STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045245	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Conway Healthcare and Rehabilitation Center	2603 Dave Ward Drive Conway, AR 72034

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(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 - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, record review, interview, and facility policy review, the facility failed to ensure resident centered care was provided to two of two (Resident #8 and Resident #69) sampled residents dependent on staff for care based on one of one observation to ensure residents physical and psychosocial needs were met. Specifically, staff did not respond to a feeding tube alarm in a timely manner, a call light was placed out of the reach of a resident, and pain was not addressed in a timely manner. The findings include: Resident #8: During an observation on 08/18/2025 at 2:13 PM, this surveyor observed Resident #8 resting with their eyes closed, their tube feed was beeping, and the pump was not running. The resident's feeding pump said, tube slip detected, remove and reload cassette. This surveyor observed the resident's feeding supplement of 1.5 calories was hanging on a pump, and 60 milliliters (mL) an hour was written on the bottle. Resident #8 was not responding verbally and was not able to demonstrate use of the call light to report continuous beeping. The resident's bed was at 45 degrees, and an enhanced barrier precaution sign was posted outside of the room. This surveyor also observed CNA #6 and therapy staff pass by Resident #8's room, and there was no response to the alarming feeding tube. During an observation on 08/18/2025 at 2:54 PM, Certified Nursing Assistant (CNA) #5 was overheard in the hall saying the nurse needed to be told about Resident #8's feeding pump beeping. During an observation on 08/18/2025 at 3:03 PM, Licensed Practical Nurse (LPN) #7 entered Resident #8's room and said, [CNA #5] just told me Resident #8's tube feeding was beeping. LPN #7 fixed the feeding pump, stopped the beeping, and revealed they last rounded on Resident #8 at 12:30 PM, and confirmed that staff were expected to round every two hours. A review of Resident #8's Medical Diagnosis revealed the facility admitted the resident with diagnoses which included stroke, failure to thrive, and dementia. A review of Resident #8's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/21/2025 revealed a Staff Assessment for Mental Status (SAMS) score of 03, which indicated the resident was severely impaired and never/rarely made decisions. Resident #8's MDS also revealed the resident had a feeding tube while a resident, required total care, was unable to respond, and was dependent on staff for bathing, eating, toileting, dressing and personal care. A review of Resident #8's Care Plan, revised 06/04/2025, revealed the resident was at risk for fluid volume deficit related to tube feeding. Resident #8's Care Plan specified interventions that directed (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045245	A. Building B. Wing	08/21/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff to monitor input and output, and report signs of dehydration. A review of Resident #8's Medication Administration Record (MAR), dated 06/14/2024, revealed the resident received a feeding supplement at 60 mL/hour and water flushes at 30 mL/hour for enteral feedings every shift. Further review of Resident #8's MAR revealed on 11/11/2024, staff were to make sure the resident's feeding tube was running each shift, and during medication pass. During an interview with Resident #8's Caregiver on 08/19/2025 at 9:34 AM, the Caregiver revealed being at the resident's bedside daily until 1:30 PM, then came back late in the evenings. The Caregiver said, sometimes the call light beeps over 30 minutes. Resident #69: During an observation on 08/18/2025 at 2:14 PM, this surveyor observed Resident #69 sitting in a wheelchair raising their right leg and arm up and down and said, my butt hurts from sitting here. Resident #69 revealed Resident #8's feeding pump had been beeping since their Caregiver left around 1:30 PM. Resident #69's call light was resting on the bed, out of the resident's reach. Resident #69 pointed out a CNA and physical therapist walking past the open door. During an observation on 08/18/2025 at 2:20 PM, this surveyor observed Resident #69 was handed their call light and demonstrated how to call for assistance, and surveyor observed for response for assistance. During an observation on 08/18/2025 at 2:29 PM, this surveyor observed CNA #6 walk into Resident #69's room to turn off the call light and asked the resident, Who is your aid, sweetie? Resident #69 said, CNA #4 I think, and I need to get off my butt I am hurting. CNA #6 turned and left the room. Resident #69's roommate [Resident #8's] feeding tube continued to beep. During an observation on 08/18/2025 at 2:50 PM, this surveyor observed CNA #4 and CNA #5 enter Resident #69's room and place the resident back in bed 30 minutes after Resident #69 used the call light. CNA #5 revealed she knew Resident #69 used the call light, because it lit up above the door and at the nurse's desk. A review of Resident #69's Medical Diagnosis revealed the facility admitted the resident with diagnoses which included stroke affecting the left side, type 2 diabetes mellitus, and cervical radiculopathy (a condition of the cervical spine leading to pain with tingling weakness in the arms and hands). A review of Resident #69's admission MDS with an ARD 06/01/2025, revealed a Brief Interview for Mental Status score of 13, which indicated the resident was cognitively intact. Resident #69's MDS also revealed the resident was dependent for toileting and personal care, required maximum to total dependence for dressing and received scheduled pain medication. A review of Resident #69's MAR, dated 07/19/2025, revealed the resident received a pain patch every morning for pain and a narcotic tablet, twice a day for pain. A review of Resident #69's Care Plan, with a revision date of 06/04/2025, revealed the resident was weight bearing/non weight bearing with ADLs related to a stroke with left side weakness. Resident #69's Care Plan also revealed the resident required total two-person assistance for bed mobility and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing, with an intervention that directed staff to encourage the resident to use their call light. A review of Care Plan for Resident #69, revised 06/04/2025, Resident #69 is at risk for altered skin integrity related to immobility and incontinence. Assist and encourage repositioning as needed, Resident #69 needs a pressure relieving device for bed and wheelchair, perineal care as needed. A review of Resident #69's Medication Administration Record (MAR) showed on 08/03/2025 an order was discontinued to turn Resident #69's feeding pump off at 7:00 AM, for breakfast and at lunch for caregiver to feed the resident a supplement. During an interview on 08/20/2025 at 4:30 PM, CNA #6 stated the process for answering call lights on another hall was to find the residents CNA and let them know the resident needed assistance. CNA #5 was found in the dining room and I let him know [Resident #69] wanted back in bed. CNA #6 confirmed call lights could be seen above the resident doors and at the nurse's station, and that staff were expected to answer call lights within five minutes. During an interview on 08/20/2025 at 4:35 PM, the Director of Nursing (DON) revealed all staff were expected to respond to call lights within 10-15 minutes. The DON then stated, Ideally the CNA will assist the resident, but in the real world, they will find the assigned CNA. The DON then confirmed the facility was unable to run a call light report, because the call light system is old. CNA are to tell nursing when a resident complains of pain or ask for the nurse. During an interview on 08/21/2025 at 2:25 PM, the Administrator revealed the expectation was that call lights would not beep for more than 15 minutes. The Administrator then stated, If it is something small that resident wants any CNA can handle it, and if they need a lift or something then staff would tell that CNA caring for the resident, because it will take two staff members. The Administrator revealed complaints of pain should be taken to the resident's nurse. If a call light was going off and staff were walking up and down the hall, the Administrator revealed any staff could answer the call light, and it did not have to specifically be a CNA. The Administrator said he was not aware of any call light problems and did not know if Percutaneous Endoscopic Gastrostomy (PEG) tube [tube that provides nutrition and medication directly to the stomach] alarms could be heard at the nurses station, but 50 minutes would be too long for a feeding tube to beep, because it could affect the residents nutrition. The Administrator then said, If a resident such as [Resident #8] cannot use a call light, and their PEG tube is beeping, the standard is to check on residents every two hours. During an interview on 08/21/2025 at 5:30 PM, the Administrator stated he could check into it, but Resident #8's feeding tube could be turned off during ADLs. During the 50 minutes, this surveyor observed Resident #8, and no activities or services were provided. A review of an in-service/lecture on PEG tubes, dated 04/04/2025, revealed nurses were to ensure PEG tube feedings and flushes were changed as soon as possible when empty or near empty, and CNAs were to alert nursing if PEG tubes were beeping or bags appeared low or empty. Based on the sign-in sheet, CNA #4, CNA #5, CNA #6, and LPN #7 were not part of this in-service. A review of an untitled in-service, dated 07/29/2025, was done on call response time and two-hour checks. Based on the sign-in sheet, CNA #4, CNA #5, CNA #6, and LPN #7 were not part of this in-service. A review of an in-service on Perineal Care, PEG tube use and care, Call light use, dated 08/20/2025, (continued on next page)

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	045245	A. Building B. Wing	08/21/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed call lights should be in easy reach of the resident. Based on the sign-in sheet, CNA #5 participated in this in-service, but CNA #4, CNA #6, and LPN #7 were not in attendance. A review of an in-service on Reasonable Accommodation of Needs, dated 03/26/2025, addressed staff were to make sure call lights were in reach of residents at all times in the room. Based on the sign-in sheet, CNA #4, CNA #5, CNA #6, and LPN #7 were not part of this in-service. A review of a policy titled Pain Management revealed the facility had to ensure residents who required pain management services received those services in a manner consistent with professional standards.

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	045245	A. Building B. Wing	08/21/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, record review, and interview it was determined that the facility failed to ensure proper hand hygiene during perineal care to prevent cross contamination for two (Resident #69 and Resident #74) of two sampled residents observed for bowel and bladder care. The findings include: Resident #69: During an observation on 08/18/2025 at 2:54 PM, this surveyor observed Certified Nursing Assistant (CNA) #4 and CNA #5 assist Resident #69 to bed and inform the resident that their brief would be checked, without further instruction. Then this surveyor observed CNA #5 pull down Resident #69's wet brief. CNA #4 used wipes to clean Resident #69's front perineal area and placed the wipes in a trash bag. CNA #5 rolled the resident onto their right side and CNA #4 wiped Resident #69's buttocks using one wipe in one direction. Resident #69 complained of buttocks pain. CNA #4 inspected Resident #69's buttocks, then opened the resident's bedside drawer, without changing gloves, and found a non-prescription ointment to use on Resident #69's buttocks. CNA #4 informed Resident #69 there was no skin breakdown on their buttocks. Resident #69 was rolled back onto a clean brief, and it was pulled up by both CNAs. Resident #69 was covered with a sheet, and CNA #5 returned the wipes to the bedside drawer, without changing their soiled gloves. A review of Resident #69's Medical Diagnosis revealed the facility admitted the resident with diagnoses which included stroke, type 2 diabetes mellitus, and protein malnutrition. A review of Resident #69's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/01/2025, revealed a Brief Interview for Mental Status score of 13, which indicated no cognitive impairment. Resident #69's MDS also revealed the resident required total care for toileting, personal care, and dressing the lower body, and maximum assistance for bathing. During an interview on 08/18/2025 at 2:58 PM, Resident #69 stated that for the last few days it felt like they had a sore on their buttocks, but they had not reported it. Resident #69 also said CNA #4 always did a good job with personal care, but sometimes the resident had to wait. During an interview on 08/18/2025 at 3:00 PM, CNA #4 revealed the process for perineal care was to wipe off all sides making sure you get the back side, and front side of the perineal area from left to right. CNA #5 revealed staff were trained to put on gloves before starting perineal care, and to remove gloves and wash your hands when done. CNA #5 confirmed they should have changed their gloves during Resident #69's perineal care, when going from dirty to clean to prevent cross contamination. Resident #74: During an observation on 08/18/2025 at 1:18 PM, this surveyor observed CNA #2 and CNA #3 stand Resident #74 up with the sit to stand lift for perineal care and both CNAs removed the resident's wet brief after explaining perineal care, while wearing gloves. CNA #3 removed clean wipes and proceeded to wipe Resident #74's buttocks, CNA #3 then removed three wipes and wiped down Resident #74's front skin folds left to right, then wiped the urinary meatus in a quick circular motion. CNA #2 placed a clean brief on Resident #74 and CNA #3 assisted in securing the tabs. CNA #3 stored wipes in a drawer and pulled Resident #74's clothing up, then CNA #2 and CNA #3's dirty gloves were removed. (continued on next page)

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	045245	A. Building B. Wing	08/21/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Proper hand hygiene was not performed during Resident #74's perineal care. A review of Resident #74's Medical Diagnosis revealed the facility admitted the resident with diagnoses which included dementia, overactive bladder, and ataxia (a disease characterized as poor muscle control causing clumsy movements). A review of Resident #74's quarterly MDS with an ARD of 07/16/2025, revealed a Staff Assessment for Mental Status (SAMS) score of 03, which indicated the resident was severely impaired, and rarely/never made decisions. Resident #74's MDS also revealed the resident required total care and was on scheduled pain medication. Resident #74's MDS also revealed they were always incontinent of bowel and bladder. During an interview with CNA #2 and CNA #3, CNA #3 stated staff were trained to wash their hands and put on gloves before starting perineal care. CNA #3 continued to say when perineal care was completed, CNAs were expected to remove their gloves and wash their hands. CNA #3 said, there is no time to change gloves during perineal care with the closed unit residents. CNA #2 said, you have to work fast with people that have dementia. Both CNAs agreed there was a risk of cross contamination during Resident #74's perineal care because their gloves were not changed during the care, they touched the sit to stand lift, Resident #74's clothing, the resident's wheelchair, and their drawer while wearing dirty gloves. During an interview on 08/20/2025 at 4:45 PM, the Director of Nursing (DON) confirmed that during perineal care, hand hygiene needed to be performed between clean and dirty tasks to prevent cross contamination. This surveyor asked the DON for the facilities perineal care policy/procedures, male perineal care, and signed in-services. The DON stated, We do not have a perineal care policy. During an interview on 08/21/2025 at 2:14 PM, the Administrator stated, Staff should ensure privacy and close the blinds, curtain, and door. Staff should sanitize hands and wear gloves before perineal care and then remove gloves and sanitize hands when going from dirty to clean. The Administrator revealed, the purpose of the facility having staff change gloves and sanitize hands when going from dirty to clean is about infection control. It prevents the spread of infection. Staff have annual competencies, and in-services throughout the year and as needed. A review of a facility Perineal Competency revealed for male residents, it did not address hand hygiene during perineal care, but instructs staff to remove gloves, wash and dry hands after perineal care before repositioning with bed covers, touching the call light, cleaning the basin and bed stand then washing and drying hands thoroughly. The call light should be in easy reach of the resident. On exit, the survey team was given Competency Assessment Perineal Care revised October 2010. CNA #2 completed on 02/27/2025, CNA #5 completed on 02/26/2025. A review of a facility lecture dated 04/04/2025, revealed staff were expected to tell the resident what care was being done before starting. It was the residents' right and ensured their dignity. Based on the sign-in sheet, CNA #2, CNA #3, CNA #4, and CNA #5 were not included in this lecture. A review of in-service dated 06/27/2025, revealed perineal care was a fundamental skill for CNA's and was crucial for hygiene and preventing skin breakdown, odors, and infection. Proper perineal care improved comfort and dignity. CNAs should use gentle cleaning agents and work from the back to the front to avoid contamination. Based on the sign-in sheet, CNA #2, CNA #3, CNA #4, and CNA #5 were not included in this in-service. (continued on next page)

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	045245	A. Building B. Wing	08/21/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of an in-service on Perineal Care, Peg tube use and Care, Call light use, dated 08/20/2025, revealed staff were educated using the Competency Assessment Perineal Care. Based on the sign-in sheet, CNA #2 attended this in-service, but CNA #3, CNA #4, and CNA #5 were not in attendance. A review of an in-service titled Handwashing dated 08/20/2025, revealed handwashing protected residents from getting sick. Wash hands often, especially during times that will spread germs: after changing briefs or cleaning up a resident who has used the toilet. Based on the sign-in sheet, CNA #2 and CNA #3 were not included in this in-service. New in-service has not been seen by all staff at this time.

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	045245	A. Building B. Wing	08/21/2025

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review, facility document review, interview, and facility policy review, it was determined that the facility failed to not discharge on e (Resident #81) of one sampled resident after an appeal was filed. The findings include: A review of Resident #81’s admission Record indicated the facility admitted the resident on 12/23/2024, with diagnoses which included anxiety disorder. A review of Resident #81’s discharge Minimum Data Set with an Assessment Reference Date of 07/24/2025, revealed a Brief Interview of Mental Status score of 15, which indicated the resident was cognitively intact. A review of Resident #81’s Care Plan Report, revised on 12/26/2024, revealed there were no discharge plans anticipated. Resident #81’s Care Plan Report indicated plans for the resident to remain in the facility for long-term care. Resident #81’s Care Plan did not indicate that the resident smoked. A review of a Discharge Notice, dated 07/23/2025 and signed by the Administrator, indicated that a decision had been made to discharge Resident #81 effective 30-days from 07/23/2025. The Discharge Notice also documented that Resident #81’s discharge may be appealed within seven days from 07/23/2025. A document titled, Resident #81’s Appeal, dated 07/23/2025, documented “I, [Resident #81], wish to appeal this involuntary discharge from [facility name].” A review of Resident #81’s progress note dated 7/22/2025 revealed Resident #81 refused to give up a pack of cigarettes and lighter. Her son was called, and he was informed that if Resident #81 have any other behaviors within the 30 days the discharge will be immediate. A review of a progress note dated 6/02/2025 indicated Resident #81 instigated conflict with another resident. [Resident #81 was in the hallway and would purposely stop in front of the other resident causing a collision with another resident. During an interview on 08/19/2025 at 2:54 PM, the Administrator indicated Resident #81 was admitted around December 2024, and the resident filed an appeal before they were discharged . The Administrator then stated the Ombudsman helped Resident #81 file the appeal. During a telephone interview on 08/19/2025 at 3:18 PM, the Ombudsman stated Resident #81 indicated they were not given a choice about discharging. The Ombudsman stated she informed Resident #81 and their family member, that Resident #81 did not have to leave if they wanted to appeal the discharge. The Ombudsman revealed she called and cancelled the appeal after the facility discharged the resident. She then stated she could not get in contact with Resident #81’s family member after she found out the facility had discharged the resident. The Ombudsman indicated that Resident #81’s family member did not want the resident discharged to a different facility. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 08/20/2025 at 2:39 PM, Resident #81's family member revealed the resident filed an appeal before they were discharged from the facility, and Resident #81 was still discharged . The family member then stated Resident #81 did not want to be discharged . During a phone interview on 08/21/2025 at 11:15 AM, Resident #81 confirmed they were admitted to the facility December 2024 and did not know why they were discharged from the facility. Resident #81 revealed they informed the Administrator they wanted to file an appeal the day they were told they had to leave. The resident stated the Administrator informed them they had no choice. Resident #81 indicated she did not want to leave the facility, they never smoked in the facility, never had cigarettes or a lighter in their room, and the only drug they had ever taken, before being admitted , was marijuana. Resident #81 indicated they only had a urine test for a urinary tract infection and was never asked or informed of a drug test being completed. During an interview on 08/21/2025 at 1:50 PM, Certified Nurse Aide (CNA) #5 indicated Resident #81 was never witnessed being physically abusive to another resident. During an interview on 08/21/2025 at 2:03 PM, CNA #9 indicated she did not remember Resident #81 physically harming another resident. During an interview on 08/21/2025 at 2:34 PM, the Administrator indicated Resident #81 was discharged for improper behavior and for not following smoking policies. He revealed Resident #81 was issued a 30-day notice on 07/23/2025 and discharged to a different facility the next day on 07/24/2025. The Administrator indicated that he was aware that Resident #81 filed an appeal, and he chose to discharge the resident to another facility anyway. The Administrator then revealed Resident #81 never physically abused another resident, but there was a need for an immediate discharge because Resident #81 bumped their chair into another resident’s wheelchair. During an interview on 08/21/2025 at 2:53 PM, CNA #6 stated she did not know why Resident #81 was discharged from the facility. She revealed she had never witnessed Resident #81 physically abusing another resident or smoking in their room. During a phone interview on 08/21/2025 at 3:14 PM, the Medical Director stated he did not know why Resident #81 was discharged from the facility. A review of a facility policy titled, Admission, Transfer, and Discharge revealed, The nursing facility will not transfer or discharge a resident while an appeal is pending, unless the failure to discharge would endanger the health or safety of the resident or other individuals in the nursing facility.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on record review, observation, interview, and facility policy review, the facility failed to ensure the medication error rate was less than 5%, to prevent potential complications for two (Residents #35 and #76) of two sampled residents observed during the medication pass. The medication error rate was 6.67%, based on observations of 30 medications administered. The findings include: A review of Resident #35's Order Summary Report revealed an order for [Brand Name] eye drops for dry eyes, with the order to instill two drops in both eyes twice a day for dry eyes. The eye drops started on 11/18/2024. A review of Resident #76's Order Summary Report indicated an order for 80 milligrams (mg) of an anti-flatulent medication twice a day for gas. During an observation on 08/19/2025 at 8:14 AM, this surveyor observed Licensed Practical Nurse (LPN) #12 administer Resident #35 one drop of [Other Brand Name] eye drops in each eye, for dry eyes. During an observation on 08/19/2025 at 8:57 AM, this surveyor observed Medication Assistant Certified (MAC) #11 administer one 125mg chewable anti-flatulent tablet to Resident #76. During an interview on 08/21/2025 at 10:10 AM, LPN #12 indicated Resident #35 was getting [Other Brand Name] eye drops because that was the only eyedrop available in the medication room. She indicated the eyedrops started 2-3 weeks ago, and she was not sure if the doctor was aware the ordered [Brand Name] eye drops were not available. During an interview on 08/21/2025 at 10:15 AM, the Assistant Director of Nursing (ADON) indicated the facility could not get [Brand Name] eye drops from the pharmacy. She then stated the order was not clarified with the Medical Director, and he was not notified the order for [Brand Name] eye drops was not available. The ADON revealed she was not sure when the order changed and confirmed the nurses gave Resident #35 the eyedrops that the facility had available. During an interview on 08/21/2024 at 3:15 PM, the Medical Director stated he should be contacted if an ordered medication was not available. He then stated he would order a substitution for an eye drop if the ordered medication was not available, and that the substitution of the eye drop should be documented. During an interview on 08/21/2025 at 3:51 PM, the Director of Nursing indicated the nurses should have contacted the doctor to get an order for eye drops that were in stock. During an interview on 08/21/2025 at 4:33 PM, the Administrator confirmed the nurses should contact the doctor if a medication is not available. A review of a policy titled, Preparation and General Guidelines indicated the medication record is used during medication administration. Prior to administration the medication record is compared to the medication label. When a medication is changed the change should be communicated to the pharmacy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045245	A. Building B. Wing	08/21/2025

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an in-service titled, Medication Administration revealed the medication order should be compared with the label three times: when getting the medication from storage, before removing the medication from the container, and before giving the medication to the resident. MAC #11 signed the in-service.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document review the facility failed to ensure one (Resident #52) of one sampled resident was free of a significant medication error, which caused Resident #52 to be hospitalized for acute toxic encephalopathy. The findings include: During an interview on [DATE] at 3:23 PM, Resident #52 revealed they went to the hospital around [DATE], due to being given the wrong medications. Resident #52 said they spent the night at the hospital and almost died, because the medicine they were given was not theirs, but belonged to a resident who lived down the hall. A review of Resident #52's Medical Diagnosis revealed the facility admitted the resident with diagnoses which included high blood pressure, reflux, diabetes mellitus, hyperlipidemia, Alzheimer's disease, anxiety disorder, post-traumatic stress disorder (PTSD), chronic obstructive pulmonary disease, constipation, history of falling, sleep apnea, and insomnia. A review of Resident #52's annual Minimum Data Set (MDS) with an Assessment Reference Date of [DATE], revealed a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact. Resident #52's MDS also revealed the resident was to be independent for most Activities of Daily Living. A review of Resident #52's Progress Note dated [DATE] at 9:25 AM, revealed Registered Nurse (RN) #1 had stepped outside to give medication to a different resident when she noticed Resident #52 with their head down. When RN #1 returned to the medication cart, she noticed Resident #52's medications were still in the cart. RN #1 then requested help from a Certified Nursing Assistant (CNA) to return Resident #52 to their room and get a set of vital signs. RN #1 immediately notified the Director of Nursing (DON) and the Advanced Practical Registered Nurse (APRN). A review of a Change in Condition Evaluation listed in Resident #52's Progress Notes on [DATE] at 9:44 AM, documented the resident had an altered mental status. The resident's vital signs were documented as follows: Blood Pressure (BP) - 108/78, Pulse - 77; Respiratory Rate - 18; Temperature - 98; weight 188.9, taken [DATE] at 9:00 AM; Pulse Oximetry (O2) 88% - room air; Blood Glucose was 123. The Physical Assessment revealed Resident #52 had an altered level of consciousness. RN #1 took the resident's vitals and called the APRN and the DON. Oxygen was recommended and was started with a nasal cannula at two liters a minute; normal saline was started and two doses of a medication used to reverse the effect of opioids, were administered. A review of Resident #52's Progress Note dated [DATE] at 2:59 PM, revealed the residents' vitals were taken at 10:45 AM, and were documented as follows: BP of 104/69, Heart Rate (HR) of 68, and O2 of 94%. Resident #52's family member was then called, and a voicemail was left. At 10:53 AM, Resident #52's Blood Glucose was 136, BP was 108/69, HR was 72, and O2 was 96%. At 11:00 AM, the resident's BP was 105/64, HR was 67, O2 was 93%. It was then documented at 11:05 AM, the facility contacted ambulance services for transport to the local hospital. A review of Resident #52's Progress Note dated [DATE] at 1:35 AM, revealed a facility nurse (unnamed) called the local hospital Intensive Care Unit (ICU) for an update. The nurse was told (continued on next page)

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	045245	A. Building B. Wing	08/21/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #52 was doing better, vitals were staying within normal limits, and that the resident had eaten applesauce and had been awake throughout the day. The nurse was told the resident would start speech therapy the following day and that the resident's short-term memory had not yet returned. A review of Resident #52's Progress Note dated [DATE] at 1:34 PM, revealed Resident #52 returned to the nursing home, via family vehicle. The resident was oriented to person, place, time, and event, with no changes in medication. The local hospital stated they did not give Resident #52 any medications, except for a medication used to reverse the effect of opioids in the emergency room (ER). A review of the facility Medication Error report filed for Resident #52 on [DATE] at 4:37 PM, was dated [DATE] at 8:30 AM, with RN #1 identified as the nurse who made the error. The Medication Error Report revealed Resident #52 was given the wrong medications inadvertently, with a Physician Order for an opioid antagonist to counteract the error. Resident #52's condition before the incident was documented as alert and oriented and the resident's condition after the incident was documented as drowsy.RN #1 provided a handwritten statement and documentation in the residents' Progress Notes. Resident #52's Medication Administration Record (MAR) was included, and the DON signed the Medication Error report on [DATE]. A review of Resident #52's Hospital Records revealed the reason for hospitalization was due to the administration of sedative mediations, which caused Resident #52 to have with an official diagnosis of acute toxic encephalopathy: secondary to accidental administration of multiple medications capable of altering mentation. Resident #52 was drowsy and kept eyes closed most of the interview but was easily wakened. Resident #52 was able to recall their birthday and knew where they were. Resident #52's family was at their bedside and reported to the hospital the resident had mistakenly been administered another resident's medications. Resident #52's family reported the resident had a history of Alzheimer's dementia, was wheelchair-bound, but otherwise usually alert and oriented times three. Per the ER Physician, the medications Resident #52 had accidentally been given were Seroquel, paroxetine, meclizine, gabapentin, aspirin, cyclobenzaprine, alprazolam, ciprofloxacin, methylphenidate, and hydrocodone. The record revealed that Resident #52 was not on any sedating medications at the nursing home and had received two doses of an opioid antagonist, prior to arrival at the ER. It was noted that it was unclear if the medications made a difference to residents' mentation. At the ER, the resident's vital signs and labs were noted to be normal and the resident was resting comfortably on room air. Resident #52's initial electrocardiogram was done in the ER which showed a QTc interval of 464 milliseconds, this was considered borderline prolonged, which indicated the heart ventricles were taking longer than normal to recharge between beats. Resident #52 was monitored in the ICU with no complications reported, and was discharged on [DATE], back to the nursing home. A review of Resident #52's Medication and Diagnosis contraindications utilizing the Mayo Clinic contraindicators for methylphenidate hydrochloride documented appropriated studies on the relationship of age to the effects of methylphenidate have not been performed in the geriatric population. Resident #52 had a diagnosis of high blood pressure which was contraindicated for use of methylphenidate hydrochloride. Resident #52 was prescribed a medication used to treat excess stomach acid on [DATE], which was contraindicated for methylphenidate hydrochloride. Symptoms of an overdose of methylphenidate hydrochloride were noted to be a change in consciousness, irregular heartbeat or pulse, loss of consciousness, and unusual tiredness. (continued on next page)

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	045245	A. Building B. Wing	08/21/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #52's Medication and Diagnosis contraindications utilizing the Mayo Clinic contraindicators for hydrocodone, documented hydrocodone was contraindicated for use with Ketoconazole and Tiotropium. Resident #52's MAR revealed the resident had been prescribed to ketoconazole external shampoo, on [DATE]. The MAR also documented Resident #52 had been prescribed Tiotropium monohydrate inhalation aerosol solution related to COPD, on [DATE]. The Mayo clinic information stated using Hydrocodone may cause an overdose, with signs of change in consciousness, sleepiness, or unusual drowsiness. A review of Resident #52's Medication and Diagnosis contraindications utilizing the Mayo Clinic contraindicators for alprazolam. Elderly patients were more likely to have unwanted effects of severe drowsiness, dizziness, confusion, clumsiness, or unsteadiness and kidney, liver or lung problems. Symptoms of overdose included change in consciousness, confusion, dizziness, faintness, lightheadedness, drowsiness, and sleepiness. A review of the Medication Guide, provided by the facility on [DATE] at 1:16 PM, revealed a compound opioid pain medication was defined as a strong prescription pain medicine that contained an opioid used to manage severe pain. An opioid pain medicine could put you at risk for overdose and death. Important information listed in the guide about this medication was to get emergency help right away, if you take too much or overdose, serious or life-threatening breathing problems that could lead to death may occur. Taking this medication with other opioid medicines, benzodiazepines, or other central nervous system depressants could cause severe drowsiness, decreased awareness, breathing problems, coma, and death. Never give anyone else your medication, they could die from taking it. Do not take this medication if you have severe asthma, trouble breathing, or other lung problems. Possible side effects are constipation, tiredness, dizziness. Get emergency medical help if trouble breathing, shortness of breath, fast heartbeat, chest pain, swelling of face, tongue, or throat, extreme drowsiness, feeling faint, and mental changes such as confusion. A review of the Medication Guide provided by the facility on [DATE] at 1:16 PM, revealed methylphenidate hydrochloride was a federally controlled substance. The following issues had been reported: Heart-related problems and Mental Psychiatric problems. This drug was a central nervous system stimulant prescription medicine. The side effects of this medication could be painful, including prolonged erections, circulation problems in fingers and toes, fast heartbeat, abnormal heartbeat, headache, trouble sleeping, nervousness, sweating, decreased appetite, dry mouth, nausea, and stomach pain. A review of the Medication Guide, provided by the facility on [DATE] at 1:16 PM, revealed alprazolam is a benzodiazepine medicine. Taking benzodiazepines with other opioid medicines, or other central nervous system depressants could cause severe drowsiness, breathing problems (respiratory depression), coma, and death. This medication could make you sleepy or dizzy and can slow your thinking and motor skills. This is a federal controlled substance. Elderly patients are especially susceptible to dose related adverse effects when taking this medication. During an interview on [DATE] at 11:10 AM, RN #1 revealed they had been working at the facility since March of 2025 and have been a nurse for 15 years. RN #1 stated they were the Treatment Nurse and worked the floor at times. RN #1 stated they had started their med-pass on the 200-hall and had prepared a resident's medication, who resided on the same hall as Resident #52, but was interrupted by two to three other residents asking for things. One of the residents, who can have behavior issues, wanted their meds right then and the other resident wanted their hair done. So, to prevent the one resident from having a behavior, RN #1 put the medication they had prepared belonging to a resident (continued on next page)

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	045245	A. Building B. Wing	08/21/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who lived down the hall from Resident #52 in the top drawer of the cart and then pulled the medication for the resident who had behaviors. RN #1 stated, when I went back to the cart, Resident #52 was sitting at the cart, and I was flustered. I inadvertently gave Resident #52 the medication I had previously prepared for the other resident. RN #1 said it was between 8:00 AM – 8:30 AM, Resident #52 kept driving their wheelchair toward the dining room, but they guessed Resident #52 decided to go outside because Resident #52 was later seen outside. RN #1 said they did not look at the MAR before handing the cup of medications to Resident #52. RN #1 said they then moved to 300-hall and the resident RN #1 was looking for had gone outside. RN #1 said it was about 9:30 AM and I went outside. RN #1 stated, that is when I noticed [Resident #52] sitting there and they appeared drowsy. I went back to the Medication Cart, and I noticed [Resident #52] medications were still in the cart. RN #1 then said, I immediately realized what medications I had given [Resident #52] and that is why I was so concerned. [Resident #52] was not prescribed any of those medications. RN #1 said they immediately went to the DON, and they called the APRN. We took [Resident #52's] vitals, got an order for oxygen, an order for an opioid antagonist, intravenous fluids-normal saline, then we gave [Resident #52] a second opioid antagonist. The DON immediately took me off the medication cart and suspended me for two days. RN #1 said they were concerned Resident #52 was over sedated and expressed further concern for the resident, their family, and other residents not trusting RN #1 as a nurse. RN #1 stated they felt they might have lost the resident's trust. During an interview on [DATE] at 11:10 AM, RN #1 said they had never made a medication error before and revealed they had been a med-pass nurse since [DATE]. RN #1 stated she was in-serviced/trained and the Pharmacy Consultant and the DON observed her four times, after returning to work. During an interview on [DATE] at 3:56 PM, the DON said they had started working at this facility on [DATE]. The DON said they were notified of the medication error around 9:30 AM the morning of [DATE]. The DON said prior to going into the facility morning meeting they had noticed RN #1's med-cart was parked at the beginning of the 200-hall. The DON revealed there was another resident at the med-cart. The DON confirmed RN #1 was getting the residents their medications. The DON said RN #1 had gone outside to give a resident their medication when RN #1 noticed Resident #52 was drowsy and difficult to arouse, and RN #1 tried to figure out what was going on. The DON said then they understood RN #1 went back to the med-cart and realized they had given Resident #52 another resident's medications. The DON said they then called the APRN and took Resident #52 to their room, took the resident's vitals, gave a dose of an opioid antagonist, and started intravenous fluids. The APRN wanted a second dose of an opioid antagonist to be given, and then the resident was to be sent to the ER. The DON said Resident #52 knew where they were, they could open their eyes, and they knew who the staff were, they were just really drowsy. The DON confirmed RN #1 should have had Resident #52's MAR pulled up on the screen and matched the medications given to the card to the MAR. The DON said, my concerns with the medications was Resident #52 respiratory status, I looked up the meds Resident #52 had been given, which was quite concerning, the combination and the strengths. The DON stated, I did not run a contraindicator report, but we did contact the APRN. During an interview on [DATE] at 3:30 PM, the Medical Director (MD) said they were familiar with Resident #52, because they and the APRN were Resident #52's primary care givers. The MD said they were aware Resident #52 was inadvertently given the wrong medications and was then sent to the hospital. The MD said the Nurse Practitioner had ordered an opioid antagonist be given while the resident was still at the nursing home. The MD said their concern was that medications be given as ordered. The MD said, mistakes happened and I had to accept that fact. The MD stated they and the facility kept a close eye on the residents and the medications. The MD said the negative outcome of (continued on next page)

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	045245	A. Building B. Wing	08/21/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	receiving the wrong medication was it affected Resident #52's respirations and blood pressure, and that was likely the immediate side effects. The MD stated they did not expect Resident #52 to have any long-term negative outcomes. The MD revealed the process that a nurse should use when giving medications was, the nurse should have checked the resident's orders and the MAR, and dispense the medications as they were written on the MAR. During an interview on [DATE] at 2:18 PM, the Administrator stated a nurse should check the resident name, the resident's MAR and check the medication card three times before administering their medications. The Administrator then said, I was made aware immediately after the nurse told the DON about the medication error. At that point we got [Resident #52] assisted to their room and assisted to bed, and an IV was started. The Administrator said they looked to see what medications were missing for the other resident and they called and got a one-time order for that resident. The Administrator said they monitored and assessed Resident #52's BP, HR, O2 and any interventions that were requested by the APRN were followed. The Administrator stated, we notified the family, and the nurse [RN #1] was immediately taken off the floor. RN #1 did assist with the interventions and notifications. RN #1 counted out with a different nurse to take over the med cart. The Administrator said their understanding of how this happened was that the nurse was doing a med-pass as normal and there were some distractions that occurred away from that resident, so the nurse went to deal with the distraction and when the nurse got back, the nurse administered the wrong meds to Resident #52. Resident #52 was transported to the hospital for observations, but there were no other medications or fluids given at the hospital. The Administrator stated Resident #52 had drowsiness and slurred speech. The Administrator reviewed the hospital paperwork and stated Resident #52 did not receive any opioid antagonist at the hospital but had received two doses prior to arrival at the ER. The Administrator said the risk concerns they had related to a resident receiving medications not prescribed for them was the change in condition varying from this incident to a worse outcome. The Administrator said it was important for a nurse to follow the appropriate procedures when passing medications to ensure the health and safety of the resident. The Administrator said their expectations for the nurses was to follow the policy and procedures of medication administration. A review of an in-service Education Report provided by the Administrator on [DATE], documented RN #1 had been trained on the 6-Rights of Medication Administration on [DATE]. A review of the facility Policy Medication Preparation – General Guidelines provided to the survey team documented, Five Rights include Right resident, right drug, right dose, right route and right time are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication administration: when the medication is selected, when the dose is removed from the container, and finally, just after the dose is prepared and the medication put away. The policy also revealed, when medications are administered by mobile cart taken to the resident's location (room, dining area, etc.) medications are administered at the time they are prepared. Residents are identified before medication is administered using two methods of identification: checking photograph attached to medical record, calling resident by name, having the resident verify his/her last name, or verifying resident identification with other facility personnel. Finally, the policy revealed, Medications supplied for one resident are never administered to another resident. A review of the facility policy Medication Administration revealed the six rights of medication administration are as follows: Right patient – identify residents before giving a medication, Right Medication – compare the order with the label three times- when getting medication; before removing from the container; and before giving to the resident; Right Dosage – Check the (continued on next page)

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	045245	A. Building B. Wing	08/21/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	label three times, Right Route, Right Time, Right Documentation – record on the MAR immediately.

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	045245	A. Building B. Wing	08/21/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility policy review, the facility failed to ensure one of four medication carts were always locked to prevent accidents. The findings include:During an observation on 08/20/2025 at 10:18 AM, this surveyor observed a medication cart was parked in front of the nurse's station, unlocked.During an observation on 08/20/2025 at 10:21 AM, the Director of Nursing walked by the medication cart and locked it. She confirmed medication carts should be locked, to prevent the residents from going into the carts.During an observation on 08/20/2025 at 10:28 AM, this surveyor observed Licensed Practical Nurse (LPN) #12 walk to the unlocked medication cart. She indicated the cart was for the residents on the 200 and 300-halls. LPN #12 stated she did not realize the medication cart was unlocked and confirmed the cart should always be locked for the safety of the residents.During an interview on 08/21/2025 at 4:33 PM, the Administrator revealed the medication carts should be always locked to keep the residents safe.A review of a policy titled, Medications Storage in the Facility, indicated that medications are stored safely, securely, and properly.