For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

**Level of harm - Minimal harm or potential for actual harm**

**Residents Affected - Many**

**Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)**

**F 0712**

**Level of harm - Minimal harm or potential for actual harm**

**Residents Affected - Some**

Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.

Complaint # (AR 691) was substantiated, all or in part, with these findings:

Complaint # (AR 723) was substantiated, all or in part, with these findings:

Based on observation and interview, the facility failed to ensure palatable food that was seasoned and not overcooked was served to promote good nutritional intake during 1 of 2 meals observed. This failed practice had the potential to affect 104 residents who received food from the kitchen (total census: 108), according to a diet list provided by the Administrator on 7/31/18. The findings are:

1. Resident Council Meeting and Minutes documented the following:
   1/19/18 - Breakfast is still cold
   4/10/18 - Residents would like less of rice
   5/8/18 - The veggies need to be soft but they are almost mushy
   7/10/18 - Meals aren't good

2. The Grievance Logs were reviewed from (MONTH) (YEAR) to (MONTH) (YEAR) with the following:
   1/6/18 - Husband reported the resident food was cold
   4/16/18 - Orange juice not opened and breakfast tray was cold
   5/3/18 - Resident reported his is constantly receiving items he does not like and within the past 7 days, only 3 of his meals were warm
   7/3/18 - Resident reported he would like to be served something other than hamburger in the evening time

3. On 7/17/18 at 12:32 p.m., a test tray that contained the food items served to the residents for the noon meal was checked by the Surveyor and Dietary Manager. The noodles were mushy, overcooked and bland to taste. The broccoli / cauliflower mixture was bland and mushy. The Salisbury steak was bland to taste. The Dietary Manager tasted the food and stated the noodles and Salisbury steak were bland.

4. On 7/17/18 at 5:45 p.m., 2 alerts and oriented residents were asked about their satisfaction with the lunch meal that consisted of Salisbury steak and noodles. The residents both stated the pasta tasted like paste and they couldn't eat it. They also stated the food they were served for supper was bland and had no taste and, We have too much pasta.

**F 0812**

**Level of harm - Minimal harm or potential for actual harm**

**Residents Affected - Many**

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

Complaint # (AR 691) was substantiated, all or in part, with these findings:

Based on observation and interview, the facility failed to ensure food items on the steam table were maintained at or above a temperature of 135 degrees Fahrenheit (F.); failed to ensure kitchen equipment was maintained in clean condition and proper working order; and failed to ensure the kitchen area was free of standing water and other unsanitary conditions to prevent potential food borne illness for residents who received meals from 1...
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
045385

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OF SUPPLIER
THE WATERS OF NORTH LITTLE ROCK, LLC

STREET ADDRESS, CITY, STATE, ZIP
2501 JOHN ASHLEY DRIVE
NORTH LITTLE ROCK, AR 72114

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 (continued... from page 2)
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F0812
Level of harm - Minimal harm or potential for actual harm
Residents Affected - Many

of 1 kitchen. This failed practice had the potential to affect 104 residents who received meals from the kitchen (total census: 108), according to the Diet List received from the Administrator on 7/31/18. The findings are:

1. On 7/17/18 at 11:10 a.m., there was a large puddle of water on the floor, extending from the steam table to the serving table, approximately 6 feet. During food preparation, the kitchen staff were walking through the water and tracking the water throughout the kitchen.

At 11:15 a.m., the Dietary Manager stated the steam table leaked and there was too much water for the drain to handle. There was a black, electrical device in the floor that had wires exposed. The Dietary Manager stated the device was not active. At 11:30 a.m., the water was cleaned up by staff; however, by 12:10 p.m., the puddle of water was again standing in the floor in an area that extended approximately 6 feet from the steam table.

2. On 7/17/18 at 11:20 a.m., there was a box sitting to the right side of the sink that was wet and falling apart. The Dietary Manager was asked what was in the box and stated the box contained freezer packs that were given to the kitchen and, We didn't need them. They have been there about 2 weeks.

3. On 7/17/18 at 11:27 a.m., Cook #1 was washing dishes in the 3-compartment sink. The cook washed 2 large metal bowls, then placed the bowls on a storage shelf while they were still wet.

4. On 7/17/18 at 11:58 a.m., the steam table food temperatures for the residents' lunch were checked by the Dietary Manager with the following findings:
   Mechanical soft Salisbury steak - 124.6 degrees F.
   Pureed broccoli /cauliflower mixture - 126 degrees F.
   Pureed Salisbury steak - 132 degrees F.

5. On 7/17/18 at 12:03 p.m., Dietary Aide #1 had a piece of brown paper, which she lit on fire and used to light a burner on the stove. The Dietary Aide stated the pilot wasn't working. The Dietary Aide was asked about the appearance of the stove and stated it was cleaned last week.

   a. At 12:50 p.m., the 6-burner stove had a thick, crusty coating covering the entire stove, around the burners and on the brackets. There were burnt food particles around all burners, a piece of elbow macaroni on one burner, and burnt pieces of paper inside one burner. On the backsplash behind the stove, there was a blackish-brownish greasy build-up that extended approximately 1 to 2 feet above the back of the stove. The range hood above the stove had a greasy film, with dirt and white particles on the left corner.

   b. At 1:50 p.m., the Administrator accompanied the surveyor to the kitchen. The Surveyor showed the Administrator the water on the floor and the condition of the stove and informed the Administrator of the burner that staff were lighting with burning paper. The Administrator stated, I was not aware of the water in the floor and stated that they would address the issues in the kitchen.

   c. At 2:20 p.m., the Director of Nursing (DON) accompanied the surveyor to the kitchen and was shown all areas that had been pointed out to the Administrator. The DON was asked if she would eat food prepared in this kitchen and stated, No.

   d. At 2:59 p.m., the interior of the oven was inspected. The oven racks had a build up of a brownish-blackish, crusty substance. The glass panes in the oven doors had a greasy, brown build-up. The area behind the deep fryer had a greasy build-up with bits of food and whole French fries on the floor. There was an 8 to 10-inch area of greasy build-up under the front of the deep fryer. The outer surfaces of the stove and oven remained as previously described, and the large puddle of water remained in the floor by the steam table. The wet, disintegrating box of freezer packs remained by the sink.