STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045371	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Health and Rehab, Inc	802 S West End Street Springdale, AR 72764

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews, and record review, the facility failed to ensure a resident was free from resident-to-resident abuse for 1 (Resident #44) of 3 sampled residents reviewed for abuse. The lack of effective behavior monitoring resulted in Resident #44 having resident to resident abuse that occurred on 04/11/2024, 04/19/2024, 07/10/2024, 08/06/2024, 08/12/2024, 12/07/2024, 12/20/2024, 12/25/2024, and 01/09/2025. Of those incidents, Resident #9 was the physical aggressor for 3 instances. On 12/07/2024, Resident #9 hit Resident #44 in the stomach. On 12/20/24, Resident #9 pushed resident #44, resulting in the resident falling. On 01/08/2025, Resident #9 pushed Resident #44, resulting in the resident falling. Resident #44 was sent to the emergency room and was found to have a fractured hip. All of the other incidents were completed by other residents on the locked unit and Resident #44 had been kicked, hit in the face, hit in an unknown area, pushed, punched in the hand, struck in the hand, and hit in the head. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.12 (Freedom from Abuse, Neglect, and Exploitation) at a scope and severity of J. The IJ began on 12/07/2024 at 10:59 PM, when Resident #44 was punched in the stomach by Resident #9. The Administrator, Director of Nursing, Nurse Consultant, and Director of Operations were notified of the IJ on 01/29/2025 at 10:28 AM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 01/29/2025 at 3:54 PM. The IJ was removed on 01/31/2025 after the survey team performed onsite verification that the Removal Plan had been implemented. The findings are: A review of the facility Abuse Prevention, revised 11/16/2017 revealed during abuse investigations, Allegations involving residents will require assessment and appropriate interventions to protect the victim and other residents. Interventions may include temporary one-on-one supervision, transfer to another level of care or discharge to a family member/responsible party. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of OLTC Incident and Accident Report (I&A) indicated on 01/08/2025, Resident #9 pushed Resident #44 into a wall. Resident #44 grabbed at their hip as if the resident was in pain. Both residents resided in the Alzheimer ' s unit. Resident #44 had a hip fracture as a result of this incident. The findings of the facility ' s investigation indicated, The facility can not substantiate this allegation of abuse as both residents involved are mentally deemed to have no capacity and there was no intentional means of abuse. A review of State Operations Manual Appendix PP, F600 indicates, Willful actions include, but are not limited to, the following: hitting, slapping, punching, choking, pinching, biting, kicking, throwing objects, grabbing, shoving .The action itself was deliberate or non-accidental, not that the individual intended to inflict injury or harm . Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. A review of the admission Record, indicated the facility admitted Resident #44 with diagnoses that included dementia with agitation, disorientation, insomnia, restlessness and agitation. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/9/2024, revealed Resident #44 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated moderately impaired cognitive skills for daily decision making. Resident #44 showed physical behavior symptoms directed towards others as well as wandering. Resident #44 was able to ambulate independently. A review of Resident #44 ' s care plan initiated on 03/08/2024, revealed the resident needed a secured/special care neighborhood due to dementia. The following was listed: - 04/11/2024: Physical aggression received - 04/19/2024: Physical aggression received - 07/10/2024: Physical aggression received - 08/06/2024: Physical aggression received - 08/12/2024: Physical aggression received - 08/21/2024: Physical aggression initiated - 12/07/2024: Physical aggression received - 12/20/2024: Physical aggression received - 12/25/2024: Physical aggression received - 01/09/2025: Physical aggression received (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility developed interventions that included to encourage the resident to fold laundry or take care of a baby doll when noted wandering in other resident ' s rooms, numerous interventions in place for other resident, and the resident was to be placed on 1 on 1 observation on 08/21/2024. Further review of the care plan indicated Resident #44 lacked capacity to understand and make decisions. The resident also exhibited behaviors of wandering into other residents ' rooms. A review of the admission Record, indicated the facility admitted Resident #9 with diagnoses that included dementia, autistic disorder, psychosis, cognitive communication deficit, and schizophrenia. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/23/2024, revealed Resident #9 had a Brief Interview for Mental Status (BIMS) score of 00 which indicated severe cognitive impairment. Resident #9 was not documented as having physical or verbal behavior symptoms directed toward others. Resident #9 had no impairments to upper or lower extremities and was able to independently ambulate. A review of Resident #9 ' s Care Plan initiated on 10/26/2024, revealed the resident needed a secured/special care neighborhood. Interventions included: administering and monitoring the effectiveness and side effects of medications as ordered, medication review with antidepressant increased, kept one-on-one observation until discharge, and to support resident ' s needs to spend time in room in self-direct pursuits. A review of facility incident and accident reports for the last twelve months for Resident #9 indicated on 12/7/2024, Resident #9 punched another resident in the stomach. On 12/20/2024, another resident wandered into Resident #9 ' s room, resulting in Resident #9 pushing the other resident, making the resident fall to the floor. On 1/8/2025, Resident #9 pushed another resident. A review of facility incident and accident reports for the last twelve months for Resident #44 indicated on 04/11/2024, Resident #44 was pushed down to the ground by another resident. On 4/19/2024, Resident #44 was kicked by another resident. On 7/9/2024, Resident #44 was smacked in the face by another resident. On 08/06/2024, Resident #44 was pushed to the floor by another resident. On 08/12/2024, Resident #44 ' s left hand was stuck with a closed fist by another resident. On 08/21/2024, Resident #44 hit another resident. On 12/7/2024, Resident #44 was punched in the stomach. On 12/20/2024, Resident #44 was pushed by another resident, causing Resident #44 to fall. On 12/25/2024, Resident #44 was hit in the head by another resident. On 1/8/2025, Resident #44 was pushed to the floor by another resident and appeared to be in severe pain and was sent to the emergency room. A review of Resident #44 ' s hospital records indicated on 01/09/2025, the resident was admitted to the hospital related to a fall with left hip pain and was diagnosed with a left femur fracture and required surgery. During an interview on 01/28/2025 at 2:00 PM, Certified Nursing Assistant (CNA) #13 was in Resident #44 ' s room and stated the resident was not aggressive but at times, the resident takes things that belong to other residents, which agitates those residents resulting in pushing Resident #44. CNA #13 stated Resident #44 did fall and break their hip and did not walk anymore and uses a wheelchair for mobility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/28/2025 at 2:16 PM, the Director of Nursing (DON) stated Resident #44 was sent to the hospital because the resident was touching another resident who had autism. The DON stated Resident #44 used to be a CNA and likes to pick up things and was trying to pick things up in the other resident ' s room. This resulted in the other resident pushing Resident #44, causing the resident to fall. The DON stated the other resident no longer resided in the facility. During an interview on 01/29/2025 at 8:20 AM, CNA #2 stated Resident #44 was not aggressive but did go into other resident ' s rooms. CNA #2 stated that Resident #9 got aggressive easily and the resident would make fists and grumble, even if no one was bothering the resident. CNA #2 stated that staff remove other residents out of Resident #9 ' s way when the resident was upset or overwhelmed. CNA #2 stated she was aware of an altercation between Resident #9 and Resident #44 and stated Resident #9 was eating a snack when Resident #44 entered the resident ' s room and tried to grab the snack. This resulted in Resident #9 pushing Resident #44 to the floor. CNA #2 stated residents on the secure unit are monitored by having at least one staff member on the hall in the middle. CNA #2 stated that during the altercation, both herself and CNA #1 were at the nurse ' s station, monitoring the cameras. CNA #1 was teaching CNA #2 how to chart in the medical record. CNA #2 stated she looked up at the camera and saw Resident #44 walk towards Resident #9 and CNA #2 got up and ran from the nurse ' s desk to get Resident #44. During an interview on 01/29/2025 at 8:35 AM, CNA #1 stated when Resident #9 charges at you, staff were told to get out of the way and when Resident #9 was frustrated, the resident would hit the air or themselves. CNA #1 stated staff were advised to get the residents away from Resident #9. CNA #1 stated Resident #44 was very grabby but did not have aggressive behaviors. CNA #1 stated that Resident #9 had behaviors, and the facility had to move Resident #9 ' s roommate to a different room. CNA #1 stated that Resident #9 was autistic with mixed personalities and would freak out. CNA #1 stated she was showing CNA #2 how to chart in the medical record at the nurse ' s station and CNA #2 took off running and that ' s when she looked up at the camera and saw Resident #44 head towards Resident #9. CNA #1 stated another CNA was supposed to be monitoring the hall but did not know where that CNA went. During an interview on 01/29/2025 at 11:23 AM, the Administrator stated there were interventions in place to safeguard Resident #44 but was unable to provide them to the surveyor. The Director of Nursing (DON) stated the facility placed a stop sign on Resident #9 ' s door but was removed because Resident #9 did not want it. The DON also stated that there were medication changes for Resident #44 to help with anxiety. The Administrator stated the facility did monthly in-services regarding behaviors but there was a new staff member completing those in-services and the Administrator could not locate the in-services. During an interview on 01/29/2025 at 2:00 PM, Licensed Practical Nurse (LPN) #12 stated Resident #44 goes into other resident ' s rooms and staff were to distract the resident. LPN #12 stated CNA #1 and CNA #2 being at the nurse ' s station during the incident between Resident #44 and Resident #9 was not appropriate and they should be charting at the kiosk in the hallway. LPN #12 stated that Resident #44 was trying to get something from Resident #9 and Resident #44 was pushed, making the resident fall and resulted in a broken hip. LPN #12 stated she was not made aware of resident-to-resident interactions except from verbal reports from other shifts and she does not review the resident ' s medical record unless there is an every-shift requirement to chart. Removal Plan: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident #44 who received physical aggression placed 1:1 observation on 01/29/2025 by facility staff. 2. Resident #9 who initiated physical aggression discharged facility 01/09/2025. 3. Licensed nurse will assess all residents currently on secured unit for signs and symptoms of physical aggression as well as assess for signs of trauma and physical abuse by skin audits on 01/29/2025. 4. DON/Designee will initiate an in-service on all staff currently in facility on handling residents with behaviors as well as Dementia training on 1/29/2025. Staff not present will be in-serviced prior to the start of their shift. Onsite Verification: The IJ was removed on 01/31/2025 after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 01/30/2025. Resident #9 was verified to have been discharged from the facility on 01/09/2025. Resident #44 had a staff member one on one with the resident as of 01/30/2025. The facility assessed all residents on the unit for signs and symptoms of physical aggression and body audits were completed. A total of 30 staff interviews were conducted with staff from all shifts to verify training had been completed. The staff interviewed included certified nursing assistants, licensed practical nurses, registered nurses, Administrator, business office staff, laundry staff, kitchen staff, activity staff, housekeeping staff, physical therapy staff, and maintenance staff. The staff interviewed verified they had been trained in handling residents with behaviors and dementia. A review of the in-service sheets provided indicated 45 of 105 had been provided training. Those staff who were not physically present to receive the in-services were to be in-serviced prior to the start of their shift.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review, it was determined that the facility failed to ensure that resident to resident events were reported within 24 hours even if no serious bodily injury occurred for 1 (Resident #9) of three residents reviewed for abuse and neglect. Findings include: A review of the facility policy, Abuse Prevention, revised 11/16/2017 revealed that all reports of resident abuse, neglect, injuries of an unknown source, resident-to-resident abuse and resident-to-staff abuse are promptly and thoroughly investigated by facility management, and that when an alleged or suspected abuse is reported, the facility administrator or his/her designee, would notify the following: 1. The State licensing/certification agency 2. The resident ' s representative 3. Law enforcement 4. The resident ' s attending physician. A review of OLTC Incident and Accident Report (I&A) indicated on 01/08/2025, Resident #9 pushed Resident #44 into a wall. Resident #44 grabbed at their hip as if the resident was in pain. Both residents resided in the Alzheimer ' s unit. Resident #44 had a hip fracture as a result of this incident. The findings of the facility ' s investigation indicated, The facility can not substantiate this allegation of abuse as both residents involved are mentally deemed to have no capacity and there was no intentional means of abuse. A review of State Operations Manual Appendix PP, F600 indicates, Willful actions include, but are not limited to, the following: hitting, slapping, punching, choking, pinching, biting, kicking, throwing objects, grabbing, shoving .The action itself was deliberate or non-accidental, not that the individual intended to inflict injury or harm .Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. A review of the admission Record, indicated the facility admitted Resident #44 with diagnoses that included dementia with agitation, disorientation, insomnia, restlessness and agitation. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/23/2024, revealed Resident #44 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated moderately impaired cognitive skills for daily decision making. Resident #44 showed physical behavior symptoms directed towards others as well as wandering. Resident #44 was able to ambulate independently. A review of Resident #44 ' s care plan initiated on 03/08/2024, revealed the resident needed a secured/special care neighborhood due to dementia. The following was listed: - 04/11/2024: Physical aggression received - 04/19/2024: Physical aggression received - 07/10/2024: Physical aggression received - 08/06/2024: Physical aggression received - 08/12/2024: Physical aggression received - 08/21/2024: Physical aggression initiated - 12/07/2024: Physical aggression received - 12/20/2024: Physical aggression received - 12/25/2024: Physical aggression received - 01/09/2025: Physical aggression received The facility developed interventions that included to encourage the resident to fold laundry or take care of a baby doll when noted wandering in other resident ' s rooms, numerous interventions in place for other resident, and the resident was to be placed on 1 on 1 observation on 08/21/2024. Further review of the care plan indicated Resident #44 lacked capacity to understand and make decisions. The resident also exhibited behaviors of wandering into other residents ' rooms. A review of facility incident and accident reports for the last twelve months for Resident #44 indicated on 04/11/2024, Resident #44 was pushed down to the ground by another resident. On 4/19/2024, Resident #44 was kicked by another resident. On 7/9/2024, Resident #44 was smacked in the face by another resident. On 08/06/2024, Resident #44 was pushed to the floor by another resident. On 08/12/2024, Resident #44 ' s left hand was stuck with a closed fist by another resident. On 08/21/2024, Resident #44 hit another resident. On 12/7/2024, Resident #44 was punched in the stomach. On 12/20/2024, Resident #44 was pushed by another resident, causing Resident #44 to fall. On 12/25/2024, Resident #44 was hit in the head by another resident. On 1/8/2025, Resident #44 was pushed to the floor by another resident and appeared to be in severe pain and was sent to the emergency room. Of all of the reports, only one was reported to the State Agency. During an interview on 01/31/2025, at approximately 11:00 AM, the Administrator was unaware of the regulation that resident-to-resident altercations had to be reported to the State Agency and stated only interactions that resulted in injury should be reported.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety 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. Based on observation, record review, and interview, the facility failed to ensure the comprehensive person-centered care plan included an objective for monitoring a resident with wandering behaviors who was at risk for resident-to-resident altercations for 1 (Resident #44) of 3 residents reviewed for abuse. The lack of effective interventions resulted in Resident #44 having resident-to-resident abuse that occurred on 04/11/2024, 04/19/2024, 07/10/2024, 08/06/2024, 08/12/2024, 12/07/2024, 12/20/2024, 12/25/2024, and 01/09/2025. All of the incidents took place on the locked unit and Resident #44 had been kicked, hit in the face, hit in an unknown area, pushed, punched in the hand, struck in the hand, punched in the stomach, pushed down numerous times, and hit in the head. The last incident resulted in a broken hip. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.21 (Comprehensive Resident Centered Care Plan) at a scope and severity of J. The IJ began on 04/11/2024, when Resident #44 was first pushed down by another resident while residing on the secure unit. The Administrator, Director of Nursing, Nurse Consultant, and Director of Operations were notified of the IJ on 01/29/2025 at 10:28 AM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 01/29/2025 at 3:54 PM. The IJ was removed on 01/31/2025 after the survey team performed onsite verification that the Removal Plan had been implemented. The findings are: A review of a policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated the Interdisciplinary Team (IDT) along with the resident and/or resident representative develops and implements the comprehensive care plan to include measurable objectives and timetables to meet the resident ' s physical, psychosocial, and functional needs. Further review indicated, Care plan interventions are chosen after data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making. A review of OLTC Incident and Accident Report (I&A) indicated on 01/08/2025, Resident #9 pushed Resident #44 into a wall. Resident #44 grabbed at their hip as if the resident was in pain. Both residents resided in the Alzheimer ' s unit. Resident #44 had a hip fracture as a result of this incident. The findings of the facility ' s investigation indicated, The facility can not substantiate this allegation of abuse as both residents involved are mentally deemed to have no capacity and there was no intentional means of abuse. A review of the admission Record, indicated the facility admitted Resident #44 with diagnoses that included dementia with agitation, disorientation, insomnia, restlessness and agitation. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/23/2024, revealed Resident #44 had a Staff Interview for Mental Status (SAMS) score of 3 which indicated moderately impaired cognitive skills for daily decision making. Resident #44 showed physical behavior symptoms directed towards others as well as wandering. Resident #44 was able to ambulate independently. A review of Resident #44 ' s care plan initiated on 03/08/2024, revealed the resident needed a secured/special care neighborhood due to dementia. The following was listed: - 04/11/2024: Physical aggression received - 04/19/2024: Physical aggression received - 07/10/2024: Physical aggression received - 08/06/2024: Physical aggression received - 08/12/2024: Physical aggression received - 08/21/2024: Physical aggression initiated - 12/07/2024: Physical aggression received - 12/20/2024: Physical aggression received - 12/25/2024: Physical aggression received - 01/09/2025: Physical aggression received The facility developed interventions that included to encourage the resident to fold laundry or take care of a baby doll when noted wandering in other resident ' s rooms, numerous interventions in place for other resident, and the resident was to be placed on 1 on 1 observation on 08/21/2024. Further review of the care plan indicated Resident #44 lacked capacity to understand and make decisions. The resident also exhibited behaviors of wandering into other residents ' rooms. A review of facility incident and accident reports for the last twelve months for Resident #44 indicated on 04/11/2024, Resident #44 was pushed down to the ground by another resident. On 4/19/2024, Resident #44 was kicked by another resident. On 7/9/2024, Resident #44 was smacked in the face by another resident. On 08/06/2024, Resident #44 was pushed to the floor by another resident. On 08/12/2024, Resident #44 ' s left hand was stuck with a closed fist by another resident. On 08/21/2024, Resident #44 hit another resident. On 12/7/2024, Resident #44 was punched in the stomach. On 12/20/2024, Resident #44 was pushed by another resident, causing Resident #44 to fall. On 12/25/2024, Resident #44 was hit in the head by another resident. On 1/8/2025, Resident #44 was pushed to the floor by another resident and appeared to be in severe pain and was sent to the emergency room. A review of Resident #44 ' s hospital records indicated on 01/09/2025, the resident was admitted to the hospital related to a fall with left hip pain and was diagnosed with a left femur fracture and required surgery. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 01/28/2025 at 2:00 PM, Certified Nursing Assistant (CNA) 13 was in Resident #44 ' s room and stated the resident was not aggressive but at times, the resident takes things that belong to other residents, which agitates those residents resulting in pushing Resident #44. During an interview on 01/28/2025 at 2:16 PM, the Director of Nursing (DON) stated Resident #44 was sent to the hospital because the resident was touching another resident who had autism. The DON stated Resident #44 used to be a CNA and likes to pick up things and was trying to pick things up in the other resident ' s room. This resulted in the other resident pushing Resident #44, causing the resident to fall. The DON stated the other resident no longer resided in the facility. During an interview on 01/29/2025 at 8:20 AM, CNA #2 stated Resident #44 was not aggressive but did go into other resident ' s rooms. CNA #2 stated interventions for Resident #44 included redirecting or distracting the resident. CNA #2 stated she was aware of an altercation between another resident and Resident #44 and stated the other resident was eating a snack when Resident #44 entered the resident ' s room and tried to grab the snack. This resulted in the other resident pushing Resident #44 to the floor. CNA #2 stated residents on the secure unit are monitored by having at least one staff member on the hall in the middle. CNA #2 stated that during the altercation, both herself and CNA #1 were at the nurse ' s station, monitoring the cameras. CNA #1 was teaching CNA #2 how to chart in the medical record. CNA #2 stated she looked up at the camera and saw Resident #44 walk towards the other resident and CNA #2 got up and ran from the nurse ' s desk to get Resident #44. This would indicate Resident #44 was not one-on-one per the resident ' s care plan. During an interview on 01/29/2025 at 8:35 AM, CNA #1 stated Resident #44 was very grabby but did not have aggressive behaviors. CNA #1 stated staff would give Resident #44 towels to fold or give the resident something to do to keep the resident ' s mind busy. CNA #1 stated she was showing CNA #2 how to chart in the medical record at the nurse ' s station and CNA #2 took off running and that ' s when she looked up at the camera and saw Resident #44 head towards Resident #9. CNA #1 stated another CNA was supposed to be monitoring the hall but did not know where that CNA went. During an interview on 01/29/2025 at 11:23 AM, the Administrator stated there were interventions in place to safeguard Resident #44 but was unable to provide them to the surveyor. The Director of Nursing (DON) stated the facility placed a stop sign on another resident ' s door but was removed because the resident did not want it. The DON also stated that there were medication changes for Resident #44 to help with anxiety. The Administrator stated the facility did monthly in-services regarding behaviors but there was a new staff member completing those in-services and the Administrator could not locate the in-services. During an interview on 01/29/2025 at 2:00 PM, Licensed Practical Nurse (LPN) 12 stated Resident #44 goes into other resident ' s rooms and staff were to distract the resident. LPN #12 stated CNA #1 and CNA #2 being at the nurse ' s station during the incident between Resident #44 and another resident was not appropriate and they should be charting at the kiosk in the hallway. LPN #12 stated that Resident #44 was trying to get something from another resident and Resident #44 was pushed, making the resident fall and resulted in a broken hip. LPN #12 stated she was not made aware of resident-to-resident interactions except from verbal reports from other shifts and she does not review the resident ' s medical record unless there is an every-shift requirement to chart. LPN #12 stated the intervention of redirecting Resident #44 was not an appropriate intervention because the resident would just continue with the behavior. LPN #12 stated that an appropriate intervention would have been to remove one of the residents from the neighborhood. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045371	A. Building B. Wing	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Health and Rehab, Inc	802 S West End Street Springdale, AR 72764

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Removal Plan: 1. Resident #44 who received physical aggression placed on observation 1:1 on 01/29/2025 by facility staff. 2. Resident #9 who initiated physical aggression discharged from the facility 01/09/2025 3. DON/Designee will initiate an in-service on all staff currently in facility on handling residents with behaviors on 01/29/2025 and continue training staff as they clock in until all staff have been trained. 4. On 1/29/2025, the DON/Designee will initiate in-service related to following care plan interventions for direct care staff currently in facility. Direct care staff not present will be in-serviced prior to the start of their shift. Any newly hired direct care staff will also be in-serviced. 5. DON/Designee will review all care plans for residents residing in the Dementia care unit for appropriate interventions related to behaviors and update the care plans as needed on 1/29/2025. 6. Nurse Consultant/Designee will initiate in-service with the Minimum Data Set (MDS) coordinator and all nurse managers on reviewing and updating care plans and that interventions are appropriate and effective on 1/29/2025. Onsite Verification: The IJ was removed on 01/31/2025 after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 01/30/2025. Resident #9 was verified to have been discharged from the facility on 01/09/2025. Resident #44 had a staff member one on one with the resident as of 01/30/2025. The facility assessed all residents on the unit for signs and symptoms of physical aggression and body audits were completed. A total of 30 staff interviews were conducted with staff from all shifts to verify training had been completed for behavior interventions. The staff interviewed included certified nursing assistants, licensed practical nurses, registered nurses, Administrator, business office staff, laundry staff, kitchen staff, activity staff, housekeeping staff, physical therapy staff, and maintenance staff. The staff interviewed verified they had been trained in handling residents with behaviors and dementia. A review of the in-service sheets provided indicated 45 of 105 had been provided training. Those staff who were not physically present to receive the in-services were to be in-serviced prior to the start of their shift. A total of 6 staff interviews were conducted regarding care plans being updated. The staff interviewed included the DON, the MDS Nurse, the ADON, and three LPNs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, record review and interview, the facility failed to ensure that the resident received prompt treatment after noticing a change in condition for 1 (Resident #112) of 4 residents reviewed for abuse and/or neglect. Specifically, Resident #112 showed signs of a stroke and was not sent to the emergency room until approximately 4 hours after noticing the change in condition. The findings are: A review of an admission Record indicated Resident #112 had diagnoses of neurocognitive disorder with Lewy bodies, chronic obstructive pulmonary disease, altered mental status, atrial fibrillation (irregular and often rapid heart rhythm that can lead to stroke), cerebrovascular disease (term for conditions that affect blood flow to your brain), cognitive communication deficit. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/2025 documented the resident scored 00, (0-7 indicates the resident was severely cognitively impaired) on a Brief Interview for Mental Status (BIMS). Further review indicated the resident ambulated with a walker and was independent with care. A review of Resident #112 ' s care plan, initiated on 11/27/2023, indicated the resident was on an anticoagulant (blood thinning) medication related to atrial fibrillation. The facility developed interventions to include administering the medication as ordered and monitor for side effects and effectiveness every shift. The blood thinning medication had a black box warning and premature discontinuation increased the risk of blood clots and to monitor for warning and side effects of the medication. Staff were to monitor, document, and report any adverse reactions of the blood thinner medication. Review of Resident #112 Progress Notes dated 10/3/2024 at 3:23 PM, staff reported to Licensed Practical Nurse (LPN) #12 that Resident #112 was acting a bit strange during smoke break. When staff spoke to the resident, there was slurred speech and the resident reported to be tired. Resident #112 denied any pain or discomfort and was alert and oriented. Resident #112 was able to ambulate with no difficulty and the resident ' s vital signs were within normal limits for the resident. LPN #12 requested the doctor to see Resident #112 during rounds. Review of Resident #112 Physician Notes indicated on 10/03/2024 at 7:35 PM, an Advanced Practice Registered Nurse (APRN) provided an interactive audio and visual telecommunication with the resident. The APRN indicated Resident #112 ' s chief complaint was a change in mental status and staff reported slurred speech and left side weakness. The staff reported that this started around 4 hours ago. Resident #112 had significant left sided facial droop on exam, had slurred speech, and complained of back pain. The APRN indicated the resident needed to be sent to the emergency room for an evaluation due to a possible stroke. The APRN indicated the resident ' s doctor was made aware of the visit and new orders. Review of Resident #112 Progress Notes dated 10/3/2024 at 7:52 PM, Registered Nurse (RN) #14 indicated Resident #112 continued with slurred speech and staff reported she the resident was not acting like themselves. The on-call provider was notified and new orders were received to send the resident to emergency room for evaluation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #112 Progress Notes showed no physician entries for this resident on 10/03/2024. A review of Resident #112 ' s admission H&P [history and physical] notes indicated Resident #112 ' s family member was at the resident ' s bedside at the hospital and told the APRN the resident had stop talking all of their medication approximately 3 months ago. The resident was admitted to the hospital on [DATE] at 8:06 PM. Imaging of the resident ' s head and neck indicated a medium vessel occlusion (most common artery involved in acute stroke) and Resident #112 was not a candidate for intravenous thrombolysis (the use of medication to dissolve blood clots) due to it being outside of the timeframe for administration. During an interview on 01/29/2024 at 4:48 PM. LPN #12 stated on 10/03/2024, the doctor was doing rounds in the facility and was notified of the resident ' s change in condition and that the resident needed to be seen by the doctor. LPN #12 stated staff let the resident rest until seen by the doctor. Review of OLTC Witness Statement Form, dated 01/30/2025 at 9:56 AM the Director of Nursing (DON) indicated On October 3rd, 2024, I received a phone call from the resident ' s Medical Physician (MP). Medical Physician stated that he had seen the resident per [the resident ' s] nurse ' s request. At that time, the resident did not wish to go to the hospital to be evaluated. The resident was also non-compliant with [the resident ' s] medications, including [a blood thinner]. In light of this, the residents Medical Physician called me on my personal phone and requested that a care plan be scheduled with the resident and [the resident ' s family member] to discuss goals of care and potential comfort care measures. I was on the way home from daycare with children at the time, so the time of call would have been around 5pm. This information provided above is true to the best of my knowledge. A review of Resident #112 ' s electronic health record did not indicate there was a conversation between Resident #112 ' s MP and the DON on 10/03/2024. During an interview on 01/30/2025 at 11:08 AM, The MP was asked if he saw the resident on 10/03/2024 while completing rounds on other residents at the facility and the MP stated he did not see the resident and did not have any notes on the resident for that day. Review of facility policy titled Change in a Resident ' s Condition, which indicated Our facility promptly notifies the resident, his or her primary care provider, and the resident representative of changes in the residents medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility failed to acquire a current Clinical Laboratory Improvement Amendment (CLIA) certificate appropriate for the level of testing performed within the facility, as required, for 1 of 1 facility. The findings are: The Centers for Medicare and Medicaid Services (CMS) Guidance at tag F770 documented, .If a facility provides its own laboratory services or performs any laboratory tests directly (e.g. [for example], blood glucose monitoring, etc. [et cetera]) the provisions of 42 CFR [Code of Federal Regulations] Part 493 apply and the facility must have a current Clinical Laboratory Improvement Amendment (CLIA) certificate appropriate for the level of testing performed within the facility. On 1/29/25 at 11:52 a.m., Observation of the facility's CLIA certificate documented an expiration date of 1/25/25. The Administrator was asked if the facility had a current CLIA certificate in her office. She stated, I will have to get that for you. A review of Pay.gov Payment Confirmation: CLIA Laboratory Program indicated the facility paid for the CLIA license on 1:22 PM. The facility was unable to provide a current CLIA certificate.