STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045369	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Meadows Health and Rehabilitation	1680 Batesville Boulevard Batesville, AR 72501

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: [NAME] Based on observation, interview, and facility policy review, the facility failed to ensure food items stored in the freezer were covered or sealed, and staff washed their hands between dirty and clean tasks and before handling clean equipment for 3 of 3 meals observed. The findings include: During an observation and interview on 08/10/2025 at 10:34 AM, Dietary Aide (DA) #1 turned on the hand washing sink faucet and washed her hands. After washing her hands, DA # 1 turned off the faucet with her bare hands, which contaminated her hands. Without rewashing her hands, DA #1 placed gloves on her hands, contaminating the gloves. DA #1 used her gloved hands to place slices of strawberries on top of the cake to be served to the residents for lunch. This surveyor asked DA #1 what she should have done after touching dirty objects and before handling food items. DA #1 stated she should have washed her hands. During an observation and interview on 08/10/25 at 10:52 AM, this surveyor observed an opened box of fish on a shelf in the walk-in freezer. The box was not covered or sealed, which exposed it to freezer burn. The Dietary Manager confirmed that the box of fish was not covered and would result in freezer burn. During an observation and interview on 08/10/25 at 11:04 AM, DA #1 used a marker to write the date on lids that covered bowls and contained cake to be served to the residents for lunch. Without washing her hands, she placed gloves on her hands, contaminating the gloves. DA #1 used her gloved hands, with her fingers inside the clean bowls, to be used in portioning dessert to be served to the residents for lunch, contaminating the bowls. DA #1 stated that before picking up the bowls she should have washed her hands. During an observation and interview on 08/10/25 at 11:59 AM, this surveyor observed DA #2 turn on the food preparation sink faucet to fill a pitcher with water. DA #2 turned the water off with her bare hands, contaminating her hands. Without washing her hands, DA #2 used her contaminated hands to pick up cups by the rims, placed them on the counter and poured water into the cups to be served to the residents for lunch. This surveyor asked DA #2 what she should have done after touching dirty (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	objects and before handling clean equipment. DA #2 stated she should have washed her hands. During an observation and interview on 08/10/2025 at 3:50 PM, this surveyor observed DA #3 remove a pitcher that contained beverage from the refrigerator and placed it on the counter. Without washing his hands, DA #3 picked up cups by the rims and placed them on the counter. DA #3 poured beverages into the cups to be served to the residents for supper. This surveyor asked DA #3 what he should have done after touching dirty objects and before handling clean equipment. DA #3 stated, he should have washed his hands. During an observation and interview on 08/11/2025 at 7:35 AM, this surveyor observed DA #4 who was assisting with the breakfast meal, picked up cartons of yogurt, milk, milk shakes, and condiments and placed them on trays. Without washing her hands, DA #4 picked up cups with beverages in them by the rims and placed them on the trays to be served to the residents during the breakfast meal. This surveyor asked DA #4 what she should have done after touching dirty objects and before handling clean equipment. DA #4 stated, she should have washed her hands. A review of a facility policy titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary indicated, employees should wash their hands whenever entering or reentering the kitchen, before encountering any food surfaces, during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, and after engaging in other activities that contaminate the hands.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, interviews, and facility policy review, the facility failed to ensure that staff handled, stored, processed, and transported laundry in a manner that prevented the spread of infection based on two of two observations made. The findings include: During an observation on 08/10/2025 at 11:44 AM, Certified Nursing Assistant (CNA) #5 walked out of room [ROOM NUMBER] with linens that were touching her clothes. She took the linen to a linen room that was next door to room [ROOM NUMBER]. When asked, CNA #5 indicated the linens were removed from one of the beds in room [ROOM NUMBER]. During an observation on 08/10/2025 at 11:45 AM, CNA #6 walked out of room [ROOM NUMBER] with linens that were touching her clothes. She took the linen to a linen room next door to room [ROOM NUMBER]. She indicated these linens were removed from one of the beds in room [ROOM NUMBER]. During an interview on 08/10/2025 at 11:50 AM, CNA #5 stated that the dirty linen should have been in a plastic bag to prevent the spread of germs. She stated the facility was out of the plastic bags that were used to transport linen and there have not been dirty linen bags available for two days. During an interview on 08/10/2025 at 10:56 AM, CNA #6 stated that there were no bags on the unit large enough for the dirty linen. She acknowledged that the dirty linen should not have been touching her clothes. During an interview on 08/12/2025 at 5:20 PM, the Director of Nursing (DON) stated dirty linen should be in a bag when transported. He stated the dirty linen should be in a barrel in the shower room that's located outside of the secure unit and that housekeeping keeps 10-gallon trash bags for blankets. The DON pointed to the trash bags that were located on top of a barrel outside of the laundry room. During an interview on 08/12/2025 at 5:55 PM, the Administrator stated that linen should be placed in a trash bag before being taken out of a resident's room. During an interview on 08/13/2025 at 12:54 PM, Housekeeper #7 stated that the Housekeeping Department provided the staff with bags to put the linen in and that the bags were big enough for one blanket. Review of a policy titled, Laundry and Bedding Soiled, indicated that soiled laundry should be handled and transported according to best based practice for infection control. Contaminated linen should not be held close to the body during transport.