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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, and interview the facility failed to ensure that cross contamination did not occur to ensure meals were served in a sanitary manner during lunch service for one of one kitchen. During an observation of the lunch meal service on 06/10/2025, the following was observed: a. At 11:40 AM, Dietary Aide (DA) #13 was using a thermometer to obtain temperatures of food items on the steam table. While testing the regular pork and fried rice, DA #13 was observed pushing the entire thermometer, including the top portion that was being held and had not been sanitized before use, into the food intended to be served to residents. b. At 12:00 PM, this surveyor observed that the mechanical soft pork was piled above the top of the tray containing it on the steam table. While portioning the food from the steam table onto trays, DA #13 touched the mechanical soft pork five different times with the bottom of the trays she was filling. This surveyor observed the scoop being moved back by the tray each time, this surveyor also observed mechanical soft pork on the line and the bottom of the trays when being loaded onto hall carts. c. At 12:10 PM, this surveyor observed DA #14 pour coffee into cups for trays, then observed DA #14 add coffee, silverware, and condiments to the lunch tray. DA #14 was then observed picking up a plate containing chicken tenders. The chicken tenders slipped forward, and DA#14 touched the chicken tenders with their contaminated hands to prevent them from falling. This surveyor observed DA#14 finish preparing the tray and sent it out the window to be served to the resident. DA #14 did not perform hand hygiene until after lunch service was completed. d. At 12:15 PM, and again at 12:36 PM, this surveyor observed DA #13 preparing trays. Regular pork fell off the scoop into the regular carrots, the regular carrots were used for the rest of the lunch service. During an interview on 06/12/2025 at 10:15 AM, DA #13 stated that the top portion of the thermometer and the bottom of the trays should not touch food, that would be considered cross contamination. DA #13 stated that regular pork should not fall into the carrots as the residents with mechanical diets get the same carrots as well, in addition to the risk of cross contamination, which could spread germs or sickness. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 06/12/2025 at 10:20 AM, DA #14 stated she had touched other things with her hands, contaminating them, before touching the chicken strips, and that was considered cross contamination. During an interview on 06/12/2025 at 10:25 AM, the Dietary Manager (DM) stated that touching the food with dirty hands, trays touching the food, and the unsanitized portion of the thermometer touching the food were cross contamination and people could get sick from that. The DM stated that the dietary aide should not have crossed over from the regular pork to the regular carrots, the residents on mechanical diet eat carrots too, that was cross contamination. On 06/12/2025 at 10:40 AM, the DM stated the facility did not have a policy or procedure referencing cross contamination.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure that transmission-based precautions were utilized as ordered for one (Resident #8) of one resident reviewed. A review of an Order Summary indicated that Resident #8 had a physician ' s order indicating contact precautions were needed because the resident had tested positive for Extended-Spectrum Beta-Lactamases (ESBL) in their urine. The order indicated personal protective equipment (PPE) should be used as follows: gloves, gown, eye protection, and mask every shift for five days from 06/525 to 06/10/2025. A review of the Lab Results Report of a urinalysis on 06/03/2025 indicated that Resident #8 was ESBL positive. A review of the Antibiotic Stewardship Medication Regimen Review indicated Resident #8 started antibiotics on 06/03/2025 and that it was a true infection with a multidrug resistant organism and urinary tract infection. A review of the Medication Administration Record indicated Resident #8 was receiving an antibiotic every 12 hours for ESBL positive for five days. On 06/09/25 at 12:32 PM, this surveyor observed Certified Nursing Assistant (CNA) #10 deliver a lunch tray to Resident #8. CNA #10 sat the lunch tray down on the bedside table. CNA #10 walked past the isolation supplies in a plastic pocket hanger on the door to the left and a sign that indicated the resident was on contact precautions on the right side of the door frame. CNA #10 applied gloves, leaned down, and wrapped a gait belt around Resident #8's waist. CNA #10 then leaned down to hold onto the gait belt. Resident #8 held onto CNA's elbows while being transferred from recliner to dining room chair in room. This surveyor observed that Resident #8 ' s and CNA #10 ' s clothes touched during the transfer. This surveyor observed CNA #10 sit down with Resident #8 to set up the tray and assist with lunch. This surveyor observed no contact precautions in use by CNA #10. CNA #10 left the resident ' s room to get a straw for the lunch tray from the dining room on the unit. This surveyor observed CNA #10 come back to the room and then CNA #10 paused before stating they were not aware that Resident #8 was on contact isolation. CNA #10 then donned the appropriate PPE to assist Resident #8 with lunch. On 06/09/25 at 1:35 PM, this surveyor observed CNA #10 enter Resident #8's room with no isolation precautions in place, they went past the plastic pocket hanger on the door to the left and the sign on the right side of the door frame. CNA #10 picked up the lunch tray from the bedside table. CNA #10 was observed walking out of the unit with no biohazard bag over the tray. On 06/09/2025 at 11:46 AM, this surveyor attempted to interview Resident #8, the resident was unable to be interviewed. This surveyor observed a contact isolation sign on the right side of the doorway with a plastic pocket hanger on the door to the left with personal protective equipment and supplies. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/12/2025 at 10:49 AM, during an interview CNA #10 stated I corrected it by gowning and gloving up after I got the straw, then stated that I did transfer the resident without any PPE, that was an oversight on my part, yes. CNA #10 stated I am not as familiar with the residents on 400 hall. I did not notice that the resident was on contact isolation, that was an oversight on my part. CNA #10 stated that the process for contact isolation is to gown up and glove up. On 06/12/2025 at 10:56 AM, during an interview, the Treatment Nurse (TN) stated that they were involved in infection prevention for the facility. The TN stated the process for contact isolation was to put the barrels in the room, signage posted, make sure there were supplies and notify staff of contact isolation. The TN stated that you are to gown up and glove up when entering the room to prevent the spread of infection. On 06/12/2025 at 12:20 PM, during an interview, the Administrator stated the process for contact isolation was as follows: signage at the door, personal protective equipment (PPE) provided, bins in rooms, and that staff who encountered the resident needed to put on PPE prior to entering the room. A review of the facility policy title Isolation-Categories Transmission Based Precautions, revised in October 2018, indicated staff and visitors will wear clean, non-sterile gloves when entering the room Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching contaminated surfaces with clothing after the gown is removed. A review of the facility policy titled Policies and Practices-Infection Control revised in October 2018, indicated, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. A review of the facility policy title Personal Protective Equipment revised in October 2018, indicated that Personal protective equipment appropriate to staff task requirements is available at all times.