STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045280	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Lakes Therapy and Living	6152 Highway 202 East Flippin, AR 72634

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure residents were free of neglect for one (Resident #5) of three residents reviewed. Specifically, incontinent care was not provided in a timely manner. The findings include: A review of Resident #5 ' s Reportable, indicated that Certified Nursing Assistant (CNA) #1 and CNA #2 reported to their shift on 02/12/2025, at 6:00 AM. They found Resident #5 soiled with dried bowel movement that covered from the back and down to the ankles. Resident #5 reported to the CNAs a request was made for incontinent care to CNA #3 at 9:30 PM on 02/11/2025. CNA #3 allegedly checked Resident #5 with a flashlight and said, you're fine. No incontinent care services were provided to Resident #5 for the rest of the night shift. CNA #1 and CNA #2 reported the incident to the Administrator and an internal investigation was conducted. Based on the facility's investigation, 11 other CNAs reported that residents were not being changed in a timely manner. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 06/04/2025, indicated Resident #5 had a Brief Interview for Mental Status score of 15, which revealed the resident was cognitively intact. The MDS indicated Resident #5 was dependent on staff for toileting hygiene, meaning the helper does all the effort. A review of Resident #5' Closet Care Plan revealed the resident was incontinent of bowel and bladder and was at risk for skin breakdown. A review of an Activity of Daily Living Task dated 02/11/2025, indicated Resident #5 was provided incontinent care at 8:24 PM, and again at 10:54 PM. Resident #5 was not provided incontinent care again until 6:15 AM on 02/12/2025. A review of a Wet Check assignment task on 02/11/2025, indicated that on the 4th check of the night shift, Resident #5 was checked and documented to have a loose bowel movement but there was no documentation of incontinent care provided. A review of a skin assessment diagram, dated 02/12/2025, revealed Resident #5 ' s buttocks were red, raw, and indicated a zinc barrier cream was applied. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Grievance Logs from 07/31/2024 until 02/17/2025, nine grievances indicated that residents' call lights were not being answered, and they were having to wait a long time to receive help. During an interview on 06/12/2025 at 11:12AM, CNA #2 confirmed that at the beginning of rounds on the morning of 02/12/2025, that Resident #5 was discovered soiled with dried bowel movement that covered the resident's back, down to the ankles. CNA #2 stated Resident #5 reported that a request had been made to CNA #3 for incontinent care, but CNA #3 was not comfortable cleaning the bowel movement since the resident had a catheter. Resident #5 told CNA #2 that CNA #3 never returned during the night shift. During an interview on 06/12/2025 at 12:32PM, the Administrator acknowledged remembering the incident and results of the internal investigation, there were no negative findings. Staff were suspended during the investigation and re-educated once the investigation was final. During an interview on 06/12/2025 at 12:46 AM, CNA #2 confirmed what was written in their witness statement; Upon reporting for the morning shift on 02/11/2025, CNA #1 and CNA #2 began rounds and found Resident #5 soiled with dried bowel movement that covered the back, down to the ankles. While providing incontinent care, Resident #5 told CNA #1 and CNA #2 that CNA #3 was asked to provide incontinent care at around 9:30 PM, and CNA #3 checked for bowel movement with a flashlight and said, You're fine . CNA #3 then left and did not come back the entire night shift. A review of a facility policy titled, Abuse, Neglect, and Exploitation or Misappropriation, revised on 04/01/2021, indicated, Neglect is defined as failure to provide goods and services as necessary to avoid physical harm, mental anguish. or mental illness.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure sufficient staffing, as evidenced by the schedule not being informed by the facility assessment for 2 months, July 2024 and January 2025, which included 18 night shifts. The findings include: A review of a facility policy titled, Facility Assessment dated 01/01/2025, indicated they had an average daily census of 45. Common diagnoses of the facility's residents included mental disorders, cardiac disorders, respiratory disorders, skin disorders, cancers, musculoskeletal disorders, fractures, and gastrointestinal disorders. The facility assessed that the acuity affecting licensed nurses included four residents requiring oxygen, three receiving updraft treatments, eight exhibiting behavioral health symptoms, eight receiving medications via injection, one resident with an ostomy, seven residents on hospice, one resident receiving respite care, and one resident receiving parenteral nutrition. Acuity affecting Nurse Aides revealed 38 residents require assistance for dressing, 40 require assistance for bathing, 35 require assistance for transfers, 17 require assistance for eating, and 39 require assistance for toileting. The facility assessed their coverage needs to adequately meet the residents' daily needs per shift as: Day Shift: Certified Nursing Assistants (CNAs) 1:7 residents; Charge Nurse 2 total Evening Shift: CNAs 1:9 residents; Charge Nurse 2 total Night Shift: CNAs 1:13 residents; Charge Nurse 1 total A review of the January Staffing Schedule indicated the census for the following days along with the CNAs that were scheduled to work the night shift: 01/05/2025 - Census: 43 - Night Shift: 3 CNAs A review of the July Staffing Schedule indicated the census for the following days along with the CNAs that were scheduled to work the night shift: 07/04/2025 - Census 40 - Night Shift: 2 CNAs 07/06/2025 - Census 41 - Night Shift: 2 CNAs 07/11/2025 - Census: 42 - Night Shift: 2 CNAs (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/16/2025 - Census: 45 - Night Shift: 2 CNAs 07/17/2025 - Census: 44 - Night Shift: 2 CNAs 07/20/2025 - Census: 45 - Night Shift: 2 CNAs 07/21/2025 - Census: 45 - Night Shift: 2 CNAs 07/22/2025 - Census: 47 - Night Shift: 2 CNAs During an interview on 06/10/25 at 8:40 am, LPN #6 confirmed that staffing issues were a problem prior to the new Director of Nursing (DON) and Administrator being hired. During an interview on 06/11/25 at 6:55 am, Registered Nurse (RN) #7 confirmed that staffing had been an issue prior to the new DON and Administrator being hired but now everything had gotten better. During an interview on 06/11/25 at 9:28 am, CNA #8 confirmed that upon beginning their shift, residents would be found to be soiled and still in bed. During an interview on 06/11/2025 at 10:01 am, the DON, who was hired in March of 2025, confirmed that there were staffing issues prior to being hired. The DON stated that it had gotten better, and the facility had been working on a retention of employees program. During an interview on 06/12/2025 at 1:14 pm, the Administrator acknowledged that there were staffing issues prior to being hired and felt like those issues had been resolved. On 06/12/2025 at 4:10 pm, the facility provided a policy titled, Sufficient and Competent Staffing, which indicated that the Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment.