STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045220	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayetteville Health and Rehabilitation Center	3100 Old Missouri Rd Fayetteville, AR 72703

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure family was notified of a change in condition for one (Resident #132) of two sampled residents. The findings include: A review of Resident #132's quarterly Minimum Data Set (MDS) with an assessment reference date of [DATE], revealed the resident had diagnoses which included Alzheimer's and Non-Alzheimer's dementia, heart disease, and type II diabetes mellitus. Resident #132's MDS also revealed a brief interview for mental status score of 06, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #132 was under Hospice care. A review of Resident #132's Care Plan revealed the resident was receiving services from Hospice ([DATE]). Resident #132's Hospice Care Plan records indicated Hospice and facility staff would assist family member in having an active role in care planning and the family member would be kept informed of Resident #132's care and changes in disease progression. A review of Resident #132's Progress Notes, dated [DATE] at 4:55 AM, revealed Licensed Practical Nurse (LPN) #1 documented that a change in condition was noted at 6:00 PM on [DATE]. According to the Progress Note, Resident #132 was described as significantly less responsive and lethargic with increased respirations. Resident #132's Progress Note revealed that Hospice was notified at that time, and again at 3:30 AM, and medication recommendations were made. A review of Resident #132's Hospice Contract on [DATE] at 9:22 AM, revealed the nursing home should inform the provider of any significant change in condition of the Hospice patient, and that both parties should comply with rules and regulations. During a telephone interview on [DATE] at 3:38 PM, a family member of Resident #132 reported that neither the facility or Hospice company called any family member when Resident #132 took a sudden decline and died 12 hours later in the facility on [DATE]. Resident #132's family member refused to answer any additional questions. During an interview with the Administrator and Assistant Director of Nursing (ADON) on [DATE] at 1:31 PM, the ADON stated, Hospice and the facility are responsible for notifying the family when there is a change of condition. The Administrator agreed the facility should have made sure the family was contacted regarding Resident #132's change in condition. The ADON stated that in the resident's Progress Notes on [DATE] at 8:38 AM, LPN #3 charted that at 6:48 AM, Hospice was notified that Resident #132 was without respirations and the Hospice Nurse told them they could not come out due (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the weather on the roads, but that they would contact the family. The ADON then stated the Hospice Nurse called and told Director of Nursing she forgot to call the family after the 6:48 AM phone conversation. This surveyor pointed out that on [DATE] at 4:55 AM, LPN #1 documented at 6:00 PM on [DATE], there was a significant change in condition and Resident #132 was significantly less responsive and lethargic. When asked who was responsible for notifying the family that Resident #132 had a significant decline, the ADON reiterated that both Hospice and the facility were responsible for making sure the family was informed. The Administrator agreed with this statement. On [DATE] at 4:12 PM, this surveyor received a copy of a Progress Note from a Hospice Nurse stating LPN #1 called and Resident #132 was getting pain medication every hour and anti-anxiety medication as ordered. The Progress Note also revealed the resident's respiration rate was 30 breaths per minute and labored [the normal respiratory rate for adults at rest is between 12 and 20 breaths per minute], pulse was in the 30s [a normal resting heart rate for adults ranges from 60 to 100 beats per minute], pulse oxygen (SpO2) was in the 70s [SpO2, or peripheral oxygen saturation, measures the percentage of oxygen in your blood, with a normal range for healthy individuals being 95% to 100%]. LPN #1 was instructed to give a one-time dose of pain medication to see if that was more effective and call back with further concerns. During an interview on [DATE] at 9:02 AM, LPN #1 stated she worked the 10:00 PM-6:00 AM shift and could not recall any Hospice in-services being done at the facility. LPN #1 said, I was trained to call Hospice and follow instructions when there is a change in condition. LPN #1 revealed the Hospice company might tell facility staff to give medication or take vitals. LPN #1 said, It is my understanding Hospice should call the family when there is a change in condition, and said a change in condition was any type of change in baseline from mental status, vitals, pulse, increase or decrease in respirations or temperature, and/or reduced output. LPN #1 confirmed nobody called Resident #132's family during her shift when the resident declined. LPN #1 then stated she could not remember having a conversation with the charge nurse about Resident #132, but LPN #1 always communicated with the charge nurse and would have called the resident's family if told to. LPN #1 said she was under the impression Hospice would contact Resident #132's family. During an interview on [DATE] at 12:00 PM, LPN #2 reported previously caring for Hospice residents, and that it was their understanding staff were to call the Hospice company with a change in condition. LPN #2 said, I do not know what the regulation is, so when I call Hospice, I always just ask them if they are calling the family, or do they want me to call the family. LPN #2 said she could not remember if she took care of Resident #132. During an interview on [DATE] at 1:29 PM, LPN #3 stated she was not familiar with Resident #132 and did not remember being involved with Resident #132's care. LPN #3 revealed the facility called Hospice when there was a change in condition, and we will contact the family if Hospice asks us to call the family. LPN #3 revealed she had not received any Hospice in-servicing. During an interview on [DATE] at 1:30 PM, the Administrator said, I expect the family to be notified. Going forward, the expectation is that staff will have a conversation with Hospice about who is notifying the family and will make sure family is notified. I can understand how this happened because Hospice normally does contact the family, so I can see how staff would expect them to contact the family. The Administrator revealed Hospice provided in-services to the facility and he believed they had done an in-service within the year but was unable to find documentation. The Administrator said, I reached out to Hospice, but they have not provided in-service documentation.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, interview, and facility policy review, the facility failed to ensure interventions of the comprehensive care plan were implemented to prevent possible skin tears to one (Resident #22) of two residents sampled. The findings include: During an observation on 09/22/2025 at 2:07 PM, this surveyor observed Resident #22 ambulating in the hallway of the [gender specific] secure neighborhood. Resident #22 was observed wearing a short sleeve top and had a partially healed skin tear to the outer aspect of their right elbow that was actively bleeding, as well as a bandage to the area below the thumb of their right hand. The resident was not wearing protective sleeves of any type at this time. During subsequent observations on 09/23/2025 at 8:56 AM and 1:43 PM, and again on 09/24/2025 at 11:50 AM, this surveyor observed Resident #22 wearing clothing that did not have long sleeves, nor was the resident wearing any type of protective sleeve. A review of Resident #22's Face Sheet indicated the facility admitted the resident on 09/18/2023 with diagnoses, which included dementia, chronic obstructive pulmonary disease, and cerebrovascular disease. A review of Resident #22's significant change of condition Minimum Data Set (MDS) with an assessment reference date of 08/13/2025, revealed a staff assessment of mental status score of 03, which indicated Resident #22 was severely cognitively impaired and never/rarely made decisions. Resident #22's MDS indicated the resident ambulated without assistance, required moderate to maximal assistance with hygiene and maximal assistance with dressing, had experienced two or more falls with injury, and took an antiplatelet medication [medication used to prevent or treat blood clots, which prevents platelets from sticking together]. A review of Resident #22's Care Plan, with an edited date of 04/15/2025 indicated, . [Resident #22] is at risk for bruises and skin tears related to fragile skin. Staff educated to ensure resident wears long sleeves or (brand name for protective sleeves) [protective sleeves designed to shield fragile skin, particularly in the elderly, from friction, shearing, and subsequent tears and abrasions]. During an interview on 09/23/2025 at 3:16 PM, Certified Nursing Assistant (CNA) #4 was asked how staff knew what care each resident required and verbalized that staff used the Care Plan to guide each resident's care and provide what they required. CNA #4 went on to relate that following the Care Plan was part of orientation when employees were hired. During an interview on 09/24/2025 at 12:15 PM, the Director of Nursing indicated she expected the staff to follow each resident's plan of care. A review of the facility policy titled, Person Centered Care Plans with an effective date of 08/15/2018 indicated, This will provide the CNA with individualized information needed to meet the resident care needs.

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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, record review, interview, and facility policy review, the facility failed to ensure staff followed appropriate Enhanced Barrier Precautions (EBP) when providing care for one (Resident #14) of one sampled resident. The findings include: During an observation on 09/24/2025 at 9:50 AM, this surveyor observed an EBP sign outside Resident #14's door and the Treatment Nurse preparing to provide wound care. She put on gloves and walked into Resident #14's room, without putting on a gown. During an observation on 09/24/2025 at 9:52 AM, this surveyor observed the Treatment Nurse remove a bandage from Resident #14's right outer heel. The bandage was dated 09/22/2025 and had a yellowish drainage on it. She cleaned the resident's wound with wound cleanser and patted it dry. Resident #14 had a low bed and the Treatment Nurse was kneeled on the side of the bed. When she leaned over to provide treatment to Resident #14's wound, her shirt and pants touched the resident's bed. A review of Resident #14's Face Sheet indicated the facility admitted the resident on 03/11/2024, with diagnoses, which included an unspecified open wound to the right foot. A review of Resident #14's quarterly minimum data set with an assessment reference date of 07/02/2025, revealed a brief interview of mental status score of 01, which indicated the resident had severe cognitive impairment. A review of Resident #14's Physician Orders documented, Enhanced Barrier Precautions related to wound, start date 08/02/2024. During an interview on 09/24/2025 at 10:04 AM, the Treatment Nurse indicated that she just started Monday, and today [09/24/2025] was her second time providing wound care treatment for Resident #14. She indicated Resident #14 was on EBP, and a gown and gloves should be worn for direct resident care. The Treatment Nurse confirmed she should have worn a gown when she provided wound care for Resident #14 but forgot to wear a gown because she thought her clothing would not come in contact with the resident. During an interview on 09/24/2025 at 4:05 PM, the Medical Director indicated that Resident #14 had a wound, therefore a gown and gloves should be worn when providing wound care. During an interview on 09/24/2025 at 4:20 PM, the Director of Nursing verified Resident #14 was on EBP and a gown and gloves should be worn during wound care. A review of a form titled, One on one in-service education and training report, dated 09/24/2025, was signed by the Treatment Nurse. It documented, Follow EBP policy when providing direct patient care to residents with any portal of entry for possible infection, i.e., wound, PEG [Percutaneous Endoscopic Gastrostomy], ostomy, catheter, and IV. A review of a policy titled, Enhanced Barrier Precautions, revealed, EBP requires donning of gown and gloves during high contact resident /guest care activities that provide opportunities for transfer of MDRO's [Multidrug-Resistant Organisms] to staff hands and clothing.