| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045373 | A. Building<br>B. Wing | 05/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bradford House Nursing and Rehab, LLC | 1202 S E 30th Street<br>Bentonville, AR 72712 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on observation, record review, interview and facility policy review, the facility failed to ensure residents requiring two-person assistance for transfers were transferred by the appropriate number of staff to prevent falls and/or injury for 2 (Resident #36 and #178) of 4 sampled residents reviewed for falls. Specifically, Certified Nursing Assistants (CNAs) attempted to transfer residents with 1 person assistance, resulting in falls on 11/06/24 and 03/31/25.<br><br>The findings include:<br><br>1. Review of Medical Diagnosis revealed Resident #178 had diagnoses of closed left femur fracture, left heel pressure ulcer, and periorbital cellulitis.<br><br>a. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. The MDS indicated Resident #178 required assistance with indoor mobility, used a motorized wheelchair/scooter and walker, was dependent with eating, toileting, bathing, personal care, and dressing. The MDS also indicated the resident fell within one month prior to admission, resulting in a fracture.<br><br>b. A review of Care Plan, (updated 11/06/2025) revealed Resident #178 had an actual fall with head injury. Staff were instructed to monitor, document, and report changes to the physician for the next 72 hours, and monitor for pain, bruising and changes in mental status.<br><br>c. A review of nursing Progress Notes dated 11/07/2025 at 11:18 PM, indicated Resident #178's spouse stated the resident fell when a single CNA attempted to transfer them from the bed to the shower chair, indicating both the CNA and Resident #178 fell during the incident. Resident #178 told a nurse the resident's feet slipped; they lost their balance and fell. A quarter size abrasion was found on the top of Resident #178's head. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) assessed the resident and Resident #178 denied pain.<br><br>d. A review of a Reportable with a discovery time of 11/06/2024 at 4:30 PM, revealed the Administrator was notified Resident #178 had alleged CNA #18 attempted to transfer Resident #178 without a second staff member present, moving from the bed to the wheelchair. When Resident #178's feet started to slide, CNA #18 had to lower Resident #178 to the floor, and in the process CNA #18 went to the floor with the resident. Resident #178 scraped the top of their head.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | e. Facility investigation findings from the Reportable stated the facility was unable to confirm Resident #178 was lowered to the floor, but CNA #18 was called by the Administrator and admitted to transferring Resident #178 from the bed to shower chair without assistance. CNA #18 revealed Resident #178's feet slipped, and the resident fell into the shower chair, but denied Resident #178 fell to the floor. CNA #18 confirmed he was aware Resident #178 was a two-person assist and should have asked for assistance transferring the resident and was sorry. CNA #18 was terminated for not following facility policy and not reporting the witnessed fall to the charge nurse.<br><br>f. Review of a witness statement, dated 11/11/2024 and provided by CNA #18, revealed the CNA offered Resident #178 a shower and the resident agreed. Resident #178 was placed in the sitting position on the side of the bed, they then grabbed the bar on the side of the bed, CNA #18 assisted resident to their feet, and had resident transfer to their chair. CNA #18 stated Resident #178 did drop their weight onto the chair. At no time did CNA #18 believe this to be a fall.<br><br>g. Review of the Closet Care Plan, included in the reportable file, showed Resident #178 was a two-person assist.<br><br>h. Review of CNA #18's employee file (hire date 11/28/23) showed pre-employment competency training dated 10/03/23 covered abuse and neglect, and accident and incidents, and resident demonstrated one - two - person assist gait belt transfers. Termination papers dated 11/06/24 indicate CNA #18 was terminated for not following proper level of care for transfers, dropping a resident with an open investigation.<br><br>i. During an interview on 05/29/25 at 09:12 AM, the DON revealed a fall was reported to her by the charge nurse (Registered Nurse #5) that CNA #18 transferred Resident #178 and the resident fell and hit their head. The DON confirmed Resident #178 was currently being monitored for a scab on top of the head. The DON stated CNA #18 said he was trying to transfer Resident #178 by himself, and the resident was supposed to be a two-person assist. Resident #178 told a family member that the resident fell. Family reported the fall to staff. The DON said Resident #178 confirmed a fall to the floor and CNA #18 helped resident get up off the floor. CNA #18 was terminated for not following the closet care plan and not reporting the fall. The DON stated staff were expected to follow the closet care plan to see if one- or two- person assistance was needed and use a gait belt. If two-person assistance was required, they needed to make sure the resident was safe to transfer and the resident could safely complete the transfer. If they had any doubts, they should not move the resident and contact the charge nurse right away.<br><br>j. During an interview on 05/29/25 at 09:33 AM, Resident #178 ' s family member revealed Resident #178 was having rehab and CNAs were instructed that Resident #178 required two-person assistance with transfers, and a gait belt had to be used with transfers. CNA #18 came in by himself to transfer Resident #178. Resident #178 told the family member the resident had fallen, then CNA #18 fell to the floor and landed on top of Resident #178.<br><br>k. During an interview on 05/29/25 at 03:03 PM, the Administrator stated CNA #18 chose to transfer a resident that required two-person assistance alone, and the resident fell. Protocol was not followed. The Administrator described the abrasion on top of the resident's head as it looked fresh. The Administrator said, I go over abuse and neglect monthly, and staff are expected to look at the closet care plan and follow that process. The Administrator stated CNA #18 reported seeing physical therapy transfer Resident #178 with one-person during therapy and thought that he could do it as well.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. A review of the admission Record, indicated the facility admitted Resident #36 on 02/26/2025 with diagnoses which included fracture of right arm, muscle wasting, anemia, unsteadiness on feet, blindness, and abnormalities of gait and mobility.<br><br>a. A review of the Medication Administration Record (MAR) dated March 2025 indicated Resident #36 was taking a blood thinner to prevent blood clots. The resident started taking the blood thinner on 03/19/2025 daily, with a dose taken on the morning of 03/31/2025 when CNA #12 failed to follow the care plan of maximum two-person assistance with transfers.<br><br>b. A review of Resident #36's Closet Care Plan dated 05/15/2025 indicated the resident required maximum assistance of two staff for transfers.<br><br>c. A review of Resident #36's Comprehensive Care Plan dated 03/05/2025 indicated the resident required maximum assistance of two staff for transfers.<br><br>d. A review of the Morse Fall Scale and Care Plan with Tasks dated 04/01/2025 indicated the resident had an impaired gait. It incorrectly indicated the resident had not fallen before, but they had fell during a transfer on 03/31/2025. The resident's score was 35. Morse Fall Scoring indicated resident was a moderate risk for falls in the range of 25-44.<br><br>e. A review of Incident and Accident Report (I&A), dated 04/01/2025, revealed Resident #36 was being assisted from the bed to the wheelchair on 03/31/2025 by a single staff member when the resident took a step and fell back. CNA #12 lowered the resident to the floor. The resident suffered an abrasion to the top of the scalp and had a bruise to left forearm. CNA #12 transferred the resident without the assistance of two staff members. The report indicated the Administrator interviewed CNA #12 to establish if she knew the resident was a two-person maximum assistance and if the CNA read the closet care plan. CNA #12 stated she knew the resident was a two-person assistance and the care plan was not referenced. The I&A indicated CNA #12 neglected to follow the resident transfer plan of care.<br><br>f. A review of Hospital Emergency Department Visit dated 03/31/2025 at 9:24 PM, revealed Resident #36 was taken to the Emergency Department (ED) by ambulance post fall after hitting their head. Upon arrival to the ED, the resident started vomiting. Resident #36 had complaints of nausea, vomiting, headache, and pain to right arm from previous fracture. A computed tomography (CT) scan of the head was indicated for moderate to severe trauma post fall since resident was taking an anticoagulant. Scans were negative for any acute findings. Resident #36 was discharged back to the facility.<br><br>g. The following Nursing Neurological Assessments were performed:<br><br>i.03/31/2025 5:15 PM, Resident alert; Change from baseline; Verbal and Non-Verbal expressions of pain; Pain rated 10.<br><br>ii. 03/31/2025 5:30 PM, Resident alert; no change from baseline; Verbal and Non-Verbal expressions of pain; Pain rated 10.<br><br>iii. 03/31/2025 5:45 PM, Resident alert; no change from baseline; No Verbal or Non-Verbal expressions of pain; No pain rating.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | iv. 03/31/2025 6:00 PM, Resident alert; no change from baseline; Verbal and Non-Verbal expressions of pain; Pain rated 10.<br><br>v. 03/31/2025 6:15 PM, Resident alert; no change from baseline; No Verbal or Non-Verbal expressions of pain; No pain rating.<br><br>vi. 03/31/2025 6:45 PM, Resident alert; no change from baseline; Verbal and Non-Verbal expressions of pain; Pain rated 5.<br><br>vii. 03/31/2025 7:15 PM, Resident alert; no change from baseline; No Verbal or Non-Verbal expressions of pain; No pain rating.<br><br>viii. 03/31/2025 7:45 PM, Resident alert; no change from baseline; Verbal and Non-Verbal expressions of pain; Pain rated 4.<br><br>ix. 03/31/2025 8:15 PM, Resident alert; no change from baseline; Verbal and Non-Verbal expressions of pain; No pain rating.<br><br>x. 03/31/2025 9:15 PM, Not done; Resident sent to the ER per family request.<br><br>h. A review of Situation, Background, Appearance, Review and Notify (SBAR) dated 03/31/2025 at 8:00 PM, indicated the primary care provider was notified of Resident #36 ' s witnessed fall with an injury to the right side of their head; contusion to back of head and indicated the resident had pain.<br><br>i. A review of Skilled Nursing Facility/Nursing Facility Hospital Transfer Form (SNF/NF) dated 03/31/2025 at 8:45 PM indicated Resident #36 had fallen and hit the back of the head and exhibited a bruise to left arm.<br><br>j. A review of a concurrent Office of Long-Term Care Incident and Accident Report (I&A) dated 04/04/2025 indicated the Administrator reported CNA #12 did know that Resident #36 was a two-person assist and did not follow the care plan. He reported the allegation was substantiated and the facility terminated CNA #12 for not following the resident's care plan.<br><br>k. During an interview on 05/29/2025 at 8:37 AM, the DON stated if direct care staff found a resident on the floor, they were to immediately call for help. The nurse would assess, if not injured the resident would be returned to the bed or wheelchair. They would notify the physician if there were significant changes. The nurse would talk to the CNA to find out the situation. The nurse followed the basic investigation of the incident, and they would let the DON know after the provider and family were notified. If an intervention changed, the charge nurse would let the staff know and an in-person in-service was done at that time. The closet care plan was updated. All direct care staff should look at the closet care plan before they take care of the resident. The hall managers were the ones that update the closet care plans.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | l. During an interview on 05/30/2025 at 8:38 AM, the Medical Director (MD) stated the facility did notify him when there was a change of condition or a fall with a resident. The MD said fall assessment should be done after each fall to assess for injuries and prevent future falls. He stated if a resident fell with complaints of pain, the facility should contact him immediately. For residents which required two-person assistance for transfers, his expectation was they had two persons assist on all transfers. The MD was aware of Resident #36 and Resident #178 falling during a transfer. He expected staff to follow the orders, and the closet care plans for the residents. He stated staff making their own decisions to transfer with one-person would be an outlier.<br><br>m. During an interview on 05/30/2025 at 8:58 AM, LPN #10 stated if a CNA found a resident on the floor, they should alert the nurse, and the nurse would do an assessment. If the resident was not injured, a skin assessment would be done. Then they got assistance and help the resident to bed or wheelchair. If the resident was injured, Emergency Medical Services would be called.<br><br>n. During an interview on 05/30/2025 at 9:07 AM, CNA #11 stated first and foremost the staff should check the closet care plan before providing care. CNA #11 stated staff should never lift a resident that was a two-person assist without help.<br><br>o. During an interview on 05/29/2025 at 7:58 AM, Resident #36's family representative stated they were notified when the resident was dropped by CNA #12 and Resident #36 hit their head on the floor. The family representative stated the resident had a knot and bruise on the head and was sent to the emergency department. The family representative stated CNA #12 was moving the resident from the wheelchair to the bed and did not follow procedure. CNA #12 did not get a second person to help with transfer resulting in the Resident #36 getting hurt.<br><br>3. A review of facility document Incident and Accident Policy (I&A) revision date 11/22/2017, indicated all incidents or accidents occurring at the facility would be reported to the Administrator and DON, and investigated. A fall should be reported immediately, and staff would assist the injured person. The resident would be assessed for injury. If unwitnessed injury or suspected head injury, the nurse would perform neurological checks and vital signs for 72 hours. Treatment would be provided as ordered by the physician. The charge nurse would complete an I&A. The administrator would report it to the state agencies if determined to be reportable. |