

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045371	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER Westwood Health and Rehab, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 802 S West End Street Springdale, AR 72764	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 50505 Based on interviews and record review, it was determined that the facility failed to ensure that resident to resident events were reported within 24 hours even if no serious bodily injury occurred for 1 (Resident #9) of three residents reviewed for abuse and neglect. Findings include: A review of the facility policy, Abuse Prevention, revised 11/16/2017 revealed that all reports of resident abuse, neglect, injuries of an unknown source, resident-to-resident abuse and resident-to-staff abuse are promptly and thoroughly investigated by facility management, and that when an alleged or suspected abuse is reported, the facility administrator or his/her designee, would notify the following: 1. The State licensing/certification agency 2. The resident ' s representative 3. Law enforcement 4. The resident ' s attending physician. A review of OLTC Incident and Accident Report (I&A) indicated on 01/08/2025, Resident #9 pushed Resident #44 into a wall. Resident #44 grabbed at their hip as if the resident was in pain. Both residents resided in the Alzheimer ' s unit. Resident #44 had a hip fracture as a result of this incident. The findings of the facility ' s investigation indicated, The facility can not substantiate this allegation of abuse as both residents involved are mentally deemed to have no capacity and there was no intentional means of abuse. A review of State Operations Manual Appendix PP, F600 indicates, Willful actions include, but are not limited to, the following: hitting, slapping, punching, choking, pinching, biting, kicking, throwing objects, grabbing, shoving .The action itself was deliberate or non-accidental, not that the individual intended to inflict injury or harm .Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record, indicated the facility admitted Resident #44 with diagnoses that included dementia with agitation, disorientation, insomnia, restlessness and agitation. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/23/2024, revealed Resident #44 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated moderately impaired cognitive skills for daily decision making. Resident #44 showed physical behavior symptoms directed towards others as well as wandering. Resident #44 was able to ambulate independently. A review of Resident #44 ' s care plan initiated on 03/08/2024, revealed the resident needed a secured/special care neighborhood due to dementia. The following was listed: - 04/11/2024: Physical aggression received - 04/19/2024: Physical aggression received - 07/10/2024: Physical aggression received - 08/06/2024: Physical aggression received - 08/12/2024: Physical aggression received - 08/21/2024: Physical aggression initiated - 12/07/2024: Physical aggression received - 12/20/2024: Physical aggression received - 12/25/2024: Physical aggression received - 01/09/2025: Physical aggression received The facility developed interventions that included to encourage the resident to fold laundry or take care of a baby doll when noted wandering in other resident ' s rooms, numerous interventions in place for other resident, and the resident was to be placed on 1 on 1 observation on 08/21/2024. Further review of the care plan indicated Resident #44 lacked capacity to understand and make decisions. The resident also exhibited behaviors of wandering into other residents ' rooms. A review of facility incident and accident reports for the last twelve months for Resident #44 indicated on 04/11/2024, Resident #44 was pushed down to the ground by another resident. On 4/19/2024, Resident #44 was kicked by another resident. On 7/9/2024, Resident #44 was smacked in the face by another resident. On 08/06/2024, Resident #44 was pushed to the floor by another resident. On 08/12/2024, Resident #44 ' s left hand was stuck with a closed fist by another resident. On 08/21/2024, Resident #44 hit another resident. On 12/7/2024, Resident #44 was punched in the stomach. On 12/20/2024, Resident #44 was pushed by another resident, causing Resident #44 to fall. On 12/25/2024, Resident #44 was hit in the head by another resident. On 1/8/2025, Resident #44 was pushed to the floor by another resident and appeared to be in severe pain and was sent to the emergency room . Of all of the reports, only one was reported to the State Agency. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/31/2025, at approximately 11:00 AM, the Administrator was unaware of the regulation that resident-to-resident altercations had to be reported to the State Agency and stated only interactions that resulted in injury should be reported.		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50505 Based on observation, record review, and interview, the facility failed to ensure the comprehensive person-centered care plan included an objective for monitoring a resident with wandering behaviors who was at risk for resident-to-resident altercations for 1 (Resident #44) of 3 residents reviewed for abuse. The lack of effective interventions resulted in Resident #44 having resident-to-resident abuse that occurred on 04/11/2024, 04/19/2024, 07/10/2024, 08/06/2024, 08/12/2024, 12/07/2024, 12/20/2024, 12/25/2024, and 01/09/2025. All of the incidents took place on the locked unit and Resident #44 had been kicked, hit in the face, hit in an unknown area, pushed, punched in the hand, struck in the hand, punched in the stomach, pushed down numerous times, and hit in the head. The last incident resulted in a broken hip. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.21 (Comprehensive Resident Centered Care Plan) at a scope and severity of J. The IJ began on 04/11/2024, when Resident #44 was first pushed down by another resident while residing on the secure unit. The Administrator, Director of Nursing, Nurse Consultant, and Director of Operations were notified of the IJ on 01/29/2025 at 10:28 AM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 01/29/2025 at 3:54 PM. The IJ was removed on 01/31/2025 after the survey team performed onsite verification that the Removal Plan had been implemented. The findings are: A review of a policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated the Interdisciplinary Team (IDT) along with the resident and/or resident representative develops and implements the comprehensive care plan to include measurable objectives and timetables to meet the resident 's physical, psychosocial, and functional needs. Further review indicated, Care plan interventions are chosen after data gathering, proper sequencing of events, careful consideration of the relationship between the resident 's problem areas and their causes, and relevant clinical decision making. A review of OLTC Incident and Accident Report (I&A) indicated on 01/08/2025, Resident #9 pushed Resident #44 into a wall. Resident #44 grabbed at their hip as if the resident was in pain. Both residents resided in the Alzheimer 's unit. Resident #44 had a hip fracture as a result of this incident. The findings of the facility 's investigation indicated, The facility can not substantiate this allegation of abuse as both residents involved are mentally deemed to have no capacity and there was no intentional means of abuse. A review of the Admission Record, indicated the facility admitted Resident #44 with diagnoses that included dementia with agitation, disorientation, insomnia, restlessness and agitation. (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/23/2024, revealed Resident #44 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated moderately impaired cognitive skills for daily decision making. Resident #44 showed physical behavior symptoms directed towards others as well as wandering. Resident #44 was able to ambulate independently. A review of Resident #44 ' s care plan initiated on 03/08/2024, revealed the resident needed a secured/special care neighborhood due to dementia. The following was listed: - 04/11/2024: Physical aggression received - 04/19/2024: Physical aggression received - 07/10/2024: Physical aggression received - 08/06/2024: Physical aggression received - 08/12/2024: Physical aggression received - 08/21/2024: Physical aggression initiated - 12/07/2024: Physical aggression received - 12/20/2024: Physical aggression received - 12/25/2024: Physical aggression received - 01/09/2025: Physical aggression received The facility developed interventions that included to encourage the resident to fold laundry or take care of a baby doll when noted wandering in other resident ' s rooms, numerous interventions in place for other resident, and the resident was to be placed on 1 on 1 observation on 08/21/2024. Further review of the care plan indicated Resident #44 lacked capacity to understand and make decisions. The resident also exhibited behaviors of wandering into other residents ' rooms. A review of facility incident and accident reports for the last twelve months for Resident #44 indicated on 04/11/2024, Resident #44 was pushed down to the ground by another resident. On 4/19/2024, Resident #44 was kicked by another resident. On 7/9/2024, Resident #44 was smacked in the face by another resident. On 08/06/2024, Resident #44 was pushed to the floor by another resident. On 08/12/2024, Resident #44 ' s left hand was stuck with a closed fist by another resident. On 08/21/2024, Resident #44 hit another resident. On 12/7/2024, Resident #44 was punched in the stomach. On 12/20/2024, Resident #44 was pushed by another resident, causing Resident #44 to fall. On 12/25/2024, Resident #44 was hit in the head by another resident. On 1/8/2025, Resident #44 was pushed to the floor by another resident and appeared to be in severe pain and was sent to the emergency room . A review of Resident #44 ' s hospital records indicated on 01/09/2025, the resident was admitted to the hospital related to a fall with left hip pain and was diagnosed with a left femur fracture and required surgery. (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/28/2025 at 2:00 PM, Certified Nursing Assistant (CNA) 13 was in Resident #44 ' s room and stated the resident was not aggressive but at times, the resident takes things that belong to other residents, which agitates those residents resulting in pushing Resident #44. During an interview on 01/28/2025 at 2:16 PM, the Director of Nursing (DON) stated Resident #44 was sent to the hospital because the resident was touching another resident who had autism. The DON stated Resident #44 used to be a CNA and likes to pick up things and was trying to pick things up in the other resident ' s room. This resulted in the other resident pushing Resident #44, causing the resident to fall. The DON stated the other resident no longer resided in the facility. During an interview on 01/29/2025 at 8:20 AM, CNA #2 stated Resident #44 was not aggressive but did go into other resident ' s rooms. CNA #2 stated interventions for Resident #44 included redirecting or distracting the resident. CNA #2 stated she was aware of an altercation between another resident and Resident #44 and stated the other resident was eating a snack when Resident #44 entered the resident ' s room and tried to grab the snack. This resulted in the other resident pushing Resident #44 to the floor. CNA #2 stated residents on the secure unit are monitored by having at least one staff member on the hall in the middle. CNA #2 stated that during the altercation, both herself and CNA #1 were at the nurse ' s station, monitoring the cameras. CNA #1 was teaching CNA #2 how to chart in the medical record. CNA #2 stated she looked up at the camera and saw Resident #44 walk towards the other resident and CNA #2 got up and ran from the nurse ' s desk to get Resident #44. This would indicate Resident #44 was not one-on-one per the resident ' s care plan. During an interview on 01/29/2025 at 8:35 AM, CNA #1 stated Resident #44 was very grabby but did not have aggressive behaviors. CNA #1 stated staff would give Resident #44 towels to fold or give the resident something to do to keep the resident ' s mind busy. CNA #1 stated she was showing CNA #2 how to chart in the medical record at the nurse ' s station and CNA #2 took off running and that ' s when she looked up at the camera and saw Resident #44 head towards Resident #9. CNA #1 stated another CNA was supposed to be monitoring the hall but did not know where that CNA went. During an interview on 01/29/2025 at 11:23 AM, the Administrator stated there were interventions in place to safeguard Resident #44 but was unable to provide them to the surveyor. The Director of Nursing (DON) stated the facility placed a stop sign on another resident ' s door but was removed because the resident did not want it. The DON also stated that there were medication changes for Resident #44 to help with anxiety. The Administrator stated the facility did monthly in-services regarding behaviors but there was a new staff member completing those in-services and the Administrator could not locate the in-services. During an interview on 01/29/2025 at 2:00 PM, Licensed Practical Nurse (LPN) 12 stated Resident #44 goes into other resident ' s rooms and staff were to distract the resident. LPN #12 stated CNA #1 and CNA #2 being at the nurse ' s station during the incident between Resident #44 and another resident was not appropriate and they should be charting at the kiosk in the hallway. LPN #12 stated that Resident #44 was trying to get something from another resident and Resident #44 was pushed, making the resident fall and resulted in a broken hip. LPN #12 stated she was not made aware of resident-to-resident interactions except from verbal reports from other shifts and she does not review the resident ' s medical record unless there is an every-shift requirement to chart. LPN #12 stated the intervention of redirecting Resident #44 was not an appropriate intervention because the resident would just continue with the behavior. LPN #12 stated that an appropriate intervention would have been to remove one of the residents from the neighborhood. (continued on next page)		

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Removal Plan: 1. Resident #44 who received physical aggression placed on observation 1:1 on 01/29/2025 by facility staff. 2. Resident #9 who initiated physical aggression discharged from the facility 01/09/2025 3. DON/Designee will initiate an in-service on all staff currently in facility on handling residents with behaviors on 01/29/2025 and continue training staff as they clock in until all staff have been trained. 4. On 1/29/2025, the DON/Designee will initiate in-service related to following care plan interventions for direct care staff currently in facility. Direct care staff not present will be in-serviced prior to the start of their shift. Any newly hired direct care staff will also be in-serviced. 5. DON/Designee will review all care plans for residents residing in the Dementia care unit for appropriate interventions related to behaviors and update the care plans as needed on 1/29/2025. 6. Nurse Consultant/Designee will initiate in-service with the Minimum Data Set (MDS) coordinator and all nurse managers on reviewing and updating care plans and that interventions are appropriate and effective on 1/29/2025. Onsite Verification: The IJ was removed on 01/31/2025 after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 01/30/2025. Resident #9 was verified to have been discharged from the facility on 01/09/2025. Resident #44 had a staff member one on one with the resident as of 01/30/2025. The facility assessed all residents on the unit for signs and symptoms of physical aggression and body audits were completed. A total of 30 staff interviews were conducted with staff from all shifts to verify training had been completed for behavior interventions. The staff interviewed included certified nursing assistants, licensed practical nurses, registered nurses, Administrator, business office staff, laundry staff, kitchen staff, activity staff, housekeeping staff, physical therapy staff, and maintenance staff. The staff interviewed verified they had been trained in handling residents with behaviors and dementia. A review of the in-service sheets provided indicated 45 of 105 had been provided training. Those staff who were not physically present to receive the in-services were to be in-serviced prior to the start of their shift. A total of 6 staff interviews were conducted regarding care plans being updated. The staff interviewed included the DON, the MDS Nurse, the ADON, and three LPNs.		

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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. 42018 Based on observation, record review and interview, the facility failed to ensure that the resident received prompt treatment after noticing a change in condition for 1 (Resident #112) of 4 residents reviewed for abuse and/or neglect. Specifically, Resident #112 showed signs of a stroke and was not sent to the emergency room until approximately 4 hours after noticing the change in condition. The findings are: A review of an Admission Record indicated Resident #112 had diagnoses of neurocognitive disorder with Lewy bodies, chronic obstructive pulmonary disease, altered mental status, atrial fibrillation (irregular and often rapid heart rhythm that can lead to stroke), cerebrovascular disease (term for conditions that affect blood flow to your brain), cognitive communication deficit. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/2025 documented the resident scored 00, (0-7 indicates the resident was severely cognitively impaired) on a Brief Interview for Mental Status (BIMS). Further review indicated the resident ambulated with a walker and was independent with care. A review of Resident #112 's care plan, initiated on 11/27/2023, indicated the resident was on an anticoagulant (blood thinning) medication related to atrial fibrillation. The facility developed interventions to include administering the medication as ordered and monitor for side effects and effectiveness every shift. The blood thinning medication had a black box warning and premature discontinuation increased the risk of blood clots and to monitor for warning and side effects of the medication. Staff were to monitor, document, and report any adverse reactions of the blood thinner medication. Review of Resident #112 Progress Notes dated 10/3/2024 at 3:23 PM, staff reported to Licensed Practical Nurse (LPN) #12 that Resident #112 was acting a bit strange during smoke break. When staff spoke to the resident, there was slurred speech and the resident reported to be tired. Resident #112 denied any pain or discomfort and was alert and oriented. Resident #112 was able to ambulate with no difficulty and the resident 's vital signs were within normal limits for the resident. LPN #12 requested the doctor to see Resident #112 during rounds. Review of Resident #112 Physician Notes indicated on 10/03/2024 at 7:35 PM, an Advanced Practice Registered Nurse (APRN) provided an interactive audio and visual telecommunication with the resident. The APRN indicated Resident #112 's chief complaint was a change in mental status and staff reported slurred speech and left side weakness. The staff reported that this started around 4 hours ago. Resident #112 had significant left sided facial droop on exam, had slurred speech, and complained of back pain. The APRN indicated the resident needed to be sent to the emergency room for an evaluation due to a possible stroke. The APRN indicated the resident 's doctor was made aware of the visit and new orders. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #112 Progress Notes dated 10/3/2024 at 7:52 PM, Registered Nurse (RN) #14 indicated Resident #112 continued with slurred speech and staff reported she the resident was not acting like themselves. The on-call provider was notified and new orders were received to send the resident to emergency room for evaluation. Review of Resident #112 Progress Notes showed no physician entries for this resident on 10/03/2024. A review of Resident #112 's Admission H&P [history and physical] notes indicated Resident #112 's family member was at the resident 's bedside at the hospital and told the APRN the resident had stop talking all of their medication approximately 3 months ago. The resident was admitted to the hospital on 10/03/2024 at 8:06 PM. Imaging of the resident 's head and neck indicated a medium vessel occlusion (most common artery involved in acute stroke) and Resident #112 was not a candidate for intravenous thrombolysis (the use of medication to dissolve blood clots) due to it being outside of the timeframe for administration. During an interview on 01/29/2024 at 4:48 PM. LPN #12 stated on 10/03/2024, the doctor was doing rounds in the facility and was notified of the resident 's change in condition and that the resident needed to be seen by the doctor. LPN #12 stated staff let the resident rest until seen by the doctor. Review of OLTC Witness Statement Form, dated 01/30/2025 at 9:56 AM the Director of Nursing (DON) indicated On October 3rd, 2024, I received a phone call from the resident 's Medical Physician (MP). Medical Physician stated that he had seen the resident per [the resident 's] nurse 's request. At that time, the resident did not wish to go to the hospital to be evaluated. The resident was also non-compliant with [the resident 's] medications, including [a blood thinner]. In light of this, the residents Medical Physician called me on my personal phone and requested that a care plan be scheduled with the resident and [the resident 's family member] to discuss goals of care and potential comfort care measures. I was on the way home from daycare with children at the time, so the time of call would have been around 5pm. This information provided above is true to the best of my knowledge. A review of Resident #112 's electronic health record did not indicate there was a conversation between Resident #112 's MP and the DON on 10/03/2024. During an interview on 01/30/2025 at 11:08 AM, The MP was asked if he saw the resident on 10/03/2024 while completing rounds on other residents at the facility and the MP stated he did not see the resident and did not have any notes on the resident for that day. Review of facility policy titled Change in a Resident 's Condition, which indicated Our facility promptly notifies the resident, his or her primary care provider, and the resident representative of changes in the residents medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37634 47916 Based on observations, interviews, and record reviews, the facility failed to (1) properly transfer 1 (Resident #41) of 9 residents reviewed for accidents; (2) ensure keys were not left in the janitor closet door unattended where chemicals were stored for 1 (100 hall) of 4 halls observed; (3) ensure the rear casters/wheels of the mechanical lift were in the unlocked position when raising and lowering residents affecting 1 (Resident #8) of 9 residents reviewed for accidents; (4) ensure the beauty shop on the secured unit was locked when not in use or when there were no staff present. The findings are: 1. A review of an Order Summary Report revealed Resident #41 had a diagnosis of hemiplegia and hemiparesis following cerebral infarction (paralysis after a stroke) affecting the dominant side. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/23/2024 revealed Resident #41 had a Brief Interview of Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Further review indicated the resident had upper and lower extremity range of motion impairment to one side. Resident #41 was able to transfer from the bed to the chair independently. A care plan with a revision date 1/30/2025 indicated that Resident #41 was a risk for falls related to balance problems. The facility developed interventions that included staff were to ensure the resident was wearing appropriate footwear when ambulating in the wheelchair and to have non-skid strips at the bedside. Resident #41 also had an activity of daily living (ADL) self-care performance deficit and was able to move between surfaces independently. During an observation on 1/28/25 8:45AM the staff were informed that Resident #41 was on the floor in their bedroom. Certified Nurse Assistant (CNA) #11 and the Medical Records Coordinator put a gait belt around Resident #41's waist. When the two staff went to pick up the resident, they placed their hands under the resident ' s arms and lifted the resident up without using the gait belt. A review of Resident #41's Incident Note dated 1/28/25 indicated that Resident #41 went to transfer themselves to a wheelchair to use the bathroom. Resident #41 did not have on proper footwear, missed the wheelchair, and went to the floor. There were no injuries. A sock was placed on the resident's foot, and non-skid strips were at the resident's bedside. Interventions included non-skid sock, non-skid strips placed on bedside, and neuro checks. During an interview on 1/29/25 at 3:56 PM the Medical Records Coordinator indicated that she and CNA #11 picked Resident #41 up off the floor when the fell on [DATE]. Medical Records Coordinator indicated that she was not sure why she picked Resident #41 up with her hand positioned under the resident's arm pits. Medical Records Coordinator indicated that Resident #41 could have received a shoulder injury by being picked up improperly. Medical Records Coordinator indicated that a lift was not used because Resident #41 transfers on their own. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Westwood Health and Rehab, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 802 S West End Street Springdale, AR 72764	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/31/2025 the Director of Nurse (DON) indicated that staff should use a gait belt when picking a resident up from the floor after a fall. The DON indicated that a resident should never be picked up by staff placing their hands under a resident's arm pit. The DON indicated that if the staff does not use a gait belt that the resident or the staff could be injured. A review of facility policy, Falls - Clinical Protocol, with a revision date of 03/2018 did not indicate how residents should be transferred after a fall. 2. A review of a facility policy titled, Hazardous Areas, Devices, and Equipment revised July 2017, indicated that a hazard is defined as anything in the environment that has the potential to cause injury. Further review indicated, The Safety Committee will recommend measures to ensure that vulnerable residents cannot access hazardous areas in the facility (locks, alarms, supervision, etc.). On 1/27/2025 at 2:39 PM, the Housekeeping Supervisor went into the tub room on the 100 halls, left the keys to the janitor's closet in the door, and shut the door behind them. At 2:41 PM the Housekeeping Supervisor walked out of the janitor ' s closet on the 100 hall and began to walk down the hall. She was informed by the surveyor that she had left her keys in the janitor closet door. At 2:44 PM, the Housekeeping Supervisor indicated that she did not realize that she had left her keys in the door. She indicated that a resident could have gone into the closet where chemicals are stored. At 2:46 PM, the Housekeeping Supervisor opened the door to the janitor's closet. There was a gallon of glass cleaner, a gallon of bathroom cleaner, a gallon of odor solution, a gallon of sanitizer, and a container of urine cleaner in the closet. 3. A review of Medical Diagnosis revealed Resident #8 had diagnoses of dementia, heart failure, and schizoaffective disorder. A review of Resident #8 ' s annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/26/2024 indicated a Staff Assessment for Mental Status (SAMS) was completed, which indicated the resident was moderately impaired for cognitive skills for daily decision making. Further review indicated the resident required a manual or electric wheelchair, and the resident required total care for eating, bathing, dressing, personal care, transfers, and toileting. A review of Resident #8 ' s care plan revealed a self-care performance deficit related to disease processes, requiring two staff members to transfer Resident #8 with a mechanical lift. During an observation on 01/28/2025 at 9:31 AM, Certified Nursing Assistant (CNA) #7 assisted CNA #8 were in Resident #8 ' s room to transfer the resident using a mechanical lift. Both CNAs positioned the open legs of the mechanical lift around Resident 8 ' s specialty chair. CNA #8 was observed locking the rear casters/wheels of the lift and raising Resident #8 up with the mechanical lift and sling from the chair to transfer to the bed. The CNAs positioned the lift over the resident ' s bed. With the legs open under the bed, the right rear caster/wheel of the lift was locked, and the left caster was left unlocked and resident was lowered to the bed. During an interview on 01/28/2025 at 9:34 AM, CNA #8 stated when they transferred Resident #8 using the mechanical lift, the legs of the mechanical lift were open for stability, and the rear casters/wheels were locked so the mechanical lift would not move when raising and lowering Resident #8. CNA #7 and CNA #8 both stated they have been in-serviced on using a mechanical lift. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Batter Powered Patient Lift User Manual, dated 2018, revealed on page 6 that it was not recommended to lock the rear casters/wheels of the mechanical lift when lifting a resident, because it could cause the lift to tip and endanger the resident and assistants. On page 12, a warning label revealed, DO NOT lock the casters of the Patient Lift when lifting an individual. [NAME] MUST be left unlocked to allow Patient Lift to stabilize during lifting procedures. During an interview on 01/29/2025 at 9:35 AM, the Director of Nursing (DON) stated during a transfer, the legs of the mechanical lift were to remain open to provide stabilizing and the rear casters/wheels were left unlocked. The DON stated leaving the rear wheels unlocked would prevent the mechanical lift from tipping. The DON stated if the weight shifts when a resident was being raised, the base of the lift would shift with the resident to prevent tipping. The DON stated it would not be appropriate to lift a resident with the rear casters locked, and stated she does not know why staff would lock the right wheel and leave the left wheel or rear caster unlocked when lowering the resident to the bed. A review of facility policy titled Lifting Machine, Using a Mechanical, revised July 2017, and it did not indicate locking the rear casters/wheels when lifting a resident with a mechanical lift. The policy did indicate that lift designs and operations may vary depending on the manufacture and staff must be trained and demonstrate competency using the lift. A review of Competency Assessment Lifting Machine, Using a Mechanical indicated a competency and/or return demonstration of using a mechanical lift. The checklist was verbatim of the above facility policy and did not indicate the rear casters should be locked. 4. During an interview on 01/31/2025 at 10:00 AM, the Administrator stated the facility did not have a policy for the beauty shop. During an observation on 01/29/2025 at 2:01 PM, while making rounds on the secure unit, the beauty shop door was noted to be open, and no staff were present. Three residents on the secured unit were wandering the hallway. One resident was in a wheelchair and two residents were ambulatory. Inside of the beauty shop was a floor scrubber and a 2-wheeled [NAME], shampoos, 2 spray bottles with clear liquid (unlabeled), vinegar, hair products and a can of clipper cleaning spray. Electrical supplies (clippers and a curling iron) were plugged in and ready for use. During an observation on 01/29/2025 at 2:06 PM, the beautician returned to the beauty shop with a resident from the main facility, while this surveyor remained beside the open door to the beauty shop. During an interview on 01/29/2025 at 2:12 PM, the beautician confirmed that the door was left ajar due to not having a key to get in after getting another resident to do the resident 's hair. The beautician stated that the door to the beauty shop should be shut and locked when not in use or if no one is present. During an interview on 01/30/2025 at 3:15 PM, the Administrator confirmed that the beauty shop should not have been left open and was not aware that the beautician did not have a key, stating, I ' m going to make it where it has a code to get in. The Administrator stated the beautician had been working for the facility for approximately one month as a full-time certified nursing assistant and did the beauty shop 2-3 times a month. (continued on next page)		

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50505		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 49596 Based on observations, interviews, and record review, the facility failed to ensure garbage and refuse was disposed of properly for one of one dumpster observed. The findings are: During an observation on 01/28/2025 at 3:00 PM, the trash dumpster gates were opened, exposing the trash dumpster and the trash inside. Sitting directly next to the dumpster was a used recliner and broken wooden fencing. A. The trash dumpster door was left open, exposing trash bags containing briefs, gloves, and other waste items inside. B. The fence around the dumpster had a large section of the fence missing, exposing a large black trash bag lying on the ground beside the dumpster that contained unknown debris and a dirty recliner sitting beside the dumpster. The black trash bag was torn open in several places. Items that had spilled out of the black trash bag included an empty sugar bag, several foam containers, plastic lids, a stack of white cups, plastic bags, used plastic gloves and an empty bottle of thickened water. [NAME] bags, used gloves, paper and other debris were on the grounds around the fencing and dumpster. C. A white bag of used rolled baby diapers was tossed on the ground along the fence that ran along the back of the facility grounds. D. Several tree limbs and brush were piled up between the fencing around the dumpster and the fencing along the backside of the grounds with a white plastic bag on the ground, a snicker bar wrapper, used gloves, and other debris under the limbs. E. Approximately 3 feet behind the trash bin fence was a pair of used gloves. There were several plastic bags lying along the fence row along the back yard of the facility. A white bag with rolled used briefs was observed lying on the ground along the fence of the back yard. F. A large screw, approximately 2 inches long with a sharp point, was protruding out the side of the fence post, eye level with the surveyor. 2. During an interview on 01/29/2025 at 8:15 AM, the Administrator stated the dietary department was responsible for cleaning the dumpster area. 3. During an interview on 01/29/2025 at 8:30 AM, the Dietary Manager (DM) stated she checked the dumpster three times a week to ensure the bags were picked up. The DM stated she removed the black trash bag that was on the ground yesterday (01/28/2025), and stated the bag had been there since last week. (continued on next page)		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent observation and interview on 01/29/2025, at 8:37 AM, the DM and Surveyor observed the dumpster area and noted the dumpster gates surrounding the dumpster were open. The DM stated the gates were always left open. The dumpster door was noted to be opened. The DM stated the dumpster door should be closed and she closed the dumpster door. The DM stated the gloves could be a danger to a resident if the resident got the gloves because the gloves could have infectious things on them and cross contaminate the resident with whatever is on the glove. The DM stated the brush and tree limbs between the dumpster fence and the backyard fencing could be a danger to a resident if the resident walked back there and got hung up in the branches and maybe even pass away if no one thought to look back there. The DM identified a clear white plastic cup lying on the ground as being one the nurse 's use. The DM stated the fencing had been broken and missing pieces for about a month. The DM stated the recliner was put next to the dumpster over the weekend. The DM stated she tells her staff to pick up the trash around the dumpster when they take the trash out and to make sure the door is closed to the dumpster. 5. During an observation on 01/29/2025 at 8:52 AM, the black trash bag was lying on the ground and hanging from under the dumpster, the sugar bag was hanging on the back corner of the dumpster, the glove behind the dumpster fencing was lying on the ground, the trash was under the brush and limbs, a pair of used gloves was lying on the ground beside the fencing, the bag of diapers was still lying on the ground beside the fence, two used masks were lying on the concrete just outside the dietary department. 6. During an interview on 01/29/2025 at 9:23 AM, the DM stated she did not have any training documentation and/or in-services to indicate training had been provided to dietary employees related to the disposal of refuse/garbage and/or the facility dumpster. 7. A review of facility policy Food-Related Garbage and Refuse Disposal revised 10/2017, indicated Garbage and reuse containing food wastes will be stored in a manner that is inaccessible to pests .Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 50505 Based on observations, interviews, record review, facility document review, facility policy review, it was determined that the facility failed to ensure hand hygiene was performed during one of one meal service observed. Findings include: A review of a facility policy titled, Handwashing/Hand Hygiene, revised October 2023, indicated, handwashing was the primary means to prevent the spread of infections and stated that hand hygiene is indicated immediately before touching a resident, after contact with contaminated surfaces and after touching a resident or the resident ' s environment. During an observation on 01/27/2025 at 12:38 PM, Nursing Assistant (NA) #9 rubbed their hands on their shirt, then placed their hands in their lap, then picked up a spoon and started feeding a resident without sanitizing hands. After feeding the bite, NA #9 placed their hands back in between their knees, then grabbed a spoon to feed the resident, without sanitizing hands. NA #9 reached across another second resident and adjusted the resident, then picked up a glass and offered the first resident a drink without sanitizing hands. During an interview on 01/27/2025 at 1:40 PM, NA #9 stated it was a bad habit that hands were placed in between the knees and confirmed that hands should have been sanitized prior to feeding the residents after touching clothes or between the residents. During an interview on 01/31/2025 at 8:50 AM, the Director of Nursing (DON) confirmed that it is not right to hold hands between the legs and then go to assist one resident and then to move to another resident to feed without hand sanitizing in between.		