STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045479	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooken Hill Health and Rehab, LLC	9000 Hwy 71 South Fort Smith, AR 72908

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility policy review, it was determined the facility failed to obtain and implement physician orders to provide care for a post-operative surgical wound for one (Resident #2) of three residents reviewed for wound care quality. Resident #2 experienced wound dehiscence, rehospitalization, and emergency surgery. The findings include: A review of a facility undated document titled, Admission/Readmission/Transfer back from hospital heads up form, indicated ways to prepare the room, gather needed equipment, and gathering of specific resident history. No guidance was provided for physician contact or intake of orders. A review of a facility document titled, Dressing Change Using Aseptic Technique, dated 11/22/2016, indicated steps for gathering equipment and supplies as well as steps through the procedure. There was no mention of referring to Physician Orders for assessment or instructions of documentation of the process. A review of the Charge Nurse Job Description revised on 09/25/2019 was provided by the Administrator as the Licensed Practical Nurse (LPN) Job Description on 11/07/2025 and stated, the nurse was to Render skilled technical services to residents on an assigned hall or unit in support of medical care as directed by the attending physician and registered nursing staff to ensure that quality of care is provided to all residents. The position is a safety sensitive position as defined by applicable state law. Perform nursing services for the comfort and well-being of the residents and in accordance with physician's orders. Assess, record and report changes in residents' condition to supervisor and attending physician. During an interview on 11/07/2025 at 12:33 PM the Administrator stated there was no job description for the Registered Nurse (RN) Supervisor position. A review of an admission Record, indicated the facility admitted Resident #2 with diagnoses which included multiple myeloma in remission (a malignant tumor of the bone marrow), intra-abdominal and pelvic swelling, mass and lump, and pain. A review of Resident #2's Hospital Discharge Records dated 10/25/2025, indicated the resident underwent surgery on 10/16/2025 for mass resection. Staples were left in place over the incision and were to be removed on post operation day ten, 10/26/2025. No instruction for wound assessments, care, documentation, or when to notify the Physician were provided. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045479	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooken Hill Health and Rehab, LLC	9000 Hwy 71 South Fort Smith, AR 72908

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/2025 for Resident #2, four days after the resident was discharged , indicated the cognitive portion was incomplete. A review of Resident #2's Nsg Admit/Readmit/Quarterly Assessment dated 10/25/2025 at 1:21 PM and signed off by LPN #2, indicated Resident #2 had a Brief Interview of Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The assessment also indicated a midline incision with staples and a dressing, drain removal area, and colostomy stoma to the right lower quadrant (A stoma is a surgically created opening in the abdomen that allows waste (urine or feces) to exit the body into a collection pouch, as the normal elimination path is diverted). The resident's pain was identified as almost constant, occasionally affecting sleep, almost constantly interfering with therapy and day-to-day activities. On a pain scale of 0-10, a score of 14 was recorded and described as severe. Both verbal complaints and protective body movements were documented, ABD [abdominal] guarding noted-medicated with PRN [as needed] pain meds. A review of Resident #2's Nsg-admission Summary note documented by LPN #2 on 10/25/2025 at 6:27 PM, indicated a midline abdominal incision with staples in place, a large amount of drainage from the naval which had settled into the resident's perineal area, and abdominal tenderness to palpitation. A review of Resident #2's Care Plan Report, dated 10/25/2025, revealed no Plan of Care (POC) for the resident's surgical wound or interventions to include care, monitoring, documenting, or reporting to physician. A POC for pain was described as acute related to abdominal surgery. Interventions included anticipating the resident's need for pain relief and responding immediately to any complaint of pain. Goals included the resident would have no interruption in normal activities due to pain and the resident would verbalize adequate relief of pain. A review of the Order Summary Report, revealed Resident #2 had no orders related to wound care, assessments, how and when to monitor for sign/symptom of wound complications, or when to notify the provider related to the surgical midline incision. A review of Resident #2's October Medication Administration Record (MAR), revealed Resident #2 had no documentation of the midline surgical incision dressing changes provided. Narcotic pain medication was administered seven times during the forty-eight hours Resident #2 was in the facility, twice it was recorded as ineffective. During an interview on 11/07/2025 at 8:25 PM, LPN #2 stated Resident #2 arrived at the facility on a Saturday, 10/25/2025. The hospital sent pain medications with the spouse, they were counted, and narcotic pain medication was administered. A sanitary napkin had been placed over the incision at the prior facility and was saturated. LPN #2 stated she cleaned up the resident, including the incisional area, and applied a new dressing. LPN #2 stated there was an estimated four inches that was not approximated on the incision line and the incision was draining a lot more than was explained to her in report from the prior facility. LPN #2 reported RN #4 was in the facility when the resident arrived but did not assess Resident #2's wound. LPN #2 stated I just do it, and that she, did not call the on-call provider. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045479	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooken Hill Health and Rehab, LLC	9000 Hwy 71 South Fort Smith, AR 72908

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/07/2025 at 10:50 AM, RN #4 stated she did not do Resident #2's admission assessment, did not assess the surgical wound, and spoke more to the spouse than the resident. I asked the floor nurse to let me know when she did the skin assessment, but she did not, I was in the middle of something. I did not go back to assess. I was confident in LPN #2's assessment. When Monday rolled around, I felt bad I never looked at her. I shamed myself and wished I had gone and looked. A review of Resident #2's October Treatment Administration Record, reveal no documentation of the surgical incision assessment, complication monitoring, or dressing changes including cleansing of the surgical site for Saturday October 25, 2025, or Sunday October 26, 2025. A review of Resident #2's Nsg Admit Skin Audit (Tx Nurse) dated 10/27/2025 at 11:29 AM and signed by LPN #6 indicated, Abdominal incision from the xiphoid process (the xiphoid process is a small, triangular part at the bottom of the sternum (breastbone) that serves as an attachment point for muscles and ligaments) to the pubic area measuring 21.5 centimeters (cm) long, well approximated with 37 staples, orders for staples to be removed on 10/26/2025 per discharge paperwork, staple sites light pink, 37 staples removed and tolerated well, no dehiscence noted, serous drainage noted to old dressing and small amount from naval, no s/s [signs/symptoms] of infection noted, no drainage noted from incision, area cleaned with wound cleanser, skin prep applied, covered with absorbent dressing. During an interview on 11/07/2025 at 8:03 AM Resident #2's spouse stated, on Saturday 10/25/2025 after admission, Resident #2 called and informed them of uncontrolled pain. The resident was crying and upset. On Monday 10/27/2025 the family member noted a wet spot on the resident's bedding, when three layers of blankets were pulled back the resident was bloody, the staples had been removed, and the top four inches of the incision was not completely together. Resident #2's spouse stated, The staff said they had an order from the hospital paperwork to remove staples on post-op day ten, but the incision was still leaking, and they (facility staff) should know better than to take staples out if it was still leaking that much. Resident #2 was sent to the local hospital after the wound dehisced, who transferred the resident to the hospital where the original surgery took place. Emergency surgery was performed on 10/28/2025 for dehiscence of postoperative wound of the abdomen. Resident #2 has been in the Intensive Care Unit (ICU) since the procedure on a ventilator and was not available for interview. During an interview on 11/06/2025 at 2:17 PM, Resident #2's family member stated they felt the facility was negligent in their care of the resident. The resident had called Saturday night complaining of on-going pain and after the staples were removed Monday the bedding and dressing were saturated in bloody drainage. The family member, who self-identified as having a background in the medical field, stated, I don't know the orders for the staples, but you must use your nursing judgement if it was not healed. During an interview on 11/06/2025 LPN #3 stated he cared for Resident #2 for a few hours on Monday 10/27/2025. The resident was admitted on [DATE] with an abdominal surgical incision, the discharge orders were to remove the staples on post-op day 10, but that landed on Sunday, so LPN #6 removed them on Monday. Physical Therapy got the resident up about two hours after and completed out of bed exercises. LPN #3 stated that, when the wound dehisced wound care placed a wet-dry dressing, and I sent the resident to the local hospital who sent Resident #2 back to the hospital who completed the surgery .During wound care a nurse should observe any redness, drainage, warmth, increased uncontrolled pain, or tenderness to the area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045479	A. Building B. Wing	11/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooken Hill Health and Rehab, LLC	9000 Hwy 71 South Fort Smith, AR 72908

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/06/2025 at 3:23 PM, LPN #1 stated he took over care of Resident #2 on admission day Saturday October 25, 2025, and Sunday October 26, 2025. He provided pain medication for abdominal pain after the spouse returned to the facility Saturday night to follow-up on the uncontrolled pain. LPN #1 stated he did not look at the wound site on Saturday or Sunday, but the dressing was a little saturated, not with any red (bloody) drainage, but a whitish, yellow color. During an interview on 11/07/2025 at 10:05 AM, LPN #6 stated he was one of the treatment nurses. Job duties included managing skin audits, educating aides on creams, regular skin treatments, and pressure wounds. He worked with both the Advanced Practice Registered Nurse (APRN) and surgical centers for wounds. He reported had no wound nurse certification, and his wound specific education comes from hands on work over the last couple of years. When preforming wound care a nurse should observe for signs of dehiscence, erythema, assess for new epithelial tissue that was pink and purple, or if the staple sites have any signs of rejections. He stated, most of the time we don't get orders on admission to remove them, but I don't mind taking them out if the surgeon is ok with it. Resident #2 admitted on Saturday 10/25/2025, when I came in on Monday 10/27/2025 I saw the post-op orders stated staples should be removed on post-op day 10 which was the day before. There was no drainage, there was some light serosanguinous drainage of the dressing that was dry. The wound was pink with no open areas. I removed the staples with no dehisced. I removed them first thing in the morning and about 3-4 hours later I got called that the wound dehisced. It was about 2-2.5 inches long at the top and deep enough you could put fingers in there. No one else looked at it prior to me removing the staples. I heard she had a coughing fit and felt her dressing leak. A review of Resident #2's Operate Note dated 10/28/2025 revealed, a preoperative diagnosis of dehiscence of postoperative wound of abdomen and a postoperative diagnosis of dehiscence of postoperative wound of abdomen, findings were colon protruding through midline incision. Fascial edges mildly debrided and primarily closed. Onlay vicryl mesh (for temporary wound or organ support) placed. During an interview on 11/07/2025 at 10:30 AM, the APRN stated she would not have typically seen Resident #2 for wound care because she does not see surgical incisions unless the surgeon has released the wound to them. Saturated dressings (covering a wound) may not be a sign of infection, but an underlining pocket. If the dressings are saturating, or the edges are separated, then it would be appropriate to let the surgeon know. They could have called me as a resource, I am always available, but I would have referred them to the surgeon. During an interview on 11/07/2025 at 12:07 PM, the Director of Nursing (DON) stated admissions were usually completed by the admission nurse, but the DON did not know who completed Resident #2's on that Saturday. The care of the wound would be the responsibility of the treatment nurse or the charge nurse for the day. Wound care should start with the orders, and documentation in the Electronic Health Record (EHR). The treatment nurse should track all the wounds in the building. During an interview on 11/07/2025 at 12:33 PM, the Administrator stated on a Saturday the nurse on duty would do an assessment and the treatment nurse would follow up when they came in. During an interview on 11/07/2025 at 1:02 PM the Medical Director stated he would think an RN would have more knowledge than an LPN. He did not remember staff contacting him on Saturday, it would have been an on-call provider. If the resident was admitted over the weekend the Medical Director assumed somebody like the Assistant Director of Nursing (ADON) would make sure the wound was ok.