STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore Healthcare and Rehabi of Malvern	1820 West Moline Street Malvern, AR 72104

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 50580 Based on document review, record review, interviews, and facility policy review, the facility failed to ensure a resident was free from resident-to-resident abuse for 1 (Resident #1) of 4 residents reviewed for abuse. Specifically, Resident #2 verbally abused Resident #1 by commenting I am going to kill [pronoun] (Resident #2) on 10/30/2024. Resident #2 was not moved to another room until 11/01/2024 after a second verbal abuse, that resulted in physical abuse. 1. Resident #1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 01/31/2025 documented a Brief Interview for Mental Status (BIMS) score of 08, which identified the resident as having moderate cognitive impairment. Diagnoses included: diabetes mellitus (DM), chronic kidney disease, cerebrovascular accident (CVA), cognitive communication deficit, delirium, and obstructive and reflux uropathy. Resident #1 had an indwelling urinary catheter. a. Review of an Incident and Accident (I & A) Information Report, revealed the findings and actions taken documented: On 10/30/2024, the Assistant Director of Nursing (ADON), observed Resident #1 sitting in the common area when Resident #2 came out of Resident #2's room yelling/cussing at Resident #1 with Resident #2's finger pointed in Resident #1's face. Certified Nursing Assistant (CNA) #4 immediately removed Resident #2 from the area. Resident #2 was combative with CNA #4 at this time and told CNA #4 [Resident #2] would kill her [CNA #4]. On 11/01/2024 at 6:09 am, Treatment Nurse #3 observed Resident #2 on Resident #1's side of the room yelling I'm gonna kill [Resident #1], I'm gonna kill [Resident #1] and advancing toward Resident #1. Resident #2 was redirected and moved to another room. b. Review of an I & A Report revealed findings and Actions Taken 11/05/2024 at 11:30 am, CNA #10 observed Resident #1 sitting in the resident's wheelchair outside of the resident's room. CNA #10 witnessed Resident #2 walk over to Resident #1, hit Resident #1 in the face and multiple times in the chest and called Resident #1 a [expletive]. CNA #10 immediately separated the two residents. Resident #2 was immediately placed on one-on-one precautions. Resident #1 was taken aside with other staff for support. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER: Encore Healthcare and Rehabi of Malvern		STREET ADDRESS, CITY, STATE, ZIP CODE: 1820 West Moline Street Malvern, AR 72104	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. On 3/5/25 at 1:50 pm, this surveyor interviewed CNA #10 regarding the incident on 11/05/24 between Resident #1 and Resident #2. CNA #10 stated Resident # 2 was coming out of the resident's room and saw Resident #1 sitting outside Resident #1's door. Resident #2 headed in the direction of Resident #1 immediately and began hitting Resident #1 before CNA #10 could make it to Resident #1. The residents were immediately separated. CNA #10 took Resident #2 down the hall and redirected the resident. CNA #10 immediately informed the Administrator. This surveyor asked if she knew what caused the incident. CNA #10 stated Resident #1 and Resident #2 do not get along. Resident #2 had a history of trauma. CNA #10 was aware of this and did not know what caused outbursts. Resident #1 was not verbally abusive and did not say anything to Resident #2. d. On 03/5/25 at 2:08 pm, this surveyor interviewed LPN #9 who was here during the incident. This surveyor asked Licensed Practical Nurse (LPN) #9 if Resident #1 had ever been verbally abusive to her or anyone. LPN #9 stated no. This surveyor asked LPN #9 about the incident on 11/05/24 between Resident #1 and Resident #2. LPN #9 stated she heard someone requesting her assistance down the hall. LPN #9 stated Resident #2 attacked Resident #1 unprovoked. The residents were separated immediately and LPN #9 assessed and observed injuries of bruises only to right arm and left side of face. LPN #9 stated Resident #2 did have a history of childhood trauma. Staff were unaware of what set Resident #2 off. Resident #2 could not stand Resident #1 for some reason. Resident #2 was redirected due to aggressive behavior. e. On 03/06/25 at 2:00 pm, this surveyor interviewed the Director of Nursing (DON) regarding the incident on 11/05/24 between Resident #1 and Resident #2. The DON was not at the facility at the time of this incident. This surveyor asked the DON what the procedure was following a resident-to-resident altercation. The DON said to ensure safety of residents, body audits on all residents and do what you have to keep the residents safe. The DON was not aware of anyone Resident #1 was afraid of, or current issues with other residents. This surveyor asked what steps would be taken if resident to resident altercations occur. The DON said she would ensure the residents were not around each other. This surveyor asked what the DON would do if she did not know who a resident is afraid of. The DON responded, I would investigate, figure out triggers, get labs and mental health evaluation and behavior health referral. This surveyor asked what staff members were involved in the stand-up meetings in the mornings. The DON stated, Department heads and therapy. f. On 03/06/25 at 3:30 pm, this surveyor interviewed the Administrator regarding what was done to protect Resident #1 from Resident #2 ' s verbal abuse. The Administrator said Resident #1 was redirected by CNA #4. Residents #1 and #2 were still roommates on 10/30/24. Resident #2 changed rooms on 11/01/24 after the second verbal abuse altercation. The Administrator stated, Just separated them and gave Resident #2 some time to cool down. g. On 03/07/25 at 8:45 am, this surveyor interviewed Treatment Nurse #3 regarding the physical and verbal abuse from Resident #2 to Resident #1 on 11/05/24. Treatment Nurse #3 said there was no other verbal abuse she could recall. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore Healthcare and Rehabi of Malvern	1820 West Moline Street Malvern, AR 72104

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. On 03/07/25 at 9:09 am, this surveyor interviewed the Assistant Director of Nursing (ADON) regarding the incident on 10/30/24 between Resident #1 and Resident #2 in which the ADON observed Resident #1 sitting in the common area when Resident #2 came out of Resident #2's room yelling and cussing at Resident #1. The ADON stated CNA #4 immediately removed Resident #2 from the area. Resident #2 was combative with CNA #4 at that time and told her Resident #2 would kill her. This surveyor asked why Resident #1 was not removed from the room at that time. The ADON stated it was not fully clear who the anger was directed at. i. On 3/7/25 at 10:30 am, this surveyor interviewed CNA #4 regarding the incident on 10/30/24 between Resident #1 and Resident #2. CNA #4 stated she could not remember the exact date; however, she observed Resident #1 sitting in the common area when Resident #2 came out of the resident's room yelling and cussing at Resident #1 with Resident #2's finger pointed in Resident #1's face. CNA #4 immediately removed Resident #2 from the area and placed the resident on one-on-one supervision. Resident #2 was combative with CNA #4 at that time and told her Resident #2 would kill her. Per CNA #4, Resident #2 was referring to Resident #1. Resident #1 was not removed from the room at that time. j. On 3/7/25 at 11:00 am this surveyor received a policy from the Administrator titled, Abuse, Neglect and Maltreatment Investigation & Reporting. The policy documented in section III .The facility shall take all necessary steps to prevent further potential abuse .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925 Based on record review and interview, the facility failed to ensure a care plan was revised to include an intervention for a fall mat for a resident who had a fall which resulted in the resident sustaining injuries of small collections of blood between the brain and outer covering in the front areas of the brain (bifrontal subdural hematomas) for 1 (Resident #5) of 3 (Residents #5, #6 and #7) sampled residents whose care plans were reviewed for falls. The findings are: Review of Resident #5's medical diagnosis screen revealed diagnoses of hemiparesis (partial muscle weakness on one side of the body) and hemiplegia (total paralysis on one side of the body), dementia (a decline in a person's mental thinking affecting daily life), fracture (break) of unspecified (not clear) part of neck or right femur (part of the thigh bone), and unspecified fracture of sacrum (break in the bone between the two hip bones). Review of the Order Summary Report revealed an order dated 12/14/2024 for a fall mat to the right (R) side of the bed every shift related to issues with thinking and communicating (cognitive communication deficit) and a history of falling. Review of a significant change Minimum Data Set (MDS) with an Assessment Reference Date of 01/08/2025 revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident was severely cognitively impaired, used a wheelchair for mobility, required substantial/maximal assistance for toilet and personal hygiene, dependent for chair/bed-to-chair and tub/shower transfer and had two falls with no injury, no falls with injury and no falls with a major injury since admission/entry or reentry or the prior assessment. Review of the care plan revised 01/07/2025 revealed, Resident #5 was at risk for falls. Interventions included the following: every one hour toileting, initiated 01/09/2025; educated staff to keep bed in lowest position, initiated 01/17/2025; mattress placed at bedside, initiated 01/21/2025; one to one (1:1) with nonclinical staff to call for assistance when the resident is trying to get out of bed and staff education to place mattress to bedside, initiated 2/5/2025 and more frequent checks, initiated 02/13/2025. Review of an incident and accident (I and A) report dated 01/15/2025 at 15:59 (3:59 PM), revealed aide [Certified Nursing Assistant (CNA)] alerted nurse resident had fallen. Upon the nurse entering room, the resident was lying on the left side, head at the foot of bed, bed was raised high, left side of face was on the floor and the wheelchair was on the other side of nightstand. The resident stated resident was trying to get from the bed to the chair. The resident had knots on the left side of the head. Immediate action: The resident was transferred to a local hospital and the staff were educated to lower the bed to the lowest position. Injury type: hematoma to back of head. (continued on next page)

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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	On 03/06/2025 at 10:59 AM, CNA #1 was interviewed and stated she walked into the resident's room on 01/15/2025 and the resident was lying on the left side, on the floor, with the resident's head at the foot of the bed and the legs at the head of the bed. She stated the resident was asking for help and she left the room to get the nurse. She stated the resident had knots on the upper left side of the head. On 03/06/2025 at 11:48 AM, CNA #11 was interviewed and stated Resident #5 was not able to get out of bed without assistance and fell the last time the resident tried. She stated there was a fall mat by the resident's bed. On 03/07/2025, CNA #11 was interviewed and stated Resident #5 was not able to work the bed controls, she had observed the resident's bed not in the lowest position on rounds a few times and thought she noticed the fall mattress on the resident's floor in February 2025 but was not able to give an exact date. On 03/06/2025, CNA #15 was interviewed and stated Resident #5 was not able to get out of bed without assistance but did try hard and was at risk for falls. She stated the resident did fall some time ago and had a bump on the back of the head. On 03/07/2025 at 10:28 AM, CNA #15 was interviewed and stated Resident #5 was able to use the bed controls when not confused. CNA #15 had noticed the bed not in the lowest position and did not know when the fall mattress was placed on the resident's floor. On 03/07/2025 at 11:02 AM, Licensed Practical Nurse (LPN) #12 was interviewed and stated Resident #5 was not able to use the bed controls and could not recall the exact date the fall mattress was placed on the resident's floor. She confirmed she did receive the order on 12/14/2024 to place a fall mat on the resident's floor. She stated the fall mat was down and that the fall mattress was placed on the resident's floor, but she could not recall when the fall mat was placed. She stated she thought the fall mat was placed on the resident's floor the day the wound nurse alerted her the resident was on the floor. She stated she informed the CNAs of the order for the fall mat, but did not inform the other nurses or the MDS Coordinator. On 03/07/2025 at 11:19 AM, MDS Coordinators #13 and #14 were interviewed. MDS Coordinator #14 stated the MDS Coordinators revised most of the residents' care plans and other staff contributed. MDS Coordinator #13 stated residents' care plans are updated as needed and every quarter. She stated everything they need from the electronic health records (EHR), including [physician] orders, were gathered for information to be included in the care plan. The MDS Coordinators were asked to review Resident #5's care plan and let this surveyor know when the intervention for a fall mat was placed on the care plan. MDS Coordinator #14 stated the mattress was more recent but did not see where the fall mat was included on the care plan. MDS Coordinator #14 reviewed Resident #5's EHR and stated LPN #12 entered the order for the fall mat, but she did not see the intervention placed on the I and A report. She stated the I and A reports were discussed in morning meeting each day. On 03/07/2025 at 12:24 PM, the prior Director of Nursing (DON) was interviewed by telephone and she stated February 14, 2024, was her last day at the facility. She stated she was not at the facility the day Resident #5 had the fall and returned to the facility on [DATE]. She stated if a nurse enters an order for a fall mat, an in-service would be done to make other staff aware by her. She stated the MDS Coordinator updated the resident's care plan, but other nursing staff made revisions at times. She verified during her time at the facility as DON, the I and A reports were reviewed each morning with upper management. She stated the nurses initiate the I and A report and she would complete the I and A report and do a follow-up on the I and A. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/07/2025 at 1:39 PM, the DON was interviewed and stated she started in her role two weeks ago. She stated the MDS Coordinator updates the care plan quarterly and as needed. She stated she completes an in-service to ensure the staff were aware of any new interventions for resident care. The DON was asked who was responsible for ensuring the interventions were implemented and stated she will put the intervention in place and staff rounds daily. On 03/07/2025, the Administrator was asked to provide a policy for revising care plans. On 03/07/2025 at 2:01 PM, the DON stated the facility uses the Resident Assessment Instrument (RAI) manual and the Centers for Medicare and Medicaid Services (CMS) guidelines regarding revising the care plans. She stated the version of the RAI manual the facility has is v (version)1.19.1, effective October 2024.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37925

Based on record review and interview, the facility failed to ensure a physician's order for a fall mat was implemented as evidenced by a resident sustaining small collections of blood between the brain and outer covering in the front areas of the brain (bifrontal subdural hematomas) after a fall for 1 (Resident #5) of 3 (Residents #5, #6 and #7) sampled residents reviewed for falls.

The findings are:

Review of a 7734 Incident and Accident Information form with a status date of 01/24/2025, revealed the prior Director of Nursing was reviewing Resident #5's medical records from a fall with a hospital encounter on 01/15/2025. A computer tomography (CT) scan showed small collections of blood between the brain and its outer covering in the front areas of the brain (bifrontal subdural hematomas). The left hematoma was 5.5 millimeters (mm) in maximum diameter (measurement from one side to the next) and the right hematoma was 2.5 mm in maximum diameter.

Review of Resident #5's medical diagnosis screen revealed diagnoses of hemiparesis (partial muscle weakness on one side of the body) and hemiplegia (total paralysis on one side of the body), dementia (a decline in a person's mental thinking affecting daily life), (fracture (break) of unspecified (not clear) part of neck or right femur (part of the thigh bone), and unspecified fracture of sacrum (break in the bone between the two hip bones).

Review of the Order Summary Report revealed an order dated 12/14/2024 for a fall mat to right (R) side of bed every shift related to issues thinking and communicating (cognitive communication deficit) and a history of falling.

Review of a significant change Minimum Data Set with an Assessment Reference Date of 01/08/2025 revealed Resident #5 has a brief interview for mental status (BIMS) score of 1, which indicates severely cognitively impaired, uses a wheelchair for mobility, requires substantial/maximal assistance for toilet and personal hygiene, dependent for chair/bed-to-chair and tub/shower transfer and had two falls with no injury, no falls with injury and no falls with a major injury since admission/entry or reentry or the prior assessment.

Review of Incident and Accident (I and A) reports revealed the following:

12/14/2024 at 10:00 (AM), Certified Nursing Assistant (CNA) [un-named] was walking by resident room and found resident lying on floor on right side of bed after attempting to get out of bed to toilet. The residents' assist rails were up, and the call light was in reach. The fall was unwitnessed, and the resident sustained no injuries. Immediate action: resident was assisted back to bed following peri-care and vital signs/ neuro checks were started.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	01/15/2025 at 15:59 (3:59 PM), alerted nurse resident had fallen. Upon the nurse entering room, the resident was lying on the left side, head at the foot of bed, bed was raised high, left side of face was on the floor and the wheelchair was on the other side of nightstand. The resident stated resident was trying to get from the bed to the chair. The resident had knots on the left side of the head. Immediate action: The resident was transferred to a local hospital and the staff were educated to lower the bed to the lowest position. Injury type: hematoma to back of head. 01/17/2025 at 14:02 (2:02 PM), nurse was called to the resident's room by the wound care nurse stating the resident was on the floor again. The resident was on the floor beside the wheelchair (w/c). The CNA stated the resident was assisted to bed approximately 15 minutes prior to the fall and she had provided peri-care for the resident. The fall was unwitnessed, and the resident sustained no injuries. Immediate Action: The resident was checked for injuries, assisted to the w/c per 2 [staff members] and the resident was sitting at the nurses' desk and neuro checks were started. Review of a Computerized Tomography (CT) scan of Resident #5's head without contrast, dated as performed 01/15/2025 at 16:33 (4:33 PM), revealed an impression of small bifrontal subdural hematomas. Review of the care plan dated as revised 01/07/2025 revealed Resident #5 was at risk for falls. Interventions included the following: every 1 hour toileting, initiated 01/09/2025; educated staff to keep bed in lowest position, initiated 01/17/2025; mattress placed at bedside, initiated 01/21/2025; one to one (1:1) with nonclinical staff to call for assistance when the resident is trying to get out of bed and staff education to place mattress to bedside, initiated 02/05/2025 and more frequent checks, initiated 02/13/2025. On 03/06/2025 at 10:59 AM, CNA #1 was interviewed and stated she walked into the resident's room on 01/15/2025, and the resident was lying on the left side, on the floor, with the resident's head at the foot of the bed and the legs at the head of the bed. She stated the resident was saying help and she left the room to get the nurse. She stated the resident had knots on the upper left side of the head. On 03/06/2025 at 11:48 AM, CNA #11 was interviewed and stated Resident #5 was not able to get out of bed without assistance and fell the last time the resident tried. She stated there is a fall mat by the resident's bed. On 03/07/2025, CNA #11 was interviewed and stated Resident #5 was not able to work the bed controls, she had observed the resident's bed not in the lowest position on rounds a few times and thinks she noticed the fall mattress on the resident's floor in February 2025 but was not able to give an exact date. On 03/06/2025, CNA #15 was interviewed and stated Resident #5 was not able to get out of bed without assistance but does try hard and is at risk for falls. She stated the resident did fall some time ago and had a bump on the back of the head. On 03/07/2025 at 10:28 AM, CNA #15 was interviewed and stated Resident #5 was able to use the bed controls when not confused, CNA #15 has noticed the bed not in the lowest position and did not know when the fall mattress was placed on the resident's floor. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/07/2025 at 11:02 AM, Licensed Practical Nurse (LPN) #12 was interviewed and stated Resident #5 was not able to use the bed controls and could not recall the exact date the fall mattress was placed on the resident's floor. She confirmed she did receive the order on 12/14/2024 to place a fall mat on the resident's floor. She stated the fall mat was down and then the fall mattress was placed on the resident's floor, but she could not recall when the fall mat was placed. She stated she thinks the fall mat was placed on the resident's floor the day the wound nurse alerted her the resident was on the floor. She stated she informed the CNAs of the order for the fall mat, but did not inform the other nurses or the MDS Coordinator. On 03/07/2025 at 11:19 AM, MDS Coordinators #13 and #14 were interviewed. MDS Coordinator #14 stated the MDS Coordinators revised most of the residents' care plans and other staff contributed. MDS Coordinator #13 stated residents' care plans are updated as needed and every quarter. She stated everything they need from the electronic health records (EHR), including [physician] orders, were gathered for information to be included in the care plan. The MDS Coordinators were asked to review Resident #5's care plan and let this surveyor know when the intervention for a fall mat was placed on the care plan. MDS Coordinator #14 stated the mattress was more recent but did not see where the fall mat was included on the care plan. MDS Coordinator #14 reviewed Resident #5's EHR and stated LPN #12 entered the order for the fall mat, but she did not see the intervention placed on the I and A report. She stated the I and A reports were discussed in morning meeting each day. On 03/07/2025 at 12:24 PM, the prior Director of Nursing (DON) was interviewed by telephone and she stated February 14, 2024, was her last day at the facility. She stated she was not at the facility the day Resident #5 had the fall on 01/15/2025 and returned to the facility on [DATE]. She stated if a nurse enters an order for a fall mat, an in-service would be done to make other staff aware by her. She stated the MDS Coordinator updated the resident's care plan, but other nursing staff made revisions at times. She verified during her time at the facility as DON, the I and A reports were reviewed each morning with upper management. She stated the nurses initiate the I and A report and she would complete the I and A report and do a follow-up on the I and A. On 03/07/2025 at 1:39 PM, the DON was interviewed and stated she started in her role two weeks ago. She stated the MDS Coordinator updates the care plan quarterly and as needed. She stated she completes an in-service to ensure the staff were aware of any new interventions for resident care. The DON was asked who was responsible for ensuring the interventions were implemented and stated she will put the intervention in place and staff rounds daily. She stated she or the Assistant Director of Nursing (ADON) reviews the residents' charts for new orders. The DON stated she or the ADON reviewed the residents progress notes for any new changes but did not indicate physician's orders were reviewed.