STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045308	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Living Center	1175 Morningside Drive Conway, AR 72034

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. Based on observations, record review, interview, facility document review, and facility policy review, it was determined that the facility failed to ensure behavioral health services were provided to meet the needs of a resident with a history of suicide and a family history of suicide. Specifically, the admission nurse did not include the resident’s suicide history in the Care Plan, and facility staff were not trained to identify or respond to behavioral health needs for one (Resident #1) of one sampled resident reviewed for death. The findings include: During an observation on 08/11/2025 at 1:19 PM, all of Resident #1’s belongings had been removed from their room, except for their mattress. This surveyor observed the closet and railing where the incident took place. During an observation on 08/11/2025 at 2:25 PM, while in the Administrators office, the Administrator showed this surveyor a clear bag which contained the remaining shoestrings that were cut from the closet railing. The shoestring that was around Resident #1’s neck was left on but cut off at the neck. This surveyor then observed a pair of white and gray shoes in a box, with the strings removed. The Administrator stated Resident #1’s family wanted the residents’ remaining clothes and shoes to be donated to charity. During an observation on 08/11/2025 at 3:00 PM, the Housekeeping Supervisor showed this surveyor the large clear bag of clothes and shoes that had been removed that morning from Resident #1’s room. She stated maintenance personnel would take the bag to a donation center, as instructed by the family. During a concurrent observation and interview on 08/12/2025 at 9:15 AM, this surveyor attempted to interview Resident #1’s roommate, however, the roommate did not respond. A review of a facility document titled Facility Assessment, dated 10/31/2024, indicated the facility offered services and care related to psycho/social/spiritual support, by making sure staff that cared for the resident had the information; supported emotional well-being and helpful coping mechanisms. Staff competencies on caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or Post-Traumatic Stress Disorder (PTSD) with implemented interventions. Residents with behavioral symptoms and cognitive performance would have a nursing distribution percentage of 5.03%. (continued on next page)

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

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1’s admission Record, indicated the facility admitted the resident on 02/07/2025, for rehabilitative services due to a pubis fracture, and with diagnoses that included major depressive disorder, anxiety disorder, and a personal history of suicidal behavior. A review of Resident #1’s [Local Hospital] Geriatric Behavioral Health Documents, dated 01/09/2025-01/27/2025, indicated the resident was admitted to the Geri-Psych facility for depression, anxiety, and an intentional self-harm drug overdose. Resident #1 was administered medications for these diagnoses. Further review of Resident #1’s Geriatric Behavioral Health Documents revealed the resident had a family history of suicide, which include one immediate family member that committed suicide and another immediate family member that attempted suicide. On 01/26/2025 the day before discharge, the psychiatrist had documented the resident was withdrawn, positive for suicidal ideas, seemed lonely, and the resident mentioned to the physician they seemed a little anxious and depressed over this fall. A review of Resident #1’s admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/10/2025, revealed a Brief Interview of Mental Status (BIMS) score of 12, which indicated Resident #1 had moderate cognitive impairment. Resident #1’s MDS also revealed the symptom of thoughts that you would be better off dead, or of hurting yourself in some way was not addressed, and the symptom of feeling down, depressed or hopeless was coded as not present. Further review of Resident #1’s MDS revealed the resident was coded as rarely for feeling isolated or lonely from those around you. Furthermore, Resident #1’s MDS revealed the resident had active diagnoses, which included anxiety disorder and depression and that the resident was actively taking an antidepressant and an anticonvulsant. A review of Resident #1’s quarterly MDS with ARD of 05/13/2025, revealed a BIMS score of 12, which indicated Resident #1 had moderate cognitive impairment. Resident #1’s MDS also revealed the symptom of thoughts that you would be better off dead, or of hurting yourself in some way was not addressed, and the symptom of feeling down, depressed or hopeless was coded as not present. Further review of Resident #1’s MDS revealed the resident was coded as rarely for feeling isolated or lonely from those around you. Furthermore, Resident #1’s MDS revealed the resident was independent in their care, had active diagnoses which included anxiety disorder and depression, and the resident was actively taking an antidepressant and an anticonvulsant. A review of Resident #1’s Care Plan, dated 02/07/2025, revealed the resident had a diagnosis of major depressive disorder, was on routine and as needed pain medication, used anti-depressant medication, and had the potential for nutritional problems related to major depressive disorder. Resident #1’s Care Plan included interventions to observe for acute sadness, interest in activities, change in sleep patterns, loss of appetite, administer medications as ordered, monitor and document side effects, and monitor for social isolation, depressive mood/behavior, anxiety, changes in usual routine, suicidal thoughts, withdrawal and insomnia. A review of Resident #1’s Care Plan Meeting Invitation, dated 07/31/2025, revealed the facility had a scheduled Care Plan meeting dated 08/13/2025 at 11:30 AM, with Resident #1 and their family. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1’s Physician Progress Note, dated 02/07/2025, revealed the resident had been in Geri-Psych for depression and it was found Resident #1 had not been taking their prescribed medications while at home. All of Resident #1’s behavioral medications were restarted after admission to Geri-Psych, with improvement to their mood. Resident #1 and their family opted for the resident to go to long term care. A review of Resident #1’s Medication Administration Record (MAR), dated 02/2025, revealed the resident was on a medication for major depressive disorder which was discontinued on 02/17/2025, and medications for insomnia, major depressive disorder, Parkingson’s, pain, and tremors. A review of Federal Drug Administration Package Inserts, indicated the side effects for the medications Resident #1 was taking were insomnia, depression, anxiety, suicide, disorientation, impulsive behavior, psychosis, dementia, suicidal behavior and ideation, mental impairment, abnormal thinking, and emotional instability, A review of Resident #1’s Progress Notes, dated 02/07/2025 -08/11/2025, indicated there were ongoing assessments regarding Resident #1’s behaviors. A review of Resident #1’s Social Service Note dated 02/10/2025, revealed Resident #1 had a BIMS of 12, was oriented to person, place, time, situation, and had mental function that varied over the course of the day. Resident #1’s Social Service Note revealed diagnoses which included major depressive disorder and anxiety disorder. Further review of Resident #1’s Social Service Note revealed a Patient Health Questionnaire-9 (PHQ-9) score of 00, which indicated no depression. Furthermore, the residents Social Service Note indicated Resident #1 did not have a history of difficulty coping, therefore PTSD/trauma would not be addressed on the Care Plan. A review of Resident #1’s Social Service Note dated 05/13/2025, revealed Resident #1 had a BIMS of 12, was oriented to person, place, time, and situation. Resident #1’s Social Service Note revealed diagnoses which included major depressive disorder and anxiety disorder. Further review of Resident #1’s Social Service Note revealed a PHQ-9 score of 00, which indicated no depression. Social isolation was marked as rarely, which triggered mood state to be addressed on the Care Plan. Furthermore, the residents Social Service Note indicated Resident #1 did not have a history of difficulty coping, therefore PTSD/trauma would not be addressed on the Care Plan. A review of Resident #1’s Weight Warning Progress Note dated 07/30/2025, indicated Resident #1 had dropped 5.2 pounds in one week with a food intake of 77% that day [07/30/2025]. Further review of the residents Weight Warning Progress Note revealed Resident #1 had updated their food preference on 07/28/2025 and walked around the building all day and exercised in their room. Staff were to monitor the resident weekly. A review of Resident #1’s Progress Notes revealed Resident #1 stated on a nursing general note on 02/07/2025, that Yes, I have my apartment. I am here for a little while then yeah. The residents Progress Notes also revealed nursing had multiple entries of Resident #1’s complaints of pain. A review of Resident #1’s Progress Notes revealed on 03/17/2025, Resident #1 had an increase of medication for neuropathy pain, which had side effects of suicidal thoughts and depression. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1’s Progress Notes revealed on 05/28/2025, Resident #1 requested the as needed pain medication to be administered at bedtime as scheduled. The resident did not like to bother staff when they were in the middle of their medication pass. A review of Resident #1’s Progress Notes revealed on 07/28/2025, Resident #1 complained of right shoulder pain and had an x-ray done with no fractures. A review of Resident #1’s Progress Notes revealed on 08/06/2025, the resident saw the physician during rounds with complaints of pain all over. The physician increased Resident #1’s neuropathy pain medication at bedtime to 200 milligrams (mg) from 100 mg, which had side effects of mood changes and increased risks of suicidal thoughts or actions. A review of Resident #1’s Progress Notes revealed on 08/10/2025, Resident #1 was found at 5:25 AM, hanging in the closet with body hanging from the neck, knees to floor, no pulse, no respiratory effort, blood pooling in feet/lower legs, skin color white, cold to the touch. Do Not Resuscitate (DNR) status was verified. A review of the Arkansas Incident Report dated 08/10/2025, indicated the police officer entered Resident #1’s room and saw the resident hanging from the coatrack of the closet by what appeared to be a shoestring. An investigation was done with the case closed as a completed offense status. A review of a facility document titled In-Service on Residents Behavior dated 08/10/2025, indicated the facility held an in-service after the incident on what to look for in a resident’s behavior, such as decreased appetite, decreased interaction, self-harm, voiced self-harm, or mental health signs or symptoms. The staff were instructed to report these behaviors immediately to the charge nurse and protect the resident. During an interview on 08/11/2025 at 1:23 PM, Licensed Practical Nurse (LPN) #1 stated she saw Resident #1 last on 08/07/2025, and was informed of the incident this morning [08/11/2025] in report. She stated the resident had walked around the facility, visited with other residents, played bingo, and never acted differently while she worked. LPN #1 stated Resident #1 was independent, while the roommate was dependent and that staff checked on Resident #1 when they provided care for the roommate. During an interview on 08/11/2025 at 1:39 PM, the Director of Nursing (DON) stated she had 34 missed calls, on 08/10/2025, the morning the facility tried calling her. She arrived at the facility around 6:00 AM, and the police had left, but the coroner was still there. The Administrator and DON spoke to the night shift Registered Nurse (RN) #5, and asked if Resident #1 acted any out of the ordinary and the nurse stated, No. The DON stated Resident #1 had gotten new tennis shoes last week and walked into the DON’s office to show them to her. The resident sat down in a chair and bragged about getting a size 15 shoe, when they wore an 11, because the resident said they did not like their shoes tight. The DON described Resident #1 to have been a very tall person, around 6 feet. During an interview on 08/11/2025 at 1:56 PM, the Activities Director (AD) stated Resident #1 was a very tall person around 6 feet, and participated in the facility activities, especially bingo. The AD stated Resident #1 was always smiling. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/11/2025 at 1:58 PM, the Assistant Director of Nursing (ADON) stated she arrived at the facility on 08/10/2025, between 6:40 AM-6:50 AM, after the investigators and coroner arrived. The ADON stated she saw them cut Resident #1 down and let Resident #1 fall to the floor. The resident landed on their right side with their back facing the closet with the front of the body facing the footboard of the bed, and their legs bent. Resident #1 had on a white t-shirt and boxers, no socks or shoes. Resident #1’s roommate had already been removed. The ADON stated Resident #1 had an increase to their medication last week for pelvic pain and neuropathy and the physicians saw Resident #1 every other Wednesday for pain. During an interview on 08/11/2025 at 2:12 PM, the Administrator, the Nurse Consultant, and a member of the governing body were in the Administrators office. The Administrator stated she was notified around 5:30 AM, by RN #5 that a resident had hung themselves. The Administrator stated, I instructed her to call 911 and the police. I arrived at the facility at 6:00 AM and received an update from the staff. The family had been notified by the RN on duty prior to my arrival. The coroner informed the Administrator that Resident #1 was found with shoestrings around their neck and was on their knees. The Administrator stated she did not know Resident #1 and had only met them just a couple of times, since she started in July of 2025. She stated she looked through Resident #1’s cell phone to see if there had been a note or message left. The Administrator confirmed no note or message was found, and the last text was sent to the resident’s family member around 10:30 PM, with no typed message just a picture of a green tractor. Resident #1’s dresser drawers were also checked for a note, and nothing was found, per the Administrator. During an interview on 08/11/2025 at 4:25 PM, the Deputy Coroner stated he was notified around 5:57 AM and arrived on scene at 6:09 AM. The Deputy Coroner stated, as he was walking through Resident #1’s room, he took pictures. He stated he noticed there were two beds in the room, a curtain divided the two beds, and it was pulled open so both beds were visible. The right closet door was opened about 90 degrees, so you could not see inside of the closet from the doorway. The Deputy Coroner stated when he stepped around the door, Resident #1 was hanging by the neck, it was later determined it was shoestrings that were used. Resident #1 was 6’ tall. He verified Resident #1 had tied the knot that put pressure on the front of their neck and had the strings so tight that it cut off the carotids and the resident probably passed out after 15-20 seconds. The Deputy Coroner stated the shoestring was tied at the highest point in the closet, the residents’ knees were bent 90 degrees, and their feet were toward the outside of the closet. There were deep ligatures in the front of the neck, where most of the pressure was and along the jaw line, lower mandible of the neck. There was mild blood pooling in the residents' lower legs when the coroner arrived and was worse before he left. The Deputy Coroner stated rigor mortis had not set in yet, which usually takes four to five hours and would have started in the jaw and neck area, but since the resident was hanging, it would not be seen due to the trauma of the neck area. He then stated the residents’ fingers and arms were still pliable, and that a nylon shoestring was strong enough to withstand Resident #1’s weight and hanging. The Deputy Coroner stated no foul play was suspected, and that he spoke to Resident #1’s family member on the cell phone while at the hospital and the family member stated, [the resident] finally did it and had talked about doing it for a long time. The resident hated being in the nursing home and admitted self to the facility to not be a burden on the family. The Deputy Coroner stated, if a person was thinking of suicide and they had a plan, they would act normal to force people and make people think they were okay. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/11/2025 at 4:52 PM, CNA #2 stated she was the one that found Resident #1 in the closet. She stated she was working the hall with two other CNAs and the female residents on the 400-hall did not want male staff to change their briefs, so the CNAs decided to split the hall. CNA #2 and CNA #6 would round on the female residents, and CNA #3 would round on the male residents. CNA #3 checked the residents in Resident #1’s room at 2:30 AM. At 5:25 AM, CNA #2 and CNA #6 finished the female residents before CNA #3 finished the men, so CNA #2 went into Resident #1’s room to change, dress, and get up the dependent roommate. CNA #2 turned on the night light so it would not wake up Resident #1. As CNA #2 was walking to the closet, she noticed Resident #1 was not in bed and assumed the resident had already gotten up and walked to the kitchen, so she opened both of the closet doors. CNA #2 stated she had to let her eyes adjust because it was still dark in there but noticed Resident #1’s feet and jumped back and was about to help, when she saw Resident #1 was hanging. She stated, I freaked out, screamed, and took off running down the hall. CNA #2 stated she could not get the words out. CNA #3 took off to Resident #1’s room and came out and stated to RN #5, Oh my God, the resident hung themself. CNA #2 stated the RN told the CNAs they had to remove the roommate immediately, but CNA #2 said, I could not go back in there. CNA #2 confirmed she wrote a statement for the police and facility without coercion from anyone at the facility on the wording used in the statements. During an interview on 08/11/2025 at 5:20 PM, CNA #3 stated when he got to work on 08/10/2025, there were three CNAs scheduled on that hall and he immediately thought to himself, we are going to have a good night. The CNA stated the CNAs split the hall, and he had all the male residents. The CNAs did rounds at 2:30 AM and again around 5:25 AM. CNA #3 stated he had gotten behind, so CNA #2 walked into Resident #1’s room to help CNA #3 finish the hall. CNA #3 stated he heard a scream and CNA #2 came running out of the room, so he asked CNA #2 what happened, and CNA #2 could not talk, but said closet. CNA #3 stated he walked into Resident #1’s room, saw the closet doors were opened and saw Resident #1 hanging. CNA #3 revealed he was freaked out. CNA #3 described Resident #1 as having had on a white t-shirt and boxers, their legs were really purple and bent, the front of their body was facing the left wall of the closet, and the resident’s knees were not touching the bottom of the closet, they were about six inches from the ground. CNA #3 described the resident as a tall person, around 6’-6’1 inch. CNA #3 stated, You see this on television and think that is all made up, but it is not. All the resident had to do was put their feet down and stand up. CNA #3 stated he could not see Resident #1’s neck area, the residents’ head was hunched over, and their eyes were halfway closed. CNA #3 stated staff immediately got the roommate out of the room and left Resident #1 alone until the police arrived. CNA #3 then stated staff locked down the hall and kept all the residents in their rooms, until things settled down. During an interview on 08/12/2025 at 9:22 AM, Resident #2, a resident on the 200-hall, wheeled themselves in a wheelchair down the 400-hall towards Resident #1’s room when this surveyor asked the resident their name. The resident stated the last time they saw Resident #1 was on Saturday, 08/10/2025, during the day. Resident #2 stated Resident #1 always complained of headaches and neuropathy, did not like the food here, and often spoke about how sad they were because their spouse passed away 10 years ago. Resident #2 stated they received a voicemail Saturday night with Resident #1 being a jokester asking if I wanted to go out to eat dinner, then said oh yeah, we cannot leave the facility. Then Resident #2 stated Resident #1 said, Thank you for the refrigerator, I will see you at church in the morning. Resident #2 stated, staff told me that [Resident #1] did not wake up. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/12/2025 at 12:22 PM, CNA #4 stated she worked with Resident #1 all the time and gave the resident a shower on Saturday, 08/10/2025. She stated the resident never acted differently than normal. CNA #4 revealed Resident #1 was independent and would get their roommate ice water and would go to Resident #2’s room on the 200-hall to visit. She stated, the resident did make statements all the time about missing their spouse and did not understand why God kept them here but never made statements of suicide or comments related to what happened. During an interview on 08/12/2025 at 3:36 PM, RN #5 revealed she was late administering medications on Saturday night, 08/10/2025, and informed Resident #1 of it, to which the resident responded, No rush. During rounds at 2:30 AM, Resident #1 was in bed. RN #5 stated she always saved Resident #1’s rooms morning medications for last, so the residents could sleep longer. RN #5 stated as she was at the end of the hall when she saw CNA #2 running out of Resident #1’s room and was hysterical. RN #5 stated CNA #2 was shaking and backing down the hall toward the desk. CNA #3 heard CNA #2 scream, came down the hall and entered Resident #1’s room. CNA #3 came out and told RN #5 what happened, and RN #5 ran into the room and saw Resident #1 hanging with their body toward the window. The resident had a string around their neck, their legs were bent, their knees were off the floor, and their feet were touching the floor. RN #5 stated she checked Resident #1 for a pulse and respiratory effort, but there was not any. RN #5 stated she knew the resident had a DNR code status. She described that Resident #1 was cold to touch, pale, white, and their legs were reddish in color. RN #5 stated she called the DON and ADON, with no answer. She then called the Administrator, 911, the police, and Resident #1’s family. RN #5 reported off to each of them as they arrived. The Deputy Coroner arrived and spoke to Resident #1’s family member on the cell phone. RN #5 stated she never knew Resident #1 had a recent suicide attempt before admission to the facility, but she had overheard Resident #1’s family member tell the coroner that. RN #5 stated staff did close the 400-hall doors to block traffic and kept all residents in their rooms until everything calmed down. Resident #1’s roommate was immediately removed from their room, prior to the arrival of the police. During an interview on 08/12/2025 at 5:03 PM, CNA #6 stated when she got to work on 08/10/2025, there were three CNAs for the 400-hall, so they split it up the residents by male and female. CNA #2 and CNA #6 would take care of all the female residents and CNA #3 would take care of the male residents on the 400-hall. CNA #6 stated they made rounds at 2:30 AM, and she never saw Resident #1 at that time, but CNA #3 did. At 5:25 AM, CNA #6 stated they finished the female side before the male side, so they helped CNA #3 finish the male residents in order to be done. CNA #2 entered Resident #1’s before CNA #6 made it up there and as CNA #6 was putting her gloves on she heard a scream, and CNA #2 came running out of Resident #1’s room hysterically. CNA #6 revealed she went into the room and peeked around the corner, saw Resident #1 hanging with something white around their neck. The residents' legs were bent, they had a t-shirt was on, there was a shirt on a hanger laying across Resident #1’s bed, and CNA #6 revealed she took off running. CNA #3 went into the resident’s room and came out to report to RN #5. RN #5 then went into Resident #1’s room and started calling management, the police and 911. CNA #6 stated RN #5 instructed us to get the roommate out of the room. CNA #6 revealed she could not go back in the resident’s room. CNA #3 and CNA #7 immediately removed Resident #1’s roommate. CNA #6 stated she was given a statement to write by RN #5 and was instructed to put the last time she saw the resident was at 2:30 AM, but I did not see the resident at that time, so I did not put that down on my statement. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/13/2025 at 8:26 AM, LPN #8 revealed to know how to care for a resident, they were to look at the residents' closet Care Plan, look in the chart, or ask staff that had worked with the resident. LPN #8 stated the admitting nurse would fill out the closet Care Plan, if it was at night. During the day, the ADON or nurse would fill it out. If a resident had a history of suicide or suicidal ideations, it would be on their Care Plan or in their chart. LPN #8 stated she did not know Resident #1 had a prior suicide attempt. During an interview on 08/13/2025 at 8:36 AM, the Admission’s Coordinator (AC)/Medical Records/Infection Preventionist stated the admission of a resident was done by a group of people. The AC stated she would be informed when a resident was coming to the facility, and the diagnoses codes were entered along with details and orders. The AC stated she would take the telephone report and pass it to the nurse that would receive the resident. The AC revealed whatever nurse was on duty that day, would do the admission. The AC stated the facility had standard orders they followed and if a discharge packet was received, she entered the medications in the queue but did not activate them. Then the doctor would review the medications, and they would get activated. If the doctor wanted to make changes, he would call the facility. The AC then stated the MDS Coordinators did the assessments. During an interview on 08/13/2025 at 9:27 AM, RN #9 stated she had been the treatment nurse for the past two weeks, and prior to that was the RN on the 400-hall. To care for a resident, staff looked at the closet Care Plans, physician orders, talked to aides for residents’ personal preferences, and talked to the residents if coherent. RN #9 stated she worked with Resident #1 up until two weeks ago. RN #9 stated Resident #1 did not act differently and saw Resident #1 on Saturday, 08/10/2025. She revealed the resident told her They tricked you into coming in on Saturday, because Resident #1 liked to joke with people. Resident #1 mentioned having depression problems. RN #9 stated if a resident had a history of a suicide attempt, she thought it would be on the residents Care Plan, but she had never had a suicidal resident before. RN #9 stated she was not aware of looking for anything suicide related for Resident #1. RN #9 stated if a resident mentioned something odd or had behaviors, she would report it and would mention it to the CNAs. Resident #1 only saw the general doctors at the facility. The resident was an insanely sweet person and joked a lot; always sat around the fireplace and talked to everyone. I never saw it coming. During an interview on 08/13/2025 at 10:04 AM, CNA #4 stated she would look in the closet at the closet Care Plan to know how to care for a resident, or the nurses would mention what to do. CNA #4 stated if a resident was suicidal or had thoughts about it, the nurse would tell staff to watch out for it. CNA #4 stated no staff were aware that Resident #1 had tried to commit suicide prior to admission and was not told to look for anything on Resident #1. CNA #4 stated the resident did not see a psychiatrist, only the two general doctors at the facility. During a concurrent interview on 08/13/2025 at 10:10 AM: The Long-Term Care (LTC) MDS Coordinator, stated if a resident was admitted to LTC, she did the paperwork. Once a resident transitioned from rehab to LTC, she monitored the residents quarterly MDS. The LTC MDS Coordinator stated she would receive the resident’s information from a recent hospital stay or skilled services, and from their primary care physician (PCP) to develop the Care Plan. She then stated CNA documentation was looked at to add to the Care Plan. The LTC MDS Coordinator revealed she did not know Resident #1 had a suicide attempt prior to admission. Resident #1 always spoke, sat by the fireplace by the outside windows, loved to play bingo, and had to exercise and walk all the time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045308	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Living Center	1175 Morningside Drive Conway, AR 72034

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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medicare Manager Rehab (MMR)/MDS Coordinator, she stated if a resident was admitted to rehab, she did the paperwork. She stated different people would input in the MDS, which included social services, dietary staff, the treatment nurse, and the activities director. When specific questions were answered on the MDS, it triggered for the Care Plan. The MMR MDS stated she received information from therapy to get function levels of the residents, from the nursing admission screen, documents from the hospital or from the facility the resident came from. It was a collaboration based on history from the PCP and inputs from other designations, such as nursing, and therapy. If a resident had a history of suicide attempts or ideation, it would be in their history and physical, care plan, and medical diagnoses. The MMR/MDS Coordinator stated she recalled reading Resident #1 overdosed on medications prior to being admitted to the facility and had been admitted to a Geri-Psych facility where the resident had sustained a fall and was subsequently sent to the hospital. The resident was then discharged home and then admitted to the nursing home facility per the decision of the resident and family. The MMR MDS stated when a resident was admitted with a major depressive disorder, the primary focus was for the current diagnosis and with that being said, hopefully being medicated and interventions would apply to that diagnosis. Suicide was not current diagnosis for Resident #1. She stated Resident #1 did not see a psychiatrist while at the facility, simply because the resident only saw that one while in the facility, no follow up was ordered and nursing documentation did not reference a change in behavior for the general doctors here to refer the resident to a psychiatrist. During an interview on 08/13/2025 at 10:47 AM, the DON stated staff would not know if a resident had a history of suicidal thoughts or attempts and would only know of active diagnoses. The DON stated, I think I knew Resident #1 had attempted suicide but had forgotten about it then re-read their paperwork after the incident. The resident did not have any signs or symptoms while here to remind us of the attempt. The DON stated Resident #1 did not have a follow up scheduled with a psychiatrist, so they only saw the general doctors at this facility. If the doctors saw any issues, they would have referred to a specialist. The resident’s family member told the coroner that the resident finally did it. The DON stated, you would think if they felt that way, they would have said something to us or that the resident was capable of doing this and would have shared that with us at the facility. I do not know if it would have changed the outcome but at least we would have known it. During an interview on 08/13/2025 at 2:20 PM, Administrator in Training (AIT) stated, she had started this position in the middle of June and had been the Social Director for the past 5.5 years. She worked with Resident #1 from February to June, and stated the resident was admitted in February to [TRUNCATED]