

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/18/2025
NAME OF PROVIDER OR SUPPLIER Encore Healthcare and Rehabi of Malvern		STREET ADDRESS, CITY, STATE, ZIP CODE 1820 West Moline Street Malvern, AR 72104	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report allegations of abuse within the required 2-hour time frame for three (Resident #1, #3, and #4) of four residents involved in incidents reported to the state agency. The findings include: Incident #1 Review of an Incident and Accident (I&A) Report of alleged abuse that was discovered by the facility on March 10th, 2025, at 11:30 AM, was not submitted to the state agency until March 10th, 2025, at 3:56 PM. The incident involved Resident #1 and Resident #7. The alleged incident included Resident #7 threatening Resident #1 due to Resident #1 playing their television too loud and keeping their light on, which agitated Resident #7. The report indicated, [Resident #1] told [an LPN] that [Resident #1's] roommate had threatened [Resident #1]. Review of Resident #1's admission Record indicated the facility admitted Resident #1 with diagnoses which included cognitive communication deficit and recurrent depressive disorder. Review of Resident #1's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/2025, revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS also indicated Resident #1 had no identified behaviors, had not exhibited rejection of care, and used a wheelchair to ambulate. Review of Resident #7's admission Record indicated the facility admitted Resident #7 with diagnoses which included disorder affecting memory, thinking and behavior; cognitive communication deficit; anxiety disorder and depression. Review of Resident #7's quarterly MDS with an ARD of 07/07/2025 revealed a BIMS score of five (indicating severe cognitive impairment), a depression score of six (indicating depression was identified), and that Resident #7 exhibited no behaviors or rejection of care. Incident #2 Review of an I&A Report of resident-to-resident alleged abuse, indicated the incident was discovered by the facility on 05/05/2025 at 7:30 AM and was not submitted to the state agency until 05/05/2025 at 12:54 PM. The I&A report alleged physical abuse by Resident #6 to Resident #3. The report indicated, [CNA] was making rounds and changing out urinals when she went into [Resident #3's] room and found resident [Resident #6] in bed with [Resident #3] with [Resident #6's] hand over (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[Resident #3's] mouth. Review of Resident #3's admission Record indicated the facility admitted Resident #3 with diagnoses which included disorder affecting memory, thinking and behavior with anxiety, hemiplegia and hemiparesis (Hemiplegia is the complete paralysis of one side of the body, while hemiparesis is the partial weakness on one side of the body), and cognitive communication deficit. Review of Resident #3's admission MDS with ARD of 04/04/2025, revealed a BIMS score of three (indicating a severe cognitive deficit), and that Resident #3 exhibited no behaviors. Review of Resident #6's admission Record indicated the facility admitted Resident #6 with diagnoses which included a disorder affecting memory, thinking, and behavior with mood disturbance, cognitive communication deficit, major depressive disorder, and generalized anxiety disorder. Review of Resident #6's quarterly MDS with an ARD of 09/04/2025 revealed a BIMS score of three (indicating severe cognitive impairment), and that Resident #6 exhibited no behaviors. Incident #3 Review of an I&A Report of staff to resident abuse indicated that the incident was discovered on 04/29/2025 at 4:00 PM and was not submitted to the state agency until 04/30/2025 at 11:17 AM. This incident involved Resident #4 and CNA #2. The report indicated, Resident #4 stated that [Resident #4] was going to the bathroom and pushed [Resident #4's] call light and [CNA #2] wasn't able to assist [Resident #4] at the time but told [Resident #4] that if you get up, I'll give you a shot. Review of Resident #4's admission Record indicated the facility admitted Resident #4 with diagnoses which included sensorineural hearing loss (a type of hearing loss caused by damage to the inner ear, the cochlear hair cells, or the auditory nerve,) and cognitive communication deficit. Review of Resident #4's admission MDS revealed a BIMS score of 14(indicating the resident was cognitively intact), and that Resident #4 exhibited no behaviors. During an interview on 11/17/2025 12:02 PM, the Administrator stated she did not follow the regulation mandating a two-hour time frame to report allegations of abuse, stating she, needed to investigate the allegations first. Review of a facility policy titled, Abuse, Neglect and Maltreatment Investigation and Reporting read in part .all allegations of abuse or neglect must be reported according to state and federal law.2 hour limit: if the events that cause the reasonable suspicion include allegations of abuse or serious bodily injury to a resident, the staff must report the suspicion immediately, but no later than 2 hours after forming the suspicion.		

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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. Based on interview and facility document review, the facility failed to ensure staff initiated and completed provider orders for one (Resident #6) of two residents reviewed for implementation of psychiatric consult orders. The findings include: Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The MDS also indicated Resident #6 had diagnoses that included a disorder affecting memory and thinking, anxiety disorder, and depression. A review of Resident #6's Progress Notes indicated the following: On 05/05/2025 at 11:13 AM, an Advanced Practice Registered Nurse's (APRN) note indicated the APRN referred Resident #6 to the Psych team after an incident where Resident #6 initiated physical aggression toward another resident, and Resident #6 had increased confusion and hallucinations. On 05/09/2025 at 2:26 PM, a Nurses Note indicated the resident was referred to Mental health. On 05/09/2025, a Nurses Note titled Dementia/Mental/Supportive Care Referral indicated Resident #6 had increased paranoia and confusion at night and on weekends. In addition, it was indicated the resident was to have a Dementia Care and Mental Health consult as a new patient. There was no evidence of the Mental health (Behavioral health) or Psych team consult being completed. During an interview on 11/18/2025 at 12:00 PM, the APRN indicated the process for new orders included making rounds, entering orders electronically, and then providing a handwritten list to the Licensed Practical Nurse regarding any new orders. The APRN indicated the need to rule out a physical indication for the change in behavior in Resident #6 by completing a urinalysis (UA) prior to the order being placed for a referral to behavioral health. When the UA resulted negative, a new order was entered for a behavioral health consultation on 05/12/2025. On 11/18/2025 at 12:43 PM, the APRN provided a scanned copy of the handwritten note dated 05/12/2025, listing any changes or orders which had been given to facility staff after completing rounds. The note indicated a new order for Resident #6 to be referred to Behavioral Health consultants for dementia and hallucinations. During an interview on 11/18/2025 at 2:45 PM, the Director of Nursing indicated the facility was unable to provide the order for the Behavioral Health consult intended for Resident #6 and the order for the behavioral health consultation was not followed. A review of the Licensed Practical Nurse (LPN) Supervisor Job Description indicated requisitions and arrangements for therapeutic services are to be made per physician orders.		