STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045354	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fianna Hills Nursing and Rehabilitation Center	8411 South 28th Street Fort Smith, AR 72908

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review and facility policy review, it was determined that facility staff failed to follow care planned interventions for two (Resident #2 and Resident #3) of three residents reviewed for assistance and supervision. The findings include: Resident #2 Review of Resident #2's Medical Diagnosis, indicated the facility admitted Resident #2 with diagnoses which included Alzheimer's disease (progressive brain disorder that destroys memory and thinking skills over time), spastic hemiplegic cerebral palsy (brain damage that affects movement on one side of the body), and a neuromuscular dysfunction of the bladder (loss of bladder control due to nerve damage preventing brain-bladder communication). Review of a Care Plan Report revealed Resident #2 required assistance of two staff members for bathing/showering, bed mobility, personal hygiene, toilet use and transferring. Review of a Facility Incident and Accident Report dated 06/05/2025, indicated on 06/04/2025 at 10:46 PM, the DON, and LPN #9 reported being called to Resident #2's room where the resident was found on their back on the floor. Certified Nursing Assistant (CNA) #1 reported attempting to perform incontinent care on the resident without other assistance and Resident #2 rolled out of bed. The incident report indicated CNA #1 was not following the Care Plan which indicated Resident # 2 was a two person assist for bed mobility, transfers, and personal hygiene. During a telephone interview on 02/06/2026 at 10:58 AM, CNA #1 indicated she tried to change resident #2 this was attempted without assistance. CNA #1 stated, upon hiring it was not made clear on how to access the electronic system for Care Plan information. CNA #1 verified that CNAs did receive training upon hiring on the electronic system but it was done really quickly by the DON one morning, it was crowded and the training was not able to be seen well during the demonstration. During an interview on 02/05/2026 at 3:12 PM, CNA #4 stated they had been working at the facility for about two weeks. CNA #4 confirmed new admit care plans can be found at the Nurses' Station in a binder, or after the new admit is added on the electronic record that the Kardex in the electronic record lets staff know how to care for residents. CNA #4 opened the electronic medical record for Resident #2 and demonstrated how to look up transfer status, needs for personal care, and eating performance. CNA #4 confirmed Resident #2 required assistance of two staff members for all tasks involving transfers, toileting or personal care, except eating, which required assistance and encouragement. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #3 Review of Resident #3's Medical Diagnosis, indicated the facility admitted Resident #3 with diagnoses which included spinal stenosis (narrowing of spaces in the spine causing pain, numbness and weakness) of the cervical (neck) region, cervical disc disorder with radiculopathy (damaged, herniated or degenerated spinal disc of the neck which compresses or irritates a nerve root), generalized muscle weakness and encounter for surgical aftercare following surgery on the nervous system (surgery date 01/07/2026). Review of a Care Plan Report indicated Resident #3 required assistance of one staff member for toileting, bathing/showering, dressing, and bed mobility. Resident #3 required assistance of two staff members for transferring. The Care Plan Report also indicated Resident #3 may transfer with a sliding board and assistance of two staff members. Review of a Progress Note dated 01/15/2026 at 10:10 AM, revealed Licensed Practical Nurse (LPN) #8 was called to Resident #3's room. The resident was lying face down on the floor when the nurse arrived and was wearing a Cervical (C) Collar on their neck. Resident #3 reported to LPN #8 they had been told to dress themself. The Progress Note also indicated Resident #3 had been sent to the local emergency department via emergency transport to further assess the resident for injury. During an interview on 01/21/2026 at 3:15 PM, Resident #3 recalled that a fall occurred where the resident was sent to the hospital on [DATE]. The Resident had been repositioned by CNA #2 to a seated position, sitting on the edge of the bed. CNA #2 had helped the resident to that position then the resident was told to dress themself. CNA #2 that had been assisting Resident #3 suddenly left the room with another staff member while the resident attempted to dress themself. The resident reported falling and being found on the floor when CNA #2 returned. During an interview on 01/22/2026 at 8:04 AM, CNA #2 stated on 01/15/2026 they had been assisting Resident #3 helping with perineal care and dressing before leaving Resident #3's room to help the therapist with another resident. While the CNA was out of the room, Resident #3 experienced a fall. CNA #2 stated the CNAs get their instruction on each resident's care needs from the electronic Care Plan on each. CNA #2 stated the electronic Care Plan for Resident #3 indicated the resident required assistance for all tasks, and did not perform any tasks alone, except for meals. During an interview on 01/22/2026 at 9:30 AM, CNA # 3 stated 500 hall was the primary hall that she worked on and was working on 500 Hall when Resident #3 fell. CNA #3 stated, The Kardex is how we know what a resident's needs are for transferring. The CNA also stated she was the only one in the room at times when transferring Resident #3 with a slide board, and Resident #3 was dependent on staff to help hold pressure on the board to stabilize it when the resident transferred. During an interview on 02/05/2026 at 3:22 PM, CNA #5 confirmed all care requirements were listed in the electronic Care Plan and if a change had been made to a resident's care it would be found in the electronic system. During an interview on 02/05/2026 at 4:05 PM, the Director of Nursing (DON) reported that a daily huddle was held every morning to discuss new admits and updated electronic Care Plans. The DON stated failure to follow the Care Plan was grounds for immediate disciplinary action up to termination. During an interview on 02/06/2026 at 8:58 AM, the MDS Coordinator stated the entries by CNAs on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tasks were often different and the MDS Coordinator verified with observation and then updated the Care Plans to reflect any changes, which would then update on the electronic system the CNAs used. During an interview on 02/06/2026 at 9:37 AM, the DON stated all aides were trained with return demonstration on using the electronic Care Plans by 1:1 training after morning huddles. The DON stated they alert staff to changes during the huddles. The DON stated the facility did not have a policy for CNA training on the electronic Care Plans other than the 1:1 training given after huddles in the morning. During an interview on 02/06/2026 at 11:17 AM, the Administrator stated CNAs should verify what care was required within the electronic Care Plan before providing care, every time. Changes to the residents' care plan should be discussed during huddles every day as well as added to the electronic Care Plan. During an interview on 02/06/2026 at 11:39 AM, the Medical Director stated that it was his expectation that orders were followed as written in the Care Plan. Review of standard of practice indicated Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: to ensure facilities identify and provide needed care and services that are resident centered, in accordance with the resident's preferences, goals for care and professional