STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Johnson County Health and Rehab, LLC	1451 East Poplar Street Clarksville, AR 72830

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, it was determined that the facility failed to ensure staff followed a care planned intervention while performing a transfer for one (Resident #113) of six residents reviewed.The findings include:A review of an admission Record revealed the facility admitted Resident #113 on 06/30/2025 with diagnoses which included acute and chronic respiratory failure, damaged or enlarged air sacs in the lungs, lung disease that blocks air flow making it difficult to breathe, urinary tract infection, and disorders of the skin and subcutaneous tissue.A review of an admission Minimum Data Set (MDS) with Assessment Reference Date of 07/06/2025, revealed Resident #113 had a Brief Interview for Mental Status score of 12, which indicated Resident #113 had moderate cognitive impairment. The MDS also revealed Resident #113 required substantial or maximum assistance with transfers.A review of a Care Plan with initiation date of 07/08/2025, indicated Resident #113 required a mechanical lift for all transfers. The Care Plan also revealed Resident #113 was to be evaluated and treated by Physical and Occupational Therapy per Physician Orders.A review of Physician Orders with an order date of 07/03/2025 revealed Resident #113 was to have a mechanical lift for all transfers.A review of an Incident and Accident (I&A) Report dated 07/29/2025 at 3:31 PM, revealed two Medication Aides (MA-C), MA-C #1 and MA-C #2, reported to the nurse that they went to obtain a weight on Resident #113, did not read the Care Plan, and did not use the mechanical lift for the transfer. The I&A indicated that the MA-Cs had to lower the resident to the floor and that the resident did not sustain any injuries. The I&A also indicated vital signs were obtained, the resident's family and the Advanced Practice Registered Nurse (APRN) were notified of the incident.A review of a Progress Note dated 07/29/2025 at 7:13 PM, revealed Resident #113 was transferred by MA-C #1 and MA-C #2, without using a mechanical lift, the resident was unable to help with the transfer, and was lowered to the floor. The progress note revealed that the MA-Cs did not review the Closet Care Plan prior to the transfer and the resident had recently been changed from two-person assistance to a mechanical lift for all transfers.A review of an I&A follow up progress note completed by the Director of Nursing (DON) dated 08/06/2025 at 8:54 AM, revealed that MA-C #1 and MA-C #2, were attempting to obtain a weight on Resident #113. The two MA-Cs attempted to transfer Resident #113 by two-person assistance and had to lower the resident to the floor. The progress note revealed MA-C #1 and MA-C #2 did not review the Care Plan prior to the incident.During an interview on 08/05/2025 at 8:15 AM, Resident #113 stated they had been transferred without the mechanical lift and fell. Resident #113 reported they were sore, but no injuries were sustained.During an interview on 08/06/2025 at 10:12 AM, Physical Therapist #3 revealed Resident #113 did not have the strength and was too weak to stand at that time but was receiving therapy for strengthening.During an interview on 08/06/2025 at 1:05 PM, MA-C #1 revealed that she and MA-C #2 had not reviewed the Care Plan prior to transferring Resident #113. She reported she had recently transferred Resident #113 prior to this incident and the resident was not lifted with a mechanical lift, she was unable to give the exact date of transfer (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045168	A. Building B. Wing	08/07/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at that time. MA-C #1 reported, she and MA-C #2 sat Resident #113 up on the side of the bed and stood Resident #113 to turn them to the wheelchair. The resident was unable to pivot, and they lowered the resident to the floor. MA-C #1 revealed they did not use a gait belt, and that they placed one arm under each of the resident's arms to transfer them. MA-C #1 also revealed that the nurse was immediately notified of the incident and no injuries were observed. MA-C #1 also reported that she did not have a gait belt, because she did not transfer that often. MA-C #1 revealed that it was important to review the Closet Care Plan prior to providing care because the Care Plan indicated how to transfer, toilet, and take care of the resident. She also revealed that she had an in-service about Closet Care Plans and received a verbal warning for not reviewing the Care Plan prior to transferring Resident #113.During an interview on 08/06/2025 at 1:14 PM, MA-C #2 reported to this surveyor, that was the first time providing any type of care to Resident #113 besides giving them medications. MA-C #2 revealed that she did not look at the Closet Care Plan prior to the transfer of Resident #113. MA-C #2 reported that she relied on MA-C #1's guidance on how to transfer the resident. MA-C #2 revealed they did not use a mechanical lift for the transfer. She reported that they under armed Resident #113 and did not use a gait belt. The resident's legs started to give out and they lowered the resident to their knees. No other part of the resident touched the floor. MA-C #2 revealed that the nurse was immediately notified and there were no injuries observed. MA-C #2 revealed that she received a verbal in-service from the DON to check the Closet Care Plan prior to providing care to a resident. MA-C #2 also revealed that it was important to review the Closet Care Plan prior to providing care because it provided information regarding resident safety, information to help avoid falls and indicated how to care for the resident.During an interview on 08/06/2026 at 1:57 PM, the DON revealed that no in-service documentation could be found about the change in Resident #113's transfer status.During an interview on 08/06/2025 at 1:59 PM, the MDS Coordinator revealed that she normally put out an in-service when there was a transfer status change in the Certified Nursing Assistant (CNA) book to update the staff. She revealed that she could not find the in-service. She also revealed the proper way to transfer a resident was to use a gait belt. The MDS Coordinator stated she updated the Closet Care Plans and Care Plans sometimes daily and that they were constantly changing. The MDS Coordinator revealed that she was the one responsible for the changes. The MDS Coordinator stated she kept a master copy and put a copy of the Closet Care Plan out for the staff to review which was in the closet of each resident's room. The MDS Coordinator also indicated Resident #113 was changed to a mechanical lift for all transfers, and a lift Sling Size Assessment was completed on 07/03/2025.During an interview on 08/06/2025 at 3:06 PM, the DON revealed that staff should always review the Closet Care Plan prior to providing care. She also revealed that the MA-Cs should have used a mechanical lift for the transfer and to obtain the resident's weight. She stated, it is important for the Care Plan to be reviewed to ensure resident safety. During an interview on 08/07/2025 at 8:55 AM, Medical Records, who was filling in as the Administrator, revealed that the Closet Care Plan should be reviewed prior to care being provided. She stated that it was important to review the Care Plan because they could change daily and the staff were responsible for providing care according to the Care Plan. She also stated that if the staff did not follow the Care Plan or Closet Care Plan it could result in a fall or a major injury.