STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045422	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lakes at Maumelle Health and Rehabilitation	103 Alexandria Drive Maumelle, AR 72113

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews, record review, and facility policy review, the facility failed to ensure residents were free from neglect for one (Resident #42) of three residents reviewed. The findings include: A review Resident #42's quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 06/26/2025, revealed the facility admitted Resident #42 on 09/22/2022. Resident #42 had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS also revealed, Resident #42 used a manual wheelchair for mobility. A review of Resident #42's Medical Diagnoses report revealed diagnoses that included a long-lasting open sore that developed due to poor circulation in the veins of left lower extremity, swelling, paralysis and weakness following a stroke which affected the left side, muscle wasting and atrophy, unsteadiness on feet, stage 3 chronic kidney disease, venous insufficiency, depression, anxiety, and high blood pressure. A review of Resident #42's Active Orders revealed active orders to assess the left lower extremity dressing for intactness every morning and at bedtime, assess for pain every shift related to venous ulcer lower extremity, elevate left leg during morning and night medication pass for one hour two times a day, and provide wound care as ordered. A review of Resident #42's Care Plan revealed the resident had a chronic venous hypertensive ulcer to the left leg. Resident #42's Care Plan interventions dated 09/28/2023, included to evaluate the wound, document the progression of wound healing and notify the physician as indicated. Resident #42's Care Plan, revised on 12/12/2024, indicated the resident had actual impairment to skin integrity of the left lower leg related to a venous wound. The resident's Care Plan interventions included treatments as ordered, monitor and document location, size, and treatment of skin injury. Interventions dated 07/10/2025, revealed compression dressing as ordered by doctor for drainage/edema control, change dressing and compression wrap every Wednesday and Friday and as needed, treatment per orders, observe dressing daily for cleanliness, drainage and compression, check toes daily for circulation, document abnormalities and report to MD [Medical Doctor]. A review of Resident #42's MAR/TAR (Medication Administration Record/Treatment Administration Record) from January 2025 through September 2025 revealed 14 of 33 missed scheduled wound care/dressing changes in the facility. A review of Resident #42's Wound Clinic Visit Reports revealed on 12/05/2024, the resident was (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the wound care clinic with a bacterial infection of a chronic venous ulcer on the left leg. Wound care was provided and dressing changes were ordered to be completed at the wound care clinic. The wound care clinic provider cared for Resident #42 from 12/05/2024 to 09/19/2025 (present). Wound care was provided in wound care clinic and varied from weekly, twice weekly and three times weekly. Weekly Discharge Instructions Details sent from wound clinic to facility via Resident #42's transportation revealed detailed instructions for the facility including wound care orders, appointments to make, appointments to attend, supplies to order and bring to the wound clinic and when to return to clinic for next wound care appointments. A review of Resident #42's 03/19/2025 Wound Care Clinic Visit notes revealed, The resident reported extreme left lower leg pain today. Patient's left lower leg wound has regressed due to poor drainage control as [pronoun] has not had a wrap change in nine days, since last seen in clinic A review of Resident #42's Wound Care Clinic Visit notes dated 01/31/2025, 02/07/2025, 02/11/2025, 02/24/2025, 03/12/2025, 03/24/2025, 07/07/2025, 07/11/2025, 07/21/2025, 08/18/2025, revealed the resident returned for follow up care with wet bandages, unchanged bandages, inconsistent rewraps, and no primary dressing. A review of Resident #42's Wound Care Clinic Visit notes dated 08/20/2025 indicated, [Resident #42's] wounds are extremely wet, and peri wound was macerated, and wound was nearly circumferential today. The Wound Care Clinic Visit notes dated 08/20/2025 also indicated, patient is extremely distraught today as [the resident] noticed a maggot in wound. On 09/16/2025 at 9:30 AM, during a phone interview, the wound care clinic doctor indicated the resident was seen in the office on 09/15/2025. They reported the wound clinic was currently providing wound care three times a week and the plan, at this point, was to continue providing wound care three times a week, which was not something the wound clinic generally does. The wound care clinic doctor stated it was necessary because the nursing home was not providing wound care. They reported the resident was clean and appropriate for appointments, but the resident was very distraught when we found the maggot and the condition of the wound. On 09/18/2025 at 3:30 PM, during an interview Social Services indicated that if a resident had wound care orders and the wound care was not provided it would absolutely be considered neglect. On 9/19/2025 at 8:55 AM, during an interview, Advance Practice Registered Nurse (APRN) stated she was aware of Resident #42, and the resident was alert and oriented. She reported the resident had a chronic wound to their left lower extremity. She reported the facility provided wound care in the past because the resident anticipated pain from debridement. The APRN reported that the resident went to the wound clinic three times a week for wound care now. On 09/19/2025 at 11:29 AM, during an interview, the DON indicated her role in wound care for the facility was to make sure wounds got healed. The DON indicated on 08/18/2025, a phone call was received which indicated Resident #42's wound care was not being provided. The DON reported she gave a verbal warning to Licensed Practical Nurse (LPN) #5, who was the treatment nurse, on 08/19/2025 after an investigation revealed wound care dates were missing. The DON indicated she would go with LPN #5 on Fridays to evaluate wound care. She reported on Friday, 09/12/2025 she discussed the treatments with LPN #5 in her office. On 09/19/2025 at 12:54 PM, during an interview, the Administrator reported he had not received any (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information nor complaints of wound care not being provided for a resident. He reported the facility did have a treatment nurse but if the treatment nurse did not provide wound care the floor nurses were able to complete that care. He indicated if a resident had wound care orders and the wound care was not done it would be considered neglect. He reported it was important for a resident to receive wound care as ordered so they will heal. On 09/19/2025 at 5:15 PM, during an interview, the DON verified that she first knew about Resident #42 not receiving wound care dressing changes on 08/18/2025. The DON reported she spoke with LPN #5 on 08/19/2025 and gave a verbal warning. The DON added LPN #5 did not disagree that the wound care was not completed. She reported on 09/09/2025 she in serviced LPN #5, gave a written warning to LPN #5 and instructed LPN #5 you will report to me once a week on all the treatments in the facility with pictures and measurements. The DON reported she met with LPN #5 on 09/12/2025 and discussed the treatments with LPN #5 in the DON's office. She reported LPN #5 was placed on medical leave 09/18/2025. The DON indicated it was undetermined if LPN #5 would continue employment when returning from medical leave. The DON indicated when a resident had ordered wound care and did not receive that wound care it can be seen as neglect. On 09/19/2025 the DON provided a Performance Plan for LPN #5 dated 09/09/2025. The plan was signed on 09/09/2025 by LPN #5, the DON and Administrator. A review of a facility document titled admission Documents included [State]Patient Rights section, dated 05/2017, which indicated the residents have the right to be adequately informed of their health, medical conditions, treatments, refuse medication or treatment and be notified of the consequences of refusals. Residents have the right to 8. Receive adequate and appropriate health care, protective and support services with recognized practice standards. A review of a facility policy titled Abuse Prevention dated 2001, revised 04/2021, indicated Residents have the right to be free from abuse, neglect. The policy interpretation indicated residents will be protected from abuse, neglect by facility staff and any other individual. A review of a facility titled Inservice Education Report dated 05/02/2025 stated g. neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, mental illness or the deterioration of a resident's physical or mental condition A review of a facility document titled Wound Care indicated the purpose of wound care is to promote healing of wounds. The wound care includes verify physician's orders, assemble the supplies that are needed, utilize personal protective equipment (PPE), wash hands thoroughly, clean wound, apply treatments as indicated, dress wound, and document findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure a Physician's Order for the administration of oxygen was received for one (Resident #50) of two residents reviewed for oxygen administration. The findings include: A review of Resident #50's admission Record from the Electronic Health Record (EHR) revealed the resident was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD) and congestive heart failure. A review of Resident #50's Physician's Orders from the resident's EHR revealed there was no order for the administration of oxygen. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date of 02/14/2025, revealed Resident #50 had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS also indicated that Resident #50 received oxygen therapy while a resident at the facility. A review of Resident #50's Care Plan Report, initiated on 02/07/2025, did not reveal a focus area of oxygen usage or interventions for oxygen usage. A review of Resident #50's electronic Medication Administration Record (eMAR)for February 2025, did not reveal an order for oxygen administration. A review of Resident #50's Progress Notes revealed the following: -On 02/08/2025 at 5:20 PM, the resident arrived to the facility at approximately 2:30 PM, using oxygen by way of a nasal cannula at 4 liters. -On 02/13/2025 at 5:40 AM, oxygen was in use by way of nasal cannula with no shortness of breath. -On 02/19/2025 at 5:39 PM, pulse oximetry 96% at 5:19 AM, and oxygen via nasal cannula was in use. -On 02/22/2025 at 11:37AM, oxygen saturation at 96% on 4 liters of oxygen per minute by way of nasal cannula. During an interview with the Director of Nursing (DON) on 09/19/2025 at 5:49 PM, she stated the nurses knew how much oxygen to administer to a resident by [looking at] the Medication Administration Record (MAR). The DON also stated the resident should have an order [from the medical provider] for oxygen to be administered, unless it was a situation where the resident was short of breath, but the nurses should call the doctor [for an order for this]. A review of an Oxygen Administration policy, revised October 2010, revealed the purpose for the policy was to provide guidance for safe oxygen administration and that in preparation for oxygen administration, the Physician's Order should be verified.