STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045220	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fayetteville Health and Rehabilitation Center	3100 Old Missouri Rd Fayetteville, AR 72703

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. Based on record review, interview, and facility policy review, the facility failed to ensure one (Resident #94) of one sampled resident received an ordered medication, and to ensure a physician's order was followed for one (Resident #4) of one sampled resident. The findings include: Resident #94 A review of Resident #94's Resident Face Sheet indicated the facility admitted the resident on 12/30/2019 with diagnoses which included unspecified intellectual disabilities, depression, and generalized anxiety disorder. A review of Resident #94's quarterly minimum data set with an assessment reference date of 07/14/2025, revealed a staff assessment for mental status score of 03, which indicated the resident was severely cognitively impaired and never/rarely made decisions A review of Resident #94's September Physician Orders documented, [Name Brand Contraceptive] administer 150mg intramuscularly every three months. Once a day on the 29th of every 3rd month, start date 03/31/2025. The medication was used to induce amenorrhea [the absence of monthly periods]. A review of Resident #94's Medication Administration Record (MAR) for the month of June did not indicate the [Name Brand Contraceptive] injection was administered. During an interview on 09/24/2025 at 1:30 PM, Licensed Practical Nurse (LPN) #10 indicated that Resident #94 received a [Name Brand Contraceptive] injection on 03/29/2025, but did not receive the scheduled injection in June. LPN #10 then stated that Resident #94's next [Name Brand Contraceptive] injection was scheduled to be administered in September. LPN #10 revealed she did not know why Resident #94 did not receive the ordered injection in June. During an interview on 09/24/2025 at 3:00 PM, the Director of Nursing (DON) indicated she ordered the [Name Brand Contraceptive] in March and she was not sure why Resident #94 did not get the ordered June injection. The DON revealed any of the nurses could order the [Name Brand Contraceptive] injection, and that Resident #94 did not receive the June dose, because it was not ordered. She stated the [Name Brand Contraceptive] shot should be scheduled with the pharmacy. The DON revealed the injection was reordered for September, and Resident #94's guardian was aware. The DON indicated that an in-service was not completed after the facility determined that Resident #94 did not receive the ordered [Name Brand Contraceptive] injection. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/24/2025 at 4:00 PM, the Medical Director indicated that Resident #94 should receive a [Name Brand Contraceptive] injection every three months, to maintain the medication's effect. During an interview on 09/25/2025 at 10:46 AM, the Administrator indicated staff should follow physician orders and make sure the medications are documented on the MAR. A review of a policy titled, General Dose Preparation and Medication Administration, indicated to document medications when they are given, injection site of the medication, and if medications are refused. Resident #4 A review of Resident #4's Physician Orders revealed an order, dated 10/09/2025 with an open-ended end date, for the resident's HOB to be positioned at 30-45 degrees while in bed. A review of Resident #4's Care Plan revealed an intervention of Head of bed elevated, created on 10/14/2024. A review of Resident #4's annual Minimum Data Set (MDS) with an assessment reference date of 09/26/2025, revealed a staff assessment for mental status score of 03, which indicated Resident #4 was severely cognitively impaired and never/rarely made decisions. The resident's MDS also indicated Resident #4 was dependent on staff for bed mobility, with the helper doing all of the effort. During an observation on 09/22/2025 at 3:00 PM, this surveyor observed Resident #4 lying flat on their back while in bed, with the Head of Bed (HOB) not elevated, as ordered. During an observation on 09/22/2025 at 4:47 PM, this surveyor observed Resident #4 lying flat on their back while in bed, with the HOB not elevated, as ordered. During an observation on 09/23/2025 at 8:30 AM, this surveyor observed Resident #4 lying flat on their back while in bed, with the HOB not elevated, as ordered. During an observation on 09/23/2025 at 3:14 PM, this surveyor observed Resident #4 lying flat on their back while in bed, with the HOB not elevated, as ordered. During an observation on 09/25/2025 at 8:00 AM, this surveyor observed Resident #4 lying flat on their back while in bed, with the HOB not elevated, as ordered. During an interview on 09/23/2025 at 3:28 PM, CNA #6 stated, I mainly work on the shower team, but I am helping out on the floor today [09/23/2025] since showers are done. CNA #6 revealed they had worked at the facility for five years and had received trainings on caring for a resident with a feeding tube, providing perineal care, keeping the tubing for the feedings clean, and making sure the feeding tubing was clamped and if it was not, to were to notify the nurse. Resident #4 was observed lying in their bed with the HOB not elevated, during the interview. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/24/2025 at 10:15 AM, Licensed Practical Nurse (LPN) #3 said Resident #4 should never be allowed to sleep or lay flat on their back, the HOB should be elevated. LPN #3 stated the resident's guardian requested the resident's HOB be elevated while the resident was in bed. LPN #3 looked at Resident #4's Physician Orders, and confirmed the order dated 10/09/2024, instructed for the resident's HOB to be elevated to 30-45 degrees, while in bed. During an interview on 09/24/2025 at 10:25 AM, the MDS Nurse confirmed Resident #4's Physician's Order specified the residents HOB should be raised 30-45 degrees, while in bed. The resident's Care Plan stated, HOB elevated, but did not specify a degree. The MDS Nurse said Resident #4's Care Plan did not include the Physician's Order for the HOB to be elevated while the resident was in bed. During an interview on 09/24/2025 at 12:00 PM, the Director of Nursing (DON) said the Physician's Order and Care Plan should be followed by the facility staff when providing care to any resident. The DON reviewed Resident #4's Physician Order and confirmed the order required the resident's HOB to be elevated at 30-45 degrees, while in bed. The DON then said, if the HOB was not elevated; the resident could aspirate. During an interview on 09/24/2025 at 12:30 PM, the Administrator said they expected the staff to follow the Physician's Orders and Care Plan when providing care to any resident. During an interview on 09/24/2025 at 2:54 PM, the Medical Director (MD)/Physician stated any resident who received bolus feedings, should have their HOB elevated when lying in bed, so they would not aspirate or regurgitate. The MD said they were familiar with Resident #4 and with their order for their HOB to be elevated 30-45 degrees, while in bed. The MD then confirmed Resident #4's HOB should be elevated at 30-45 degrees, and their expectations of the staff at the facility was that the Physician Orders be followed word for word.