

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

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>045476                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>07/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Hampton Place Healthcare, LLC                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2029 South Hampton Place<br>Rogers, AR 72758 |                                                 |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                           |                                                 |
| F 0600<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on review of video footage, interviews, record review, and facility policy review, it was determined that the facility failed to ensure a resident was free from physical abuse. Specifically, the facility failed to ensure one (Resident #57) of three residents were free from physical abuse and mental anguish.</p> <p>The findings included:</p> <p>Review of Resident #57's annual Minimum Data Set (MDS) with an Assessment Reference Date of 05/15/2026, revealed the resident had a Brief Interview for Mental Status score of 06 which indicated the resident had severe cognitive impairment. The MDS also indicated Resident #57 was independent for all mobility, personal care and dressing needs, and refused showers/baths. The MDS indicated Resident #57 had active diagnoses that included Alzheimer's disease, anxiety, bipolar and psychotic disorder.</p> <p>Review of Resident #57's Care Plan indicated Resident #57 was in the secure unit with an Activities of Daily Living (ADL) self-care deficient due to Alzheimer's/Dementia. Resident #57 exhibited a history of behaviors related to confusion, verbal aggression, yelling, physical aggression, and the resident refused to allow staff to shower, but will do a sink bath. interventions included re-direction, offer snacks, and call family for a 1:1 conversation. If resident refuses and /or becomes agitated try a different approach such as having another staff member attempt care, postpone care and try again later.</p> <p>Review of Resident #57's Physician Orders Summary indicated Resident #57 was admitted to Long Term Care Secure Unit on 05/21/2025, no behaviors were noted on the Physician Orders Summary.</p> <p>Review of the Reportable dated 07/06/2026, revealed a description of the incident as such: Resident #57 threw water on the Licensed Practical Nurse (LPN#4), LPN#4 told the resident that they could not do that and that they were going to clean their room. Certified Nursing Aide (CNA) # 6 took a linen/trash caddy to the hallway in front of Resident #57 room and removed items from Resident #57 room, such as soiled linens and dishes in front of Resident #57. Later, on 07/06/2026 at 12:59 PM, (continued on next page)</p> |                                                                                           |                                                 |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE                   | (X6) DATE                                                              |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                      | Event ID:<br><br>045476 | Facility ID:<br><br>045476<br><br>If continuation sheet<br>Page 1 of 5 |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>LPN #4 followed Resident#57 down the hall telling them they could not take cups into the room, Resident #57 turned and threw the fluid from the cup on LPN#4. LPN#4 continued to follow Resident #57 and forcibly took the cup from Resident #57's hand. Resident #57 and LPN #4 turned to walk back down the hallway, LPN#4 dumped the remaining contents from the cup on the Resident #57's head. The Administrator included the complaint submitted to the Arkansas State Board of Nursing regarding LPN #4.</p> <p>Review of video footage with the Administrator on 07/30/2026 at 2:55 PM, revealed on 07/06/2026 Resident #57 threw a cup of liquid at LPN #4 who then followed Resident #57 from the table, stepped extremely close to Resident #57 and was seen on camera waving her hands at Resident #57. The sound was not audible. CNA #5 and CNA #6 witnessed the incident. A different camera view showed LPN #4 followed Resident #57 down the hall toward their room. LPN #4 touched the resident on the left arm in two places. Resident #57 turned and threw a cup of liquid at LPN #4, who then took the cup from Resident #57's hands. Medication Aid-Certified (MAC) # 9 came out of another resident's room and turned towards Resident #57 and LPN #4. LPN #4 took her right hand and poured the contents of the cup on Resident #57's head. Resident #57 immediately turned toward LPN #4 and raised their hand toward LPN #4; MAC #9 immediately stepped in between LPN #4 and Resident #57. At the end of the hallway in line-of-sight CNA #7 and CNA #8 can be seen watching the incident. LPN #4 walked toward CNA #7 and CNA #8 and could be seen speaking with them.</p> <p>During an interview on 07/29/2026 at 9:18 AM, CNA #19 stated Resident #57 would take everything to their room, cups or anything laying around. Staff wait to remove the items from the room when they are not around, to prevent them from getting upset.</p> <p>During an interview on 07/29/2026 at 9:34 AM, CNA #20 stated, Resident #57 did have a hoarding behavior, we [staff] go in the room to remove the items with the resident is not around, if Resident #57 sees us taking items out of the room they become upset.</p> <p>During an interview on 07/30/2026 at 10:05 AM, CNA #11 stated, The only time I go into [Resident #57's] room to clean it out is when they are not around, or Resident #57 will become upset. I coordinate with housekeeping to clean the room when the resident will not see them.</p> <p>During an interview on 07/30/226 at 12:52 PM, CNA #5 stated I saw Resident #57 throw the water into the face of LPN #4, and then LPN #4 got into Resident #57's face and stated, let's go clean out your room. CNA #5 stated, I did not report this because I was not sure it was something that needed to be reported.</p> <p>This surveyor attempted to contact MA-C #9 for an interview with no success.</p> <p>During an interview on 07/30/2026 at 1:05 PM, LPN #4 stated, I did not pour water on Resident #57 at any time, I did gesture like I was going to dump tea on them. Earlier in the day I explained to Resident #57 that the room needed cleaned out. I was irritated at this time and took the cups from the resident.</p> <p>During an interview on 07/30/26 at 11:57 AM, the Director of Nursing (DON) stated, we usually let [Resident #57] take cups to the room, and retrieve them later, it is not a big deal. I never would have (continued on next page)</p> |                                                                                           |                                                 |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>expected to see what was on the video. After I saw the video, I knew we had to do something. I spoke with LPN #4 on 07/06/2026 regarding Resident #57's behaviors and let her know handling behaviors like this was expected on a dementia unit. The next day LPN # 4 requested to change assignments.</p> <p>During an interview on 07/30/2026 at 3:10 PM, the Administrator stated he believed LPN #4 went to clean out Resident #57's room to cause frustration. After the incident was discovered he immediately suspended LPN #4, CNA #5, #6, #7, #8 and MA-C #9 and terminated them after the investigation. The Administrator also stated that after the incident, the facility conducted education and training on Abuse and Neglect with posttest for staff to ensure understanding.</p> <p>Review of a facility policy titled Abuse, Neglect, Misappropriation and Exploitation Investigation and Reporting with a revised date of 10/18/22, revealed The facility will endeavor to protect residents from Maltreatment, which means adult abuse, sexual abuse, neglect, misappropriation of resident property, and exploitation of residents. It recognizes resident rights to be free from physical, verbal or mental abuse, corporal punishment, involuntary seclusion, and any chemical and physical restraints as defined by federal regulation.</p> <p>The facility has implemented the following actions prior to surveyor entry to the facility to correct the deficient practice effective 07/21/2026: Termination of involved staff, Abuse in-service with posttest, seven days of behavioral monitoring for residents with a BIMS less than 12 in the facility, and the Administrator instituted a Behavioral Care Plan in the secure unit for baseline behaviors and likes. The DON reviews the progress notes every day to monitor for any new behaviors.</p> |                                                                                           |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on interview, record review, and facility policy review, the facility failed to ensure staff reported a witnessed incident of abuse which occurred on 07/06/2026, affecting one (Resident #57) of three residents reviewed. Specifically, staff that witnessed the incident of abuse did not report the incident to the Administrator.</p> <p>The findings include:</p> <p>Review of an annual Minimum Data Set (MDS) with an Assessment Reference Date of 05/15/2026, revealed Resident #57 had a Brief Interview for Mental Status score of 6, which indicated the resident had severe cognitive impairment. The MDS also revealed Resident #57 was independent for all mobility, personal care, and dressing needs, and refused showers/baths. Diagnoses included Alzheimer's disease, anxiety, bipolar and psychotic disorder.</p> <p>Review of the Care Plan revealed Resident #57 resided in the secured unit with an Activities of Daily Living (ADL) self-care deficient due to Alzheimer's/Dementia. Resident #57 exhibited a history of behaviors related to confusion, verbal aggression, yelling, physical aggression, and refusals to allow staff to provide showers. Interventions included for staff to attempt re-direction, offer snacks, and to call the resident's family for a 1:1 conversation.</p> <p>Review of Physician Orders Summary for Resident #57 indicated the resident was admitted to the Long-Term Care Secure Unit on 05/21/2025, no behaviors noted on the Physician Orders Summary.</p> <p>Review of the Reportable, dated 07/06/2026, revealed Resident #57 threw water on Licensed Practical Nurse (LPN) #4. LPN #4 told the resident they could not do that and that staff were going to clean their [Resident #57's] room. Certified Nurses Aid (CNA) #6 took a linen/trash caddy to the hallway in front of Resident #57 room and removed items from Resident #57 room, such as soiled linens and dishes, in front of Resident #57. LPN #4 was described as following Resident #57 down the hall, telling them they could not take cups into [the resident's] room. Resident #57 turned and threw the fluid from the cup on LPN #4. LPN #4 continued to follow Resident #57 and forcibly took the cups from Resident #57's hand. Resident #57 and LPN #4 turned to walk back down the hallway, LPN #4 dumped the remaining contents from the cup on the Resident #57's head.</p> <p>Review of video footage dated 07/06/2026, with the Administrator on 07/30/2026 at 2:55 PM, revealed Resident #57 threw a cup of liquid at LPN #4, who then followed the Resident #57 from the table, stopped extremely close to Resident #57 and was seen on camera waving her hands at Resident #57, the sound was not audible. CNA #5 and CNA #6 were seen in frame, witnessing the incident. LPN #4 followed Resident #57 down the hall toward their room. LPN #4 touched the resident on the left arm in two places. Resident #57 turned and threw a cup of liquid at LPN #4, who then took (continued on next page)</p> |                                                                                           |                                                 |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>the cups from Resident #57's hands. Medication Aid-Certified (MAC) # 9 came out of another resident's room and turned towards Resident #57 and LPN #4. LPN #4 took her right hand and poured the contents of the cup on Resident #57's head. Resident #57 immediately turned toward LPN #4 and raised their hand toward LPN #4; MA-C #9 stepped in between LPN #4 and Resident #57 to intervene. At the end of the hallway in line-of-sight CNA #7 and CNA #8 can be seen watching the incident. LPN #4 walked toward CNA #7 and CNA #8 and could be seen speaking with them.</p> <p>During an interview on 07/30/2026 at 11:57 AM, the Director of Nursing (DON) stated she was following up with a request from mental health services to find the triggers for increased behaviors for Resident #57. While reviewing video footage on 07/08/2026 she found the incident from 07/06/2026 involving Resident #57 and LPN #4. The DON noted which staff had witnessed the incident and reported the findings to the Administrator, who started an investigation.</p> <p>During an interview on 07/30/2026 at 12:50 PM, CNA #5 stated, I did not report this because I was not sure if this was something I needed to report. I should have reported it and know now I was in the wrong.</p> <p>During an interview on 07/30/2026 at 1:50 PM, CNA #6 stated, I did not know it was not a reported incident by another staff.</p> <p>During an interview on 07/30/2026 at 3:15 PM, the Administrator stated upon learning of the allegation on 07/08/2026 from the DON, they immediately started an investigation, notifying the Office of Long-Term Care, Police Department, Medical Provider, and the family. All staff that were involved in the incident and who witnessed the incidents without reporting were immediately suspended and later terminated.</p> <p>Review of the facility policy, Abuse, Neglect, Misappropriation and Exploitation Investigation and Reporting Policy, with a revised date of 10/18/2022, revealed alleged, witnessed, or suspected resident maltreatment, including abuse, sexual abuse, neglect, misappropriation of resident property and exploitation of residents, shall be immediately reported to Administrator or immediate supervisor and investigated by Facility management.</p> |                                                                                           |                                                 |