

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Conway Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2603 Dave Ward Drive Conway, AR 72034	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility failed to adequately monitor one (Resident #1) of one resident after an unwitnessed fall, which had resulted in a periprosthetic fracture of the right hip and a ping-pong ball sized knot to the left lateral scalp. Specifically, the nursing staff did not perform the ninth (7:15 AM) neuro check following an unwitnessed fall and did not alert the resident's provider when the resident later reported the possibility of striking their head during the fall. The findings include: Review of an admission Record revealed that the facility admitted Resident #1 on 05/28/2026 with diagnoses which included cognitive communication deficit, orthostatic hypotension, and presence of unspecified artificial hip joint. Review of Resident #1's Physician Orders (PO) revealed an order, dated 06/16/2026, for a blood thinner to be administered twice a day. The PO also revealed an order with a revision date of 06/22/2026 to transfer Resident #1 to [name of hospital] emergency room for evaluation due to an unwitnessed fall and decreased (Range of Motion) ROM in the right lower extremity. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/30/2026, revealed Resident #1 had a Brief Interview for Mental score of 12, which indicated Resident #1 had moderate cognitive impairment. The admission MDS also revealed that Resident #1 was dependent on toileting hygiene and required substantial/maximal assistance with chair/bed-to-chair transfers and had a fracture related to a fall in the six (6) months prior to an admission/entry, reentry or prior assessment. Review of Resident #1's Care Plan with a review date of 06/18/2026, revealed Resident #1 required substantial/maximal assistance for transfers, which the helper did more than half of the effort. Review of a Facility Incident Report for Resident #1 dated 06/21/2026 at 11:30 PM revealed the following: -Incident description: This nurse heard resident hollering out help! This nurse and two CNAs (Certified Nursing Assistants) entered resident's room. Resident was sitting by bathroom door on bottom with feet in front of [them] with no socks on. W/C (wheelchair) next to resident in locked position. This nurse assessed resident, small skin tear to right forearm near elbow. Resident complained of pain to right hip. Scratch noted to area. ROM WNL (within normal limits) for this resident. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 045245	Facility ID: 045245 If continuation sheet Page 1 of 4

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Immediate action taken: Started neuro checks, ROM WNL, ordered right hip x-ray, called mobile x-ray company at 11:57 PM. Resident taken to hospital? N (no). -Injury Type: skin tear to right elbow -Level of pain: 6 [out of 1-10 pain scale] -Notes: 06/22/2026 DON Follow Up: resident admitted to [name of hospital] due to fx (fracture) R (right) hip. POC (plan of care) to be updated upon return to facility. 06/26/26-footboard removed. Review of the Neuro Checks Recurring form for Resident #1 revealed instructions for documentation were as follows: [every] Q 15 min for first hour, Q 30 minutes X 2[hours]; Q Hour X 2 [hours]; Q 4 Hours X 2[shifts]; Q Shift for the remaining 72 hours and until stable. Review of the Neuro Checks Recurring Form with an effective date of 06/22/2026 for Resident #1 revealed that LPN #1 completed and signed the neuro checks for the following checks: initial neuro check #1, Q 15 min check #2, Q 15 min check #3, Q 15 min check #4, Q 30 min check #1, Q 30 min check #2, Q hour check #1 and Q hour check #2. There was no signature indicated for the following neuro checks: Q 4(four) hour check #1, which should have been completed at 7:15 AM on 06/22/2026. The remaining neuro checks were not completed because the resident was transferred to the hospital per review of an incident note dated 06/22/2026 at 9:53 AM, located in Resident #1's progress notes. Review of a Provider Note dated 06/22/2026 at 12:34 PM, revealed Today's visit is medically necessary because of a fall. [Resident #1] seen today lying in bed. Patient states [they] fell last night in the bathroom around midnight. Denies hitting [their] head but states the left side of [their] head is sore. C/O (complains of) significant right hip pain. Unable to straighten right leg completely 1. Right hip pain d/t [due to] hx [history] of RTHA [Right Total Hip Arthroplasty], previous dislocations, and on blood thinner. Patient sent to ER [emergency room] for further evaluation, 2. History of total right hip replacement Review of a Radiology Report dated 06/22/2026 located in Resident #1's hospital records dated 06/29/2026 revealed the following: -Procedure: CT [Computed Tomography] Pelvis -History: fall with right hip pain, multiple prior surgeries -Impression: Periprosthetic fracture of the right proximal femoral diaphysis along the posterior medical aspect cortex [fracture around or very close to an artificial hip implant], new from prior examinations. During a telephone interview on 06/29/2026 at 2:49 PM, CNA #1 stated Resident #1 could not get out of bed alone, was able to use the call light system, but did not do so. He stated Resident #1 required assistance from one staff member and used a wheelchair for mobility. He stated on the night of 06/21/2026, he was working the 11 PM to 7 AM shift and heard someone yelling for help but was (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unable to give an exact time. He stated that when he entered Resident #1's room, the resident had made it to the corner of the bathroom door, and the wheelchair was by Resident #1's bed. He stated Resident #1 was not able to tell him what happened at that time. He stated when he first reported to LPN #3, Resident #1 had stated they did not hit their head and was not having any pain in their head but was complaining of leg pain. CNA #1 could not recall which leg. He stated about an hour later, Resident #1 stated their head was hurting and was constantly complaining of leg pain, but he could not recall which leg. He stated that as soon as Resident #1 asked for something for their head, he immediately reported this to LPN #3. During a telephone interview on 06/29/2026 at 9:17 AM, LPN #3 stated she was working on the night of 06/21/2026. She stated around 11:30 PM, she heard Resident #1 hollering out and when she made it to Resident #1's room, Resident #1 was sitting on the floor in the corner by the bathroom door on their bottom. She stated when she assessed Resident #1, their ROM was WNL. She stated Resident #1 had a little tear near the right elbow, and a red area on the right hip. She stated Resident #1 stated they were hurting from the fall in the right hip. She stated initially Resident #1 reported they did not hit their head. She stated later in the shift (she was not able to give an exact time), CNA #1 went back to check on Resident #1, and CNA #1 was told by Resident #1 that they believed they might have hit their head. LPN #3 stated she then started neuro checks on Resident #1. She stated after CNA #1 reported to her that Resident #1 had stated they might have hit their head, she assessed Resident #1 again but was unsure of the time. LPN #3 stated she did not see any markings, redness, or knots on Resident #1's head at that time. She stated after she was made aware that Resident #1 may have hit their head, she did not call the provider back to provide an update on Resident #1's condition. She stated that for an unwitnessed fall with a possible head injury, the facility's protocol was to notify the doctor. She stated the provider should have been notified that Resident #1 hit their head. She stated that she started the neuro checks on Resident #1 before midnight, and she administered a pain pill to Resident #1 around midnight. LPN #1 stated she did not notice or feel a knot or contusion to Resident #1's head during any of the neuro checks she performed. LPN #3 stated she reported to LPN #4, Resident #1's fall and complaints of right hip pain, an x-ray had been ordered but had not been completed yet. She stated she could not recall if she informed LPN #4 of Resident #1 hitting their head during the fall. During an interview on 06/29/2026 at 12:29 PM, LPN #4 stated she had been a nurse at this facility for about a month. She stated she came to work on the morning of 06/22/2026 around 6:45 AM. She stated she received report from LPN #3 regarding Resident #1's fall but she could not recall if LPN #3 told her that Resident #1 hit their head. She stated she did not assess Resident #1 after she received shift report and began her morning (8 AM) medication pass. She stated around 9:15 AM, she was told by the Medication Assistant Certified (MA-C) (LPN #4 could not recall the name of the MA-C) that Resident #1 requested a pain pill. LPN #4 stated by the time she went to see Resident #1, the APRN had been in to see Resident #1 and the APRN requested for her to check on the status of the radiology results. LPN #4 stated after the APRN was told that the x-ray had not been completed and would not be performed within the next 30 minutes, the APRN ordered Resident #1 to be sent to the hospital. LPN #4 stated the APRN stated upon her assessment, Resident #1 had decreased ROM in their leg. She stated she administered Resident #1 a pain pill between 9:15 AM and 9:20 AM and did not see any injuries on Resident #1 at that time. She stated someone at the facility, but she could not recall who, showed her the neuro check sheet and stated what to do with it. She stated she had not had to (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	initiate neuro checks on a resident previously, but she was aware Resident #1 was to have neuro checks completed. During an interview on 06/29/2026 at 4:04 PM, Resident #1 was lying in bed on their right side. Resident #1 stated they had just received a pain pill due to pain. Resident #1 stated on the night of the fall, they woke up due to being cold and remembered they had a blanket in their closet. Resident #1 stated they usually got out of bed on the left side, but that night they decided to get out of bed without help on the right side of the bed and fell. Resident #1 acknowledged they were supposed to call when they needed something but did not call. During a second interview on 06/29/2026 at 4:45 PM, Resident #1 stated they did not recall hitting their head at first but started to realize the area to the left of their scalp was tender. Resident #1 stated they told LPN #3 their head was soft, and sensitive. Resident #1 stated that LPN #3 felt around on their head after being made aware they might have struck their head but indicated she did not feel anything. During an interview on 07/02/2026 at 10:20 AM, the DON stated LPN #3 had reported to her Resident #1 had an unwitnessed fall and stated they did not hit their head. She stated LPN #3 did not report that Resident #1 had hit their head during the fall. She stated if a resident complains of head discomfort or reports they did hit their head, later in the shift (after an unwitnessed fall), the nurse should assess the resident, start neuro checks, notify the provider, and document the concern. She stated the provider should be notified of the change in the resident because they need to know and may change the treatment the resident receives. She stated if a resident had neuro checks due at 7:15 AM, the 7AM to 3PM shift was responsible for completing the task. During a telephone interview on 07/07/2026 at 3:27 PM, the Medical Director stated he could not recall receiving a phone call on 06/22/2026 from a nurse regarding Resident #1 having an unwitnessed fall. He stated he knew Resident #1 had a fall because he completed a daily computer review of residents and knew when residents go out or return to the facility. He stated if he was notified that Resident #1 had hit their head, he would have asked if there were any signs/symptoms of head trauma, if there were physical evidence of trauma such as bruising or tenderness and given that information, he may or may not have given orders for a scan. He stated for any patient that had a fall and reported that they bumped their head, he would expect the nurse to take a history and perform neuro checks at appropriate intervals. He indicated it was important for him to be notified of changes in the resident's condition, and he stated the staff reported any changes to the nurse practitioner or the physician on call.		