their areas. MDS Coordinator confirmed the care plan was updated once the MDS has been completed. Stated Resident #2 must have had a significant change, and that resident would be reevaluated. Confirmation was given by MDS Coordinator that MDS and Care Plan did not match on either Resident #2, #14, or #23, and had not been updated when the MDS had been completed. During an interview on 10/30/2024 at 3:00 PM, the Director of Nursing (DON) stated the inaccuracy of MDS ' had been identified and were brought to the attention of the Quality Assessment and Assurance Committee in June 2024. An action plan was put into place which included 1) Interdisciplinary team members were in-serviced to make sure information was entered correctly on the MDS the first time, 2) MDS coordinator and DON/Assistant Director of Nursing (ADON) in-serviced to ensure accuracy prior to signing and/or submitting the MDS, 3) MDS coordinator will ensure the care plan is updated when completing the MDS, 4) MDS sections will be audited weekly to ensure all sections are being completed timely and accurately by the DON or designee, 5) hire new MDS coordinator, and 6) sign MDS coordinator up for training. DON stated the issue of MDS ' was discussed in the morning meetings and that Administrator would have the minutes. When asked how the staff would know what plan to follow when caring for the residents, since care plan, closet care plan and MDS did not match, DON stated staff had a fall binder which would tell what interventions had been put into place and what assistance would be required. During an interview on 10/30/24 at 3:10 PM, the Administrator was asked to review the morning meeting minutes to see if there was any information regarding the MDS inaccuracy issues. From June 2024 to October 2024, the Administrator confirmed there was no mention of MDS inaccuracy or care plan issues. The Administrator confirmed there was a mention of the MDS inaccuracy in the July 2024 Quality Assurance meeting, but no further follow-up was documented in the following months. The Administrator stated the DON had sent an email, titled Corrections/Plans from Mock Survey, dated 09/11/24 at 3:55 pm, which stated five care plans would be reviewed in the morning start up. During an interview on 10/30/24 at 3:52 PM, the DON provided paperwork showing care plan reviews, but no issues were described and no details on how those issues would have been corrected. Most of the pages had no dates, no last names of residents and only 100 hall was provided. No other forms were provided to support any evidence that ongoing reviews for the MDS and care plan inaccuracies were being completed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility document review, facility policy review, it was determined that the facility failed to ensure resident was shaved, failed to clean resident ' s face and hands after meals and failed to assist resident with changing clothing after being soiled during meals for 1 (Resident #2) of 1 resident reviewed for activities of daily living. Findings include: A review of a facility policy titled, Activities of Daily Living (ADLs), Supporting, revised in March 2018, indicated, residents who were unable to independently carry out ADLs would receive services to maintain good nutrition, grooming and personal and oral hygiene. A review of Resident #2 ' s admission Record, indicated the facility admitted Resident #2 with diagnoses that included Parkinsonism, dementia, chronic pain, and muscle weakness. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2024, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact; needed supervision or touching assistance with personal hygiene; and partial to moderate assistance with upper body dressing. A review of Resident #2's Care Plan, initiated on 12/26/2023, revealed Resident #2 had an ADL deficit. Interventions included extensive assistance by one staff for personal hygiene and oral care and extensive assistance by one staff for dressing. A review of an intervention/task on the Documentation Survey Report, revealed Resident #2 had personal hygiene every shift, and staff were to layer clothing instead of applying loose articles such as a lap blanket to accommodate feeling cold while up to wheelchair related to mental awareness. A review of Resident #2 ' s MDS [NAME] Report , printed on 06/21/2024, indicated Resident #2 needed extensive assistance with personal hygiene and dressing. A review of an In-service Education Report, dated 08/02/2024, indicated staff were in-serviced on ADLs, baths, wheelchairs, transfers, and gait belts. During an observation on 10/28/2024 at 1:28 PM, Resident #2 returned to room after noon meal in the dining room, the area around the mouth, chin and hands were covered in orangish-red sauce from meal and the tee shirt that was worn was stained with droppings from the noon meal. Resident #2 had the appearance of not being shaved for several days as indicated by the hair growth on the cheeks and chin. During an observation on 10/29/2024 at 8:14 AM, Resident #2's room was darkened due to the light being off. Resident #2 was sitting in wheelchair waiting to go to bed. Resident #2 was in need of a shave due to facial hair growth on chin and cheeks. Droppings of food were noted on the shirt being worn at that time. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 10/29/2024 at 12:30 PM, Resident #2 was sitting at the dining room table eating lunch and was noted with long facial hair on chin and cheeks and the same shirt that Resident #2 was wearing at breakfast was still being worn with the same stains visible. During a concurrent interview and observation on 10/29/2024 at 1:47 PM, Resident #2 was made aware of the facial hair growth and the stains of food on the face and beard and that the shirt had not been changed since breakfast and was still soiled with droppings of food from breakfast and lunch, and a large coffee stain around the neck of the shirt. When asked, Resident #2 stated a preference to be clean and did not want to be dirty. During an interview on 10/30/2024 at 8:55 AM, Certified Nursing Assistant (CNA) #4 stated Resident #2 did like to be shaved and that with dressing, it was extensive assistance that was needed. CNA #4 confirmed CNAs provide showers and sometimes Resident #2 will refuse to be shaved, only when not feeling good, but most of the time will allow staff to shave when needed. CNA #4 confirmed Resident #2's face and hands should have been cleaned prior to leaving the dining room, and shirt should have been changed if Resident #2 agreed and that it should have been offered. During an interview on 10/30/2024 at 12:39 PM, Director of Nursing (DON) confirmed Resident #2 should have had his face and hands cleaned prior to leaving the dining room and staff should have offered to change the soiled shirt.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure medications were not pre-popped prior to administering medications to residents for 7 (Resident #5, #11, #15, #16, #26, #28, and #49) of 7 residents reviewed for preparation of medication administration. Findings include: A review of facility policy titled, Pharmacy Services Overview, revised in April 2007, stated pharmacy services were to provide feedback about performance and practices related to medication administration and medication errors. Services will collaborate with staff and practitioners to address and resolve medication problems. A review of facility policy titled, Administering Medications, revised April 2019, stated that medications will be administered in a safe, timely manner and as prescribed. Medications administered are to be verified with the resident ' s identity before administering medication and the person administering the medication must check the medication label three times to verify the correct resident, correct medication, correct dose, the right time and the right method. The person administering the medication was to sign the Medication Administration Record (MAR) after administering the medication and before administering any other resident ' s medication. During an observation on 10/30/2024 at 4:15 PM, Licensed Practical Nurse (LPN) #3 was noted to be placing empty medication cups on top of the medication cart. Some of the medication cups were noted to have initials on the outside of the cup and LPN #3 was holding a black marker. On 10/30/2024 at 4:24 PM, LPN #3 was observed taking a stack of cups that had medications in them and placed the cups in the top drawer of the medication cart. When LPN #3 was asked what was put in the medication cart, LPN #3 stated I was getting my medications together for the residents. LPN #3 confirmed medications were not to be pre-popped prior to giving and that medications were not supposed to be prepared that way. When asked why the medications had been pre-popped, LPN #3 stated, I thought you were gone. LPN #3 stated the Director of Nursing (DON) would not be happy about it. The DON walked out of the medication room behind the nurse ' s station, at that time and stopped at the medication cart. The DON was asked if it was known that LPN #3 was pre-popping medications and DON stated, No, and I am not happy about it. During an observation on 10/30/2024 at 4:33 PM, the DON went down the hall stating education was being provided for the rest of the nursing staff on duty. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/30/2024 4:34 PM, LPN #3 revealed staff had been educated on medication pass with lots of in-services. Confirmation was given that medications that had been pre-popped had been destroyed by crushing and putting the medications in the sharps container. LPN #3 described the proper way to prepare for medication administration was to confirm the right resident, look at the MAR, look at the medication card, make sure it was the right day scheduled, then pop the medication, go administer the medication and then come back and sign the medication off on the MAR. LPN #3 was asked what the importance was of not pre-popping medications and she stated, I know it is wrong, it is a bad habit. LPN #3 confirmed she had previously pre-popped medications and by stating, I know I did it yesterday too. LPN #3 stated the resident could die if they got the wrong medications. On 10/30/2024 at 4:46 PM, the DON informed the surveyor the facility was going to replace medications that had to be wasted at the facility ' s expense and that LPN #3 had been in-serviced and the Assistant Director of Nursing (DON) was observing medication administration with LPN #3. On 10/31/2024 at 11:04 AM, the DON stated she had no competencies on medication administration for LPN #3. The DON provided a list of the residents whose medications were observed being pre-popped on 10/30/2024, a list of what had been done to prevent recurrence of the same event and a copy of the Medication Administration Observation that had been completed on 10/30/2024 by the ADON. Two in-service records were provided by the DON titled, Preventing Medication Errors, dated 08/02/2024 and the in-service dated 10/30/2024 which stated, it is not best practice to pre-pop medications. Follow all steps for safe medication administration by preparing one resident at a time.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interview, the facility failed to ensure hot foods were served hot and cold dairy products were served cold to maintain palatability and encourage adequate nutritional intake for 1 of 1 meal observed. The findings are: 1. On 10/28/24 at 11:48 AM, Resident #30 stated the food was cold when served in the dining room and even colder if served in the resident's room. 2. On 10/30/24 at 12:38 PM, an unheated food cart was in the main dining room by the kitchen window. The first lunch tray for the unit was placed on a shelf in the unheated food cart by the Certified Nursing Assistant (CNA) #3. While CNA #3 was loading food trays in the unheated food cart, she left the door open. At 12:29 PM, as CNA #3 finished loading food trays onto the left side shelf of the food cart, she closed the door. The right side of the door remained open while she continued loading food cart. Once the right side was filled, she closed that door and delivered the food cart to the unit. The door was left open as the CNA #3 removed food trays from the food cart and served them to the residents in the unit dining room. At 1:13 PM, immediately after the last resident was served on the unit, the temperature of the food items on the test tray were taken and read by CNA #3 with the following results: a. Milk - 54.8 degrees Fahrenheit. b. Mashed potatoes - 108.1 degrees Fahrenheit. c. Pepper steak - 113 degrees Fahrenheit. d. Pureed pepper steaks with gravy - 111.7 degrees Fahrenheit. e. Sausage 107.4 degrees Fahrenheit. f. Ground sausage 98.7 degrees Fahrenheit. g. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045367	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windcrest Health and Rehab Inc	2455 Lowell Road Springdale, AR 72764

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)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fried potatoes - 109 degrees Fahrenheit. h. Fried Okra - 101.1 degrees Fahrenheit. i. Macaroni and Cheese - 110.1 degrees Fahrenheit. j. Vegetable blend - 110 degrees Fahrenheit. k. Pureed macaroni and Cheese - 95.9 degrees Fahrenheit. l. Pureed corn bread with milk - 97 degrees Fahrenheit. m. Pureed vegetable blend - 93 degrees Fahrenheit. n. Pureed ham and bean - 96.5 degrees Fahrenheit. 3. On 10/30/24 at 1:25 PM, CNA#3, was asked whether an unheated food cart should be left open when loading meal trays for lunch and when passing meal trays to the residents receiving their meal trays in dining room on the 100- hall (unit). CNA #3 mentioned that she had left the food cart open when passing the meal trays but had considered closing it. CNA#3 later confirmed she should have closed one side of the door.

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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 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. Based on observation, record review, interview, and facility policy review, the facility failed to ensure dish washing machine air vent was cleaned; floors, base boards, dish washer and kitchen walls were free of dirt; chipped floor tiles were replaced; a sanitary environment for food preparation was provided, and expired spices and leftover fruit items were promptly removed from stock for 1 meal observed. The findings are: 1. On 10/30/24 at 8:06 AM, the scoop holder on a wall by the ice machine in the kitchen had a gray, wet residue at the bottom of it. The scoop was directly touching the residue. The Lead Dietary [NAME] (LDC) was asked to wipe the gray residue at the bottom of the scoop holder. He did so, and the substance easily transferred to the paper towel. The LDC, when interviewed, stated, it [the residue] was gray in color. They use it [the ice machine] to fill beverages served to the residents at mealtimes, the CNAs (certified nursing assistants) use the ice for the water pitchers in the residents' rooms, and it is cleaned once a week. 2. On 10/30/24 at 8:07 AM, one container of leftover diced peaches, dated 8/21/24, was on a shelf in the refrigerator. The LDC stated it had been there too long. 3 On 10/30/24 at 8:09 AM, the wall around the water hose sink, on the dirty side of the dish machine, had discoloration of sage color. 4. On 10/30/24 at 8:13 AM, the base board, below the rack where clean pans were stored, was loose, the area that was exposed had sage color. 5. On 10/30/24 at 8:26 AM, the ceiling air vent, in the dish washing machine room, was rusty. 6. On 10/30/24 at 8:27 AM, the container of red pepper, on a shelf below the counter, had an expiration date of 9/24/2024. 7. On 10/30/24 at 11:27 AM, Dietary Aide (DA) removed crackers from a box under the counter for the residents. Without washing her hands, she picked up glasses by the rims and placed them on the tray to be used in serving beverages to the residents for lunch. 8. On 10/30/24 at 11:55 AM, the following observations were made in the kitchen. a. Dietary Aide, turned on the food preparation sink faucet, and filled a pitcher with water. Without washing her hands, she picked up glasses by the rims and placed them on the trays and poured beverages into each glass, to be served to the residents for lunch. b. The floor in front of the steamtable was chipped, exposing the concrete. c. There was a gap on the floor in front of the food preparation sink, exposing the cement. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. The floor, between the ice machine and the rack, where canned goods were stored in the storage room, was chipped, exposing the cement. e. 10/30/24 at 11:58 AM, the Dietary Aide removed a pitcher of tea from the refrigerator and placed it on the counter. Without washing her hands, she picked up glasses by the rims and poured beverages in them to be served to the residents for lunch. The Dietary Aide, when interviewed, stated she should have washed her hands. 9. A review of facility policy titled, Preventing Foodborne Illness -Employee Hygiene and Sanitary Practices, initiated October 2017, provided by the Administrator on 10/30/2024 indicated, employees should wash their hands after engaging in other activities that contaminate the hands.