STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445320	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk River Health & Rehabilitation of Fayetteville	4081 Thornton Taylor Parkway Fayetteville, TN 37334

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, medical record review, and interview, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for two residents (Resident #1 and Resident #29) related to anticoagulant use and two residents (Resident #6 and Resident #28) related to Level II PASARR (Pre-admission Screening and Resident Review) of 15 MDS assessments reviewed.The findings include: Review of the MDS 3.0 Resident Assessment Instrument (RAI) [NAME] Version 19.1, dated 10/2024, revealed instructions .Health-related Quality of Life .residents covered by Level II PASRR .process may require certain care and services provided by the nursing home .Steps for Assessment .Code .yes .if PASRR Level II screening determined that the resident has a serious mental illness .High-Risk Drug Classes: Use and Indication Do not code antiplatelet medications such as aspirin .or clopidogrel [antiplatelet medication that prevents blood clots] as anticoagulant [blood thinner] medications . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Diabetes, and History of a Stroke with Paralysis. Review of current Physician Orders revealed .clopidogrel .Tablet, 75 mg [milligram] daily .aspirin .81 mg . Further review revealed Resident #1 did not have an order for an anticoagulant medication. Review of the Medication Administration Record (MAR) for Resident #1 dated 7/1/2025-7/31/2025, revealed Resident #1 did not receive an anticoagulant medication. Review of a quarterly MDS assessment dated [DATE], revealed Resident #1 received an anticoagulant medication. Review of the medical record revealed Resident #29 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Traumatic Subarachnoid Hemorrhage, and History of Transient Ischemic Attack. Review of current Physician Orders, revealed .Clopidogrel .75 mg .daily . Further review revealed Resident #29 did not have an order for an anticoagulant medication. Review of the MAR for Resident #29 dated 6/1/2025-6/30/2025 revealed the resident did not receive an anticoagulant medication. Review of an admission MDS assessment dated [DATE], revealed Resident #29 received an anticoagulant medication. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Anxiety Disorder, Major Depressive Disorder, and Schizoaffective Disorder, Bipolar Type. Review of a PASRR dated 6/24/2024, revealed Resident #6 had a PASRR Level 2 Outcome related to a serious mental illness (Schizoaffective Disorder). Review of an annual MDS assessment dated [DATE], revealed Resident #6 scored a 12 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed the resident was not coded for a PASRR Level 2 Outcome. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, and Depression. Review of a PASRR dated 9/21/2023, revealed Resident #28 had a PASRR Level 2 Outcome related to a serious mental illness (Bipolar Disorder). Review of an annual MDS assessment dated [DATE], revealed Resident #28 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident was not coded for a PASRR Level 2 Outcome. During an interview on 9/10/2025 at 12:32 PM, the MDS Coordinator stated (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
	445320	A. Building B. Wing	09/10/2025

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents #1 and #29 had not received an anticoagulant medication and Residents #6 and #28 had a serious mental illness. The MDS Coordinator confirmed the assessments for Residents #1, #29, #6, and #28 were inaccurate.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview the facility failed to revise the care plan for 1 resident (Resident #27) of 15 residents reviewed for care plans.The findings include: Review of the facility's policy titled, Goals and Objectives, Care Plans, revised 4/2009, revealed .Care plans will be modified accordingly .Are resident orientated .meet .resident's needs in accordance with the comprehensive assessment .objectives are entered .resident's care plan so that all disciplines have access to .information .are reviewed and revised .change in the resident's condition . Review of the medical record revealed Resident #27 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Diabetes, and Hypertension. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #27 scored 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed Resident #27 required partial/moderate assistance with eating. Review of the comprehensive care plan for Resident #27 revised 8/15/2025, revealed .Resident is independent with eating at this time . During an interview on 9/8/2025 at 2:25 PM, Certified Nursing Assistant (CNA) D stated Resident #27 was dependent upon staff with eating. During an interview on 9/9/2025 at 7:46 AM, Licensed Practical Nurse (LPN) E stated Resident #27 was dependent upon staff with eating. During an interview on 9/10/2025 at 12:19 PM, LPN MDS Coordinator confirmed Resident #27's care plan had not been revised to reflect the resident was dependent on staff with eating. During an interview on 9/10/2025 at 12:20 PM, the Director of Nursing confirmed Resident #27's care plan had not been revised to reflect the resident was dependent on staff with eating.