

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Innisfree Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 301 South 24th Street Rogers, AR 72758	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Number of residents sampled: Number of residents cited: Based on record review and interviews, the facility failed to notify an emergency contact of an unstageable pressure ulcer in a timely manner for one (Resident #88) of two residents reviewed. The findings including: Review of Resident #88's admission Record revealed the facility admitted Resident #88 on 04/01/2025 with an original admission date of 09/26/2024. The admission Record revealed Resident #88 had diagnoses that included unstageable pressure ulcer with an onset date of 05/23/2025 and admitting diagnoses of diverticulitis with perforation, and ischemic cardiomyopathy dated 04/01/2025. Review of admission Minimum Data Set (MDS) with an Assessment Reference Date of 04/07/2025, revealed Resident #88 had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS revealed Resident #88 had no active diagnoses of pressure ulcers on admission. The MDS also revealed Resident #88 was dependent on staff for toileting and ambulating 10 feet, required maximum assistance for sitting to standing, chair to bed, and bed to chair transfers. Review of Progress Notes dated 04/14/2025 at 12:41 PM, revealed Resident #88 was very confused, and a Care Plan meeting was held with the resident's family member. The Progress Note also revealed that Resident #88 had skilled services, new ostomy and a wound vac. Review of a Nursing Weekly Skin Audit dated 04/22/2025, revealed an ostomy to left upper quadrant [LUQ], wound vac mid chest to pelvis, and a stage 2 pressure ulcer to coccyx. Intervention put in place were pressure reduction mattress, skin protectant, moisturizer and treatment orders written. The Skin Audit was signed by Licensed Practical Nurse (LPN) #9. Review of Progress Notes from 04/29/2025 at 9:18 AM, revealed [named] person from [named] General Surgery clinic called revealing that Resident #88's family member had advised the surgeon that resident had not been cognitively the same since undergoing a sigmoidectomy with ostomy (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placement and was leaning in the wheelchair since admission. Doctor, Physician Assistant and nurse were consulted. Review of Progress Notes on 04/30/2025 at 4:39 PM, revealed Resident #88's family member was concerned with Resident #88's sleepiness and leaning in chair. The Progress Note revealed the Physician Assistant stopped Resident #88's opioid medication and would re-evaluate. Review of Advanced Practice Registered Nurse (APRN) #2's notes dated 05/06/2025, revealed the unstageable pressure ulcer to coccyx was first discovered and documented on 4/23/2025 in the facility's electronic records, and left and right medial and lateral buttocks skin shearing was discovered on 05/06/2025. Review of a Physician Progress Note dated 05/12/2025, revealed Resident #88's family member was called due to worsening of coccyx pressure ulcer with tunneling and concern for osteomyelitis. The family member revealed Resident #88 would require extra medication for a Magnetic Resonance Imaging and the family member stated they would meet Resident #88 at the hospital to assist with the scan. Review of [named] Hospital Records dated 05/14/2025, revealed Resident #88 was lethargic, and Resident #88's family member revealed to hospital staff they were told about a week ago that Resident #88 had a sacral pressure ulcer. During an interview on 07/22/2026 at 1:39 PM, LPN #9 stated Resident #88 had a new colostomy, and abdominal surgical wound with a wound vac on admission. LPN #9 looked through Resident #88's electronic record and stated, [Resident #88's] pressure ulcer started on 05/06/2026. LPN #9 stated she talked to the wound care nurse about Resident #88's pressure ulcers but did not recall talking to Resident #88's family. During an interview on 07/22/2026 at 3:23 PM, Registered Nurse/Wound Care Consultant stated Resident #88 was in very poor health, had a wound vac on their abdomen and developed pressure ulcers. Wound Care Consultant stated, I remember them (family) being very involved in [Resident #88's] care but the Wound Care Consultant did not remember speaking with the resident's family member. During an interview on 07/23/2026 at 2:10 PM, the Director of Nursing (DON) reviewed shower sheets from April 2025-May 2025 and revealed Resident #88 had a shower on 04/22/2025 and there was no documentation of a pressure ulcer. The DON revealed the Nursing Weekly Skin Audit, dated 04/22/2025, revealed Resident #88 had a stage II on the coccyx. When asked was Resident #88's family notified of the pressure ulcer, the DON confirmed there was no documentation indicating the family was notified that pressure ulcers had been discovered on 04/22/2025. DON stated, they think [family member] may have been informed at the bedside. During an interview on 07/23/2026 at 3:34 PM, the Administrator stated if a new pressure ulcer was found on a resident the family should be contacted right away so they can be involved in the plan of care. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This Surveyor attempted to interview the family member of Resident #88 who declined the interview. Review of a facility policy titled Change of Condition or status, revised on 11/22/2016, revealed the resident's legal representative or responsible party will be notified promptly of a change of condition. A significant change in a resident's physical health would be a major decline that will not normally resolve itself without intervention of staff or disease related clinical interventions. Deterioration in health in either a life-threatening condition or resident has clinical complication. The DON or charge nurse or designee will record changes in a resident's medical condition in the electronic record, nurse action or interventions and will include physician and responsible party contacts. Physicians' notification will include time and response. Abnormal findings should be reported to the charge nurse, and date and time the condition was identified, assessment, emergency care, notification of physician and of legal representative, and signature and title of person performing procedure should be documented.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Number of residents sampled: Number of residents cited: Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to ensure a resident was free from physical and verbal abuse for one (Resident #37) of four residents reviewed. The findings include: A review of Resident #37's admission Record indicated the facility admitted Resident #37 on 02/27/2024, with diagnoses that included vascular dementia with other behavioral disturbance, cognitive communication deficit, nontraumatic intracerebral hemorrhage, depression, macular degeneration and legal blindness. A review of the annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/04/2026, revealed Resident #37 had a Staff Assessment for Mental Status (SAMS) score of 3 which indicated Resident #37 had severe cognitive impairment. The MDS also revealed Resident #37 was dependent on staff for all self-care and mobility activities. A review of Resident #37's Care Plan, initiated on 03/23/2024, revealed a focus that the resident had the potential to be verbally aggressive related to dementia. Interventions included, when the resident becomes agitated: intervene before agitation escalates, guide away from source of distress, engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. A review of an Order Summary Report revealed Resident #37 had laboratory orders with a start date of 06/04/2025, for blood tests that included, complete blood count (CBC) and comprehensive metabolic panel (CMP) every six months in April and October; and Lipids and Vitamin D level yearly in April. A review of a Reportable for verbal abuse dated 04/15/2025, alleged a Phlebotomist used a curse word toward Resident #37, stating [the resident] needed to keep their [expletive] arm still. A review of a Reportable for Physical abuse dated 04/15/2026 revealed the Phlebotomist called CNA #4 to Resident #37's room to assist with a lab draw. CNA #4 allegedly sat on Resident #37's shoulder area in an attempt to keep the resident still for the lab draw. During a phone interview on 07/23/2026 at 11:17 AM, CNA #4 reported that on 04/15/2025 the Phlebotomist asked for her assistance with Resident #37's lab draw because the resident did not like that stuff. CNA #4 indicated Resident #37 had dementia and that she tried to talk to Resident #37 calmly. She reported she did not physically restrain the resident, and she did not abuse the resident. CNA #4 reported she had attended in-services about abuse at the facility. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's electronic education records indicated the Phlebotomist completed competencies for Neglect, Abuse and Theft on 05/24/2024 with a score of 100. The review revealed CNA #4 completed competencies for Neglect, Abuse and Theft on 08/01/2024 with a score of 100. During a phone interview on 07/23/2026 at 11:58 AM, CNA #5 reported she was in Resident #37's room to ask a question while the Phlebotomist was preparing for a lab draw from Resident #37. She reported the resident was not cognitive, was being combative and the Phlebotomist was telling the resident to keep your [expletive] arm still. CNA #5 reported the resident was not being still and the Phlebotomist called CNA #4 to the room for more assistance. CNA #5 reported that CNA #4 put her hip on the resident's shoulder and upper chest area, as if sitting on the resident, to keep the resident still. CNA #5 reported that CNA #4 then reached across the resident to also hold the right arm still. CNA #5 reported that the Phlebotomist attempted to obtain the lab sample without success, the Phlebotomist and CNA #4 left the resident's room. During an interview on 07/23/2026 at 2:54 PM, the Director of Nursing (DON) reported at the time of the incident in April 2025, Resident #37 was not cognizant and was not able to tell staff about the incident. She reported that staff should not hold a resident down during a lab draw due to that being a restraint and abuse. She reported that staff should not curse nor use a harsh tone with a resident during a lab draw due to possible emotional abuse and added that cursing or using a harsh tone was disrespectful. She indicated if a resident was being combative or refusing a lab draw, the staff should reapproach the resident later or change the staff attempting the task. During an interview on 07/23/2026 at 3:38 PM, the Administrator reported Resident #37 was not cognizant and was not able to tell her what took place during the lab draw in April 2025. The Administrator reported staff should never use physical strength to hold a resident with dementia during a lab draw. She indicated this would be a form of abuse. She indicated staff should never use curse words toward a resident and added this also would be a form of abuse. She reported a staff in-service was conducted on 04/15/2026 and that staff were in-serviced on the abuse and neglect policy emphasis on verbal abuse. She indicated if a resident was being combative or refusing a lab draw the staff should get a nurse, redirect or reapproach the resident. The Administrator reported that the Phlebotomist and CNA #4 were suspended immediately upon the notification of the allegation, pending investigation. She reported neither the Phlebotomist nor CNA #4 were brought back to work at the facility because she felt it was in the best interest of the facility after the investigation was completed. During an interview on 07/23/2026 at 2:27 PM, the Advanced Practice Registered Nurse (APRN) indicated if a resident was refusing or being combative during lab draws the staff should back off and give the resident time to calm down and relax. She reported staff should not use physical strength to hold a resident during a lab draw. She indicated using physical strength to hold a resident during a lab draw could cause potential injury. She reported that staff should not use curse words toward a resident nor use a harsh tone with the resident. She added that the residents deserve respect. During an interview on 07/23/2026 at 1:10 PM, the Medical Director (MD) indicated it was not acceptable for staff to ask other staff to sit on a resident to keep the resident still or to hold a resident down for lab draws, nor for staff to use curse words toward a resident. MD reported it was (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dangerous for a resident to be held down due to possible brittle bones. He indicated if a resident was refusing lab draws it should be discussed with the resident or their representative. A review of CNA #4's employee file revealed CNA #4 signed acknowledgement form & abuse investigation and reporting policy on 10/31/2023. A review of the facility's electronic competencies for CNA #4 revealed she passed courses neglect, abuse and theft and residents rights with a score of 100 on 08/01/2024. A review of Phlebotomist employee file revealed Phlebotomist signed acknowledgement form & abuse investigation and reporting policy on 09/07/2022. A review of the facility's electronic competencies for phlebotomist revealed she passed courses neglect, abuse and theft and residents rights with a score of 100 on 05/24/2024. A review of a facility policy titled, Abuse, neglect, misappropriation and exploitation investigation and reporting policy, revised 11/20/17, revealed the policy and procedures for investigation and reporting of alleged violations that included abuse. The policy indicated the facility will endeavor to protect residents from maltreatment, and the facility recognizes residents have a right to be free from physical and verbal abuse. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting physical harm, pain or mental anguish. Verbal abuse was defined as any intentional act that a reasonable person would believe subjects an endangered person or an impaired person, regardless of age, ability to comprehend, or disability, to ridicule or psychological injury in a manner likely to provoke fear or alarm. A review of revised facility policy dated 11/22/16 titled, Resident Rights, revealed residents have rights which included be given the opportunity to refuse treatment and be free from physical abuse. The facility re-educated all staff on 04/15/2025 on the topic of abuse and neglect policy with emphasis on verbal abuse. In addition, CNA #4 and the Phlebotomist were suspended during facility investigation and then terminated following the incident involving Resident #37. These actions were performed before the survey team entered the facility, verified by document review and staff interview resulting in this finding being cited as past non-compliance.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Number of residents sampled: Number of residents cited: Based on observation, record review and interview the facility failed to appropriately monitor and supervise a resident with severe cognitive impairment to prevent elopement for one (Resident #91) of one residents reviewed. The findings include: Review of an admission Record indicated Resident # 91 was admitted by the facility on 12/12/2025 with diagnoses that included dementia, diabetes and benign prostatic hyperplasia. Review of an admission Minimum Data Set (MDS) with an Assessment Reference date of 12/18/2026, revealed Resident #91 had a Brief Interview for Mental Status score of 3, which indicated the resident had severe cognitive impairment. The MDS also revealed Resident #91 had no wandering behaviors, that Resident #91 had a Urinary Tract Infection (UTI) in the last 30 days and was not on antibiotics at the time. Review of Resident #91's Care Plan initiated on 12/24/2025, revealed the resident was an elopement risk/wanderer related to dementia. Interventions included offer a distraction to Resident #91 when wandering, offer toileting assistance, snack, conversation or television. Review of a facility Day/Night assignment sheet dated 12/19/2026 at 6:00 PM, revealed the following staff were scheduled to work with a census of 81:-9 CNA's-1 Lead CNA-3 LPN-2 MA-C's Review of Witness Statement dated 12/19/2025 by Certified Nursing Assistant (CNA) #3, revealed CNA #3 clocked out around 6:10 PM, and told Resident #91 to have a good day, then got in her car that was parked facing away from the building, without a view of the 300 Hall exit. Review of CNA #3's Timecard dated 12/19/2026, confirmed she clocked out at 6:10 PM. During an interview on 07/21/2026 at 11:30 AM, the Administrator revealed that on 12/19/2025 at 6:30 PM, [after CNA #3 exited the building], Resident #91 used a foot to hold open the 300 Hall exit door, rolled down the wheelchair accessible sidewalk in their wheelchair and turned over. During an interview on 07/21/2026 at 1:47 PM, CNA #1 stated that on 12/19/2025 he became concerned when Resident #91 was not sitting outside their room near the 300 Hall exit and he started looking for Resident #91. CNA #1 stated he had witnessed Resident #91 trying to elope from the facility soon after admission but could not remember who this had been reported to. During an interview on 07/21/2026 at 2:18 PM, Medication Administration Certified (MA-C) #2 they (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were assisting CNA #1 in the search for Resident #91, looking in the bathrooms and then went outside. MA-C #2 stated, from the corner of my left eye I noticed Resident #91's wheelchair laying on its side in the dark about 30 foot away from 300 Hall exit. MA-C #2 stated Resident #91 had a knot on the back of the head, and a scrape on one of their hands. During an interview on 07/22/2026 at 8:47 AM, Licensed Practical Nurse (LPN) #7 stated on 12/19/2025 she noticed Resident #91 had changed sitting locations and she was keeping an eye on Resident #91 but had not seen any exit seeking behaviors. LPN #7 stated, I would have alerted all the staff for more eyes on [Resident #91] and made [Resident #91] 1:1 if they were exit seeking. During an interview on 07/23/2026 at 2:27 PM, the Director of Nursing (DON) stated she was not in the facility when Resident #91 eloped. The DON revealed Resident #91 got out of the building when CNA #3 was leaving, and the door was not closed before she got to her car and drove off. The DON stated, Resident #91 caught the door with their foot. The DON confirmed Resident #91 had a skin tear and knot on their head. The DON stated they could not remember the temperature outside but did not remember the weather being very cold at the time. The DON stated, I thought Resident #91 was wearing a shirt and sweatpants. The DON stated, When [Resident #91] came out of the 300 Hall exit doors they tipped over right at the ramp. The DON stated, when staff thinks a resident is missing, they immediately look for the resident, check the surroundings and make sure nobody is outside. Then we call the Medical Director [MD], police, family, administrator/DON, and then report the incident. During a follow-up interview on 07/22/2026 at 2:00 PM, CNA #1 stated Resident #91 was wearing jeans, a short-sleeved shirt, and shoes when the resident had exited the facility, and it was not cold outside at the time. Review of a facility Weekly Exit Door Inspections monthly report from 12/3/2025-1/21/2026, revealed the 300 Hall doors were documented as functioning properly. Review of a facility document titled, Q15 Minute Safety Checks, dated from 12/26/2025 until 12/30/2026 at 13:15 PM revealed the resident was monitored [after the incident] until Resident #91 was transferred to a memory care unit. Review of CNA #3's employee file indicated the handbook acknowledgement including abuse investigation and reporting was signed on 04/24/2025. Review of a facility in-service on Abuse and neglect policy with emphasis in elopement, dated 12/19/2025, revealed 114 staff signatures, including CNA #3. Review of a facility in-service on Be aware of your surroundings and ensure the door lock has engaged after entering or exiting the facility dated 12/19/2025, revealed 114 signatures that included CNA #3 Review of a facility in-service on elopement risk, dated 12/24/2025, revealed it was signed by CNA #3. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Elopement and Wandering, revised 11/22/2017 revealed residents are assessed on a quarterly basis for elopement and wandering. Security system should always be on, any suspicion that a resident has left the facility should be reported to the charge nurse or Director of Nursing [DON], obtain staff assistance in the immediate vicinity and make a thorough search of the facility and grounds. If not located call appropriate code, notify police, physician and notify state within 1 hour after it has been discovered resident has been missing from the facility for 3 hours then complete the wandering/elopement risk information sheet. On return examine residents for injuries and notify physician with findings, responsible party and state agency. Staff shall be in-serviced annually and on hire, and employees should know their responsibility regarding door alarms, reporting wandering behaviors and elopement. Review of facility in-service documentation, interviews with staff, relocation of the resident to a secure area, and review of facility documents that revealed no further incidents occurred following December 2025 resulted in this finding being classified as past non-compliance.		