STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045172	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dermott City Nursing Home	702 West Gaines St Dermott, AR 71638

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 0656 Level of Harm - Minimal harm or potential for actual harm 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 record review, interview, and facility policy review, the facility failed to ensure a comprehensive care plan was consistently implemented for one (Resident #1) of three residents whose care plans were reviewed. The findings include: Review of an admission Record, indicated the facility admitted Resident #1 on 10/03/2024 with diagnoses which included scoliosis (lateral deviation of the spine), unsteadiness on feet, and dementia (loss of memory, thinking, and reasoning skills). Review of an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/07/2025, revealed a Brief Interview for Mental Status (BIMS) score of 09, which indicated Resident #1 had moderate cognitive impairment and was dependent on staff for toileting hygiene, shower/bathe self, chair-/bed-to-chair transfers. The MDS indicated active diagnoses which included fractures and other multiple trauma; falls since admission/entry or reentry or prior assessment; recent surgery requiring active Skilled Nursing Facility (SNF) care and surgical procedures for repair of fractures of the pelvis, hip, leg knee or ankle (not foot). Review of a Care Plan, with a last review date of 10/14/2025, indicated Resident #1 had an Activities of Daily Living (ADL) self-care performance deficit and required a mechanical lift, stand up lift with assistance of two staff for transfers. The date initiated and revised was 01/22/2025. Review of an Incident Report dated 12/02/2025 at 10:34 AM, for Resident #1, revealed that Licensed Practical Nurse (LPN) #5 reported to the Director of Nursing (DON) that Certified Nursing Assistant (CNA) #1 informed LPN #5 that Resident #1 fell to their knees, when CNA #1 was transferring Resident #1 from the bed to the wheelchair, due to shoes slipping off Resident #1's feet. The Incident Report also indicated that Resident #1's legs were weak and gave out when pivoting during the transfer. LPN #5 reported to the DON that Resident #1 was up in a wheelchair when LPN #5 entered Resident #1's room. The report indicated the immediate action taken was that CNAs #1 and #2 assisted Resident #1 up to a wheelchair and notified former LPN of the incident. An x-ray of the right knee was ordered due to Resident #1's level of pain being reported as 10 (there was no pain scale indicated on the incident report to show what level 10 indicated.) Resident #1 was sent to [an acute care facility] due to the results of the x-ray. Other information noted in the report indicated the resident had on house shoes with no grips and that Resident #1 was care planned for two person-assistance with a mechanical stand-up lift for transfers. (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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Dermott City Nursing Home	702 West Gaines St Dermott, AR 71638

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Radiology Report, dated 12/02/2025, revealed an exam date of 12/02/2025 for pain in right knee. The findings revealed an acute obliquely (side) oriented and overriding fracture of the distal right femoral (lower part of the right thigh bone) metadiaphysis (where the flared, growing end of a long bone and the bone's shaft meet) and mild displacement (abnormal positioning) of distal fracture fragments. The impression revealed that an Orthopedic (bone) consultation was recommended. During an interview on 12/19/2025 at 12:27 PM, CNA #1 stated she looked at care plans to know how to care for residents. She stated she knew how to use a stand-up lift, and that two staff members are required to use the stand-up lift. She stated on 12/02/2025 she was assisting Resident #1 into the chair and during the transfer, Resident #1 tried to pivot, and the resident's [right] shoe went one direction and Resident #1's [right] foot went another direction, she then lowered Resident #1 to the floor. CNA #1 was asked if Resident #1 required assistance and she stated, It's just one to transfer because she can bear weight and she can pivot. CNA #1 stated Resident #1 may have required the use of a stand-up lift before she began working at the facility in October 2025. CNA #1 stated she had received an in-service on transfers on October 6, 2025. CNA #1 admitted since her hire date she had completed skills checkoffs which included how to transfer residents and using the stand-up lift. In a later interview on 12/19/2025 at 1:20 PM, CNA #1 stated she did not use a stand-up lift during Resident #1's transfer on 12/02/2025. During a telephone interview on 12/19/2025 at 2:31 PM, CNA #2 stated that a resident's plan of care indicated how the resident was to be transferred. She stated on 12/02/2025 CNA #1 called her to help with Resident #1. CNA #2 stated that when she entered Resident #1's room, Resident #1 was on the floor. She admitted knowing Resident #1 required the use of two persons to assist Resident #1 with a sit-to-stand lift (stand-up lift). During a telephone interview on 12/19/2025 at 1:01 PM, LPN #5 stated a CNA, whose name she did not recall at the time, came to her and stated Resident #1's feet pivoted from under them and the CNA lowered Resident #1 to their knees. The LPN also stated she then went to report the incident to the DON. The former LPN stated she knew Resident #1 was a two person assist and required the use of a stand-up lift for transfers. During an interview on 12/19/2025 at 2:11 PM, the DON stated LPN #5 came and told her Resident #1 had fallen. She stated LPN #5 told her CNA #1 was in the room with Resident #1 and as Resident #1 pivoted from the bed to the wheelchair, Resident #1's legs gave out and CNA #1 lowered Resident #1 to the floor. The DON stated, once she entered Resident #1's room, she observed Resident #1 sitting up in a wheelchair. The DON stated, she checked Resident #1's right side because of a complaint of pain and a complaint of right knee pain. The DON stated Nurse Practitioner (NP) #3 was telephoned and an order was obtained to get an x-ray. The DON stated the facility's in-house x-ray service came and completed the x-ray of Resident #1's [right] leg and later confirmed Resident #1's right leg was broken. Resident #1 was sent to [an acute care facility]. The DON stated Resident #1 was a two person-assist with transfers with the use of a stand-up lift and that CNA #1 did not use the stand-up lift to transfer Resident #1 on 12/02/2025. During a telephone interview on 12/22/2025 at 1:23 PM, CNA #1 stated she did not remember if she looked at Resident #1's Care Plan on 12/02/2025 prior to taking care of the resident that day. CNA #1 stated she did not remember the last time she looked at Resident #1's Care Plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/23/2025 at 2:11 PM, NP #4 stated she was notified on 12/02/2025 of Resident #1's fall, but NP #3 did the assessment. NP #4 stated she was informed of Resident #1's radiology results which revealed an acute femur fracture. NP #4 stated her expectation for staff transferring residents at the facility was that residents with immobility deficits were care planned with how the transfer should be done. NP #4 stated she knew Resident #1 was care planned for two person-assistance for transfers and her expectation was to have two CNA's to transfer them. During an interview on 12/23/2025 at 4:45 PM, the Compliance Officer (CO) stated her expectation for staff locating, reviewing and following the resident's Care Plan was if staff did not know how a resident should be transferred, the staff would go to the [facility's electronic computer system] and look at the Care Plan to see how to transfer a resident and what care the resident needed. The CO stated her expectation for resident transfers was for staff to know what kind of transfer was needed, such as if the resident needs the stand-up lift. Review of a facility policy titled Care Plans, Comprehensive Person-Centered revised March 2022, indicated that the comprehensive care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. This policy also indicated services provided for or arranged by the facility and outlined in the comprehensive care are provided by qualified persons. This policy revealed care plan interventions are chosen after gathering data, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes and relevant decision making.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on record review, interview, and facility policy review, the facility failed to ensure Certified Nursing Assistants (CNAs) #1 and #2 demonstrated competency in the care of a resident by moving a resident prior to a nurse assessment following a fall, and by not following the resident's care plan, which indicated the use of a mechanical stand-up lift with two-person assist for transfers, for one (Resident #1) of three residents reviewed for falls. 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, 483.35 (Nursing Services) at a scope and severity of J. The IJ began on 12/02/2025 around 10:34 AM, when CNA #1 performed an improper transfer of Resident #1 from the bed to a wheelchair without the use of a mechanical stand-up lift or a second person to assist, which resulted in Resident #1 falling to their knees on the floor. CNA #1 requested CNA #2 assist in moving Resident #1 from the floor to the wheelchair, which was conducted before Resident #1 was assessed by the nurse. Resident #1 sustained an acute right femoral (thigh bone) fracture, which required surgical intervention. The Compliance Officer and Director of Nursing (DON) were notified of the IJ on 12/22/2205 at 2:38 PM. A Plan of Removal was requested. The Removal Plan was accepted by the State Survey Agency on 12/23/2025 at 11:37 AM. The IJ was removed on 12/23/2025 at 4:34 PM after surveyor performed onsite verification that the Removal Plan had been implemented. The findings include: Review of a Staffing, Sufficient and Competent Nursing policy, dated as revised August 2022 and provided by the Compliance Officer (CO), indicated the facility will provide adequate numbers of nursing staff with appropriate skill and competency necessary to provide nursing and related care and services for all residents according with resident care plans and the facility assessment. Review of an admission Record indicated the facility admitted Resident #1 on 10/03/2024, with diagnoses which included scoliosis, unsteadiness on feet, and dementia. Review of the Medicare 5-day Minimum Data Set (MDS) with an Assessment Reference Date of 12/07/2025, revealed a Brief Interview for Mental Status score of 09, which indicated Resident #1 was moderately cognitively impaired. The MDS also indicated the resident was dependent on staff for toileting hygiene, shower/bathe self, chair-/bed-to-chair transfer; had active diagnoses of fractures and other multiple trauma; had experienced falls since admission/entry or reentry or prior assessment; had a recent surgery requiring active Skilled Nursing Facility care and surgical procedures of repair of fractures of the pelvis, hip, leg knee or ankle (not foot). Review of the Care Plan, with a last review date of 10/14/2025, indicated Resident #1 had an activities of daily living self-care performance deficit and for transfers required a mechanical lift, stand up lift with assistance of two staff (date initiated and revised was 01/22/2025). Review of fall risk evaluations for Resident #1 indicated the following: -admission fall risk evaluation dated 10/03/2024, revealed a score of 9.0, which indicated no risk. -Quarterly fall risk evaluation dated 10/16/2025, revealed a score of 10.0, which indicated at risk for falls. Review of an incident report for Resident #1 dated 12/02/2025 at 10:34 AM revealed the following: -Incident description: Licensed Practical Nurse (LPN) #5 reported to the DON that CNA #1 informed LPN #5 that Resident #1 fell to their knees when CNA #1 was transferring Resident #1 from the bed to wheelchair, due to shoes slipping off Resident #1's feet. The nursing description further indicated Resident #1's legs were weak and gave out when pivoting. The LPN #5reported to the DON that Resident #1 was up in a wheelchair when LPN #5 entered Resident #1's room. -Immediate action taken: CNAs #1 and #2 assisted Resident #1 up to a wheelchair and notified LPN #5. X-ray to right knee ordered and Resident #1 was sent to [an acute care facility] due to the results of the x-ray. -Level of pain: 10 (There was no pain scale indicated on the incident report to show what level 10 indicated.) -Other info (information): House shoes with no grips. Care planned for two person-assist with mechanical stand-up lift. Review of the Radiology Interpretation, dated 12/02/2025, revealed an exam date of 12/02/2025, for pain in right knee. The findings revealed an acute obliquely (side) oriented and overriding fracture of the distal right femoral (lower part of the right thigh bone) metadiaphysis (where the flared, growing end of a long bone and the bone's shaft meet) and mild displacement (abnormal positioning) of distal fracture fragments. The impression revealed an orthopedic (bone) consultation was recommended. Review of an Operating Room (OR) Record dated 12/3/2025 at 11:58 AM revealed a pre-operative diagnosis of right femur fracture. Review of an Orthopedic Post Op (operative) note dated 12/4/2025 at 09:52 AM revealed: - status post right retrograde intramedullary nailing (The resident had surgery to fix a broken bone in the right leg using an internal metal rod). Post op day 1. -Chief complaint/Impression/Plan: 1. Closed fracture of distal end of right

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review, interview and facility policy review, the facility failed to ensure a Licensed Administrator was hired to oversee the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines and regulations that govern nursing facilities for one of one facility reviewed for administrative duties. The findings include: Review of a facility Administrator Job Description, with a revision date of October 2022, indicated that the primary purpose of the position is to direct the day-to-day functions of the facility in accordance with current, federal, state and local standards, guidelines and regulations that govern the nursing facilities to assure the highest degree of quality care can be provided to residents at all times. Experience indicated as, must have a current unencumbered nursing home Administrator's license or meet the license requirements of the state. Review of a facility policy titled Administrative Management Governing Body with a revision date of January 2025, indicated that the governing body shall be responsible for the management and operation of the facility. This policy indicated that the governing body has the responsibility for the management and operation of the facility and that the governing body is responsible for but not limited to oversight of facility care and services in accordance with professional standards of practice and principles. Review of an Office of Long-Term Care (OLTC) Incident & Accident Report (I&A) dated 12/02/2025 at 10:34 AM, indicated that Certified Nursing Assistant (CNA) #1 performed an improper transfer of Resident #1, which resulted in Resident #1 sustaining an acute right femur (thigh bone) fracture which required surgical intervention. The I&A indicated that the Compliance Officer (CO) name was in the area designated for the name of the Administrator. During the entrance conference on 12/19/2025 at 9:15 AM, the Director of Nursing (DON) stated the facility had an interim administrator, [the CO], who was not in the facility at that time. A review of the Key Personnel Sheet did not list the name for the Administrator. During an interview with the CO on 12/22/2025 at 3:38 PM, she stated she was not the Administrator, and she does not have an Administrator's license. She stated no one was filling the capacity as the Administrator at the facility at that time and they were currently working on hiring someone. During an interview with Human Resources (HR) on 12/22/2025 at 4:17 PM, she stated the last Administrator resigned and her last day was 07/28/2025. On 12/23/2025 at 3:51 PM, this surveyor unsuccessfully attempted to reach the Board President (BP) by telephone and a voicemail with contact information was provided with a request for a return call. As of 12/23/2025 at 5:40 PM, this surveyor had not received a return call. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with the CO on 12/23/2025 at 4:45 PM, she stated the facility had been without an Administrator since July 2025. She stated no candidates had been interviewed for the Administrator position since July 2025. She stated the facility was advertising on [an internet site] and in the local newspaper for the open Administrator position at the facility.