| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045404 | A. BUILDING _____ B. WING _____ | 09/11/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| LAKEWOOD THERAPY AND LIVING CENTER | 260 LAKEPARK DRIVE HOT SPRINGS, AR 71901 |

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 0550<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and interview, the facility failed to ensure residents in the same dining room and at the same table were served concurrently to promote dignity and respect for 1 (Resident #10 ) of 1 sample case mix resident who ate meals in the main dining room and required set up help from staff only for eating, failed to ensure staff sat at eye level while assisting a resident with meals to promote dignity for 1 sampled resident (Resident #51), and failed to ensure signs with care instructions were not posted over resident beds to promote dignity for 2 sampled residents (Residents #53 and #54). These failed practices had the potential to affect 1 resident who ate meals independently in the main dining room, 10 residents who were dependent for eating as documented on a list provided by the Office Manager on 09/09/2020 at 2:00 p.m. and 2 residents who required cueing/assistance with eating as documented on a list provided by the Administrator on 09/10/2020 at 7:54 a.m. and had the potential to affect all 54 residents who reside in the facility as documented on the Resident Census and Conditions of Residents that was provided by on 9/09/20 by the MDS Coordinator on 09/09/2020. The findings are: 1. Resident # 10 had [DIAGNOSES REDACTED]. The 5 day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/01/2020 documented the resident scored 15 (13-15 indicates cognitively intact) per a Brief Interview for Mental Status (BIMS) and required independent set up help for eating. a. On 09/08/2020 at 12:57 p.m., during the lunch meal there were 14 residents in the dining room. Thirteen residents were served their meal and were eating. Resident #10 did not receive her meal. She was sitting in the dining room while the other residents were eating their meal. b. On 09/08/2020 at 1:17 p.m., Resident #10 stated, They forgot me. The Activity Director was asked if the resident had eaten. The Activity Director stated, It must be on the first cart that went to the hall. They knew she came to the dining room to eat, that way she can get her food on time. c. On 09/08/2020 at 1:19 p.m., Resident #10 received her lunch tray after 1 hour and 34 minutes. She was the last resident to be served in the dining room. The Activity Director stated, She said that because she saw everybody has their tray. She came to the dining room to eat so she can get her food earlier. She told me if she stays on the 500 hall, she will get her tray later than she normally does. She used to be on 200 hall and the tray goes to the 200 and 100 halls first. d. On 09/08/2020 at 1:42 p.m., Resident #10 was asked, Is your meal normally late? She stated, Most of the time. Usually late. I usually get my tray on time in the morning. That's the reason I come to the dining room in the morning. e. On 09/09/2020 at 1:20 p.m., the Activity Director was asked if she knew the reason Resident #10 said they forgot me. She stated, Because she saw everybody has their tray. 2. Resident #51 had a [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 08/21/2020 documented the resident was severely impaired in Cognitive<br>Skills for Daily Decision Making per a Staff Assessment for Mental Status (SAMS) and required supervision, oversight, encouragement, and cueing and the assist of one person for eating. a. The May 2020 physician's orders [REDACTED]. diet. b. A Care Plan dated 05/21/2020 documented, . has an ADL (activities of daily living) self-care performance deficit r/t (related to) Alzheimer's, Dementia .EATING: . requires limited assistance x (times) 1 staff to eat . c. The Eating Support policy provided by the Director of Nursing (DON) on 09/09/2020 at 2:25 p.m. documented, . Purpose: Assist the resident with feeding as necessary, ensure adequate nutrition . Sit so you are at the same level as the resident . d. On 09/08/2020 at 12:58 p.m., Certified Nursing Assistant (CNA) #2 was setting up a lunch tray for Resident #51 in the dining room. CNA #2 stood to the left side of the resident and gave the resident a bite of spaghetti and walked away. CNA #2 asked CNA #3 to help, but then sent him down the hall, leaving Resident #51 with no one to assist her. The resident did not attempt to feed herself. e. On 09/08/2020 at 1:10 p.m., CNA #2 gave Resident #51 a bite of food and a drink of water while standing in front of the resident. CNA #2 continued to stand in front of the resident and gave the resident several bites of food and then walked away, leaving no one to assist the resident with the meal. The resident made no effort to feed herself. f. On 09/10/2020 at 7:40 a.m., CNA #2 was asked, What is the correct position to be in when you assist a resident with feeding? She replied, Sitting at eye level and have a conversation. She was asked, Should you stand up to assist with feeding? She replied, No, personally that's like looking over them. She was asked, Could that be a dignity issue? She replied, For me it is. 3. Resident #53 had a [DIAGNOSES REDACTED]. a. The June 2020 physician's orders [REDACTED]. b. The August 2020 physician's orders [REDACTED]. c. A Care Plan dated 08/19/2020 documented, . requires tube feeding Fibersource 60 ml/hr (milliliters per hour) r/t (related to) dysphasia . keep head of bed 30-45 degrees while in bed . d. On 09/08/2020 at 10:30 a.m., Resident #53 had two signs on the wall of her room that documented, Keep HOB (head of bed) elevated 35-40 degrees and NPO (nothing by mouth). (Photo taken.) e. On 09/08/2020 at 5:28 p.m., the same signs were on the wall in Resident #53's room. f. On 09/09/2020 at 8:07 a.m. and at 2:07 p.m., the same signs were on the wall in Resident #53's room. g. On 09/10/2020 at 8:35 a.m., Licensed Practical Nurse (LPN) #2 was asked, If today was your first day on the job and there were no signs on the wall saying NPO or Head of Bed elevated, how would you know that she was NPO and to keep her head elevated? She answered, I'm pretty sure it's on the MAR. I know the NPO is on the MAR. She was asked, How are the CNA's notified of resident care? She answered, I don't know that answer. She was asked, Could signs on the wall with care instructions be a violation of privacy and dignity? She answered, Yes it could. h. On 09/10/2020 at 08:40 a.m., CNA #4 was asked, How are the CNA's notified of resident care needs? He answered, The nurse tells us. He was asked, If today was your first day on the job and there were no signs on the wall saying NPO or Head of Bed elevated, how would you know that she was NPO and to keep her head elevated? He answered, Well, the feeding tube gives it away. Everyone knows that. He was asked, Could signs on the wall with care instructions be considered a violation of privacy and dignity? He answered, Yes it could. 2. Resident #54 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 08/26/2020 documented the resident scored 15 (13-15 indicates<br>cognitively intact) per a BIMS and received [MEDICAL TREATMENT]. a. The May 2019 physician's orders [REDACTED]. b. The Care Plan dated 08/30/2019 documented, . I need [MEDICAL TREATMENT] r/t (related to) [MEDICAL CONDITION]. I refuse sometimes. I<br>have [MEDICAL TREATMENT] at (city, phone number) 3 day a week . will have no s/sx (signs/symptoms) of complications from [MEDICAL TREATMENT] through the review date .) c. On 09/08/2020 at 10:30 a.m., a sign posted on the wall in Resident #54's room documented, NO FINGERSTICKS BP (BLOOD PRESSURE) LAB DRAWS ECT (excetra) LEFT ARM (Photo taken.) d. On 09/08/2020 at<br>3:00 p.m., the same sign was on the wall in Resident #54's room. e. On 09/09/2020 at 10:08 a.m. and 2:00 p.m., the same sign was on the wall in Resident #54's room. f. On 09/10/2020 at 02:00 p.m., The DON was asked, What is the correct way for a CNA to be positioned when assisting a resident with their meal? He answered, At resident height. He was asked, Should a CNA ever stand up to feed a resident? He answered, No. He was asked, How is the staff notified of how to care for the residents? He answered, It's in the computer Kardex. He was asked, Could a sign over the bed with care instructions be a violation of privacy or dignity? He answered, If it is too descriptive, yes. |

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

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| F 0550<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1) |
| F 0584<br><br>**Level of harm -** Potential for minimal harm<br><br>**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.**<br><br>Based on observation, record review, and interview, the facility failed to ensure effective housekeeping and maintenance services were provided to maintain a clean and orderly environment as evidenced by failure to ensure the dining room walls and floors were maintained in clean condition to enhance the residents' quality of life. This failed practice had the potential to affect 54 residents who required access to the dining room according to the Residents Census and Conditions of Residents provided by the Administrator on 09/08/2020. The finding are: 1. On 09/08/2020 at 08:26 A.M., a window in the kitchen was dirty and there was a sticky substance on the floor, a dried substance on the wall approximately 2 x 3 inches, a brown sticky substance all along the base boards next to the floor tile and approximately 1/2 inch thick dust was on the window looking out in the dining room. 2. On 09/08/2020 at 12:13 P.M., a window in the kitchen was dirty and there was a sticky substance on the floor, a dried substance on the wall approximately 2 x 3 inches, a brown sticky substance all along the base boards next to the floor tile and approximately 1/2 inch thick dust was on the window looking out in the dining room. Photo taken. 3. 09/10/2020 at 03:53 P.M., The Administrator was shown the photos of the dining room and was asked, Should the walls have a red substance on them? He said, No. He was asked, Should the residents have a clean dining room? He said, Yes. |
| F 0623<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on record reviews and interviews the facility failed to ensure that the Ombudsman was notified at least monthly of residents who were discharged from the facility for 3 (Residents #15, #45 and #49) sampled residents of 9 (Resident #14, #15, #23, #28, #30, #38, #45, #49, and #51) sampled residents who had discharged from the facility. This failed practice had the potential to affect 52 residents who were discharged from the facility in the last 9 months based on a list provided by Business Office Manager (BOM) on 09/10/2020 at 3:44 p.m. The findings are: 1. Resident #15 had [DIAGNOSES REDACTED]. a. The resident's records documented the resident discharged from the facility to a hospital on [DATE] and returned to the facility on [DATE]. There was no documentation of the notification of discharge to the Ombudsman. 2. Resident #45 had [DIAGNOSES REDACTED]. A Quarterly MDS with an ARD of 08/19/2020 documented the resident scored 14 (13-15 indicates cognitively intact), and required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, toilet use, and personal hygiene; required limited assistance locomotion off the unit; did not walk, supervision with eating, and total for bathing. a. The resident's record documented the resident was hospitalized from [DATE] to 02/14/2020. There was no documentation of notification to the Ombudsman of discharge. 3. Resident #49 had [DIAGNOSES REDACTED]. The 5-day readmission MDS with an ARD of 08/21/2020 documented the resident scored 15 (13-15 indicates cognitively intact) per a BIMS and required supervision with transfers and eating; limited assistance with locomotion, dressing, toileting, and personal hygiene; extensive assistance with walking and bathing; independent with bed mobility and eating. a. The resident's records documented the resident was discharged to the hospital from 08/02/2020 through 08/05/2020. There was no documentation of notification to the Ombudsman of discharge. 4. On 09/10/2020 at 10:58 a.m., the BOM was asked for her monthly reports she sent to the Ombudsman and she stated, We don't often notify (the Ombudsman). It would be my understanding that we would only notify of residents we are not going to accept back. I can only think of two residents who left the facility. They discharged because they wanted to go, one went to assisted living and one to (Facility). It was their choice. |
| F 0636<br><br>**Level of harm -** Potential for minimal harm<br><br>**Residents Affected -** Some | **Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and interview, the facility failed to document the use of a [MEDICAL CONDITION] (Continuous Positive Airway Pressure) machine on the Comprehensive Assessment for one resident (Resident #23). This failed practice had the potential to affect 1 resident who used a [MEDICAL CONDITION] machine, as documented on a list provided by Minimum Data Set (MDS) Coordinator #1 on 09/11/2020 at 7:58 A.M. The findings are: Resident #23 had a [DIAGNOSES REDACTED]. The Admission MDS with an Assessment Reference Date of 10/21/2019 documented the resident scored 15 (13 to 15 indicates cognitively intact) on the Brief Interview for Mental Status and required supervision for dressing and eating and physical assistance of 1 person for personal hygiene. The use of [MEDICAL CONDITION] is not documented while not a resident or while a resident. a. The October 2019 physician's orders [REDACTED].@ 8.0 cm (centimeters) H2O (water) pressure - apply q (every) night @ (at) HS (hour of sleep) as tolerated at bedtime . b. A Care Plan dated 10/24/2019 documented, . I wear a c-pap at 8.0cm H2O pressure . I will be compliant with my c-pap and wear my mask every night and when I take a nap . c. On 09/08/2020 at 10:30 A.M., Resident #23 was lying on the bed on his left side, asleep with a [MEDICAL CONDITION] on. d. On 09/10/2020 at 9:00 A.M., MDS Coordinator #1 was asked, Should the use of a [MEDICAL CONDITION] be on (Resident #23's) Admission MDS? She answered, I will have to look. I think I missed it. e. On 09/10/2020 at 09:15 A.M., MDS Coordinator #2 was asked, Should the use of a [MEDICAL CONDITION] be on (Resident #23's) Admission MDS? She answered, He brought one from home that he rented. When he came here we sent it back and provided him with a new [MEDICAL CONDITION]. There may have been some days when he didn't have it, but it wasn't very long. It should be on the MDS. |
| F 0677<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide care and assistance to perform activities of daily living for any resident who is unable.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to ensure residents fingernails were clean, trimmed and smooth to maintain good personal hygiene for 4 (Residents #9, #11, #30, and #51) of 27 (Residents #9, #10, #11, #12, #14, #15, #17, #23, #27, #28, #30, #33, #35, #36, #37, #38, #42, #43, #44, #45, #46, #47, #49, #51, #53, #50, and #54) who required nail care and 3 (Residents #11, #45 and #36) sampled residents who required assistance with showers, hygiene and shaving. These failed practices had the potential to affect 54 residents who required assistance with showers and hygiene according to the Resident Census and Conditions of Residents provided by the Administrator on 09/08/2020 and 24 residents who required assistance for shaving as documented on a list provided by MDS Coordinator #1 on 09/10/20. The findings are 1. Resident #9 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 07/01/2020 documented the resident scored 2 (0-7 indicates severely impaired) per a Brief Interview for Mental Status (BIMS) and required extensive assist with two person for bed mobility, transfer and extensive assist of one person for dressing and hygiene. a. The care plan documented, . has an ADL (activities of daily living) self-care performance deficit r/t (related to) impaired mobility & impaired cognition. Date Initiated: 05/08/2019 . PERSONAL HYGIENE .: The resident requires extensive assist of 1 with personal hygiene. b. On 09/08/20 at 10:43 A.M., Resident #9 was sitting in a wheelchair, her fingernails were thick, jagged and had a brown substance under them. c. On 09/09/20 at 08:26 A.M., Resident #9 was sitting in a wheelchair eating breakfast, her fingernails were thick, jagged and had a brown substance under them. 2. Resident #11 had [DIAGNOSES REDACTED]. The Quarterly MDS with ARD of 07/02/2020 documented the resident scored 3 (3 indicates severely impaired) per a Staff Assessment for Mental Status (SAMS) and required extensive assist with two people |

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| F 0677<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 2)<br>for transfer and extensive assist of one person for bed mobility, dressing and hygiene. a. The care plan documented, .has an ADL self-care performance deficit r/t impaired cognition. Date Initiated: 05/16/2019 . PERSONAL HYGIENE . The resident requires extensive assist of 1 with personal hygiene . has potential for impairment to skin integrity r/t fragile skin / (and or) incontinent. Date Initiated: 10/07/2019 .Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short . b. On 09/08/20 at 10:47 A.M., Resident #11 was lying in the bed and had chin hairs approximately 1/4 inch long and a brown substance was under her fingernails. (Photo taken of fingernails.) c. On 09/08/20 at 2:34 P.M., Resident #11 was lying in the bed and had chin hairs approximately 1/4 inch long and a brown substance was under her fingernails. d. On 09/09/20 at 8:32 A.M., Resident #11 was sitting up in the bed with a staff member assisting her with breakfast. The resident had chin hairs approximately 1/4 inch long and a brown substance was under her fingernails. e. On 09/10/2020 at 08:42 A.M., Certified Nursing Assistant (CNA) #4 was asked, Does her fingernails look discolored and need to be cut? She said, Yes. She was asked, What do you see on her chin? She said, Whiskers. f. On 09/10/2020 at 08:47 A.M., the Director of Nursing (DON) was shown the pictures of the fingernails and asked, Should they look like that? He said, No. He was asked, What do you think it is? He said, It could be fecal or from scratching. He was asked, Do women have chin hairs? He said, No. 3. Resident #30 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 07/28/2020 documented the resident<br>scored 15 (13-15 indicates cognitively intact) per a BIMS and required extensive assist of two people for bed mobility, transfer and extensive assist with one person for dressing and hygiene. a. The care plan documented, has an ADL self-care performance deficit r/t [MEDICAL CONDITIONS] Date Initiated: 03/15/2019 . PERSONAL HYGIENE/ORAL CARE: The resident requires extensive to total assist of one staff member with hygiene . b. On 09/08/2020 at 11:04 A.M., Resident #30 was lying in the bed, a brown substance was under his fingernails. c. On 09/09/2020 at 08:27 A.M., Resident #30 was sitting up eating breakfast, a brown substance was under his fingernails. 4. Resident #51 had [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 08/21/2020 documented the resident scored 3 (3 indicates severely impaired) per a SAMS and required extensive assist with two person for bed mobility, transfer, hygiene and extensive assist of one person for dressing. a. The care plan documented, . has an ADL self-care performance deficit r/t Alzheimer's, Dementia . PERSONAL HYGIENE/ORAL CARE: requires extensive assistance (2) staff with personal hygiene b. On 09/08/2020 at 10:57 A.M., Resident #51 was sitting in her wheelchair at the nurse's station, a brown substance was under her fingernails. c. On 09/08/2020 at 01:09 P.M., Resident #51 was sitting in her wheelchair in the dining table, a brown substance was under her fingernails. d. On 09/09/2020 at 08:26 A.M., Resident #51 was lying in the bed eating breakfast, a brown substance was under her fingernails. e. On 09/10/2020 at 08:33 A.M., Resident #51 was lying in the bed sleeping. Her breakfast was on the over bed table. A brown substance was under her fingernails. Certified Nursing Assistant (CNA) #1 was trying to get the resident to wake up and eat. CNA #1 was asked, What do you see under her fingernails? She said, It looks like poop. 5. Resident #45 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 08/19/2020 documented the resident scored 14 (13-15 indicates cognitively intact) per a BIMS and required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, toilet use, and personal hygiene; required limited assistance locomotion off the unit; did not walk, supervision with eating, and total for bathing. a. The care plan documented, . has an ADL self-care performance deficit r/t obesity, [MEDICAL CONDITION] / dementia with behaviors. PERSONAL HYGIENE/ORAL CARE: . requires extensive assist of 1 for . Date Initiated: 04/22/2019. b. Resident #45 was lying in the bed, her toenails were thick, encrusted, yellow and approximately 1/8 to 1/4 inch beyond the nailbed. (Photo taken.) c. On 09/09/2020 at 10:30 A.M., Resident #45 was asked, Have you had a bath today? She stated, They didn't come get me for my bath and I don't know why. d. On 09/20/2020 at 2:00 P.M., MDS Coordinator #1 provided documentation for baths for (Resident #45) for August and September. She stated, She is care planned to refuse care, but there is no refusals in August or September. The bathing documents for Resident #45 documented: .TOTAL DEPENDENCE on 08/03/2020, 08/05/2020 08/10/2020, 08/12/2020 08/14/2020, 08/21/2020, and 08/28/2020., NOT APPLICABLE on 08/07/2020, 08/17/2020, 08/19/2020 08/24/2020, 08/26/2020 08/31/2020 09/04/2020 and 09/07/2020, INDEPENDENT - No help provided on 09/02/2020 . There were no refusals. MDS Coordinator #2 stated, They are not supposed to put not applicable. e. On 09/11/2020 at 08:24 A.M., the Director of Nursing was asked, How do you ensure that scheduled baths are completed? He stated, Through ADL task list. We also have a shower list. We get a clinical alert if they are not bathed. The nurses on the floor usually redirect and attempt a prn (as needed) in bathing time if possible. He was asked, If the CNA's chart not applicable, what does that mean? He stated, Not applicable should not be a choice, but we are arguing that. It could mean that the resident is not available at the time. Some CNA's write that instead of refused. We don't have access to change how the choices are. Refused is a choice, they just have to scroll down. I'd have to talk to the CNA to see if it was done or attempted and refused. My experience with her is she does not want to go to the shower room and when she does agree, it is for a bed bath only. When the clinical alerts to be cleared, a progress note must be written. f. 09/11/2020 at 8:45 at A.M., the nurse's notes from 08/01/2020 through 09/11/2020 had no documentation of baths. 6. Resident #36 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 08/08/20 documented the resident was severely impaired in cognitive skills per a Staff Assessment for Mental Status (SAMS). He required extensive assistance from one staff member for personal hygiene and total assistance from one staff member for bathing. a. The Care Plan dated 04/02/2019 documented, . has an ADL self-care performance deficit r/t Activity Intolerance & right AKA (above the knee amputation) - BATHING/SHOWERING: The resident is totally dependent upon staff for showering. Requires total assist of 2 . PERSONAL HYGIENE/ORAL CARE: The resident requires total assist of 2 for personal hygiene and oral care . b. On 09/08/2020 at 10:30 A.M., Resident #36 was lying in bed and had whisker stubble growth on his face. c. On 09/09/2020 at 8:51 A.M. and at 2:10 p.m., Resident #36 continued to have whisker stubble growth on his face. d. On 09/09/2020 at 6:26 P.M., Resident #36's scheduled bath time was on the 3:00 P.M. to 11:00 P.M. shift on Mondays, Wednesdays and Fridays per the Tasks list in the Electronic record. e. On 09/10/2020 at 10:29 A.M., Resident #36 continued to be unshaven. There was no documentation in the Electronic Record of refusal to bathe or shave from the evening prior. f. On 09/10/2020 at 2:00 P.M., the DON was asked, How often are the male residents shaved? He answered, On their shower day and by request. If they are not able to request, then definitely on their shower day. g. 09/11/2020 at 7:48 A.M., CNA #7 was asked, How often are the men shaved? He answered, Usually on their bath day or when they ask for it. That's all I know. He was asked, Does (Resident #36) look like he needs a shave? He answered, Yes. 7. 09/10/2020 at 11:12 A.M., The Bath, Bed policy and procedure provided by the DON documented, .Purpose: Cleanse, refresh and soothe the resident, stimulate circulation, Inspect the body . Procedure .21. Care of fingernails is part of the bath. Be certain nails are clean. If toenails are difficult to cut, inform the charge nurse . |
| F 0687<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide appropriate foot care.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to ensure residents toenails were clean, trimmed, smooth, and free of jagged edges to promote good personal hygiene and grooming for 3 (Residents #9, #43 and #45) of 27 (Residents #9, #10, #11, #12, #14, #15, #17, #23, #27, #28, #30, #33, #35, #36, #37, #38, #42, #43, #44, #45, #46, #47, #49, #51, #53, #50, and #54) sampled residents who were dependent on staff for toenail care. This failed practice had the potential to affect all 54 residents who resided in the facility per verbal information from the Director of Nursing. The findings are: 1. Resident #9 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with Assessment Reference<br>Date (ARD) of 07/01/2020 documented the resident scored 2 (0-7 indicates severely impaired) per a Brief Interview for Mental Status (BIMS) and required extensive assist with two person for bed mobility, transfer and extensive assist of one person for dressing and hygiene. a. The care plan documented, . has an ADL (activities of daily living) self-care performance deficit r/t (related to) impaired mobility & impaired cognition. Date Initiated: 05/08/2019 . PERSONAL HYGIENE/ORAL CARE: The resident requires extensive assist of 1 with personal hygiene. b. On 09/08/20 at 10:43 A.M., Resident #9 was sitting in a wheelchair, her toenails were thick and jagged. c. On 09/09/20 at 08:26 A.M., Resident #9 was sitting in a wheelchair eating breakfast, her toenails were thick and jagged. d. On 09/10/20 at 8:33 A.M., Certified Nursing Assistant (CNA) #8 was asked, Does her toenails need cut? She said, Yes. e. On 09/10/20 at 8:47 A.M., the Director of Nursing (DON) was shown the pictures of Resident #9's toenails and asked, Should they look like that? He said, No. He was asked, Do they look jagged? He said, Yes. f. On 09/10/20 at 11:12 A.M., the Foot Care policy and procedure provided by the DON documented, . Purpose: Prevent infection of the feet, prevent irritation of the feet, Prevent break in skin integrity of the feet Procedure: . 8. Toenails are to be clipped and filed smoothly . 2. Resident #43 had [DIAGNOSES |

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|---|---|---|---|
| | **045404** | A. BUILDING _____ B. WING _____ | **09/11/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **LAKEWOOD THERAPY AND LIVING CENTER** | **260 LAKEPARK DRIVE HOT SPRINGS, AR 71901** |

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

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| F 0687<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 3)<br>REDACTED]. The Quarterly MDS with ARD of 08/14/2020 documented the resident scored 3 (3 indicates cognitively intact) per a Staff Assessment for Mental Status (SAMS) and required total assist of two people for bed mobility, transfer and dressing and extensive assist of two person for hygiene. a. On 09/09/2020 at 2:04 P.M., The care plan documented, . has an ADL self-care performance deficit r/t Activity Intolerance, Impaired balance, Limited Mobility Date Initiated: 03/28/2020 . PERSONAL HYGIENE/ORAL CARE: The resident is totally dependent on staff for personal hygiene. b. On 09/08/2020 at 2:43 P.M., Resident #43 was lying in the bed with her feet uncovered, her toenails were thick and jagged with dry skin. (Photo taken.) c. On 09/09/2020 at 08:27 A.M., Resident #43 was lying in the bed with her feet uncovered, her toenails were thick and jagged with dry skin. 3. Resident #45 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 08/19/2020 documented the resident scored 14 (13-15 indicates cognitively intact) per a BIMS and required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, toilet use, and personal hygiene; required limited assistance locomotion off the unit; did not walk, supervision with eating, and total for bathing. a. The care plan documented, . has an ADL self-care performance deficit r/t obesity, [MEDICAL CONDITION] / dementia with behaviors. PERSONAL HYGIENE/ORAL CARE: . requires extensive assist of 1 for . Date Initiated: 04/22/2019. b. On 09/09/2020 at 10:30 A.M., Resident #45's toenails were long, thick, curled and extended over the end of her toes approximately 1/8 to 1/4 inches. (Photo taken.) She stated, The last time the podiatrist came, he did not see me. c. On 09/10/2020 at 11:25 A.M., the DON was asked if the Podiatrist still comes into the facility. He stated, Not since Covid. He was asked, Who has been cutting the toenails? He stated, The Treatment Nurse has taken over that role. We were working on a contact with (mobile company) to take care of it . d. On 09/10/2020 at 12:59 P.M., the Treatment Nurse was asked if she did the resident's toenails. She stated, I do diabetics, and I try to also to do those that don't get out of bed. She was asked, What about (Resident #45)? She stated, Usually the CNA's do that. When they go to the shower. She was asked if the (Resident #45's) nails are done in the shower. She replied, She does bed baths a lot. She is kind of picky about who does her care. I know that. She was asked, Where would nail care be documented? She stated, On the Kiosk. e. On 09/10/2020 at 1:04 P.M., CNA#2 was asked if she did (Resident #45's) baths. She stated, She gets her baths on 3/11 (3:00 p.m. to 11:00 p.m. shift). She was asked, Who would do her toenails? She stated, We (CNAs) don't do her toenails. The podiatrist does her toenails. She was asked, How long has it been since she saw a podiatrist? She stated, 5 to 6 months. We should look every day. I am a CNA so I should be checking them. f. On 09/10/2020 at 2:00 P.M., MDS Coordinator #1 was asked to provide documentation of nail care and baths and was unable to find documentation for nail care. She stated, She (Resident #45) is care planned to refuse care, but no refusal was documented on the August and September bath records. |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br><br>Based on observation, record review and interview the facility failed to ensure 2 of 2 clothes dryers remained free of lint build-up to decrease the potential for fire and loss of laundry services for 1 of 1 laundry room. This failed practice had the potential to affect all 54 residents according to the Resident Census and Conditions of Residents form dated 09/08/2020. The findings are: 1. On 09/09/2020 at 9:10 A.M., Dryer 1 had a small amount of lint in the left corner of the dryer floor. (Photo taken.) Dryer 2's lint trap was covered with lint and there was lint in the back of dryer floor. (Photo taken.) Laundry Aide #1 was asked, What is that in the back of the dryer? Laundry Aide #1 stated, Lint. Laundry Aide #1 was asked, What can happen with the lint being in there? Laundry Aide #1 stated, A fire. Laundry Aide #1 was asked, How often to do you clean the lint out? Laundry Aide #1 stated, Every two hours. 2. On 09/09/2020 at 9:12A.M., Maintenance #1 was asked, What can happen with lint in the dryer? Maintenance #1 stated, It can cause a fire. Maintenance #1 was asked, How often do you clean out the lint? Maintenance #1 stated, Every two hours. 3. The Laundry/ (and or) Maintenance policy for lint in dryers provided by Maintenance #1 on 09/09/2020 at 9:30 A.M. documented, Laundry/Maintenance - Lent traps are to be cleaned every 2 hours while on shift the times are listed below - Days- 7am, 9am, 11am, 1pm, 3pm - Evenings 5pm, 7pm, 9pm, 11pm Maintenance is to clean behind dryers once a week. Maintenance #1 provided documentation of the dates of the weekly dryer vent inspections. The last inspection date was 09/04/2020. 4. The Dryer Lint Check log provided by the Administrator on 09/10/2020 at 7:58 A.M. documented times 09/09/2020 for 7:00, 9:00 11:00. 5. On 09/11/2020 at 8:42 A.M., the Administrator was shown the picture of the lint in Dryer 2's lint trap. The Administrator was asked, What do you see in this picture? The Administrator stated, Lint. The surveyor asked, What can happen? Administrator stated, A fire. |
| F 0690<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interview and record review, the facility failed to ensure complete, thorough, and appropriate incontinent care hygiene measures were used to prevent skin breakdown and prevent possible urinary tract infections for 1 (Resident #45) of 12 (Residents #9, #11, #14, #15, #33. #37, #43, #44, #45, #48, #51, #53) female sampled mix residents. This failed practice had the potential to affect 24 female residents that were dependent on staff for incontinent care based on a list provided by Minimum Data Set (MDS) #1 on 09/10/2020 at 3:50 P.M. The findings are: 1. Resident #45 had [DIAGNOSES REDACTED]. The Quarterly MDS with an Assessment Reference Date of 08/19/2020 documented the resident scored 14 (13-15 indicates cognitively intact) per a Brief Interview for Mental Status and required extensive assistance with bed mobility, transfers, locomotion on the unit, dressing, toilet use, and personal hygiene; required limited assistance locomotion off the unit; did not walk, supervision with eating, and total for bathing. a. The care plan documented, . has an ADL (activities of daily living) self-care performance deficit r/t (related to) obesity, [MEDICAL CONDITION] / (and or) dementia with behaviors. Toilet Use: . requires extensive to total assist of 1-2 with incontinent care. Date Initiated: 04/22/2019. On 09/09/2020 at 9:57 A.M., Certified Nursing Assistant (CNA) #6 and CNA #2 knocked on Resident #45's door. They explained to the resident what they were going to do and begin setting up bags at the end of the bed. They donned gloves without washing or using hand gel. CNA #6 untaped the resident's brief and handed wet wipes to CNA #2. CNA #2 wiped down the resident's left groin with a wet wipe and tossed it in the bag at end of bed. Using a clean wipe with each swipe she wiped down the right groin, across the abdomen and then without separating the labia she wiped down between the resident's legs. She made a second swipe without separating the labia. The resident was then turned, and without changing gloves, CNA #2 began to swipe upward cleaning bowel movement off of the resident's buttocks. She changed her gloves when they became soiled with feces. The resident was then rolled onto her back and CNA #6 cleaned a few places where she saw feces on the resident's left side. A brief was placed between her legs and left unfastened. CNA #6 and #2 left the room and carried the trash and dirty linens out. They did not wash their hands prior to leaving the room. After they placed their bags in the appropriate container in the hall, they each went into another resident's room and washed their hands. b. The Perineal Care policy and procedure provided by the DON on 09/10/2020 documented . 7. Female perineal care. f. Use one gloved hand to stabilize and separate the labia, with other hand wash from front to back . rinse and pat dry with towel. c. On 09/11/2020 at 8:08 A.M., the DON was asked, Should staff perform complete and thorough incontinent care? He replied, Yes. |
| F 0692<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide enough food/fluids to maintain a resident's health.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and interview, the facility failed to ensure one resident (Resident #33) had access to drinking water in her room. This failed practice had the potential to affect 48 residents in the facility who receive regular thin consistency liquids by mouth as documented on a list provided by Minimum Data Set (MDS) Coordinator #1 on 09/11/2020 at 7:55 A.M. The findings are: Resident #33 had a [DIAGNOSES REDACTED]. The Quarterly MDS with an Assessment Reference Date of 08/01/2020 documented the resident scored 0 (0 - 7 indicates severely impaired) per a Brief Interview for Mental Status and required supervision and set up assistance with eating. She did not have limits to the range of motion to the upper or lower extremities. The September 2020 Physician order [REDACTED]. Order date 02/11/2019 There was no order for thickened liquids, fluid restriction, or no water pitcher in the room. The Care Plan documented, . has potential for impairment to skin integrity r/t (related to) fragile skin/ (and or) ageing process . Encourage good nutrition and |

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| LAKEWOOD THERAPY AND LIVING CENTER | 260 LAKEPARK DRIVE HOT SPRINGS, AR 71901 |

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| F 0692<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>hydration in order to promote healthier skin . Date Initiated: 10/01/2019. On 09/08/2020 at 10:30 A.M., Resident #33 was standing in her room talking to her roommate. There was no water pitcher on her side of the room. On 09/09/2020 at 08:36 A.M., Resident #33 was eating breakfast in her room. There was no water pitcher on her side of the room. On 09/09/2020 at 02:05 P.M., there was no water pitcher on Resident #33's side of the room. On 09/10/2020 at 08:10 A.M., Certified Nursing Assistant (CNA) #3 was asked, Does (Resident #33) have a water pitcher in her room? He answered, No. He was asked, Is there a medical or behavioral reason why she doesn't have a water pitcher in her room? He answered, I guess I forgot to get her one. He was asked, Is there any reason why she would go all week without a water pitcher in her room? He answered, No that's just my mistake. Sometimes she carries things off though. He was asked, Do you pass out ice water on your shift? He answered, Yes, every day. He was asked, Do you remember giving her any ice water this week? He answered, No. It's my mistake. 09/10/2020 at 2:00 P.M., The Director of Nursing (DON) was asked, Who should have a water pitcher in their room? He answered, Everyone who is not on thickened liquids. He was asked, What could happen if a resident didn't have a water pitcher? He answered, Dehydration. He was asked for a Policy on Hydration. The Nurse Consultant reported at approximately 3:50 P.M. that the facility does not have a hydration policy. |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation and interview, the facility failed to ensure food items stored in the refrigerator and freezer and storage area were covered and dated, food in the freezer was frozen solid, 2 of 2 ice machines was maintained in clean condition, the can opener was maintained in clean and sanitary condition, expired food items were promptly removed / discarded on or before the expiration or use by dates, dietary staff washed their hands before handling clean equipment or food items, hot foods were maintained at or above 135 degrees Fahrenheit on the stove while awaiting to be served, and the temperature in the low-water dish machine reached and maintained a minimum wash temperature and rinse temperature of 120 degrees Fahrenheit as specified by the manufacturer's instructions to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 54 residents who received meals from the kitchen (total census: 54), as documented on the list provided by Dietary Employee #2 on [DATE]. The findings are: 1. On [DATE] at 10:43 A.M., during initial tour of the kitchen with Dietary Employee #1 the following observations were made in the dining room and the kitchen: a. The left inside corner of the ice machine panel in the dining room had yellow residue on it. Dietary Employee #1 was asked to wipe the wet yellow residue on the panel. She did so, and the wet yellow residue easily transferred to the tissue paper. Dietary Employee #1 was asked to describe what was found on the left inside corner of the ice machine panel. She stated, It was yellow something. On [DATE] at 2:59 P.M., Dietary Employee #4 was asked, Who uses the ice from the machine? She stated, The CNAs (Certified Nursing Assistants) use it for the water pitchers in the residents' rooms. b. The can opener attached at the end of the counter had dried black/brown food matter on the blade. Dietary Employee #2 was asked, How often do you clean can opener? She stated, We clean it every day, but it does not look like it has been cleaned. 2. On [DATE] at 10:48 A.M., The inside interior surfaces of the ice machine in the kitchen had wet brown residue on them. Dietary Employee #3 was asked to wipe the wet brown residue on the interior surfaces. She did so, and the wet brown residue easily transferred to the tissue paper. She was asked, How often do you clean the ice machine and who uses the ice from the machine? She stated, We clean it once a month. We use it to fill beverages served to the residents at meals. 3. On [DATE] at 10:50 A.M., the temperature of the freezer in the storage room was 45 degrees Fahrenheit and the following food items were not frozen solid: Six bags of pancakes in a box on the shelf in the freezer were soft to touch. The box documented keep frozen. 4. On [DATE] at 11:00 A.M., the following observations were made in the refrigerator: a. An open zip lock bag of parmesan cheese was on a shelf in the storage room. The bag was not sealed. b. An open box of hot dogs was on a shelf in the refrigerator and was not covered or sealed. 5. On [DATE] at 11:07 A.M., Dietary Employee #2 took out fresh tomatoes from the original box inside the refrigerator, laid them on the cutting board on the counter. Without rinsing the tomatoes, she sliced 2 whole fresh tomatoes and placed them in a bowl to be served to the residents who requested tomatoes with their meal. 6. On [DATE] at 11:09 A.M., there were 2 boxes of baking soda in a cabinet above the food preparation counter with an expiration date of [DATE]. 7. On [DATE] at 11:20 A.M., the manufacturer's specifications for the facility's dish machine located on the side of the machine documented the minimum wash temperature was to be 120 degrees Fahrenheit (F.) a. On [DATE] at 11:24 A.M., the temperature of the wash water in the low water dish washing machine was 85 degrees Fahrenheit and the rinse cycle temperature was100 degrees Fahrenheit. At 11:32 A.M., the wash temperature was 100 degrees Fahrenheit and the rinse cycle temperature 100 degrees Fahrenheit. Dietary Employee #2 was asked to perform a chlorine test. She did so and obtained a result of 100 parts per million (PPM). b. The Dishwasher temperature Log for [DATE] documented from [DATE] through [DATE] documented a wash temperature of 100 degrees<br>Fahrenheit and a rinse temperature of 110 degrees Fahrenheit., instead of 100 for rinse as per observation. c. On [DATE] at 9:01 A.M., dish washing temperature 110 F, rinse temperature 110 F PPM 100 d. The Dishwasher Temperature Log for [DATE] documented a wash temperature of 110 degrees Fahrenheit and a rinse temperature of 110 degrees Fahrenheit. e. On [DATE] at 8:15 A.M., the Food Service Supervisor used digital temperature gauge to check the temperature of the water inside the machine and it registered 110 F. f. On [DATE] at 8:28 A.M., the Eco Lab Representative stated, Their machine has no heat. The only way they can get hot water is from their heater. g. On [DATE] at 8:34 A.M., the Maintenance Supervisor stated, The kitchen heater is combined with the rest of the building. Water temperature in the resident's room cannot exceed 110 F. The Dishwasher Temperature Log for [DATE] documented a wash temperature of 110 degrees Fahrenheit and a rinse temperature of 110 degrees Fahrenheit. 8. On [DATE] at 11:45 A.M., the following observations were made around the stove and around the steam table: a. The stove's grease trap had buildup of caked on greasy food in it. Dietary Employee #2 was asked, How often do you clean it? She stated, We clean it every day. It doesn't look like it. b. The grill was covered with a thick accumulation of grease and food crumbs. There were loose food crumbs inside the pans where serving spoons and scoops were stored. 9. On [DATE] at 12:04 P.M., Dietary Employee #2 with gloves on her hands, placed 7 servings of bread sticks into a blender, took out three 8oz (ounce) bottles of whole milk from the refrigerator and placed them on the counter. Without changing gloves, she pushed bread sticks down into a blender. She added milk and pureed the bread sticks, added one more bottle of whole milk, pureed and poured the contents into a pan. She covered the pan with a piece of foil and placed it in a pan of hot water on the stove. On [DATE] at 8:59 A.M., Dietary Employee #2 was asked, What should you have done after touching dirty objects before handling clean equipment or food items? She stated, I should have changed gloves and washed my hands. 10. On [DATE] at 12:16 P.M., the temperature of the cut green beans on the steam table was tested by Dietary Employee #2. The temperature of the cut green beans registered 128 degrees Fahrenheit. The food item was not reheated before being served to the residents. |
| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br><br>Based on observation, record review and interview, the facility failed to ensure staff wore their masks, so it covered their nose and mouth to prevent the potential spread of infectious material. These failed practices had the potential to affect all 54 residents who resided in the facility according to the Resident Census and Conditions of Residents provided by the Administrator 09/08/2020. The findings are 1. On 09/08/2020 at 12:09 P.M., Licensed Practical Nurse (LPN) #1 was wearing her mask below nose. LPN #1 was, How are you supposed to wear your mask? LPN #1 pulled her mask up over her nose. She was asked, How did you have your mask? LPN #1 stated, It was below my nose. 2. On 09/08/2020 at 12:29 P.M., Certified Nursing Assistant (CNA) #1 was wearing her mask below her nose. CNA #1 was asked, How are you supposed to wear your mask? CNA #1 stated, Above my nose and cover my mouth. She was asked, How did you have it when I walked up to you? CNA #1 stated, Below my nose. It slid down. 3. On 09/08/2020 at 12:56 P.M., CNA #5 was wearing her mask below her nose. CNA #5 was asked, How are you supposed to wear your mask? CNA #5 stated, Above my nose and cover my mouth. She was asked, How did you have it when I walked up to you? CNA #5 stated, It was below my nose. She was asked, What can happen when the mask isn't worn correctly? CNA #5 stated, It can spread germs. 4. On 09/10/2020 at 10:02 A.M., Cook #1 was in the lobby with her mask below her nose. She was asked, How are you supposed to wear your mask? Cook #1 pulled her mask up over her nose and stated, Like this. She was asked, How did you have it when I walked up? Cook #1 stated, It was below my nose. 5. On 09/11/2020 at 8:39 A.M., the Director of Nursing (DON) was asked, What is the proper way to wear a face mask? The DON stated, Covering the nose and mouth at all times. The DON was asked, What can happen if the mask is below the nose? The DON stated, It is |

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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 5)<br>ineffective and spreads germs. 6. On 09/11/2020 at 8:41 A.M., the Administrator was asked, How are you supposed to wear your face mask? The Administrator stated, Covering your mouth and nose at all times in patient areas. The Administrator was asked, What can happen if the mask is below the nose? The Administrator stated, It can spread germs. 7. On 09/11/2020 at 9:00 A.M., The Crisis Standards of Care for Disposable Facemask Utilization provided by the Administrator states, .place an ear loop on each ear. When applicable, mold the stiff edge to shape of the nose. Pull the bottom of the mask over your mouth and chin . |