STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045434	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Katherine's Place at Wedington	4405 West Persimmon Street Fayetteville, AR 72704

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to report to the State Licensing Agency an incident of resident allegation of verbal abuse for one (Resident #5) resident of five residents reviewed for abuse. The findings are: A review of facility policy Abuse Investigations and Reporting revealed that all allegations would be reported immediately, but not later than two hours of allegation of abuse to the State Licensing/Certification Agency. A review of admission Record revealed Resident #5 was admitted on [DATE], with medical diagnoses which included: acute congested heart failure, high blood pressure, muscle wasting and atrophy, and difficulty walking. A review of Resident #5 ' s annual Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 04/13/25, revealed Resident #5 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated no cognitive impairment. The MDS revealed Resident #5 had adequate hearing, used a mobility device (wheelchair), required maximum assist with transfers, bathing and toileting, and set up assist with oral hygiene and eating. A review of Resident #5 ' s Care Plan, with a revision date of 03/15/2025, revealed Resident #5 had a cognitive communication deficit and had an intervention of staff allow adequate time to respond, staff ensure the resident was understanding, staff anticipate and meet needs, and staff speak on an adult level. During an interview with Resident #5, during initial round, on 04/16/2025, the resident reported that a Certified Nursing Assistant (CNA) stated to the resident to get [pronoun] fat ass over here, while performing care. Resident #5 did not disclose the CNA's name, but it was during a bed bath. Resident #5 reported the incident was immediately reported to the Administrator in Training (AIT) the day the incident occurred, 04/08/25. Review of witness statements on 04/17/2025, revealed the date of 04/08/2025. Initially, the Administrator reported that the dates were done today, and they reflected the date of the incident instead of when they were completed. (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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(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 - Few	A phone interview with CNA #1 on 04/17/25 at 2:24 PM, revealed that CNA #1 and CNA #2 gave Resident #5 a bed bath on 04/08/25. The CNAs were giving Resident #5 a bed bath and conversing amongst each other, when CNA #1 told CNA #2 that her niece called her nephew a big back and they both laughed about it. CNA #1 revealed that she was not talking to Resident #5 when she said that, and she did not call the resident that. CNA #1 asked Resident #5 to roll over toward the window, and the resident must have thought CNA #1 was talking to Resident #5. CNA #1 reported that Resident #5 called their nephew, and the nephew called and spoke to the facility. CNA #1 revealed approximately thirty (30) minutes after the bed bath, she was called into the DON's office and spoke to her about it and wrote a witness statement. An interview with the Director of Nursing (DON) on 04/17/2025 at 2:41 PM, revealed she was notified of Resident #5 allegations. She followed up with Resident #5. The resident was not upset and could not recall most of the incident. The DON stated she received witness statements from CNA #1 and CNA #2 and concluded that there was no verbal abuse. It was found that the two CNAs were having a conversation between themselves, and CNA #1 was talking about her family members stating one called another family member a fat back . CNA #1 was not talking to the resident. The DON also reported that any form of abuse was to be reported immediately. An interview with the Administrator on 04/17/2025 at 2:47 PM, revealed abuse was to be reported immediately. She revealed that if there were times she was not there, the DON would gather witness statements on allegations, and 04/16/25 was the first time of hearing of this allegation. An interview with CNA #2 on 04/17/2025 at 3:05 PM, revealed that while giving Resident #5 a bed bath, she and CNA #1 were talking amongst themselves about CNA #1's niece and nephew, and how they were saying mean things about each other. CNA #2 revealed that Resident #5 thought CNA #1 was talking about the resident. CNA #2 reported she was spoken to about the incident by the DON and filled out a witness statement. CNA #2 reported that 04/17/2025 was the first time she had spoken to the Administrator about the incident. CNA #2 stated abuse was to be reported immediately. An interview with the Administrator on 04/17/25 at 3:30 PM, revealed she had been notified of an incident on 04/08/25 and she was not in the office at the time. The Administrator stated the DON and the Administrator in Training had been notified and had spoken to Resident #5 about the allegation of being called a big back by CNA #1. The DON had received witness statements and spoken to the CNAs. She felt like after the investigation it was not considered verbal abuse or a reportable to the State Licensing Agency. She also stated that since the initial allegation, Resident #5 had changed her words from big back to fat ass and she had thought this was a new allegation from Resident #5 and began a new reportable. An interview with the AIT on 04/18/2025 at 8:27 AM, revealed the AIT was notified of an abuse/neglect incident on 04/08/25. The AIT stated he immediately went and spoke to Resident #5, and had felt like the incident had been blown out of proportion and everything was alright. The AIT revealed the resident could not remember a lot about the incident that had occurred. AIT reported the incident to Administrator and the DON spoke to the CNAs and received witness statements. The AIT stated the follow up investigation was completed by the DON. The follow up was completed at the end of that day, but he had left town so was unsure of the outcome. The AIT reported they had felt like it was cut and dry after the interviews with the CNA's were completed.