

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2323 McCain Boulevard North Little Rock, AR 72116	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>37925</p> <p>Based on observation, record review and interview, the facility failed to ensure nail care was consistently provided to promote good grooming and personal hygiene for 1 (Resident #39) of 2 (Resident #39 and #223) sampled residents who were reviewed for activities of daily living (ADL) care.</p> <p>The findings are:</p> <p>Resident #39 had diagnoses of abnormalities of way of walking (gait) and mobility and lack of coordination as indicated on the Order Summary.</p> <p>A quarterly Minimum Data Set with an Assessment Reference Date of 05/06/2024 indicated Resident #39 had a Brief Interview for Mental Status score of 4, which indicated the resident was severely impaired.</p> <p>Resident #39's Care Plan, initiated 05/24/2024, indicated the resident had an ADL (Activities of Daily Living) self-care performance deficit related to confusion and limited mobility and required supervision of staff with bathing/showering on Monday, Wednesday and Friday and staff were to check the resident's nail length and trim and clean on bath days and as necessary.</p> <p>On 07/08/2024 at 9:43 AM, Resident #39 was lying in bed. The resident's feet and the toenails on both feet were thick and discolored.</p> <p>On 07/09/2024 at 3:06 PM, Resident #39 was asked if anyone at the facility had provided toenail care. Resident #39 removed the right foot from a shoe and looked down at the toes and stated, They do need trimming. Resident #39 denied being diabetic. Resident #39 stated no one here has ever taken care of Resident #39's toes. Resident #39 was asked if they liked their fingernails long and Resident #39 looked at both hands and confirmed the fingernails needed trimming also because they weren't usually that long but had not been paying attention to them. Resident #39's fingernails were greater than a quarter inch in length on both hands but were clean.</p> <p>On 07/11/2024 at 12:55 PM, Certified Nursing Assistant (CNA) #16 confirmed Resident #39's fingernails were grown and the toenails were thick and layered. She confirmed that she provided nail care to the resident's toenails last week and that was the best she could do because they were layered and thick.</p> <p>(continued on next page)</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 07/11/2024 at 1:10 PM, CNA #27 confirmed Resident #39's fingernails needed to be trimmed and shaped and the toenails on the right foot were thick and the resident probably needed to see a Podiatrist. She confirmed that if a resident's fingernails and toenails were too long or ingrown, this could cause an infection, or they could scratch themselves.</p> <p>On 07/11/2024 at 1:40 PM, the Administrator reported they did not have a policy on nail care.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49596</p> <p>Based on record review, interview, and observation, the facility failed to ensure an assessment for siderail use was completed for Resident #60 prior to installing siderails; to ensure an assessment of the bed, mattress and siderails was completed prior to the use of the siderails; to review the risks and benefits of siderails with Resident # 60; to obtain informed consent prior to the installation of the siderails on Resident #60 bed; to attempt the use of appropriate alternatives prior to installing siderails.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. A review of an annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/20/2024, revealed Resident #60 had a Brief Interview for Mental Status (BIMS) of 11, indicating moderate cognitive impairment. Section GG0170 indicated Resident #60 is dependent on staff to do all the effort to complete an activity; or the assistance of 2 or more helpers is required for the resident to complete the activity of Mobility. Section P0100 indicated Resident #60 was coded, bed rail - not used. Section I-Active Diagnoses identified Resident #60 had neurological diagnoses of stroke and seizure disorder or Epilepsy. <ol style="list-style-type: none"> a. A review of Resident #60's Care Plan revealed an ADL (Activities of Daily Living) self-care performance deficient related to limited mobility with an intervention for bed mobility, identified Resident #60 to be totally dependent on staff for turns and repositioning while in bed, identified Resident #60 to be totally dependent on staff to be moved between surfaces, identified that Resident # 60 had impaired cognitive function or impaired thought processes as evidenced by BIMS(Brief Interview for Mental status) score of 0 (06/28/2023), and that Resident #60 was at risk for falls related to resident being unaware of safety needs. The use of side rails was not addressed in the care plan. b. A review of the Nursing Quarterly assessment dated [DATE] indicated the use of Side Rails were not indicated at this time. c. On 07/08/2024 at 1:15 PM, the surveyor observed Resident #60 lying in bed with both half-length siderails raised on the right and left sides of the bed. The siderails were positioned in the center of the bed, leaving the two ends of the bed opened on the right side with the left side of the bed pushed against the wall. d. On 07/08/2024 at 1:28 PM, the surveyor spoke with Resident #60's family member. The surveyor asked if Resident #60 used the rails for turning and positioning. Resident #60's family member stated, I've never seen (Named Resident) use the siderails for anything and (Named Resident) doesn't use them for turning or positioning. e. On 07/10/2024 at 7:52 AM, the surveyor observed Resident # 60 in a wheelchair. The Resident's bed was made with quarter length siderails up on both sides of the bed. The surveyor asked Resident # 60 if they used the siderails. Resident #60 stated I want the siderail folded down when I'm in bed. Resident #60 motioned for the quarter rail to be pulled down to the half-rail position. <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>f. On 07/10/2024 at 9:07 AM, the surveyor conducted an interview with the Director of Nursing (DON) and asked how a determination is made for use of siderails for residents. The DON stated, The DON and nurses complete an assessment upon admission. The DON presented the surveyor with the assessment form the facility uses for assessing siderails. The surveyor asked if it is determined that siderails are to be used, would the use of siderails be care planned. The DON stated, Yes. The surveyor asked if a physician's order would be received for siderails. The DON stated, No. The surveyor asked if a resident request siderails how the facility handles that request. The DON stated, It would not be a restraint, the staff would monitor the resident and typically we will not utilize the siderail. The surveyor asked if they try other things before using a siderail and if they explain the risk vs benefits to the resident. The DON said, We usually go straight to the siderail, if that is what they want.</p> <p>g. On 07/10/2024 at 1:30 PM, the surveyor observed Resident #60 lying in bed with the siderail up, positioned in the center of the bed.</p> <p>h. On 07/10/2024 at 2:08 PM, the surveyor observed Resident #60 lying in bed with siderail up, positioned in the center of the bed.</p> <p>i. On 07/10/2024 at 2:30 PM, the surveyor conducted an interview with Certified Nursing Assistant (CNA) #12. The surveyor asked CNA #12 if Resident #60 uses siderails. CNA #12 stated, Yes. The surveyor asked CNA #12 why the side rails are used. CNA #12 stated, Most of the time for positioning, but [Resident #60] doesn't move in the bed. The surveyor asked CNA #12 if side rails are considered to be a restraint. CNA #12 stated, No. The surveyor asked CNA #12, How do you monitor the resident while the siderails are in use? CNA #12 stated, I check on them every 30 to 45 minutes. The surveyor asked CNA #12 if Resident's #60 care plan identifies Resident #60 to use side rails. CNA #12 stated, Yes.</p> <p>j. On 07/10/2024 at 2:45 PM, the surveyor conducted an interview with the DON. The surveyor asked the DON if Resident #60 used siderails. The DON stated, I will need to look because I cannot recall off the top of my head. The DON checked his computer and stated, [Resident #60's] assessment shows side rails are not indicated. The DON asked, Why? Does [Resident #60] have siderails? The surveyor confirmed the siderails were in use. The surveyor asked the DON why the siderails are used. The DON stated, I'm honestly not sure because [Resident #60] hasn't had any falls and is dependent on staff for transfers. The surveyor asked the DON if siderails are considered a restraint. The DON stated, Yes. The surveyor asked the DON how the staff monitors residents while siderails were in use. The DON stated, They should be checking [the residents] every two hours. The surveyor asked the DON if Resident #60 had been care planned for the use of siderails. The DON stated, No.</p> <p>k. On 07/10/2024 at 2:58 PM, the surveyor conducted an interview with the DON and Administrator. The surveyor asked the DON if they had an assessment for entrapment on the application of the side rails on Resident #60's bed. The DON stated, No. The surveyor asked for the manufactures guidelines for applying the siderails to the bed and requested to see documentation of where the installation of the siderails, with an assessment of the bed, mattress, and siderails, for the risk of entrapment was completed.</p>		

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<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, record review and interview, the facility failed to ensure an inhaler was properly stored after use for 1 (Resident #35) of 1 sampled resident who had an inhaler on an over-bed table.</p> <p>The findings are:</p> <p>Resident #35 had a diagnosis of chronic obstructive pulmonary disease (COPD) as indicated in the Medical Diagnosis section of the electronic health record (EHR)</p> <p>An admission Minimum Data Set with an Assessment Reference Date of 04/07/2024 revealed Resident #35 had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact.</p> <p>A review of Resident #35's Care Plan dated 04/12/2024 indicated Resident #35 had Emphysema/COPD and an intervention specified giving the resident an aerosol or bronchodilators as ordered.</p> <p>Review of Resident #35's Order Summary indicated an order for budesonide-formoterol (Symbicort) 160-4.5 mcg (micrograms)/actuation inhaler and to take two puffs inhale orally two times a day for COPD. There was no physician's order that indicated the inhaler could be left at the resident's bedside.</p> <p>Review of Resident #35's Electronic Medication Administration Record (eMAR) for July 2024 indicated an order for budesonide-formoterol (Symbicort) 160-4.5 mcg (micrograms)/actuation inhaler and to take two puffs inhale orally two times a day and the times were scheduled for 0800 (8:00 AM) and 1600 (4:00 PM). The eMAR indicated this medication was administered on 07/01/2024 - 07/10/2024 at 8:00 AM and on 07/01/2024 -07/09/2024 at 4:00 PM.</p> <p>On 07/08/2024 at 10:46 AM, Resident #35 was observed lying in bed on back with eyes closed. There was an inhaler, budesonide and formoterol fumarate mcg inhalation/aerosol 160 mcg / 4.5 mcg, lying on the over-bed table that was across the resident's bed. The resident did not open their eyes when their name was spoken.</p> <p>On 07/08/2024 at 3:25 PM, attempted to speak with Resident #35 but the resident was yet in bed with eyes closed and did not open eyes when a name was spoken. There was an inhaler, budesonide and formoterol fumarate mcg inhalation / aerosol 160 mcg / 4.5 mcg, lying on the over-bed table that was across the resident's bed.</p> <p>On 07/09/2024 at 8:31 AM, Resident #35 was awake, sitting up in bed opening the condiments to put on the breakfast meal that was on the over-bed table across the resident's bed. There was an inhaler, budesonide and formoterol fumarate mcg inhalation / aerosol 160 mcg / 4.5 mcg, lying on the over-bed table and Resident #35 confirmed Resident #35 was allowed to use the inhaler twice a day.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/11/2024 at 12:03 PM, Licensed Practical Nurse (LPN) #26 confirmed that after an inhaler has been used, it is stored in the medication cart.</p> <p>On 7/11/2024 at 1:20 PM, LPN #19 confirmed that after an inhaler has been used, it should be stored back in the medication cart.</p> <p>A Medication Storage in The Facility policy, (revised January 2018), indicated, . Policy Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications . Bedside Medication Storage Policy Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team .</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>03508</p> <p>Based on observation, record review and interview, the facility failed to ensure meals were served in a method that maintained a palatable appearance, and at temperatures acceptable to the residents during 2 of 2 meals observed. This failed practice had the potential to affect 15 residents who receive meal trays in their rooms on the 100 Hall, 10 residents who receive meal trays on the 200 hall, 15 residents who receive meal trays on 300 hall and 13 residents who receive meal trays in their room on the 400 -hall.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. On 07/08/2024 at 10:10 AM, the surveyor asked Resident #32, How is the food in the facility? Resident #32 stated, The food is always ice cold. 2. On 07/10/2024 at 11:53 AM, an unheated food cart that contained 15 trays for lunch was delivered to 300-hall by Staff #2. At 12:09 PM, immediately after the last resident was served in their room on 300-hall, temperature of the food items on the tray used as a test tray were taken by the and was and read by Certified Nursing Assistant (CNA)#14 with the following result: <ol style="list-style-type: none"> a. Milk 45 degrees Fahrenheit. 3. On 07/10/24 at 11:58 AM, an unheated food cart that contained 15 trays for lunch was delivered to 100-hall by Dish Washer #2. At 12:15 PM, immediately after the last resident was served in their room on 100-hall, temperature of the food items on the tray used as a test tray were taken by the Dietary Manager and was and read by CNA#15 with the following results: <ol style="list-style-type: none"> a. Milk 44 degrees Fahrenheit. b. Lasagna 110 degrees Fahrenheit. 4. On 07/10/2024 at 12:13 PM, an unheated food cart that contained 10 trays for lunch was delivered to 200-hall by Dish Washer #2. At 12:20 PM, immediately after the last resident was served in their room on 200-hall, temperature of the food items on the tray used as a test tray were taken by the Dietary Manager and was read by CNA #15 with the following results: <ol style="list-style-type: none"> a. Milk 44 degrees Fahrenheit. b. Lasagna 110 degrees Fahrenheit. 5. On 07/11/2024 at 7:10 AM, an unheated food cart that contained 15 trays for lunch was delivered to 300 -hall by Dietary Aide #17. At 12:20 AM, immediately after the last resident was served in their room on 300-hall, temperature of the food items on the tray used as a test tray were taken and read by CNA #16 with the following results: <ol style="list-style-type: none"> a. Scrambled eggs 88 degrees Fahrenheit. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. Ground sausage with gravy 89 degrees Fahrenheit.</p> <p>6. On 07/11/2024 at 7:16 AM, an unheated food cart that contained 15 trays for lunch was delivered to 100-hall by Dietary Aide #17. At 7:26 AM, immediately after the last resident was served in their room on 100-hall, temperature of the food items on the tray used as a test tray were taken and read by CNA# 14 with the following results:</p> <p>a. Sausage 85 degrees Fahrenheit.</p> <p>b. Scrambled eggs 95 degrees Fahrenheit.</p> <p>7. On 07/11/2024 at 7:28 AM, an unheated food cart that contained 13 trays for breakfast was delivered to 400-hall by Dietary Aide #17. At 7:26 AM, immediately after the last resident was served in their room on 400-hall, temperature of the food items on the tray used as a test tray were taken and read by Licensed Practical Nurse (LPN) #19 with the following results:</p> <p>a. Pureed eggs 92 degrees Fahrenheit.</p> <p>b. Scrambled degrees 102 degrees Fahrenheit.</p> <p>c. Pureed eggs 101 degrees Fahrenheit.</p> <p>d. Ground sausage 98 degrees Fahrenheit.</p> <p>e. Oatmeal 103 degrees Fahrenheit.</p>

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>03508</p> <p>Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump-free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 1 of 2 meals observed. This failed practice had the potential to affect 3 residents who received pureed diet.</p> <p>The findings are.</p> <ol style="list-style-type: none"> On 07/10/2024 at 10:16 AM, Dietary [NAME] (DC) #11 used a 4-ounce spoon to place 4 servings of lasagna into a blender and pureed. At 10:21 AM, DC #10 poured the pureed lasagna into a pan and placed it in the oven. The consistency was thick, lumpy, and was not smooth. There were pieces of pasta visible in the mixture. On 07/10/2024 at 10:40 AM, DC #11 placed 3 servings of garlic bread into a blender, added a carton of whole milk and pureed. At 10:42 AM, DC #10 used a #20 scoop to portion pureed bread stick into 3 bowls. The consistency of the pureed bread was lumpy and was not smooth. On 07/10/2024 at 12:30 PM, the surveyor asked the Dietary Manager to describe the consistency. of the pureed food items served to the residents on pureed diets. He stated, There were lumpy. On 07/11/2024 at 1:00 PM, the following observations were made on the steam table. <ol style="list-style-type: none"> A pan of pureed orange chicken. The consistency of the pureed chicken was lumpy and not smooth. There were pieces of chicken visible in the mixture. A pan of pureed rice. The consistency of the pureed rice was lumpy and not smooth. There were pieces of rice in the mixture. On 07/11/2024 at 1:05 PM, the surveyor asked the Dietary Manager to describe the consistency of the pureed food items served to the residents who required pureed diets. He stated, They were lumpy. 		

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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49596</p> <p>03508</p> <p>Based on observation and interview, the facility failed to ensure raw meat was thawed properly to prevent a potential foodborne illness; failed to ensure food stored in the freezer, refrigerator and dry storage area were covered, sealed and dated the day received and when opened to assure first in, first out usage to prevent potential for food bone illness, failed to ensure manufacturer specification was followed in order to prevent food spoilage, expired food items were promptly removed from stock in order to reduce the risk of food-borne illness for residents who received meal trays from 1 of 1 kitchen, dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen These failed practices had the potential to affect 72 residents who received meals from the kitchen.</p> <p>The findings are:</p> <p>On [DATE] at 9:25 AM, the surveyor entered the facility kitchen and observed a sink with raw chicken thighs and legs soaking in standing water. The water was not running, and the sink was plugged. The chicken was not in a plastic bag but lying directly in the water. At 10:04 AM, the surveyor noted the chicken was still in the sink soaking in water. The surveyor asked [NAME] #1 to check the temperature of the water the chicken was soaking in. [NAME] #1 retrieved a thermometer and checked the water temperature. The surveyor asked Dietary Aide #3 to read the thermometer and Dietary Aide #3 stated it was 63 degrees. The Dietary Manager pulled the plug on the sink and drained the water. The Dietary Manager then turned the water on and allowed it to run over the chicken pieces directly under the running water. The surveyor asked the Dietary Manager to explain the process for thawing meat. The Dietary Manager stated, It should be thawed under running water so as to not remove all the blood from the meat and it should not be left sitting in standing water. The surveyor asked how long this meat had been soaking in this water. The Dietary Manager stated, He put it in the sink when he arrived at work, and it had been in there for about 40 minutes. The surveyor asked the Dietary Manager if this chicken was safe to serve the residents. The Dietary Manager stated, Well, not like this, it is raw. We have to cook it. The surveyor asked what a safe temp for thawing chicken would be. The Dietary Manager stated, We have to cook it after it is thawed. The surveyor asked the Dietary Manager if the 63-degree temperature was a safe temperature for chicken. The Dietary Manager stated, That is the water temperature. The surveyor asked the Dietary Manager to check the temperature inside the meat. The Dietary Manager inserted the thermometer through the center of a thigh piece and Dietary Aid #3 read the temperature to be 63-degrees. The Dietary Manager stated, They have to fry it to like 160 to 180-degrees. At 10:25 AM, the surveyor noted the [NAME] #1 prepping the chicken with seasoning and flour. The surveyor asked [NAME] #1 if she was prepping the chicken that had been in the sink thawing in the standing water. [NAME] #1 stated, yes. The surveyor asked [NAME] #1 what a safe temperature for thawing chicken would be. The Dietary Manager stated, Thirty degrees too . The Dietary Manager paused his speaking and [NAME] #1 stated, 40-degrees. The surveyor asked Dietary Aid #3, who was standing nearby, what was the reading of the thermometer and Dietary Aide #3 stated, Sixty three degrees. The surveyor asked how many pieces of chicken are you preparing to cook, after being in the standing water. [NAME] #1 stated, 120 pieces. The surveyor asked if the chicken being prepared was safe to serve. [NAME] #1 stated, No.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2323 McCain Boulevard North Little Rock, AR 72116	

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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>2. On [DATE] at 9:38 AM, the milk box did not have a thermometer inside the box to monitor the temperatures.</p> <p>3. On [DATE] at 10:33 AM, the following observations were made on a shelf in the freezer:</p> <p>a. An opened box of hamburger patties. The box was not covered or sealed. The surveyor asked the Dietary Manager why it is important to ensure items are sealed that are in the freezer. The Dietary Manager stated, To keep it from getting freezer burned.</p> <p>b. The surveyor observed a bag of chopped onions, and a chocolate cream pie not sealed sitting inside the freezer. The Dietary Manager stated, This should have been tossed last week.</p> <p>c. Two packages of pancakes that did not have any received dates. The Dietary Manager pulled a clear plastic zip bag of pancakes from the back of the freezer and tossed them stating, These have expired.</p> <p>d. An opened box of sausage links not covered or sealed.</p> <p>4. On [DATE] at 10:38 AM, the following observations were made on a shelf above the food preparation counter:</p> <p>a. A half empty jar of grape jelly beside a jar of peanut butter. The manufacturer specification on the jar documented, Refrigerate after opening. The surveyor asked the Dietary Manager to read labels instructions. Dietary aide #3 read it to the Dietary Manager. The Dietary Manager then pulled the jelly and instructed the staff to discard it.</p> <p>b. A gallon jug of black pepper, a gallon jug of paprika, and a gallon jug of parsley sitting on the shelf did not have an open date on them, only a received date. The Dietary Manager pulled the three-gallon products and discarded them.</p> <p>5. On [DATE] at 10:40 AM, the surveyor observed the water was not running over the chicken which was lying in the sink. The Dietary Manager turned the water on and stated to the staff, We need to leave this running over the frozen meat. At 10:55 AM, the surveyor observed the water was not running over the chicken lying in the sink. Again, the Dietary Manager turned the water on. At 11:00 AM, the surveyor noted the water was not running over the chicken lying in the sink. The Dietary Manager asked, Who turned the water off? The Dietary Manager stated, Leave this water running to thaw the chicken.</p> <p>6. On [DATE] at 12:00 PM, the surveyor asked the Administrator for a policy on food preparation or thawing of food. The Administrator stated, We do not have one.</p> <p>7. On [DATE] at 7:58 AM, an open box of low sodium dairy free mashed potatoes was on a shelf above the food preparation counter. The box was not covered.</p> <p>8. On [DATE] at 9:59 AM, Dietary Aide #10 opened the refrigerator and placed a zip lock bag that contained butter logs, she removed gloves from the glove box and placed them on her hands, contaminating the gloves. Without changing gloves and washing her hands, she removed bread sticks from the bag and placed them on the pans to be heated up and served to the residents for lunch meal.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Lakewood Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2323 McCain Boulevard North Little Rock, AR 72116	
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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>9. On [DATE] at 10:07 AM, the following observations were made on a shelf in the freezer with no received or opened dates in the kitchen areas:</p> <ul style="list-style-type: none"> a. An opened box of biscuits, the box has no received or opened date on it. b. An opened box of cookies had no opened date on it. <p>10. On [DATE] at 10:10 AM, DC #11 took a dirty pan to the dirt dish area, she removed gloves from the glove box and placed them on her hands, contaminating the gloves. Without changing gloves and washing her hands, she removed chicken enchiladas from the original box and placed them in the oven to bake and served to the residents who dislike lasagna for lunch.</p> <p>11. On [DATE] at 10:22 AM, an opened box of bacon was on a shelf in the refrigerator with no opened date on it.</p> <p>12. On [DATE] at 10:31 AM, the following observations were made on a shelf in the refrigerator.</p> <ul style="list-style-type: none"> a. A container of pimento cheese had an expiration date of [DATE]. b. A container of pimento cheese had an expiration date of [DATE]. c. A container of cucumber and onion salad had an expiration date of [DATE]. <p>13. On [DATE] at 10:39 AM, DC #11 opened the oven and placed a pan of pureed carrots on the rack. Without washing her hands, she picked up a clean blade and attached it to the base of the blender. As DC#11 was about to use the blender to puree food items to be served to the residents for lunch. The surveyor asked DC #11 what should you have done after touching dirty and or before handling clean equipment or handling food items? She stated, I should have washed my hands.</p> <p>14. On [DATE] at 10:46 AM, a bag that contained 9 counts of dinner rolls was on the bread rack with an expiration date of [DATE].</p> <p>15. On [DATE] at 10:51 AM, the following observations were made on a rack leading to the food storage room:</p> <ul style="list-style-type: none"> a. Three of 3 boxes of complete buttermilk pan cake with an expiration date of [DATE]. b. A box that contained bags of diced chicken was opened. c. An opened bag of diced chicken Inside the box had no open date. d. A box that contained 5 sealed bags of flour tortilla with an expiration date of [DATE]. <p>16. On [DATE] at 11:19 AM, the following observations were made on a shelf in the refrigerator in the day room:</p> <ul style="list-style-type: none"> a. A spout to a pitcher that contained grape juice was not covered, exposing the grape juice. <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>b. A container with slices of tomatoes. There was no name to whom it belongs to, with no date to indicate when it was stored. There was white fuzz on the tomatoes. The surveyor asked the Activities Director #19 to describe the appearance of the tomatoes. She stated probably mold not good.</p> <p>c. There was a banana in a bag. The banana was discolored and mushy. The Dietary Manager stated, It was cold, too mushy, and black.</p> <p>d. Two of the 2 expired bags of corn chips with an expiration date of [DATE].</p> <p>e. A bottle of almond creamer, the bottle has no name, no received date, and no opened date on it.</p> <p>f. Three opened bottles of ranch dressings, the bottles had no received or opened date on them.</p> <p>g. An opened bottle of sandwich dressing, the bottle has no date on it.</p> <p>h. An opened bottle of avocado ranch dressing, the bottle has no date on it.</p> <p>i. An opened bottle of dill pickles, the bottle has no date on it.</p> <p>J. Two of two bags of watermelon were not dated when they were stored.</p> <p>k. A bag of spaghetti with meat sauce not dated or when it was opened or received.</p> <p>l. Two of two bottles of taco sauce were not dated or have an opened date.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37925</p> <p>Based on observation, record review and interview, the facility failed to ensure enhanced barrier precautions (EBP) were consistently followed when administering medication and enteral feeding through a Percutaneous Endoscopic Gastrostomy (PEG) tube for 1 (Resident #42) of 1 sampled resident who was on enhanced barrier precautions.</p> <p>The findings are:</p> <p>Resident #42 had a diagnosis of obstruction of the tube from the throat to the stomach (esophagus), difficulty swallowing (dysphagia) and gastrostomy status indicated on the Order Summary.</p> <p>A 5-day Medicare Minimum Data Set with an Assessment Reference Date of 06/16/2024 indicated Resident #42 had a Staff Assessment for Mental Status score of 3, which indicated the resident was severely impaired, and that the resident had a feeding tube.</p> <p>Resident #42's Order Summary indicated an enteral feeding order of (Named) 1.5 and to give a 220 cc (cubic centimeters) bolus through the PEG tube one a day. It also indicated an order for enhanced barrier precautions related to the resident's PEG tube.</p> <p>Resident #42's Care Plan initiated 06/11/2024 was yet in progress and did not include any focus problems or interventions regarding the resident's gastrostomy status.</p> <p>On 07/10/2024 at 11:53 AM, Licensed Practical Nurse (LPN) #27 entered Resident #42's room without putting on gloves or a gown. She put on gloves before she checked Resident #42's PEG tube for placement, and proceeded to administer water, medications, water, enteral formula and water again, but did not put on a gown before or during this process.</p> <p>On 07/11/2024 at 11:50 AM, LPN #27 confirmed Resident #42 was on EBP, a gown and gloves were to be used, and she did not put on a gown. She said she thought EBP was just for wounds.</p> <p>On 07/11/2024 at 12:15 PM, LPN #26 confirmed gloves and a gown were to be used for residents on EBP.</p> <p>On 07/11/2024 at 1:48 PM, the Administrator stated there was no policy for enhanced barrier precautions.</p> <p>On 07/11/2024 at 1:50 PM, the Administrator provided an Inservice form dated 06/19/2024 with the topic of enhanced barrier precautions. It indicated, .Star stickers by residents' names indicate EBP, which means gloves and gowns are to be worn when providing care .These residents either have a wound, catheter, feeding tube and or central line .</p>