STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045187	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Green House Cottages of Wentworth Place	26 Warnock Springs Road Magnolia, AR 71753

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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, record review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed for two (Resident #11, Resident #66) of three residents reviewed for MDS accuracy. Specifically, the facility failed to ensure information regarding Resident #66's use of tobacco was accurately completed on the MDS and Residents #11's Special Treatments, Procedures, and Programs were accurately completed in the MDS. The findings include:Resident #66Review of Resident #66's Medical Diagnosis Report revealed, Resident #66 had diagnoses which included Chronic Obstructive Pulmonary Disease, Pulmonary Fibrosis, Asthma, Dementia, Cerebral Ischemic Attack, Vitamin D deficiency, Heart Failure, Respiratory Failure.Review of Resident #66's Care Plan dated 02/16/2026 revealed, Resident #66 smoked with smoking safety care planned.Review of Resident #66's admission MDS with an Assessment Reference Date (ARD) of 08/13/2024 identified Resident #66 as a current tobacco user. Review of Resident #66's annual MDS with an ARD of 08/11/2025 identified Resident #66 to be a non-current tobacco user. Review of Resident #66's quarterly Smoking Safety Screens dated 02/09/2026, 11/10/2025, 08/11/2025, and 05/12/2025 all indicated Resident #66 smoked 5 - 10 cigarettes a day.During an observation on 03/11/2026 at 1:11 PM, Certified Nursing Assistant (CNA) #3 was observed monitoring the residents' smoke break. CNA # 3 stated Resident #66 smoked but was at therapy and would smoke following the therapy session. During an observation on 03/11/2026 at 2:07 PM, Restorative CNA # 4 was observed monitoring Resident #66 during the smoke break. Restorative CNA # 4 stated Resident #66 attended smoke breaks regularly.During an interview on 03/12/2026 at 8:57 AM, MDS Coordinator #1 stated the facility used the Resident Assessment Instrument (RAI) manual to instruct and guide them in completing the MDS. MDS Coordinator #1 stated Resident #66's annual MDS dated [DATE] did not identify Resident #66 as a current tobacco user. MDS Coordinator #1 stated this was a coding error because Resident #66 smoked and used tobacco. MDS Coordinator #1 reviewed Resident #66 admission/entry MDS dated [DATE], and stated Resident #66 was identified to use tobacco. MDS Coordinator #1 stated Resident #66 had a period when they tried nicotine patches. MDS Coordinator #2 then stated Resident #66 had quit smoking for a period of one week from 04/10/2019 - 04/17/2019 but decided the patches did not work. MDS Coordinator #1 stated Resident #66 had smoked since that date in 2019. MDS Coordinator #1 stated it was important to ensure the residents' MDS data accurately identified what the patient condition was at the time of the assessment. It was important to ensure all information reported was accurate because the MDS data was sent to CMS. During a follow-up interview on 03/12/2026 at 9:25 AM, MDS Coordinator #2 stated she had corrected Resident #66's MDS after being alerted to the discrepancy by surveyors, and it had been accepted by CMS.Review of a Resident Assessment Instrument (RAI) version 3.0 Manual, provided by MDS Coordinator # 2 on 03/12/2026 @ 9:25 AM, revealed, Current Tobacco Use code 0 indicated no; code 1 indicated yes. Coding instructions are listed as: Code 0, no: if there are no indications that the resident used any form of tobacco. Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period. Resident #11Review of Resident # 11 quarterly MDS with an Assessment Reference Date (ARD) of 02/24/2026 revealed Resident #11 had a (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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Brief Interview for Mental Status (BIMS) score 03, which indicated the resident had severe cognitive impairment. The MDS revealed Resident #11 had diagnoses which included hemiplegia [severe or complete loss of motor function on one side of the body] and non -Alzheimer's dementia [brain disorder causing cognitive, behavioral or motor decline]. The MDS also revealed Resident #11 was on palliative care and that Resident #11 required tracheostomy care.On 03/09/2026 at 1:22 PM, this surveyor observed Resident # 11 sitting in a wheelchair in the day area. Resident # 11's neck revealed the resident did not have a tracheostomy or a scar that indicated the resident had a tracheostomy in the past.During an interview on 03/12/2026 at 9:00 AM, MDS Coordinator #1 confirmed, Resident # 11 did not have a tracheostomy and had never had a tracheostomy. MDS Coordinator #1 confirmed the MDS dated [DATE] identified Resident #11 as having a tracheostomy and required tracheostomy care. MDS Coordinator #1 stated, this is a coding error. MDS Coordinator #1 stated it was important to ensure the MDS data was accurate because all information reported on the MDS goes to Centers for Medicare and Medicaid Services (CMS) and the information was supposed to accurately identify what the patient condition was at the time of the assessment.During an interview on 03/12/2026 at 9:25 AM, MDS Coordinator #2 stated a correction had been made on Resident #11's quarterly MDS dated [DATE] after being alerted to the discrepancy by surveyors and it had been submitted to CMS. MDS Coordinator #2 indicated the changes were accepted by CMS. During an interview on 03/12/2026 at 1:25 PM, the Director of Nursing (DON) stated that the DON was not involved in the development of the MDS, other than at admission. The DON stated the MDS Coordinators were responsible for reviewing the MDS prior to submission to CMS. The DON stated it was important for the MDS Coordinators to correctly answer the questions to the best of their abilities. The DON stated she was not aware of any discrepancies in any MDS' prior to being notified by the surveyor of the discrepancies related to two residents MDS'. Review of a RAI version 3.0 Manual, provided by MDS Coordinator # 2 revealed, Tracheostomy care-code cleaning of the tracheostomy in this item.