STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045236	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Des Arc Nursing and Rehabilitation Center	2216 West Main Street Des Arc, AR 72040

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interviews, and record review, it was determined that the facility failed to ensure dignity was maintained for 1 (Resident #10) of 1 sampled resident reviewed for dignity while passing meal trays. Finding included: 1.Review of a facility policy titled Resident Rights and Responsibilities with no date indicated, The facility protects and promotes the rights of each resident admitted in order to provide a dignified existence. Review of an admission Record indicated the facility admitted Resident # 10 on 12/14/2012, with diagnoses of bipolar disorder and generalized anxiety disorder. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/06/2025, revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated Resident #10 was moderately cognitively impaired. On 01/15/2025 at 7:39 AM this surveyor observed Certified Nursing Assistant (CNA) #1 serving meal trays to the residents in the dining room. CNA #1 served all the residents in the dining room except Resident #10. CNA #1 left the dining room without serving Resident #10 a breakfast tray. Resident #10 yelled out to CNA #1 that the resident wanted a meal tray. CNA #1 stopped and provided him with his meal tray. Resident #10 was interviewed on 01/15/2025 at 7:45AM. Resident #10 stated that it was not right for the CNA to leave the dining room without passing all trays. On 01/15/2025 at 8:00 AM, CNA #1 was asked if all trays should have been served before leaving the dining room. She stated Resident #10's tray should have been served before leaving the dining room to pass other trays. On 01/15/2025 at 8:30 AM, Licensed Practical Nurse (LPN) #5 was asked if all trays should have been served before leaving the dining room. She stated she should have served Resident #10's tray before leaving the dining room to pass other trays. On 01/15/2025 at 3:00 PM, the Director of Nursing (DON) was interviewed and asked if CNA #1 should have served all the trays before leaving the dining room. The DON stated that CNA #1 should have served Resident #10's tray before leaving the dining room to pass other trays.

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, record review and interview, the facility failed to ensure call lights were placed in reach for resident's use and failed to ensure residents with functional limited range of motion call lights were placed in reach and accessible for use for 3 (Resident #27, Resident #35, and Resident #270) of 59 sampled residents. The findings are: 1. Review of the of Resident #27 ' s admission Record reveal diagnoses of Alzheimer's disease and severe dementia with agitation. a. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/2024, indicated the resident had a Brief Interview for Mental Status (BIMS) of 00 which indicated severely impaired cognitive skills. b. On 01/13/2025 at 2:21PM this surveyor observed Resident #27 in bed. The call light was at the foot of the bed along the side of the wall. Resident #27 could not reach it. c. On 01/13/25 at 2:30 PM, Resident #27 was observed lying in bed with eyes closed. The call light was at the bottom of the bed along the side of the wall. The call light was not within reach of the resident. d. On 01/13/25 3:31 PM, Resident #27 was observed with the call light to be in the same location at the bottom of the bed along the side of the wall. The call light was not within reach of the resident. e. On 01/13/25 3:38 PM, during an interview, Certified Nursing Assistant (CNA) #1 was asked if the call light was in reach of Resident #27. CNA #1 confirmed the call light was not in Resident #27's reach, but it should have been. 2. Review of Resident #35 ' s admission Record revealed diagnoses of severe dementia with agitation and anxiety disorder. f. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/01/24 indicated Resident #35 had a Brief Interview for Mental Status (BIMS) 00 which indicated the resident had impaired cognitive skills. g. On 01/13/25 at 2:32 PM, Resident #35 was observed lying in bed with eyes closed. The call light was located along the wall at the end of the resident's bed. The call light was not within the reach of the resident. h. On 01/13/25 at 3:39 PM, this surveyor observed CNA #2 reach back behind Resident 35's bed, pull the call light cord up, and clipped the cord on the blanket next to the resident. i. On 01/13/2025 at 4:00 PM, during an interview, Licensed Practical Nurse (LPN) #5 stated the call light should be placed within the resident's reach at all times. j. On 01/14/2025 at 9:00 AM, during an interview, the Director of Nursing (DON) stated the call (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	light should always be placed within the resident's reach. k. On 01/16/2025, The DON stated there was no policy on placement of call lights. 3) A review of the admission Record, indicated the facility admitted Resident #270 with diagnoses that included chronic obstructive pulmonary disease, acute and chronic respiratory failure, dysphagia, cognitive communication deficit, the need for assistance with personal care and quadriplegia. a. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/2024, revealed Resident #270 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact and had an impairment to one of the upper extremities and impairment to bilateral lower extremities. Resident #270 was using oxygen therapy and had non-invasive mechanical ventilator use. b. Review of Resident #270's Care Plan, initiated on 02/13/2024, revealed Resident #270's usual performance was weight bearing assist with Activities of Daily Living (ADL's). Interventions included: one (1) staff member to assist with bed mobility and Resident #270 used grab assist rails on bed for bed mobility. There was no indication in the current care plan of Resident #270's ability to use the call light. c. During an observation on 01/13/2024 at 11:35 AM, upon entering Resident #270's room, a therapist was noted to be leaving the room. Resident #270 was lying in bed with oxygen being delivered at four (4) liters per minute via nasal cannula. The call light for Resident #270's use was observed to be behind the lamp sitting on the nightstand and not within reach of Resident #270. d. During a concurrent observation and interview on 01/13/2024 at 11:37 AM, Registered Nurse (RN) #3 was asked to come into Resident #270's room and give the call light to the resident. RN #3 looked around and was unable to locate the call light button. This surveyor told RN #3 where the call light could be found. RN #3 then placed the call light in Resident #270's hand. RN #3 confirmed that the call light was not within reach of the resident while it was behind the lamp on the nightstand. e. During an interview on 01/14/25 at 10:00 AM, the Rehab Director was asked if the call light had been placed within reach of Resident #270 before leaving the room on 01/13/2025 at 11:35 AM. The Rehab Director stated, Yes, she had the little beige box in her hand. When it was explained that box was not the call light, but the bed control and that the call light was behind Resident #270's lamp and nightstand, the Rehab Director stated, I'm sorry, I thought it was the call light.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, interviews, and facility document review, it was determined that the facility failed to ensure mechanical soft food was ground to the right consistency to meet the needs of residents who required a mechanical soft diet during one (1) of one (1) meal service observed. The failed practice had the potential to affect eight (8) residents who required mechanical soft diets. The findings include: On 11/15/2025 at 7:36 AM, the Dietary Manager stated the facility did not have a policy for mechanically altered foods. On 11/14/2025 at 11:07 AM, [NAME] #4 stated the facility had 3 pureed and 8 mechanical soft diets and 2 regular diets who requested mechanical soft meat. After gathering supplies needed to begin preparing for mechanical soft, [NAME] #4 began by using the processor machine and added 10 pork chops to process into mechanical soft. After completing the blending process, [NAME] #4 poured the mechanically altered pork chops into a pan, covered the pan with aluminum foil, and placed on the steam table. During a concurrent observation and interview, on 11/14/2025 at 12:10 PM with [NAME] #4, the mechanically altered pork chop was at 157.8 degrees Fahrenheit temperature. [NAME] #4 was asked what the consistency was for the mechanical pork chop. [NAME] #4 responded, pork chops always have looked that way and [NAME] #4 stated it does appear to look like a thick paste. The Dietary Manager, at that time, came over to the steam table and was asked to describe the pork chops. The Dietary Manager stated, looks a little thick, and the Dietary Manager confirmed that the mechanically altered pork chops had a paste consistency. The Dietary Manager asked cook #4 if the processor machine had been pulsated and cook #4 replied, I just hit the green button. The Dietary Manager explained to [NAME] #4 that the green button was to be pushed, stopped, pushed and stopped again to pulsate. The Dietary Manager agreed that the thick paste-like mechanically altered pork chop could cause an issue with swallowing.