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	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Oaks Healthcare and Rehabilitation Center	105 Russellville Road Malvern, AR 72104

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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 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. 42965 Based on observation, record review and interview, the facility failed to report to the State Survey Agency a fall from the mechanical lift that resulted in major injury for 1 (Resident #15) sampled resident that occurred when a staff member failed to follow care planned intervention requiring two people for lift transfers. The findings are: 1. The Significant Change in Condition Minimum Data Set (MDS) with an Assessment Reference Date of 6/5/24 indicated Resident #15 had a diagnoses of heart failure, Diabetes Mellitus, arthritis, and other fracture, the Resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS), was dependent for transfers, and had one fall with major injury. a. The Care Plan with a revision date of 04/30/2024 indicated, .Problem: (Resident #15) has an ADL (Activities of Daily Living) self-care performance deficit .Approaches/Tasks .Transfer: (Resident) is dependent on total assist via Mechanical Lift with (2) staff assist for transfers with full blue sling . b. The Care Plan with a revision date of 06/03/2024 indicated, .Problem: (Resident #15) is at risk for falls r/t [related to]bilateral lower extremity weakness & daily use of psychotropic drugs. 06/01/2024- fall with injury . Goal: Will be free of falls through the review date . c. An Incident Note, dated 06/01/2024 at 8:33 PM, by Licensed Practical Nurse (LPN) #11 indicated, .Nature and Description of Incident: CNA (Certified Nursing Assistant) was transferring Resident back to bed using lift. While Resident was in lift Resident began to slowly slip out of the lift pad from the bottom. Resident was assisted to the ground by CNA to prevent hard fall. Resident stated there was no injury at the time and head was not hit. There is a scratch on [Resident's] lower back from where contact was made with the leg of the lift .Description of Injuries: Scratch noted to lower back .Immediate Action Take: CNA was reeducated on how to position lift pad and Resident while using lift and lift use safety . d. An Orders-Administration Note, dated 06/03/2024 at 12:05 AM indicated, .Hydrocodone- Acetaminophen Oral Tablet 5-325 MG (milligram) Give 1 tablet by mouth one time only for Acute pain post fall for 1-day acute paint to sacral region post fall on 06/01. Pain reports 8/10 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. A Nurses Note, dated 06/03/2024 at 1:16 AM indicated, .Resident requested a Norco this shift r/t (related to) acute pain scale of 8/10 to lumbar/sacral region post fall on 06/01/24. Resident has an active order for Norco 7.5/325 mg tablets PRN, but none available in cart r/t expiration since Resident had not taken one since January 2024. Norco 7.5/325 mg is not available in facility e-kit, so this nurse contacted on-call provider via Access Medical for further instruction. This nurse spoke with (named provider) APRN (Advanced Practice Registered Nurse) and received orders for the following: STAT x-ray of the lumbar/sacral region and 1 x dose of Norco 5/325 mg to be administered now; call back if dose ineffective. Norco 5/325 mg was administered per orders from facility e-kit, and paperwork faxed to (Named pharmacy) pharmacy as indicated. Provider reports that he will fax to pharmacy a script to provide coverage for used dose from e-kit. This nurse attempted to input order for x-ray to (Named Radiology Company) but (named Radiology Company) site shows Resident's chart as inactive and would not allow order to be processed. This nurse contacted (Named Radiology Company) and spoke with (Named radiology company employee) [at 11:56 PM], who input the order manually from her end for the STAT x-ray. Resident notified of new orders. This nurse did not place a call to Resident's RP (Responsible Party)/daughter, (named daughter), at this time r/t (related to) the non-emergent nature of the clinical situation. Report left for oncoming shifts. Plan of care continues . f. A Nurses Note, dated 06/03/2024 at 3:31 AM indicated, . (Named Radiology Company) technician presented to facility, obtained x-rays, and exited facility. Results pending at this time g. A Nurses Note, dated 06/03/2024 at 3:36 AM indicated, .results returned with the following impression noted: Suspected lower sacral nondisplaced fracture is noted denoted by cortical step deformity seen along its anterior surface. Results reported via facility secure messaging system to facility APRN, (Named APRN); response pending. Resident is resting well at this time with no complaints of pain. (Named) Director of Nursing (DON) notified via telephone correspondence. Resident notified of clinical findings. This nurse attempted to contact the Resident ' s daughter/RP, (Named RP), but was unsuccessful; not able to leave a voicemail. Report left for oncoming shifts. Plan of care continues . h. A form titled Radiology Results Report indicated, .Examination Date: 06/03/2024 .Procedure: Lumbo-sacral spine (2-3 V (View)) AP (Anterior Posterior) Lat (Lateral), Spot/Report .Impression: Suspected lower sacral nondisplaced fracture is noted denoted by cortical step deformity seen along its anterior surface . i. A Progress Note signed by the Advanced Practice Registered Nurse [APRN], dated 06/04/2024 at 10:49 AM, indicated, . This encounter was performed using interactive video and audio communications. This visit is medically indicated to evaluate Resident for sacral pain. Resident stated has pain to lower back, sacrum area following a fall. Pain is becoming worse . Assessment/Plan: 1. Sacral back pain: x-ray to lumbar/sacrum. Hydrocodone 5/325 mg x 1 dose now. RX (Prescription) sent to pharmacy . j. A Progress Note signed by the [APRN] dated 06/05/2024 at 7:01 PM indicated, This visit was conducted via telemedicine with audio and visual. This visit is medically necessary to review x-ray and pain. Resident with non-displaced fracture of sacral area complaining of pain to area at this time . Assessment/Plan: 1. Pain in pelvis: continue Hydrocodone. Hydrocodone 5 mg-acetaminophen 325 mg table - To be submitted on or around 06/06/2024 - Take 1 tablet (s) every 6 hours by oral route for 14 days . 2. Fracture of sacrum - avoid constipation - repeat x-ray in two weeks . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	k. On 06/24/2024 at 1:43 PM, Resident #15 was sitting in wheelchair in the dining room. Resident #15 was asked if had experienced a fall recently. Resident #15 stated, I fell about a month ago. I was dropped out of the sling, and I broke my tail bone. Resident #15 was asked do you have any pain now from the injury to the tail bone. Resident #15 stated No, it is healing really well. l. On 06/25/2024 at 4:10 PM, Licensed Practical Nurse (LPN) #11 was asked how much assistance Resident #15 needs with ADL's (Activities of Daily Living). LPN #11 stated that Resident #15 can help roll over when in bed but cannot get out of bed by alone. We use a total mechanical lift with two people. LPN #11 was asked if they were working the day Resident #15 had the fall from the lift. LPN #11 stated, Yes. I was working. LPN #11 was asked to describe what happened. LPN #11 stated, I was doing medication pass when [Resident #15] was being put back in bed. The CNA (Certified Nurse Aide) came out to get another CNA. Then, the other CNA came out and immediately got me. When I went into the room the Resident was sitting right beside the bed between the legs of the lift. (Named CNA #6) and the Resident both said the lift pad that was divided was not under the Resident's bottom enough and when the aide went to transfer [Resident] slipped off it. The aide said when he realized the Resident was going down, he tried to ease [Resident]down. LPN #11 was asked, when the Resident started to slip out of the lift pad, was there another aide in the room? LPN #11 stated, No it was just the one aide. LPN #11 was asked if there should have been two aides in the room when the transfer was being done. LPN #11 stated, Yes. LPN #11 was asked what they did after entering the room. LPN #11 stated, I immediately assessed the Resident. Resident did not want an x-ray, go to the hospital, and did not complain of any pain. Me and the other two CNAs got the Resident into the bed. I immediately told [CNA #6] that he should not have done it on his own. LPN #11 was asked if all mechanical lift transfers were supposed to be done by two people. LPN #11 stated, Yes, and if they don't have a second CNA, I go with them to be the second person. LPN #11 was asked if they knew how long the CNA did the transfers alone and how long has the CNA worked at the facility. LPN #11 stated, I am not sure. I did not work with him on a frequent basis, but I don't think it was very long. LPN #11 was asked who they reported the incident to. LPN #11 stated, The Director of Nursing. LPN #11 was asked what was done after this incident occurred. LPN #11 stated, We all had to have a whole new education on how to do the lift. I was in-serviced and so was everyone else. LPN #11 was asked if the CNA that did the transfer by themselves still worked at the facility. LPN #11 stated, I didn't ask, but I have not seen him since. LPN #11 was asked if they were aware of any other incidents with the use of the mechanical lift. LPN #11 stated, No. LPN #11 was asked, when they came to work for the facility, if they were trained in the use of the lift. LPN #11 stated, Yes. LPN #11 was asked if Resident #15 had an injury from the incident. LPN #11 stated, once they did convince [Resident #15] to get an x-ray it showed a fractured sacrum. LPN #11 was asked if Resident #15 required pain medication following the incident. LPN #11 stated, [Resident #15] did end up taking pain medication, but that was for a short period of time. I can look in the record and see when [Resident] last took something. The nurse looked in the electronic record and stated, [Resident] took one dose of Hydrocodone on Sunday the 23 rd of June. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	m. On 06/25/2024 at 4:45 PM, the Director of Nurses (DON) was asked if they were familiar with Resident #15's care. The DON stated, Yes. The DON was asked how much assistance Resident #15 required with ADL's. The DON stated, [Resident #15] requires the lift for transfer but is set up with a lot of [Resident's] other ADL's [Activities of Daily Living] . The DON was asked how long has the Resident required the lift for transfer? The DON stated, I have worked here for 6 months, and [Resident] has required the lift all during that time. The DON was asked how many people are required to do a mechanical lift transfer. The DON stated, Two people. The DON was asked if they were involved in the investigation when Resident #15 fell out of the lift. The DON stated, Yes. The DON was asked to describe what happened. The DON stated, (Named CNA #6) was transferring [Resident #15], and [Resident] began to slip out of the lift pad. He assisted [Resident] to the floor. The DON was asked if CNA #6 was doing the transfer by himself. The DON stated, Upon investigation it looked like he was doing it by himself. The DON was asked how long CNA #6 had worked for the facility at the time of the incident. The DON stated, I am not sure exactly, but I believe 2-3 months. The DON was asked what was done when the incident occurred. The DON stated, The immediate intervention was that the nurse that was with him educated him, and then he was suspended pending the investigation. The DON was asked what day CNA #6 was suspended. The DON stated, He was suspended on 06/03/2024. He was supposed to be on his days off, but we had called him in to work on the day of the incident. He was suspended as soon as I read his statement. That's when I identified he was by himself. I immediately pulled his lift check off to ensure that he was checked off prior to performing the lift transfer and he was. The Assistant Director of Nursing and myself trained all the CNAs on the correct use of the lift and we did all new check offs on everyone. The DON was asked how often skills check offs on lift transfers for the aide staff were performed. The DON stated, We do them on hire and then every three months. We did them again on the aides though at that time even if they had just been done. After we did the training, we . the ADON (Assistant Director of Nursing) and I .did monitoring to ensure that staff were doing the procedure correctly and that there were two people at all times. The DON was asked what happened with the CNA that did the transfer by themselves. The DON stated, He was ultimately terminated. He never worked again once he was suspended. The DON was asked if a report was sent to the state regarding the incident. The DON stated, No, we did not. The DON was asked if there had been any other incidents with lift transfers. The DON stated, No. The DON was asked if the Administrator was made aware of the incident. The DON stated, Yes. Immediately. n. On 06/26/2024 at 5:00 PM, the form titled OLTC (Office of Long-Term Care) Witness Statement Form provided by the Director of Nurses dated 06/01/2024 at 4:30 PM and signed by CNA #6 on 06/03/2024 indicated, .I used the mechanical lift by myself to transfer (Resident #15) from [the] wheelchair to [the] bed. While [Resident #15] was in the air, [Resident] began to slip out of the lift pad from the lower body. It was too late to correct the problem, so I placed my arms underneath [Resident] and gradually lowered [Resident] to the ground to prevent a hard fall. Once [Resident] was on the ground, I asked if [Resident] if okay, and [Resident] responded that [Resident] was not hurt. I went and got (named LPN #11), the nurse and (named staff member), CNA to further assist me with getting [Resident] up from the ground. I believe the cause of this accident is that I did not tuck the lift pad enough under [Resident's] body to keep [Resident] from slipping out. I used the light blue lift pad with 6 strings . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o. On 06/26/2024 at 8:50 AM, the Assistant Director of Nursing (ADON) was asked if they were familiar with Resident #15's care. The ADON stated, Yes. The ADON was asked how much assistance [Resident] required with ADL's. The ADON stated, [Resident] is a total assist for transfer so two people. Dressing can be done by one person. The ADON was asked if they were aware of the incident that happened with the lift on June 1st. The ADON stated, Yes. The ADON was asked how they became aware of the incident. The ADON stated, It happened over the weekend, so I did not know about it until I came to work on Monday. Before the morning meeting I always look at the incident and accident reports and that is when I saw [Resident #15] had an incident with the lift. We saw [Resident] had an x-ray and it showed [Resident] had a fracture. The ADON was asked what was done at that point. The ADON stated, We spoke with the Resident and called the CNA. We did an in-service and he was put on leave after we had him write a statement. After we did the rest of the investigation the CNA was terminated. The ADON was asked if anything was done with the other staff members. The ADON stated, We did a lift in-service and lift check off's on all nursing staff. The ADON was asked how they ensured that staff were doing the lift transfers correctly. The ADON stated, The Director of Nursing and I monitored lift transfers for the next two weeks to make sure there were two people and that the staff did the lift transfer correctly. The ADON was asked if a report was done and sent into the state regarding the incident. The ADON stated, Not that I am aware of. p. On 06/26/2024 at 9:30 AM, the Administrator was asked when they became aware that Resident #15 had fallen from the lift. The Administrator stated, It happened on 06/01/2024. I became aware of the incident on 06/03/2024. The Administrator was asked how they became aware of the incident. The Administrator stated, Resident #15 started complaining of pain and [Resident] had an x-ray done and I think [Resident's] tail bone was injured. The incident and accident report did not say anything about [Resident] complaining of pain and it did not say anything about him doing it (the transfer) by himself. The Administrator was asked what they did to investigate the incident. The Administrator stated, We did interviews. That is when we discovered that he did the transfer by himself. We did in-service for all staff. We did check off lists for lift transfers on staff and put a monitor in place to be sure staff were doing the transfers correctly. The employee was terminated for not following policy, but we checked first to make sure he had done the lift skills list prior to doing lift transfers and he had. The Administrator was asked if all lift transfers supposed to be done by two people. The Administrator stated, Yes. The Administrator was asked, When you discovered that the Resident had an injury from the fall, did you do a report and send it into the state? The Administrator stated, I did not. I didn't even think about it honestly. q. On 06/26/2024 at 12:00 PM, the policy titled, Abuse, Neglect, and Maltreatment Investigation and Reporting provided by the Administrator indicated, .Policy: The facility will endeavor to protect Residents/Elders from maltreatment, which means adult abuse, exploitation, neglect, physical abuse, sexual abuse, neglect, and the misappropriation of Resident/Elder property .Identifying, Investigating, & Reporting: 1. Immediate reporting. All incidents of alleged or suspected Resident/Elder maltreatment, including neglect, or abuse and misappropriation of Resident/Elder property must be reported immediately to the Administrator . The administrator will shall conduct a preliminary review of the circumstanced to determine if an allegation of abuse or neglect exists. Following this determination, the Administrator or designee will initiate actions to report incidents as required by State law or regulation, including the Office of Long-Term Care as well as the registry and/or licensing board .Definitions: Neglect: The failure to provide goods and services necessary to avoid physical harm, mental anguish, or emotional distress .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 49071 Based on observations, interviews, and record review, the facility failed to ensure residents who required extensive assistance with personal hygiene were regularly offered trimming or shaving of facial hair to maintain good grooming and hygiene for 3 (Resident #23, #49, and #53) of 3 sampled residents reviewed for activities of daily living (ADLs), and the facility failed to provide continent care every 2 hours for 1 (Resident #53) reviewed for continent care. The findings are: 1. Review of the Medical Diagnosis portion of Resident #23 ' s electronic health record revealed diagnoses of legal blindness, obsessive compulsive disorder, and anxiety disorder. a. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/05/2024 documented Resident #23 scored 13 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS). b. The Care Plan with revision date of 04/16/2024 indicated that Resident #23 (R #23) will be clean and well-groomed daily. c. On 06/24/2024 at 10:21 AM, surveyor observed R#23 up in wheelchair with 1/4-inch white hair to chin and around mouth. d. On 06/24/2024 at 1:44 PM, surveyor observed R#23 with 1/4-inch white facial hair to chin and around mouth. e. On 06/25/2024 at 8:37 AM, surveyor observed R#23 with 1/4-inch white facial hair to chin and around mouth. f. On 06/26/2024 at 8:41 AM, observed R#23 with 1/4-inch white facial hair to chin and around mouth. g. Activities of daily living (ADL) sheet provided by facility did not indicate R#23 was shaved. 2. Review of the Medical Diagnosis portion of Resident #49 ' s electronic health record revealed diagnoses of dementia, Alzheimer disease, and anxiety disorder. a. The Quarterly MDS with an ARD of 05/22/2024 documented Resident #49 scored 03 (00-07 indicates severely cognitively impaired) on the BIMS. b. The Care Plan with revision date of 05/24/2024 indicated that R#49 will shower/bathe self: Requires supervision assist of 1 staff. If bathing refused, give him an option to return later for bath/shower. c. On 06/24/2024 at 10:14 AM, surveyor observed R#49 in room with 1/4-inch white facial hair on both facial cheeks and chin. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 06/24/2024 at 1:44 PM, surveyor observed R#49 with 1/4-inch white facial hair to both facial cheeks and chin. e. On 06/25/2024 at 8:35 AM, surveyor observed R#49 with 1/4-inch white facial hair to both facial cheeks and chin. f. An Activities of Daily Living (ADL) Sheet was provided by facility but did not indicate that R#49 was shaved. 3. Review of the Medical Diagnosis portion of Resident #53 ' s electronic health record revealed diagnoses of Alzheimer ' s disease, psoriasis, and dementia. a. The Quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 4/25/2024 documented R#53 scored 99, (00-07 indicates severely impaired). Brief interview for mental status (BIMS). b. The Care Plan with revision date of 05/30/2024 indicated that R#53 has an ADL self- care performance deficit due to cognitive decline and indicates R#53 will be clean and well-groomed daily. R#53 He requires partial assistance x 1-2 staff for bathing. If he refuses his bath, please return later to offer bath again. c. On 06/24/2024 at 10:00 AM, surveyor observed R#53 with 1/2 inch black and white facial hair to both facial cheeks and chin. d. On 06/24/2024 at 2:36 PM, surveyor observed R#53 with 1/2 inch black and white facial hair to both facial cheeks and chin. e. On 06/24/2026 at 3:12 PM, Certified Nursing Assistant (CNA) #10 was asked when R#53 ' s brief was last changed. CNA #10 replied, Earlier this morning. CNA #10 was asked to observe R#53 and asked to describe what was seen. CNA #10 replied, Urine has soaked through the pajama bottoms and is on the back of the Resident ' s shirt, and the specialty chair cushion is soaked. CNA #10 was asked if R#53 should go this long without having a brief changed. CNA #10 stated, No they shouldn't, but it is just me back here and I didn't get time to change him earlier. f. On 06/25/2024 at 8:37 AM, surveyor observed R#53 with 1/2 inch black and white hair to both facial cheeks and chin. g. On 06/26/2024 at 8:41 AM, surveyor observed R#53 with 1/2 inch black and white hair to both facial cheeks and chin. h. Activities of daily living (ADL) sheet provided by the facility did not indicate R#53 had been shaved. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. On 06/24/2024 at 10:18 AM, CNA #7 was asked to describe the facility protocol for changing a resident. CNA #7 replied, Every 2 hours and depending on the resident, I may check them every hour. CNA #7 was asked why it is important to make sure residents are changed frequently. CNA #7 replied, Residents don't need to sit in soiled brief, smell and can cause skin breakdown. CNA #7 was asked how often a resident should be checked if they were unable to tell report needing changed. CNA #7 replied, Every 2 hours or even hourly if needed. CNA #7 was asked if it is appropriate for a resident to go an entire shift without having their brief changed. CNA #7 replied, Oh, my goodness no, it should be changed every 2 hours. CNA #7 was asked if a resident should be left in a brief that has soaked through residents clothing and has saturated the back of the resident's shirt and the cushion in the chair has so much urine it was liquid on the top of it. CNA #7 replied, No that means they have been in the same brief for all day at least and that can cause skin issues and odors. CNA #7 was asked how often the residents are showered. CNA #7 replied 3 times a week. How often are the residents shaved? CNA #7 replied 3 times a week. When is this done? CNA #7 replied, when they get their shower, they should be shaved. What is the facility protocol for residents who refuse their showers or to be shaved? CNA #7 replied, I go tell my nurse then I try to ask them again before the end of the shift. and then I document it in the kiosk. j. On 06/26/2024 at 11:18 AM, CNA #9 was asked how often a resident's brief should be checked. CNA #9 replied, Every 2 hours. CNA #9 was asked why it is important to make sure that a resident gets changed regularly. CNA #9 replied, So they don't sit in a soiled brief. CNA #9 was asked if it is appropriate for a resident to go 6 to 8 hours without having their brief changed. CNA #9 replied, No, that should never happen. CNA #9 was asked if a resident should be left in a brief that has soaked through their pants and soaked the back of their shirt their seat cushion has a puddle of wet substance in it. CNA #9 replied, Never ever. j. On 06/26/2024 at 10:36 AM, Licensed Practical Nurse (LPN)#8 was asked how often the residents get showered. LPN #8 replied, 3 times a week. LPN #8 was asked how often the residents get shaved. LPN #8 replied, They get shaved when they get showered and there are orders for them to be shaved on Sundays. LPN #8 was asked who is responsible for shaving the residents. LPN#8 replied, The CNA's do. LPN #8 was asked who is responsible for assuring that shaving is getting done. LPN#8 replied, Well, the nurse is, I guess. LPN #8 was asked why it is important to make sure a resident gets a bath and shaved. LPN#8 replied, They look and feel better, helps with spreading of germs. LPN #8 was asked for the facility ' s protocol when a resident refuses a shower or shave. LPN#8 replied, The CNA will tell me, then I go and attempt to get them to shower if no luck then I will call the family and document that I called them. (continued on next page)

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	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Oaks Healthcare and Rehabilitation Center	105 Russellville Road Malvern, AR 72104

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	k. On 6/26/2024 at 10:50 AM, the Director of nursing (DON) was asked for the facility protocol for changing residents. The DON replied, Every 2 hours or more if needed. The DON was asked why it is important that residents are changed every 2 hours. The DON replied, Dignity and health. The DON was asked how they ensured that residents are being changed every 2 hours. The DON replied, I go round frequently in the building and check them. The DON was asked If a resident is unable to tell you they need changed, how often should they be checked. The DON replied, Every 2 hours and as needed. The DON was asked if it was appropriate for a resident to go 6 hours without having their brief changed. The DON replied, No ma'am, that is a dignity issue and can cause skin issues. The DON was asked if a resident should be left in a brief that has soaked through their pants and the back of their shirt and the cushion in the chair had a puddle of liquid on it. The DON replied, Absolutely not. The DON was asked how often the residents get showered. The DON replied, 3 times a week or more if needed or if they ask to be showered more often. The DON was asked how often the residents are shaved. The DON replied, When they receive a shower or if their hair grows fast more often if needed. The DON was asked who is responsible for making sure showers and shaving are done. The DON replied, The CNA's are. The DON was asked for the facility protocol if a resident refuses to be showered or shaved. The DON replied, The CNA will tell the nurse, then they are asked 3 times by different staff members and then if they still will not allow us to shower or shave them, we call the family and notify them. The DON was asked why it is important that a resident receives showers and is shaved. The DON replied, Good hygiene. The DON was asked if it is appropriate for a resident to have 1/4-1/2-inch facial hair. The DON replied, No, I don't. 4. On 06/26/2024 at 1:38 PM, the facility was asked for a policy on Activities of Daily Living (ADL). The surveyor was informed the facility did not have a policy.

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	045270	A. Building B. Wing	06/27/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42965 49071 Based on observation, record review and interview, the facility failed to ensure staff followed care planned intervention requiring two staff members to perform mechanical lift transfers to promote resident safety and prevent fall with injury for 1 (Resident #15) of 8 (Residents #3, #6, #10, #15, #20, #26, #33 and #46) sampled residents who required the mechanical lift for transfer. This failed practice resulted in actual harm for Resident #15, who fell and sustained a fracture, and had the potential to cause more than minimal harm for 13 residents who required transfers with a mechanical lift. The facility failed to ensure that chemicals were kept out of reach for 1 (Resident #49) sampled resident. The findings are: 1. The Significant Change in Condition Minimum Data Set (MDS) with an Assessment Reference Date of 06/05/2024 indicated Resident #15 had diagnoses of heart failure, diabetes mellitus, arthritis, and other fracture, and that the resident scored 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS), was dependent for transfers, and had one fall with major injury. a. The Care Plan with a revision date of 04/30/2024 indicated, .Problem: (Resident #15) has an ADL (Activities of Daily Living) self-care performance deficit .Approaches/Tasks .TRANSFER: (Resident) is dependent on total assist via Mechanical Lift with (2) staff assist for transfers with full blue sling . b. The Care Plan with a revision date of 06/03/2024 indicated, .Problem: (Resident #15) is at risk for falls r/t (related to) bilateral lower extremity weakness & daily use of psychotropic drugs. 6/1/24- fall with injury .Goal: Will be free of falls through the review date . c. An Incident Note dated 06/01/2024 at 6:33 PM by Licensed Practical Nurse (LPN) #11 indicated, .Nature and Description of Incident: CNA (Certified Nursing Assistant) was transferring resident back to bed using lift. While resident was in lift resident began to slowly slip out of the lift pad from the bottom. Resident was assisted to the ground by CNA to prevent hard fall. Resident states no injury and did not hit head. There is a scratch on her lower back from where she made contact with the leg of the lift .Description of Injuries: Scratch noted to lower back .Immediate Action Take: CNA was reeducated on how to position lift pad and resident while using lift and lift use safety . d. An Order Administration Note dated 06/03/2024 at 1:05 AM indicated, .Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (milligram) Give 1 tablet by mouth one time only for acute pain post fall 1 Day acute pain to sacral region post fall on 06/01. Pain reports 8/10 . (continued on next page)

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	045270	A. Building B. Wing	06/27/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	e. A Nurses Note dated 06/03/2024 at 1:16 AM indicated, .Resident requested a Norco this shift r/t (related to) acute pain scale of 8/10 to lumbar/sacral region post fall on 06/01/24. Resident has an active order for Norco 7.5/325 mg tablets PRN [when needed], but none available in cart r/t (related to) expiration since Resident had not taken one since January 2024. Norco 7.5/325 mg is not available in facility e-kit, so this nurse contacted on-call provider via Access Medical for further instruction. This nurse spoke with (named provider) APRN (Advanced Practice Registered Nurse) and received orders for the following: STAT x-ray of the lumbar/sacral region and 1 x dose of Norco 5/325 mg to be administered now; call back if dose ineffective. Norco 5/325 mg was administered per orders from facility e-kit, and paperwork faxed to (Named pharmacy) pharmacy as indicated. Provider reports that he will fax to pharmacy a script to provide coverage for used dose from e-kit. This nurse attempted to input order for x-ray to (Named Radiology Company) but (named Radiology Company) site shows resident's chart as inactive and would not allow order to be processed. This nurse contacted (Named Radiology Company) and spoke with (Named radiology company employee) at 11:56 PM, who input the order manually from her end for the STAT (medical abbreviation for urgent or rush) x-ray. Resident notified of new orders. This nurse did not place a call to resident's RP (Responsible Party) at this time r/t (related to) the non-emergent nature of the clinical situation. Report left for oncoming shifts. Plan of care continues . f. A Nurses Note dated 06/03/2024 at 3:31 AM indicated, .(Named Radiology Company) technician presented to facility, obtained x-rays, and exited facility. Results pending at this time . g. A Nurses Note dated 06/03/2024 at 3:36 AM indicated, .results returned with the following impression noted: Suspected lower sacral nondisplaced fracture is noted denoted by cortical step deformity seen along its anterior surface. Results reported via facility secure messaging system to facility APRN, (Named APRN); response pending. Resident is resting well at this time with no complaints of pain. (Named) Director of Nursing (DON) notified via telephone correspondence. Resident notified of clinical findings. This nurse attempted to contact resident's (Responsible Party), but was unsuccessful; not able to leave a voicemail. Report left for oncoming shifts. Plan of care continues . h. A form titled, Radiology Results Report documented, .Examination Date: 06/03/2024 .Procedure: Lumbo-sacral spine (2-3 V (View)) AP (Anterior Posterior) Lat (Lateral), Spot/Report .Impression: Suspected lower sacral nondisplaced fracture is noted denoted by cortical step deformity seen along its anterior surface . i. A Progress Note signed by the Advanced Practice Registered Nurse [APRN], dated 06/04/2024 at 10:49 AM, indicated, .This encounter was performed using interactive video and audio communications. This visit is medically indicated to evaluate Resident for sacral pain. Resident states experiencing pain in lower back, sacrum area following a fall. Pain is becoming worse . Assessment/Plan: 1. Sacral back pain: x-ray to lumbar/sacrum. Hydrocodone 5/325 mg x 1 dose now. rx (Prescription) sent to pharmacy . j. A Progress Note signed by the APRN dated 06/05/2024 at 7:01 PM indicated, This visit was conducted via telemedicine with audio and visual. This visit is medically necessary to review x-ray and pain. Resident with non-displaced fracture of sacral area complaining of pain to area at this time .Assessment/Plan: 1. Pain in pelvis: continue Hydrocodone. Hydrocodone 5 mg-acetaminophen 325 mg table - To be submitted on or around 6/6/24 - Take 1 tablet (s) every 6 hours by oral route for 14 days .2. Fracture of sacrum - avoid constipation - repeat x-ray in two weeks . (continued on next page)

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	045270	A. Building B. Wing	06/27/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	k. On 06/24/2024 at 1:43 PM, Resident #15 was sitting in a wheelchair in the dining room. Resident #15 was asked if experienced a fall recently? Resident #15 stated, I fell about a month ago. I was dropped out of the sling, and I broke my tail bone. He was working the lift by himself. l. On 06/25/2024 at 4:10 PM, Licensed Practical Nurse (LPN) #11 was asked how much assistance Resident #15 needed with ADL's (Activities of Daily Living)? LPN #11 stated, Resident #15 can help roll over when in bed, but cannot get out of bed by alone. We use a total mechanical lift with two people. LPN #11 was asked if working the day Resident #15 had the fall from the lift? LPN #11 stated Yes I was working. LPN #11 was asked to describe what happened. LPN #11 stated, I was doing medication pass when [Resident #15] was being put back in bed. The CNA (Certified Nurse's Aide) came out to get another CNA. Then the other CNA came out and immediately got me. When I went into the room Resident was sitting right beside the bed between the legs of the lift. (Named CNA #6) and the Resident both said the lift pad that was divided was not under the Resident's bottom enough and when the aide went to transfer her, [Resident #15] slipped off. (The aide) said when he realized that the Resident was going down, he tried to ease [Resident] down. LPN #11 was asked when the Resident started to slip out of the lift pad, was there another aide in the room. LPN #11 stated, No it was just the one aide. LPN #11 was asked if there should there have been two aides in the room when the transfer was being done. LPN #11 stated, Yes. LPN #11 was asked, What did you do after you entered the room? LPN #11 stated, I immediately assessed the Resident. [Resident] did not want an x-ray or go to the hospital. [Resident] did not complain of any pain. Me and the other two CNAs got the Resident into the bed. I immediately told [CNA #6] he should not have done it on his own. LPN #11 was asked if all mechanical lift transfers were supposed to be done by two people. LPN #11 stated, Yes, and if they don't have a second CNA, I go with them to be the second person. LPN #11 was asked who they reported the incident to. LPN #11 stated, The Director of Nursing [DON]. LPN #11 was asked what was done after this incident occurred. LPN #11 stated, We all had to have a whole new education on how to do the lift. I was in-serviced and so was everyone else. LPN #11 was asked if the CNA that did the transfer by themselves still worked at the facility. LPN #11 stated, I didn't ask, but I have not seen him since. LPN #11 was asked, when you came to work for the facility, were you trained in the use of the lift? LPN #11 stated, Yes. LPN #11 was asked if the Resident sustained an injury from the incident. LPN #11 stated, once they did convince [Resident #15] to get an x-ray it showed a fractured sacrum. (continued on next page)

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	045270	A. Building B. Wing	06/27/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	m. On 06/25/2024 at 4:45 PM, the DON was asked if familiar with Resident #15's care. The DON stated, Yes. The DON was asked how much assistance the Resident required with ADL (Activities of Daily Living). The DON stated, [Resident #15] requires the lift for transfer but is set up with a lot of the other ADLs. The DON was asked, how long has the Resident required the lift for transfer? The DON stated, I have worked here for 6 months, and [Resident #15] has required the lift all during that time. The DON was asked how many people are required to do a mechanical lift transfer. The DON stated, Two people. The DON was asked if they were involved in the investigation when (Resident #15) fell out of the lift. The DON stated, Yes. The DON was asked to describe what happened. The DON stated, (Named CNA #6) was transferring [Resident #15], and [Resident #15] began to slip out of the lift pad. He assisted [Resident #15] to the floor. The DON was asked if CNA #6 was doing the transfer by himself. The DON stated, Upon investigation it looked like he was doing it by himself. The DON was asked how long the aide had worked for the facility at the time of the incident. The DON stated, I am not sure exactly, but I believe 2-3 months. The DON was asked what was done when the incident occurred. The DON stated, The immediate intervention was the nurse with him educated him and then he was suspended pending the investigation. The DON was asked, what day was he suspended? The DON stated, He was suspended on 06/03/2024. He was supposed to be on his days off, but we had called him in to work on the day of the incident. He was suspended as soon as I read his statement. That's when I identified he was by himself. I immediately pulled his lift check off to ensure that he was checked off prior to performing the lift transfer and he was. The Assistant Director of Nursing (ADON) and myself trained all the CNAs on the correct use of the lift and we did all new check offs on everyone. The DON was asked, how often do you do skills check offs on lift transfers on the aide staff? The DON stated, We do them on hire and then every three months. We did them again on the aides though at that time even if they had just been done. After we did the training, we, the ADON and I, did monitoring to ensure that staff were doing the procedure correctly and that there were two people at all times. The DON was asked, what happened with the CNA that did the transfer by themselves? The DON stated, He was ultimately terminated. He never worked again once he was suspended. The DON was asked, did you send a report into the state of the incident? The DON stated, No we did not. The DON then stated, We also had our service provider for the lifts (named provider) come out and check all the lifts to ensure it was not a failure with the lift. The MDS (Minimum Data Set) Coordinator also checked to make sure that every one that used a mechanical lift was appropriately marked on the kiosk. We even made a video of the correct use of the lift, and we use that with our in-service and skills check-off lists now The DON was asked if they let the Administrator know about the incident. The DON stated, Yes. Immediately. The DON then provided the Surveyor the folder with the documentation of the investigation she did after the incident and the measures that were put in place to correct the deficient practice. n. On 06/26/2024 at 5:00 PM, the form titled OLTC (Office of Long-Term Care) Witness Statement Form provided by the Director of Nurses dated 6/1/2024 at 4:30 PM and signed by CNA #6 on 6/03/2024 indicated, .I used the mechanical lift by myself to transfer (Resident #15) from the wheelchair to the bed. While [Resident #15]was in the air, [Resident] began to slip out of the lift pad from the lower body. It was too late to correct the problem, so I placed my arms underneath [Resident] and gradually lowered [Resident] to the ground to prevent a hard fall. Once [Resident] was on the ground, I asked if [Resident] was okay, and [Resident] responded that [Resident] was not hurt. I went and got (named LPN #11), the nurse and (named staff member), CNA to further assist me with getting (Resident) up from the ground. I believe the cause of this accident is that I did not tuck the lift pad enough under her body to keep [Resident] from slipping out. I used the light blue lift pad with 6 strings . (continued on next page)

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	045270	A. Building B. Wing	06/27/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	o. On 06/26/2024 at 8:50 AM, the Assistant Director of Nursing (ADON) was asked if familiar with Resident #15's care. The ADON stated, Yes. The ADON was asked how much assistance does Resident #15 require with ADL's. The ADON stated, [Resident #15] is a total assist for transfer so two people. Dressing can be done by one person. The ADON was asked if aware of the incident that happened with the lift on June 1st? The ADON stated, Yes. The ADON was asked how became aware of the incident. The ADON stated, It happened over the weekend, so I did not know about it until I came to work on Monday. Before the morning meeting, I always look at the incident and accident reports and that is when I saw [Resident #15] had an incident with the lift. We saw [Resident] had an x-ray and it showed [Resident] had a fracture. The ADON was asked what was done at that point. The ADON stated, We spoke with the Resident and called the CNA. We did an in-service and he was put on leave after we had him write a statement. After we did the rest of the investigation the CNA was terminated. The ADON was asked how they ensure that staff were doing the lift transfers correctly. The ADON stated, The Director of Nursing and I monitored lift transfers for the next two weeks to make sure there were two people and that the staff did the lift transfer correctly. p. On 6/26/24 at 9:30 AM, the Administrator was asked when they became aware that Resident #15 had fallen from the lift. The Administrator stated, It happened on 06/01/2024. I became aware of the incident on 6/3/2024. The Administrator was asked how they become aware of the incident. The Administrator stated, The Resident started complaining of pain and [Resident #15] had an x-ray done and I think [Resident' s] tail bone was injured. The incident and accident report did not say anything about [Resident] complaining of pain and it did not say anything about him doing it (the transfer) by himself. The Administrator was asked what was done to investigate the incident. The Administrator stated, We did interviews. That is when we discovered that he did the transfer by himself. We did in-service for all staff. We did check off lists for lift transfers on staff and put a monitor in place to be sure staff were doing the transfers correctly. The employee was terminated for not following policy, but we checked first to make sure he had done the lift skills list prior to doing lift transfers and he had. The Administrator was asked if all lift transfers are supposed to be done by two people. The Administrator stated, Yes. r. On 06/26/2024 at 12:00 PM, the Administrator was asked for a policy on mechanical lift transfers. s. On 06/26/2024 at 12:05 PM, the Director of Nursing stated, We do not have a policy on lift transfers, we refer to the Manufactures Guidelines 2. The Medical Diagnoses portion of Resident #49's electronic health record revealed diagnoses of Alzheimer disease, vascular dementia, and anxiety disorder. a. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/22/2024 documented Resident #49 scored 03 (00-07 indicates severely impaired cognition) on the Brief Interview for mental Status (BIMS) b. Review of the Care Plan with a revision date of 02/09/2024 revealed Resident #49 re-arranges furniture and pulls out drawers in his/her room and will also place it in bathroom related to dementia and poor safety awareness. c. On 06/24/2024 at 10:14 AM, the surveyor observed in Resident #49's bathroom a can of disinfectant spray and a can of cleaning spray solution. (continued on next page)

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	045270	A. Building B. Wing	06/27/2024

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F 0689 Level of Harm - Actual harm Residents Affected - Few	d. On 06/24/2024 at 3:55 PM, the surveyor observed in Resident #49's bathroom a can of disinfectant spray and a can of cleaning spray solution. e. On 06/25/2024 at 8:35 AM, the surveyor observed in Resident #49's bathroom a can of disinfectant spray and a can of cleaning spray solution. f. On 06/26/2024 at 8:41 AM, the surveyor observed in Resident #49's bathroom a can of disinfectant spray and a can of cleaning spray solution. g. On 06/26/2024 at 10:18 AM, Certified Nursing Assistant (CNA) #7 was asked to describe the facility protocol for allowing residents to keep cleaning agents and disinfectant sprays in their room. CNA #7 stated they are not supposed to have them in their rooms, we are supposed to lock them up in the shower room. CNA #7 was asked if residents wander into other resident's rooms. CNA #7 replied, Yes, all the time. CNA #7 was asked who is responsible for making sure chemicals and disinfectants aren't left out in resident ' s rooms. CNA #7 replied, The CNA's, nurse, housekeeping, and anyone who goes in the room. CNA #7 was asked how often the rooms checked to assure chemicals are not left out in a resident ' s room. CNA #7 replied, Every shift. The Surveyor took CNA #7 into the Resident's room to the bathroom and asked her to describe what she saw. CNA #7 identified a can of disinfectant and a can of cleaning spray. On 06/26/2024 at 10:36 AM, LPN #8 was asked to explain the facility protocol for having chemicals and disinfectants in a resident's rooms. LPN #8 replied, They should never have it in their room. LPN #8 was asked who is responsible for making sure that these chemicals are not in the residents rooms. LPN#8 replied, All the staff. CNAs should check the room every shift but anyone who goes in the room should be checking. The Surveyor took LPN #8 to Resident #49 ' s bathroom and asked her to describe what she saw. LPN #8 said there is a can of cleaning spray and a can of disinfectant. LPN #8 was asked if this was safe to be in this room. LPN #8 replied, No, it isn't. LPN #8 was asked how often rooms should be checked to assure that chemicals are not in the residents rooms. LPN #8 replied, When you first arrive on the shift and after housekeeping leaves to assure, they didn't leave a can of something in the room. On 06/26/2024 at 10:50 AM, the DON was asked for the facility protocol regarding having chemicals and disinfectants in a resident ' s room. The DON replied, They are not allowed to have them in their rooms. The DON was asked if residents wander into other residents rooms. The DON replied, Yes, all the time. The DON was asked who is responsible for making sure that chemicals are not left in a resident's rooms. The DON replied that every person who goes in that room should be checking and if found remove them. The DON was asked how often are rooms checked to ensure there are no chemicals in residents rooms. The DON replied, They are checked a minimal of every 2 hours or when someone goes in the room. On 06/26/2024 at 2:48 PM, the facility was asked to provide a policy and surveyor was informed they did not have a policy.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of residents for 1 of 1 meal observed. This failed practice had the potential to affect 36 residents who received regular diets, 23 mechanical soft diets, and 2 residents who received pureed diets from 1 of 1 kitchen. The findings are: 1. The menu for the 06/24/2024 noon meal documented all diets were to receive cake, residents who received pureed diets were to receive 6 ounces of pureed chicken fajita (2/3 cup) and all residents were to receive sour cream pound cake. 2. On 06/24/2024 at 11:25 AM, Dietary [NAME] (DC) #1 used a #16 scoop (2 ounces) (1/4 cup) to place 6 servings of chicken fajita into a blender, with no tortilla or bread, (DC)#1 added chicken broth and pureed. At 11:27 AM, DC #1 poured the pureed chicken fajita into a pan and placed it in the oven. 3. On 06/24/2024 at 12:30 PM, DC #1 used a #8 scoop (1/2 cup) to serve a single portion of pureed chicken fajita with no tortilla or bread to the residents on pureed diets. The menu specified for each resident on pureed diets to receive a #6 scoop of pureed chicken fajita (2/3 cup). 4. On 06/24/2024 at 1:15 PM, no cake served to residents during the lunch meal. On 06/25/24 at 7:50 AM, the surveyor asked Dietary Aid (DA)#2 the reason cake was not served to the residents. DA #2 stated, I totally forgot. I thought it was supposed to be peaches. 5. On 06/24/2024 at 1:16 PM, the surveyor asked DC #1 what scoop size she had used to portion out chicken fajita for the residents who required pureed diets. She stated #16 scoop. The surveyor asked DC #1 how many servings of chicken fajita she prepared for the residents on pureed diets. DC #1 stated, I put 6 servings. The surveyor asked Dietary [NAME] #1 what scoop size she used to serve pureed chicken fajita and how many servings each resident received. Dietary [NAME] #1 stated, I used a #8 scoop, and I gave one serving each. The surveyor asked DC #1 the reason tortilla was not used pureed. DC #1 stated, They may choke on it. I should have used bread.

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	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Oaks Healthcare and Rehabilitation Center	105 Russellville Road Malvern, AR 72104

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 03508 Based on observation and interview, the facility failed to ensure pureed food items were blended to a smooth, lump free consistency to minimize the risk of choking or other complications for residents who required pureed diets for 2 of 2 meals observed. The failed practice had the potential to affect 2 residents who received pureed diets. The findings are: 1. On 06/24/2024 at 10:36 AM, Dietary [NAME] (DC)#1 used a #8 scoop to place 6 servings of refried rice into a blender, added beef broth and pureed. DC #1 poured the pureed refried rice into a pan and placed it in the oven. The consistency of the pureed refried rice was runny. At 11:35 AM, DC #1 added thickener into a pan of pureed rice that was on the steam table and mixed it with a spoon, which created lumps of thickener that were not completely dissolved in the mixture. 2. On 06/24/24 10:50 AM, DC #1 used a #8 scoop to place 4 servings of refried beans into a blender and pureed. DC #1 poured the pureed refried beans into a pan and placed it in the oven. The consistency of the pureed refried was thick. 3. On 06/24/2024 at 11:57 AM, the surveyor asked DC #1 to describe the consistency of the pureed refried rice and pureed refried beans. DC #1 stated, Pureed refried beans was thick. I added thickener on refried rice because it was thin, and it left lumps. 4. On 06/24/2024 at 12:50 PM, the surveyor asked Certified Nursing Assistant (CNA) #3 who was assisting residents in the unit dining room with their meal to describe the consistency of the pureed food items served to the residents on pureed diets. She stated, They were thick. 5. On 06/24/2024 at 12:55 PM, the surveyor asked (Licensed Practical Nurse) LPN #4 to describe the consistency of the pureed food items served to the residents on pureed diets. She stated, Pureed refried beans was thick, pureed refried rice was sticky and thick, and both pureed regular peaches and pureed peaches with cottage cheese were thin. 6. On 06/25/2024 at 7:51 AM. the surveyor asked DC #1 to describe the consistency of the pureed sausage served to the residents on pureed diets for breakfast. DC #1 stated It was lumpy, it was supposed to be smooth.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, record review, and interview, the facility failed to ensure food items stored in the freezer were sealed or covered, food items stored in the storage room were stored in accordance with the manufacturer's instructions; failed to ensure dietary staff washed their hands between dirty and clean tasks and before handling clean dishes or food items; expired products were promptly removed/discarded on or before the expiration or use by date to prevent the growth of bacteria, failed to ensure hot foods was maintained at or above 135 degrees Fahrenheit (F.) while awaiting to be served to prevent potential food borne illness, and failed to ensure leftover food items were not used for residents who received meals from 1 of 1 kitchen to maintain food quality and prevent the growth of bacteria. These failed practices had the potential to affect 62 residents who received meals from the 1 of 1 kitchen. The findings are: 1. On [DATE] at 9:40 AM, the following observations were made in the kitchen. a. Dietary [NAME] (DC)#1 picked a spatula from the edge of the grill she had used to stir food items on the grill. Without washing her hands, she used her bare hand to pick up slices of bacon and placed them on the tray to be used for the breakfast meal on [DATE]. The surveyor asked DC#1 what should have been done after touching dirty objects and before handling food items? DC#1 stated, I should have washed my hands. b. There were 5 glasses that contained lemonade, 5 glasses with punch and 13 glasses with tea that did not have lids on them, exposing them to possible air contamination or pests. The surveyor asked the Dietary Manager should those glasses be covered. She stated, Yes. They should be covered. c. The floor tile in front of the freezer was peeling off. The area that was peeled off had a red color to it that caused the shoe to stick on it. 2. On [DATE] at 9:48 AM, an opened bottle of syrup was on a shelf in the refrigerator. There was no opened date on the bottle to ensure first in and first out. 3. On [DATE] at 9:51 AM, the following observations were made in the refrigerator: a. There was a container of leftover mushrooms on a shelf. The container had a date of [DATE]. The surveyor asked DC #1 how long the leftover food items should be kept in the refrigerator? DC#1 stated, We keep them for 7 days. b. A gallon of soy sauce on a shelf in the refrigerator had an expiration date of [DATE]. 4. On [DATE] at 10:01 AM, a container of ground mustard on the spices rack in the kitchen had an expiration date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. On [DATE] at 10:13 AM, the following observations were made in the dish washing machine room. a. The edges, the planes, and the inside of the vent hood in the dish washing machine has an accumulation of built up of rust on them. b. The wall in the dish washing machine room had discoloration of sage color on it. The Dietary Manager stated, There was mold build up. They needed to be stained. 6. On [DATE] at 10:18 AM, an opened box of loose tea was on a shelf below the tea maker. The box was not covered or sealed. 7. On [DATE] at 10:20 AM, DC #1 picked up a dirty pan and took it to the dish washing machine room and placed it on a dirty shelf to be washed. Without washing her hands. She picked up clean dishes and stacked them on a shelf with her fingers on the inside of the plates. 8. On [DATE] at 10:29 AM, the following personal items were on the food preparation counter by a zip lock bag that contained slices of green bell pepper: a. A telephone, cigarette lighter bag and a water bottle. The surveyor asked DC #1 if a telephone, cigarette lighter bag and personal cup were supposed to be on the food preparation table. DC #1 stated, No. 9. On [DATE] at 10:32 AM, the shelf below the food preparation counter where clean pans were stored had loose food particles. 10. On [DATE] at 10:35 AM, Dietary Aide (DA) #2 turned on the hand washing sink faucet and washed her hands. As she finished washing her hands, she turned off the faucet with her bare hands, contaminating her hands. Without washing her hands, DA #2 picked up glasses by the rims and stacked them on a shelf to be used in serving beverages to the residents for the lunch meal. DA #2 also picked up dishes with her long fingernails with nail polish inside of the plates. 11. On [DATE] at 10:47 AM, DC #1 grabbed a surveyor on her arms with her bare hands, contaminating her hands. Without washing her hands, she picked up a clean blade and attached it to the base on the blender to be used in pureeing food items to be served to the residents on pureed diets. The Dietary Manager informed DC #1 to rewash the blade and the blender before using it. 12. On [DATE] at 10:55 AM, an opened box of cobbler crust dough shell was on a shelf in the freezer. The box was not covered or sealed. 13. On [DATE] at 10:58 AM, the following observations were made in the storage room: a. An opened bottle of soy sauce was on a shelf in the storage room. The manufacturer specification on the bottle documented, Refrigerate after opening. b. 18 boxes of corn starch on a shelf in the storage room with expiration dates of [DATE]. 14. On [DATE] at 11:15 AM, the spout of a pitcher in the refrigerator that contained punch was not covered, exposing it to air or cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	15. On [DATE] at 11:57 AM, DC #1 checked and read the temperatures of the hot food items that had been placed on the serving line on the steam table in preparation for the lunch meal service. The temperature was ground chicken fajita at 128 degrees Fahrenheit. At 12:20 PM, the chicken fajita was not reheated before being served to the residents on mechanical soft diets. On [DATE] at 07:52 AM, the surveyor asked Dietary Manager and DC #1 What should you do when food items are not hot enough on the steam table? Dietary Manager stated, We should have pull it out and reheated it. 16. The facility policy titled, Hand Washing and Glove Usage in Food Service, provided by the Dietary Manager on [DATE] at 08:26 AM on documented, When food handlers must wash their hands: Before starting work .After touching anything else such as dirty equipment and work surfaces or cloths .