STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045184	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Village Rehabilitation and Care Center	903 Borgognoni Drive Lake Village, AR 71653

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to convey a resident's personal funds to the individual or representative administering the individual's estate within 30 days for 1 (Resident #164) of 3 sampled residents for whom the facility-maintained trust accounts per a list provided by the Business Office Manager (BOM) on [DATE] at 3:00 PM. The findings are: l. Review of the Mortician's Receipt-Record of Death indicated that Resident #164 passed away on [DATE]. 2. A document titled Lake Village Rehabilitation and Care Center Trust-Current Account Balance As of [DATE] documented that a trust account for Resident #164 contained a closing balance of $145.21. 3. On [DATE] at 3:00 PM the Surveyor asked the Business Office Manager (BOM) how long the facility has to return the resident money from trust accounts when a resident passes away or discharges. The BOM indicated one month. 4. On [DATE] at 10:15AM, the Surveyor asked the BOM to identify the date Resident #164 had expired. The BOM verified that Resident #164 passed away on [DATE]. 5. The BOM was asked if they had a policy regarding resident trust accounts. The BOM indicated the facility follows DHS guidelines. 6. A document titled Management of Resident and Elder Trust Accounts was provided by the BOM on [DATE] at 11:15 AM. The document did not address the return of resident funds upon resident discharge or death.

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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and record review, the facility failed to ensure a resident was able to self-hydrate by consistently keeping fluids in reach for 1 (Resident #28) of 1 sampled resident reviewed for accommodation of needs. The findings are: Resident #48 had diagnoses of arthritis in multiple joints (poly osteoarthritis) and the loss of cushioning between the disc in the back (intervertebral disc degeneration) indicated on an Order Summary dated 09/06/2024. A quarterly Minimum Data Set with an Assessment Reference Date of 07/15/2024 was reviewed and indicated Resident #48 had a Brief Interview for Mental Status score of 11, which indicated moderate cognitive impairment and required setup and/or clean up assistance with eating, as the resident had the ability to bring food and/or liquids to the mouth once the meal was placed before the resident. A Care Plan dated 08/19/2024 was reviewed and indicated Resident #48 was at risk for falls and had poly osteoarthritis. Interventions included keeping the resident's personal items within reach and encouraging adequate nutrition and hydration. On 09/03/2024 at 10:53 AM, Resident #48 was observed lying in bed on the resident's back with the head of bed (hob) slightly elevated. The resident was reaching both hands towards a water pitcher on the bedside (bs) table to the left of the resident. Resident #48 was asked if the resident was attempting to drink some water and the resident did confirm that was the intent. There was no cup on the bs table and no straw in the cup. On 09/04/2024 at 8:34 AM, Resident #48 was observed lying in bed on the resident's back and the bs table was positioned in front of the nightstand to the left of the resident's bed and out of the resident's reach. There was a water pitcher and a foam cup on the bs table. On 09/04/2024 at 2:02 PM, Resident #48 was observed lying in bed on the resident's back with the hob up and a wedge cushion to the resident's right side. A water pitcher, with a straw inside, was on the bs table which was positioned to the left of the bed and out of the resident's reach. On 09/05/2024 at 3:30 PM, Resident #48 was observed lying in bed with eyes closed. A water pitcher was on the nightstand to the left of the resident's bed and out of reach. On 09/06/2024 at 12:11 PM, Resident #48 was lying in bed with eyes closed. A water pitcher was on the nightstand to the left of the resident's bed and out of reach. On 09/06/2024 at 12:25 PM, Certified Nursing Assistant (CNA) #5 was interviewed and she was asked if Resident #48 could get a drink of water and she stated the resident could if the water was placed in front of the resident. She stated the resident required a cup and was unable to pick up the water pitcher because the resident would waste the water. CNA #5 was asked where the resident's water pitcher was at that time and she stated, Right there, as she pointed to the nightstand and confirmed it was out of the resident's reach. She stated the resident would try to reach up to get it and get some water and waste it. She confirmed there was no cup in the room for the resident to use and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed the CNAs were responsible for placing the cup in the room for the resident's use. CNA #5 confirmed that when the cup was in the room, the CNAs would pour the water in the cup for the resident. On 09/06/2024 at 2:55 PM, the Director of Nursing provided a document which was reviewed and indicated the facility did not have a policy regarding the accommodation of a resident's need for items to be within reach.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, the facility failed to revise the care plan of 1 (Resident #52) sampled resident after the quarterly assessment was completed. The findings include: Review of the quarterly Minimum Data Set (MDS) with the Assessment Reference Date of 7/07/2024 revealed Resident #52 score 5 on a Brief Interview for Mental Status, indicating severely impaired cognition. Resident #52 had a diagnosis of Schizophrenia and depression. Resident #52 was taking an antipsychotic and antidepressant. A Care Plan (revision date 05/21/2024) revealed Resident #52 used an antidepressant medication, but did not reference the use of an antipsychotic medication. A review of the Physician Order portion of Resident #53's electronic health record revealed an order for an antipsychotic intended to treat Schizophrenia, with a start date of 6/27/2024. On 9/06/2024 at 11:33 AM, the Director of Nursing confirmed the care plan did not address Resident #52 taking an antipsychotic medication. On 9/06/2024 at 11:33 AM, the Director of Nursing provided documentation that the facility did not have a resident care plan policy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, interviews, and record reviews the facility failed to ensure that 1 (Resident #35) of 2 sampled resident with an indwelling urinary catheter received proper catheter care. The findings include: According to the admission Minimum Data Set (MDS) with the Assessment Reference Date of 8/04/2024, Resident #35 had a Brief Interview for Mental Status score of 03, indicating severe cognitive impairment, and that Resident #35 had an indwelling catheter. A Care Plan (revision date 8/06/2024) revealed Resident #35 had a urinary catheter related to urinary retention, overactive bladder, and benign prostatic hyperplasia (BPH). On 09/03/24 at 02:00 PM, the Surveyor observed Resident #35 sitting in a wheelchair with catheter collection bag hooked to the back of wheelchair. The collection bag was not positioned below the level of the resident ' s bladder to facilitate the flow of urine. On 09/04/24 at 08:44 AM, the Surveyor observed Resident #35 sitting in a wheelchair in the common area. The Surveyor noted that catheter tubing was wrapped around the resident's right ankle with the tubing touching the floor. On 09/04/24 at 11:00 AM, the Surveyor observed Resident #35 sitting in a wheelchair with catheter tubing draped over the wheelchair lock. The Surveyor noted the tubing was almost full of urine due to the kinking of the tubing. On 09/04/24 at 11:53 AM, the Surveyor observed Resident #35 sitting in a wheelchair with catheter tubing draped over the wheelchair lock. The Surveyor noted the tubing was almost full of urine due to the kinking of the tubing. On 09/06/24 at 10:50 AM, the Assistant Director of Nursing stated that the facility did not have a policy on catheter care the facility follows the Lippincott Manual of Nursing.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, record review, and policy review, the facility failed to ensure the medication error rate was less than five percent (%). 31 opportunities of medication administration were observed and 2 of the 31 medications were not administered in accordance with physician's orders, resulting in a medication error rate of 6.45%. The findings are: On 09/05/2024 at 8:26 AM, Registered Nurse (RN) #3 was observed retrieving Resident #53's medication from the medication cart for the 8:00 AM medication pass. She retrieved a box of Famotidine tablets, 10 milligrams (mg) strength, removed two tablets from the box and placed them in a pill cup. Once she gathered the medication, she administered the medication to Resident #53. Resident #53's Order Summary dated 09/05/2024 was reviewed and indicated an order for Famotidine 20 mg tablets and give two by mouth one time a day for 40 mg daily. On 09/05/2024 at 4:24 PM, (RN) #3 was interviewed and asked to look at the box of Famotidine she used to administer medication from to Resident #53. She was asked what the strength of the medication was displayed on the box, and she stated, 10 mg. She was asked to look at Resident #53's medication orders in the electronic health record (EHR) and state what the strength of the medication on the order was and she stated, 20 mg. RN #3 confirmed the dose on the order was 40 mg, but she administered 20 mg to the resident. On 09/06/2024 at 8:29 AM, Licensed Practical Nurse (LPN) #4 was observed retrieving Resident #28's medication from the medication cart for the 8:00 AM med pass. She removed a bottle of Fluticasone 50 micrograms (mcg) nasal spray and placed the bottle on top of the med cart. Once she removed all the meds for Resident #28 from the medication cart, she took the meds to the resident's room and placed them on the bedside table. With gloved hands, she administered two sprays of Fluticasone nasal spray in each of the resident's nostrils. Resident #28's Order Summary dated 09/03/2024 was reviewed and indicated an order for Fluticasone Nasal Suspension, one spray in each nostril every morning and a bedtime. On 09/06/2024 at 9:21 AM, LPN #4 was interviewed, and she confirmed she administered two sprays of Fluticasone in each of Resident #28's nostrils during the 8 AM med pass. She was asked to look at Resident #28's medication orders in the EHR and state what the instructions for the Fluticasone nasal spray were. She confirmed the order was for one spray in each nostril. She was asked what should be done before administering meds to the resident and she stated, Double check the order and read it. LPN #4 stated the reason for double checking the order was to make sure the right dose was being given to the resident. On 09/06/2024 at 9:51 AM, a Specific Medication Administration Procedures policy, revised January 2018 and provided by the Assistant Director of Nursing on 09/06/2024, was reviewed and indicated before removing the medication package/container from the cart/drawer, the medication administration record (MAR) orders were to be checked. The policy indicated before removing the medication from the container, the label should be checked against the MAR.

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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, record review and interview, the facility failed to ensure foods in the pantry were dated to maintain freshness and prevent potential cross contamination. This failed practice had the potential to affect 52 residents who received meals from the kitchen according to the list provided by the Director of Nursing (DON) dated 09/03/2024 (Total Census 55). The findings are: 1. On 09/05/2024 at 9:06 AM, a shelf above the food processer next to the stove had bottles of spices. A container of onion powder with a build-up dried matter on the open, and a container of salt with the lid open were found on the shelf. The Dietary Manager (DM) was asked how spices are supposed to be stored. The DM indicated that the lids are supposed to be closed. 2. On 09/05/2024 at 9:14 AM, the following observations were made in the dry storage panty: a. One 20 liter clear dry storage container with a blue lid with a label indicating corn meal was observed to the left upon entry into the pantry. No date indicating when it was placed in the container, or a date of when it should be used by, was on the container. The DM was asked how much corn meal was left in the container and indicated about 15 quarts were left. b. One 1 gallon jug that had no markings on it or date of when opened. The DM indicated it was white vinegar, and indicated about 2 ounces were left in the jug. 3. On 09/05/2024 at 9:21 AM, the following observation was made in the walk-in cooler: a. One 48-ounce glass jar of grape jelly had been opened, with no open date. The DM was asked how much grape jelly was in the jar. The DM indicated about 3 ounces were left in the jar. 4. A Document titled Food and Nutrition Services was provided by the Director of Nursing (DON) on 09/03/2024 at 1:20 PM. The document did not address putting a date of when a food item it opened or proper closer of food items.

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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, interview, record review, the facility failed to ensure a glucometer was cleansed after being used to check a fingerstick blood sugar for 1 (Resident #2) of 1 sampled resident who was reviewed for glucometer checks. On 09/05/2024 at 4:36 PM, Licensed Practical Nurse (LPN #2) was observed gathering a glucometer machine and other items. She sanitized her hands, put on a clean pair of gloves, took the items to Resident #2's room and placed them on the bedside table. She informed the resident she was about to check the resident's blood sugar. She cleansed the ring finger of the resident's left hand, performed other steps and collected a blood sample from Resident #2's finger using the test strip in the glucometer machine. After the results were displayed on the glucometer machine, LPN #2 discarded the used items, placed hand sanitizer in her hands, rubbed her hands together and picked up the glucometer machine. She rubbed her hands over the front and back of the glucometer machine for less than five seconds and placed the glucometer machine in the top right drawer in the medication cart. On 09/05/2024 at 4:43 PM, LPN #2 was interviewed and asked what she did with the glucometer machine. She opened the medication cart, and the glucometer machine was observed in a basket in the top drawer. She was asked did she cleanse the machine and she stated, What I do is use [brand-name] sanitizer, and I rub my hands. Then I rub it on the glucometer [machine], and I put it back in the drawer. LPN #2 was asked if this was how she was instructed to cleanse the glucometer machine and she confirmed it was not. She stated no one [at the facility] instructed her on how the glucometer machine should be cleansed. On 09/05/2024, the Director of Nursing provided the manufacture's guidelines for the glucometer machine. The guidelines were reviewed, and a section titled Cleaning and Disinfecting Procedures for the Meter indicated in the disinfection instructions on page 43, the meter was to be disinfected between patient uses by wiping it with a [brand-name] towelette or EPA-registered disinfecting wipe in between tests. Page 44 of the guidelines indicated in step five if the [brand-name] towelette was used, it should remain wet for two minutes. For other wipes, the surface of the meter was to remain wet for the contact time listed on the other wipe's instructions.