STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045241	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bailey Creek Health and Rehab	1621 East 42nd St Texarkana, AR 71854

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, it was determined that the facility failed to update the Care Plans for two (Resident #54 and Resident #99) of four residents reviewed.The findings include:Resident #54A review of Resident #54's admission Record revealed the facility initially admitted the resident on 06/04/2020, with diagnoses which included unsteadiness on feet, muscle weakness, malnutrition, muscle wasting and atrophy, and a fall from a non-moving wheelchair.A review of Resident #54's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/02/2026, revealed a Brief Interview of Mental Status (BIMS) score of 04, which indicated the resident had severe cognitive impairment. Resident #54's MDS also revealed additional diagnoses, which included stroke, dementia, aphasia, bipolar disorder, and intellectual disabilities.A review of Resident #54's Progress Note entry on 03/13/2026 at 11:14 AM, revealed an unnamed Certified Nursing Assistant (CNA) delivered a breakfast tray to Resident #54. The unnamed CNA found Resident #54 on the floor, beside their bed, with blood coming from the bridge of their nose. The same Progress Note entry revealed Resident #54 was sent to the hospital for evaluation.A review of Resident #54's Progress Note entry on 03/13/2026 at 10:04 PM, described an observation of Resident #54 in bed with stitches to nose, discoloration to left eye, swelling to nose has decreased from earlier in the shift. A review of Resident #54's Progress Note entry (post-fall) on 03/16/2026, by the Director of Nursing (DON), revealed baffles [air-cushioned barrier device] to winged mattress and hand rail on left side of the bed. A review of Resident #54's Incident and Accident (I&A) report from 03/13/2026, revealed Resident has had a winged mattress in place and now changed to an enhanced height overlay with higher baffles X3 sides. This overlay further assists with defining the perimeter of the bed to minimize falls. Previously had one transfer/assist bar and now has two - to promote independence.A review of Resident #54's Care Plan revealed the resident was a high risk for falls, related to weakness, needed one staff member for transfers, and had previous falls that occurred on 04/30/2023 and 05/24/2024. Resident #54's Care Plan revealed interventions, prior to Resident #54's fall on 03/13/2026, which included:- Dropped the back of wheelchair to help prevent Resident #54 from leaning forward and falling. Date initiated 12/03/2024.- Begin restorative program. Date initiated 03/31/2025.- Monitor/document/report as needed for 72 hours to physician for signs and symptoms: pain, bruises, change in mental status, new onset confusion, sleepiness, inability to maintain posture, agitation. Date initiated 09/17/2020. Revision on 06/08/2021.- Place transfer bars on bed to prevent resident's doll from falling out of bed. Date initiated 10/02/2025. Revision on 04/07/2026.- Replaced wheelchair with a new one. Tilted wheelchair back. Add antiroll back to wheelchair by 08/30/2024. Date initiated 08/26/2024.- Skid proof socks applied to aide in fall prevention, post fall 04/30/2023. Date initiated 05/01/2023.- Wheelchair armrest pouch. Post fall 05/24/2024. Date initiated 05/31/2024.- X-ray of left hip obtained. Date initiated 05/24/2024.Resident #54's Care Plan revealed additional interventions were listed for Resident #54 under high risk for falls related to weakness. Date initiated 06/04/2020 and revised on 06/08/2021:- Anticipate and meet Resident #54's needs. Date initiated 06/04/2020. Revision on 06/08/2021.- Ensure Resident #54's call light was within (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reach and encourage to use it for assistance as needed. Resident #54 needs prompt response to all requests for assistance. Date initiated 06/04/2020. Revised on 06/08/2021.- [Name Brand] winged mattress on bed. Date initiated 06/04/2020.- Encourage Resident #54 to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Date initiated 06/04/2020. Revised on 06/08/2021.- Follow facility fall protocol. Date initiated 06/04/2020. Revised on 06/08/2021.- Physical Therapy evaluate and treat as ordered or as needed. Date initiated 06/08/2020. Revised on 06/08/2021.Further review of Resident #54's Care Plan did not reveal clear interventions that were implemented after Resident #54's fall on 03/13/2026, as evidenced by actual fall 03/13/2026 with major injury and no related interventions for a date on or immediately after 03/13/2026.During a concurrent observation of Resident #54's room and interview on 04/09/2026 at 9:31 AM, CNA #1 indicated that Resident #54's bed had baffles at the foot of the bed and on both sides of the bed, as well as bilateral assist bars. In addition, CNA #1 indicated the baffles were not on Resident #54's bed prior to the fall but were placed on the bed after Resident #54 fell on [DATE].During an interview on 04/09/2026 at 10:48 AM, the MDS Coordinator revealed they were responsible for ensuring Care Plans had been completed. The MDS Coordinator indicated he would learn of a residents fall during morning meetings, which were department leader meetings that occurred on weekday mornings. The MDS Coordinator also indicated that Care Plans were to be updated after a resident had a fall, with the new interventions implemented after the date of the fall. In addition, the MDS Coordinator indicated if a Care Plan was not updated, as appropriate, interventions might not get done.During an interview on 04/09/2026 at 1:22 PM, the DON indicated the MDS Coordinator was primarily responsible for updating Care Plans, and Care Plans needed to be updated after a fall. The DON revealed that side rails, assist bars, and baffles needed to be included in a Care Plan if in use, and the interventions were expected to be included in the Care Plan within 24-48 hours after initiation. Additionally, the DON stated Care Plans would drive the closet Care Plans, which were the reference for the CNAs to use. The DON indicated that prior to Resident #54's fall on 03/13/2026, the resident had a winged mattress that was changed to a baffle overlay after the fall. In addition, Resident #54 had one assist rail, but it was only on the side where Resident #54 got up - but another one was placed on the left side, on the side where they fell the morning of 03/13/2026. The DON was not able to locate the interventions implemented after the fall on 03/13/2026, in Resident #54's Care Plan. The DON revealed a negative result of a Care Plan not being updated appropriately was that the nurse or CNA would not have the knowledge of what interventions were in place.During an interview on 04/09/2026 at 1:55 PM, the Administrator indicated the MDS Coordinator was the one responsible for updating Care Plans, and the purpose of updating Care Plans was so the nursing staff would know what care-related interventions needed to be done for residents. The Administrator indicated that it was expected for an intervention to be reflected on a Care Plan within 48-72 hours after the intervention(s) had been implemented.A review of the Fall Prevention Binder, with a date of 2022, revealed a specific, person-centered plan of care is a large component of successfully mitigating fall risk, and ensure fall risk is identified with appropriate interventions on the Closet Care Plans for communication to CNAs and other front-line staff.Resident #99A review of Resident #99's admission MDS, revealed Resident #99's functional abilities as dependent, or that resident required the assistance of two or more helpers to complete the activity of transferring from their chair, bed-to-chair, and walking 10 feet or more, including help with turns. A review of Resident #99's Nursing Morse Fall Scale and Care Plan, dated 06/24/2025, identified the resident to be at high-risk for falls. A review of Resident #99's I&A Report dated 06/26/2025 at 7:30 PM, revealed the resident sustained an unwitnessed fall. The report indicated an unnamed CNA found Resident #99 sitting on their bottom on the floor. The report revealed Resident #99 had stated they were trying to walk and slipped. The report revealed the resident was assessed and the nurse noted a bump on Resident #99's head. The I&A Report revealed the resident did state the bump hurt, along with their left shoulder. The on-call provider was notified, and the resident was sent to the hospital for evaluation. Resident #99 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	returned from the hospital with no new orders, and no fractures reported. The report indicated the resident's room was free of clutter and a new intervention for non-skid socks was implemented. A review of Resident #99's Nursing Progress Note dated 07/06/2025 at 7:42 PM, in reference to the residents unwitnessed fall on 06/26/2025, revealed the Long-Term Intervention was for the resident to always wear nonskid socks. Resident #99's Progress Note further revealed, added to the care plan: Yes.A review of Resident #99 Care Plan revealed the resident had actual fall and was at high risk for falls related to impaired mobility. Care Plan interventions included anti roll backs on the resident's wheelchair but did not include that the resident should wear non-skid socks.A review of Resident #99's MDS with an ARD of 07/10/2025, revealed Resident #99 had sustained falls since admission/entry; one fall with no injury and two falls with injury. A review of Resident #99's printed Kardex, provided by the Administrator, dated 04/08/2026, instructed staff to follow the facility fall protocol under the Safety section.During an interview on 04/08/2026 at 2:45 PM, the DON revealed that following a resident fall an intervention should be put into place. The DON then said those new interventions would go on to the Care Plan as soon as the MDS Coordinator knew about the new intervention. The DON stated the nurses would tell the staff about a new intervention and it was verbally passed along [to other staff]. The fall would then go on the 24-hour report. If there was a head injury, the nurses would start neuro[logical] checks, and we cannot close the follow-up investigation out until the neuro checks are completed, then a fall risk assessment is completed. Non-skid socks would be added to the closet Care Plan and the MDS Coordinator would then add it to the Care Plan with any new orders, a quarterly or with an MDS assessment. The DON confirmed it was important to ensure residents' care plans were up-to-date, and accurate, because they provided a picture for every one of the care needs of the resident. During an interview on 04/08/2026 at 3:00 PM, the Administrator confirmed Resident #99 sustained a fall on 06/26/2025, where a CNA found the resident sitting on their bottom on the floor, leaned against the wall. The Administrator stated the resident had reported they were trying to walk and slipped. The Administrator confirmed the intervention for non-skid socks was implemented. The Administrator then reviewed Resident #99's Care Plan and stated the non-skid socks intervention was not listed. The Administrator then verified that is was also not on the Kardex, that the CNAs used for resident care. The Administrator provided a copy of Resident #99's Kardex to this surveyor and stated the Kardex was where the CNAs documented. The Administrator revealed Resident #99's non-skid socks should have been added to their Care Plan, or at least their closet Care Plan. The Administrator stated they did not have a copy of Resident #99's closet Care Plan to know if it was there or not. The Administrator stated they used the Resident Assessment Instrument (RAI) manual as guidance in completing resident Care Plans. The Administrator revealed Resident #99 had sustained three falls since living at the facility, one prior to the fall on 06/26/2025, the actual fall on 06/26/2025, and one following [on 07/09/2025]. The Administrator stated the resident was wearing the non-skid socks when the fall on 07/09/2025 occurred.During an interview on 04/09/2026 at 10:48 AM, the MDS Coordinator stated Resident #99 sustained an unwitnessed fall on 06/26/2025, where a CNA found the resident sitting on their bottom near the door of their room. The MDS Coordinator stated that the use of non-skid socks was a new intervention that was implemented following that fall. The MDS Coordinator looked in their computer and stated the non-skid socks had not been added to Resident #99's Care Plan and should have been added no later than 07/06/2025. The MDS Coordinator stated the CNAs, nurses, and anyone who was providing care for the resident used the Care Plan and the closet Care Plan [as guidance in care of the resident]. The MDS Coordinator confirmed if an intervention was not added to the Care Plan, the staff could not utilize the new intervention. The MDS Coordinator stated the staff used the Fall Prevention Binder located at each nurses' station, then provided a copy of the Fall Prevention Binder to this surveyor. A review of the Fall Prevention Binder, provided by the MDS Coordinator indicated, Post Fall Assessment: A comprehensive post fall management plan should include, but is not limited to: Investigate the cause of the fall: What was the resident doing before he/she fell. Revise plan of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care and/or facility practices to reduce likelihood of another fall. A review of a policy titled, Falls and Fall Risk, Managing, contained in the Fall Prevention Binder revealed, based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall Risk Factors included: footwear that is unsafe or absent.A review of the facility Fall Protocol policy provided by the Administrator, indicated under Treatment/Management1. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. 2. If underlying causes cannot be readily indemnified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling.

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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 record review, observation, interview, facility document review, and facility policy review, it was determined that the facility failed to initiate and follow Enhanced Barrier Precautions (EBP) for one (Resident #75) of three residents observed for infection control. The finding include: A review of Resident #75's admission Record indicated the facility admitted the resident on 04/23/2025, with diagnosis which included chronic diastolic congestive heart failure, protein calorie malnutrition, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominate side, gastrostomy complications, dysphagia, and gastrostomy status with an onset date of 12/22/2022. A review of Resident #75's quarterly Minimum Data Set, with an Assessment Reference Date of 03/17/2026 revealed a Brief Interview for Mental Status score of 03, which indicated the resident had severely impaired cognition. Resident #75's MDS revealed the resident was dependent on staff in all areas of Activities of Daily Living, had an indwelling catheter and a feeding tube in place, and had a pressure reducing device for their chair and bed. A review of Residents #75's Order Summary Report revealed the resident was to receive nothing by mouth. Resident #75's Order Summary Report revealed additional orders which included: clean Gastrostomy Tube (G-tube) site every shift, enteral feed order for every shift, and the resident was on EBP related to their [name brand indwelling] catheter and G-tube. A review of Resident #75 Care Plan, with a revision date of 07/03/2025, revealed the resident required EBP, related to enteral feedings. Resident #75's Care Plan specified interventions for staff such as alcohol based handrub or wash with soap and water if visibly soiled before and after leaving the room; do not wear the same gown and gloves for the care of more than one resident; and wear gloves and gowns for high-contact resident care activities. During an observation of the morning medication pass on 04/08/2026 8:55 AM, this surveyor observed Licensed Vocational Nurse (LVN) #2 prepare medication for Resident #75, to be given via G-tube, at the medication cart. The following medications were administered: a generic medication used to lower blood pressure, a urinary system supplement, a generic stool softener, a brand name medication used to treat fluid retention, a generic medication used to prevent blood clots, a generic anti-depressant, a multi-vitamin with minerals, and a digestive supplement. LVN #2 crushed each individual pill and placed them into individual cups to be mixed with water. LVN #2 initially conducted proper handwashing and the application of gloves. LVN #2 then mixed small amounts of water to each individual cup to help with dissolving medication for ease in administration. LVN #2 removed their gloves, sanitized their hands, then applied new gloves, prior to disconnecting Resident #75's feeding tubing from their G-tube. LVN #2 failed to don a gown, which was ordered as part of Personal Protective Equipment (PPE), prior to disconnecting the resident's feeding tube from their G-tube and considered a high-contact resident care activity. LVN #2's sweater then touched Resident #75's bed as she leaned over to disconnect the resident's feeding tubing and applied a syringe to Resident #75's G-tube for a water flush. LVN #2's sweater again touched the resident's bed as their medication was added to a syringe for medication administration. After completing Resident #75's G-tube medication administration, LVN #2 removed their soiled gloves, washed their hands, and applied new gloves to then instill eye drops into the residents' eyes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/08/2026 at 9:38 AM, LVN #2 confirmed that Resident #75 was on EBP. LVN #2 read the sign that was posted outside the resident's door, which indicated Enhanced Barrier Precautions. LVN #2 then informed this surveyor the required supplies to be included during direct care for Resident #75 were gloves and a gown. LVN #2 confirmed they did not use a gown when donning PPE but reported that it should have been worn during Resident #75's medication administration through their G-tube. During interview on 04/09/2026 at 12:56 PM, the Infection Preventionist (IP) revealed EBP should be used on residents with catheters, intravenous catheters (IVs), feeding tubes, and any type of indwelling devices, to decrease the spread of infections. The IP explained EBP should include wearing a barrier gown and gloves, if staff were performing direct patient care like bathing, dressing, incontinent care, or giving medication through a G-tube. The IP then added training with staff related to EBP and infection control included demonstration with returned demonstration by staff on donning and doffing PPE. During an interview on 04/09/2026 at 1:21 PM, the Director of Nursing (DON) explained the indication and purpose for EBP, was for it to be used with residents with wounds, catheters, IVs, and/or any draining fluids that may be source of infection, and its purpose was to decrease the spread of infection. The DON reported staff were in-serviced on EBP by using demonstration and return demonstration on donning and doffing PPE used for EBP and signs that were posted on appropriate resident's doors. The DON further included gown, and gloves should be worn during administration of medication through a G-tube. A review of a facility policy titled, Enhanced Barrier Precautions dated August 2022, revealed enhanced barrier precautions are utilized to prevent the spread of multi-drug-resistant organisms (MDROs). EBP employed targeted gown and glove use during high contact resident care activities. Examples of high-contact resident care activities, which required the use of gown and gloves for EBP, included: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) and wound care, any skin opening requiring a dressing, but this does not include protective coverings such as transparent covering, band aids, or steri-strips used to keep skin flaps in place. A review of facility provided policy titled, Enteral Feedings-Safety Precautions, dated November 2018, revealed all personnel responsible for preparing, storing and administering enteral nutrition formulas will be trained, qualified and competent in his or her responsibilities. The facility will remain current in and follow accepted best practices in enteral nutrition. A review of an In-service Education Report dated 02/08/2026, revealed topics of infection control: comprises evidence-based policies, procedures, and practices, designed to prevent the spread of infections in health care settings, protecting patients and staff.