STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045342	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nashville Nursing and Rehab Services of Arkansas	810 North 8th St Nashville, AR 71852

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review, interviews, and facility policy review, it was determined that the facility failed to develop, implement, and update a comprehensive person-centered care plan for three (Resident #1, #2, and #4) of four residents whose care plans were reviewed. The findings include: Resident #1 A review of Resident #1 ' s admission Record, indicated the facility admitted the resident on 10/15/2024, with diagnoses which included alcohol use, liver disease linked to alcohol abuse, psychoactive substance abuse, and post-traumatic stress disorder (PTSD). A review of Resident #1 ' s quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/05/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #1 had intact cognition. A review of Resident #1 ' s Care Plan Report, revised on 01/15/2025, revealed the facility failed to address concerns for the resident ' s diagnoses of alcohol use with intoxication, psychoactive substance abuse, liver disease linked to alcohol abuse, and PTSD. A review of Resident #1 ' s Order Summary Report revealed the resident had lab orders for a complete blood count, a comprehensive metabolic panel, and an ammonia level every three months in January, April, July, and October. The Order Summary report also revealed medication orders for a laxative, folic acid, and thiamine tablets to be given for cirrhosis of the liver and alcohol use with intoxication. A Progress Note, dated 05/12/2025 at 12:00 AM, revealed Resident #1 had returned to the facility intoxicated, unable to stand, at one point falling to her knees while being assisted into the building. Resident #2 A review of Resident #2 ' s admission Record indicated the facility admitted the resident on 11/19/2024, with diagnoses which included major depressive disorder, anxiety, kidney failure, and inflammation of the bile duct. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #2 ' s quarterly MDS with an ARD of 06/11/2025, revealed the resident had a BIMS score of 05, which indicated Resident #2 had severely impaired cognition. A review of Resident #2's Care Plan Report, initiated on 11/21/2024, revealed the facility failed to address concerns for the resident ' s diagnoses of major depressive disorder, anxiety, kidney failure, and cholangitis. A review of Resident #2 ' s Order Summary report revealed the resident had an order for an anti-anxiety tablet, an anti-depressant tablet, an iron supplement for kidney failure, and a bile acid for cholangitis. Resident #4 A review of Resident #4 ' s admission Record indicated the facility admitted the resident on 11/26/2025, with diagnoses which included an onset diagnosis of urinary tract infection (UTI), and active diagnoses for fracture of left femur, and the presence of a left artificial hip joint on 05/08/2025. A review of Resident #4 ' s quarterly MDS with an ARD of 05/04/2025, revealed the resident had a Staff Assessment for Mental Status score of 02, which indicated the resident was moderately impaired; made poor decisions and required cues and supervision. A review of Resident #4's Care Plan Report, initiated 01/08/2025, revealed the facility failed to address concerns for the resident ' s diagnoses of UTI, fracture of left femur, and the presence of a left artificial hip joint. The Care Plan also revealed Resident #4 required minimal to moderate assistance with most Activities of Daily Living. A review of Resident #4 ' s Order Summary report indicated the resident had an order on 05/08/2025, for therapy to evaluate. The Order Summary Report also indicated an order, with an order date of 05/19/2025, for physical and occupational therapy clarification. The Order Summary Report revealed a start date of 05/19/2025 and an end date of 07/17/2025, for the occupational therapy clarification. The Order Summary Report also revealed Resident #4 had an order for a compound opioid pain medication tablet to be given every 12 hours as needed for pain, a pain medication used to treat moderate to severe pain to be given every eight hours as needed, and an extra strength over the counter pain medication tablet to be given every eight hours. During an interview on 06/26/2025 at 9:36 AM, the Assistant Director of Nursing (ADON) revealed items that should have been on the Care Plan included eating, if the residents were alert and oriented, toileting, behaviors, and fall risks. The ADON indicated that the Care Plan needed to be updated with any changes. The ADON stated, I go to the Care Plan for everything. If I were to Care Plan the event of [Resident #1] being intoxicated, the goal would be for the resident to return to the facility and be monitored for any mental status changes, vital signs to be conducted, and educate the resident of the risk of behaviors. The Care Plan should have been updated to include the explanation to the resident of the dangers of their behaviors. I would have expected it to be updated within 24 hours. We have new staff coming in and they may not have been aware of the needed care for the residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/26/2025 at 9:46 AM, Certified Nursing Assistant (CNA) #1 revealed, to care for a resident properly I would look at their Care Plan or get the information in report. CNA #1 indicated to know if a resident was their own person, they would ask the nurse, the ADON, or the Director of Nursing (DON). During an interview on 06/26/2025 at 10:14 AM, the Director of Nursing (DON) revealed, The MDS Coordinator does the Care Plans and has been out on medical leave. The DON stated, I'm trying to audit all the Care Plans. The Care Plans have diet, transfers, anything specific, whether the resident prefers a bath or shower and anything they don't prefer. The DON indicated, you should be able to review a Care Plan and provide care for the resident. Any and all interventions to protect the residents should have been on the Care Plan. Resident #1 ' s Care Plan should have been updated that night or the next day with monitoring for any behaviors and drinking. I did see a history of alcoholism on the resident ' s paperwork. If I had been here at the time, I would have made sure it was on the Care Plan. During an interview on 06/26/2025 at 10:08 AM, CNA #2 revealed they used the Kardex or charts to know how to take care of the residents. During an interview on 06/26/2025 at 10:20 AM, CNA #3 revealed they looked at the care plans to determine how to take care of each resident, if she did not know them. I look at the care plans to determine who is their own responsible party. Employees can find everything they need to know on the care plan. During an interview on 06/26/2025 at 10:45 AM, the Administrator indicated anything that was important about the residents should be updated on the Care Plan. The Care Plan should have been updated after [Resident #1 ' s] incident of getting drunk. The Care Plan should be updated any time there is anything new that happens and should have been updated the next morning [after Resident #1 ' s event]. I think all kinds of stuff should have been added to the Care Plan like being outside, having the fall, being intoxicated, and alcoholism. It's important to have the information on there because that's how we plan care and monitor to make sure we don't have any recurrences. A review of an undated facility policy titled Care Plan Policy and Procedure, indicated Our Policies and Procedures must be flexible to the extent that the care provided to our residents meets the individualized needs of each resident. Regardless of the Policies and Procedures, care provided by staff must be specific to the individual needs of each resident so as to achieve the most desirable results for the resident.