STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045445	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Hamilton Health and Rehab	120 Pittman Road Hot Springs, AR 71913

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48977 Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to ensure that privacy was provided while providing care to maintain dignity for 2 (Resident #8 and #57) of 2 sampled residents observed for personal care. The findings include: 1. A review of the modified admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/24/2025, revealed Resident #8 had a Brief Interview of Mental Status (BIMS) score of 05, which indicated severely impaired cognition. a. A review of a Care Plan Report (initiated date 05/19/2025), revealed Resident #8 had an Activities of Daily Living (ADL) self-care performance deficit related to impaired balance and limited mobility. b. During an observation on 05/19/2025 at 6:25 PM, this surveyor observed Licensed Practical Nurse (LPN) #6 pull Resident #8 ' s covers back, pull the resident ' s underwear down, and place the resident on a bedpan, with the door to the resident ' s room open, the privacy curtain was not drawn. The exposed resident was visible to passersby in the hallway. c. During an interview on 05/19/2025 at 6:27 PM, LPN #6 verified that the door was open, while she provided care to Resident #8, which was a privacy issue. 2. A review of the quarterly MDS with an ARD of 03/25/2025, revealed Resident #57 had a BIMS score of 11, which indicated moderately impaired cognition. Resident #57 had a feeding tube while a resident. a. A review of a Care Plan Report (revision date 10/23/2023), revealed Resident #57 requires tube feeding related to resisting eating. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During an observation on 05/20/2025 at 11:51 AM, this surveyor observed the Assistant Director of Nursing (ADON) raise Resident #57 ' s shirt and administered the medications to the resident, via Percutaneous Endoscopic Gastrostomy (PEG) feeding tube. This surveyor observed the door to the resident ' s room was open, the privacy curtain was not drawn, and the blinds were raised while the ADON administered the medication. This surveyor observed a staff member pass the window pushing a resident in a wheelchair, while the ADON was administering the medication via the PEG tube. This surveyor observed several residents in the dining room, which was visible from the window. c. During an interview on 05/20/2025 at 12:00 PM, the ADON verified that the door was not closed, and she did not think about closing the blinds. d. During an interview on 05/21/25 12:26 PM, the Director of Nursing (DON) stated that staff should close the door, pull the curtains, close the blinds, and verbalize patient care to protect the privacy of the residents. The DON stated the residents had a right to privacy and if privacy was not provided, it would become a dignity issue. 3. A review of Resident Rights (revision date 11/22/2016) noted residents had the right to be treated with consideration, respect and full recognition of dignity and individuality.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 48977 Based on observation, interview, record review, and facility policy review, it was determined that the facility did not ensure there was a device in place to prevent further contracture and/or skin breakdown for 1 (Resident #59) of 1 resident sampled for mobility. The findings include: A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/20/2025, revealed Resident #59 had a Staff Assessment of Mental Status (SAMS) that indicated the resident had short-term and long-term memory problems. The MDS also revealed Resident #59 had bilateral impairment to upper and lower extremities. A review of the Care Plan Report (initiated date 11/16/2023) revealed Resident #59 had contractures to bilateral hands. The interventions included to apply a finger separator to bilateral hands continuously as tolerated. Resident #59 had the potential for pressure ulcer development related to immobility, severe contracture of hands, and being non-verbal. The Care Plan also revealed Resident #59 had a stage 3 wound to the left ring finger, which was resolved on 01/07/2025. A review of the Order Summary Report revealed Resident #59 had a physician's order instructing staff to keep finger separator applied to the left hand at all times for severe contracture, to be monitored every shift, and for staff to check placement of finger separators to bilateral hands, adjust as needed, ensure closure was not stuck between fingers .notify Medical Doctor/Advance Practice Nurse of signs/symptoms of skin breakdown, rash, or non-compliance, also to be performed every shift. Another ordered directed, [Patient] to wear palmar grasp splint to [right] hand and wrist daily as tolerated .in the morning for contracture management . During an observation on 05/18/2025 at 1:54 PM, Resident #59 was observed in the common area, on the 200 hall. This surveyor noted Resident #59 had bilateral hand contractures, with a device in the right hand, but nothing in the left hand. During an observation on 05/19/2025 at 8:52 AM, Resident #59 was observed sitting in the common area, on the 200 hall. This surveyor noted there were no devices, in either hand. During an observation on 05/19/2025 at 12:45 PM, Resident #59 was observed sitting in the common area, on the 200 hall. This surveyor noted there were no devices, in either hand. During an observation on 05/19/2025 at 1:17 PM, Resident #59 was observed lying in bed. This surveyor noted one brace on the bedside table, and two hand devices on the nightstand, but no devices in either hand. During an observation on 05/20/2025 at 8:55 AM, Resident #59 was observed sitting in a wheelchair, in the common area on the 200 hall. This surveyor noted there were no devices, in either hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/20/2025 at 10:19 AM, Resident #59 was observed sitting in a wheelchair, in the common area on the 200 hall. This surveyor noted there were no devices, in either hand. During an observation on 05/20/2025 at 12:38 PM, Resident #59 was observed in the dining room for meal service. This surveyor noted there were no devices, in either hand. During an interview on 05/20/2025 at 10:21 AM, Certified Nursing Assistant (CNA) #7 stated the only person CNA #7 had observed placing the brace(s) in Resident #59 hands, was the Treatment Nurse. During an interview on 05/20/2025 at 10:24 AM, the Assistant Director of Nursing (ADON), who was working as the floor nurse on 200 hall, stated the restorative aide or aides were responsible for placing the braces in Resident #59 ' s hands. The ADON verified there were currently no devices in either of the resident ' s hands. The ADON stated if the resident refused the brace(s), the floor nurse should be notified. The ADON, who was serving as the floor nurse, stated she had not been informed Resident #59 had refused the braces. During an interview on 05/20/2025 at 10:53 AM, CNA #8 showed this surveyor their documentation option for application of the brace, which included applied, removed, refused, resident not available, and not applicable. CNA #8 stated that if the resident refused, then refusal would be marked. CNA #8 stated, if there were skin issues, I would mark issue there and if none noted I would mark none of the above. The tasks sheets for Resident #59 did not indicate the resident had refused the interventions. During an interview on 05/21/2025 at 12:30 PM, the Director of Nursing (DON) stated the aides documented skin observations, made sure the hand guards were in place and adjusted as needed, and documented if the resident was wearing finger separators. The DON stated there was no documentation that she was aware of completed by the nurses indicating they had been informed Resident #59 refused the brace or finger separators. The DON stated that it was not noted that the Medical Director or Advance Practice Nurse was notified of Resident #59 ' s non-compliance. The DON stated Resident #59 had a wound to their finger, which was the reason the facility implemented the finger separators, but since Resident #59 had not had any finger separators in place, that intervention would be ineffective. The DON stated she did not know why the care plan had not been revised to note Resident #59 refused to wear the hand guard. A review of the policy titled Rehabilitative Nursing Care (revised 11/22/2016) noted, the facility will provide general rehabilitative nursing care to its residents, as ordered or required.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, interview, and facility policy review, the facility failed to ensure 1 of 1 ice machine was maintained in a sanitary condition; expired food items were promptly removed / discarded on or before the expiration or use by date; food stored in the freezer was covered; the refrigerator temperature and cold dairy products were maintained at 41 degrees Fahrenheit or below; and dietary staff washed their hands between tasks for 1 of 1 meal observed. The findings are: 1. On [DATE] at 9:29 AM, the ice machine was checked. The area of the ice machine where ice formed, before dropping into the ice collector, had a grayish residue on the left side, and a black residue on the right side. The area was pointed out to the Dietary Manager (DM), who wiped the substance away. During an interview with the DM, she was asked to describe the appearance of what she had wiped off, on the left and the right sides of the ice machine. She stated, It was mold. She was asked how often the ice machine was cleaned and who used ice from the ice machine. The DM stated she cleaned the ice machine once a month, and it was only used for residents' drinks and to fill the ice chests for resident cups, in their rooms. 2. On [DATE] at 9:35 AM, the following seasonings were observed on a shelf, above the food preparation counter, and were expired: a. Nutmeg, with an expiration date of [DATE] b. Rubbed Sage, with an expiration date of [DATE]. c. Ground Cloves, with an expiration date of [DATE]. 3. On [DATE] at 9:42 AM, there were four loose tea bags, lying uncovered on a paper towel, on top of the shelf, above the stove. The DM stated they should have been covered until used. 4. On [DATE] at 9:43 AM, the 2-door glass refrigerator temperature was 44 degrees Fahrenheit. The DM was asked to check the temperature of the buttermilk and half and half. She did, and stated the buttermilk was 53. 3 degrees Fahrenheit and the half and half was 47 degrees Fahrenheit. The DM then stated both had been out for breakfast to puree with. 5. On [DATE] at 10:15 AM, a box containing 31 individual packages of French dressing was observed on a shelf in the storage room with an expiration date of [DATE]. On [DATE] at 10:51 AM, the DM was asked about the potential concerns with expired items and she stated they should have been checked, and they (the dressing) go bad too fast. 6. On [DATE] at 11:03 AM, Dietary [NAME] (DC) #1 removed a plastic bag from the refrigerator that contained lettuce, and placed it on the counter. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	She removed gloves from the glove box and placed them on her hands. DC #1 opened the bag, removed the lettuce, and placed it on the cutting board. DC #1 then removed onions from a plastic bag and placed them on the cutting board. Without rinsing the lettuce or onions, DC #1 cut the lettuce and onions and placed them on a plate, without changing her gloves or washing her hands. 7. On [DATE] at 11:21 AM, DC #1 had gloves on when she opened a container of strawberries. She removed the unwashed strawberries, with contaminated gloves, and placed the strawberries on the cutting board. DC #1 cut the strawberries and transferred them to a plate for residents' meals. At 12:00 PM, DC #1 was interviewed and was asked what she should have done after touching dirty objects and before handling food with contaminated gloves. DC #1 stated she should have washed her hands. 8. On [DATE] at11:27 AM, DC #2 touched the inside of the blender that contained the mechanical soft meatloaf mixture, with contaminated gloves, to adjust the blade. She poured the meatloaf mixture into a sprayed pan and placed it on the steam table. At 12:13 PM, DC #2, was interviewed and asked what she should have done after touching dirty objects and before handling food with contaminated gloves. DC #2 stated she should have washed her hands. 9. On [DATE] at 11:32 AM, DC #1 and Dietary Aide (DA) #3 were talking. DC #1 touched her gloved hands to her lips. Without changing gloves or washing her hands, she then removed slices of bread from a bag. At 12:03 PM, DC #3 was interviewed and asked what she should have done after touching dirty objects and before handling food with contaminated gloves, and she stated she should have washed her hands. 10. On [DATE] at 11:34 AM, DC #4 removed turkey, ham, and cheese from the walk-in refrigerator and placed them on top of the counter, contaminating her hands. Without washing her hands, she applied gloves and removed slices of turkey and ham, from the original package, and transferred them into a pan. She adjusted the stove knob, with contaminated gloves, then used the same gloves to remove slices of turkey and ham from the package. She placed the slices of turkey in a pan on the stove, then used her gloved hand to flip the turkey meat, that was in the pan, on the stove. This surveyor asked DC #3 what she should have done after touching dirty objects and before handling food. DC #3 stated she should have washed her hands before using gloves. 11. On [DATE] at 11:50 AM, DA #3, without having gloves on, touched cream cheese and then placed gloves on her hands. DA #3 then adjusted the mixer and picked up the contaminated cream cheese and added it to the mixer to be used for residents' desserts. At 1:51 PM, DA #3 was interviewed and was asked what she should have done after touching dirty objects and before handling food. DA #3 stated she should have washed her hands. 12. On [DATE] at 11:51 AM, DA #5 touched the rims of the electrolyte drink glasses, while removing them from the 2- door glass refrigerator and placing them on a utility cart in the walk-in refrigerator. 13. On [DATE] at 11:52 AM, DC #2, without washing her hands or placing gloves on, placed three rolls, warm milk with butter, two tablespoons of protein powder, and one tablespoon of thickener into a blender to puree. She poured the pureed content into a sprayed pan and placed it on the steam table. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	14. On [DATE] at 12:24 PM, DA #5, who was assisting with lunch meal service at the tray line, picked up cartons of supplements and placed them on the trays. Without washing her hands, she picked up glasses with beverages in them, by the rims, and placed them on the trays to be served to the residents with their lunch meal. DA #5 was interviewed and was asked what she should have done after touching dirty objects and before handling food with contaminated gloves. DA #5 stated she should not have grabbed the glasses on the rim but on the side of the glasses. 15. A review of a facility policy titled, Ice Machine reviewed indicated the machine should be clean and free of bacteria and mold. 16. A review of a facility policy titled, Safe Food Handling Practices indicated employees should wash their hands when entering the kitchen, before handling food, and should never use bare hand contact with any foods ready to eat or otherwise.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48977 Based 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 followed; that staff used proper hand hygiene during incontinence care; and/or that staff wore proper Personal Protective Equipment (PPE) when care was provided, for 3 (Resident #8, #42, and #226) of 3 residents reviewed for EBP or Transmission Based Precautions (TBP). The findings include: 1. A review of the modified Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/24/2025, revealed Resident #8 had a Brief Interview of Mental Status (BIMS) score of 05, which indicated the resident had severely impaired cognition. The MDS also indicated Resident #8 had one or more unhealed pressure ulcers/injuries. a. A review of Care Plan Report (revision date 05/19/2025) indicated Resident #8 had an unstageable pressure injury to the sacrum, and Resident #8 (revision date 05/14/2025) had Vancomycin-Resistant Enterococci in their urine and was on strict contact isolation. (Vancomycin Resistant Enterococci, or VRE, is a type of enterococcus bacterium that has become resistant to antibiotics such as penicillin, gentamicin, and vancomycin. Such drugs are usually used to treat infections with Enterococci, but do not work for fighting infections caused by VRE.) b. A review of the Lab Results Report, collected on 05/09/2025, revealed Resident #8 had greater than 100, 000 colony-forming unit/per milliliter Vancomycin-resistant enterococci, which typically indicates the presence of an infection that requires treatment. c. On 05/19/2025 at 6:25 PM, this surveyor observed Licensed Practical Nurse (LPN) #6 provide care to Resident #8. LPN #6 only wore gloves at the time care was provided, and did not wear any other form of personal protective equipment such as a gown. d. On 05/19/2025 at 6:27 PM, during an interview, LPN #6 stated Resident #8 was on contact isolation, and she should have been wearing a gown and gloves to provide care to the resident. 2. A review of the quarterly MDS with an ARD of 04/30/2025 indicated Resident #42 had a BIMS score of 09, which indicated the resident had moderately impaired cognition. The MDS also indicated Resident #42 was always incontinent of bowel and bladder. a. A review of the Care Plan Report (date initiated 01/23/2025) indicated Resident #42 was incontinent of bowel and bladder. b. On 05/19/2025 at 6:40 PM, this surveyor observed Certified Nursing Assistant (CNA) #9 at the bedside, providing incontinence care to Resident #42. This surveyor observed CNA #9 touch the right bed rail and nightstand drawer, with the gloves that had previously been used to provide incontinence care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 05/19/2025 at 6:45 PM, during an interview, CNA #9 stated that she did not change her gloves during the process of providing incontinence care to Resident #42. CNA #9 stated that she touched the resident's sheets, the trash bag, the resident's pillow, and nightstand, with dirty gloves. CNA #8 did not remember if she touched the bed rail. CNA #8 stated by touching items with dirty gloves, it was cross contamination. 3. A review of Care Plan , dated 05/05/2025, revealed Resident #226 had a diagnosis of pressure induced deep tissue damage of the sacral region, chronic obstructive pulmonary disease, and benign prostatic hyperplasia. a. The Admission MDS with an ARD of 5/9/2025 for Resident #226 was still in progress. b. On 05/19/2025 at 2:00 PM, this surveyor observed the Treatment Nurse perform wound care to a pressure ulcer on Resident #266's sacral region. The Treatment Nurse entered the room with gloves on, wound care supplies in hand, and no gown on. The Treatment Nurse touched, and her body brushed against the resident ' s bed while performing wound care. Hand hygiene was not performed between glove changes, and a gown was not worn at any point during the procedure. c. On 05/19/2025 at 2:10 PM, during an interview, the Treatment Nurse was asked what she could have done differently while providing care to Resident #226. The Treatment Nurse stated she should have performed hand hygiene and worn a gown, due to Resident #226 being on EBP. The Treatment Nurse stated the purpose of performing hand hygiene was to prevent infection. 4. On 05/21/2025 at 12:39 PM, during an interview, the Director of Nursing (DON) stated staff were expected to put on gowns and gloves before caring for a resident on contact isolation. The DON stated if staff touched items with dirty gloves, they were contaminating everything. The DON stated there were many things that determine if a resident was on EBP including catheters and ostomies. 5. During a concurrent interview on 05/21/2025 at 1:00 PM, the DON stated staff should wash their hands prior to wound care and when applying PPE, after wound care and with glove changes. The DON stated staff should perform hand hygiene to prevent infections. 6. On 05/21/2025 at 10:08 AM, the Administrator stated the facility did not have a policy on Enhanced Barrier Precautions, but the facility followed CDC (Centers for Disease Control) guidelines. 7. On 05/21/2025 at 10:10 AM, this surveyor received a CDC policy titled Consideration for use of Enhanced Barrier Precautions in Skilled Nursing Facilities which indicated EBP may be applied to residents with wounds or indwelling catheters. 8. A review of a policy titled, Standard precautions Policy-Hand Hygiene indicated wash hands immediately after gloves are removed. 9. A review of the policy titled Standard Precautions (11/22/2016) revealed standard precautions will be used in the care of all residents, regardless of their diagnosis or suspected or confirmed infection status. Staff should wash hands after touching blood, bodily fluid, secretions, excretions, and contaminated items, whether or not gloves are worn. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. A review of the policy titled Infection Prevention and Control Program (11//22/2017) noted wear a disposable gown upon entering the contact precaution room. 50580