STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045284	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pocahontas Healthcare and Rehabilitation Center	105 Country Club Road Pocahontas, AR 72455

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 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility document review, the facility failed to ensure that nursing staff responded appropriately to an unwitnessed fall, specifically failing to notify the appropriate parties and initiate neurological checks for an unwitnessed fall for one (Resident #1) of three residents reviewed for falls. Following the incident and prior to the surveyors entry into the facility, the facility terminated LPN #1 and initiated and completed a corrective action plan, thus these findings indicate past non-compliance. The findings include: A review of the admission Record indicated that Resident #1 was admitted [DATE] with diagnoses that included hypertensive encephalopathy (brain dysfunction) and hypertensive emergency. A review of the admission Minimum Data Set with an Assessment Reference Date of 02/14/2025 revealed Resident #1 had a Brief Interview for Mental Status score of 8, which indicated moderate cognitive impairment. The MDS also indicated Resident #1 required partial or moderate assistance with toilet transfer, with the helper doing less than half the effort. Resident #1 had a fall in the last month, had a fall within the last two to six months, and a fracture related fall within the last six months. A review of the Care Plan, initiated on 02/13/2025, indicated that Resident #1 required weight-bearing assistance with activities of daily living due to weakness, that Resident #1 was at risk for falls, and had an actual unwitnessed fall on 02/20/2025, with the goal that Resident #1 will not sustain serious injury through the review date. A review of the Fall Risk Assessment, dated 02/20/2025 at 12:22 PM, indicated that Resident #1 scored a 13, which indicated a high risk for falls. A review of the Order Summary for Resident #1 revealed an order, dated 02/13/2025, for an anti-platelet medication to be administered one time daily. (continued on next page)

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

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F 0726 Level of Harm - Actual harm Residents Affected - Few	A review of the OLTC (Office of Long-Term Care) Witness Statement, dated 02/20/2025 at 6:43 PM and provided by LPN #5, indicated Certified Nursing Assistant (CNA) #2 had placed Resident #1 on the toilet. Resident #1 pulled the call light, which indicated they were finished. While CNA #2 was walking toward the room, she heard the resident fall. LPN #5 entered the room and found Resident #1, without their walker, on their right side lying with their right arm under their head. Resident #1 stated that their back was sore, and that the resident did not recall hitting their head. No injury was observed [Resident #1 ' s] body. [Resident #1] stated they wanted up. [Resident #1] was assisted out of the floor and sat on their bed. A neurologic check was completed by the nurse before getting the resident out of floor and a body assessment was completed. Vitals were taken and blood pressure was high. LPN #1 took the resident ' s blood pressure several times and on both arms. We did not leave the room until the blood pressure had returned to normal. Resident #1was asked why they did not wait on staff for assistance nor use their walker to leave the restroom and [Resident #1] stated, I did not think I needed it. Resident #1 asked for pain medication and received a dose. The resident was assisted to bed and only complained of a back ache. A review of a progress note, created on 02/20/2025 at 04:18 AM, indicated that Resident #1 was in the restroom. Resident #1 attempted to get up by themselves with their walker and had an unwitnessed fall. CNA #2 was walking down the hall towards Resident #1 ' s room for call light notification and heard Resident #1 fall. Resident #1 was found lying on their right side with arms extended toward the bed. A review of a progress note, created on 2/20/2025 at 2:30 PM, indicated LPN #4 was called to the resident's room at 7:30 AM due to an elevated blood pressure of 235/110. Resident #1 was notably weak and unable to sit up on their own and repeatedly stated I'm sick. Registered Nurse (RN) #6 was in the facility and was notified of the situation. At 8:00 AM, Resident #1 was reassessed by this nurse (LPN #4). Blood pressure was 225/100, pulse was 49. The resident was not responsive to verbal or physical stimuli. This nurse notified the MD in person. The MD assessed the resident at this time and ordered resident to be transferred to the emergency room for evaluation. Resident #1 was transported by ambulance to the hospital. A review of a progress note, created on 02/20/2025 at 9:24 AM, indicated that LPN #4 was notified of Resident #1's high blood pressure. Upon assessment by LPN #4, Resident #1 was lethargic and stated, I'm sick. Blood Pressure was 240/110. The MD was notified and ordered to transfer to the emergency room for evaluation. Upon transfer, Resident #1 was unresponsive to stimuli. A review of the [area hospital] Imaging Services indicated that there were new areas of bleeding on both sides of the brain, just under the outer covering (called subdural hematomas). The bleed on the left side was larger, about 1.8 centimeters wide, while the bleed on the right side was smaller, about 0.5 centimeters wide. Because of the pressure from the bleeding, the brain had been pushed about 1.9 centimeters from its normal center position, toward the right side. The grooves on the surface of the brain (called sulci) were being squeezed, more so on the left. A fluid-filled space near the base of the brain (called the suprasellar cistern) was also partially squeezed. There were no new broken bones in the skull. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	A review of the [area hospital] Hospitalist History and Physical, updated on 02/20/2025 at 12:35 PM, indicated Resident #1 presented to the emergency department from the nursing home for altered mental status. According to notes, Resident #1 had several falls recently and was admitted to the nursing home for rehab after being hospitalized from 02/8 to 02/12 for weakness and falls. Resident #1 had a fall last night in the nursing home. CT (Computed Tomography) of head revealed new areas of bleeding on both sides of the brain. The family had opted for comfort care. A review of the [areal hospital] Hospitalist History and Physical revealed a physician note, completed on 02/20/2025 at 12:35 PM, indicated Resident #1 was admitted from the nursing home after a fall last night, and found to have large left-sided and small right-sided bleeding around the brain. Resident #1 was ultimately admitted for comfort care. Family was aware that the expectation was [Resident #1] passing from this. A review of the Death Certificate indicated that Resident #1 was pronounced dead on 02/21/2025 at 4:58 PM, immediate cause subdural hematoma with an underlying cause fall, manner of death was accidental with the approximate date of injury occurring on 02/19/2025 at 2:57 AM. During an interview on 06/17/2025 at 6:00 PM, CNA #2 stated they knew Resident #1 personally. CNA #2 took the resident to the bathroom on the day of the incident, and asked Resident #1 if they wanted privacy or wanted the CNA to wait. CNA #2 stated Resident #1 asked for privacy, was given the pull cord, and instructed on usage. CNA #2 then took another resident to bathroom, then waited at the nurse's station for one of them to pull the light. CNA #2 stated they heard someone fall, and told LPN #5, I bet that was [Resident #1]. CNA#2 stated Resident #1 reported head pain when the resident was being helped up from the floor and put back into bed. CNA #2 stated that Resident #1 complained even more about a headache after being put into bed. CNA #2 stated Resident #1 told them about it every 30 minutes after that. CNA #2 notified LPN #1 about that each time. CNA #2 stated the process during a fall included CNAs were supposed to alert the nurse and do what they told them to do, but neurological checks were not initiated for Resident #1. CNA #2 stated, I got the initial vital signs, including manual blood pressure, but [LPN #1] did not ask me to get any more vital signs. CNA #2 stated that LPN #1 told her that Resident #1 had high blood pressure normally. During an interview on 06/18/2025 at 8:50 AM, LPN #4 stated that he assessed Resident #1 about 7:30 AM, and Resident #1, who was usually talkative and happy go lucky, was not their normal baseline. LPN #4 stated Resident #1 was really lethargic and complained about being sick. LPN #4 stated that they went to RN #6, who gave instruction to administer an updraft treatment (medication administered in an aerosolized form). LPN #4 went back to assess Resident #1 after the updraft; Resident #1 was not responding to stimulus. LPN #4 stated that they told the MD face to face of what was going on and received the order to send Resident #1 out to the emergency department. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/18/2025 at 9:02 AM, LPN #1 stated that at the time of the incident, there were two nurses and two aides in the building. LPN #1 reported helping CNA #7 with a resident on 600 hall, when LPN #5 came down and stated that she needed help, that Resident #1 had fallen, but that everything was fine. LPN #1 stated when they entered the room, Resident #1 was sitting on the side of the bed and had abnormally high blood pressure. LPN #1 stated they thought it was false, went to check it again, checked it on the other arm where it was also elevated. LPN #1 stated that CNA #2 went to get a manual blood pressure cuff, and it was not elevated when we checked it manually. LPN #1 stated that one of the aides reported Resident #1 needed something for pain, and LPN #5 provided pain medication. LPN #1 reported filling out an incident report. LPN #1 stated that the process for an unwitnessed fall was to check vital signs, to write down information on a piece of paper with a check list, but there was nobody in the chart to notify as Resident #1 was listed as their own POA (power of attorney). LPN #1 stated, We were told not to call the doctor unless injured and added it to the communication book. LPN #1 stated that they did not start neuro checks, to my knowledge, [Resident #1] did not hit (the resident ' s) head. LPN #1 stated they did not know if Resident #1 hit their head, stating, I never saw Resident #1 in the floor or anything. LPN #1 stated that they had contacted the medical director to notify them before for other stuff, but Resident #1 did not have a change in condition, so they did not contact. LPN #1 stated that they were terminated for violation of policies according to the Director of Nursing. During an interview on 06/18/2025 at 10:55 AM, Medication Assistant Certified (MAC) #3 reported being the permanent CNA on 200 hall. MAC #3 stated that during report they were told that Resident #1 had fallen. MAC #3 stated that Resident #1 was sitting on the side of the bed, dry heaving, drooling, and snot coming out of nose. MAC #3 stated vital signs were abnormal, they went to get the nurse, the nurse assessed the resident and re-checked blood pressure. MAC #3 stated that LPN #4 notified the registered nurse and the Director of Nursing (DON), who made the decision to send Resident #1 out to the emergency room. During an interview on 06/20/2025 at 8:40 AM, the MD reported they had just arrived at the facility when it was reported that Resident #1 was having trouble breathing. The MD stated that at the time we were dealing with COVID and the Flu in the building, so they ordered Resident #1 to be tested for those diseases. The MD stated that was the first time it was reported to them that Resident #1 had a change of condition or had fallen. The MD stated then they were told Resident #1 was unresponsive and the MD went to assess the resident. The MD stated, I cannot remember the vital signs, but I know just a few minutes later we sent [Resident #1] to the hospital. During an interview on 06/20/2025 at 10:00 AM, the Administrator stated that the process for falls was that we investigate to find out if there was anybody who witnessed it, we interview the resident themself, and if there was an injury we send them to the emergency room. The Administrator stated that staff automatically do neuro checks on everybody. We changed that to where we do it on everyone now. The Administrator stated the process for change in condition was to immediately start investigating it and contact the doctor. The Administrator stated, When I came in that morning, I was told [Resident #1] had fallen, at that time [Resident #1] was having issues. The Administrator stated the MD was in the room with Resident #1. The facility started investigating the fall, then immediately started a reportable to the state agency, when we discovered the nurse did not notify the doctor and did not initiate neuro checks. The Administrator stated that LPN #1 was terminated. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	During an interview on 06/20/2025 at 9:00 AM, the DON stated the process for when a resident falls was that a CNA stays with the resident, does not move the resident, a nurse performs an assessment, initial vitals were taken, the resident was moved if needed, staff immediately initiate fall interventions, notify appropriate parties, and follow MD orders. The DON stated that for unwitnessed falls, staff were to initiate neuro checks, every time an unwitnessed fall occurs. The DON stated that the process for a change in condition was to immediately assess the resident and notify the doctor and family. The DON stated that they consider a change of condition to include mental status change and abnormal vital signs. The DON stated that they brought LPN #1 in for questioning about the fall, and that LPN #1 was suspended for not following proper protocols, not notifying the physician, and for not initiating neuro checks after an unwitnessed fall. The DON stated that LPN #1 was then terminated for violating policies. A review of the facility policy Notification of Change indicates that the nursing facility will inform the resident/elder and consult with the physician when a significant change occurs. The nursing facility will also notify the resident/elder's legal representative or a designated contact person when a significant change occurs. A review of the facility guidelines Fall Guidelines indicates that Neuro checks (neurological checks) initiated for all head injuries for 72 hours, Documentation General Guidelines 6. Physician and legal representative notification. A review of the facility training Incident Reports on 02/3/2025 was signed by LPN #1 and indicated staff verbalized understanding on the following I wanted to remind everyone that for all incident reports, you need to conduct neuro checks unless the incident was witnessed and you can confirm there was no head impact. Following the incident, and prior to the surveyors entry into the facility, the facility terminated LPN #1 and initiated a corrective action plan, which included: 1. Auditing all resident profiles to ensure contact information is available for notification, completed 02/20/2025. 2. Audit all resident Kardex's to ensure ADL tasks are visible, completed 02/20/2025. 3. In-service MDS Coordinator to input ADL tasks to Kardex next working day after admission, completed 02/20/2025. 4. Initiate in-service to all Nurse staff on completion of admission Nursing Evaluation Form with specific focus on Functional Abilities and Baseline Care Plan sections, completed 02/23/2025. 5. Review all unwitnessed falls for the last three months to ensure neuro checks were completed. Change in Condition Assessment to be completed on all residents who did not receive neuro checks per audit, completed 02/21/2025. 6. Initiate in-service for all Nurse staff that neuro checks must be completed on all unwitnessed falls, completed 02/23/2025. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	7. Initiate in-service for all Nurses staff on immediate notification to provider and family via direct communication, completed 02/23/2025. 8. Initiate in-service for all direct care staff that residents who are assessed as high risk for falls should not be left unattended in the bathroom, completed on 02/23/2025. 9. Review all resident Kardex's to ensure residents who are high risk for falls is noted on the Kardex, completed 02/22/2025. 10. All falls will be reviewed by nurse management daily to ensure I&A is completed correctly and neuro checks are initiated as appropriate, ongoing. 11. Initiate -in-service to all Nurse staff on completing I&A, completed 02/23/2025. 12. Initiate in-service to all Nurse staff on performing an assessment with a change in condition, documenting that assessment, and notifying provider and responsible party of change, completed 02/23/2025. 13. Run Form Scoring Report for admission nursing evaluation, fall risk score, fall risk assessment, weekly and place in a binder reference, ongoing. 14. All monitoring forms related to this action plan will be reviewed by Administrator and any negative findings will be addressed immediately and included in Q&A process, ongoing. 15. Nurse Management will monitor for changes in condition and follow up through Clinical Start up, review of 24 hour/ 72 hour reports, and walking rounds, ongoing.