STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026
NAME OF PROVIDER OR SUPPLIER Brooken Hill Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9000 Hwy 71 South Fort Smith, AR 72908	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Number of residents sampled: Number of residents cited: Based on observation, record review and interview, the facility failed to ensure shaving and nail care services were regularly provided to promote good personal hygiene and grooming for one (Resident #91) resident reviewed for shaving and one (Resident #107) resident reviewed for nail care services. The findings include: 1. On 04/21/2026 at 9:14 AM, Resident #91 was observed lying in bed with eyes closed and both arms were above the bed linen, exposing both the resident's arms and hands. There was nothing covering either of the residents' arms. The fingernails on both of the resident's hands extended over the tips of the fingers. On 04/22/2026 at 9:04 AM. Resident #91 was observed sitting up in a low chair in the common area located between halls 800 and 900. Resident #91 was holding a carton of a supplemental drink in the right hand. The fingernails on Resident #91's right hand extending over the tip of the fingers. Resident #91's left hand was not visible at this time. Resident #91's arms were exposed and there was nothing covering either. A review of the physician's orders for Resident #91 revealed a diagnosis of Parkinson's disease with dyskinesia, admit to long term care on 02/17/2025, and geri-sleeves as tolerated every day shift on 01/12/2026. A review of the care plan for Resident #91 revealed an activity of daily living (ADL) self-care performance deficit related to weakness and impaired mobility secondary to Parkinson's disease. An intervention included to check nail length and trim and clean on bath day and as necessary. The care plan also indicated Resident #91 has a potential impairment to skin integrity and had a skin tear on 01/10/26 above the right elbow and on 2/5/26 had a skin tear to the right upper arm. An intervention, initiated on 01/10/2026, was to encourage geri-sleeves as tolerated. A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/20/2026 for Resident #91 revealed a Brief Interview for Mental Status (BIMS) score of 04, which indicated severe cognitive impairment. This MDS also indicated Resident #91 required substantial/maximal assistance with shower/bathe self and personal hygiene. A review of the progress notes dated 04/17/2026 at 17:37 (5:37 PM) revealed the resident did not receive a shower on scheduled day due to received shower yesterday (04/16/2026) from hospice. (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: 045479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the ADL task to check, cut and file finger and toe nails every week for Resident #91 revealed checkmark in the 'yes' box on 4/8/2026, 4/15/2026 and 4/22/2026. There were no initials to indicate which staff members completed this task. A review of the ADL task to encourage geri-sleeves as tolerated revealed a checkmark in the 'yes' box on April 20, 2026, through April 23, 2026. There were no initials in the box to indicate which staff members completed this task. On 04/23/2026 at 9:09 AM, Certified Nursing Assistant (CNA) #12 was in Resident #91's room checking the blood pressure. During an interview, CNA #12 was asked to look at Resident #91's arms and stated the resident was not wearing geri-sleeves at this time. She stated she was not aware when the geri-sleeves should be placed on Resident #91 and added the resident is normally up when we get here. She stated, I think the night shift, in response to a question of who places the geri-sleeves on the resident. She was asked to look at Resident #91's hands and describe the resident's fingernails. She stated the fingernails on the resident's right hand did extend, just a little over the tip of Resident 91's fingers. She stated the fingernails on Resident #91's left hand did extend over the tips of the fingers. She was asked when nail care was provided for Resident #91 and stated, I think hospice aid does it when they visit and added, I think three times a week regarding when the hospice aid comes to the facility. She was asked to check if Resident #91 had geri-sleeves in the room. On 04/23/2026 at 9:18 AM, Medication Aide-Certified (MA-C) #13 entered Resident #91's room and she assisted CNA #12 in the search for geri-sleeves. During the search, she was asked if she knew who was responsible for placing geri-sleeves on the resident and stated she did not. After CNA #12 and MA-C #13 were unable to locate geri-sleeves in Resident #91's room, MA-C #13 stated she would go and get geri-sleeves and both staff members exited the resident's room. On 04/23/2026 at 9:28 AM, CNA #14 was interviewed and stated she looked at Resident #91's closet list and in the facility's charting system to find out what care the resident required. CNA #14 stated she looked at the care plan every time she entered the resident's room. She stated she did provide nail care to Resident #91 when needed. She stated Resident #91's nails should be trimmed so the resident did not scratch their self and cause a skin tear. She stated Resident #91 did not wear geri-sleeves when asked if the resident was supposed to wear geri-sleeves. She stated Resident #91 would need the geri-sleeves because of fragile skin. On 04/23/2026 at 10:01 AM, the Director of Nursing (DON) stated the facility did not have a policy for ADLs and was asked if CNAs completed a skill check off for ADL and to provide this check off if available. As of 04/23/2026 at 2:38 PM, the DON had not provided any skills check offs for CNAs #12, #13 or #14. 2. On 04/20/2026 at 3:46 PM, Resident #107 was lying in bed awake, and this surveyor observe hair on the resident's chin. Resident #107 was asked if staff members have offered to shave the from the chin and stated, No. On 04/21/2026 at 2:50 PM, Resident #107 was observed sitting up in bed awake. Hair was observed on the resident's chin. A review of the physician's orders for Resident #107 revealed a diagnosis of other specified forms of tremors and admit to long term care on 08/22/2025. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the care plan for Resident #107 revealed the resident required extensive assistance by staff with bathing/showering as scheduled and as necessary. The care plan indicated Resident #107 required assistance by staff with personal hygiene. A review of the quarterly MDS with an ARD of 01/23/2026 for Resident #107 revealed a BIMS of 09, which indicated moderate cognitive impairment and required substantial/maximal assist with shower/bath self and personal hygiene. A review of Resident #107's ADL bathing task revealed Tuesday and Friday were the resident's scheduled bath days. The bathing task revealed Resident #107 was showered on 4/17/26 and received a bed bath on 4/21/26. A review of the ADL task to check resident for facial hair and shave as needed revealed this task was completed on April 17th, 20th, and 22nd of 2026. There were no initials in the box to indicate which staff members completed this task. A review of Resident #107's progress notes for 4/21/2026 did not reveal any documentation of the resident refusing to have facial have shaved. On 04/22/2026 at 5:10 PM, Certified Nursing Assistant (CNA) #15 was interviewed and stated she knew what care Resident #107 needed by looking in the resident's closet. She stated she was also the Restorative aid and looked at the resident's closet care plan whenever she had to come to the floor to work. She stated the CNAs were responsible for bathing/showering Resident #107. She was asked to look at Resident #107's chin and she stated, We got stubble. I seen it this morning and I was gonna get it before I leave today. She stated the staff does check for facial hair on the resident's shower day and should be checked every day. She stated Resident #107 has never refused to be shaved to her knowledge. On 04/23/2026, the Director of Nursing provided a Follow Up Question Report for checking facial hair and shave as needed. The report revealed CNA #15 documented completing this task for Resident #107 on 4/22/2026 at 2:59 PM. On 04/23/2026 at 11:59 AM, the DON was interviewed and stated CNAs were responsible for checking and removing facial hair from residents during showers and as needed. She stated that anyone, nurses and CNAs could check residents for facial hair. She stated residents should not have to ask to be shaved and staff should ask the residents before shaving them. She stated CNAs should not document facial hair was removed when the tasks had not been done because this could cause other staff members to think the task was done and not check it. She stated her expectation for facial hair removal for residents was all CNAs should check for resident facial hair on shower days, when other care is given and address facial hair if doing perineal care.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, record review, and interviews, the facility failed to ensure a resident with self-administration rights had the ability to follow instructions to ensure medications were not left at the bedside on three different observations for one (Resident #125) of one resident with self-administration rights reviewed. The findings include: Review of Resident #125's Medical Diagnosis report revealed the resident had diagnoses which included respiratory failure, heart failure, and type 2 diabetes. Review of an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/20/2026 indicated the status of the assessment to be in progress. The MDS indicated Resident #125 was admitted to the facility on [DATE] and did not indicate the resident was on oxygen therapy. Review of Resident #125's Order Summary revealed an order for a beta2-agonist inhaler to be taken three times a day for acute respiratory failure with a start date of 04/15/2026, and an order for a corticosteroid inhaler two puffs to be taken twice a day for chronic obstructive pulmonary disease (COPD) with a start date of 04/20/2026. No order was found for self-administration rights. On 04/20/2026 at 12:25 PM, Resident #125 was observed resting in bed with eyes closed, the resident's oxygen concentrator was running and set to deliver two liters of oxygen via nasal cannula. Resident #125 was not wearing the nasal cannula to receive oxygen. An inhaled corticosteroid, used to reduce inflammation, swelling and mucous production in the lungs, and a beta2-agonist inhaler, used to relax airway muscles, were at the bedside unsupervised on the over the bed table. Resident #125 woke up and stated, they told me I could use my own inhalers. On 04/20/2026 at 3:15 PM, Resident #125 was lying in bed with eyes open. A lockbox with a key in the lock was observed resting on the over the bed table. Resident #125 could not remember when a lockbox was given but stated it contained the resident's prescription inhalers. On 04/21/2026 8:23 AM, Resident #125 was resting quietly with eyes closed, and was receiving two liters of oxygen via nasal cannula. The lockbox with key in the lock was lying on the over the bed table on the right side of the bed. During an interview on 04/21/2026 at 1:49 PM, Licensed Practical Nurse (LPN) #7 stated Resident #125 was approved for self-administration rights. LPN #7 was then observed looking up the Nursing Self-Administration Safety Screening in Resident #125's electronic record and stated on, 4/15/2026, had been approved to administer an inhaled corticosteroid and a beta2-agonist inhaler at the bedside unsupervised. LPN #7 revealed not being familiar with the policy for self-administration but knew Resident #125 had a key to a lockbox. I think it is to be stored in the bedside table without the key in it. LPN #7 said that self-administered medications should be stored in a lockbox without the key in the lock, and medications should never be left unattended on the over bed table, because there are (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents that wander and go into other resident rooms and they could take the medication. Resident #125 told me [the resident] took an inhaled corticosteroid this morning, so it was documented on the medication administration record [MAR]. During an interview on 04/22/2026 at 12:22 PM, the Director of Nursing (DON) said the process for approving self-administration rights is to have an assessment and if resident is cognitive with a positive BIMS score, we give them a lockbox to lock up their medications. The resident must demonstrate by walking us through using the medication. The DON stated the parameters were that medications just had to be stored in a locked lockbox. The DON revealed it would not be appropriate to leave a key in the lock and medications should never be left out on the over the bed table because we have other residents and it needs to be out of reach and locked away. The DON revealed the IDT team was made up of the DON, the MDS Coordinator, Administrator and all the managers. The DON revealed that after the MDS assessment was completed the IDT team met and agreed on giving Resident #125 self-administration rights. The DON stated she was unable to provide an in-service on self-administration. During a telephone interview on 04/22/2026 at 9:02 PM, LPN #8 stated we have not had any residents with self-administration rights before, but it would not be appropriate to store medications on the over the bed table, or in a lock box with the key in the lock because someone could wander in and get the mediations from the box and take them. LPN #8 could not remember having self-administration rights training. During an interview on 04/23/2026 at 9:44 AM, the Administrator (Admin) stated if someone wanted medications at the bedside, an assessment is done to see if the resident has the ability to self-administer medication safely. The Admin confirmed following instructions, storage, and being able to follow facility directions were part of self-administration. They [the resident] have to be able to read the directions and do it correctly. The Admin stated that facility administration preferred that medications be stored in the lockbox and placed in a drawer or bedside cabinet. The Admin confirmed the facility gave Resident #125 a lockbox, and it can be on the over the bed table as long as the lockbox is locked without a key in the lock because that is not secured. The Admin stated if a resident with self-administration rights left medications at the bedside the expectation would be that the resident was reassessed and re-educated to see if resident can self-administer medications safely. The Admin confirmed there could have been other residents that wandered into the room and taken the medications out of the room, taken, threw away or lost Resident #125's medications. During a second interview on 04/23/2026 at 10:34 AM the DON confirmed that Resident #125 was the facility's first resident with self-administration rights, and Resident #125 had never had orders for self-administration but stated I fixed it now. During an interview on 04/23/2026 at 11:38 AM, Certified Nursing Assistant (CNA) #10 stated if medications were found resting on the over the bed table it would be reported to the nurse immediately. CNA #11 stated residents were not allowed to have unstored medication out in the open in their rooms. Reviewed policy titled Medication, Self-Administration of, dated 11/22/2016, revealed residents that would like to self-administer have to be assessed by the interdisciplinary team [IDT] to ensure resident can store medication in their room out of the reach of other residents, can safely administer their medication. Failure for a resident to be able to follow policy for self-administration has to be reported immediately to the DON and/or physician.

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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. Number of residents sampled: Number of residents cited: Based on record review, interview, and facility policy review, the facility failed to report an allegation of mistreatment to the proper state agency for one (Resident #74) of two residents reviewed for an allegation of abuse. The findings include: A review of the abuse policy, dated as revised 10/18/2022, 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. The abuse policy indicated that all facility personnel, including all employees and any physician, the owner and Administrator, must immediately report all incidents of alleged, witnessed or suspected resident maltreatment, including abuse to the Administrator, or Administrator's designee, who will report events as required by State law or regulation. The abuse policy indicated all alleged violations will be reported immediately, but not later than two hours after the allegation is made, if abuse if involved or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury. During an interview on 04/20/2026 at 2:37 PM, Resident #74 was asked if any staff had been physically abusive towards the resident. Resident #74 stated, A lady liked to come in the room, waste time and hang out there and was not doing any work. I think she did hit me but that was so long ago that I forgot about it. That lady was out of line. I don't remember too much about it now. Resident #74 stated the incident was reported and, they took care of it. Resident #74 stated thinking, they got rid of her, she was unusual. A review of documents in a folder provided by the Administrator on 04/21/2026 for Resident #74 revealed a witness statement for the Director of Nursing (DON), who was the Assistant Director of Nursing (ADON) during the time of the incident per the DON witness statement, on 09/09/2025, Resident #74 reported a Certified Nursing Assistant (CNA), later identified as CNA #16, came to get the resident's tray and threw items from the resident's table on the bed with the resident. The DON's witness statement also indicated Resident #74 stated CNA #16 hit the resident on the butt, not hard, but continued to do that. The resident was unable to identify the CNA at that time. This folder also contained an in-service dated 09/11/2025 which covered the subject of Abuse and Neglect. On 04/21/2026 at 1:45 PM, the Administrator was asked to provide the reportable for the incident with Resident #74 on 09/09/2025. On 04/21/2026 at 1:57 PM, the DON was interviewed and stated Resident #74 reported the incident to Social Worker #19 and then she (the DON) went to Resident #74 to investigate the incident. She stated the date of her witness statement was when she was made aware of the incident, but she was not sure if SW #18 came to her and reported the incident happened, or if SW #18 stated Resident #74 wanted to speak with her. She stated the SW #18 told her the Resident #74 stated a toothbrush and other items had been tossed on to the resident's bed. The DON stated after the incident was reported (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to her, she reported it to DON #17. The DON stated she did report this incident to the Administrator. She stated she did not remember CNA #16's last name but did recall the CNA was terminated. The DON stated she thinks she and the Administrator interviewed CNA #16, but she did not document the interview and had no specific date, time, or information from that interview with CNA #16. She stated she recalled speaking with Resident #74 and the resident did not appear to be in any distress. She stated she believed in-services on abuse had been completed with the staff after the incident on 09/09/2025. On 04/21/2026 at 2:47 PM, the Administrator stated to the Team Coordinator she did not report the incident with Resident #74 on 09/09/2025 to the state agency. On 04/22/2026 at 9:35 AM, this surveyor unsuccessfully attempted to reach CNA #16 at the last known telephone number provided by the facility. A voice message was recorded with a request for CNA #16 to return this surveyor's call and a contact number was provided. As of 04/23/2026 at 2:38 PM, CNA #16 had not returned this surveyor's call. On 04/22/2026 at 9:43 AM, this surveyor unsuccessfully attempted to reach SW #18 at the last know telephone number provided by the facility. A voice message was recorded with a request for SW #18 to return this surveyor's call and a contact number was provided. As of 04/23/2026 at 2:38 PM, SW #18 had not returned this surveyor's call. On 04/22/2026 at 9:57 AM, DON #17 was interviewed by telephone and stated he did recall the incident with Resident #74. He sated he did not recall which staff member exactly informed him of the incident involving Resident #74 but that he did remember discussing the situation with my Administrator. He stated he could not recall when he was told on 09/09/2025. He stated he could not recall verbatim what he was told, but there was an incident of a CNA tossing some items on the bed and patting the resident on the behind. He stated he did not speak to Resident #74 but spoke with the Administrator after receiving this report but could not give an exact time. He stated he did not recall who the CNA was, but he was the one who suspended her. He stated he could not remember if CNA #16 returned to work or if he or the ADON [current DON] informed CNA #16 of her suspension. He was asked if staff were in-serviced on abuse after this incident with Resident #74 and he stated he could not recall but, I am sure that is protocol. On 04/23/2026 at 12:09 PM, the Administrator was interviewed and stated she believed she was made aware of the allegations made by Resident #74 on the 11th of September, but the resident told the staff the incident happened a couple of days earlier, on the 9th. She stated the DON [ADON at that time] may have reported the incident to her. She stated she spoke with Resident #74, and the resident stated the CNA [#16] had tossed some items on to the bed and the CNA [#16] would pat the resident's bottom. She stated she asked Resident #74 if the pat on the bottom was in a way to cause pain and the resident stated the pat didn't hurt. The Administrator stated after this allegation from Resident #74, a body audit was performed on Resident #74 and witness statements were obtained from other residents on the hall. She stated she was familiar with the facility's policy on abuse. She stated she did not report the allegation to the state agency because in her investigation it did not appear to be an allegation of abuse. She stated she was sure she spoke with CNA #16. She was asked if she documented the interview and stated, It would have been in here [referring to the folder with documents about the incident] if I documented it.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Number of residents sampled: Number of residents cited: Based on record review, interview, and facility policy review, the facility failed to maintain evidence an allegation of mistreatment was thoroughly investigated for one (Resident #74) two residents reviewed for an allegation of abuse. The findings are: A review of the abuse policy, dated as revised 10/18/2022, 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. The abuse policy revealed the Administrator or Administrative Designee will conduct an immediate investigation of all alleged, witnessed or suspected resident maltreatment, including abuse. The abuse policy indicated the investigator should consider interviews with the facility employees, victim resident, other residents, family members and other persons who may have knowledge of the incident. On 04/20/2026 at 2:37 PM, Resident #74 was interviewed and when asked if any staff had been physically abusive towards the resident, Resident #74 stated, A lady liked to come in the room, waste time and hang out there and was not doing any work. I think she did hit me but that was so long ago that I forgot about it. That lady was out of line. I don't remember too much about it now. Resident #74 stated the incident was reported and they took care of it. Resident #74 stated thinking they got rid of her, she was unusual. A review of documents in a folder provided by the Administrator on 04/21/2026 for Resident #74 revealed a witness statement for the Director of Nursing (DON), who was the Assistant Director of Nursing (ADON) during the time of the incident per the DON 's witness statement, on 09/09/2025, Resident #74 reported a Certified Nursing Assistant (CNA), later identified as CNA #16, came to get the resident's tray and threw items from the resident's table on the bed with the resident. The DON's witness statement also indicated Resident #74 stated CNA #16 hit the resident on the butt, not hard, but continued to do that. The resident was unable to identify the CNA at that time. On 04/23/2026 at 12:09 PM, the Administrator was interviewed and stated she believed she was made aware of the allegations made by Resident #74 on the 11th of September, but the resident told the staff the incident happened a couple of days earlier, on the 9th. She stated the DON may have reported the incident to her. She stated she spoke with Resident #74 and the resident stated CNA [#16] had tossed some items on to the bed and CNA [#16] would pat the resident's bottom. She stated she asked Resident #74 if the pat on the bottom was in a way to cause pain and the resident stated the pat didn't hurt. The Administrator stated after this allegation from Resident #74, a body audit was performed on Resident #74 and witness statements were obtained from other residents on the hall. She stated she was familiar with the facility's policy on abuse. She stated she was sure she spoke with CNA #16. She was asked if she documented the interview and stated, It would have been in here [referring to the folder with documents about the incident] if I documented it. The Administrator was asked if she interviewed other employees and she stated she did not and could not recall why she did not do this at that time.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Number of residents sampled: Number of residents cited: Based on record review and interview, the facility failed to ensure a significant change Minimum Data Set (MDS) was completed within 14 days from the effective date of the hospice service election for one (Resident #91) of two residents reviewed for Hospice services. The findings include: Review of the Centers for Medicare and Medicaid Services' (CMS's) Resident Assessment Instrument (RAI) Version 3.0 Manual, version 1.20.1 and dated October 2025, revealed a Significant Change in Status Assessment (SCSA) is required when a terminally ill resident enrolls in a hospice program, or changes hospice providers and remains a resident at the nursing home. The Assessment Reference Date (ARD) must be within 14 days from the effective date of the hospice service election. On 04/23/2026at 9:28 AM, Certified Nursing Assistant #14 was interviewed and stated Resident #91's baths were provided by the Hospice aids and stated she thought the Hospice aid came to the facility three days a week. A review of the Physician's Orders for Resident #91 located in the electronic health records did not reveal an order for Hospice services. A review of the Care Plan, with a completed review date of 03/16/2026, for Resident #91 indicated a focus problem of a terminal prognosis related to (r/t) a diagnosis of Parkinson and the revision date was 04/07/2025. A Care Plan intervention included [name of Hospice] were to provide a CNA up to five times weekly, a Registered Nurse weekly and as needed, Social Services monthly and as needed, a Chaplain monthly and as needed. Staff may collaborate with care as needed, and a contact number was listed for the hospice provider. This intervention was initiated on 04/20/2026. A review of quarterly MDS with an ARD of 02/20/2026, revealed Resident #91 had a BIMS of 04, which indicated severe cognitive impairment and was not receiving hospice care. A review of the Progress Notes for Resident #91 from 03/01/2026, through 04/24/2026, did not indicate any hospice notes during this time period. During an interview on 04/23/2026 at 11:17 AM, the MDS Coordinator stated she completed all MDS assessments for residents at the facility. She stated she had not completed a significant change MDS after Resident #91 was admitted to hospice because there was no physician's order in place to alert her. She reviewed Resident #91's physician's orders and stated there was an order to admit the resident to hospice services on 03/24/2026 but the order was not created in the system until 04/23/2026. She stated per the RAI manual, she had 14 days to review the resident's progress, and the assessment reference date would have been 04/07/2026. She stated when completing the MDS, she gathered information from staffing reviews, the social [worker] does assessments, nurse's notes, hospice notes and multiple sources in the chart. The MDS Coordinator stated the MDS was a snapshot in time that hopefully shows the most current status of residents and assists us in creating a plan of care for the residents to meet their needs and identify any changes to the resident. (continued on next page)

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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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/2026 at 11:41 AM, the Director of Nursing (DON) stated the nurse who was at work when [Resident #91] admitted to hospice [care] should have added an admission order for hospice. After reviewing Resident #91's electronic health records, the DON stated she did not know who the nurse had been when Resident #91 was admitted to the facility. In response to if the nurses were aware they were responsible for adding an order on admission to hospice the DON stated, I sure did think they knew that. It should be treated as any other order.

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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** Number of residents sampled: Number of residents cited: Based on observations, interviews, record review, and facility document review, it was determined the facility failed to develop and implement a comprehensive person-centered care plan reflecting a communication deficit of a nonverbal resident one (Resident #99) of one reviewed for comprehensive care planning. The findings include: During concurrent observation and interview on 04/21/2026 at 2:14 PM, Resident #99 was in their room sitting in a wheelchair with two family members present. Resident #99 was unable to move the right side of their body, including face/mouth due to a stroke and was nonverbal. Resident #99 did move the left hand to indicate numbers. The family members stated, no one at the facility knew sign language and they had never seen a staff member use a communication board or anything like that, but [staff] did ask yes/no questions. A review of Nursing Admit/Readmit/Quarterly Assessment dated 03/04/2026, indicated nonverbal Resident #99 was soft spoken and mouthed words. A review of Resident #99's admission Record on 4/21/2026, revealed the resident was admitted by the facility on 03/04/2026 with diagnoses which included nontraumatic intracerebral hemorrhage in brain stem, major depressive disorder, and anxiety disorder. A review of Resident #99's admission Minimum Data Set (MDS) dated [DATE], revealed resident had unclear speech, rarely/never makes themself understood and sometimes understood others, and responded adequately to simple, direct communication only. The MDS also indicated Resident #99's Brief Interview for Mental Status (BIMS) was 15, indicating the resident was cognitively intact. A review of Baseline Care Plan dated 03/04/2026, indicated Resident #99 did not communicate easily with staff. On 04/21/2026 at 2:00 PM, a review of Comprehensive Care Plan admission date of 03/04/2026, revealed a communication deficit with interventions was not initiated on admission. A review of Nursing Admit/Readmit/Quarterly Assessment dated 03/04/2026, indicated nonverbal Resident #99 was soft spoken, mouthed words. No other form of communication or language was expressed to indicate the resident used sign language communication. A review of Nursing Functional Abilities Admission dated 03/04/2026, indicated Resident #99 was dependent on staff for all ADLs except eating and oral hygiene, for which the resident required substantial/maximal assistance. A review of Progress Notes dated 03/04/2026 - 03/21/2026, revealed on 03/04/2026 at 3:15 PM (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #99 was described as being very soft spoken and nonverbal, with the ability to shake their head yes and no, and utilized sign language. A review of Advanced Practical Registered Nurse (APRN) Progress Note dated 03/05/2026, indicated Resident #99 communicated by nodding/shaking head appropriately to questions. A review of Social admission Assessment and Note dated 03/05/2026, indicated nonverbal Resident #99's speech was clear; and used sign language as other modes of communication. The assessment indicated the resident rarely or never was able to make themselves understood but had the ability to understand others. A review of Speech-Language Pathologists (SLP) Evaluation and Plan of Treatment dated 04/13/2026, indicated Resident #99 verbalized understanding of by nodding head yes/no with communication skills being impaired. During an interview on 04/22/2026 at 9:23 AM, Certified Nursing Assistant (CNA)#3 stated she communicated to a nonverbal resident by talking to them like everyone else. She stated, I would think they would have a card or something for us to use. CNA #3 stated she communicated with Resident #99 with yes/no questions, the resident would use the left hand to make numbers, and the resident pointed to where something hurt. CNA #3 stated Resident #99 did not talk or make any sound. CNA #3 stated Resident #99 used sign language, but the CNA did not know sign language and could not communicate that way. During an interview on 04/22/2026 at 9:45 AM, CNA #4 revealed Resident #99 was nonverbal and the CNA communicated with the resident by looking at body language and facial cues. CNA #4 stated she did not know sign language and could not communicate with the residents that way. During an interview on 04/22/2026 at 1:42 PM, Licensed Practical Nurse (LPN)#5 stated she talked to nonverbal residents the same as she would verbal residents. LPN #5 indicated she would let the residents know what she was there for and what she was going to do. She stated she looked for facial expressions to read what they felt. LPN #5 stated she knew minimal sign language. LPN #5 indicated she had not seen any communication boards or knew of any interventions for communication with a nonverbal resident at this facility. During an interview on 04/22/2026 at 2:08 PM, Registered Nursing Assistant (RNA) #6 stated she had to get to know a nonverbal resident to know how to understand them such as eye contact. RNA #6 indicated she did not know sign language, and [the facility] used to have a paper that had happy/sad faces on it but hadn't seen it in a while. RNA #6 stated she had no idea if a communication deficit was on Resident #99's care plan. During an interview on 04/23/2026 at 8:35 AM, the MDS Coordinator stated when a resident that is nonverbal was admitted , if addressed correctly speech would have triggered a communication deficit on the resident's comprehensive care plan. She stated if this was triggered, a BIMS would not be completed due to the resident being nonverbal, and again a communication deficit would have been initiated on the care plan. The MDS Coordinator stated the care plan was a live document with multiple staff that made changes on it, using an interdisciplinary team (IDT) approach. She stated for the hearing, speech, and vision portion of the care plan would have been initiated by the admission nurse . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/2026 at 9:33 AM, the Director of Nursing (DON) stated, a nonverbal resident such as Resident #99 should have had a communication deficit with interventions on the comprehensive care plan at admission, but it was not on there. The DON stated the MDS coordinator was currently working on [correcting] it. During an interview on 04/23/2026 at 10:00 AM, the Administrator stated the admission nurse did an immediate plan of care when a resident was admitted . The Administrator stated a communication deficit for a nonverbal resident such as Resident #99 was important and should have been included on their person-centered care plan as a deficit with interventions. The Administrator indicated that with [the interventions] not being on the care plan, the staff in the facility would not have any formal instructions on how to communicate with a resident that was nonverbal or what was planned for that specific resident. She indicated interventions depended on each resident but for nonverbal they would include pictures, getting family recommendations and speech therapy. The Administrator stated, that it was a valid concern that Resident #99's person centered care plan did not have communication deficit interventions. After completion of the interviews on 04/23/2026 at 10:33 AM, a review of Resident #99's Comprehensive Care Plan with a revision date of 04/23/2026, indicated Resident #99 had a communication problem related to late effects of nontraumatic intracerebral hemorrhage with interventions to anticipate and meet needs; be conscious of resident position when in groups, activities, and dining room to promote proper communication with others; encourage resident to continue stating thoughts even if resident is having difficulty; monitor for/record confounding problems,; monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed; monitor/document frustration level; monitor/document residents ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend; monitor/document/report as needed changes in ability to communicate; speak on an adult level, speaking clearly and slower than normal; validate resident's message by repeating aloud. During a second interview on 04/23/2026 at 1:44 PM, the Director of Nursing (DON) stated the facility did not have a policy for care plans, comprehensive care plans, communication, or communicating with nonverbal residents.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Number of residents sampled: Number of residents cited: Based on observations, record reviews and interviews, the facility failed to utilize appropriate equipment during resident transfers for one (Resident #36) of three residents reviewed for accidents to ensure residents were not put at risk for injury. Specifically, staff transferred a resident without using a gait belt resulting in a fall with knee abrasion. The findings include: Review of a Medical Diagnosis Report revealed Resident #36 had diagnoses which included left lower leg blood clot, stage 4 kidney disease and type 2 diabetes. Review of Resident #36's admission Minimum Data Set (MDS) with an Assessment Reference Date of 02/02/2026 revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS also indicated Resident #36 had one fall in the last 2-6 months. Review of an unwitnessed Incident and Accident Report, dated 03/19/2026, Resident #36 slid out of a wheelchair while trying to pick a ring up from the floor. Resident #36 had no injuries. Review of witnessed Incident and Accident Report, dated 4/06/2026, Resident #36 stated her legs just gave away and Resident #36 was assisted to the floor without injury. The Resident was assisted back to wheelchair with gait belt and assistance of two staff members. Reviewed witnessed Incident and Accident Report, dated 4/15/2026, revealed during transfer onto the toilet Resident #36's legs gave out and they assisted resident to the floor. LPN #8 revealed during transfer to the toilet Resident #36 legs buckled and resident was assisted to the floor. An abrasion was noted to the right knee cap. Resident #36 stated that the MA-C #1 and CNA #2 did not use a gait belt during transfer and it could have prevented her falling. Predisposing factor was documented during transfer, improper equipment utilized during transfer. Review of Resident #36's Care Plan revealed the resident was at high risk for falls related to gait and balance problems, and had limited mobility related to weakness. The Care plan also included that Resident #36 was non-weight bearing to the left lower extremity and required assistance of 2 staff members with all transfers. Care Plan interventions initiated 04/06/2026 included to anticipate needs of the resident, and ensure the call light was in reach, and encourage resident to use it. Other interventions initiated on 04/07/2026 indicated to monitor, document and report as needed signs and symptoms of impaired mobility, contractures, fall related injuries, thrombus formation, and to make physical therapy and occupational therapy referrals as needed. The Care Plan indicated Resident #36 had experienced two falls: a witnessed fall without injuries on 4/06/2026, and a witnessed fall with minor injuries on 4/15/2026. After the fall on 04/15/2026 the Care Plan indicated an intervention of 1:1 education with staff. During an interview on 04/20/2026 at 1:10 PM, Resident #36 stated I have neuropathy so I cannot feel anything and early in the morning of 04/15/2026, Medication Administration- Certified [MA-C] #1 and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant (CNA) #2 assisted Resident #36 to a standing position in the bathroom to pivot to the toilet and Resident #36 fell forward and both knees came up under resident. Resident #36 revealed MA-C #1 and CNA #2 were not using a gait belt and were trying to get Resident #36 to stand up on the right leg and hang onto the bars on the bathroom wall and the right leg collapsed resulting in resident falling to the knees. [MA-C #1] went and got a gait belt and had me put my arms around his shoulders and helped me get into the wheelchair. During an interview on 04/22/2026 at 9:53 AM, Licensed Practical Nurse (LPN) #7 revealed Resident has had 1-2 falls at the facility during the 7:00 PM-7:00 AM shift, LPN #7 was told Resident #36 fell in the bathroom while transferring to the toilet. Resident #36's knees buckled and she went down. LPN #7 revealed Resident #36 was non weight bearing on the left leg and required two-person assistance and a gait belt for transfers. LPN #7 said she did not know if staff were using a gait belt when Resident #36 fell. During a telephone interview on 04/22/2026 at 9:02 PM, LPN #8 revealed two aids were trying to transfer Resident #36 from the wheelchair to the toilet and did not use a gait belt. The resident's legs were given out, and Resident #36 fell to the floor. LPN #8 stated gait belts were part of the CNA uniform. Every resident is care planned for a gait belt. LPN #8 confirmed MA-C #1 and CNA #2 did not use a gait belt, and she did not remember seeing them wearing one, there are extras that they could have borrowed, or they could have asked to use someone else's. LPN #8 indicated the aides did not explain why they did not use a gait belt. LPN #8 stated typically Resident #36 was non weight bearing on the left leg, so Resident #36 needed two people to transfer. LPN #8 indicated everyone was to use a gait belt with any and all transfers to prevent falls. During a telephone interview on 04/22/2026 at 9:15 PM, MA-C #1 stated during morning get ups Resident #36 was assisted to a wheelchair and was asked to use the bathroom. Resident #36 was wheeled into the bathroom and asked to wait while CNA #2 was asked to help transfer Resident #36 to the toilet. In report staff were told Resident #36 could pivot her good leg (right), so we stood Resident #36 up to pivot to the toilet and MA-C #1 and CNA #2 both forgot to use the gait belt. Resident #36's legs collapsed, and CNA #2 caught the resident. Resident #36 wrapped arms around CNA #2's neck and MA-C #1 provided support from behind. CNA #2 and MA-C #1 got Resident #36 standing and holding onto the grab bar on the wall. When lowering residents' pants, we noticed an abrasion on the right knee, so we contacted LPN #8. MA-C #1 stated, Resident #2 hit the right knee on the wall, in the bathroom and did not fall to the floor. CNA #2 and I (MA-C #1) were in-serviced on using a gait belt, and we were both written up. MA-C #1 stated the facility had a policy of using a gait belt with every resident transfer, every time. This surveyor was unable to reach CNA #2 for an interview. During an interview on 04/23/2026 at 8:54 AM, the Director of Nursing (DON) stated she expected staff to transfer residents safely using a gait belt, and it would not be appropriate to transfer a resident without a gait belt if they were a fall risk. The DON stated, If staff needs to transfer someone that is a two person assist and needs a gait belt, but cannot find someone the expectation would be that they would wait until they could find someone that could help to prevent falls. The DON stated they would check to see if there was a gait belt policy and provide a CNA job description, but the facility did not have a fall policy. During an interview on 04/23/2026 at 9:39 AM, the Administrator stated staff transferring a resident who needs assistance should use two staff members and a gait belt for transfers for resident safety. I expect CNAs to have a gait belt at all times, and if a CNA cannot find another CNA to assist with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfers, then a nurse should help, or they should wait until someone is available. The Administrator stated employees were trained to use a gait belt on hire with demonstrations, with yearly education and we do spot checking. Gait belts are used for the safety of the residents, because they would be at risk for falls. During an interview on 04/23/2026 at 11:30 AM, Occupational Therapy Assistant [OTA] #9 confirmed they were familiar with Resident #36, and stated the resident required two staff and a gait belt for transfers. During a dual interview on 04/23/2026 at 11:38 AM, CNA #10 and CNA #11 revealed there was training on different subjects every month and they were in-serviced on gait belts when hired and several times a year. CNA #10 stated it was never okay to transfer a resident who was a fall risk without using a gait belt. CNA #11 indicated it had never been a policy that one person could transfer a resident without using a gait belt, and CNAs were expected to always wear a gait belt. Review of a Certified Nursing Assistant Job Description, dated 11/22/2016, revealed [CNAs were] to provide care to residents under licensed nurse supervision. This is a safety sensitive position. They must complete the education offered by the facility, be flexible and professional. Assuring resident safety and following established performance standard policies and performing duties according to nursing policies and procedures is a responsibility. They are to assume personal responsibility for following facility procedures. Review of a staff in-service dated 04/15/2026 revealed Gait belts are to be used with every single transfer when assistance is needed, no exception. Review of a 1:1 in-service signed by MA-C #1 and CNA #2 presented by the DON on 04/15/2026, indicated gait belts were to be used with every transfer when assistance was needed, without exception Review of Disciplinary Warning Notice: dated 4/16/2026, revealed MA-C #1 and CNA #2 received a first warning for improper transfer, no gait belt in use. Counselling was provided by DON. Review of competencies for gait belt training indicated MA-C #1 completed training on 04/16/2026, and CNA #2 completed gait belt competency training on 01/05/2025. Review of a policy titled Gait Belts, use of, dated 11/22/2016, revealed gait belts are to be used for resident transfers from sit to stand, sit to sit or stand to sit or for resident ambulation that requires assistance. Review of a policy titled Incident and Accident Policy, revised, 11/22/2017 revealed all incidents and accidents in this facility or its premises will be investigated and must be reported to the administrator and director of nursing.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, record reviews and interviews, the facility failed to ensure scheduled orders for oxygen therapy were active before administering oxygen to a resident and failed to ensure respiratory care services in accordance with resident preferences to have humidified water for comfort, affecting one (Resident #125) of one resident reviewed for respiratory care. Specifically, Resident #125 was without humidified water for nasal comfort over three days, and on day two an empty humidified water bottle was dated 4/21/2026 when oxygen storage bag and tubing were replaced. The findings include: Review of a Medical Diagnosis report revealed Resident #125 had diagnoses which included respiratory failure, heart failure, and diabetes type II. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/20/2026 indicated the MDS was in progress. The MDS indicated Resident #125 was admitted to the facility on [DATE] but did not indicate the resident was receiving oxygen therapy. Review of Resident #125's Oxygen [O2] [Saturation] Summary, revealed Resident #125 was on oxygen from 04/14/26- 04/16/2026, and from 4/20/206-04/22/2026.One entry dated 4/20/2026 revealed Resident #125's pulse oximetry was at 97% at 2 liters of oxygen via nasal cannula. Review of an Order Summary report, for Resident #125, dated 04/15/2026, revealed an order to change oxygen tubing and filter every Tuesday night. Review of Resident #125's Medication Administration Record/Treatment Administration record revealed oxygen 2-4 liters [via] nasal cannula as needed as an unscheduled other order. Review of Resident #125's Order Summary report, revealed an active order for Oxygen 2-4 liters [via] nasal cannula was placed on 04/15/2026, but there was no start date On 04/20/2026 at 12:25 PM, Resident #125 was observed resting in bed with eyes closed, the resident's oxygen concentrator was set on two liters with nasal cannula attached; the resident was not wearing oxygen tubing. The tubing was stored in a bag dated 04/14/2026, and the humidified bottle was undated. Upon waking, Resident #125 stated their nose was very dry and there was not any water left in the humidifier bottle. I asked someone change out the water bottle. The resident was unable to identify who the request had been made to. On 04/20/2026 at 3:15 PM, this surveyor observed an undated empty humidifier bottle. Resident #125 revealed wishes that the bottle of water with oxygen would be changed out and [the lack of] was causing the resident's nose to be too dry. On 04/21/2026 at 8:23 AM, Resident #125 was resting quietly, with eyes closed, receiving two liters (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of oxygen. The humidifier bottle was observed to be undated and empty. During an interview on 04/21/2026 at 1:44 PM, Licensed Practical Nurse (LPN) #7 looked in the electronic record and stated Resident #125's oxygen was increased to 4 liters because Resident #125 was struggling to breath even with an inhaler. LPN #7 confirmed Resident #125 had an order present for 2-4 liters of oxygen since 04/15/2026. LPN #7 revealed the order did not show as scheduled and there was not an active date. On 04/22/2026 at 1:14 PM, Resident #125 was resting quietly, receiving two liters of oxygen via nasal cannula. This surveyor observed tubing and storage bag dated 04/21/2026, and an empty bottle of humidified water dated 04/21/2026. During an interview on 04/22/2026 at 1:25 PM, LPN #7 stated oxygen tubing and humidified water bottles were changed on Tuesday nights. LPN #7 accompanied surveyor to Resident #125 bedside and asked LPN #7 to looked at the oxygen tubing and LPN #7 stated that the tubing and humidified water bottle were changed last night and dated 4/21/2026. Surveyor asked LPN #7 to check the humidified water bottle and LPN #7 said, the humidified water bottle is empty. LPN #7 checked the concentrator and stated Resident #125 is on 2 liters so the humidified water bottle should not be empty but said that LPN #7 suspected someone may have dated the empty bottle and not changed the humidified water bottle out last night. LPN #7 said that the humidified water bottle should have been changed out to provide moisture to Resident #125's nose. Resident #125 told the surveyor and LPN #7 that the water bottle on the concentrator has been empty since Monday, and that their nose was still, very dry. During an interview with Administrator [Admin] on 04/23/2026 at 9:51 AM, the Admin revealed an expectation for nursing when changing out the tubing and humidified water to follow the doctors' orders and change the tubing and humidifier bottle out on Tuesday evenings. The Admin said if the humidified water bottle is empty staff should change it out, even if it is not Tuesday evening to add moisture to a resident's nose. On 4/23/2026 at 1:44 PM, the Director of Nursing [DON] revealed there is not a policy on oxygen tubing and storing or humidified water bottles. The DON said her expectation is humidified water bottles will be changed on Tuesday evenings when the tubing in changed out, or if the humidified water bottle is empty. On 04/23/2026 at 11:38 AM, CNA #11 said if a resident complained their humidified water bottle was empty and their nose was dry CNA #11 would report that to the nurse immediately. CNA #10, who was also present, said that she agreed and would also report to the nurse. Reviewed policy titled Oxygen Safety dated 11/22/2016, revealed the facility will properly handle oxygen, and did not cover equipment. A review of an online article titled AARC Clinical Practice Guideline: Management of Adult Patients With Oxygen in the Acute Care Setting, dated January 2022 for the standards of practice regarding residents wearing humidified oxygen sense less discomfort of the nares than residents that wear no humidified oxygen.