STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045458	A. Building B. Wing	01/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cottage Lane Health and Rehab of Little Rock	800 Brookside Drive Little Rock, AR 72205

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48390 51477 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure residents were free from abuse for 2 (Residents #3 and #5) of 3 sampled residents reviewed for abuse. Specifically, the facility failed to ensure Resident #3 and #5 were free from emotional and physical abuse. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to the residents. The Immediate Jeopardy (IJ) was related to the State Operations Manual, Appendix PP, S483.12 (Freedom from Abuse, Neglect, and Exploitation) at a scope and severity of J. The IJ began on 12/30/2024 at 10:40 PM, when Licensed Practical Nurse (LPN) #3 made loud and aggressive statements while standing over Resident #5. At 10:45 PM, LPN # 3 was seen going into Resident #5's room and then coming out, wheeling Resident #5 out of the room in a wheelchair with a blood-soaked towel held to the resident ' s face. LPN #3 took Resident #5 up to the nurses cart on 400 Hall and was heard telling Resident #5 to Hold your [explicit language] head back, while the towel was held up to Resident #5's face. On 12/31/2024 at 12:35 AM, LPN #2 was sent by the Director of Nursing (DON) to check on Resident #5, and Resident #5 was found to be unresponsive to stimuli. The Administrator was informed of the alleged abuse on 12/30/2024 at 11:22 PM by the DON. The Administrator completed an OLTC Incident and Accident (I&A) Report on 12/31/2024 at 12:23 AM. The report indicated that the alleged abuse occurred on 12/30/2024 and indicated that LPN #3 was heard speaking loud and aggressively while standing over Resident #5. The Administrator, Chief Nursing Officer, and LPN Nursing Consultant were notified of the IJ on 01/02/2025 at 5:44 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 01/08/2025 at 4:05 PM. These are the findings: A review of the undated facility policy titled Prevention and Prohibition of Abuse, indicted (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: 045458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER: Cottage Lane Health and Rehab of Little Rock		STREET ADDRESS, CITY, STATE, ZIP CODE: 800 Brookside Drive Little Rock, AR 72205	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff or other agencies serving the resident, family members or legal guardians, friends, or other individuals. The significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/04/2024, revealed Resident #5 had a Brief Interview for Mental Status [BIMS] score of 1, which indicated Resident #5 had significant cognitive impairment. A review of Resident #5's care plan, initiated on 02/13/2023, revealed the resident had an Activity of Daily Living (ADL) self-care performance deficit with poor safety awareness. Interventions included that the resident could perform most ADL function with 1 person assist; had the potential to be physically aggressive related to dementia and schizoaffective disorder, was aggressive and hit at other residents on 12/20/2024. Interventions included When the resident becomes agitated: intervene before agitation escalates; If response is aggressive, staff to walk calmly away and approach later. Resident #5 had a diagnosis of post-traumatic stress disorder, and a review of the resident ' s care plan revealed it did not address this diagnosis. A review of a Progress Note, dated 12/30/2024 at 10:44 PM, indicated Resident #5 was sitting on the side of the bed with nose bleeding, area was cleaned, pressure was applied, and blood pressure was 148/82, bleeding stopped with head tilted and pressure applied. A review of an incident and accident (I&A) Progress Note, dated 12/30/2024 at 11:50 PM indicated Resident #5 was found unresponsive to commands with dried blood to nose and inside mouth, was not rousable with sternum rub (painful stimulus applied with closed fist used to firmly rub the bone in the center of the chest) and blood pressure of 68/40. A review of a Progress Note, dated 12/31/2024 at 12:38 AM, indicated LPN #2 entered Resident #5's room, Resident #5 was in a sitting position, unresponsive to commands, dried blood to nose and inside of mouth. At this time this LPN #2 continued to try and awaken the resident via sternum rub and calling out with no success. An ambulance was called due to Resident #5 ' s reduced level of consciousness. A review of hospital records, dated 12/31/2024, indicated Resident #5 was unresponsive and had a scalp hematoma. Principal problem was identified as physical assault. A review of [hospital name] conversations, dated 12/31/2024 at 10:19 AM, indicated dried blood was observed in mouth, on tongue, and left nostril, and a hematoma was discovered on the left side of Resident #5 ' s scalp, remained unresponsive to all stimuli until 10:00 . A review of [hospital name] history and physical (H&P) dated 12/31/2024 at 08:21 AM, indicated dried blood was observed on tongue and back of oropharynx (middle of the throat above the voice box); pupils were pinpoint and non-reactive. A review of the ED to Hosp-Admission hospital records indicated the chief complaint was listed as altered mental status and the Final Diagnoses, included physical assault and confusion. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of intensive care unit (ICU) records dated 01/01/2025 indicated assessment for Resident #5 revealed indications of verbal and physical abuse, and scalp hematoma. A review of a computed tomography (CT) scan, dated 12/31/2024 at 02:03 AM, revealed Resident #5 had a scalp hematoma. A review of page 32 of Licensed Practical Nurse (LPN) #3's personnel file revealed LPN #3 signed a document titled Working Together to Prevent Abuse Brochure Acknowledgement on 03/04/2024. Also noted in the file on page 38, LPN #3 signed a document titled Resident Rights, it indicates that every resident has the right to Be free of verbal, psychological, physical, and sexual abuse. During an interview on 01/01/2025 at 3:45 PM, Certified Nursing Assistant (CNA) #6 indicated on 12/30/24 at 10:40 PM he was passing Resident #5's room and saw LPN #3 standing over Resident #5 speaking loudly and aggressively. CNA #6 indicated that on 12/30/2024 at 10:45 PM he saw LPN #3 get up from the nurses station and go to Resident #5's room, then he observed LPN #3 wheeling Resident #5 up to the nurses cart out by the nurses station on 400 Hall. CNA #6 indicated that he heard LPN #3 yelling at Resident #5 saying Hold your [explicit language] head back and observed Resident #5 with a towel up to his face with blood on the towel. CNA #6 indicated that Resident #5 looked at him in the eyes and he knew something was wrong. CNA #6 indicated that Resident #5 had the look of fear in his eyes. CNA #6 was asked if Resident #5 had fallen out of the bed. CNA #6 indicated that he had not. CNA #6 was asked if Resident #5 had a history of nose bleeds. CNA #6 indicted Resident #5 had never had a nosebleed while he was working. During an interview with the DON on 01/02/2025 at 10:13 AM, the DON was asked if Resident #5 had fallen out of bed and indicated that she had asked all the staff working that night and they all indicated that Resident #5 had not fallen out of bed. The DON verified Resident #5 did not have a history of nose bleeds. On 01/02/2025 at 11:13 AM, the DON indicated that she was notified by phone on 12/30/2024 at 11:00 PM, of the alleged abuse. The DON indicated that she tried to call LPN #3, but he didn't answer so she called the Administrator. The DON indicated that she and the Administrator spoke to LPN #3 by phone. The DON indicated that she asked him what happened to Resident #5. LPN #3 indicated that Resident #5 attempted to get out of bed three different times and LPN #3 went to put him back in bed and Resident #5 was sitting on the edge of the bed and LPN #3 noticed his nose was bleeding, so LPN #3 put Resident #5 in a wheelchair and took Resident #5 up to the nurses station on 400 Hall. LPN #3 indicated that he [LPN #3] had a towel up to Resident #5's nose due to the blood and told Resident #5 to keep his head back to stop the bleeding. The DON indicated that she asked LPN #3 why Resident #5's nose was bleeding. LPN #3 indicated that Resident #5's blood pressure was up. LPN #3 indicated Resident #5 ' s blood pressure was 130/87. A Police Department Incident Report, report generation date of 01/02/2025 at 12:39 PM, indicated the police department received a call from the facility on 12/31/2024 at 01:19 AM. The type of call was identified as Battery, and the narrative read, Officers were dispatched to the listed address due to a battery. Upon arrival, officers made contact with the Director of Nurse on the phone (DON named) who stated she needs to make a police report on an incident that occurred where a nurse (named LPN #3) allegedly punched an elderly resident (named Resident #5). Both [LPN #3] and [Resident #5] was not on scene (sic). Officers attempted to make contact with [Resident #5] at [named Hospital] with negative results as he was sedated and asleep for hours. [DON] was given the incident report number. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #5's Medication Administration Record (MAR) for December 2024 Indicated that on 12/30/2024 at 5:00 PM, Resident #5 did not receive his Midodrine (Midodrine is used to treat low blood pressure). The MAR had a documented BP for Resident #5 as 130/70. Removal Plan 12/30/2024 at 11:30 p.m., Licensed Practical Nurse (LPN) #3 was suspended via phone pending further investigation of alleged abuse. 12/31/2024 at 6:00 p.m., Licensed Practical Nurse was terminated via phone and did not return to work. 12/31/2024 at 12:57 a.m., Resident #5 was transferred to emergency room (ER) upon assessment from Night Nurse and Director of Nursing. 12/31/2024 at 12:30 a.m., In-service/Education started for all staff on Abuse to prevent serious harm, serious injury, serious impairment or death. Completion date 01/03/2025. If education is not provided via phone or in person, staff will be educated on Abuse Policy and Procedures prior to the start of their shift by In-service and education on Abuse Policy and Procedure, the types of abuse and when to report. Follow up is completed by verifying employee signatures to in-service document and compare to Employee Roster, as well as staff interviews. 12/31/2024 at 1:00 a.m., all 21 residents on 400 hall secured unit were assessed by the night nurse, due to alleged abuse with no negative findings, and was verified with follow up by the Director of Nursing/Chief Nursing Officer. The night nurse and two 3/11 shift Certified Nursing Assistants (CNA's) were verified no other residents witnessed the incident. 12/31/2024 Director of Nursing/Designee will begin assessing other 64 residents per census roster for needs of mental health services with follow up from Psychosocial Services with completion date of 01/03/2025. 12/31/2024 Body Audits on remaining 20 residents on 400 hall secured unit completed by treatment nurse with no negative findings. Treatment Nurse/Designee will complete other 64 residents body audits per census roster by 01/03/2025. Onsite Verification: The IJ was removed on 01/08/2025 at 4:05 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 01/03/2025 at 5:05 PM when the facility began educating staff on abuse. Termination of employment documentation for LPN #3 indicated last date worked was 12/30/2024, suspended on 12/30/2024, and terminated by telephone on 12/31/2024. Metro EMS Ambulance Patient Care Record for Resident #5 indicated the Incident #24-107185, date 12/30/2024 at 00:28 AM. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Completed body audits for 28 of 28 100-Hall residents; Completed body audits for 25 of 25 200-Hall residents; Completed body audits for 15 of 15 300-Hall residents; Completed body audits for 21 of 21 400-Hall residents. OLTC Witness Statement from DON stating 400 Hall residents were assessed due to abuse allegation with no negative findings on 12/31/2024. A total of 17 staff interviews were conducted with staff from all shifts to verify training had been completed. The staff interviewed included Certified Nursing Assistants, Medication Aide certified, Licensed Practical Nurses, and Housekeeping. The staff interviewed verified they had been trained on abuse, neglect and misappropriation of property. [Those staff who were not physically present to receive the in-services were messaged via telephone, with the in-service information provided and the employee acknowledging receipt and voicing understanding. The following was cited at F600 at a lower severity: A facility policy titled, PP Abuse Prevention indicated To provide a safe environment for all residents free of abuse. An Admission Record indicated the facility admitted Resident #3 with schizoaffective disorder. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/25/2024 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had significant cognitive impairment. Review of Resident #3 Care Plan, initiated 10/23/2024, revealed the resident at risk for alteration psychosocial wellbeing related to living in skilled facility for long term care. No interventions in place at the time of review. An OLTC Incident and Accident Report (I&A) dated 12/18/2024 revealed LPN #2 stated that CNA #1 confirmed that they popped the resident on the butt trying to get her to go the bathroom. LPN #2 revealed that they heard ouch with each of four swats. LPN #2 stated from the sound, it was not a clap that was heard. A witness statement from LPN #2 was included and read, This nurse was sitting at nurse ' s station . when [Resident #3] was screaming ouch, ouch from the swats from aide [CNA #1] x4 times. This nurse then asked aide if she hit resident. She [CNA #1] stated, No I was popping her on the butt. During interview on 12/30/2024 at 1:50pm, Resident #3 stated that they (indicating CNA #1) hit me on the butt and I hit them back first. During an interview on 12/30/2024 at 2:01pm, Human Resources (HR) stated CNA #1 was no longer with us. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/30/2024 at 8:18am, LPN #2 indicated that CNA #1 wasn't very welcoming with the residents. LPN #2 noticed that CNA #1 didn't like to repeat herself. LPN #2 reported sitting at nurses station, when CNA #1 went into Resident #3 room, then heard loud smacking sounds and CNA #1 saying, Get up and go to the bathroom. LPN #2 heard Resident #3 say ow, ow, ow with each hit. LPN#1 got the wound care nurse and informed CNA #1 that they had to leave. LPN#2 verbalized that they did not see Resident #3 being struck but heard her being struck. During an interview on 12/31/2024 at 9:24am, CNA #1 said they clapped their hands like it was time to get up, stating that Resident #3 and CNA #1 had a good relationship. CNA #1 pulled covers back, patted them on their booty, and told Resident #3 time to get up and go to the bathroom, to which Resident #3 told the CNA to not do that. CNA #1 then took care of other resident in room. LPN #2 asked if they had hit Resident #3, to which CNA #1 stated, No I clapped my hands like I always do, I don't hit residents. During an interview on 12/31/2024 at 11:52am, the DON stated that they were reported to by LPN #2 regarding the incident. A full body assessment and body audit was done on Resident #3 and their roommate during that time. The DON reported the incident to the Administrator, provider, and family. I heard from LPN #2 loud [NAME] were heard at the nurses station. LPN #2 asked if CNA #1 hit Resident #3 and that CNA #1 stated that they clapped her hand but patted her buttocks.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 51477 Based on interview, record review, and facility policy review, it was determined the facility failed to report an alleged violation involving abuse to the proper state agency within the allotted time frame for 1 (Resident #3) of 1 sampled resident reviewed for abuse allegations. The findings are: Review of a facility policy titled Prevention and Prohibition of Abuse indicated The facility administrator or designee shall complete a report to be made to the mandated state agency and may also be made to the local law enforcement agency after corporate approval or immediately if the abuse constitutes an emergency. Administrator or designee will have 5 working days from the initial report of abuse to complete SIMS (Statewide Incident Management System) report. Immediately means as soon as possible, in the absence of a shorter State time frame requirement, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. A review of an Admission Record indicated the facility admitted Resident #3 with a diagnosis of schizoaffective disorder (combination of symptoms that affect a person's emotional state and a disorder that affects a person's ability to think, feel, and behave clearly). A review of the admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/25/2024, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 07, which indicated the resident had severe cognitive impairment. A review of Resident #3 ' s Reportable, dated 12/18/2024, indicated Nurse was at nurse ' s station and heard a popping noise that they thought was a slap. Upon entering the resident's room, Certified Nursing Assistant (CNA) #1 was getting resident up to go use the bathroom. Licensed Practical Nurse (LPN) #2 asked CNA #1 if they hit the resident. CNA #1 answered back that she ' popped resident on the butt with the back of the hand ' trying to get her to go to the bathroom. LPN #2 dismissed CNA #1 from the room, assessment of resident completed with no negative findings. Resident stable with no distress noted. CNA #1 immediately suspended with investigation started. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 12/31/2024 at 12:05pm, the Administrator was familiar with Resident #3 ' s care and confirmed knowledge of alleged abuse on 12/18/2024. The Director of Nurses (DON) notified the Administrator of the alleged abuse. The Administrator confirmed the incident and accident was on 12/18/2024 at 6:00AM but notification was sent in on 12/19/2024 at 10:58AM. A body audit and assessment of Resident was completed, and the employee was suspended. The Administrator confirmed a representative and the attending practitioner were both notified. The Administrator confirmed the abuse was reported to the Office of Long-Term Care. The Administrator confirmed that an investigation had been completed and was awaiting notice from the Office of Long-Term Care. The Administrator confirmed the employee was suspended and removed from facility for their actions and to protect the alleged victim from further abuse during the investigation process. The results of the investigation were founded, and the staff member was terminated. The Administrator revealed there were no warning signs to facility to indicate prior to the incident and the facility tried to send in the reportable within a timely manner but had difficulty.

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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** 48390 Based on interview, record review, and policy review, the facility failed to develop a comprehensive care plan for one (Resident #5) of one resident reviewed for care plans, specifically that a resident ' s post-traumatic stress disorder diagnosis was addressed in the resident ' s care plan. The findings are: Resident #5 had diagnoses including schizoaffective disorder bipolar type, nightmare disorder, post-traumatic stress disorder, and type 2 diabetes mellitus without complications. A review of the significant change in status Minimum Data Set (MDS) with an assessment reference date (ARD) of 12/04/2024, revealed the resident received a score of 1 (severely impaired) on the Brief Interview for Mental Status (BIMS). The resident required moderate assistance with bed mobility and transfers. The resident required substantial assistance with personal hygiene and dressing. A review of Resident # 5's care plan, initiated on 02/13/2023, revealed the resident had an Activity of Daily Living (ADL) self-care performance deficit with poor safety awareness: interventions included the resident could perform most ADL functions with 1 person assist; had the potential to be physically aggressive related to dementia and schizoaffective disorder, was aggressive and hit at other residents on 12/20/2024: interventions included When the resident becomes agitated: intervene before agitation escalates; If response is aggressive, staff to walk calmly away and approach later. Resident #5 has a diagnosis of Post-Traumatic Stress Disorder, and a review of the care plan did not address this diagnosis. A review of Resident #5 ' s Admission Record indicated that the resident was admitted to the facility on [DATE] with diagnoses of schizoaffective disorder bipolar type, post-traumatic stress disorder, nightmare disorder, and pseudobulbar affect (a condition characterized by episodes of sudden uncontrollable and inappropriate laughing or crying). On 01/03/2025 at 2:42 PM, Licensed Practical Nurse (LPN) #13 was asked who was responsible for completing resident care plans. LPN #13 indicated that she was responsible for completing the care plans. LPN #13 was asked if the care plan should address the goals, preferences, needs and strengths of Resident #5. LPN #13 indicated that it should. LPN #13 was asked what Resident #5's mental health diagnoses were. LPN #13 indicated schizoaffective, major depressive disorder (MDD), dementia, and pseudobulbar affect (a condition characterized by episodes of sudden uncontrollable and inappropriate laughing or crying). LPN #13 was asked how active diagnoses are identified for the care plan. LPN #13 indicated the physician would give the orders on medications they [physician] let us know the diagnoses, upon admission with their paperwork and any physician they see and diagnosis they coordinate with us [facility]. LPN #13 was asked if the care plan described corresponding interventions for care that account for Resident #5's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization's? LPN #13 indicated that would be a question for the physician. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/03/2025 at 3:01 PM, the Director of Nursing (DON) was asked who was responsible for completing the care plans. The DON indicated LPN #13. The DON was asked how the active diagnoses are identified for the care plan. The DON indicated you look in the care plan. On 01/03/2025 at 3:12 PM, the Administrator was asked why it was important for the care plan to reflect Resident #5's goals, preferences, needs, strengths and interventions for care. The Administrator indicated so staff would know and understand how to provide proper care for the resident. The Administrator was asked what the policy and procedure for completing the care plan was. The Administrator indicated it meets their needs assessment in the time frame and completed upon admission within 48 hours and person-centered care based on RAI, reviewed with resident Inter-Disciplinary Team (IDT) team and responsible party and updated quarterly and as needed. A review of the facility's undated policy titled Care Plan Policy and Procedure, provided by the Administrator on 01/03/2025, indicated Each resident's care plan will remain current and inform staff of resident's needs, strengths, goals, and approaches It is the policy of this facility to utilize an advanced care planning approach to review and determine patient centered care plans.