STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045270	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Oaks Healthcare and Rehabilitation Center	955 Division Malvern, AR 72104

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review the facility failed to report an allegation of sexual abuse to the State Survey Agency within the required 2-hour time period for one (Resident #2) of three sampled residents reviewed for abuse. The findings include: Review of the Medical Diagnosis portion of Resident #2 ' s electronic health record revealed diagnoses which included right hip fracture, anxiety, and depressive disorder. The discharge Minimum Data Set (MDS) with an Assessment Reference Date of 12/26/24, revealed Resident #2 had a Staff Assessment for Mental Status assessment score of 0, which indicated memory was okay, and was independent. The MDS also indicated no behaviors were exhibited, and that Resident #2 was occasionally incontinent of bladder. Review of a, OLTC [Office of Long-Term Care] Incident and Accident Report, dated and with a discovery date of 12/26/2024 at 3:03 AM, and submitted on 12/26/24 at 8:20 AM, indicated Resident #2 alleged Certified Nursing Assistant (CNA) #3 fondled Resident #2's groin area and breast while assisting the resident to the bathroom. Resident #2 reported that while they were standing and holding onto a bathroom handrail, CNA #3 reached around and fondled Resident #2's groin and breast, before leaving the room without providing assistance. Resident #2 reported they used their wheelchair to exit their room, find a nurse, and report the incident. During an interview on 06/17/2025 at 9:20 AM, Resident #2 ' s family member revealed Resident #2 was brought to the facility on [DATE] for skilled nursing care. On 12/26/2024 between 2:00-3:00 AM, Resident #2 called and asked to be picked up. Resident #2 was described as emotional and alleged CNA #3 touched Resident #2 inappropriately. Resident #2 was picked up after 3:00 AM and family arranged home health services. During an interview on 06/17/2025 at 10:38 AM, Licensed Practical Nurse (LPN) #5 revealed no knowledge of any physical or sexual abuse allegations but would ask questions and report suspicions to the Director of Nursing (DON) or Assistant Director of Nursing (ADON) right away. LPN #5 revealed the facility had 24 hours to report sexual or physical abuse allegations. During an interview on 06/17/2025 at 12:05 PM, CNA #4 reported not being aware of any abuse complaints, but would report suspicions to the charge nurse right away, to report within 24 hours. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/17/2025 at 2:19 PM, the DON stated the alleged abuse was discovered on 12/26/2024 at 3:03 AM but was not reported to the Administrator until later, for an unknown reason. The DON indicated that the alleged perpetrator was sent home right away on suspension, and family and police were notified immediately. Resident #2 refused to go to the emergency room and the facility offered to arrange skilled care at another facility. The alleged perpetrator had no history of inappropriate behavior and answers to a charge nurse. The DON confirmed sexual abuse allegations should be reported in 2 hours. I do not know what time the Administrator was notified. On 06/18/2025 at 3:05 PM during a phone interview, this surveyor spoke with CNA #3. CNA #3 stated All I did was help this person go to the bathroom and set Resident #2 up, holding onto the handrail, assisted in pulling down their pants, guide them to the commode and instructed them on how to use the bathroom call light and left the room. CNA #3 revealed assisting Resident #2 pull down the resident ' s pants while standing behind Resident #2. CNA #3 confirmed that their hands stayed on top of Resident #2's clothing. CNA #3 indicated training in abuse was completed annually. CNA #3 knew to report suspicions of abuse right away. CNA #3 denied touching Resident #2 inappropriately. During an interview on 06/18/2025 at 3:30 PM, the Administrator revealed staff did not call to report the allegation, and stated, someone texted the Administrator ' s phone on 12/26/2024 at 3:03 AM. An allegation of abuse was submitted to the Office of Long-Term Care on 12/26/2024 at 8:20 AM because, we did not feel abuse occurred, this was why it was not reported in 2 hours. The Administrator revealed the DON, ADON, and Administrator were responsible for investigating and reporting allegations of abuse. An investigation was completed and the allegations against CNA #3 were unfounded, witness statements did not support the allegation. Staff were trained on abuse and neglect on 12/26/2024. During an interview on 06/18/2025 at 3:45 PM, the Medical Director (MD) said that someone called when the allegation of abuse occurred. The MD indicated that an assessment was not done because a family member picked Resident #2 up right away and they were going to the emergency room. Assistance with finding another facility to go to for skilled care was declined. The MD stated, It was an unusual situation, and there was no bodily injury to my knowledge. During an interview on 06/19/2025 at 10:25 AM, the Administrator stated if events or allegations do not cause abuse or bodily injury, they do not require 2-hour notice, and it was her opinion that this incident did not meet the criteria for a 2-hour reporting. The Administrator stated Resident #2 stated to the DON and [the Administrator] that CNA #3 fondled Resident #2 in the groin and breast area when taking [Resident #2] to the bathroom, and there was no serious bodily injury. During an interview on 06/19/2025 at 12:40 PM, the ADON looked at a cellphone and revealed the ADON sent a text to Administrator on 12/26/2024 at 3:03 AM. The ADON said call logs were not available to support that the ADON called the administrator by phone. The ADON said the procedure was to send a text and to call within five minutes, if there was not a response from the administrator. I do not know if I called the Administrator or not. There are no call logs to support that a call was made. Review of a policy titled, Abuse, Neglect, and Maltreatment, revealed the facility had a policy in place to protect residents from neglect, abuse, misappropriation, sexual abuse, exploitation and physical abuse. Background checks were done on all employees, and the facility would not knowingly employee someone with a history of abuse. In-services were done on hire and annually. When an allegation of abuse was made it should be reported to the administrator immediately, and the accused person would be removed from the facility during investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an in-service training on Abuse and Neglect Policy dated 12/26/2024, revealed staff were educated on the policy titled Abuse, Neglect, and Maltreatment.