STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045194	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cottages at Texarkana	4701 Jefferson Avenue Texarkana, AR 71854

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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 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** 42965 Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was completed accurately to reflect a resident was considered to be a PASARR (Preadmission Screening and Record Review) Level II by the State Authority for PASARR assessments for 1 (Resident #18) of 1 sampled resident reviewed for PASARR. The findings are: The Significant Change in Condition MDS with an Assessment Reference Date (ARD) of 06/10/2024, indicated Resident #18 had diagnoses of anxiety, major depression, and bipolar depression, and had scored 15 (13-15 indicates the resident was cognitively intact) on the Brief Interview for Mental Status (BIMS). Further review revealed the MDS indicated Resident #18 did not have a serious mental illness and/or intellectual disability, or related condition. A Determination Letter , from the state agency contracted company that completes PASARR Level IIs, dated 10/09/2024, indicated Resident #18 did require specialized services related to their mental illness, beyond the capabilities of a nursing home facility. The Care Plan with an initiated date of 11/10/2024, indicated Resident #18 had a PASARR level II that required specialized services, structured environment, and formal behavior modifications. On 03/28/25 at 9:30 AM, during an interview, the (MDS) Coordinator stated that Resident #18 had a diagnosis of bipolar type II. The MDS Coordinator confirmed that Resident #18 was considered a PASARR Level II, by the state PASARR process, and that the Significant Change in Condition MDS dated [DATE], was coded incorrectly. The MDS Coordinator stated that Residents #18 ' s MDS should be coded correctly because the information goes to CMS (Centers for Medicare Services), and it directs care planning. On 03/28/25 at 09:39 AM, during an interview, the Director of Nursing (DON) stated Resident #18 had diagnoses of anxiety and bipolar disorder. The DON confirmed that Resident #18's MDS should be coded correctly to reflect that the resident was considered a PASARR level II, by the state PASARR process, because the MDS was referenced when developing Resident #18 ' s care plan.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 48390 Based on observation, record review, and interview, the facility failed to ensure a resident received an evaluation and treatment, as appropriate, in a time frame that would meet the medical needs of the resident in accordance with professional standards of practice. Specifically, the facility failed to notify the Physician of a low blood sugar, failed to notify the Physician of resident ' s multiple refusals of evening blood glucose checks for the month of October, and failed to notify the Physician and other facility staff after a resident had a fall. This failed practice resulted in actual harm for Resident #29 who fell and sustained a right femur fracture and right hip fracture and did not receive appropriate medical care for 6 days. The failed practice affected 1 (Resident #29) of five residents reviewed for accidents. The findings are: A review of Admission Record indicated Resident #29 had diagnoses of: absence of right leg below knee, type 2 diabetes mellitus, pain in left hip, pain in left knee, pain in left ankle and joints of left foot, osteoporosis, fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing, muscle weakness, abnormalities of gait and mobility, weakness. A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/21/2025, revealed Resident #29 had a Brief Interview for Mental Status [BIMS] score of 13, which indicated the resident was cognitively intact. Further review indicated Resident #29 did not have any behavioral symptoms or refusal of care. A review of Care Plan Report with a revision date of 12/02/2024, indicated Resident #29 received hypoglycemic medication and to check blood sugar as ordered. A review of Order Summary Report indicated Resident #29 had a Physician's Order for insulin and to notify the Physician if the residents blood sugar was below 70. A review of Medication Administration Record (MAR) for October 2024, indicated Resident #29 ' s blood sugar (BS) on 10/15/2024 at 6:00 AM, was 40 and was documented by Licensed Practical Nurse (LPN) #16. The MAR also indicated that BS checks at 4:00 PM were only checked twice in October of 2024, on 10/02/2024 and 10/09/2024. Not applicable NA was indicated on the MAR in place of a BS, as well as 2 indicating Resident #29 refused for the remaining 4:00 PM entries. A review of Medical Records from a local hospital, indicated Resident #29 was admitted to the hospital on 11/08/2024, with diagnoses of: sepsis, acute cystitis, pneumonia, acute kidney injury (AKI), kidney stone, closed fracture of neck of right femur, and fracture of right hip. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/27/2025 at 10:11 AM, the Medical Director (MD) stated that his Nurse Practitioner (NP) was more aware of the residents in the facility. The MD stated if a resident was refusing insulin on numerous occasions he should be notified. At this time, the MD was shown the Medication Administration Record for Resident #29 for October 2024, which showed Resident #29 refusing insulin all, but two times that month. The MD stated the facility should have contacted the NP and if the NP had seen a problem, the NP could have notified him [Medical Director]. The MD was also shown the blood sugar of 40 and the MD stated he or the NP should have been notified. During an interview on 03/27/25 at 10:25 AM, the Nurse Practitioner (NP) was asked if he saw a problem with Resident #29's finger sticks [blood sugar checks] for October, after NP looked at Medication Administration Log for October. Resident #29's evening blood sugar checks were only done twice in October. NP stated that it was a concern, and he should have been notified. NP indicated that he was not notified by the facility regarding Resident #29's blood sugar being 40, during a morning blood sugar check on 10/15/2024. During an interview on 03/27/2024 at 11:04 AM, the Director of Nursing (DON) stated the parameters for blood sugars were over 400 or below 60 and staff were to notify the physician. The DON stated if staff did not report a low blood sugar, it could be critical for the resident and the nurse would need to be re-educated. The DON stated the former Assistant Director of Nursing (ADON) for that cottage should have noticed Resident #29's refusals of blood sugar checks for the month of October. The DON stated if a resident had constant refusals of medication, they would have other staff try and get the residents to take the medications, but if that did not work, staff were to notify the physician of the resident refusing medications. This surveyor made three (3) attempts on 03/27/2025 to contact Licensed Practical Nurse (LPN) #16 (related to the blood sugar readings on 10/15/2024) by phone. All attempts were unsuccessful. A review of a Care Plan Report with a revision date of 12/02/2024, indicated Resident #29 was dependent with activities of daily living (ADLs) due to a hip fracture, pain, below the knee amputation (BKA), and dementia. The facility developed interventions to indicate the resident was dependent on 2 staff. Resident #29 was also at risk for falls related to right leg amputation and had a fall with major injury on 11/02/2024. A review of an Incident and Accident Report (I&A) dated 11/02/2024, revealed that Resident #29 was found on the floor in the resident ' s room, with a wheelchair behind them. Two (2) certified nursing assistants (CNAs) and a nurse assisted Resident #29 back to their chair and then put the resident in bed. No injuries were observed at the time of the incident. The Physician and Administrator were not notified until 11/08/2024. A review of a Progress Note titled Late Entry with a created date of 11/19/2024, indicated Resident #29 had a fall with an effective date of 11/02/2024. A review of Progress Notes on 11/08/2024 at 11:35 AM, indicated Resident #29 had a change in condition related to altered mental status and was sent to the emergency room . A review of Medical Records from [local hospital] indicated Resident #29 was admitted to the hospital on 11/08/2024, with diagnoses of sepsis, acute cystitis, pneumonia, acute kidney injury (AKI), kidney stone, closed fracture of neck of right femur, and fracture of right hip. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 03/27/2025 at 10:11 AM, the Medical Director (MD) stated that he had an on-call service and that if they [the on-call service] did not call him, they were to call the Nurse Practitioner (NP). The NP was notified on 11/08/2024, regarding Resident #29's fall that occurred on 11/02/2024. The MD stated he was unaware of Resident #29 having a hip fracture and femur fracture from the fall. The MD indicated that his NP was more aware of the residents in the facility. During an interview on 03/27/25 at 10:25 AM, the NP stated he was not notified until 11/08/2024, of the fall that occurred on 11/02/2024. The NP stated Resident #29 was sent to the hospital on 11/08/2024, due to becoming more lethargic and not eating, so an order was given to send the resident to the hospital. The NP stated once the resident was at the hospital, the facility found out the resident had a hip and femur fracture. During an interview on 03/27/2024 at 11:04 AM, the Director of Nursing (DON) stated that when a resident fell , the nurse would assess the resident, then call the provider (doctor), notify the family, Administrator and DON. The nurse would also complete a full body assessment on every joint, assess the skin, and the resident should be assessed from head to toe. The DON stated once the resident was stable, then notify everyone. The DON stated she did not know why LPN #15 did not complete an Incident and Accident (I&A) Report for Resident #29's fall that occurred on 11/02/2024. The DON stated she was made aware of Resident #29's injuries when the resident went to the hospital on 11/08/2024. During an interview on 03/27/2025 at 11:23 AM, LPN #15 stated she did not report Resident #29's fall because she was new to the facility and trying to learn her residents and medications. LPN #15 indicated that a CNA came and alerted her that Resident #29 had fallen. LPN #15 stated she could not remember which CNA it was that came and alerted her to Resident #29's fall. LPN #15 stated that she assessed Resident #29 from head to toe and the resident did not complain of any pain. LPN #15 stated that she, along with two CNAs, were able to get the resident onto a sheet then used the sheet to get the resident up and into bed. LPN #15 stated on 11/08/2024 she had to come into work and fill out the I&A Report, after the facility found out, from the hospital, that Resident #29 had a fractured hip and femur. LPN #15 stated during orientation, she was paired with another nurse, and she could not remember if I&As were discussed or not. On 03/27/2025, the Administrator was asked for a fall policy. The Administrator stated the facility did not have a fall policy.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review, interview, and review of the menu, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 3 of the 3 meals observed in 6 of 6 cottages. The findings are: A review of the 03/24/2025 noon meal menu indicated residents on a regular diet were to receive 8 ounces (oz) (1 cup) of Fritos pie and residents on a mechanical soft diet were to receive 8 ounces (1 cup) of ground Fritos pie. During an observation and interview on 03/24/25 at 12:01 PM, in Cottage #6, Certified Nursing Assistant (CNA) #1 used blue scoop #16 (2 oz) to serve a serving of chili totaling 2 oz of chili and 2 servings of corn chips with a total of 4 oz, instead of 8 oz. CNA #1 did not review the menu prior to serving the noon meal. During an observation and interview on 03/24/25 at 12:05 PM, in Cottage #5, CNA #2 used a 4 oz serving spoon to serve a single portion of chili and 2 oz of corn chips, instead of 8 oz of Fritos pie, as specified on the menu. CNA #2 stated she did not review the menu prior to serving the noon meal. During an observation on 03/24/25 at 12:32 PM, during the noon meal service in Cottage #2, CNA #3 used a #12 scoop (3 ounces or 1/3 cup) to serve a serving of chili, total of 3 ounces of chili, 2 ounces of corn chips with 2 oz spoon total of 5 ounces, instead of 8 ounces of Frito pie, as specified on the menu. During an interview on 03/24/25 at 1:21 PM, CNA #3 stated he used the green scoop, a #12 (3 oz or 1/3 cup), to serve a serving of chili and a 2 oz spoon to serve a serving of chopped chips, instead of 8 ounces, as specified on the menu. CNA #3 stated he did not know anything about scoop sizes and the cook always put the scoop out and he used what was placed out by the cook to serve. CNA #3 stated he did not look at the menu. On 03/24/25 at 12:53 PM, Cottage #1-A, CNA #5 used a 4 oz spoon to serve a single portion of chili, with 2 ounces of corn chips, instead of 8 ounces as specified on the menu. At 1:35 PM, CNA #5 stated she did not review the menu prior to serving a noon meal. During an observation on 3/24/25 at 1:18 PM, in Cottage #1, CNA #12 used a #8 scoop (1/2 cup or 4 oz), to serve a single portion of chili with 2 oz of corn chips, instead of 8 ounces as specified in the menu. During an observation on 03/25/25 at 8:02 AM, in Cottage #1-A, the breakfast meal menu indicated the residents on regular diets and mechanical soft diets were to receive 3/4 cup of cereal and a slice of French toast. During the breakfast meal preparation, French toast was not prepared and served to the residents. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/25/25 at 8:08 AM, Dietary [NAME] (DC) #13 stated, there was no time for her to prepare French toast because the bread was frozen, and she would be making toast. During an interview on 03/25/25 at 9:00 AM, the Dietary Manager was interviewed and was asked if there was French toast in the building. She stated there was French toast in the storage freezer in the main building where they stored all the foods that been distributed to all the cottages. She did not understand why DC #13 made that statement. During breakfast observations, all cottages except Cottage #1, served French toast. During the completion of rounds, there were bags of French toast in the walk-in freezer in the main building. During an observation and interview on 03/25/25 at 8:37 AM, CNA #6 used a #6 scoop (6 oz) to serve oatmeal, but she gave half a portion (3 oz or 1/3 cup) per serving. CNA #6 stated she should have given full serving to the residents, instead of half servings. 4. A review of the 03/24/2025 dinner meal menu indicated residents on regular diets were to receive 4 oz of steak fingers and 2 oz of gravy. Residents on mechanical soft diets were to receive 4 oz of ground steak fingers and 2 oz of gravy, and residents on pureed diets were to receive a #8 scoop (4 ounces) of pureed steak fingers and 2 oz of gravy. During an observation on 03/24/25 at 5:25 PM, in Cottage #2, DC #4 placed 4 pieces of breaded chicken tenders into a blender, of which 2 pieces weighed 3 ounces, ground and placed onto a plate to serve to 2 residents who received mechanical soft diets and stated residents get two pieces each. During an observation on 03/24/25 5:42 PM, in Cottage #2, the residents on regular diets were served 2 chicken tenders each, which weighed 1.7 ounces, instead of 4 ounces. There was no gravy served to the residents on pureed diets or residents on mechanically soft diets. During an interview on 03/24/25 at 5:45 PM, in Cottage #2, DC #4 was asked if she could weigh the same amount of chicken served to the residents, she did and stated it weighed 3 ounces. DC #4 stated residents were supposed to receive 3 ounces of meat. DC #4 stated she did not review the menu before preparing the meal. DC #4 was asked the reason she was using chicken fingers, instead of steak fingers. She stated there were not enough steak fingers. DC #4 reviewed the menu. She stated it was supposed to be 4 ounces of meat and she forgot to serve gravy to residents on pureed and mechanical soft diets. During an observation on 03/24/25 at 5:31 PM, in Cottage #3, CNA #8 served 4 pieces of steak fingers to the residents for supper. At 5:36 PM, CNA #8 was asked to weigh the same amount of meat served to the residents for supper. She did so, and stated 4 pieces weighed 3 ounces, 3 pieces weighed 1.7 ounces, 2 pieces weighed 1.5 ounces, and 1 piece weighed 0.5 ounces, which was also confirmed by CNA #9. CNA #9 was interviewed and was asked if she could weigh the same amount of steak fingers served and was asked if she reviewed the menu before serving supper meal and she stated she did not. During an observation on 03/24/25 at 5:33 PM, 3 steak fingers were served to the residents who had their supper meals in Cottage #4. During an observation on 03/24/25 at 5:55 PM, in Cottage #5, CNA #10 stated she had given 2 chicken tenders to each resident. She stated she did not review the menu prior to serving the supper meal. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/24/25 at 5:57 PM, in Cottage #6, CNA #7 stated she gave 3 pieces of steak fingers to each resident for the supper meal.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, record review, interview, and facility policy review, the facility failed to ensure foods stored in the freezer, refrigerator and dry storage area were covered; refrigerated foods were kept refrigerated; dented cans were removed from stock; expired food items and leftover food items were promptly removed / discarded on or before the expiration or use by date; dietary staff washed their hands between dirty and clean tasks and before handling clean equipment; manufactures instructions were followed; Cold food items were maintained at 41 degrees Fahrenheit or below and hot food items were maintained at above 135 degrees Fahrenheit on the steam table, while awaiting service for 3 of 3 meals observed. The findings are: 1. On [DATE] at 10:11 AM, the following observations were made on a shelf in the storage room in Cottage #2: - An opened bag of coffee was not sealed. During an interview with the Dietary Manager (DM), she was asked how bags of coffee were stored, and she stated they were supposed to be sealed. - An opened bag of potato chips, the bag was not sealed. - An opened bag of bread, the bag was not sealed. The D M confirmed the bags were not sealed. - An opened bag of tea, the bag was not sealed, leaving it open for pests to crawl into. - There were 2 bags of tortillas with an expiration date of [DATE]. 2. On [DATE] at 10:26 AM, an opened box of cobbler dough crust was on a freezer shelf in Cottage #1. The box was not covered or sealed, exposing them to freezer burn. The Dietary Manager stated that the box was not covered and leaving the box uncovered could cause freezer burn. 3. On [DATE] at 10:29 AM, the following observations were made on a shelf in freezer #2 in Cottage #1's kitchen: - An opened box of sausage, the box was not covered or sealed. - An opened box of fish filets, the box was not covered or sealed. The Dietary Manager stated that the box of sausage patties and box of fish filets were not covered or sealed. 4. On [DATE] at 10:32 AM, a container of sour cream on a shelf in refrigerator #2, in the storage room in Cottage #1, had an expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On [DATE] at 10:34 AM, the scoop holder on the wall by the ice machine had wet-grayish residue all around the corner and the ice scoop was resting on it. The surveyor asked the Dietary Manager to wipe the wet grayish residue. She did so and the wet grayish residue easily transferred to the tissue. During an interview with the Dietary Manager, she was asked to describe what was observed around the corners of the scoop holder, how often they cleaned the scoop holder, and who used the ice from the ice machine. She stated, It was grayish residue. The staff cleans it once a week, The CNAs [Certified Nursing Assistants] use it for the water pitchers in the residents' rooms and for beverages served to the residents. 6. On [DATE] at 10:39 AM, the following observations were made in the kitchen cabinet in Cottage #2: - An opened box of salt. The box was not covered, exposing it to pests and air. - A container of onion powder. The top of the container had dried loose onion powder stuck on it, making it impossible to close the container. The Dietary Manager stated she had to clean off all the dried onion powder to be able to close the lid. 7. On [DATE] at 10:47 AM, the following observations were made in Cottage #2 kitchen: - There was an open clear bag of butter on the inside door shelf in the refrigerator. The bag was not sealed. The Dietary Manager stated the bag was supposed to be sealed to avoid something from spilling over it. A sealed bag that contained sealed raw pasteurized eggs was stored on a shelf above bowls of tossed salad. The Dietary Manager stated it was left over salad from yesterday, [DATE], that was supposed to have been tossed out. - The Dietary Manager stated any open food items in the refrigerator were supposed to be covered, sealed, and dated. 8. On [DATE] at 10:57 AM, the following observations were made in the cabinet in Cottage #2 kitchen area: - An opened box of salt was in the cabinet. The box was not covered, exposing it to pests and air. Dietary manager confirmed that the box of salt was not covered. - A bottle of lime juice in the cabinet had an expiration date of [DATE]. During an interview with the Dietary Manager, she was asked what the kitchen staff use lime juice for. She stated she had residents who requested it. 9. On [DATE] at 11:02 AM, the following observations were made in Cottage #2's kitchen: - One half gallon of chocolate milk in the refrigerator, had an expiration date of [DATE]. - A can of pears on a shelf in the storage room was dented. The Dietary Manger was asked what her concern was about the dented cans. She stated the dented cans should not have been on the shelf and the facility had a place in the main storage room where they keep all dented cans. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. On [DATE] at 11:09 AM, the following observations were made on the shelf in the storage room in Cottage #2: - A can of diced pears on a shelf in the storage room was dented. During an interview with the Dietary Manager, she was asked what the concerns of dented cans were. She stated when a can was dented it produced bacteria and could not be used. - An opened box of tea, the box was not covered. - An opened bag of grits, the bag was not sealed. - An opened box of coconut, the box was not sealed. - A container of flour had a measuring cup directly in it. - A container of sugar had a measuring cup directly in it. - A container of salt had a measuring cup directly in it. - A container of cornmeal had a measuring cup directly in it. - A container of the flour had a measuring cup directly in it. - A container of dry milk had a measuring cup directly in it. The Dietary Manager was interviewed and was asked what the concerns were of leaving measuring cups inside the food items. She stated, It's cross contamination. - There were unidentified brown /black particles resting directly on top of the sugar inside the storage bin. The Dietary Manager was asked to describe what was observed on top of the sugar. She stated it looked like coffee spilled on it. - 8 of 8 small containers of cocktail marinade had an expiration date of [DATE]. The Dietary Manager was asked what the rule of expiration date was she stated, it should not have been with other stock. It should have been taken out of stock and tossed. It also affected food quality. 11.On [DATE] at 11:23 AM, the following observations were made in the freezer in the storage room in Cottage #2: - An opened clear bag, that contained biscuits, was on a shelf in the freezer. The Dietary Manager was interviewed and asked what happened when food items were not stored properly in the freezer. She stated it would cause it to have freezer burn. - An opened box of mushroom hamburger patties was on a shelf in the freezer. The box was not covered or sealed. 12. On [DATE] at 11:28 AM, the following observations were made in the refrigerator in Cottage #2 kitchen: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045194	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cottages at Texarkana	4701 Jefferson Avenue Texarkana, AR 71854

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- A container of cucumber and onion on a shelf, had an expiration date of [DATE]. - A leftover container of fruit with the preparation date of [DATE] and a use date of [DATE], had exceeded the expiration time and the documented date to be used was [DATE]. The Dietary Manager stated it should have been thrown away. 13. On [DATE] at 11:31 AM, the following observations were made in refrigerator #1 in the kitchen area in Cottage #2: - 2 of 2 containers of sour cream were on a shelf in the refrigerator, with an expiration date of [DATE]. - A container of taco soup with an expiration date of [DATE]. - An opened box of cream cheese, the box was not covered or sealed. 14. On [DATE] at 12:21 PM, Cottage #2, the temperatures of food items, when checked and read on the steam table by the Dietary [NAME] (DC) #4, were the following: - Corn wagon: 126 degrees Fahrenheit. - Cream corn: 105 degrees Fahrenheit. 15. On [DATE] at 12:27 PM, Cottage #2A. The temperatures of food items, when taken and read by DC #4, were the following: - Cream corn: 115 degrees Fahrenheit. - Pureed chili: 90 degrees Fahrenheit. - Pureed corn: 82 degrees Fahrenheit. - Pureed soft tortilla: 85 degrees Fahrenheit. -The above food items were not reheated before being served to the residents. The Dietary Manager stated it should have been reheated. DC #4 stated foods should have been reheated. 16. On [DATE] at 4:50 PM, in Cottage #2, CNA #1 pushed a cart with a tray that contained glasses towards the ice machine. Without washing her hands, she picked up glasses by their rims and scooped ice in them. CNA #1 then poured beverages in each glass to be served to the residents with their lunch meal. CNA #1 stated she should have washed her hands. 17. On [DATE] at 8:24 AM, in Cottage #1A, the temperature of the food on the steam table was taken and read by DC #4: ground sausage was 120 degrees Fahrenheit. The ground sausage patties were not reheated before served to the residents. The Dietary Manager stated they should have been reheated. 18. On [DATE] at 2:14 PM, in Cottage #3. The following observations were made in the cabinet: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045194	A. Building B. Wing	03/28/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An opened box of salt, the box was not covered. - An opened box of baking soda, the box was not covered. The Dietary Manager was interviewed and was asked what the concerns were about leaving the boxes open. She stated, to prevent bugs from crawling in. 19. On [DATE] at 2:20 PM, the following observations were made in the storage room in Cottage #3: - An opened bottle of lemon juice was on the shelf. During an interview with the Dietary Manager, she was asked what the concerns were once lemon juice was opened and not put in the refrigerator. She stated it would change the taste or cause bacterial growth. - A box of grape juice concentrate on a shelf in the storage room had an expiration date of [DATE]. The second box of grape juice concentrate had an expiration date of [DATE]. The Dietary Manager stated both boxes of grape juice concentrate were expired and would be tossed. 20. On [DATE] at 2:42 PM, an opened bag of diced chicken was on a shelf in the freezer. The bag was not sealed. CNA #8 stated the bag was not sealed and supposed to be sealed, to prevent something from getting on it. 21. On [DATE] at 5:16 PM, the temperatures of the food on the steam table in Cottage #3, were checked and read by CNA #8 with the following results: - Baked potatoes: 110 degrees Fahrenheit. - Mashed potatoes, with milk and butter: 110 degrees Fahrenheit. - Gravy: 130 degrees Fahrenheit. -CNA #8 stated the above food items were not reheated before being served to the residents but they should have been reheated. 22. On [DATE] at 2:48 PM, in Cottage #4, the following observations were made inside the kitchen cabinet. - An opened box of salt in the cabinet, the box was not covered, exposing it to air or possible pests. - An opened container of onion powder, the container was not covered. - An opened container of chili powder, the container was not covered. - An opened container of garlic powder, the container was not covered. - An opened container of lemon pepper seasoning salt, the container was not covered. - An opened container of parsley, the container was not covered. (continued on next page)

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	045194	A. Building B. Wing	03/28/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The Dietary Manager was interviewed and was asked what the concerns were about leaving spices open. She stated to prevent bugs from getting in spices. 23. On [DATE] at 2:59 PM, in Cottage #4, the following observations were made on a shelf in the storage room: - A measuring cup was on top of the cornbread, inside a bin. -CNA #8 was interviewed and asked if a measurement cup should be inside the storage bin. She stated it was not supposed to, and it could lead to cross contamination. 24. On [DATE] at 3:09 PM, in Cottage #4, the following observations were made in the storage room: - An opened bottle of lemon juice. -During an interview with the Dietary manager, she was asked what lemon juice was used for. She stated the kitchen staff used it when a recipe called for it and they used it in lemonade served to the residents. The manufacturer specification on the bottle were to refrigerate after opening. The Dietary Manager was interviewed and asked what the concerns were about storing lemon juice in the refrigerator once opened. She stated due to bacteria or taste. - An open clear bag that contained 4 loose bags of tea, the bag was not sealed, exposing it to air, moisture, and light. - An opened clear bag of pancake mix, the bag was not sealed, exposing it to air. - A bag of honey wheat bread, with expiration date of [DATE]. - An opened bag of bread with no received date on it. 25. On [DATE] at 3:11 PM, in Cottage #4, the fridge had an open clear bag containing slices of cheese on a shelf. The bag was not sealed. The Dietary Manager confirmed the bag of cheese was not sealed. 26. On [DATE] at 3:14 PM, in Cottage #4, the following observations were made on a shelf in the freezer: - A clear bag of biscuits, the bag was not sealed. - An open clear bag of biscuits, the bag was not sealed. 27. On [DATE] at 12:05 PM, in Cottage #5, the temperatures of the food on the steam table in the kitchen in Cottage #5 were checked and read by the CNA #2 with the following results: - Corn wagon - 105 degrees Fahrenheit. - Chili -105 degrees Fahrenheit. (continued on next page)

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	045194	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CNA #2 was interviewed and asked what she should have done when the food was not hot enough and she stated she should have reheated it. 28. On [DATE] at 3:22 PM, the following observations were made in the cabinet: - An opened bottle of lemon juice. The manufacturer specifications on the bottle were to refrigerate after opening. - An opened bag of white gravy, the bag was not sealed. - An opened bag of brown sugar, the bag was sealed. - An opened bag of sugar, the bag was not sealed. - An opened bag of potato pearls, the bag was not sealed. 29. On [DATE] at 3:30 PM, the following observations were made on a shelf in the storage room in Cottage #5: - An opened bag of brown gravy, the bag was not sealed. - An opened bag of pecans, the bag was not sealed. - An opened bag of sloppy joe mix, the bag was not sealed. - An opened bag of chicken and dumpling seasoning, the bag was not sealed. - An opened bag of lemon fruit punch, the bag was not sealed. - An opened bag of vanilla pudding, the bag was not sealed. - An opened bag of country while gravy mix, the bag was not sealed. - An opened box of oatmeal, the box was not covered. - An opened box of baking soda, the box was not covered. - An opened bag of chips, the bag was not sealed. - An opened box of grits, the box was not sealed. - There was an unidentified matter, in the corn meal. The Dietary Manager stated she thought it looked like breadcrumbs. - An opened box of coconuts, the box was not covered or sealed. 30. On [DATE] at 3:40 PM, two containers of chopped garlic were on a shelf in the refrigerator and had an expiration date of [DATE]. (continued on next page)

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	045194	A. Building B. Wing	03/28/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	31. On [DATE] at 3:44 PM, the following observations were made in the freezer in Cottage #5: - An opened box of biscuits, the box was not covered or sealed. - An opened box of corndogs was on a shelf in the freezer, the box was not covered or sealed. 32. On [DATE] at 3:54 PM, in Cottage #6, the following observations were made in the kitchen area: - A container of flour had a measuring cup directly in it. - A container of sugar had a measuring cup directly in it. - A container of cornmeal had a measuring cup directly in it. - A container of rice had a measuring cup directly in it. -The Dietary Manager was interviewed and was asked for the reason cups should not be inside the food items. She stated, It's cross contamination. - An opened box of corn starch was in the cabinet, the box was not covered or sealed. 33. On [DATE] at 3:57 PM, the following observations were made on a shelf in the storage room in Cottage #6: - An opened bag of tortillas, the bag was not sealed. - An opened bag of coffee, the bag was not sealed. - An opened box of coconut, the box was not sealed, exposing the opened bags and a box of the dried food products to air, moisture, light and possible for pests to enter. -During an interview with the Dietary Manager, she was asked what could happen if dried foods were left open and she stated the bags of the food products, and a box of coconuts were supposed to be in sealed bags to prevent entering of any bugs. 34. On [DATE] at 4:00 PM, the following observations were made on a shelf in the freezer in Cottage #6: - An opened bag of dinner rolls, the bag was not covered or sealed. - An opened bag of diced potatoes, the bag was not sealed. - An opened box of corndogs, the box was not covered or sealed, exposing them to freezer burn. The Dietary Manager stated all foods should be sealed. 35. On [DATE] at 4:04 PM, the following observations were made on a shelf in the freezer in Cottage #6: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045194	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- An opened bag of French toast sticks, the bag was not sealed. - An opened bag of French fries, the bag was not sealed. - An opened bag of pepperoni, the bag was not sealed. - An opened bag of corn nuggets, the bag was not sealed - An opened bag containing solid frozen hamburger meat, the bag was not sealed, exposing them to freezer burn and texture changes. The Dietary Manager removed the hamburger meat and stated it was frozen solid, and all foods should be sealed to prevent freezer burn. 36. On [DATE] at 4:08 PM, in Cottage #6, there was an unopened box of bacon that was stored above an unopened bag of lettuce. The Dietary Manager stated the box of bacon was supposed to be stored below to prevent contamination. A bowl of leftover chicken salad with a storage date of [DATE] was on a shelf in the refrigerator. The Dietary Manager asked how long leftover food could be kept in the refrigerator and she stated it could last for 3 days. The leftover chicken salad exceeded the date of leftover by 9 days. 37. On [DATE] at 4:10 PM, in Cottage #6, there was a leftover container of marinated sauce dated [DATE], that was on a shelf in the refrigerator. There was a white spot on top of the sauce, the Dietary Manager was interviewed and asked if she could describe the appearance of the sauce, and she stated the marinated sauce had a white spot on it. She was asked how long leftover food would be kept in the refrigerator and she stated it could last for 3 days. The leftover marinara sauce exceeded the date of leftover by 24 days. -There was a container of sliced pineapples with a storage date of [DATE] on a shelf in the refrigerator. The Dietary Manager stated all leftover food should last for 3 days. 38. On [DATE] at 4:15 PM, in Cottage #6, a can of sour cream was on a shelf in the cooler with an expiration date of [DATE]. 39. On [DATE] at 4:33 PM, in Cottage #6, the following observations were made on a shelf in the storage room: - An opened bag of brown sugar, the bag was not sealed. - An opened bag of powdered sugar, the bag was not sealed. - An opened box of baking soda, the box was not sealed. - An opened bag of chocolate, the bag was not sealed. - 3 opened bags of taco seasoning mix, the bags were not sealed, exposing them to air and moisture. The Dietary Manager stated they were supposed to be in sealed bags to prevent any bugs from getting in. (continued on next page)

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	045194	A. Building B. Wing	03/28/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40. On [DATE] at 4:36 PM, in Cottage #6, CNA #7 wore gloves on her hands when she touched the container of sour cream on the counter, contaminating them. Then, using the same contaminated gloves, she held the potatoes while scooping sour cream into the middle of the potatoes to be served to the residents for supper meal. CNA #7 was interviewed and was asked what she should have done after touching dirty objects and before handling food items and she stated she should have washed her hands. 41. A review of facility policy titled, Handwashing and glove usage in food service indicated hands should be washed before starting work, after leaving and returning to the kitchen prep area and after touching anything else such as dirty equipment and work surfaces.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42965 Based on observations, record review, interview and policy review, the facility failed to ensure staff followed enhanced barrier precautions (EBP) and performed appropriate hand hygiene to prevent the potential for cross contamination when administrating medications through a feeding tube for 1 (Resident #29) of 3 sampled residents, observed for medication administration. The findings are: A review of a quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 02/21/2025 indicated Resident #29 had diagnoses of end stage renal disease, diabetes mellitus, and dysphagia (difficulty swallowing), scored 13 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS) and received 51% or more of total calories through a feeding tube. A review of a Care Plan, with a revision date 11/18/2024, indicated Resident #29 was on enhanced barrier precautions related to having a gastrostomy tube and gowns and gloves should be worn during high-contact care. A review of Order Summary Report indicated Resident #29 had a Physician's Order for enhanced barrier precautions related to the Percutaneous Endoscopic Gastrostomy (PEG) tube. During an observation on 03/26/2025 at 3:45 PM, Licensed Practical Nurse (LPN) #14 put on gloves and began to prepare medication for Resident #29 to be administered through the resident ' s feeding tube. LPN #14 put her right gloved hand in her uniform pocket and got out keys and unlocked the medication cart. LPN #14 touched the laptop screen with her gloved hands, as well as the computer mouse. With the same gloved hand, she took a bottle from the medication cart and put one pill in a medication cup. LPN #14 took a medication bubble pack out of the medication cart, punched the pill into her hand and placed the pill in another medication cup. LPN #14 then stated there was a piece of paper on the pill and reached into the medication cup with her gloved hand, touched the pill, and removed the paper. LPN #14 used the pill crusher to crush Resident #29's medication. LPN #14 did not change her gloves or wash her hands during the preparation of the medications. On a personal protective equipment (PPE) bin on the right side of the entrance to Resident #29's room was a sign that indicated Enhanced Barrier Precautions: Everyone must clean their hands before entering and leaving the room. Providers and staff must also wear gloves and gown for High- Contact Resident Care Activities, which includes use of a feeding tube. LPN #14 entered Resident #29's room and administered the medication via Resident #29 ' s feeding tube. LPN #14 did not change her gloves or wash her hands prior to administering the medications and did not put on a gown while administering the medication. During an interview directly after the observation, LPN #14 confirmed Resident #29 was on enhanced barrier precautions and that she should have worn a gown, in addition to gloves, when administering Resident #29's medications through the feeding tube. LPN #14 also confirmed that she should not have touched the resident's pill with her gloved hand after touching the keys in her pocket and the computer equipment without changing gloves and washing her hands, since that could lead to infection control problems. (continued on next page)

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	045194	A. Building B. Wing	03/28/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/28/25 at 7:59 AM, during an interview, the Infection Preventionist (IP) stated, Resident #29 was on enhanced barrier precautions because the resident had a feeding tube. A gown and gloves should be worn when administering medication through the feeding tube. The IP stated staff were made aware that residents were on enhanced barrier precautions by signage, either on the resident's door or by the resident's door. Residents were placed on enhanced barrier precautions to prevent the spread of infections. The IP confirmed the nurse should have changed her gloves and washed her hands prior to touching Resident #29's medication if the nurse touched her keys and computer screen with her gloved hand while preparing the residents medication. On 03/28/25 at 8:53 AM, during an interview, the Director of Nursing (DON) stated residents that have indwelling lines, targeted Multi Drug Resistant Organisms (MDRO) or chronic wounds were placed on enhanced barrier precautions to prevent the residents from catching anything from the staff. The DON stated staff were made aware residents were on enhanced barrier precautions by a sign placed on the resident's door. The DON confirmed that Resident #29 had a feeding tube and staff should wear gloves and a gown when administering medications through the feeding tube. The DON also confirmed that if the nurse touched items such as keys and the computer screen with their gloved hands when preparing medications, they should have washed their hands and changed gloves prior to touching the resident's pills. A review of a policy titled Enhanced Barrier Precautions indicated Enhanced barrier precautions' refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [Multi Drug Resistant Organism] as well as those at an increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices). High contact resident care activities include feeding tube care/use.