STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045191	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Forest Senior Living at Hot Springs Village	121 Cortez Rd Hot Springs Village, AR 71909

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review, interview and facility policy review, it was determined the facility failed to ensure written notification was provided to the resident and/or the resident's representative of transfer or discharge to the hospital for two (Resident #45 and Resident #7) of two residents reviewed for transfer or discharge to the hospital. The findings include: Resident #45 Review of Resident #45's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/08/2025, indicated Resident #45 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #45's MDS also indicated the resident had diagnoses which included heart disease and acute respiratory failure with decreased oxygen to tissues and organs. During an interview on 09/05/2025 at 10:00 AM, this surveyor requested the Administrator (AD) provide the documentation that was provided to Resident #45 and/or the resident representative at the time of transfer. The AD provided a document titled View Progress Note that indicated on 07/16/2025 at 5:15 PM Nursing Progress Note indicates that Resident follow up chest x-ray sent to Dr. [named], he gave order to send resident to ER for worsening pulmonary edema. The resident's wife was present in the room and was notified. Resident requested to go to [NAMED] hospital. EMS arrived at 5:20 PM and resident left via stretcher. The document was a copy of the electronic records progress note and did not contain a complete notice of transfer and bed hold. Resident #7 Review of Resident #7's Quarterly MDS with an ARD of 06/13/2025, indicated Resident #7 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Resident #7's MDS also indicated the resident had diagnoses which included end stage kidney disease, respiratory failure, and condition of brain dysfunction. Review of a Discharge summary dated [DATE], indicated Resident #7 was admitted to the hospital on [DATE] with diagnoses which included acute respiratory failure with decreased oxygen to tissues (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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and organs secondary to health care associated lung infection and severe bloodstream infection. Review of a Discharge summary dated [DATE] indicated Resident #7 was admitted to the hospital on [DATE] for acute brain dysfunction. On 09/04/2025 2:00PM, this surveyor reviewed Resident #7's Medical Record and did not see a notice of bed hold or notice of transfer to the hospital for 05/24/2025 or 06/26/2025. On 09/04/2025 2:35 PM, the AD was asked for documentation of the notice of bed hold and notice of transfer that was given to the resident and/or the resident representative when the resident transferred to the hospital on [DATE] and 06/26/2025. During an interview on 09/04/2025 3:03 PM, the AD provided three documents titled Other Progress Note with effective dates of 05/19/2025, 06/26/2025 and 06/27/2025 and indicated these were the only documents the facility had for notification of bed hold and transfer for these two hospitalizations on Resident #7. Review of a document titled Other Progress Note dated 5/19/2025 7:14 AM, indicated the Power of Attorney (POA) for Resident #7 was contacted regarding whether they wanted to hold the bed for the resident since the resident was in the hospital and the POA indicated they would have to speak with other family members before making the decision and would get back with facility staff later in the day. Review of a document titled Other Progress Note dated 06/26/2025 3:33 PM, indicated Social Services attempted to contact Resident #7's family member to ask about bed hold but was unable to reach them and unable to leave a message. Review of a document titled Other Progress Note dated 6/27/25 11:44 AM, indicated Social Services spoke with the resident's family member and they did say they wanted to hold the resident's bed. During an interview on 09/05/2025 11:35 AM, the Director of Nursing (DON) was asked who was responsible for sending the notice of transfer and bed hold the resident and/or the resident's representative. The DON indicated that the nurse on duty was the one responsible for sending out the notice of transfer and bed hold. The DON was asked if the notice of transfer and bed hold was completed for Resident #45 when he was transferred to the emergency room on [DATE]. She indicated that it was not done. The facility could not provide evidence that Resident #45 and the resident's representative received complete information for the hospitalization on 07/16/2025. During an interview on 09/04/2025 3:17 PM, the Administrator indicated the nursing department was responsible for giving the notice of bed hold and transfer to the resident and/or the resident representative when a resident goes to the hospital. The Administrator indicated that social services would follow up as she did on those two hospitalizations with Resident #7. The Administrator indicated that they had identified a problem with notice of bed hold and transfers being sent out and that she would check with the DON to identify when they did the performance improvement plan and in-serviced staff. On 09/05/2025 8:35 AM, the DON provided in-service documentation dated 07/11/23 that indicated all residents and/or family are to be asked if they want a bed hold. The form should be completed to indicate yes or no if they want a bed hold. Also, a transfer form should be filled out and given to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident/family at the time of transfer. A form titled Bed-Hold and Return Agreement and Release of Bed Space was attached. In addition, the DON provided a form titled Quality Assurance Performance Improvement (QAPI) Works Sheet dated 08/19/25 that indicated issues identified were bed holds and transfer forms. The work sheet indicated forms to be combined to make one and staff would need to be in-serviced on the new form. There was a form attached titled Notice of Transfer and Bed-Hold. The form did not include a statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. During an interview on 09/05/2025 9:03 AM, Licensed Practical Nurse (LPN) #2 indicated when a resident goes to the hospital she filled out a hospital hold form that the resident or family must sign, but she does not give any other paperwork at the time of transfer or discharge to the hospital, resident or family. During an interview on 09/05/2025 9:27 AM, the Admissions Coordinator/Social indicated that when a resident goes to the hospital the nurse was to give the resident a notice of bed hold, but she was not aware of the notice of transfer being given to the resident or their representative. During an interview on 09/05/2025 10:00 AM, the DON indicated that she was still in the process of revising the notice of bed hold and transfer or discharge to the hospital and that she had done a verbal in-service with staff but had not put this in-service in writing. The DON indicated the notice of transfer or discharge should include the location the resident transferred to, the reason for the transfer or discharge and the price of the bed hold. The DON did not indicate that the notice would contain information regarding the appeal process if the resident did not agree with the transfer. The DON was asked for a policy on bed hold and transfer or discharge. During an interview on 09/05/2025 at 12:17 PM, the Administrator indicated that the form attached to the QAPI plan dated 8/19/25 was from their corporate office and she believed the DON was making the changes that were needed to the form, and she would have to confirm with the DON that the changes had been made. The administrator confirmed that the notice of transfer should include where the resident discharged or transferred to, the reason for the transfer and the appeal process. A review of a policy titled Transfer or Discharge Notice (revised March 2021) indicated that the resident and/or their representative would be notified in writing, and in a language and format they understand at least within 30 days or as soon as practicable but before the transfer or discharge if an immediate transfer or discharge was required by the residents urgent medical needs. The notice includes: a. The specific reason for the transfer or discharge. b. The effective date of transfer or discharge. c. The location to which the resident is being transferred or discharged to. d. An explanation of the residents' rights to appeal the transfer or discharge to the state, including: 1. The name, address, email and telephone number to the entity which receives appeal hearing requests. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Information on how to obtain, complete and submit an appeal request; and 3. How to get assistance completing the appeal process. A review of a policy titled, Bed Holds and Returns (revised March 2022) indicated, all residents/representatives are provided written information regarding the facilities bed-hold policy which address holding or reserving a resident's bed during periods of absence such as hospitalization at the time of the transfer or within 24 hours if the transfer was an emergency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Number of residents sampled:3Number of residents cited:2Based on observations, interviews, record review, and facility policy review, it was determined that the facility did not ensure Enhance Barrier Precautions (EBP) were implemented; and that staff donned proper Personal Protective Equipment (PPE) when care was provided for 2 (Resident #3, Resident # 52) of 3 residents, who were reviewed for PEG tube care and IV medication administration. Based on record review, observation, interview, and facility policy review, it was determined that the facility did not ensure Enhance Barrier Precautions (EBP) were implemented; and that staff donned proper Personal Protective Equipment (PPE) when care was provided for two (Resident #3, Resident # 52) of three residents, who were reviewed for Percutaneous Endoscopic Gastrostomy (PEG) tube care and Intravenous (IV) medication administration. The findings include: Resident #3 Review of a Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/18/2025, indicated Resident # 3 had a Brief Interview for Mental Status (BIMS) score of 00, which indicated the resident had severe cognitive impairment. The MDS also indicated that Resident # 3 had diagnoses which included blocked blood flow to the brain (Stroke); memory, thinking and behavior problems; loss of feeling to one side of the body and surgical opening to the stomach to provide nutrition via feeding tube. Review of Resident # 3's Care Plan report with a completion date of 08/18/25 indicated the resident required EBP related to the presence of a PEG tube. Review of Physicians Order dated 08/04/2025 indicated Resident # 3 required EBP related to Gastrostomy Tube (GT) placement. During an observation on 09/04/2025 12:08 PM, this surveyor observed Licensed Practical Nurse (LPN) # 1 perform PEG placement check and tube flush on Resident # 3. LPN # 1 entered Resident #3's room with gloves on and PEG tube flush supplies in hand, with no gown on. LPN # 1 brushed against resident # 3's bed and Resident # 3's body while performing PEG tube placement check and PEG tube flush. During an interview on 09/04/2025 12:30 PM, LPN # 1 stated she was not aware of any EBP to for PEG tube care. This surveyor noted signage on the door indicating the resident was on EBP. LPN # 1 stated the purpose of EBP was to prevent infections. During an interview on 09/05/2025 10:35 AM, the Infection Preventionist (IP) stated gloves and gowns were to be worn for PEG tube care including PEG tube flushes with the purpose being to prevent infections. During an interview on 09/05/2025 10:50AM, the Director of Nursing (DON) stated a gown, and gloves are to be worn when providing care to residents with a PEG tube. The DON stated the purpose was to prevent the transmission of bacteria to residents with open areas such as PEG tube and that all staff have been in serviced on proper PPE. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #52 Review of an admission MDS with an Assessment Reference Date (ARD) of 09/04/2025 for Resident #52 indicated it was unavailable due to it being in progress. Review of an admission Record indicated the facility admitted Resident #52 on 08/29/2025 with diagnoses which included infection and inflammatory reaction due to an internal artificial left knee, urinary tract infection, and diabetes mellitus. Review of a Care Plan with an initiation date of 09/04/2025 indicated Resident #52 was on EBP related to a Peripherally Inserted Central Catheter (PICC) for administration of antibiotics and staff were to provide care according to EBP guidelines. Review of an Order Summary report dated 09/04/2025 indicated Resident #52 was to receive IV antibiotics every 12 hours for urinary tract infection until 09/22/2025. The Order Summary also indicated Resident #52 was on EBP related to PICC placement. During an observation on 09/04/2025 8:25 AM, LPN #2 prepared an antibiotic to administer intravenously through a PICC line in Residents #52's left arm. LPN #2 washed her hands and put on gloves. LPN #2 did not put on a gown. This surveyor observed the door to Resident #52's room and there was not a sign indicating the resident was on EBP. LPN#2 entered Resident #52's room and explained to the resident what she was about to do. LPN #2 took off the cap to the IV catheter and cleaned the hub with an alcohol preparation pad. LPN #2 checked for patency of the IV line, flushed the line with 10 milliliters of normal saline and connected the tubing to the IV infusion pump setting the IV to infuse over 30minutes. LPN #2 removed her gloves and washed her hands. LPN #2 exited the resident's room after ensuring the resident had no requests. During an interview on 09/04/2025 8:35 AM, LPN #2 indicated Resident #52 was on EBP because of the PICC line and there had been a sign on the door yesterday indicating the resident was on EBP. When this surveyor asked LPN #2 what PPE should be worn when providing care for the resident's IV catheter. She stated that the resident had a urinary infection and when providing care that involved the urinary tract, she would wear a gown and gloves but for the PICC line she would wear only gloves. LPN #2 indicated that EBP were used to prevent the spread of infection to herself, and other residents. During an interview on 09/05/2025 10:35AM, the IP indicated staff are made aware that residents are on EBP by a sign that was placed on the door. The IP indicated Resident #52 was on EBP because the resident had a PICC and that during direct care to the PICC, a gown and gloves should be worn to help reduce the risk of spreading infection to the resident. During an interview on 09/05/2025 10:45AM, the Director of Nursing (DON) indicated that Resident #52 was on EBP because the Resident had a PICC and when the line was accessed to administer antibiotics, staff should wear a gown and gloves. The DON stated when Resident #52 was admitted a sign stating they were on EBP had been placed on the resident's door, but they had to replace it yesterday because it was no longer on the door. The DON indicated a PICC was an open access and EBP are used to prevent any possible blood splashes getting on staff during the procedure and to prevent the spread of infection. The DON was asked for any in-services or policies on EBP. A review of an in-service dated 07/10/2025, titled Enhanced Barrier Precautions the who, what and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	why indicated providers and staff must wear gloves and gowns for the following high contact resident care activities that include direct care or use of central line, urinary catheter, tube feeding or tracheostomy. A review of a policy titled Enhanced Barrier Precautions indicated EBP are recommended by the Centers of Disease Control (CDC) to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. EBP indicated the use of gown and gloves during high contact resident care such as direct care or use of a central line or feeding tube. .