STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045467	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Superior Health & Rehab, LLC	625 Tommy Lewis Dr Conway, AR 72033

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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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility record review it was determined that the facility failed to ensure that residents were treated with dignity and respect for two (Resident #93 and Resident #88) of two residents observed for dignity. The findings include: Resident #93 A review of an admission Record indicated Resident #93 was admitted to the facility on [DATE] with diagnoses that included paralysis affecting one side of the body, one-sided muscle weakness, stroke, difficulty swallowing, and altered mental status. A review of an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/09/2025, revealed Resident #93 had a Brief Interview for Mental Status (BIMS) score of 03, which indicated Resident #93 was severely cognitively impaired. The MDS also indicated Resident #93 was dependent on staff for eating. A review of a Care Plan Report indicated Resident #93 was able to feed themselves after setup, had an actual or the potential for a nutritional problem, and had a stroke that affected the right side of their body initiated 07/07/2025 and limited physical mobility initiated 07/08/2025. Resident #88 A review of an admission Record indicated Resident #88 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder, abnormal weight loss, dementia, paralysis affecting one side of the body, one-sided muscle weakness, difficulty swallowing, and stroke. A review of the quarterly MDS with an ARD of 05/22/2025 revealed Resident #88 had a BIMS of 08, which indicated Resident #88 was moderately cognitively impaired. The MDS also indicated Resident #88 was dependent on staff for eating. A review of a Care Plan Report with an initiated date of 09/11/2024, indicated Resident #88 had a self-care deficit, related to one sided muscle weakness, and paralysis affecting the dominant side. The Care Plan Report also indicated Resident #88 was dependent on staff for food intake. (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 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	A review of Resident #88’s active Physician’s Orders as of 08/14/2025 indicated the resident had a regular-enhanced diet with pureed texture, and honey consistency. Investigation On 08/11/2025 at 12:26 PM, Resident #93 and Resident #88 were observed during the lunch meal. A red napkin was observed under a white napkin on the table next to Resident #93 and Resident #88. CNA #1 indicated the red napkin meant the resident was a “feeder”. CNA #1 clarified a feeder” meant the resident was a feeder pointing to both Resident #93 and a tablemate Resident #88. The tray cards were reviewed while at the resident’s table, both Resident #93 and Resident #88’s meal tray cards indicated feeder in the alerts section. On 08/13/2025 a policy on treating residents with dignity and respect was requested of the Administrator. On 08/13/2025 the Activity Director reported the facility did not have a specific policy on resident dignity and respect, but the facility had the resident’s rights documented in the admission packet and the admission packet was provided to all residents on admission. The Activity Director provided a copy of the dignity in-service training presented in July 2025, that all employees were required to participate in. Certified Nursing Assistant (CNA) #1’s signature was next to her name on the dignity in-service which read in part that dignity was the quality or state of being worthy of respect, esteem, nobility and honor. An “admission Packet” with a review date of “12/21” was reviewed and read in part that the facility would promote and protect the rights of each resident. The residents had the right to be treated without discrimination regardless of their disability. Each resident had the right to be treated with consideration and respect. On 08/13/2025 at 12:53 PM, the Administrator reported all employees go through dignity training during orientation and yearly. On 08/13/2024 at 12:57 PM, the Dietary Manager (DM) while speaking with another surveyor made the statement, “they were through with the dining room service, with only the feeders left.” The DM was asked to clarify what “feeders” meant. The DM indicated feeders were in reference to the residents who had to be fed, not the aides who provided assistance with the meal. The DM indicated not being aware that labeling a resident a “feeder” was a derogatory term. The DM reported never being told not to call a resident a “feeder”. The DM reported the meal cards also labeled the residents as “feeders. The DM stated she would get right on that and get the cards changed. During a phone interview on 08/14/2025 at 9:47 AM, CNA #1 confirmed participating in the dignity training in July 2025, during the facility wide training. CNA #1 reported being a CNA for more than eight years and while working as a CNA had dignity training yearly. CNA #1 explained that when a resident was referred to as a feeder, it meant they had to be fed. CNA #1 stated, “when they are feeders, we have to assist them with feeding.” A review of CNA #1’s employee training regarding resident’s rights and agreement to comply with the Resident’s Rights Policy, revealed CNA #1’s name on the signature line. (continued on next page)

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F 0550 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 08/14/2025 at 10:12 AM, the Director of Nursing (DON) reported that when a resident was referred to as a feeder, it signified that the resident required feeding or extensive assistance with feeding. The DON reported labeling a resident, who required extensive assistance, as a feeder was how they had always referred to them. The DON indicated the facility expectation was for all facility staff to follow policies. The DON indicated CNA #1 should not have pointed to the residents and called them “feeders. During an interview on 08/14/2025 at 8:45 AM, the Administrator, who remarked that she understood how it must have sounded, stated she had already instituted a change in the meal tickets. The administrator stated the aide should not have pointed at the residents and referred to them as feeders.

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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 document review, the facility failed to ensure care plan interventions were consistently implemented for one (Resident #109) of four residents reviewed. The findings include: A review of Resident #109’s Nursing Progress Notes on 04/23/2025 at 3:37 PM, read in part, the resident was transferred from their wheelchair to their recliner by Certified Nursing Assistant (CNA) #2. The Nursing Progress Notes also indicated Resident #109’s “legs gave out”, the resident fell backwards onto the floor and hit their head on the wheelchair. Resident #109 sustained a small abrasion to the rear left of their head. The Medical Director was notified via secure conversation on 04/23/2025 at 3:00 PM. The facilities Advance Practice Registered Nurse was in the facility at the time of the incident and assessed the abrasion with no new orders obtained. A review of Resident #109’s admission Record indicated the facility admitted the resident on 12/18/2019, with diagnoses which included acute and chronic respiratory failure, chronic right sided heart failure, muscle wasting and atrophy, type 2 diabetes with diabetic polyneuropathy, and severe obesity. A review of Resident #109’s Minimum Data Set (MDS) with an Assessment Reference Date of 02/05/2025, revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. Resident #109’s MDS also revealed the resident required partial to moderate assistance for transfers and used a wheelchair for mobility. A review of Resident #109’s Care Plan Report, with a revision date of 02/21/2025, indicated the resident had a history of falls. Resident #109’s Care Plan Report specified interventions of a two-person assist during transfers, directed staff to encourage resident to let staff assist them to ensure safe transfers, and the resident needed prompt response to all requests for assistance. During an interview on 08/12/2025 at 1:17 PM, Medication Aide-Certified (MA-C) #3, who relayed their observation of the incident that occurred on 04/23/2025, indicated that while passing Resident #109’s room, MA-C #3 observed the resident fall. She then stated that Certified Nursing Assistant (CNA) #2 was there but could not hold the resident. MA-C #3 went to be of assistance after going for a nurse CNA #2 and MA-C #3 did not complete Resident #109’s transfer until the nurse assessed the resident. During an interview on 08/12/2025 at 1:41 PM, CNA #4 reported the closet care plan was where a CNA would look for care instructions on a resident. CNA #4 then stated fall interventions were added to the closet care plan, and the nurses kept the CNAs updated as well. During an interview on 08/12/2025 at 1:50 PM, CNA #5 reported the CNAs have face sheets and pages in the resident’s closet that help CNAs to know what care needs are. CNA #5 then stated the CNAs chart in kiosks and could have also referred to resident care plans there. CNA #5 verified if a resident had a history of falls, the bed would have been put in a low position, and interventions would have been checked to see if in place. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/12/2025 at 1:55 PM, CNA #6 indicated if the resident had not been seen before, if they were a new admit, or it was the staff member’s first time to work that particular hall, reviewing the face sheet or closet care plan would have been first step in providing care. The face sheet and care plan were one and the same and would have been in the resident’s closet. CNA #6 stated review of the closet care plan should be daily, because it could change daily. During an interview on 08/12/2025 at 1:58 PM, CNA #7 reported the caregivers learn about the residents through the closet care plan in the resident’s room. The CNAs would look to find interventions that are in place on the closet care plan if the resident had a history of accidents or falls. During an interview on 08/12/2025 at 2:15 PM, the Assistant Director of Nursing (ADON) indicated when residents were admitted with a history of accidents, the information would have been relayed to the nurses and CNAs during report. The appropriate interventions would be on the closet care plan like low bed position, and whatever else the resident needed. The closet care plan was completed by the admission nurse upon admission. This surveyor placed a call on 08/14/2025 to CNA # 2, there was no answer, and a message was left requesting a call back. During an interview on 08/14/2025 at 10:17 AM, the Director of Nursing (DON) reported that it was expected that all staff review the closet care plans every time they enter a room, and the closet care plan should be updated every three months. DON indicated she agreed with the termination of this staff member for non-compliance with closet care plan. During an interview on 08/14/2025 at 12:53 PM, the Administrator reported the employees must acknowledge and sign the “orientation document” indicating understanding that it was expected the care plan was to be followed, before they started to work at the facility. The Administrator reported that CNA #2 was interviewed after the incident and asked if they knew better than to transfer a resident independently when Resident #109 was a two person assist, and CNA #2 replied she did know better. The Administrator reported asking “then why did you do it?” CNA #2 indicated not knowing why. On 08/13/2025, this surveyor requested a policy regarding utilization of resident closet care plans from the Administrator. On 08/14/2025, the DON reported that no policy existed. A review of an orientation document provided by the Administrator, signed on 06/29/2023 with CNA #2’s name, read in part, that in signing this form the employee acknowledged understanding and acceptance of the disciplinary action when not following the resident’s face sheet or plan of care. A review of the Centers for Medicare and Medicaid Services (CMS) form 7734 for Resident #109 revealed that a closet Care Plan was copied by the facility after the incident on 04/23/2025, and included in the CMS 7734 documentation, under the heading of transfers: assist of two was clearly marked. Further review of CMS form 7734, confirmed through attached signed witness statements, facility documents, signed orientation on boarding document, and Resident #109’s closet care plan, Resident #109 was transferred by CNA #2 independently, which resulted in a fall. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/2025 at 9:01 AM, CNA #2 returned this surveyor’s call and confirmed that she had known the resident had a care plan for a two person assist. CNA #2 confirmed she had signed the pre-employment agreement to follow care plans and that failure to follow would result in termination. CNA #2 stated she felt pressured by Resident #109 to hurry and did not wait for help to transfer the resident.