

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Cottage Lane Health and Rehab of Little Rock		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Brookside 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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>37925</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure a bottle of acid reducer liquid medication was properly stored in the refrigerator, per the pharmacy instructions on the bottle, for 1 (Resident #33) of 1 sampled resident whose medication was in the 100-hall medication cart.</p> <p>The findings are:</p> <p>On 11/19/2024 at 3:18 PM, this surveyor reviewed the contents inside the 100-hall medication cart with Registered Nurse (RN) #1. A drawer on the right side of the 100-hall medication cart contained a bottle of acid reducer 2 milligrams per milliliter (mg/ml) liquid for Resident #33 with instructions to give 10 ml (20 mg) by percutaneous endoscopic gastrostomy (PEG) (a tube inserted through a surgical opening in the abdominal wall leading into the stomach). The bottle of acid reducer had a blue sticker which indicated to refrigerate the medication and contained approximately 210 ml to 240 ml of liquid. The bottle was not cold and did not have any condensation on the outside.</p> <p>Resident #33's electronic Medication Administration Record (eMAR) was reviewed and indicated the medication was last administered on 11/19/2024 at 0630 (6:30 AM), by RN #1.</p> <p>On 11/19/2024 at 3:26 PM, RN #1 was interviewed with concurrent observations. She stated the resident did receive the liquid acid reducer around 6:00 AM each morning. She stated the stickers on the bottle of acid reducer indicated to shake well and refrigerate. She confirmed the bottle of acid reducer liquid should have been stored in the refrigerator.</p> <p>A Medication Storage Policy and Procedure, not dated and provided by the Director of Nursing (DON) on 11/21/2024, was reviewed and indicated the purpose was to properly secure medications and biologicals according to the Centers for Medicare and Medicaid Services (CMS) guidelines. The procedure indicated designated personnel would perform weekly and as needed review of medication storage areas and carts for compliance of policy.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned, written menu to ensure that nutritionally balanced meals were provided for the residents for 1of 1 meal observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. On 11/19/2024, the menu for the supper meal revealed residents on pureed diets were to receive two #8 scoops (1 cup) of pureed chili. <ol style="list-style-type: none"> a. On 11/19/24 at 5:13 PM, Dietary [NAME] (DC) #2 used a #8 scoop (1/2 cup) to serve a single portion of pureed chili to all the residents on pureed diets, instead of 2 #8 scoop s (1 cup). b. On 11/19/24 at 5:40 PM, DC #2 was asked, during an interview, what scoop size he had used when serving pureed chili to the residents who required pureed diets. DC #2 stated he used the gray scoop (#8), which was equivalent to 1/2 cup, to give a single serving of pureed chili to each resident. When asked if he had looked at the menu. DC #2 confirmed he had not.

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>03508</p> <p>Based on observation, interview and record review, the facility failed to ensure foods stored in the dry storage areas were covered, sealed and dated; 1 of 2 ice machines were maintained in clean and sanitary condition; the kitchen light fixtures were covered; ceiling tiles and door frames were maintained in good repair and were free of chips, stains and rust; baseboards were secured and were maintained in clean sanitary conditions, and dietary staff washed their hands before handling clean equipment or food items for 2 of 2 meals observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. On 11/19/24 at 2:34 PM, the following observations were made in the kitchen: <ol style="list-style-type: none"> a. An opened box of salt was on the food counter. The box was not covered. b. An opened box of mashed potatoes was on the counter. The box was not fully covered. c. An opened bag of grits was in a basket on the counter. The bag had no opened date on it. 2. On 11/19/24 at 2:38 PM, Dietary [NAME] (DC) #2 pushed a cart toward the counter that contained bowls to be used in portioning dessert to be served to the residents for supper. He picked up gloves and placed them on his hands, contaminating the gloves in the process. <p>On 11/18/24 at 11:55 AM, he used his contaminated glove to pick up slices of frosted vanilla cake in the bowls to be served to the residents for supper. DC #2 was asked what he should have done after touching dirty objects and before handling clean equipment, DC #2 stated he should have washed his hands.</p> <ol style="list-style-type: none"> 3. On 11/18/24 at 2:40 PM, the following observations were made in the kitchen: <ol style="list-style-type: none"> a. The outside of a black utility cart, where 2 baskets of condiments were kept, had stains all over it. There were loose food crumbs inside of the baskets. The Dietary Manager (DM) was interviewed and was asked how often the kitchen should be cleaned. He stated the kitchen staff were supposed to clean it every shift. b. Five (5) of eight (8) leg supports of the food preparation counter had accumulation of grease stains on them. There was an accumulation of dry food crumbs on the floor under food preparation counter. c. One of 2 drip pans above the deep fryer had accumulation of grease build up hanging down from it. One vent had buildup of greasy stains in them d. The ceiling tile above the plate warmer, by the steam table, was cracked. e. Six (6) of six (6) fluorescent lights in the kitchen did not have a covering over them. <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>f. Two (2) of two (2) bottom door frames leading to the storage room were missing, exposing the metal,</p> <p>g. The baseboards throughout the storage room were missing and the door frames leading to the dining room from the dish washing machine had rust on them.</p> <p>h. One (1) ceiling tile in the storage room was loose and had ten (10) areas with water damage.</p> <p>i. The floor in front of a 3-door freezer in the storage room was chipped exposing the cement. Floor in front of the storage rack was chipped exposing the cement.</p> <p>j. The floor in front of the hand washing sink was chipped exposing the cement</p> <p>k. The ceiling tiles above the refrigerator had water damage in six (6) different areas.</p> <p>l. The bottom of the door frames leading to the rest room were rotten, exposing the concrete.</p> <p>4. On 11/18/24 at 2:45 PM, the following observations were made on a rack in the storage room.</p> <p>a. An opened gallon of barbeque sauce. The manufacture ' s specification on the gallon indicated to refrigerate after opening.</p> <p>b. An opened of gallon of stir fry sauce. The manufacture ' s specification on the gallon indicated to refrigerate after opening.</p> <p>5. On 11/18/24 at 3:06 PM, two (2) of two (2) air vents in the dish washing room had brown -yellow stains on them. The Dietary Manager (DM) stated the two air vents were dirty and needed to be cleaned.</p> <p>6. On 11/18/24 at 3:17 PM, the ice machine, on the hall leading to the laundry, had wet black residue on the panel where ice touched before dropping into the ice collector. The surveyor asked the Dietary Manager if DM could wipe the wet black residue on the ice machine panel. He did so, and the wet black substance easily transferred to the paper towel, and he stated it had a black dirt. The DM was asked who uses the ice from the ice machine and how often he cleans the ice machine. He stated Certified Nursing Assistants (CNA)s used it to fill the water pitchers for the residents' rooms and the kitchen staff used it to fill beverages served to the residents at mealtimes. The maintenance man cleans the ice machine once a month.</p> <p>7. On 11/19/ 24 at 4:10 PM, Dietary [NAME] (DC) #2 used a scissor to open a bag of shredded lettuce. As he opened it, he emptied it into a pan and poured shredded cheese on it. DC #2 picked up gloves and placed them on his hands, contaminating the gloves in the process.</p> <p>On 11/19/24 at 4:11 AM, he used his contaminated gloved hands to mix it. DC #2 when he was asked what he should have done after touching dirty objects, and before handling clean equipment, DC #2 stated he should have washed his hands. On 11/19/24 at 4:12 PM DC #2 placed the pan of salad on a shelf in the refrigerator.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>8. On 11/20/24 at 11:16 AM, Dietary [NAME] (DC) #3 turned on the food preparation sink and rinsed the blender blade with hot water. However, DC #3 did not apply soap when washing the blade or sanitized it properly. DC #3 then attached the blade, which was not thoroughly washed at the base of the blender to be used in pureeing food items to be served to the residents who required pureed diets. As DC #3 prepared to place food items into the blender. DC #3 was asked what she should you have done after touching dirty objects and before handling clean equipment, she stated she should have washed her hands.</p> <p>9. On 11/20/24 at 3:09 PM, DC #2 removed a pan of tuna salad from the freezer and placed it on the counter. DC #2 then picked up a bag of bread from the bread rack and placed it on the counter, contaminating his hands, further contaminating the gloves, using his contaminated gloved hand, DC #2 removed slices of bread from the bag as he was ready to put them into the blender. DC #2 was interviewed and asked what he should have done after touching dirty objects and before handling clean equipment, he stated he should have washed his hands.</p> <p>10. A review of facility policy titled, Hand Hygiene Policy and Procedure not dated, and provided by the Dietary Manager on 11/21/2024 indicated hands should be washed prior to food preparation, before and after eating or handling food.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>37925</p> <p>Based on record review and interview, the facility failed to ensure the facility assessment included pertinent information to assure the necessary care and resources were allocated to meet the needs of the residents in 1 of 1 facility. This deficient practice had the potential to affect all residents of the facility. The total census was 81 residents.</p> <p>The findings are:</p> <p>The Facility Assessment 2024, dated as completed 05/15/2024, was reviewed and did not contain the following required information:</p> <ul style="list-style-type: none"> -The involvement of the medical director, director of nursing and direct care staff (these signatures were missing on the review page dated 08/22/2024). -Staffing plan which addressed staffing needs for each resident unit and each shift. -The facilities resources including all personnel (management, direct care staff and volunteers) which included employees and contracted employees along with their education and competencies. <p>On 11/21/2024 at 1:26 PM, the Administrator was interviewed and stated this was the first facility assessment she had completed. She stated a member of the governing body, and the Director of Nursing (DON) assisted her with completing the facility assessment. The Administrator stated she did not speak with the medical director during the completion of the facility assessment. She stated the purpose of the facility assessment was to provide overall quality of care for the residents.</p> <p>A Facility Assessment Tool Policy and Procedure, not dated and provided by the Administrator on 11/21/2024, was reviewed and indicated the intent of the facility assessment was for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents required.</p>		