STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045434	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katherine's Place at Wedington	4405 West Persimmon Street Fayetteville, AR 72704

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews, record review, document review the facility failed to provide incontinent care during an eight-hour shift for one resident (Resident #30) of four residents reviewed for neglect. The findings include: Review of a quarterly Minimum Data Set (MDS) with assessment reference date of 08/08/2025, revealed that Resident #30 had a Brief Interview of Mental Status score of 14, which indicated that Resident #30 was cognitively intact. The MDS also revealed that Resident #30 required substantial to maximal assistance with toileting hygiene. A review of Care Plan for Resident #30 with initiation date of 02/26/2025 indicated that staff should anticipate and meet the resident's needs. The Care Plan included an intervention with an initiation date of 02/08/2025, for staff to keep Resident #30's skin clean and dry. During an interview with Resident #30 on 09/03/2025 at 2:52 PM, it was revealed that Resident #30's brief was not checked or changed during a night shift back in July. Resident #30 stated that The day shift Certified Nursing Assistants (CNAs) came in and found me in the shape I was in and were upset. Resident #30 revealed that there were dried urine spots on the bed from where urine had dried throughout the night. The resident reported that their brief would hold one incontinent urine episode, but it would leak out with two incontinent episodes. Resident #30 reported that night they did not use the call light and had no mental anguish resulting from incident. During an interview on 09/03/2025 3:28 PM, CNA #6, revealed that on 07/19/2025 she worked the 11-7 shift. CNA #6 revealed that her partner was CNA #16 that night. She revealed that she thought CNA #16 had checked Resident #30, and that she kept having to wake CNA #16 up throughout the shift. CNA #6 reported that she did not check or change Resident #30 that shift and was written up for not making rounds on Resident #30 that night. During an interview on 09/04/2025 at 9:24 AM, the Administrator revealed that CNA #16 was written up for not making rounds on Resident #30 and terminated for sleeping while on the clock. During a telephone interview on 09/04/2025 at 9:27 AM, CNA #17 revealed that Resident #30 was still in bed upon making rounds right after she had gotten to work on dayshift. She went in to check the resident and observed that Resident #30 was soaking wet, had brown rings on both sides of the bed, their brief was falling apart, the urine had soaked through the mattress, and urine was dripping onto the floor. There was so much urine on the floor that she had to call housekeeping to come in and mop the floor. CNA #17 reported that Resident #30 was bleeding on the buttocks from being so wet. She also revealed that the resident had taken off their shirt and put it in between their legs to absorb (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	some of the urine. CNA #17 stated she notified LPN #18, who came to the room. CNA #17 they had also notified the administrator of the incident. During a simultaneous interview with the Administrator in training (AIT) and Director of Nursing (DON) on 09/04/2025 at 10:34 AM, the Director of Nursing (DON) reported that CNA #16 was terminated due to sleeping on the clock on 07/19/2025. She also revealed that unless indicated more often rounds were to be made every two hours, for checking residents who were incontinent and to turn and reposition the residents. The DON continued that incontinent care was provided to prevent skin breakdown, and to promote dignity and independence. The DON stated that the CNAs make rounds every two hours to encourage toileting and for overall care for the residents. The Administrator in training (AIT) reported that CNA #16 was terminated for sleeping on his shift on 07/19/2025. She reported that CNA #16 was responsible for Resident #30 that shift and did not check or change Resident #30 the entire 11-7 shift. During an interview on 09/04/2025 at 10:47 AM, LPN #15, treatment nurse, reported that Resident #30 had a body audit after the incident. LPN #15 did not recall Resident #30 having any skin breakdown, redness, excoriation, or pressure ulcers. LPN #15 reported that Resident #30 had just been treated with a prescription skin cream and the prescription cream was stopped the resident's perineal area because the perineal area did not have any excoriation. During an interview on 09/04/2025 at 12:21 PM, LPN #18 reported that she was notified by the CNA #17 about Resident #30 not being changed. LPN #18 reported that she came in about midway through the resident being changed. She observed the saturated adult brief, brown ringed bed sheets and urine saturated bed linen. She revealed that Resident #30 reported to her that they had not been changed all shift. LPN #18 reported that she applied medicated skin cream to the resident's perineal area and there was some drainage coming from the broken skin. LPN #18 reported that the area had a current treatment that was in place, but she only worked on the weekends, so she was unsure if Resident #30's buttocks or perineal area were any worse or not. She revealed that residents are to be checked, turned and repositioned every two hours to prevent skin breakdown. During an interview on 09/04/2025 at 12:27 PM, CNA #19 reported that CNA #17 and herself observed Resident #30's bed linen was saturated with urine all the way to their neck. She also reported that there was urine on the floor next to bed. CNA #19 revealed that Resident #30 reported they were unsure if the night shift CNAs had changed them or not. If so it had been a while, but Resident #30did not want to get anyone in trouble. CNA #19 reported that LPN #18 came in and doctored Resident #30's perineal area. She reported that she and CNA #17 provided incontinent care and dressed Resident #30, changed the resident's bed linens and then got the resident out of bed. CNA #19 reported that residents were to be rounded on every two hours in order to prevent skin breakdowns. During an interview on 09/04/2025 at 1:07 PM, the Administrator reported that residents were to be checked, changed, turned and repositioned every two hours to prevent skin breakdown and ensure safety. During an interview on 09/05/2025 at 8:21 AM, LPN #20 reported that he was the licensed nurse that was responsible for Resident #30 on 07/19/2025 11-7 PM shift. LPN #20 reported that he had peeked in on Resident #30 during that shift. LPN #20 reported that he was not aware that the CNAs had not made rounds on Resident #30that shift. LPN #20 went on to state that he relied on the CNAs to make rounds on the residents like they were supposed to. LPN #20 reported that the CNAs were to make rounds every two hours and as needed. He reported that Resident #30's perineal area would become (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	excoriated at times from incontinence but was unsure at the time if the resident had any excoriation being treated. During an interview on 09/05/2025 at 1:05 PM, CNA #16 reported that he did not check or change Resident #30 on 07/19/2025 during the 11-7 PM shift. He reported that he and his partner, CNA #6, forgot to round on Resident #30 the last round and that he had thought that his partner, CNA #6, had rounded on Resident #30 during the night. CNA #16 reported that he [CNA #16] slept a lot on that shift and was terminated. A review of Abuse Prevention Program policy revised December 2016, revealed that the residents have the right to be free from neglect. Following the incident, but before the survey team entered the facility, the administration completed the following corrective actions, resulting in this deficiency being cited as past non-compliance: Immediate identification and action. The facility promptly identified the incident of alleged abuse/neglect on 7/22/2025 Staff immediately implemented interventions to protect the resident, including suspending Cna #6 and Cna #16, resident was immediately changed, sheets were changed and LPN #18 applied skin cream to the perinea! area. Social Services interviewed resident #30 and no signs of mental anguish resulted from the incident and no other new allegations were founded. Thorough Investigation A full investigation was initiated from 7/22/2025-7/28/2025 in accordance with facility policy and state/federal regulations. The investigation was completed on 7/28/2025 with findings documented and submitted timely. Cna #16 was found sleeping in car during night shift, employee was terminated for failure to change resident #30 and sleeping during night shift. Cna #6 was written up for failure to change #30 in a timely manner. On 7/23/2025 the Staff Development Coordinator and CNA Preceptor in-serviced staff. The Staff Development Coordinator educated staff on identifying reportable events (abuse, neglect, injuries of unknown source) and quarterly training on abuse and neglect. Body audits were conducted to ensure no further additional concerns for neglect, no negative outcomes were noted. The DON /designee monitored 400 hall peri care, weekly for 4 weeks or until compliance was verified by OLTC to ensure all residents are changed and checked throughout the night. Any new allegations of neglect are to be reported to the Office of Long-term care. Any negative findings will be corrected immediately, and Administrator/Designee notified. During the monitoring, no new allegations were founded. Notification and Reporting The facility promptly notified the resident's representative, the state agency, and law enforcement as (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required. Documentation reflects that all mandated reporting timelines were met. Corrective Actions and Prevention The facility implemented retraining for all staff on abuse/neglect recognition, reporting, and prevention. Additional monitoring and auditing were put into place to ensure compliance. Policy and procedure reviews were completed with revisions as needed. Status at Time of Survey At the time of survey entrance on 9/2/2025, the incident had been fully resolved. On 9/5/2025 during the exit, the Governing Body, DON, ADON, AIT and Resident council President was present. All corrective actions were in place, staff were retrained, and systemic changes have been implemented. There was no ongoing noncompliance, and no residents were at risk during the survey window.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observation, interview and facility policy review the facility failed to ensure good hand hygiene was maintained for 1(Resident #54) of 2 sampled (Resident #54 and Resident #101) residents observed during perineal care and reviewed for bowel and bladder. The findings include: Review of a Medical Diagnosis report revealed Resident #54 had diagnoses which included inflammation and swelling of the kidney, urinary tract infection, and inability to voluntarily move the upper and lower body. Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 08/19/25 revealed a Brief Interview for Mental Status score of 3, which indicated Resident #54 had severe cognitive impairment. The MDS also indicated Resident #54 was always incontinent with bowel and stool. Review of a Care Plan revealed Resident #54 had bowel incontinence related to advanced disease process and decreased mobility with interventions in place to check the resident every two hours and assist with toileting needs. The Care Plan also indicated to provide perineal care after each episode of incontinence. On 09/03/2025 at 10:36 AM, Licensed Practical Nurse (LPN) #12 and LPN #13 were observed transferring Resident #54 from the chair to the bed with a mechanical lift. LPN #12 explained to Resident #54, that Certified Nursing Assistant (CNA) #11 and CNA #14 would be assisting with perineal care. On 09/03/2025 at 10:46 AM, CNA #11 and CNA #14 presented to the bedside, put on gloves and assisted LPN # 12 and LPN #13 in rolling Resident #54 off the lift pad. CNA #11 pulled down the front of a wet brief and CNA #14 handed clean wipes to CNA #11. Resident #54 was wiped one time in one direction on the left and right side of the perineal area, and wipes were disposed of in a plastic trash bag at the foot of the bed. CNA #11 described the brief as wet from the front to the back. On 09/03/2025 at 10:49 AM, LPN #12 presented at the bedside and asked to observe perineal care to assess Resident #54's buttocks. Resident # 54's buttocks appeared very pink, and this surveyor observed a wound where the right buttocks met the right upper thigh. LPN #12 left to find cream to put on Resident #54's buttocks. On 09/03/2025 at 10:55 AM, CNA #11 was observed turning to the bedside table to the right of Resident #54 bed and without removing contaminated gloves CNA #11 opened the top dresser drawer and handled multiple bottles of lotion and pulled out one to use on Resident #54. On 09/03/2025 at 10:58 AM, LPN #12 presented back to the bedside with a moisture barrier cream to place on Resident #54's buttocks. CNA #11 assisted Resident #54 in staying in position while LPN #12 applied the cream. The resident was then rolled onto their back. CNA #11 was observed putting Resident #54's clothing in position and pulling up linens without performing hand hygiene or removing soiled gloves. CNA #11 removed soiled gloves and dropping them into a plastic garbage sack, CNA #14 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gathered two bags of garbage and was followed out by CNA #11. During an interview on 09/03/2025 at 11:03 AM, CNA #11 stated she had not changed gloves when touching linens and opening Resident #54's drawer looking for cream to put on the resident's skin because CNA #11 was nervous. CNA #11 revealed not changing gloves or performing hand hygiene during perineal care and going from dirty to clean tasks can cause cross contamination. During an interview on 09/03/2025 at 1:35 PM, CNA #14 revealed staff rounds every two hours to check and see if residents need to be changed to protect residents' skin and prevent infection. CNA #13 confirmed changing gloves and performing hand hygiene when going from dirty to clean tasks helps prevent cross contamination. During an interview on 09/04/2025 at 3:00 PM, the Administrator revealed to maintain good hand hygiene during perineal care two CNAs would assist with perineal care, and hand hygiene would include washing hands and wearing gloves. The Administrator stated staff round every two hours to keep residents clean and dry to prevent skin conditions. The Administrator revealed staff were trained on perineal care when hired, as needed and during yearly competency. During an interview on 09/04/25 at 3:22 PM, the Director of Nursing (DON) stated staff are expected to round on residents every two hours to prevent skin breakdown. The DON revealed CNA staff came to her yesterday informed her there was a concern during perineal care yesterday, and it appears we need additional peri care training. Review of an in-service titled Handwashing, dated 04/10/25, revealed hands should be washed after encountering body fluids. CNA #11, CNA #14, LPN #13 and LPN #12 signed the Handwashing in-service in acknowledgment to follow procedure. Review of a policy titled Handwashing/Hand Hygiene, 2001, revealed hand hygiene is the primary means to prevent the spread of healthcare infections, and all personnel are regularly in-serviced. Hand hygiene is indicated after contact with blood, contaminated surfaces and bodily fluids. Review of a policy titled Perineal Care, date 2001, revealed the purpose is to provide cleanliness to the residents to prevent skin irritation and infections. To prepare, review resident's care plan and identify special needs and arrange supplies so they are in reach.