

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER The Springs Searcy		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 Skyline Drive Searcy, AR 72143	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>38200</p> <p>Based on observation, interviews, record review, facility document review, it was determined that the facility failed to ensure the comprehensive care plan addressed and individualized appropriate care and services for 01 (Resident #101) of 2 (Resident #101, #9) sample mix residents reviewed for care plan; and to ensure care plan interventions were implemented for 1 (Resident #9) of 2 (Resident #101, #9) sample mix residents reviewed for care plan. The findings include:</p> <p>On 10/1/24 at 9:43 AM, the Surveyor interviewed Resident #101 and they revealed they are a smoker and that they have a smoking apron offered to them during smoke break, but they don't wear it.</p> <p>Review of Resident #101's Care Plan with an initiated date of 2/7/2024 did not note the resident is wear a smoking apron.</p> <p>The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/10/2024 revealed Resident #101 scored a 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). The MDS also revealed Resident #101 has a diagnosis of Alzheimer's disease.</p> <p>Review of Resident #101's Smoking Safety Screening completed on 9/18/2024 noted the resident is to wear a smoking apron with supervision while smoking.</p> <p>On 10/2/2024 at 11:20 AM, the Surveyor observed Resident #101 on smoke break with seven (7) other residents present. Certified Nurse Aid (CNA) #12 was present to supervise the smoke break. CNA #12 was observed asking the residents if anyone needed a smoking apron and all residents responded no. Resident #101 was observed sitting in wheelchair with no smoking apron.</p> <p>On 10/2/2024 at 11:20 AM, the Surveyor interviewed CNA #12 and she revealed the residents were evaluated for smoking aprons but that only one (1) resident was assessed to wear an apron and that was Resident #45. CNA #12 confirmed that the residents were assessed for wearing a smoking apron for safety and that none of the residents present were wearing a smoking apron.</p> <p>On 10/3/2024 at 11:29 AM, the Surveyor interviewed the Assistant Director of Nursing (ADON) and she confirmed that residents are assessed to wear smoking aprons during smoke breaks for safety reasons and that should explain why it should be worn. The ADON confirmed that Resident #101 is a smoker and assessed to wear a smoking apron but was not care planned to wear a smoking apron and that the care plan is how staff know how to properly care for the residents.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/3/2024 at 11:50 AM, the Surveyor interviewed the Director of Nursing (DON) and she confirmed that residents are assessed to wear smoking aprons during smoke breaks for safety reasons, and that staff observing the smoke break should not be asking residents assessed to wear a smoking apron if they want to wear it based on their assessment they are to have one on. The DON confirmed that Resident #101 is a smoker and assessed to wear a smoking apron but was not care planned to wear a smoking apron and that the care plan is how staff are aware of how to care for the resident.</p> <p>49413</p> <p>Based on observation, interviews, record review, facility policy review, it was determined that the facility failed to ensure the comprehensive care plan addressed and individualized appropriate care and services for 1 (Resident #101) of 2 sample mix residents reviewed for care plan; and to ensure care plan interventions were implemented for 1 (Resident #9) of 2 sample mix residents reviewed for care plan.</p> <p>The findings include:</p> <p>1. On 10/01/2024 at 9:43 AM, Surveyor interviewed Resident #101, who revealed they were a smoker and that they had a smoking apron offered to them during smoke break, but they do not wear it.</p> <p>Review of Resident #101's Care Plan with an initiated date of 02/07/2024 did not note the resident was to wear a smoking apron.</p> <p>Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/10/2024 revealed Resident #101 scored a 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). The MDS also revealed Resident #101 had a diagnosis of Alzheimer's disease.</p> <p>Review of Resident #101's Smoking Safety Screening completed on 09/18/2024 noted the resident was to wear a smoking apron with supervision while smoking.</p> <p>On 10/02/2024 at 11:20 AM, Surveyor observed Resident #101 on smoke break with seven (7) other residents present. Certified Nurse Aid (CNA) #12 was present to supervise the smoke break. CNA #12 was observed asking the residents if anyone needed a smoking apron and all residents responded no. Resident #101 was observed sitting in wheelchair with no smoking apron.</p> <p>On 10/2/2024 at 11:20 AM, Surveyor interviewed CNA #12, and she revealed the residents were evaluated for smoking aprons but that only one (1) resident was assessed to wear an apron and that was not Resident #101. CNA #12 stated residents were assessed for wearing a smoking apron for safety and none of the residents present were wearing a smoking apron.</p> <p>On 10/03/2024 at 11:29 AM, Surveyor interviewed the Assistant Director of Nursing (ADON) who stated residents were assessed to wear smoking aprons during smoke breaks for safety reasons and staff should explain why it should be worn. The ADON confirmed that Resident #101 was a smoker and assessed to wear a smoking apron but was not care planned to wear a smoking apron and t the care plan was how staff knew how to properly care for the residents.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/03/2024 at 11:50 AM, Surveyor interviewed the Director of Nursing (DON) who stated residents are assessed to wear smoking aprons during smoke breaks for safety reasons, and staff observing the smoke break should not be asking residents assessed to wear a smoking apron if they want to wear it. Based on their assessment the residents are to have a smoking apron on. DON indicated Resident #101 was a smoker and assessed to wear a smoking apron but was not care planned to wear a smoking apron and the care plan was how staff were aware of how to care for the resident.</p> <p>2. Review of a facility policy titled Residents Rights 2001 MED-PASS, Inc. (Revised February 2021) indicated federal, and state laws guarantee certain basic rights to all residents of the facility, including resident's right to be treated with respect, kindness, dignity, and self-determination.</p> <p>Review of facility policy titled Activity Programs 2001 MED-PASS, Inc. (Revised February 2021) indicated activity programs support the well-being of residents and encouraged independence and community interaction. Activities were based on comprehensive resident centered assessment and preferences of each resident that promote or enhance physical, cognitive or emotional health. Activities were not limited to those only provided by activities staff. Other staff members may also provide activities. Adequate equipment would be provided to ensure needed services in the resident's care plan are met.</p> <p>Review of facility policy Care Plans, Comprehensive Person-Centered 2001 MED-PASS, Inc. (Revised December 2016) indicated care plan would be consistent with the resident's rights to receive the services and/or items included in the care plan.</p> <p>Review of a Medical Diagnosis report indicated the facility admitted Resident #9 on 07/28/2021 with diagnoses of senile degeneration of the brain and sever dementia with other behavioral disturbance. Resident #9 has a cognitive ability of 0 which indicates a severe cognitive impairment. Resident #9's care plan indicated the following behaviors of combative with care, yells, curses, throws objects, disruptive, and bites. Likes to have a baby doll and will take other resident's (doll) and has impaired communication. Resident #9 resides on secure unit hall 8.</p> <p>On 09/30/2024 at 11:17 AM, Resident #9 was at the dining room table in a wheelchair. Resident #9 self-propelled into the hallway. Certified Nursing Assistant (CNA) #11 returned Resident #9 to the dining room table without explaining what was being done or asked if Resident #9 needed anything. Resident #9 was placed at a dining room table without any interaction or anything to do.</p> <p>On 09/30/2024 at 11:26 AM, Resident #9 self-propelled from the dining room for a second time. Resident #9 sat in the hallway in the wheelchair quietly. 11:28PM, CNA #11 returned Resident #9 to the dining room table without an explanation of what was being done or asking if Resident #9 needed anything. Resident #9 was placed at the dining room table without any interaction or anything to do. CNA #11 told Resident #9 they would eat real soon. Lunch meal was brought to Hall 9 between 12:45PM and 1:00PM.</p> <p>On 09/30/2024 at 12:10 PM, Resident #9 sat next to another Resident's walker. The Resident became agitated with Resident #9, told Training Nursing Assistant (TNA) #8 to move Resident #9. TNA #8 pushes Resident #9 to a dining room table away from the other resident. TNA #8 did not inform Resident #9 she was going to be moved. Resident #9 had no interaction from staff, other residents nor was provided any activity.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 09/30/2024 at 12:13 PM, a resident yelled out here [Resident # 9] comes. TNA #8 wheeled Resident #9 to the back dining room table. TNA #8 did not inform Resident #9 they would be moved prior. Resident #9 sat by themself without any interaction. Resident #9 became agitated after continuously being moved from one area to another. Resident #9 told TNA #8 to get out of here.</p> <p>On 09/30/2024 at 12:16 PM, another resident was upset that Resident #9 was coming back in their area. The resident was coloring and stated Resident #9 will take the color pencils.</p> <p>At 12:19 PM, another resident was agitated with Resident #9. CNA #11 moved Resident #9 to face the back wall dining room table.</p> <p>At 12:23 PM, Resident #9 tried to leave dining room for a third time in 17 minutes. CNA #11 returned Resident #9 to the back dining table and told Resident #9 to stay in dining room. After asking another resident if anything was needed CNA #11 then pulled Resident #9 (who was in a wheelchair) to the dining room table. Resident #9 asked what the [expletive] did I do [to be kept at the table].</p> <p>At 12:27 PM, Resident #9 left the dining room table, CNA #11 then pushed Resident #9 back to the dining room table while Resident #9 said [expletive] don't push me this way.</p> <p>At 12:29 PM, Resident #9 self-propelled from the dining room again, asked which way to go, then rolled down the hallway, TNA #8 returned Resident #9 to the dining room table and stated, lunch is almost here.</p> <p>At 12:35 PM, Resident #9 left the dining room table. Both CNA #11 and TNA #8 attempted to push resident #9's wheelchair back to the dining room table. Resident #9 told the CNAs to get the [expletive] away from them. CNA #11 and TNA #8 told Resident #9 lunch would be there soon.</p> <p>At 12:38 PM, Lunch meal was brought to Hall 9 dining room. TNA #8 pushed Resident #9 to table without explaining lunch had arrived. Resident #9 pushed away from table.</p> <p>At 12:44 PM, Resident #9 went to other side of dining room as they continued to wait for meal tray. Resident #9's care plan shows to provide resident with baby doll, sensory activities, assess and anticipate needs for food, thirst, toileting needs, redirect with conversation or other activity.</p> <p>At 1:04 PM, Resident #9 finished eating and self-propelled out of the dining room. Certified Nursing Assistant Supervisor pushed Resident #9 back to the dining room table. Resident #9 was not provided any type of activity or interaction.</p> <p>At 1:41 PM, Resident #9 remained in dining room without any activity or interaction from staff.</p> <p>On 9/30/2024 at 2:00 PM, 10/01/2024 at 8:35 AM, and 2:30 PM, Resident #9 did not have a baby doll with them or in their room as care plan showed.</p> <p>On 10/02/2024 at 11:08 AM, during an interview, CNA #9 stated, a resident should not be placed at a dining room table by themself unless they choose to. Staff needs to watch Resident # 9 to keep them from entering other resident's rooms which had caused other residents to become upset and angry. There is not a reason Resident # 9 should be at a table with nothing to do.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/02/2024 at 11:37 AM, during an interview LPN #10 stated a resident should not be placed at a table with nothing to do. They may get lonely which could cause them to get upset or angry. There is not a reason Resident # 9 was to be kept in the dining room.</p> <p>On 10/02/2024 at 3:12 PM, during an interview the ADON stated a resident should not be placed at a table alone. Staff can always get something for them to do. There was not a reason Resident # 9 was to remain in the dining room all the time.</p> <p>On 10/02/2024 at 3:40 pm, Activity Assistant stated Halls 9 and 10 have baby dolls and pop-it fidgets in cabinet for residents to use.</p> <p>On 10/02/2024 at 3:42 PM, Activities Director was unaware of the baby doll in Resident #9's care plan until Activities Director reviewed the care plan at this time.</p> <p>On 10/03/2024 at 11:00 AM, during an interview, MDS/Care Planner stated, the care plan goes to the task list. For example, activities interventions would show on activities tasks. Activities would let Hall 9 CNA staff know how to redirect or other interventions for the resident. Sensory redirect was for when activity department was with Resident #9. Resident #9's day to day activity without Activity Department involvement would be television and music usually played on Hall 9. Resident #9 did not have alternate activities documented.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>38200</p> <p>Based on observation, interviews, record review, facility document review, facility policy review, it was determined that the facility failed to ensure residents who were assessed to wear a smoking apron wore one during the facility allotted smoke break time, and to ensure residents were not in possession of a lighter for 1 (Resident #101) of 1 sample mix residents reviewed for smoking.</p> <p>The findings include:</p> <p>On 10/1/24 at 9:43 AM, Surveyor interviewed Resident #101 who revealed they are a smoker and that they have a smoking apron offered to them during smoke break, but they don't wear it.</p> <p>Review of Resident #101's Care Plan with an initiated date of 2/7/2024 revealed Resident #101 was a smoker, facility was to store all smoking materials and the resident was to be supervised while smoking.</p> <p>Review of the Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/10/2024 revealed Resident #101 scored a 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). The MDS also revealed Resident #101 has a diagnosis of Alzheimer's disease</p> <p>Review of Resident #101's Smoking Safety Screening completed on 09/18/2024 noted the resident was to wear a smoking apron with supervision while smoking, and the facility was to store the resident ' s lighter.</p> <p>On 10/02/2024 at 11:20 AM, Surveyor observed Resident #101 on smoke break with seven (7) other residents present. Certified Nurse Aid (CNA) #12 was present to supervise the smoke break. CNA #12 asked the residents if anyone needed a smoking apron, and all residents responded no. Resident #101 was observed sitting in wheelchair with no smoking apron. Resident #101 was observed pulling a blue lighter out of their left shirt pocket and using it to light two cigarettes during the smoking break. The resident placed the lighter back in their shirt pocket and was allowed to re-enter the facility and go to their assigned room with the lighter.</p> <p>On 10/02/2024 at 11:20 AM, Surveyor interviewed CNA #12 who revealed the residents were evaluated for smoking aprons but that only one (1) resident was assessed to wear an apron and that was not Resident 101. CNA #12 stated residents were assessed for wearing a smoking apron for safety and none of the residents present were wearing a smoking apron. CNA #12 confirmed residents should not have possession of their own lighter for safety reasons, and Resident #101 was not permitted to keep their own lighter.</p> <p>On 10/02/2024 at 11:47 AM, Surveyor went to Resident #101's room and asked resident #101 if they still had their lighter they used to light the two cigarettes they smoked during smoke break. Resident #101 pulled out a blue lighter from their left shirt pocket, showed it to the surveyor and stated, I'm not supposed to have it.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/03/2024 at 11:29 AM, Surveyor interviewed the Assistant Director of Nursing (ADON) who stated, residents are assessed to wear smoking aprons during smoke breaks for safety reasons and staff should explain why it should be worn. ADON confirmed residents are not permitted to keep their own lighters for safety reasons and the facility stores them. ADON confirmed Resident #101 was not permitted to keep their own lighter.</p> <p>On 10/03/2024 at 11:50 AM, Surveyor interviewed the Director of Nursing (DON) who confirmed residents are assessed to wear smoking aprons during smoke breaks for safety reasons, and that staff observing the smoke break should not be asking residents assessed to wear a smoking apron if they want to wear it based on their assessment they are to have one on. DON stated residents are not permitted to keep their own lighters due to the potential danger to the whole facility and that Resident #101 was not permitted to keep their own lighter.</p> <p>Review of a facility policy titled Smoking Policy- Residents with a revision date of July 2017 revealed in the 'Policy Statement' that the facility will establish and maintain safe resident smoking practices. 'Policy Interpretation and Implementation' noted 7. The staff shall consult with the attending physician and the DON to determine if safety restrictions are needed for a resident's smoking privileges based on their safe smoking evaluation.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>03508</p> <p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on observation, record review and interview, the facility failed to ensure meals were served in a method that maintained the appearance of cold and hot foods at temperatures that were acceptable to residents to improve palatability and encourage good nutritional intake during 2 of 2 meals observed on the following halls: 8, 10, 11, 200, 300 and 500.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. A Grievance Form dated 7/3/2024, was reviewed and indicated cold food as a concern at the supper meal. 2. On 10/01/24 at 12:46 PM, an unheated food cart that contained 17 lunch trays was delivered to the Hall 8 dining room by the Certified Nursing Assistant #3. At 12:52 PM, immediately after the last resident tray was served in the dining room, the temperatures of the food items on the test tray from the cart were checked by the Dietary Manager with the following results: <ul style="list-style-type: none"> a. Milk, 48 Degrees Fahrenheit. b. Vegetable blend 114 .6 Degrees Fahrenheit. c. Pureed vegetable 108 Degrees Fahrenheit. d. Pureed carrots 112.9 Degrees Fahrenheit. e. Pureed potatoes 105.5 Degrees Fahrenheit. f. Vegetable blend 106.9 Degrees Fahrenheit. 3. On 10/01/24 at 1:02 PM, an unheated food cart that contained 15 lunch trays was delivered to hall 10 dining room by the Certified Nursing Assistant #3. At 1:15 PM, immediately after the last resident tray was served in the dining room, the temperatures of the food items on the test tray from the cart were checked by the Dietary Manager with the following results: <ul style="list-style-type: none"> a. Pureed potatoes 113 Degrees Fahrenheit. b. Pureed carrots 91.4 Degrees Fahrenheit. c. Pureed bread 110 Degrees Fahrenheit. d. Vegetable blend 112 Degrees Fahrenheit. e. Pureed carrots 110 Degrees Fahrenheit. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. On 10/01/24 at 1:19 PM, Restorative Certified Nursing Assistant #7 began loading breakfast meal tray for hall 11 into the unheated food cart by the kitchen window in the dining room. She left the food cart door open while loading, finishing at 1:27 PM. After closing the food cart door. The unheated food cart that contained 9 lunch trays was delivered to hall 11 by the Certified Nursing Assistant #4. At 1:37 PM, immediately after the last resident tray was served in the dining room, the temperatures of the food items on the test tray from the cart were checked by the Dietary Manager with the following results:</p> <ul style="list-style-type: none"> a. Milk 48 Degrees Fahrenheit. b. Vegetable blend 100 Degrees Fahrenheit. c. Pureed carrots 106. Degrees Fahrenheit. d. Pureed pot pie 102 Degrees Fahrenheit. e. Pureed carrots 106.9 Degrees Fahrenheit. <p>5. On 10/02/24 at 11:32 AM, Restorative Certified Nursing Assistant #7 was interviewed and asked what would happen when an unheated food cart was left open from the time you began loading the food trays into it, until the time you finished and close the door to it? She stated, it will get cold.</p> <p>6. On 10/02/24 at 7:40 AM, an unheated food cart that contained 6 breakfast trays was delivered to the 300 Hall by Certified Nursing Assistant #5. At 7:50 AM, immediately after the last resident tray was served in their room, the temperatures of the food items on the test tray from the cart were checked by the Dietary Manager with the following results:</p> <ul style="list-style-type: none"> a. Milk 48 Degrees Fahrenheit. b. Sausage links 105.5 Degrees Fahrenheit. c. Scrambled eggs 99.5 Degrees Fahrenheit. <p>7. On 10/02/24 at 7:51 AM, an unheated food cart that contained 15 breakfast trays was delivered to the 500 Hall by Certified Nursing Assistant #6. At 8:07 AM, immediately after the last resident tray was served in their room, the temperatures of the food items on the test tray from the cart were checked by the Dietary Manager with the following results:</p> <ul style="list-style-type: none"> a. Milk 48.7 Degrees Fahrenheit. b. Pureed eggs 103 Degrees Fahrenheit. c. Pureed sausage 95 Degrees Fahrenheit. d. Scrambled eggs 97.6 Degrees Fahrenheit. e. Pureed French toast with milk 89 Degrees Fahrenheit. 		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure dishware were not exposed to dust, or other contamination; kitchen equipment was maintained in a clean and sanitary condition; dietary employees washed their hands or changed gloves before handling food items and clean equipment when contaminated; expired food products were promptly removed/discarded on or before the expiration or use by date to prevent the growth of bacteria, and ice machine and ice scoop holder were maintained in clean and sanitary condition.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. On The following observations were made in the kitchen: <ol style="list-style-type: none"> a. On [DATE] at 10:18 AM, 24 small plates, located on the bottom storage shelf in the kitchen, had food serving side uncovered. b. On [DATE] at 10:21AM, the can opener had an orangish-brown and a white fuzzy unknown substance adhered to the blade. c. On [DATE] at 10:26AM, a trash can was located next to the microwave used to heat residents' food. d. On [DATE] at 10:27AM, 12 drinking cups had brown stains on the inside. 2. On [DATE] at 12:18 PM, the Assistant Dietary Manager took out trays that contained glasses and placed them on the counter, then opened the refrigerator and removed 2 boxes of nutritional drinks and placed them 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. 3. On [DATE] at 12:23 PM, Assistant Dietary Manager, who was on the tray line assisting with lunch meal, picked up cartons of nutritional drinks and placed them on the trays. Without washing her hands, Assistant Dietary Manager picked up glasses of beverages and placed them on the trays to be served to the residents for lunch. Assistant Dietary Manager confirmed, she should have washed her hands. 4. On [DATE] at 1:45 PM, Two boxes of hash browns were on a shelf in the refrigerator with an expiration date of [DATE] 5. On [DATE] at 2:17 PM, A section above the ice machine top panel in the break room on <p>100 Hall had wet, black/brownish residue on it. Dietary Manager wiped the area where the wet, black/brownish residues were observed, and the residues easily transferred to the paper towel. She stated, CNAs use it to fill the water pitchers for the residents' rooms, and the maintenance man cleans it every month. The Dietary Manager stated the area had wet, black /brownish residue on it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045140	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER The Springs Searcy		STREET ADDRESS, CITY, STATE, ZIP CODE 1205 Skyline Drive Searcy, AR 72143	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>6. On [DATE] at 2:19 PM, the ice scoop holder on the wall, by the ice machine in the break room on 100 hall, had buildup of wet, black residue in it. The ice scoop was in direct contact with the buildup of wet, black residue. Dietary Manager confirmed, the scoop holder had buildup of wet, black residue in it.</p> <p>7. On [DATE] at 10:42 AM, Dietary [NAME] (DC) #13 was observed wearing gloves on his hands when he picked up a paper listing the names of residents who requested salad and sandwiches with their lunch meal. After reviewing the list, he placed it back on the counter, without changing gloves and washing his hands he picked up clean plates from the plate warmer and placed them on the counter, touching inside of the plates with his contaminated gloved fingers. DC #1 removed slices of bread from the bag and placed them on individual plates. DC#1 then removed slices of cheese from a container and placed them on top of the bread slices to be used in preparing ham and cheese sandwiches that would be served to the residents who asked for them. DC #1 confirmed she should have washed her hands.</p> <p>8. A review of facility policy titled, Preventing Foodborne Illness -Employee Hygiene and Sanitary Practices, revised October2017, provided by the Dietary Manager on [DATE] indicated, employees must wash their hands after engaging in other activities that contaminate the hand.</p>		