STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045374	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robinson Nursing and Rehabilitation Center LLC	519 Donovan Briley Blvd. North Little Rock, AR 72118

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure Resident Assessment and Minimum Data Set [MDS] were coded correctly to ensure residents were provided with individualized treatment plans and goals for six (Resident #1, #31, #45, #51, #67, and #79) of six residents reviewed.The findings include:Resident #31Review of the admission Record for Resident #31 revealed the facility admitted Resident #31 with diagnoses that included fracture of left patella, sprain of anterior cruciate ligament of left knee, effusion, pain, hypertension, anxiety, and diabetes mellitus.Review of end of PPS Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed this was Resident # 31's most recent MDS.Review of a Progress Note dated [DATE] indicated Resident #31 discharged to a nursing home closer to family.During an interview on [DATE] at 3:12 PM, MDS #2 reported that Resident #31's most recent resident assessment did not accurately reflect the resident's status. She indicated that Resident #31 should have had a discharge MDS completed. MDS #2 stated I guess I just did not complete that one. Resident #45Review of the admission Record for Resident #45 revealed the facility admitted Resident #45 on [DATE] with diagnoses that included volvulus, depression, and tachycardia.Review of the Order Summary Report for Resident #45 revealed an order dated [DATE] for transfer to hospital due to possible ileus (decreased bowel motility).Review of a Progress Note dated [DATE] at 9:55 PM, revealed Resident #45 was transported via ambulance to the emergency department at a hospital due to abdominal x-ray results.Review of the most current discharge MDS with an ARD of [DATE], revealed resident return was anticipated.During an interview on [DATE] at 3:12 PM, MDS #2 reported that Resident #45's resident assessment did not accurately reflect the resident's status. She also stated, maybe I thought the resident was going to return. She indicated a discharge, return not anticipated should have been completed. Resident #67Review of Resident #67's Medical Diagnosis revealed diagnoses which included seizure disorder, depression and pain.Review of Resident #67's quarterly MDS with an ARD of [DATE], revealed Resident #67 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated the resident had severe cognitive impairment.Review of Progress Notes dated [DATE] revealed Resident #67 discharged home with family.During an interview on [DATE] at 2:17 PM, MDS #1 confirmed Resident #67 was discharged from the facility and stated, I missed putting in the Discharge MDS. MDS #1 also stated, Discharges should be coded on the MDS because it was used to track the residents. Resident #79Review of Resident #79's Medical Diagnosis revealed diagnoses which include polyneuropathy (causes nerve damage in multiple areas), anemia, and anxiety.Review of Resident #79's MDS Assessment Transmittal History revealed there was a quarterly MDS with ARD of [DATE] and an entry MDS with an ARD of [DATE].Review of a Progress Notes dated [DATE], indicated Resident #79 transferred to the emergency room (ER) and passed away in less than 24 hours.During an interview on [DATE] at 2:17 PM, MDS #1 stated, Resident #79 died in the hospital and I forgot to do the discharge, return not anticipated. When a resident dies at the hospital in less than 24 hours it is considered a death in the facility. MDS #1 revealed the process was to call and check on residents that were hospitalized , or a family member might call the facility to let staff know. MDS #1 stated, I was aware Resident #79 passed and forgot to code Resident #79's discharge. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Daily Checklist for MDS Coordinators undated, revealed MDS coordinators should complete discharge assessments if [resident] admitted to hospital for inpatient or observation.Review of documentation from the Resident Assessment Instrument [RAI] Manual revealed if a resident is discharged and not expected to return to the facility must be completed in 30 days. It must also be completed in 30 days if a resident is expected to return to the facility. Death in facility must be completed when a resident dies in the facility or when on leave of absence [LOA]. Must be completed within 7 days.Resident #1Review of the admission Record revealed the facility admitted Resident #1 on [DATE] with diagnoses that included bipolar disorder and unspecified intellectual disabilities.Review of an annual MDS with an ARD of [DATE], revealed Resident #1 was not currently considered by the State Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition.Review of Resident #1's Care Plan revised [DATE], revealed Resident #1 had a mood problem related to unspecified mood [affective] disorder and obsessive-compulsive disorder (OCD) and had a PASRR.Review of a [company name] document dated [DATE], revealed that Resident #1 did not require specialized services for their mental illness, intellectual disability, and/or developmental disability beyond the capabilities of a nursing facility.During an interview on [DATE] at 10:59 AM, MDS #1 stated the annual MDS with an ARD of [DATE] was not correct due to Resident #1 did have a [company name] PASSRR in the EHR. She stated this was something she should have caught. MDS #1 stated she did receive training in 2024 when she started. She stated the MDS coordinator, who was no longer employed at facility, at the time of her hire taught her how to fill out the MDS and she had been to several trainings but was unable to find a copy of a certificate.Resident #51Review of Resident #51's Medical Diagnosis revealed the facility admitted Resident #51 with diagnoses which included paranoid schizophrenia, bipolar disorder and diabetes.Review of Resident #51's annual MDS with an ARD of [DATE], revealed Resident #51 had a BIMS score of 13, which indicated the resident was cognitively intact. Section A1500 did not show that Resident #51 has a PASRR II.Review of Care Plan for Resident #51 revealed Resident #51 was a level II PASRR ([DATE]) and to report significant findings and perform behavioral health consults as needed.Reviewed a [company name] document dated [DATE] that stated Resident #51 would require a level II PASRR.Reviewed a [company name] document dated [DATE] that revealed Resident #51 was approved for nursing home placement, must contact the state designated authority with client's admission date to receive a completed PASRR evaluation.Reviewed [company name] document dated [DATE] revealing an evaluation was completed and determined Resident #51 did not require specialized services. Provision of a structured environment was recommended at the facility. During an interview on [DATE] at 11:40 AM, MDS #1 reviewed Resident #51's EHR and stated Resident #51 had a PASRR II and then looked at the MDS and stated, It looks like I missed that one. MDS #1 stated, it should be coded correctly to ensure Resident #51 is getting the right services. During an interview on [DATE] at 9:27 AM, MDS #2 indicated the MDS coordinators use Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 dated [DATE].During an interview on [DATE] at 1:53 PM, MDS #1 provided information from the RAI manual showing that a resident with a level II PASRR, serious mental illness and/or intellectual disability should be coded 1 to indicate yes the resident had a PASRR II.During an interview on [DATE] at 11:16 AM, the DON stated the facility did not have a policy for the Minimum Data Set (MDS) and that the facility uses the Resident Assessment Instrument (RAI) manual, she also provided an undated facility document titled Daily Checklist for MDS Coordinators that the MDS staff utilize.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review, it was determined that the facility failed to ensure a resident who had not been assessed to safely self-administer medications was not left alone while receiving medications via nebulizer for one (Resident #100) of one resident reviewed. The findings include:A review of facility policy Medication, General Administration of item 1. Stated Drugs and biologicals may be administered only by licensed physicians, licensed registered or practical nursing personnel, or other personnel wo are duly authorized to perform such services under state law. Item 9. Self-administration of drugs is permitted when approved by the interdisciplinary team and with a physician's order. A review of Resident #100 Medical record did not show an assessment for self-administering of the nebulizer/breathing treatment.A review of Resident #100 Care Plan does not identify the resident to receive Nebulizer treatments.During a concurrent observation and interview on 06/03/2026 9:45 AM, this surveyor observed Resident #100 receiving a breathing treatment. The resident was holding the plastic nebulizer hose mouthpiece in their mouth. There were no staff in the resident's room. The surveyor observed the Medical Aide Certified (MA-C) in the hallway two doors down with the medication cart preparing another resident's medications. The MA-C stated she had started the nebulizer treatment on Resident #100 and was going in and out of the room checking on the resident. The MA-C stated they are allowed to start and stop the breathing treatments for residents and that she had received the additional training allowing them to administer the nebulizer treatment. The MA-C then went into another resident's room, two doors down the hall from Resident #100.During a concurrent observation and interview on 06/03/2026 at 3:10 PM, this surveyor observed Resident #100 in bed with the nebulizer treatment running. There were no staff in the resident's room. The resident was observed laying the nebulizer pipe, while still running with white vapor coming from the end of the tubing indicating medication was being administered, on their lap. The surveyor stepped out into the hallway and spoke to Certified Nursing Assistant (CNA) #3, who stated they had just assisted with dressing Resident #100 after their bath and assisted in situating Resident #100 in their bed. CNA #3 stated they saw MA-C give Resident #100 an updraft and turn their breathing treatment on, and then the MA-C left. CNA #3 said the MA-C had left work a little after 3:00 because her shift was over. During an interview on 06/03/2026 at 3:14 PM, CNA #4 stated they saw the MA-C do the updraft and start the breathing treatment and then the MA-C left the room and left work for the day. On 06/03/2026 at 3:18 PM during an interview Licensed Practical Nurse (LPN) #5 stated they were not aware Resident #100 was receiving a breathing treatment because it was ordered for noon, but they had put it off because the resident wanted to take a shower. LPN #5 stated Resident #100 was due their next breathing treatment at 4:00 PM. LPN #5 stated the nurse, or the MA-C can start a breathing treatment. LPN #5 stated they did not talk to the MA-C prior to the MA-C leaving for the day because they had been tied up on another hall. On 06/03/2026 at 3:23 PM during an interview, CNA #6, stated when Resident #100 was finished with the breathing treatment the resident would take it off and push their call light for someone to come in and turn it off and take it. CNA #6 stated either the nurse or the MA-C will come in and turn it off. CNA #6 stated when they came into Resident #100's room the resident was already on the machine and Resident #100 can do their own breathing treatment. CNA #6 stated the MA-C, or the LPN will start the treatment and then they will let the resident do their treatment and then they will come back and turn it off when the resident has finished. CNA #6 stated the treatments were timed and they know when to come back and turn the machine off. CNA #6 stated there are other residents that get them too. On 06/03/2026 3:26 PM, this surveyor observed Resident #100 with the nebulizer pipe in her mouth and vapor coming from end of plastic tube. Resident #100 stated they had a little more left in the tube. CNA #6 was in the resident's room and provided the resident with a wet washcloth and then left the room. During a concurrent observation and interview on 06/03/2026 at 3:27 PM, LPN #7 entered Resident #100's room and turned off the nebulizer. The surveyor asked LPN if they were aware that the MA-C had (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	started the breathing treatment. LPN #7 stated a CNA, but did not give a name, had told him that the MA-C had started it before leaving for the day. LPN #7 then left the room and retrieved a bag for the nebulizer tubing. LPN #7 stated they had other residents on breathing treatments and that either the LPN #7 or the MA-C can start the updraft and then monitor for 10 - 15 minutes, checking in and out. LPN #7 stated they check the residents' oxygen at the end of the treatment but check on them periodically during the treatment. LPN #7 stated that was the proper way to monitor a resident while they receive a breathing treatment. LPN #7 stated they had been trained in their nursing program and at the facility but could not remember when the last training was at the facility.On 06/03/2026 at 3:58 PM during an interview, the Director of Nursing (DON) stated the facility policy on updrafts requires a doctor's order. The DON stated if a resident requested an updraft, due to short of breath, the nurse should assess the resident and using their nursing judgement and they should do the updraft. The DON stated only LPN, or Registered Nurses (RN) can administer an updraft. The MA-C cannot administer the updrafts. The nurse was required to stay in the room with the resident the entire time the updraft was running. The nurse could not leave the room or leave the resident unsupervised during the treatment because anything could go wrong, and some residents would take it off. The DON stated they want to make sure the resident received all the medication as ordered. The DON stated a negative outcome could be the machine could stop working properly, the resident could become short of breath, and the treatment may not be helpful. The DON also indicated that the nurse was required to be in the room to assess the resident should something go wrong. The DON stated the nursing staff were trained by their contracted pharmacy group prior to the DON hiring in March of 2026. The DON stated the updraft/nebulizer treatments were treated like any other medication and were covered in their medication policy. The DON stated there were no residents assessed to self-administer their own updrafts and MA-Cs are not permitted to perform an updraft treatment because they cannot assess a resident, and it was beyond their scope of practice in this facility.On 06/04/2026 the Director of Nursing (DON) provided a statement stating MA-Cs are not permitted to administer nebulizer treatments and it is performed by a licensed nurse only.On 06/04/2026 at 8:35 AM during an interview with MA-C, they said they had administered the breathing treatment for Resident #100 on 06/03/2026. MA-C said they had been trained on administering updrafts and monitoring of residents during the updrafts when they increased the MA-Cs scope of practice. The MA-C indicated they monitor things like if a resident was on oxygen they should not have lip balm, if they smoke, they cannot be around a tank, when transporting a tank to put it in a rolling cart, always look for signs on the person, checking the O2 levels, checking the tank for oxygen levels, check for discoloration of the resident. Follow the five steps when administering any medication, make sure it is the right person, the right medication, the right dose, make sure there is no food in their mouth, make sure the whole session has been completed and then tell the nurse. The MA-C stated they did not realize they did not stay in the room on 06/03/2026 to make sure the treatment was completed. The MA-C stated they went in the room two or three times, but the resident had to have a shower and was meticulous about how you handle them. The MA-C looked at the Medication Administration Record and stated they had started the updraft at 3:05 PM and stated it was at the end of their workday, and it had slipped their mind to stay in the room while the resident took the treatment. The MA-C stated they were not in the room when the treatment finished because they had left work, but it normally takes about 15 minutes. The MA-C indicated it was important to stay in the room with the resident to make sure they get all of the dosage. The MA-C said the dangers or concerns of leaving the room while the treatment was running would be the resident wouldn't get all the medicine or there may be a malfunction of the machine. The MA-C stated, prior to retraining on 06/03/2026, they did not know the facility policy on MA-Cs administering breathing treatments, but they are sure the facility would have told them. The MA-C stated they know they should have stayed in the room, notified the nurse, let the nurse know what they were doing, let the nurse know if a resident doesn't take it, if they fight against it, if any slight change to notify the nurse, if they had to coach the resident into taking it, if a resident said they (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were tired of the medication. The MA-C stated, I notify the nurse of everything. The MA-C stated prior to them leaving work on 06/03/2026 they did not notify the nurse [of the ongoing nebulizer treatment]. The MA-C stated she had been trained [on administering nebulizer treatments] by the Infection Preventionist right after they changed a MA-Cs scope of practice but could not remember when.On 06/04/2026 at 9:30 AM the MA-C reviewed Resident 100's MAR for 06/03/2026 and stated they had started the resident's morning breathing treatment at 9:31 AM and had not stayed in the room with the resident while the treatment was going but was going in and out of the room monitoring the resident. On 06/04/2026 at 10:00 AM during an interview the Administrator stated MA-Cs were not permitted to administer nebulizers to residents in this facility because a MA-C cannot assess a resident for effective breathing, especially if it was a PRN breathing treatment. The Administrator indicated the nurse has to remain with the resident while the treatment was being rendered to make sure the medication was being administered. The Administrator stated if the nurse was not there they cannot know if the resident had the treatment on the entire time and received the medication as ordered, if they suffered from shortness of breath, had increased anxiety, had a critical situation occur like shortness of breath that could lead to death because the resident was needing the treatment to open the airways so they could breathe better.On 06/04/2026 at 11:40 AM the Nurse Consultant stated their employee trainings were online, and they could not provide a copy of those in-services. On 06/04/2026 at 11:41 AM DON stated they did not have a functional job description for the MA-C.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on record review and interview, the facility failed to ensure a significant change Minimum Data Set (MDS) was completed within 14 days from the effective date of hospice service election for one (Resident #84) of four residents reviewed.The findings include:Review of the Centers for Medicare and Medicaid Services' (CMS's) Resident Assessment Instrument (RAI) Version 3.0 Manual version 1.20.1 dated October 2025, revealed a Significant Change in Status Assessment (SCSA) is required when a terminally ill resident enrolls in a hospice program, or changes hospice providers and remains a resident at the nursing home. The Assessment Reference Date (ARD) must be within 14 days from the effective date of the hospice service election.Review of an admission Record revealed the facility admitted Resident #84 on 10/11/2024 with diagnoses that included malignant melanoma of skin.Review of Resident #84's Order Summary Report revealed an order dated 01/20/2025 for [name of hospice] to eval [evaluate] and admit.Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/15/2026 revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of 07, which indicated Resident #84 had severe cognitive impairment. The MDS also revealed Resident #84 had hospice care while a resident.Review of the MDS section of the electronic health record (EHR) for Resident #84 did not indicate a significant change MDS was completed after Resident #84 was admitted to hospice services on 01/20/2025. According to the RAI manual timeframe, 14 days after the effective date of the hospice service election indicates the assessment was due to be completed by February 3, 2025.During an interview on 06/04/2026 at 9:27 AM, MDS Coordinator #1 stated she used the RAI Manual version 1.20.1 dated October 2025 for guidance when completing assessments. She stated Resident #84 was receiving hospice services as of January 2025. She reviewed Resident #84's EHR and stated she did not see a time when the resident was discharged from hospice services and readmitted . She confirmed a significant change MDS was not completed for Resident #84 to address the resident enrolling in hospice. She stated a significant change MDS should have been completed for Resident #84 so many days after the significant change but she was not able to state when this should have been completed. She stated the significant change MDS was not completed for Resident #84 because, [It] just got missed.During an interview on 06/04/2026 at 11:16 AM, the Director of Nursing (DON) was interviewed and stated the MDS Coordinators used the RAI manual in the MDS office. She provided a Daily checklist for MDS Coordinators.Review of the Daily Checklist for MDS Coordinators undated, revealed admission and significant change assessments only have 14 days to complete from admission date or change noted date.

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and facility policy review it was determined that the facility failed to develop and implement a comprehensive person-centered care plan that included measurable objectives and timeframes to meet one (Resident #100) of one residents reviewed. Specifically, the resident's care plan did not identify the resident as receiving medications via nebulizer (a medical device that turns liquid medication into a breathable mist, delivering it directly to the lungs). The findings include: Review of an admission Record revealed Resident #100 had diagnosis of type 2 diabetes mellitus, acute embolism and thrombosis, dementia, chronic obstructive pulmonary disease, asthma, tachycardia, depression, anxiety disorder, and edema. Review of Resident #100's quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8 which indicated moderate cognitive impairment. The MDS did not indicate Resident #100 received oxygen therapy. Review of the resident's Progress Notes effective date range 05/04/2026 – 06/04/2026, revealed the resident had a physician's order to inhale one application (of medication) using a nebulizer three times a day for asthma. Review of Resident #100's Electronic Medical Record (EMR) revealed there was no assessment completed for self-administering a nebulizer/breathing treatment. Review of Resident #100's Care Plan last reviewed on 03/20/2026, revealed the Care Plan did not identify that Resident #100 received nebulizer treatments. During an observation and concurrent interview on 06/03/2026 9:45 AM, Resident #100 was holding a plastic nebulizer hose mouthpiece in their mouth. There were no staff present in the resident's room. This Surveyor observed the Medical Aide Certified (MAC) in the hallway two doors down preparing another resident's medications. During an interview, the MAC stated she had started the nebulizer treatment for Resident #100 and was going in and out of the room checking on the resident. The MAC stated MACs were allowed to start and stop the breathing treatments for residents and that she had received additional MAC Expanded Scope training that allowed a MAC to administer the nebulizer treatment. The MAC then went into the room to administer the other resident's medications. On 06/03/2026 at 3:10 PM, this Surveyor observed Resident #100 in bed with the nebulizer treatment running. There were no staff present in the resident's room. The resident was observed laying the nebulizer pipe, while still running with white smoke coming from the end of the tubing, on their lap. During an interview on 06/04/2026 at 10:30 AM, the Minimum Data Set Coordinator (MDS) reviewed Resident #100's care plan and stated it did not reflect the updraft/nebulizer treatment and stated it should be on the care plan. MDS stated, The care plan tells staff how to care for the resident, how to watch for signs and symptoms of a problem, and what to look for related to a specific area. The MDS stated if a breathing treatment was left off the resident's care plan, the nurse or other staff may not know what to look for, as far as signs, symptoms, warnings, and know why the breathing treatment (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was needed for that specific resident. The MDS stated it was their responsibility to ensure a resident's breathing treatment was on the care plan. The MDS was looking in their computer software and stated Resident #100 started breathing treatments in February of 2026, that this resident had their initial care plan done in February of 2026 with an updated care plan done on March 8, 2026, and their quarterly was due now, but these assessments did not have the nebulizer/breathing treatment on them. During an interview on 06/04/2026 at 10:44 AM, the Administrator stated if a resident was receiving a breathing treatment, it should be on the resident's care plan because the care plan directed staff on how to take care of a resident. The Administrator stated the nebulizer was an order of medication, and it should be on the care plan. The Administrator stated the MDS Coordinator, and each department reviewed their own sections of the care plan. The Administrator stated, all orders should be added [to the care plan] within seven days and that was actual regulation. During an interview on 06/04/2026 at 10:48 AM, the DON stated the Unit Manager completed the medication section of the care plan, but the MDS coordinator was responsible for ensuring the medications were on the care plan and the nebulizer should be on the care plan so, we know the resident was receiving nebulizer/breathing treatments/oxygen. During an interview on 06/04/2026 at 11:40 AM, the Nurse Consultant stated the facility's employee trainings were online, and they could not provide a copy of those in-services. During an interview on 06/04/2026 at 11:41 AM, the DON stated they did not have a functional job description for the MAC. During an interview on 06/04/2026 at 12:16 PM, MDS stated the Minimum Data Set is a guide for the development of the resident's care plan. They stated the facility uses the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 Manual for completing the MDS, dated [DATE]. During an interview on 06/04/2026 at 12:29 PM, the Nurse Consultant stated they do not have a care plan policy and stated they used the RAI manual for developing the care plan. Review of a facility policy titled Medication, General Administration of, with a revised date of 11/22/2026, revealed that drugs and biologicals may be administered only by licensed physicians, licensed registered or practical nursing personnel, or other personnel who are duly authorized to perform such services under state law and that self-administration of drugs is permitted when approved by the interdisciplinary team and with a physician's order.

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	045374	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robinson Nursing and Rehabilitation Center LLC	519 Donovan Briley Blvd. North Little Rock, AR 72118

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Number of residents sampled: Number of residents cited: Based on record review and interview, the facility failed to ensure a comprehensive care plan was revised to include the signs, symptoms, and adverse reactions staff were to monitor for related to the use of a diuretic medication for one (Resident #84) of one resident reviewed. The findings include: Review of Resident #84's admission Record revealed the facility admitted Resident #84 on 10/11/2024 with diagnoses that included acute kidney failure. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/15/2026, revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of 07, which indicated the resident had severe cognitive impairment. The MDS also revealed Resident #84 was taking high-risk drugs including a diuretic. Review of Resident #84's Care Plan with a last reviewed date of 04/17/2026, revealed Resident #84 was on diuretic therapy related to kidney failure. Interventions included to administer diuretic medication as ordered by the Physician and monitor for side effects, but did not include what signs, symptoms or adverse reactions staff were to monitor the resident for. Review of the Order Summary Report for Resident #84 revealed a diuretic medication to be given one tablet by mouth one time a day with an order date of 03/13/2025. The Physician's Order did not include what signs, symptoms, or adverse reactions staff were to monitor the resident for. Review of the Food and Drug Administration (FDA) Label revised in 09/2010 for the diuretic medication revealed for precautions, all patients receiving [drug name] therapy should be observed for signs or symptoms of fluid or electrolyte imbalance, which included dryness of mouth, thirst, weakness, fatigue, hypotension, and oliguria. During an interview on 06/04/2026 at 9:27 AM, MDS Coordinator #1 stated she updated the resident care plans. She was asked to review Resident #84's care plan for signs and symptoms or adverse reactions to monitor for the use of a diuretic and she stated she did not see this information. She stated she could not state why this information was not care-planned. She stated the signs, symptoms and adverse reactions for use of a diuretic should be included on the care plan so all staff caring for the resident would know what signs to look for. She stated the nurses know how to provide the necessary care to residents by looking at the care plan and the Certified Nursing Assistants (CNAs) have the closet care plans to reference. During an interview on 06/04/2026 at 11:16 AM, the Director of Nursing (DON) stated the nurses and CNAs know how to care for residents by reviewing the care plan or the closet care plan. She stated the staff should review the care plan every day in case something changes. She stated upon hire, CNAs complete competencies and were taught how to read and review the care plan in CNA school. The DON also stated the facility did not have a policy on care plans.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Number of residents sampled: Number of residents cited: Based on observation, interviews, and record reviews, the facility failed to ensure a physician's order for a sensor device to check blood sugar results was placed on the physician orders and the medication administration record of a resident's electronic health record for one (Resident #99) of one resident reviewed. The findings include: Review of Resident #99's admission Record revealed that the facility admitted the resident on 06/11/2024 with diagnoses that included diabetes mellitus. Review of a quarterly Minimum Data Set with an Assessment Reference Date of 03/21/2026, revealed Resident #99 had a Brief Interview of Mental Status score of 15, which indicated the resident was cognitively intact. Review of a Care Plan with a revised date of 03/20/2026, revealed that Resident #99 was resistant to care as evidenced by refusing blood sugar checks and that Resident #99 refused finger pricks in the event the sensor device to check blood sugar results was not available. Review of Resident #99's Order Summary Report June 2026, did not indicate that the resident had an order for a sensor device to check blood sugar results. Review of Resident #99's Medication Administration Record dated June 2026, did not have a sensor device to check blood sugar results on the record. During an interview on 06/01/2026 at 12:05 PM, a sensor device patch was observed to Resident #99's left upper arm. During an interview on 06/02/2026 at 12:15 PM, a sensor device patch was observed to Resident #99's left upper arm. During an interview on 06/03/2026 at 11:15 AM, a sensor device patch was observed to Resident #99's left upper arm. During an interview on 06/03/2026 at 12:34 PM, Licensed Practical Nurse (LPN) #8 indicated that she started working at the facility in 9/2024. LPN #8 indicated that she did not see an order in Resident #99's chart on how the residents' blood sugars should be taken. LPN #8 indicated that the resident checked blood sugars using a sensor device and the results show up on the resident's phone. LPN #8 indicated that she would obtain the blood sugar results from Resident #99's phone. LPN #8 indicated that the sensor device patch was changed every 10 days. LPN #8 indicated that she did not know who the doctor was that wrote the original order for the sensor device. LPN #8 called the pharmacy and was informed that the sensor device was ordered by Doctor #9. LPN #8 indicated that Resident #99 would get a notification on the resident's phone when it was time to order the sensor device. LPN #8 indicated that sensor devices should be on the Physician Orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/03/2026 at 12:40 PM, LPN #10 indicated that she had been employed at the facility for two years. She indicated that the Endocrine Doctor wrote the order for the sensor device. LPN #10 indicated that she thinks that the Sensor device should be on the Physician Orders. LPN #10 indicated that Resident #99 informed her that blood sugars are checked by using the sensor device. During an interview on 06/03/2026 at 12:50 PM, Pharmacy Staff #11 indicated that Resident #99 had the sensor device filled on 11/10,2025, 12/10/2025, 1/09/2026, 2/16/2026, 3/17/2026, and 5/12/2026. Pharmacy Staff #11 indicated that each refill had three sensors, and each sensor lasted for 10 days. Pharmacy Staff #11 indicated that the order for the sensor device was written by Doctor #9. During an interview on 06/03/2026 at 2:29 PM, Resident #99 indicated they had the sensor device for over eight months. During an interview on 06/03/2026 at 2:57 PM, LPN #10 indicated that it was a habit to give Resident #99 the sensor without having a Physician Order. She indicated that Resident #99 handled their own affairs. During an interview on 06/04/2026 at 9:10 AM, the Director of Nursing (DON) indicated that she started in March of 2025, and Resident #99 had the sensor device then. The DON indicated that Resident #99 received the order for the sensor device from an outside physician. The DON indicated that the Medical Director did not have to review orders from outside doctors before they were added to the Physician Orders. The DON indicated that she was not sure how the nurses knew when to change the sensor device since it was not on the medication administration record, or on the Physician Orders. During an interview on 6/04/2026 at 11:35 AM the Medical Director indicated that he doesn't directly take care of Resident #99. The Medical Director indicated that he was not aware Resident #99 was using a sensor device. The Medical Director indicated that if Resident #99 was using a sensor device then it should be on the Physician Orders. During an interview on 6/04/2026 at 12:15 PM the Administrator indicated that the facility does not have a policy for quality of care. Review of a facility Inservice Education Report titled [Name Brand] Orders and Blood Glucose Monitoring dated 06/03/2026, revealed that staff responsibilities were to verify a current Physician/Provider order was present before applying or utilizing a sensor device. Do not initiate sensor device monitoring based solely on resident or family request. Review of a facility Inservice Education Report titled Blood Glucose Monitoring dated 06/03/2026 indicated that blood glucose checks must be performed as ordered by the physician. Review of a facility policy titled Physician Services with a revised date of 11/22/2026 revealed that medications, diets, specialized rehabilitation, therapy, or any other treatment may not be administered to the resident without the written approval of the attending physician. The policy also revealed that the residents' total program of care should be reviewed at each physician visit.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Number of residents sampled: Number of residents cited: Based on record review and interview, the facility failed to ensure a written plan of care included both the most recent hospice plan of care and a description of the services provided by the long-term care (LTC) facility to maintain the highest practicable physical, mental, and psychosocial well-being for one (Resident #84) of one resident reviewed. The findings include: Review of the admission Record for Resident #84 revealed the facility admitted the resident on 10/11/2024 with diagnoses that included malignant melanoma (cancer) of skin. Review of Physician's Orders for Resident #84 revealed an order dated 01/20/2025 for [name of hospice] to eval [evaluate] and admit the resident. There was no information in the orders to indicate the diagnosis for admission to hospice services or contact information for the hospice agency. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/15/2026, revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of 07, which indicated the resident had severe cognitive impairment. The MDS also revealed the resident received hospice care while a resident. Review of Resident #84's Care Plan last reviewed on 04/17/2026, revealed the care plan did not include any information for hospice services to be provided to the resident or any contact information for the hospice agency. Review of a Hospice Agreement revealed the facility entered into an agreement with the hospice provider on September 1, 2013. The agreement was signed by the facility Administrator on 01/21/2014. The hospice agency's director signed the form on 09/04/2014. During an interview on 06/04/2026 at 9:27 AM, MDS Coordinator #1 stated that Resident #84 was receiving hospice services as of January 2025. She reviewed Resident #84's electronic health record (EHR) and stated she did not see a time when the resident was discharged from hospice services and readmitted to the facility. MDS #1 was asked to review Resident #84's care plan for hospice services provided and she stated she did not see any information. She stated hospice information should be care planned because, The care plan is for us to be able to take care of the resident and for the aides to see. She stated she updated resident care plans and hospice services was not care planned because, It just got missed. During an interview on 06/04/2026 at 11:16 AM, the Director of Nursing (DON) stated the nurses and Certified Nursing Assistants (CNAs) know how to care for residents by reviewing the care plan or the closet care plan. She stated the staff should review the Care Plan every day in case something changed with the care provided. She stated upon hire, CNAs completed competencies and were taught how to read/review the care plan in CNA school. She stated the MDS Coordinator was responsible for adding hospice information to the residents' care plans. The DON was asked to provide a policy for hospice care and informed the survey team that the facility did not have a policy.