STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045402	A. Building B. Wing	11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highlands of Bella Vista Health & Rehab, LLC	670 Rogers Road Bella Vista, AR 72715

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 facility policy, record reviews, interviews, and facility document review, it was determined that the facility failed to ensure an allegation of abuse was immediately reported to the administrator for two (Resident #3 and Resident #7) of three residents reviewed for an allegation of abuse. The findings include: Resident #3 Review of Resident #3's admission Record revealed the facility admitted Resident #3 with diagnoses which included major depressive disorder, generalized anxiety disorder, chronic pain syndrome, blindness in one eye, difficulty swallowing and difficulties in communication stemming from cognitive impairments. Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/06/2025 indicated Resident #3 had a Staff Assessment for Mental Status (SAMS) score of 3 which indicated a short- and long-term memory problem with decision making skills that were severely impaired. The MDS also indicated Resident #3 did not usually exhibit behavior problems and could roll side to side independently but was dependent on staff for hygiene. Review of Resident #3's Order Summary Report revealed Resident #3 was comfort care only, was transferred via mechanical lift, and had orders for scheduled and as needed pain medication. Review of a Care Plan Report revealed Resident #3 lacked the capacity to understand and make decisions related to progressive dementia. Resident #3 had a self-care deficit related to progressive functional decline associated to a diagnosis of amyotrophic lateral sclerosis [ALS] which was a progressive disease that caused degeneration of the nerves. The Care Plan Report also revealed Resident #3 was dependent on staff for daily care and had combative behavior during care at times, such as grabbing, slapping and attempting to scratch or pinch staff. Review of an OLTC Incident and Accident Report (I&A)form dated 02/06/2025 revealed, CNA reported that on 02/02/2025 she was helping [CNA #2] lay [Resident #3] down in bed and [CNA #2] was rough with [Resident #3] when she rolled [Resident #3] and when tucking under the [name brand](lift) pad. [Resident #3] was being aggressive, and [CNA #2] took [Resident #3's] hand and pushed it back [at the resident] and told [Resident #3 that the resident] could not hit [CNA #2] because hitting a healthcare worker is a felony. Under Findings and Actions Taken, the I &A revealed, Body audit completed on [Resident #3], a small red area found on [the resident's] hand.It is undetermined if the red mark is from abuse or is self-inflicted from gripping [the resident's] own hands together. (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 #7 Review of Resident #7's admission Record revealed Resident #7 had diagnoses which included Alzheimer's disease, dementia, fatigue, abnormal side-to-side curvature of the spine, and back pain. Review of a quarterly MDS with an ARD of 09/18/2025 revealed Resident #7 had a SAMS score of 3 and their cognitive skill for decision making was severely impaired. The MDS also indicated Resident #7 was dependent on staff for all aspects of care. Review of a Care Plan Report revealed Resident #7 lacked the capacity to understand and make decisions regarding their care due to Alzheimer's disease. The Care Plan Report also indicated Resident #7 had a self-care deficit related to Alzheimer's disease, dementia and chronic pain; was totally dependent on one to two staff to turn and reposition while in bed and for daily hygiene needs. Additionally, the Care Plan Report revealed Resident #7 had limited physical mobility related to weakness, impaired cognition and communication deficits secondary to dementia and that Resident #7 exhibited resistive and physically aggressive behaviors during personal care. Review of an OLTC Incident and Accident Report (I&A) form dated 02/06/2025 revealed, CNA today 02/03/25 reported working with [CNA #2] yesterday and when they took care of [Resident #7], CNA reports [CNA #2] was rough with [Resident #7]. CNA reports [CNA #2] hit [Resident #7] on the arm and then held [Resident #7's] arm down to finish care. CNA also reported [CNA #2] told [Resident #7] that he was a piece of [expletive] and smelled like [expletive]. Review of an Office of Long-Term Care Witness Statement Form revealed that on 02/03/2025 at 1:30 PM, Certified Nursing Assistant (CNA) #1 reported that while working on 02/02/2025 with CNA #2, CNA #2 was aggressive with Resident #3. Resident #3 was showing signs of frustration, attempting to hit CNA #2. CNA #1 reported that CNA #2 took [the resident's] hand and pushed it back toward Resident #3. Later in the shift, around 4:00 PM, CNA #1 and CNA #2 provided care for Resident #7 who became combative, tried to hit when CNA #2 hit Resident #7 on their arm, and remarked [residents name] you're a piece of [excrement profanity]. CNA #1 reported CNA #2 also remarked toward Resident #7 that the resident smelt like [excrement profanity] because [Resident #7] had peed all over themselves. CNA #1 continued that CNA #2 held [Resident #7's] arm down after [CNA #2] hit them. A document titled Employee Memorandum dated 02/03/25 and signed by the Administrator and CNA #1, indicated CNA #1 was suspended due to failure to report abuse of a resident until the next day of business. CNA #1 reported to the lead CNA on the hall at 1:40 PM, and the alleged incident occurred on 02/02/25. Review of an Acknowledgment Form-Abuse Investigation and Reporting Policy revealed CNA #1's signature with a date of 12/03/2024. The Policy indicated that by their signature, the employee acknowledged their receipt and understanding of the policy, had received training related to the facilities Abuse Investigating and Reporting Policy. This acknowledgement indicated the employee would immediately report any suspected maltreatment. Review of an electronic training program completion report for CNA #1 revealed Neglect, Abuse and Theft training was completed on 12/03/2024. During an interview on 11/25/2025 at 9:38 AM, CNA #1 reported that while providing care for Resident (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#3 and Resident #7 on 02/03/2025, CNA #2 was rough with the residents and made the statement Resident #7 smells like [excrement profanity] while in the residents' room. CNA #1 reported that while providing care in the room with Resident #3, CNA #2 was a little rough with the resident. CNA #2 was not gentle with Resident #3, and the resident tried to hit her, that was when CNA #2 told Resident #3 that it was a felony to hit a health care worker. CNA #1 reported later on the same shift, CNA #2 hit Resident #7. CNA #1 indicated the reason the abuse was not reported immediately to the Administrator, or the supervisor was that she was nervous. CNA #1 reported that it was weighing on her conscious and had to report it the next day. She came in early for her shift to report the incident [the incident was reported at 1:40 PM the next day]. CNA #1 reported their suspension was due to failure to report an allegation of abuse immediately, and that she understood, any allegation should be reported immediately to the supervisor or the Administrator. During an interview on 11/25/2025 at 9:45 AM, the Administrator indicated CNA #1 had been suspended due to failure to report an allegation of abuse immediately. During an interview on 11/26/2025 at 8:45 AM, the Director of Nursing (DON) indicated that abuse training was conducted on hire, during orientation, and throughout the year. The reporting of abuse was expected to occur immediately to the Administrator or the supervisor. The DON reported they would consider rough handling or hitting any resident or calling them a name as abuse that should have been reported immediately to the Administrator. If this incident with Resident #3 had been reported immediately, the incident with Resident #7 would not have occurred. CNA #2 would have already been removed from the facility pending investigation. During an interview on 11/26/2025 at 10:30 AM, the Administrator reported the alleged abuse incident with Resident #3 and Resident #7 was reported at 1:40 PM on 02/03/2025 when the incident allegedly occurred on 02/02/2025. CNA #1 was placed on suspension due to failure to follow facility policy of reporting suspected allegations of abuse immediately. The Administrator reported CNA #1 was retrained prior to being allowed to return to providing care. The Administrator reported abuse training was usually completed on hire, quarterly and with incidents. CNA #2 was suspended pending investigation for Resident #3 and Resident #7. The Administrator reported that during their interview with CNA #2, that CNA #2 remarked she may or may not have said to a co-worker, that Resident #7 smelled like [excrement profanity]. The Administrator indicated CNA #2 was terminated due to this statement, but the physical abuse was not founded. The Administrator reported that if CNA #1 had reported the first allegation of suspected abuse with Resident #3, then the alleged abuse incident with Resident #7 would not have occurred, as CNA #2 would have already been suspended. Review of an Employee Memorandum signed by the Administrator, dated 02/06/2025 revealed CNA #2 was suspended on 02/03/25 for an allegation of abuse and terminated on 02/06/25 for a founded allegation of abuse. Review of a policy, without a review date, titled, Abuse Investigation and Reporting, revealed the facility would endeavor to protect its residents from maltreatment. The facility recognized the residents' rights to be free from physical, verbal and mental abuse. The section titled, Staff Training and Competency indicated that new employees would be given a copy of the facilities abuse policy, at which time the employees were expected to sign acknowledging they had read and understood the information provided. Under the section titled, Immediate reporting the policy revealed all facility staff must immediately report all incidents of alleged, witnessed or suspected resident mistreatment including abuse. The Administrator or their designee will immediately initiate an investigation of all alleged incidents. Any employee who fails to immediately report an allegation of abuse would be (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	subject to disciplinary action. Additionally in the section titled, Protecting Residents the policy revealed to protect the resident(s) involved with the incident, the employee may be reassigned, shadowed or suspended immediately pending the completion and determination of the investigation. The facility terminated CNA #2 on 02/06/2025 per an employee memorandum. The facility suspended pending investigation CNA #1 per an employee memorandum. CNA #1 was retrained before returning to work. These actions were performed before the survey team entered the facility, resulting in this finding being cited at past non-compliance.