STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 50682 Based on interviews, record review, and facility policy review, it was determined the facility failed to ensure a written discharge summary and information form was completed for 1 (Resident #90) of 1 resident reviewed for discharge. The findings included: Review of updated facility policy titled Resident Discharge Process dated 06/28/2024, indicated when a resident was discharged home, the Director of Nursing/Designee will ensure a discharge note was completed. A review of resident medical diagnoses indicated the facility admitted Resident #90 with diagnoses of dementia and diabetes. The quarterly Minimum Data Set with an Assessment Reference Date of 08/14/2024 revealed Resident #90 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. A review of Resident #90's medical records revealed no completed discharge summary was present. During an interview with the Director of Nursing (DON) on 12/11/2024 at 11:00AM, the DON stated that the discharge summary was not completed for Resident #90.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 0675 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor each resident's preferences, choices, values and beliefs. 50505 Based on observations, interviews, record review, and facility document review, it was determined that the facility failed to ensure a resident was in the proper position for consuming a meal while in bed for 1 (Resident #13) of 1 resident reviewed for proper positioning during meal consumption. The findings include: On 12/12/2024 at 11:55 AM, the Director of Nursing (DON) stated the facility did not have a policy for positioning during meal consumption. A review of the Medical Diagnosis, indicated the facility admitted Resident #13 with diagnoses that included dementia, dysphagia (difficulty swallowing), gastrointestinal hemorrhage (bleeding of the digestive tract), and gastro-esophageal reflux disease with esophagitis (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed Resident #13 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated the resident was severely impaired for daily decision making. Resident #13 was dependent with bed mobility. A review of Resident #13's Care Plan, revised on 12/18/2023, revealed Resident #13 had potential risk for complications related to deficits in self-care activities of daily living and preferred to stay in bed most days. Interventions included substantial assistance with all bed mobility which included lying to sitting and dependent assistance of one staff member with eating. During an observation on 12/09/2024 at 12:53 PM, Resident #13 was lying in bed with the over-the-bed table across the bed. Resident #13 was down in the bed, unable to see what was on the table. A plate of pureed food was sitting in front of Resident #13 and had not been eaten. Resident #13 stated I'm not too hungry right now. During an observation on 12/10/2024 at 8:16 AM, Resident #13 was lying in bed with the head of the bed elevated approximately 30 degrees, a breakfast tray was on the over-the-bed table which was across the resident. Resident #13 was not upright in the bed with the resident's head barely above the over-the-bed table and the resident could not see what was on the table. During an interview on 12/10/2024 at 8:25 AM, the Certified Nursing Assistant (CNA) #5 confirmed that Resident #13 should not be down in the bed when asked if Resident #13 was in the correct position to eat. During an interview on 12/10/2024 at 2:22 PM, the Director of Nursing (DON) confirmed that Resident #13 should have been pulled up in the bed and someone should have assisted the resident with eating. The DON stated that being down in the bed could lead to choking.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 47916 Based on observation, record review, and interview, the facility failed to ensure medications were not stored on top of the nurse ' s station counter near residents, to prevent misappropriate use of resident owned medications or accidents affecting 1sampled (Resident #72) resident. The facility also failed to ensure the appropriate temperature range was maintained in the 300 Hall medication refrigerator to ensure flu vaccines were stored at the recommended temperatures. The findings include: 1.a. On 12/11/2024 at 09:48 AM, Five (5) medication cards of an anti-viral medication were observed resting on top of the nurse ' s station counter near an empty pharmacy bag. Licensed Practical Nurse (LPN) #3 was observed with her back turned talking on the telephone. Two (2) residents in specialty chairs and Resident #72, an ambulatory resident, was sitting in a nearby chair. LPN #3 was asked the process for receiving medications from the pharmacy. LPN #3 stated medications are counted together with the pharmacy on arrival. LPN #3 also stated she did not know where the anti-viral medications came from. LPN #1 walked up and said this was his fault. He stated, he removed the medication cards from the top of my cart and placed them on the counter of the nurse ' s station and walked off to give medication to a resident and just forgot. The survey asked if this was an appropriate way to store medications. LPN #1 responded, no. LPN #1 stated a resident could have taken the medications and he would not have known and confirmed medications should be locked on the cart or in the medication room. 2.a. On 12/11/2024 at 09:49 AM, Licensed Practical Nurse (LPN) #1 opened the narcotic refrigerator, located in the 300 Hall medication room, and verified the temperature was 30 degrees Fahrenheit. LPN #1 counted a box of flu vaccines with three (3) remaining doses, and an unopened box of flu vaccines with 10 doses. This surveyor asked at what temperature vaccines were to be maintained. Licensed Practical Nurse (LPN) #1 read from the flu vaccine box 35-46 degrees Fahrenheit. This Surveyor asked what process was followed to make sure the narcotic refrigerator is at the right temperature. LPN #1 stated third shift recorded the temperature, and if it was wrong the nurse was supposed to adjust the temperature until it was correct. This surveyor asked why it was important to maintain the appropriate temperature. LPN #1 responded the medication might not be as effective. LPN #1 pointed out the temperature log on front of the refrigerator that indicated the temperature should be between 36-46 degrees Fahrenheit, and if the temperature was incorrect, it should be adjusted until it was in range. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During an interview, the Director of Nursing DON was asked if it was appropriate to store medications on top of the nurse ' s station counter, what the facility process was, and if any of the three residents at the counter were able to ambulate independently to where the medication was left. The Director of Nursing (DON) identified Resident #72 could ambulate and confirmed that someone could have taken the medications, and they would not have known. This surveyor asked what process the nurses follow to make sure refrigerated medications were stored at the right temperature. The DON stated nurses were to check the thermometer and let the DON know if it was not correct. This surveyor asked if staff notified the DON of the temperature on 12/08/2024. The DON looked at the temperature log and confirmed that no staff let her know the temperature was 32 degrees on 12/08/24. This surveyor asked the DON why it was important to monitor refrigerator temperatures. The DON stated because vaccines and medications could become less effect when not stored at the recommended temperature. This surveyor requested the medication storage policy and in-services. c. On 12/11/2024 at 01:00 PM, the DON provided Medication Administration in-service documentation that showed staff, including LPN #1, received training on 10/3/24 and 03/06/24. The in-service did not cover medication storage, or maintaining temperatures for refrigerated medications. d. On 12/12/2024 at 09:30 AM. DON was asked again for a medication storage policy and the information provided in their Medication Administration in-service addressed medication storage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 50505 Based on observations, interviews, record review, and facility document review, it was determined that the facility failed to ensure resident received the correct physician ordered diet for 1 (Resident #13) of 1 resident reviewed for therapeutic diet. The findings include: On 12/12/2024 at 11:31 AM, the Director of Nursing (DON) stated the facility did not have a policy regarding checking meal trays prior to serving. A review of the Medical Diagnosis, indicated the facility admitted Resident #13 with diagnoses that included dementia, dysphagia, gastrointestinal hemorrhage, and gastro-esophageal reflux disease with esophagitis. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/03/2024, revealed Resident #13 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated the resident was severely impaired mental cognition and indicated Resident #13 was on a therapeutic and mechanically altered diet. A review of Resident #13's Care Plan, revised on 11/16/2023, revealed Resident #13 was at risk for potential nutritional problem inadequate protein/caloric intake related to disease progression and decreased nutrient intake. Interventions included providing and serving a low concentrated sweets (LCS) diet with pureed texture. A review of the Order Summary Report, revealed Resident #13 had an order for LCS diet with pureed texture, and regular consistency liquids. During an observation, on 12/10/2024 at 8:19 AM, Resident #13 was observed with a plate of food on the over-the-bed table, in front of the resident. The eggs appeared lumpy, the meat was grainy in appearance, and the cereal was glazed over. There was a spoon in the eggs and a spoon in the meat. No one was assisting Resident #13 with eating. Resident #13's tray ticket for the meal called for LCS Pureed. During an interview on 12/10/2024 at 8:25, Certified Nursing Assistant (CNA)#5 stated Resident #13's food was pureed. CNA #5 confirmed the meat was grainy in appearance and the eggs were regular scrambled eggs when CNA #5 turned the food over with the spoon. CNA #5 stated Resident #13's roommate had gotten a tray early that morning due to an appointment and that dietary had sent a tray for Resident #13 as well. CNA #5 stated, we are about to go get another tray. During an interview on 12/10/2024 at 10:47 AM, the Certified Dietary Manager/Kitchen Director (CDM/KD) confirmed that the meat appeared to be minced, and the eggs were regular scrambled eggs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2024 at 2:22 PM, the Director of Nursing (DON) stated the meat appeared to be minced and the eggs from the meal tray of Resident #13 appeared to be regular scrambled eggs. The DON stated the nurses, CNAs or resident assistants (RAs) were responsible for making sure the right diet and consistency were served to the residents when passing out meal trays.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 - 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** 49413 Through observations, interviews, and policy/procedure reviews, it was determined the facility failed to ensure that essential equipment and appliances were kept clean and free of debris and food items were properly stored and labeled. The findings are: On [DATE] at 10:10 AM, one bag of sliced white bread was not closed after being used for breakfast. The Certified Dietary Manager (CDM) confirmed the bag was left open after the breakfast meal. There was a possibility to cross-contaminate the bread in the bag. On [DATE] at 10:15AM, the drink cooler contained the following drinks without a received date nor an open date: 15 half pint whole milk containers, four half pint - one percent low-fat buttermilk, 16 half pint - two percent milk, three half pint - fat free milk, four - eight fluid ounce advanced therapeutic milk chocolate nutrition, two - eight fluid ounce vanilla almond milk, 28 - four fluid ounce thickened lemon water, three - four fluid ounce thickened orange juice, seven - four fluid ounce thickened apple juice, eight - four fluid ounce apple juice, three - four ounce fluid ounce cranberry juice cocktail, ten - for fluid ounce grape juice, six - four fluid ounce prune juice. The Certified Dietary Manager confirmed there were not any received nor open dates for the drinks in the drink cooler. On [DATE] at 10:22AM, the drink cooler tray that held the four-ounce prune juice containers had unknown brownish syrupy, sticky substance under the juice containers and on one - four-ounce prune juice container. The Certified Dietary Manager stated the tray was on the rotation clean list to be done at least once a week and stated the tray shouldn't be like this; the tray should have been changed; the prune juice container should be disposed of for safety reasons and was unable to identify what the unknown brownish syrupy sticky substance was. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 - Some	On [DATE] at 10:28AM, the food serving area contained two wheeled silver carts. The first wheeled cart's first sheet pan appeared to have five unknown white dried, crusty type spills with unknown white particles along the sides and bottom of the sheet pan. The sheet pan contained the following snacks for residents: four - 50-gram honey buns, three individual, packaged wheat peanut butter and strawberry jam sandwiches, four individual blueberry breakfast bars, three individual, packaged chocolate chip cookies, two individual, packaged peanut butter cookies, two individual, packaged oatmeal raisin cookies, two individual, packaged vanilla sandwich cookies, and one individual, packaged graham crackers. The second shelf contained 15 disposable food domes, not properly covered to keep foreign objects from being on the food covering surface and unknown brown and white particles near the disposable food domes. The second sheet pan contained one package puffy cheese snacks, two package baked barbeque chips and one package salted baked chips. The third sheet pan held the toaster, used at breakfast. The toaster contained numerous unknown brown and white specks on top of the toaster surrounding the four slots to put bread into. The bottom of the sheet pan had numerous unknown brown and white specks surrounding the toaster. The Certified Dietary Manager stated the sheet pans were scheduled to be cleaned at least one-time weekly or as needed and confirmed that the food domes should be inverted to keep unknown particles from landing inside and cross-contaminating when flipped over the food and confirmed the toaster should had been cleaned after breakfast to not attract various pests. On [DATE] at 10:29AM, the second wheeled cart's first sheet pan appeared to have the appearance of broken flake cereal towards the front edge of the pan and the back third section of the pan. This pan contained the following cereals without a received date or an opened date for residents to consume: six factory individualized, pre-portioned sugar covered flakes, seven factory individualized, pre-portioned grain O rings, and four kitchen portion plain flakes. On [DATE] at 10:31AM, the second wheeled cart's second sheet pan contained the following cereals without a received date or an opened date for residents to consume: nine factory individualized, pre-portioned sweetened cereal with marshmallows, three factory individualized, pre-portioned unsweetened crisped rice, five factory individualized, pre-portioned bran flakes with raisins, and two factory individualized, pre-portioned grain circles of various colors. On [DATE] at 10:32AM the Certified Dietary Manager confirmed the cereals on both shelves of the second wheeled cart did not have neither the received date nor the open date. On [DATE] at 10:34AM, above the tray line serving area a container of adapted forks and spoons looked to had been tossed in into an uncovered silver steam table container where the eating part of one utensil crossed the handle of a different eating utensil. The regular forks, spoons and knives were placed in an uncovered divided container. The Certified Dietary Manager confirmed neither set of utensils for resident's use were covered. The Certified Dietary Manager stated the utensils were used for the meals. On [DATE] at 10:39AM, five open coffee carafes were in an upright position, without a cover on the bottom shelf, underneath the drink preparation table. The Certified Dietary Manager confirmed the open carafes should had been inverted or covered to keep out debris and other cross-contaminations that could cause the residents to become sick. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 - Some	On [DATE] at 10:43AM, the kitchen condiment area contained the following condiments in containers without a received date or open date: three full containers of individual ketchup cups, one container of individual sized white creamy dressing, two containers of individual sized salsa, two containers of barbeque sauce, one container of individual sized sugar-free pancake syrup, one container of individual sized pancake syrup, one container of individual sized relish, one container of individual sized raspberry vinegar dressing, one container of individual sized creamy red dressing, one container of individual sized herb flavored dressing. The Certified Dietary Manager confirmed there was neither a received date nor an expiration date for any of the condiments. On [DATE] at 10:43AM, the bulk sugar container was approximately three-quarters of the way full held various sized white and brown crumbly debris on the top with unknown black ground-in debris in various areas, to include the handle used to open the lid. The outside walls of the bulk sugar container also had the same unknown black ground-in debris in various areas. The carrying handle had an unknown yellowish-brown substance built up. Along the top inside edges of the container were gouges and scratches with dark brown and black unknown substance. The indents from the carrying handles has a black ground in looking unknown substance. The Certified Dietary Manager stated the bulk sugar container was not considered clean and there was too much build up around the edges of the container. The Certified Dietary Manager stated areas of concern were how long the substance build up had been there and not knowing what the built-up substance was due to the possibility for the substance to get into the sugar used for various foods provided to the residents for consumption. On [DATE] at 10:53AM, the dish warmer's lid closure was prevented by 42 plates on the left side and 28 plates on the right side above the maximum limit. The dish warmer's lid ' s inability to close properly resulted in the plates not having the serving side properly covered. The Certified Dietary Manager confirmed that the plates should be inside the plate warmer with the lid closed. The lid not closed could cause cross-contamination of all the plates in the plate warmer. On [DATE] at 11:05AM, on the inside door around the clasp to hold the door shut of the walk-in refrigerator was an unknown brown substance built up around and in the seam of the clasp bracket. The unknown brown substance built up was also in the indentations around the door clasp on the inside of the refrigerator door and the crevasse of the inside door that meets the refrigerator frame ' s edge. The latch secured to the outside wall of the refrigerator contained a scaley brown and white unknown substance built in the seams of the latch plate around the bolts to secure the latch plate and on the wall surrounding the latch plate. Approximately 40 inches above the latch towards the ceiling the unknown brown substance was encrusted in the wall. The left inside door frame had a piece of plastic missing that exposed the wood beneath. The outside panel above the door contained an unknown dark greyish substance the spread the length of the panel and about half the height. The right side of the walk-in refrigerator outside wall contained a dark brown unknown substance that ran the entire height of the door. The door hinges and plates were encrusted with an unknown reddish-brown substance. The seal around the entire walk-in refrigerator door held a black grimy sludge like unknown substance. This black grimy sludge like unknown substance was embedded into to grooves of the seal. There was a gap between the floor edging under the walk-in refrigerator door and the wall. The gap was filled with various unknown debris, with a thick brown and white unknown substance attached to the wall and floor edging. The Certified Dietary Manager confirmed the unknown substances were in the crevasses, hinges, plates, grooves, gaps. The Certified Dietary Manager stated there were concerns of the unknown substance growth in the walk-in refrigerator area due to possible cross contamination of food stored in the walk-in refrigerator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 - Some	On [DATE] at 11:11AM, in the three-door pastry refrigerator on the left side of the kitchen a five-pound container of egg salad expired on [DATE]. The Certified Dietary Manager confirmed the egg salad was expired. The Certified Dietary Manager sent a staff member to collect all egg salad sandwiches that had been sent to the facility's halls for residents' snacks. The Certified Dietary Manager confirmed that expired food should not be served due to concern of bacterial growth. On [DATE] at 11:26AM the dry good storage shelving contained the following food items without a received date or an open date: 54 individual four fluid ounce cranberry juice, 45 individual four fluid ounce thicken sweet tea, 32 individual four fluid ounce thickened apple juice, 65 individual four ounce prune juice, 80 individual eight fluid ounce of various flavors, 18 individual four fluid ounce thickened orange juice, 70 individual four ounce thickened lemon water, 90 individual four fluid ounce grape juice, 57 individual eight fluid ounce high protein nutritional drink, 60 individual four fluid ounce apple juice, 42 individual four fluid ounce orange juice. The Certified Dietary Manager confirmed there were not received dates nor open dates for the drinks stored on the dry good shelves. On [DATE] at 11:32AM the storage container with chocolate cake mix was not completely sealed. The back right corner was not completely sealed. The outside cover of the storage container was covered with an unknown powdery white substance with some small white clumps scattered within the powdery unknown substance. The Certified Dietary Manager confirmed the unknown white powdery substance, and clumps were able to cross-contaminate the cake mix inside the storage container. With the seal not properly closed it could allow other contaminants to enter the storage container with the cake mix that was used for residents' meals. On [DATE] at 12:09PM the dishwasher machine had an unknown white crusty substance over the entire outside housing unit. The unknown white crusty substance had water drip marks that ran down the machine sides. The dirty side entrance had a white and blue unknown substance build up in the crevasses. The front right third edge of the dishwashing machine had an unknown brownish substance in the crevasse. The long side of the dishwashing machine crevasse had a white and blue unknown substance in the crevasse. The left edge side of the top of the dishwashing machine held a buildup of an unknown crusty white substance. The right edge middle side of the top of the dishwashing machine held approximately three inches by four-inch gooey bluish unknown substance. The clean side of the dishwashing machine had a thick unknown white build up substance on the cloth strips the clean dishes pass through to exit the machine. The dishwashing machine clean side top back wall had unknown thick white build up in the crevasses and a quarter of the way up the wall. The back wall had brownish unknown substance that gathered in various sections on top of the thick white build up and along the right side back wall. The left side crevasse held the unknown white substance that ran the entire length of the crevasse. The Certified Dietary Manager confirmed the dishwasher needed to be deep cleaned weekly and wiped down daily. On [DATE] at 12:06PM three baking sheets of sausage sitting on a wheeled cart preparation cart were stacked on top of each other without a barrier placed between the frozen sausage patties and the bottom of the baking sheet on top. The Certified Dietary Manager confirmed the sausage patties should have something to cover the sausage patties before the baking sheet was placed on top. The CDM stated cross contamination could occur due to not knowing what the bottom of the baking sheet had touched. A review of the cleaning schedules dated [DATE] through [DATE] showed that: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 - Some	[DATE] the dishwasher was not cleaned by kitchen staff [DATE], [DATE], and [DATE] the dishwasher was cleaned by kitchen staff [DATE] and [DATE] 3 dietary roll carts were cleaned by staff A review of the facility approved policy or procedure Infection Prevention in Dietary for Infection Prevention Dietary Services Policy Number 1C#VII A effective date of [DATE]; Last revision date [DATE]; Last review date [DATE] showed B1. Cleaning schedules will be followed, department director is responsible to see that cleaning schedules are followed. B2. Equipment will be checked often to ensure proper working condition. B3. Employees are to report equipment defects immediately to the department director, who makes sure defects are repaired quickly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47916 50505 Based on observation, record review, interview, and facility policy review, the facility failed to ensure the 200 Hall Soiled Utility door was locked to prevent resident access to dirty linens and trash, failed to ensure the 200 Hall Linen Closet door was locked to prevent resident access to linens, and failed to prevent clean laundry items from resting against the floor to prevent cross contamination. The facility also failed to ensure appropriate hand hygiene was performed during perineal care for 1 (Resident #20) of 1 sampled resident, and during meal service to prevent cross contamination and the risk for infection. The findings include: 1.a. On 12/09/2024 at 11:35 AM, the Soiled Utility door on 200 hall was found to be open despite a push button lock, and sign stating Soiled Utility please keep door closed. b. On 12/09/2024 at 01:38 PM, Registered Nurse (RN) #2 revealed the Soiled Utility door should be locked to prevent residents from going inside because it contained dirty linens and trash that they would not want the residents to have access to. It is an infection control issue, stated RN #2. 2.a. On 12/09/2024 at 01:33 PM, the Linen Closet door on 200 hall was found to be open despite a push button lock. There was a folded towel, wash cloth, pillow care, and lift pads resting on the floor. b. On 12/09/2024 at 01:34 PM, RN #2 identified lift pads, folded blanket, washcloth and pillowcase resting on the floor. Rn #2 stated, It is unsanitary. The surveyor asked RN #2 who was responsible for the linen closet. RN #2 stated, Laundry stocks it, but aides are in and out getting supplies. Anyone that gets something from this closet is responsible for making sure nothing is on the floor. It is an infection control issue. c. On 12/10/2024 at 02:10 PM, during an interview the Director of Nursing (DON) was asked what the procedure was for maintaining the Soiled Utility room and Linen Closet on 200 Hall outside the closed unit. The DON confirmed that the linen and supply closets should remain locked to prevent residents ' access to the dirty linens and trash in the Soiled Utility room. The surveyor asked if it was appropriate for linens and clean lift pads to touch the floor or be on the floor of the Linen closet. The DON confirmed that linens and lift pads should not rest on the floor and resident access to dirty linens and trash were infection control issues. The DON confirmed that lift pads were sent to the linen closet in a bag and the bag should be hung on the hook in the linen room to prevent pads from touching the floor because it is an infection control issue. The surveyor requested any in-services and policies and procedures on storing linen and resident access to dirty linens or trash. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. 12/11/24 09:25 AM, The DON provided education titled July 2024 Education, revealing when linens are taken off the cart, they should be placed in a bag to keep them from being soiled. If any linens touch the floor without a barrier, they are considered dirty and should be sent to the laundry. Nothing should be placed on the floor even if it is in a bag. Education, dated 09/2024, revealed if any linens, including resident clothing, touch the floor, they were to be sent to the laundry. The DON did not have a policy addressing linen and trash storage, and stated she provided the education piece. 3. A review of Medical Diagnosis revealed Resident #20 had diagnoses of psychosis, anxiety, and arthritis. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/10/2024, revealed a Staff Assessment for Mental Status (SAMs) indicating Resident #20 had memory problems. Section H0300, and H0400 suggest Resident #20 was always incontinent of bowel and bladder. a. On 12/09/24 01:50 PM, Certified Nursing Assistant (CNA) #4 was observed picking up a package of wipes and pulling out one wipe at a time, using both hands, while providing peri care to Resident #20's perineal area and buttocks. CNA #4 did not perform hand hygiene between holding the package of wipes and pulling out clean wipes. b. On 12/09/24 01:55 PM, CNA #4 was asked the process for removing gloves and maintaining good hand hygiene when removing wipes. CNA #4 stated that the wipes get stuck, and she must grab onto the bag with one hand and use the other to pull them out with a shake, and confirmed the wipes are not clean if hand hygiene is not performed before pulling wipes from the package during peri care. c. During an interview on 12/11/24 at 11:15 AM, the DON was asked what process staff were expected to use during perineal care to ensure wipes were used in a manner that promotes good hand hygiene. The DON stated that staff are trained to pull out multiple wipes before peri care, when their gloves are clean, and to place wipes on a clean barrier so staff are not grabbing clean wipes with a dirty hand during peri care, because that is an infection control issue. The surveyor asked for in-services and policies and procedures for perineal care. d. On 12/11/24 at 01:00 PM, the DON provided an in-service titled Hand Hygiene, date range 01/01/2024-12/11/2024 which revealed gloves help reduce the spread of organisms and must be worn properly when there is a risk of contact with infectious material. Change gloves when visibly soiled with body fluids, or changing from a contaminated to a clean body site. e. On 12/11/24 at 03:47 PM, the Infection Preventionist (IP) provided a policy titled Hand Washing Technique, revealing handwashing was the most important way to prevent the spread of disease, and staff should perform hand hygiene when going from a contaminated body site to a clean body site. Policy titled Infection Prevention and Control Plan, revealed healthcare workers, visitors, and others in a healthcare environment can be protected when education emphasizes hand washing. 4. A review of a facility policy titled, Hand Washing Technique, revised in April 2009, indicated that handwashing was important in preventing the spread of infections and that hand washing facilities were conveniently located throughout the facility and that approved antimicrobial soaps and alcohol-based hand rubs were also available in all the appropriate areas. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045452	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence Hall Health & Rehabilitation	1051 West Free Street Walnut Ridge, AR 72476

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/10/2024 at 8:00 AM, Licensed Practical Nurse (LPN)/Staffing Coordinator (SC) started serving the breakfast meal in the dining room on 400 hall. The LPN/SC did not sanitize hands prior to serving the first tray from the meal cart. At 8:03 AM, the LPN/SC went to the meal cart and got another tray and did not sanitize hands prior to serving the tray to the resident, unwrapped the silverware and set the tray up. Then LPN/SC left the dining room, went across the hall, and returned to the dining room holding two milk cartons. At 8:06 AM, the LPN/SC went back across the hall for more milk and returned to the dining room holding a disposable cup and gave the cup to a resident. After delivering the cup, the LPN/SC went to the meal cart, did not sanitize hands, and got another tray to deliver. During an interview on 12/10/2024 at 9:30 AM, the LPN/SC confirmed that hands were not sanitized prior to serving trays and in between residents. The LPN/SC stated, I couldn't find any, then I finally saw it on top of the cart after I had already served the trays. During an interview on 12/11/2024 at 10:32 AM, the Director of Nursing (DON) confirmed that hands should be washed, or hand sanitizer used between residents/trays. When asked what the importance of hand sanitation was, the DON stated, for infection control.