

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER The Green House Cottages of Walnut Ridge		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 West Main Street Walnut Ridge, AR 72476	

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 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>03508</p> <p>Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for 1 of 1 meal observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> On 12/16/24 at 11:20 AM, Certified Nursing Assistant (CNA) #2 used a 6 ounce spoon to place a serving of chicken and dumplings into a blender, pureed, and poured in a divided plate to serve to residents. The texture of the pureed chicken and dumpling was too thick. On 12/16/24 at 12:26 PM, CNA #2 used a regular spoon to place 2 servings of cut green beans into a blender, pureed and poured it in a divide plate. The texture of the pureed cut green beans was not smooth, not form, water was separated from the vegetables and there were noticeable pieces of stringy beans in the mixture. On 12/16/24 at 11: 35 AM, CNA #2 placed a serving of cornbread into a blender, added milk, and pureed. CNA #2 poured the pureed cornbread into a divided plate. The texture of the pureed cornbread was too thick. On 12/16/24 at 12:28 PM, CNA #2 was interviewed and was asked if she could describe the texture of the pureed food items prepared and served to the resident on a puree diet. She stated pureed cut green beans were stringy and was hard to puree. Pureed cornbread and pureed chicken and dumpling were too thick. CNA #2 was asked if residents on pureed diets would be able to eat those pureed food items. CNA #2 confirmed the pureed cornbread and dumplings would be hard for the resident on pureed diet to eat.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 045151	If continuation sheet Page 1 of 3

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>03508</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure CNAs thoroughly washed their hands before handling clean equipment, and 1 of 1 ice machine in the main building was maintained in clean and sanitary condition for 2 of 2 meals observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> On 12/16/24 at 11:13 AM, Certified Nursing Assistant (CNA) #1, who was preparing lunch meal in Cottage #1 's kitchen, placed a serving of strawberry cake into a blender, added whole milk and two tablespoons of thickener, and pureed. At 11:20 AM, CNA #1 picked up a spatula that was resting on top of a coffee pot inside the dirty side of the food preparation sink waiting to be washed, which had been in contact with food residue, and used it to scrape pureed strawberry cake into a bowl to be served to the resident on the pureed diet, there by contaminating the food. CNA #1 immediately was interviewed and was asked should a spatula in contact with the coffee pot inside the dirty sink be used in food. CNA #1 confirmed she should not have used dirty spatula in food. On 12/16/24 at 11:20 AM, Certified Nursing Assistant (CNA) #2 walked into the kitchen in Cottage #2, putting on her apron and hair net, then sanitized her hands with hand sanitizer, without properly washing her hands with soap and water, she removed a spoon from the drawer by grabbing the tip that would touch the food and used it to place a serving of chicken and dumpling into a blender and pureed to be served to the resident on a pureed diet for lunch meal. CNA #2 was interviewed, and was asked what she should have done after touching dirty objects before handling clean equipment. She stated she should have washed her hands. On 12/16/24 at 11:24 AM, CNA #2 turned on the sink and washed the blender, pureed food and poured it into a divided plate. CNA #2 turned on the sink and washed the blender lid, bowl, and blade with hot water and soap, but did not sanitizer them before assembling them for use, On 12/17/24 at 2:27, when the Dietary Manager was interviewed and was asked who what was would happen if the equipment was not properly sanitized before being used to puree food, she stated it will contaminate the food. On 12/17/24 at 11:39 AM, CNA #2 turned on the hand washing sink faucet and washed her hands. Without washing her hands, CNA #2 picked up a blade and attached it to the base on the blender to be used in pureeing food items to be served to the resident on a puree diet. On 12/16/24 at 12:31 PM, inside the opening wall of the ice machine in a room on 400-Hall in the area where ice forms before dropping in to the ice collection had a buildup of wet black residue on it. The surveyor asked the Dietary Manager if she could wipe the area where wet black residue was observed. She did so, solid black residue easily transferred to the tissue. The surveyor asked the Dietary Manager if she could describe what she saw on the opening wall of the ice machine. She stated it was wet black residue. The Dietary Manager was interviewed and was asked how often the ice machine is cleaned and who uses the ice from the ice machine. She stated it is cleaned by the maintenance man once a month. The kitchen staff use it to fill beverages served to the residents at mealtimes. The Certified Nursing Assistant (CNA) use it to for the water pitchers in the residents' rooms. <p>(continued on next page)</p>		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. A review of facility policy titled, Hand washing, undated, provided by the Dietary Manager indicated hands should be washed entering the kitchen at the start of a shift and after engaging in other activities that contaminate the hands.		