STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045259	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Woodland Hills Rehab & Nursing Cen	8701 Riley Drive Little Rock, AR 72205

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 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** 47916 Based on observations, record review, and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment for 4 (Resident #1, Resident #2, Resident #3, Resident #4) of 4 sampled residents reviewed of physical environment. The findings are: 1) On 12/3/24 at 8:54 AM, the Surveyor observed the community shower room with one (1) door on E Hall, which had been left open. The surveyor entered the shower and observed the following: a. Several areas of the shower floors, walls, and edges with broken and/or missing tiles, with rough edges. b. The doorframe of the bathroom, in the shower room, was rusted out on both sides of the frame. It is not secured to the wall on either side. The frame moved back and forth. Rust was on the floor at the base of the frame, on both sides. c. Several holes in the tile baseboards around the showers with broken tiles, leaving large holes in the walls. d. The grout was black and brown between the tiles. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) The Surveyor asked Certified Nursing Assistant (CNA) #8 if she could come into the shower room with surveyor. CNA #8 entered shower room [ROOM NUMBER] on E hall. The Surveyor interviewed CNA #8. CNA #8 said she was not aware the door had been left ajar until she saw this surveyor open the door. CNA #8 said I thought oh no. CNA #8 said the door should have been locked to prevent a resident from entering the room, because if a resident got in this room the resident could fall, and no one would know anything about it. CNA #8 said the doorknob was broken off on the inside so a resident would not be able to open it to get out, and a resident could get locked in there and we would not be able to find them. The Surveyor asked how long these missing tiles, cracks in the tiles, and broken edges had been that way. CNA #8 said she had been on leave since the first part of August and was just getting back, but they were not busted when she left. CNA #8 said she was concerned that if a wheelchair or shower bed rolled in the crack of missing tiles it could fall or tilt over causing a resident to fall. The Surveyor asked CNA #8 what concerns she had with the cabinet being opened and unlocked. CNA #8 said she was concerned about a resident getting the items in the cabinet and drinking them or getting them in their eyes because these items could hurt a resident if they drank them. 3) CNA #8 assisted this surveyor in identifying the items in the cabinet. The contents were: a. A perineal cleanser with a caution label showing it may cause eye irritation and keep out of reach of children. b. Five (5) deodorant sprays - with warning labels of do not use on broken skin, avoid contact with eyes, ask doctor before using if you have kidney disease, if swallowed, contact Poison Control Center right away. c. Twenty-four (24) bath cleansers for skin and hair - with labels with a caution statement for external us only, avoid contact with eyes. d. Two (2) silicone creams - with labels for external use only. e. Seven (7) tubes of skin protectant - with labels with a warning in case of ingestion contact a physician or Poison Control Center right away. f. Derma vera skin and hair - 2.5 gallons g. Nine (9) daily moisturizing lotion with/ aloe vera. h. One (1) clinical cleanse no -rinse - with a bold statement that showed for external use only. i. One (1) and 1/8 bottles of baby oil - with a label with bold print that showed for external use only and a safety tip to keep out of reach of children. j. One (1) bottle of conditioner. k. One (1) bottle of soothing lotion 32 oz. l. As identified by the CNA, 1/8 of a bottle of hair conditioner. m. Three (3) travel size cans of shaving cream. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	n. Two (2) 3.5 oz. containers of baby powder - with warning labels which included - for external use only; not for consumption; keep out of reach of children; avoid contact with eyes; Do not use on broken skin; Keep powder away from child ' s face to avoid inhalation. o. Antifungal powder - 1 contains Miconazole Nitrate 2.0% p. One (1) hand sanitizer wipe with a label that showed for external use only; Flammable; avoid contact with eyes; if skin becomes irritated contact doctor; if swallowed get medical attention or contact poison control right away. q. Twenty-four (24) blue razors were in the unlocked/unsecured cabinet and two (2) blue razors were lying on shower bed located in the room. r. Four (4) packages of adult washcloths wipes were in the unsecured cabinet. s. Two (2) boxes of vinyl gloves size medium were in the unsecured cabinet. t. Two (2) boxes of medium, two (2) boxes of large, and two (2) boxes of large latex gloves were in the unsecured cabinet. 4) The surveyor asked CNA #8 what the brown spot on the shower bed was. CNA #8 said it looked like dried up bowel movement (BM). CNA #8 said her concern with the dried brown substance was that it could be infectious. BM has germs in it. CNA #8 stated that it could be from a resident with clostridium-difficile and another resident smear it and then put their hands in their mouth and become sick due to the germs. CNA #8 said if a resident got one of the razors, they could play in the BM with it and cut themselves. The second shower bed, with a long blue foam lying on top, had a brown/black substance on the blue shower bed where the foam was lying. CNA #8 said, Now that looks like mold. The shower bed was noted to be frayed along the sides of the mesh. 5) The second shower room on Hall E had broken tiles along the outside corner of the shower stall, leaving sharp rough edges. The floor of the shower had missing and broken tiles in the shower floor where a resident would stand to shower, leaving sharp rough edges. The grout was black and brown between the tiles. 6) The shower room on Hall D contained shower stalls with missing tiles in the center of the shower floor, leaving sharp rough edges. The ceiling had two (2) large areas where it was peeling off, leaving particles on the floor. The grout was black and brown between the tiles. 7) On 12/2/24 at 11:32 AM, Resident #4's over-the-bed tabletop had large sections of the finish peeling off, leaving the pressed board exposed. The surveyor asked the resident how long the table had been like that. Resident #4 indicated it was not known. At the entrance to Resident #4's bathroom, the tiles were cracked and missing, leaving sharp edges. 8) On 12/3/24 at 11:00 AM, Resident #4's over-the-bed tabletop had large sections of the finish is peeling off, leaving the pressed board exposed. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9) On 12/3/24 at 1:50 PM, this surveyor and the Maintenance Supervisor made observations in shower room [ROOM NUMBER] on E hall. The Maintenance Supervisor said he was not aware of the shower room door needing a knob on the inside until today. The Maintenance Supervisor said the shower had been closed a couple of weeks to allow him time to do some repairs on the tiles. The Maintenance Supervisor said he was not aware the bathroom door was rusted out. The Maintenance Supervisor stated the staff had stopped using the Maintenance Request Log months ago. He stated needed repairs were not being written on the log anymore, but employees tell him things as he goes down the hall. He said he had started to make his own spreadsheet to keep up with things. The Maintenance Request Log, given to the surveyor by the Maintenance Supervisor identified numerous items not completed. 10) On 12/4/24 at 8:15 AM, the Surveyor and Administrator made observation rounds in the shower rooms. The Administrator said she had shut the shower room [ROOM NUMBER] on E Hall down in September or October to have the room repaired for a more therapeutic look. The Administrator said she wanted it painted, and the tiles repaired. The Administrator said she was concerned that the door was open on two (2) occasions, because a resident could get in the shower room alone. Residents could get a skin tear from the broken tiles. The Administrator said she was not aware of the doorframe of the bathroom being rusted and detached like that and the rusted-out doorframe had taken years to get that bad. It was not an overnight problem. 11) On 12/3/2024 at 10:02 AM., a surveyor observed an outlet under the sink in the shower room on D Hall pushed into the sheetrock with large holes on both sides. On 12/4/24 at 8:15 AM, during rounds the Administrator said she had told the Maintenance Supervisor to repair that outlet under the sink on Monday. An electrical cord was observed hanging from a fan above the sink. The outlet did not have a set/reset button on it to indicate it was a Ground Fault Circuit Interrupter outlet. The outlet was pushed into the wall on the right side with a large hole the length of the cover approximately 1 inch by 3 inches and a large gap on the other side approximately 1 inch by 1.5 inches.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide care and assistance to perform activities of daily living for any resident who is unable. 47916 Based on observation, record review and interview the facility failed to ensure personal care including bathing and toenail care was provided for residents that required activity of daily living (ADL) assistance to promote good hygiene and prevent infections. This failed practice affected 1 sampled (Resident #11) resident of 2 sampled (Resident #10, and Resident #11) residents reviewed for personal care. The findings include: The medical diagnoses revealed Resident #11 with diagnoses of delusions, hallucinations, bipolar disorder, and anxiety. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/13/2024, suggest a Brief Interview for Mental Status (BIMS) score of 04 (0-7 indicates severe cognitive impairment). a. Review of a policy titled Care of Fingernails/Toenails, revised October 2010, revealed procedures were in place to clean the nail bed and trim nails to prevent infections. Nails that are too hard or thick to trim should be reported to the nurse supervisor, and unless permitted do not trim the nails of diabetics. b. Review of Resident #11's Care Plan, dated 08/28/2024, revealed Resident #11's nails were to be checked on bath day, and if they need trimmed it should be reported to the nurse. It was documented, Resident #11 needed the partial assistance of 1 staff member during bathing. c. A review of an In-Service taught by the Director of Nursing (DON), on 10/15/2024, revealed a skills fair was done that included Certified Nursing Assistant (CNA) skills check offs. d. On 12/02/2024 at 10:50 AM, Resident #11 was observed on the closed unit with feet in the air. Dry, white flaky skin on both arms and legs was observed. [NAME] flakes were resting in the bed from the knees to feet. The right and left great toenails were thick and extended an estimated 1/2 inch from the nail bed, curving over the front of the toe. The Surveyor observed Resident #11 had purple looking polish like substance on the top half of the toenails. The surveyor and asked if the resident liked to have nails polished. Resident #11 stated they liked polish, and my skin has stuff on it. When asked when the resident's last bed bath or shower was, Resident #11 did not know. e. On 12/03/2024 at 10:00 AM, Certified Nursing Assistant (CNA) #9 was asked if they have shower aids, and she confirmed they did. CNA #9 does not give showers on the closed unit. The CNA was asked what they would do if the shower aid went home, and a resident needed a bath. CNA #9 revealed that residents have personal care wipes at the bedside, and she would clean them up with a wipe. CNA #9 confirmed there was not a shower room on the closed unit. The Surveyor asked where a resident would go to get a shower. CNA #9 stated that she did not know. f. On 12/03/2024 at 9:20 AM, Resident #11 was observed resting in bed, arms and legs appeared dry, white, and flaky. The left and right great toes were extending well above the bed of the toenails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	g. During an interview with the Administrator, on 12/03/2024 at 11:00 AM, the Administrator was asked to provide a bathing sheet for Resident #11 and a list of residents scheduled to see the podiatrist. h. On 12/03/2024 at 3:50 PM, the Administrator provided a bathing sheet showing 1 shower in the month of November 2024 and a podiatrist list that did not include Resident #11. The surveyor asked the Administrator how many baths or showers Resident #11 had received. The Administrator confirmed it looked like one (1) but was sure that was not correct. The Administrator stated the Director of Nursing, (DON) could better explain the shower sheet. i. During an interview with the DON, on 12/03/2024 at 3:33 PM, the DON stated that CNAs had stopped charting all the baths and showers. She did not know why but was letting staff go due to this practice. The DON stated she was certain Resident #11 was getting baths or showers. The DON accompanied the surveyor to the bedside. She stated Resident #11 should have been referred to the podiatrist list after inspecting the resident's feet. The surveyor asked if there was any risk to a resident with toenails extending well above the bed of the toenail. The DON stated if she were to walk on them, it might bother the top of the toes. The DON stated she could give the resident a bath right now and the resident's skin would look the same way tomorrow. The surveyor asked who was responsible for reporting toenails that needed clipped. The DON stated when a resident was bathed or showered the CNAs are responsible for letting someone know if someone needs to be seen for toenail care. The surveyor requested the facility policy and procedures for nail care. j. On 12/03/2024 at 4:10 PM, CNA #10 accompanied the surveyor to Resident #11's room. CNA #10 confirmed the resident's left and right great toenails are too long and needed to be clipped. CNA #10 also confirmed the resident's skin appeared dry. When asked what process CNAs follow when they find residents that need toenail care, CNA #10 said she would report it to the nurse and let them follow their procedure because the resident might be a diabetic. CNA #10 revealed she had never seen Resident #11's feet before, because she usually wears socks.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 Based on observation, record review, interview, and facility policy review, the facility failed to ensure resident medications were not left at the bedside to prevent accidents and injuries for 1 (Resident #13) sampled resident. The findings include: 1. A review of Resident #13's Care Plan does not identify this resident to self-administer medications. 2. A review of the physician orders for Resident #13 does not show an order for this resident to self-administer medications. The physician order is for anti-diarrhea oral tablet 2 milligram (mg), to be given, one (1) table by mouth, every 24 hours as needed. 3. A review of the Minimum Data Set (MDS), dated [DATE], identified Resident #13 to have a Brief Interview for Mental Status (BIMS) score of 14. The MDS identified Resident #13 to have diagnoses of anemia, hypertension, end stage renal disease, and diabetes mellitus. 4. On 12/03/2024 at 9:29 AM, the Surveyor observed a medicine cup with a blue/green colored liquid sitting on Resident 13's nightstand. The Surveyor asked the Assistant Director of Nursing (ADON) to come to the room. The Surveyor then asked the ADON if she could identify the liquid in the medicine cup sitting on Resident #13's bedside table. The ADON picked the cup up and said she didn't know what it was, but it should not be left in the resident's room. Resident #13 was out of the room. The ADON asked Licensed Practical Nurse (LPN) #11 if she could identify what was in the medicine cup. The ADON informed LPN #11 the medication was found in Resident #13's room, on the bedside table. LPN #11 said she had not given Resident #13 medications, but it was that resident's anti-diarrhea oral medication. LPN #11 took a bottle of liquid anti-diarrhea medication from the medication cart and identified it as Resident #13's medication, despite the physician's order for anti-diarrhea pills. The ADON looked at the resident's Medication Administration Record (MAR) and determined it was pulled for Resident #13 on 12/2/24 at 11:57 PM. 5. On 12/03/2024 at 9:43 AM, the Director of Nursing (DON) was notified of the medication being left at Resident #13's bedside. The DON said the medications should not be left in the room. The DON stated concerns that other residents could go in there and drink it. The DON verified to this surveyor that this resident had not been assessed to self-administer medications and Resident #13 did not self-administer medications. The DON said she will start an in-service and address it with LPN #12 who would have left the medications at the resident's bedside.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47916 Based on observation, record review and interview, the facility failed to ensure hot foods were served hot and cold foods were served cold, to maintain palatability and encourage adequate nutritional intake for 2 of 2 meals observed on halls A, B, C, D, E and H. The findings are: 1. On 12/02/2024 at 10:30 AM, Resident #6 was interviewed about the food and stated food is cold most of the time. 2. On 12/02/2024 at 11:58 AM, Resident #7 was interviewed about the food and stated the food is cold at times. 3. On 12/02/2024 at 12:08 PM, Resident #8 was interviewed about the food and stated food was cold. 4. On 12/02/2024 at 12:25 PM, Resident #9 was interviewed about the food and stated the food was always cold and not good. 5. On 12/02/2024 at 12:30 PM, Resident #10 was interviewed about the food and stated the food was cold. 6. On 12/02/2024 at 12:53 PM, Dietary Aide #2 began loading lunch meal trays for A-hall into the unheated food cart in the kitchen. He left the food cart door open while loading, finishing at 1:00 PM. After closing the food cart door, the unheated food cart that contained 19 lunch trays and 2 trays at the top of the cart was delivered to A-hall by the Dietary Manager. At 1:14 PM, immediately after the last resident tray was served in their room, the temperatures of the food items used as test trays, in the food cart and on top of the food cart, were checked by Certified Nursing Assistant (CNA) #3 with the following results: a. Breaded beef fried steak 113 degrees Fahrenheit b. Carrots 113.5 degrees Fahrenheit. 7. On 12/02/24 at 1:03 PM, the unheated food cart, that contained 15 lunch trays and 2 trays at the top of the cart, was delivered to E-hall by CNA #4. The door was left open as CNA #4 removed food trays from the food cart and served them to the residents in the unit's dining room. At 1:29 PM, immediately after the last resident tray was served in their room, the temperatures of the food items used as test trays in the food cart were checked by CNA #4 with the following results: a. Breaded ground beef fried steak 104.7 degrees Fahrenheit. b. Ground carrots 109.5 degrees Fahrenheit. c. Regular bread fried beef steak 110.4 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	8. On 12/02/24 at 1:15 PM, Dietary Aide (DA) #2 began loading lunch meal trays for B and C- halls into the unheated food cart in the kitchen. DA #2 left the food cart door open while loading. At 1:22 PM, the unheated food cart that contained 10 lunch trays and 2 trays at the top of the cart was delivered to hall B-hall by the CNA #3. At 1:45 PM, the same food cart was delivered to the C-hall by the CNA #3. The food cart was left opened while the trays were passed to the residents. At 1:53 PM, immediately after the last resident's tray was served in their room on C-hall, the temperatures of the food items used as a test tray in the food cart were checked by the Assistant Director of Nursing (ADON) with the following results: a. Health shake 58.4 degrees Fahrenheit. b. Breaded beef fried steak 95.9 degrees Fahrenheit. c. Ground carrots 96.6 degrees Fahrenheit. d. Mashed potatoes 111.3 degrees Fahrenheit. 9. On 12/02/24 at 2:00 PM, the unheated food cart that contained 11 lunch trays for D-hall was delivered to the nurse's station for A, B, C, and D-halls by Dietary Aide #2. At 2:05 PM, the food cart was pushed into the D-Hall by CNA #5. At 2:08 PM, immediately after the last resident tray was served in their room on D-hall, the temperatures of the food items used as a test tray in the food cart were checked by CNA #5 with the following results: a. Ground breaded beef steak 99.3 degrees Fahrenheit. b. Ground carrots 96.9 degrees Fahrenheit. c. Mashed potatoes 114.0 degrees Fahrenheit 10. On 12/03/24 at 8:30 PM, Dietary Aide #2 began loading breakfast meal trays for B and C-halls into the unheated food cart in the kitchen. DA #2 left the food cart door open while loading, finishing at 8:38 AM. After closing the food cart door, the unheated food cart that contained 16 breakfast trays was delivered to the nurses' station for halls A, B, C, and D, by DA #2. The food cart was then pushed to B-hall by CNA #3. The food cart was left open while meal trays were passed to the residents in their rooms. At 8:54 AM, the same food cart with remaining 8 breakfast meal trays was pushed to C-hall by the CNA #3. At 9:04 AM, immediately after the last resident tray was served their room on C-hall, the temperatures of the food items used as test trays in the food cart were checked by the CNA #5 with the following results: a. Milk 51 degrees Fahrenheit. b. Chocolate shake 53.5 degrees Fahrenheit. c. Pancake 83.1 degrees Fahrenheit. d. Scrambled eggs 92.4 degrees Fahrenheit. e. Grits 110.8 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	f. Fortified cereal 102.3 degrees Fahrenheit. g. Pureed bacon 92.6 degrees Fahrenheit. 11. On 12/03/24 at 8:12 AM, the unheated food cart that contained 15 breakfast trays was delivered to H-hall by the CNA #6. On 12/03/24 at 08:18 AM, immediately after the last resident tray was served in their room, the temperatures of the food items used as test trays in the food cart were checked by CNA # 6 with the following results: a. Milk 52 degrees Fahrenheit. b. Scrambled eggs 88.3 degrees Fahrenheit. c. Pancake 80.9 degrees Fahrenheit. d. Sausage 79.3 degrees Fahrenheit. CNA #6 felt sausage with her and stated it was cold. 12. On 12/03/24 at 8:58 AM, the Dietary Aide #2 delivered the unheated food cart that contained 11 breakfast trays to the nurse's station for halls A, B, C, and D. At 8:59 AM, CNA#5 pushed the food cart to D-hall. At 9:29 AM, immediately after the last resident tray was served to the residents in their room on D-hall, the temperatures of the food items used as test trays in the food cart were checked by the CNA#5 with the following results: a. Milk 54.1 degrees Fahrenheit. b. Scrambled eggs 78.9 degrees Fahrenheit. c. Pancake 83.1 degrees Fahrenheit. d. Scrambled eggs 92.4 degrees Fahrenheit. e. Grits 95.2 degrees Fahrenheit. f. Pancake 75 degrees Fahrenheit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045259	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Woodland Hills Rehab & Nursing Cen	8701 Riley Drive Little Rock, AR 72205

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 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. 47916 Based on observation, record review, interview, and facility policy review, the facility failed to ensure kitchen ceiling tiles, air vents, walls, storage racks, exhaustion fan, and garbage disposal were cleaned, door frames were free of chips, and dietary staff thoroughly washed their hands and changed gloves when contaminated, before handling food and clean equipment for 2 of 2 meals observed. The findings are: 1. On 12/02/2024 at 9: 58 AM, the following observations were made in the kitchen: a. The ceiling vent, close to a rack where clean pans were stored, had rust and black stains on it. b. The ceiling tile between the steam table and the 3- compartment sink had rust over it. c. The metal support bracket, attached to the pole across the ceiling tiles from the area where a rack that contained clean pans were stored extending to the area leading to the dish machine room, had accumulations of sage and black colors on them. On 12/04/2024 8:35 AM, the Maintenance Supervisor was interviewed and asked to describe the appearance of the ceiling tiles he stated ceiling tiles had sage buildup. d. The wall leading to the dish washing machine and walls and ceiling tiles in the dish washing room had accumulation of a sage color. e. The door frames leading to the dish washing machine room had sage or gray colors and were chipped. The areas that were chipped showed exposed metal. f. The garbage disposal was not operational. There were leftover food items and black stains inside the disposal. There was strong odor permeating from the disposal. On 12/04/2024 at 8:35 AM, the Maintenance Supervisor was asked if the garbage disposal was working. He stated it stopped working for about three (3) weeks ago and that was the reason it looked like that. g. The bottom right side of frame leading to the dish machine room was rotted and exposing the cement. h. The door leading to A, B, C, and D halls from the kitchen had sage colors on them. The frames were chipped, and the areas that were chipped were exposing the metals. i. The wall above and below the dish washing machine, where the exhaustion fan was located on the clean side, had a mixture of brown and sage accumulation of grease build up on them. The edges of the exhaustion fan above the counter, where clean dish racks were kept drying, had greasy dust build up on it. j. The ceiling tile, above the ice machine was chipped, exposing the cement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045259	A. Building B. Wing	12/04/2024

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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	k. The metal shelf, below the steam table, had buildup of rust on it and was bent. 2. On 12/02/2024 at 10:07 AM, Dietary Aide (DA) #2 pushed a utility cart from the dish washing machine room into the kitchen. Without washing his hands, he removed gloves from the glove box and placed them on his hands, contaminating the gloves. Without changing gloves and washing his hands, he picked plates, to be used in portioning food items to be served to the residents for lunch meal, and placed them on the plate warmer, with his fingers inside the plates. 3. On 12/02/2024 at 10:23 AM, Dietary [NAME] (DC) #1 removed a box of dinner rolls from the freezer and placed it on the counter. DC #1 turned on the hand washing sink faucet and washed his hands. After washing his hands, he turned the faucet off with his hands, contaminating his hands. Without washing his hands, DC#1 removed dinner rolls from the bag inside the box and placed them on the pans, to be baked and served to the residents for lunch meal. 4. On 12/02/2024 at 11:11 AM, the DC #1 turned on the food preparation sink and washed the blender blade, bowl, and lid with hot water. DC #1 did not use soap when washing the blade, bowl, and lid or sanitize them properly. DC #1 then attached the blade, which was not thoroughly washed, at the base of the blender, to be used in grounding food items to be served to the residents who required mechanical soft diets. As DC #1 prepared to place food items into the blender, DC #1 was asked what he should have done after touching dirty objects and before handling clean equipment, he stated he should have re-washed his hands. 5. A review of the facility policy titled, Hand Washing, not dated, provided by the Dietary Manager on 12/3/2024, indicated employees should wash their hands when entering the kitchen, at the start of a shift, and after engaging in other activities that contaminate the hands.