

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Chapel Ridge Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  4623 Rogers Ave Fort Smith, AR 72903	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46724</b></p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set [MDS] assessment accurately reflected a level II Preadmission Screening and Resident Review [PASARR] under section A1500 for one (Resident #16) sampled resident, and failed to accurately identify medication class under Section N on the MDS for one (Resident #64) of two sampled residents reviewed for MDS accuracy. Specifically, the facility failed to ensure medications without a physician 's order were not reflected on the MDS.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. A review of Medical Diagnosis revealed Resident #16 had diagnoses, which included: schizophrenia, dementia, and type II diabetes.             <ol style="list-style-type: none"> <li>a. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/16/2024, indicated a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Section A1500 was coded as 0, indicating the resident did not have a mental illness or intellectual disability.</li> <li>b. A review of a letter from the state designated authority, dated 10/29/2021, instructed the facility to contact the state designated authority within 30 days.</li> <li>c. A review of a letter from the state designated authority, dated 11/18/2021, indicated no special services are required.</li> <li>d. On 05/06/2025 at 4:15 PM, the Business Office Manager (BOM) confirmed Resident #16 had a level II PASARR, and provided a packet containing information sent to, and received from, the state designated authority.</li> <li>e. On 05/07/2025 at 1:57 PM, the MDS Coordinator in-training stated that an outside MDS Coordinator had been coding to the MDS because she had not started doing that. The MDS Coordinator in-training stated that a letter dated 11/18/2021 revealed Resident #16 had a level II PASRR. The MDS Coordinator in-training pulled up Resident #16's electronic health record (EHR) and it revealed that Section A1500 was not coded correctly. It should have been answered as yes for #1, Resident #16 had a mental illness.</li> </ol> </li> </ol> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Chapel Ridge Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  4623 Rogers Ave Fort Smith, AR 72903	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>f. On 05/07/2025 at 3:00 PM, this surveyor spoke with the Director of Nursing (DON), and she had been made aware the PASARR was not coded correctly for Resident #16 and should have been, to make the MDS accurate.</p> <p>g. On 05/07/2025 at 3:10 PM, the MDS Coordinator in-training, provided a portion from the Resident Assessment Instrument (RAI) manual showing Section A1500 should be coded with a 1 if the state designated authority revealed a resident had a mental illness or intellectual disability.</p> <p>2. A review of Resident #64's Admission Record indicated the resident was admitted with diagnoses, which included: malignant neoplasm of the brain (brain cancer), bipolar disorder (a mental health condition characterized by extreme shifts in mood, energy, and activity levels, causing periods of intense highs [mania or hypomania] and lows [depression]), mood disorder (a mental health condition characterized by persistent and intense changes in mood, energy, and behavior that significantly impact a person's life), and pain.</p> <p>a. A review of Resident #64's Physician Orders indicated that the resident should be assessed for pain every shift, received an antidepressant medication, and to monitor for side effects of the medication. No antianxiety medication, anticoagulants, or opioids were ordered.</p> <p>b. A review of Discontinued Medications indicated Resident #64 ' s antianxiety medication had been discontinued on 06/04/2024, their anticoagulant had been discontinued on 05/09/2024, and that the opioid had been discontinued 10/22/2024.</p> <p>c. A review of Resident #64's Plan of Care indicated the resident received an antidepressant medication, with interventions including: to be used as ordered and to monitor for side effects, of the antidepressant use.</p> <p>d. A review of Resident #64's MDSs with ARDs of 05/08/2024, 08/06/2024, 11/06/2024, and 02/06/2025 indicated medication usage of an antianxiety medication, anticoagulant, and an opioid. The MDSs also revealed that the resident did not receive an antidepressant or antipsychotic.</p> <p>3. On 05/07/2025 at 2:10 PM, Licensed Practical Nurse (LPN) MDS Coordinator #2, who had been in the position since January 2025, stated she did not perform the assessments yet, she was still training, and that an outside source was completing the assessments at the time.</p> <p>4. On 05/08/2025 at 9:20 AM, when instructions used by the facility for completion of Section N of the MDS were requested, the LPN/MDS Coordinator #1 provided instructions for, RAI Manual SectionN0410: Medications Received with a date of October 2019. These instructions indicated this section was to identify select medications used during the seven (7) day look back period. Under Steps for assessment, it indicated to review the residents Medication Administration Records (MAR), (Page N-1).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  Chapel Ridge Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  4623 Rogers Ave Fort Smith, AR 72903	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. On 05/08/2025 at 10:50 AM, off-site MDS Coordinator #2 reported she had been working, as needed, with the facility to complete MDSs since September 2024. She reported she used documentation and assessments staff had completed in the resident ' s electronic health records (EHR) to obtain information to complete the MDSs. When asked what was used for guidance to assist her in completing the MDSs, off-site MDS Coordinator #2 responded she had been doing MDSs for 12 and a half years, so she knew how to complete them. When asked if she ever used the RAI Manual to assist in completing MDSs, she confirmed that manual was available on the computer software used to complete assessments. She stated she reviewed the resident ' s medication prior to completing Section N of the MDS, then went on to say, It seems I ' ve messed up on some of those. When asked why it was important to ensure MDSs were accurately completed, she stated to keep up with the resident and provide the best care possible.</p> <p>6. On 05/08/25 at 10:52 AM, the MDS Coordinator was contacted by phone and stated, the social worker, dietary manager, and activities director assess residents in-house, and I review documents in the chart, nursing assessments, and really all assessments from the chart online to code to the MDS. The MDS Coordinator was asked what guided her when coding and she stated [AGE] years of experience, and the RAI Manual. The MDS Coordinator revealed that she was made aware she had made some mistakes and Section A1500 should have been answered yes Resident #16 had a PASRR level II, because it was important to code correctly to the MDS so the facility could accurately track a resident ' s antipsychotics, reductions, and use.</p> <p>47916</p>		