

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Bradford House Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 S E 30th Street Bentonville, AR 72712	
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 - Immediate jeopardy to resident health or safety 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** Number of residents sampled: Number of residents cited: Based on record review and interview, the facility failed to identify and assess two (Resident #72 and Resident #78) of three residents' change in condition resulting in their death. 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) situation was related to, Appendix PP, CFR 483.35 at a scope and severity of J. The IJ began on [DATE] at 5:30 PM after reviewing Resident #72's Progress Notes, Neuro Assessments, Minimum Data Sheet (MDS) Assessments, Comprehensive Care Plan with interventions, Medication Administration Record (MAR), and interviews; and Resident 78's Progress Notes, MDS assessments, Comprehensive Care Plan with interventions, MAR, and interviews. The Administrator was notified of the IJ on [DATE] at 11:30 AM. A Plan of Removal was requested and accepted by the State Survey Agency on [DATE] at 4:12 PM. The IJ was removed on [DATE] at 2:58 PM after the survey team performed onsite verification that the Removal Plan had been implemented. The findings include: Resident #72 Review of an admission Record revealed Resident #72 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus type 2, Parkinson's disease, epilepsy, hypertension, occlusion and [blockage and narrowing of both carotid arteries, [plaque buildup in the aorta], repeated falls, dementia, and a cognitive communication deficit. Review of a signification change MDS, with an Assessment Reference Date (ARD) of [DATE], revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of 00 which indicated the resident had severe cognitive impairment. The MDS revealed Resident #72 was dependent for oral hygiene, shower/bathing/lower body dressing, putting on footwear, personal hygiene; required (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	substantial/maximal assistance for toileting, upper dressing, and transfers. The MDS also revealed Resident #72 had active diagnoses that included atrial fibrillation (Afib), coronary artery disease (CAD), hypertension (HTN), diabetes mellitus (DM), non-Alzheimer's Dementia, depression, anxiety, Parkinson's disease and used a wheelchair for mobility. The MDS revealed Resident #72's medications included an antidepressant, an antianxiety, an opioid, and anticonvulsant, and Resident #72's health conditions indicated the resident had two or more falls since the prior assessment. Review of Resident #72's Care Plan Report with a last reviewed date of [DATE], revealed the resident had a code status of do not resuscitate (DNR) indicating that if the resident's heart stops or the resident stops breathing, cardiopulmonary resuscitation (CPR) would not be initiated. The Care Plan indicated the resident had a self-care performance deficit related to debility; had limited physical mobility related to weakness and required moderate assistance of one person to walk with a walker and a gait belt and used a manual wheelchair. Resident had CAD with interventions to monitor BP, signs and symptoms of CAD, nausea and vomiting, and excessive sweating. The Care Plan Report also indicated Resident #72 had a communication problem related to receptive aphasia and slurring. Interventions included to allow time to respond, ensure safe environment, put call light in reach, ensure the bed was in low position with wheels locked, monitor physical and non-verbal indicators of discomfort/distress, monitor and report changes in ability to communicate. The Care Plan Report indicated Resident #72 had hypertension (HTN). Interventions included monitor and document BP, monitor document and report headache, confusion, disorientation, lethargy, nausea and vomiting. Resident had delirium or acute confessional episode related to change in condition (COC). Interventions included to observe and report concerns of delirium and indicated symptoms that increase safety risk are confusion and falls. Interventions included report signs and symptoms of delirium, changes in behavior, altered mental status, communication decline, lethargy. The Care Plan Report also indicated Resident #72 had a risk for falls related to gait/balance problems. Interventions included call light in reach, padded call light, concave mattress, bed/chair alarm, low bed, hourly toileting, bolsters to mattress, fall mat, bed alarm, bed alarm power box out of resident's reach. Resident had a terminal prognosis related to dementia. Interventions included comfort care, no transfer out to hospital or routine labs. Review of an Order Summary Report revealed that Resident #72 had the following orders:-DNR on file dated [DATE].-Admit to comfort care, DNR, do not transport [to hospital], no routine labs dated [DATE].-May send to emergency room (ER) for evaluation [DATE].-An antiemetic 4 milligram to be given as needed for nausea and vomiting, dissolve tablet on top of tongue then swallow with saliva dated [DATE]. Review of a MAR dated [DATE]-[DATE] revealed Resident #72 was administered an antiemetic 4mg on [DATE] at 10:01 PM. Review of Progress Note dated [DATE] at 11:03 PM indicated the [antiemetic] medication was effective. Review of a facility document titled, Nsg (Nursing) Neurological Assessment, dated [DATE] at 9:15 PM, indicated and initial assessment, 15-minute assessments x 4, 30-minute assessments x 4 and hourly assessments. The initial assessment indicated a temperature of 99 (no route indicated), pulse (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	between 7:00 AM and 7:30 AM, he was told by a CNA (unknown name) that Resident #72 had fallen, was not doing good, was having stroke-like symptoms, and was unable to move their left side. Upon entering the room, RN #23 stated he observed Resident #72 as having stroke-like symptoms, could not smile on the left side, and could not squeeze hands on the left side. RN #23 stated that APRN #30 sent Resident #72 out to the local hospital. RN #23 stated he had been told by the CNA that they [the CNA] told the RN on the hall[about the change in Resident #72]. RN #23 did not know if the RN responded. RN #23 could not remember if the CNA said or insinuated that the RN did not respond and did not recall any specific times of fall being mentioned. During an interview on [DATE] at 5:37 PM, the Director of Nursing (DON) stated they were on vacation on the date of the incident regarding Resident #72 and returned on [DATE] at 6:30 AM and was updated by the ADON on Resident #72's fall. The DON stated that the nurse was alerted of the fall and placed the resident on every 15-minute checks. There were not any changes in condition until the next morning, the nurse practitioner was in the building and transferred the resident out to the hospital. The DON stated the fall occurred at approximately 9:15 PM and Resident #72 was transferred sometime the next morning. The nurse was trying to reach the resident's family to see if they wanted the resident sent to the hospital; the resident should have been sent to the hospital. The DON stated Resident #72 was listed as no transport for aggressive interventions and the DON was unsure if that meant for no heartbeat, breathing, or all emergencies. The DON stated the priority was comfort of the resident above aggressive management. During an interview on [DATE] at 8:33 AM, Minimum Data Set Coordinator (MDSC) stated Resident #72's Physician Orders for Life Sustaining Treatment (POLST) included, do not resuscitate (DNR), only comfort treatment, do not transport and no routine labs. The MDSC stated basically, we are focusing on comfort, pain, and discussing with the family about stopping medications such as statins and focusing on pain management. The MDSC stated Resident #72 had a terminal disease of advanced dementia and Resident #72's family member chose comfort care when the resident began getting to later stages. MDSC stated comfort care does not mean residents would not be treated for an acute situation such as a stroke. During an interview on [DATE] at 8:57 AM, LPN #24 stated she worked on [DATE] from 3:00 PM to 11:00 PM and Resident #72 fell during medication pass around 9:00 PM. LPN #24 stated she checked on Resident #72 several times during the night and did neuro checks, none were out of range, and the CNAs did the vital signs. LPN #24 stated an assessment was completed and entered into the electronic health record. LPN #24 stated No CNAs came to me about anything. LPN #24 did not have information on if the provider was notified. LPN #24 stated that comfort care was keeping a resident comfortable and does not mean a change is not addressed. During an interview on [DATE] at 9:23 AM, CNA #25 stated she worked the 11:00 PM shift on [DATE] and received report that Resident #72 rolled out of bed, and vitals were taken throughout the night. CNA # 25 stated, I asked if [resident] wanted to get up and [resident] said no because of a headache, [resident] was cold and clammy. Vitals were obtained, LPN #6 was called to assess the resident and was notified that Resident #72 was clammy and cold, oxygen and Blood Pressure (BP) were fine. CNA #25 stated that CNA #3 came in Resident #72's room to help with rounds and stated Residents #72's face looked droopy, CNA #3 was trying to get the resident to squeeze her hands and Resident #72 stated no and wanted to be left alone. CNA #3 notified LPN #6 that Resident #72 was having a stroke. LPN #6 stated the APRN and family were called. CNA #25 stated I was in the library (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	resident's sheets were changed during shift. CNA stated Resident #72 was a fall risk, bed was in the low position, a fall mat was in place and CNAs checked on Resident #72 every 10 minutes. CNA #27 stated Resident #72 was found by CNA #26 lying on the floor on their side with their feet in the bed and their head was lying on the fall mat and Resident #72 was vomiting. CNA #27 stated she was notified of the fall by CNA #26 and stayed with Resident #72 while CNA #26 went to get the nurse. CNA #27 stated she told LPN #6 upon entry to resident's room that Resident #72 was vomiting. LPN #6 stated that she was aware of Resident #72 vomiting and the resident had already received medication for vomiting. CNA #27 stated that Resident #72 was no longer vomiting after LPN #6 gave the resident more medication. During an interview on [DATE] at 12:51 PM, the DON confirmed that neuro checks were completed for residents with falls involving hitting of the head and unwitnessed falls. The DON stated that vital signs were completed by CNAs; the rest of the neuro assessment is done by the nurses. Review of a Progress Note dated [DATE] at 10:01 PM, revealed Resident #72 received an [antiemetic] oral tablet 4 mg, take 2 tablets by mouth every 6 hours as needed for nausea and vomiting (dissolve tablet on top of tongue, then swallow with saliva), signed by LPN #6. Review of the Medication Administration Record (MAR) dated [DATE], revealed Resident #72 received an antiemetic on [DATE] at 10:01 PM, signed by LPN #6. Review of a Progress Note dated [DATE] at 11:03 PM, revealed the administration of [antiemetic] to Resident #72 was effective, authored by LPN #6. Review of a Progress Note dated [DATE] at 5:22 AM, revealed Resident #72 received [analgesic] oral tablet 325 mg, give 2 tablets by mouth every 6 hours as needed for fever and/or pain, authored by LPN #6. Review of the MAR dated [DATE] revealed Resident #72 received an analgesic on [DATE] at 5:22 AM for pain at level 5. Review of a Progress Note dated [DATE] at 7:30 AM, revealed Resident #72 was found on the floor, parallel to bed, and had vomited on self. Resident #72 was assisted to sitting position, had redness to left elbow/arm and left side of abdomen. Resident was moved from the floor to the wheelchair and taken to toilet. Resident #72 complained of nausea and vomited during toileting. Nausea medication given, initiated neuro checks every 15 minutes for 24 hours and was authored by LPN #6. Review of a Progress Note dated [DATE] at 8:10 AM, revealed Resident #72 was pale, skin was warm and moist to touch, dry heaving up yellow green bile with brown colored fluid. Resident #72 was lethargic with temperature of 99.0, pulse 117 and irregular, respirations 16, B/P 183/109, the provider was at bedside and was authored by LPN #22. Review of a Progress Note dated [DATE] at 8:53 AM, revealed Resident #72's spouse was contacted and the spouse requested transport to hospital emergency department for evaluation of possible CVA [stroke], authored by ADON. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Bradford House Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 S E 30th Street Bentonville, AR 72712	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a document titled Physician Orders for life-Sustaining Treatment (POLST) date prepared [DATE], signed by physician on [DATE], revealed Do Not Attempt Resuscitation/DNR, (Allow Natural Death), Comfort Treatment, indicated the primary goal was maximizing comfort. Transfer to hospital should be requested only if comfort needs cannot be met in current location. Additional orders indicated Do not transport. No routine labs. Review of document titled, eInteract Change in Condition Evaluation Notifications Report dated [DATE] at 5:00 PM by LPN #22 revealed, Resident #72 had a resting heart rate greater than 100 or less than 50; sudden change in level of consciousness; and diastolic pressure greater than 90 mmHg (millimeters of mercury) but less than 115 mmHg. Review of a facility document titled, SBAR Communication Form dated [DATE] revealed incident began on [DATE] with abnormal vital signs, falls, nausea/vomiting, condition has not occurred before; vitals 183/109, P 117, R 16, T 99, SPO2 90%; blood glucose 192.0; altered LOC, fall, nausea vomiting, no changes observed to neurological evaluation, dated [DATE] 8:10 AM. Signed LPN #22 Review of a document titled Emergency Medical Services (EMS) Pre-Hospital Care Report dated [DATE] at 8:53 AM revealed the EMS unit arrived on scene at 8:57 AM, departed scene at 9:08 AM and arrived at the hospital 8:15 AM. Provider primary impression was Intracranial & Stroke (CVA) Infarction. Advanced Directive listed as DNR or Medical Order Form. Assessment summary included altered mental status, abnormal cerebellar function, asymmetric strength, left facial weakness/drooping, left sided weakness, pain, asymmetric smile or droop, left leg abnormal/weakness motor function, right leg abnormal/weakness motor function, left arm motor function absent. Review of a Progress Note dated [DATE] at 9:16 AM, revealed report was called to emergency room, authored by LPN #22. Review of the Nurse Schedule for June revealed LPN #22 worked 7:00 AM to 7:00 PM on [DATE] and was not scheduled for [DATE]. Review of a Hospital Record dated [DATE] at 9:17 AM, indicated Resident #72 presented to the emergency department with facial droop, with a last known well time of 4:00 AM at the facility. Facility nursing staff did not report fevers, vomiting, or diarrhea to the emergency medical services (EMS) crew. Physical exam revealed right facial droop and flaccid (limp) left arm and leg. Computed tomography (CT) imaging included large parenchymal hemorrhage (bleeding directly into brain tissue) affecting several areas of the brain. Resident #72 was transitioned to comfort measures only. Transfer destination inpatient hospice care. Review of an untitled facility document referred to as Incident and Accident (I&A) with fall protocol, dated [DATE] at 9:15 PM, indicated Resident #72 was found in room, on floor, lying on left side, parallel to the bed. Resident had vomited on self, was assisted into sitting position, noted with redness to left elbow/arm, and left side of abdomen. Resident #72 was assisted to wheelchair and toileted per request. Resident was nauseated and vomited while toileting. Resident was assisted back to bed and given an antiemetic. Immediate action taken included Neuros (neurological) checks Q (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Bradford House Nursing and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 S E 30th Street Bentonville, AR 72712	
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 - Immediate jeopardy to resident health or safety Residents Affected - Some	(every) 15 minutes for 24 hours. Mental status indicated Resident #72 was oriented to person. Injuries reported indicated No injuries observed post incident. Predisposing factors included fall alarm, confusion, incontinent, impaired memory, other. Other info included active vomiting before and after incident. Review of Resid		