STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045396	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johns Place of Arkansas, LLC	1400 Hwy 79/167 Bypass Fordyce, AR 71742

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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to provide evidence that notice of transfers or discharges were sent to the state Ombudsman for residents transferred out of the facility to a local hospital for one (Resident #74) of two residents reviewed for hospitalization. The findings include: A review of Resident #74's admission Record revealed the facility initially admitted the resident on 01/01/2017, with diagnoses which included gastro-esophageal reflux disease without esophagitis and hyperlipidemia. A review of a Standard Forms Screen for Notice of Transfer/Discharge revealed a Notice of Transfer/Discharge form was completed for Resident #74 on 08/13/2025 and 09/16/2025. A review of the Emergency Transfers from Facility form revealed Resident #74 was transferred to the hospital on [DATE] and 09/16/2025. A review of a Notice of Transfer/Discharge/Leave of Absence with Bed Hold Policy form, dated 09/16/2025, indicated Resident #74 was transferred to [local hospital name] on 09/16/2025 for shortness of breath. The form did not indicate the Ombudsman was notified of this transfer. A review of Resident #74's Progress Notes for 08/16/2025 to 11/18/2025, did not reveal documentation of the notification of transfer/discharge forms being sent to the Ombudsman for the resident's transfers to the hospital on [DATE] or 09/16/2025. During an interview by another surveyor on 11/19/2025 at 11:10 AM, the Administrator acknowledged the Social Worker sent the transfer logs and transfer notices to the state Ombudsman. The Administrator added that he could not provide proof of the emails, because the Social Worker was out on leave. On 11/19/2025 at 11:25 AM, this surveyor attempted to reach the state Ombudsman by telephone, and the call was intercepted by voicemail. On 11/19/2025 at 11:27 AM, this surveyor attempted to reach the Program Coordinator for the state Ombudsman, and the call was intercepted by voicemail. During an interview on 11/19/2025 at 1:22 PM, the Administrator stated the Social Worker sent notifications [transfer/discharge] to the state Ombudsman around the first week of the month. He stated (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: 045396	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER St Johns Place of Arkansas, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1400 Hwy 79/167 Bypass Fordyce, AR 71742	

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	he did not know if the Social Worker was or was not sending the transfers and he would ask the Social Worker when she returned to work. The Administrator later stated the facility did not have a policy on Ombudsman notification. Following the survey exit, the State Agency contacted the Administrator on 12/04/2025, to provide an opportunity for the facility to supply the documentation requested during survey that was unavailable due to the facility Social Worker being on leave. The Administrator reported the Social Worker had returned from leave but was unable to produce evidence that the Ombudsman was contacted.

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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 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure required components were included in the facility assessment dated [DATE]. The findings include: A review of the Facility Assessment, with the date of assessment or update of 05/01/2025, revealed no governing body member was listed as being involved in the completion of the facility assessment and no staff retention information was documented in the facility assessment. During an interview on 11/19/2025 at 2:56 PM, the Administrator stated he completed the facility assessment. If he had any nursing questions, he involved the Director of Nursing (DON) and reviewed the facility assessment with the Medical Director for input. The Administrator reported there was not a member of the governing body that was actively involved in the formation of the facility assessment. He stated the Medical Director, the DON, and himself should be involved with the completion of the facility assessment, but that he was not 100 percent sure what the federal requirements were for the facility assessment. He stated the facility had not held any Quality Assurance and Assessment meetings since May 2025 to review the facility assessment, and that he did not know why the plan for staff retention was not put in the assessment. A review of a document, Attachment 1 Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities Federal Register/Vol. [volume] 81, No. [number] 192/Tuesday, October 4, 2016/Rules and Regulations, which the Administrator provided when asked for a policy, did not indicate which members were included in the completion of the facility assessment and did not include the inclusion of a staff retention plan. Page 17 titled, Attachment 2 Sample Process for Conducting the Facility Assessment indicated the facility assessment leader reviewed the regulation for the facility assessment requirements and invited team members on the assessment team, including the Administrator, representative of the governing body, the Medical Director, and DON, and considered other persons to be on the team. Attachment 2 indicated the team leader and others assigned were to complete the assessment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, interview, and facility policy review, the facility failed to ensure proper hand hygiene was consistently implemented during incontinence care for one (Resident #54) of one resident reviewed for bowel and bladder incontinence. The findings include: During an observation on 09/29/2025 at 1:12 PM, this surveyor observed Certified Nursing Assistant (CNA) #4 and CNA #5 assist Resident #54 from their wheelchair to their bed, using a mechanical lift, to provide incontinence care. Both CNAs put on gloves and a gown. CNA #4 then pulled an undetermined number of wet wipes from a package on the over-bed table and left them on top of the package. CNA #4 positioned the resident on their right side, removed their adult brief and began using the wipes to cleanse the resident's bottom. Resident #54's brief was wet and contained loose bowel movement that was malodorous. After CNA #4 had used all the loose wipes from on top of the package, without changing gloves or sanitizing her hands, she began pulling clean wet wipes directly from the package to continue cleaning feces off the resident's bottom. CNA #5 did not perform care, but she held the resident in position during incontinence care. After CNA #4 had completed cleaning the resident's bottom, without changing gloves or sanitizing her hands, she placed a clean brief under the resident's buttocks and continued removing wet wipes from the package to cleanse the resident's pubic area and groin. Again, without changing gloves or sanitizing her hands, CNA #4 fastened the resident's brief. After Resident #54's pants were put on, CNA #4 used the same gloves that were used to perform perineal care, to hook the lift pad to the mechanical lift, touching the metal parts of the lift. After Resident #54 was lifted off the bed, CNA #4, yet wearing the same gloves, guided the resident in the chair as the lift was lowered. After the resident was in their wheelchair, CNA #4 discarded the soiled pair of gloves in the resident's trash can in the room, then performed hand hygiene before exiting the resident's room. A review of Resident #54's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 09/18/2025, revealed a Brief Interview for Mental Status score of 07, which indicated the resident had severe cognitive impairment. Resident #54's MDS also revealed the resident required substantial/maximal assistance with toileting and personal hygiene, shower/bathe self and chair/bed-to-chair transfer. A review of Resident #54's Care Plan, reviewed 09/25/2025, revealed the resident required staff assistance with activities of daily living due to weakness and had leg contractures. Resident #54's Care Plan also revealed the resident required a mechanical lift with staff assist x2; and had some bladder incontinence related to overactive bladder, with an intervention that directed staff to clean the resident's perineal area with each incontinence episode. During an interview on 11/19/2025 at 1:55 PM, CNA #4 stated hands should be sanitized/washed before going into a resident's room and after leaving the resident's room. She stated, during incontinence care of a resident who had a bowel movement, she [usually] sanitizes her hands after entering the resident's room and put gloves on. She stated, during incontinence care of a resident; gloves should be changed before removing clean wipes from a package, after bowel has been cleansed from a resident, and then hands should be sanitized. CNA #4 revealed the reason gloves should be changed and hands should be sanitized was because bowel was present. She the stated she has had education/training on how to perform hand hygiene during incontinence care, but it had been a while, and she did not give the time frame. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/2025 at 2:17 PM, CNA #7 stated hands should be washed when you first walk in the door, sanitize [hands] and change your gloves before you start the actual care on a resident. She stated during incontinence care of a resident, you should change gloves before removing clean wipes from a package, unless you have an assistant helping you by pulling out your wipes for you because of cross contamination, and after you have cleansed bowel from the resident. CNA #7 then stated you should not use the same gloves used to cleanse bowel from a resident's skin, to put an adult brief on the resident because of cross contamination. During an interview on 11/19/2025 at 3:39 PM, the Director of Nursing (DON) stated hand hygiene was important to prevent the spread of germs and infection. She stated her expectation for staff and hand hygiene was they needed to keep their hands clean when dealing with bodily fluids, when going from dirty to clean staff needed to change their gloves, and they need to wash their hands after they removed their gloves. The DON later stated the facility did not have a policy on hand hygiene. A review of an undated Infection Prevention and Control Program policy, revealed for standard precautions, hand hygiene shall be performed in accordance with our [the facility's] hand hygiene guidance. A review of a Hand Hygiene document that was posted in the ladies restroom, located on the hallway to the left of the DON's office, revealed hand hygiene should be performed before having direct contact with patients; after contact with blood, body fluids or excretions; if hands will be moving from a contaminated -body site to a clean-body site during care; and after removing gloves.