STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045440	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Health and Rehab	287 South Country Club Road Osceola, AR 72370

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 record review, facility document review, interviews, and facility policy review, it was determined that the facility failed to ensure resident rights were maintained for one (Resident #71) of one resident reviewed. The findings include: A review of Resident #71’s admission Record indicated the facility admitted the resident on 05/28/2025, with diagnoses which included late onset Alzheimer’s disease. A review of Resident #71’s admission Minimum Data Set, with an Assessment Reference Date of 06/06/2025, revealed a Brief Interview for Mental Status score of 09, which indicated Resident #71 had moderately impaired cognition. A review of Resident #71’s Care Plan, revised 06/09/2025, revealed the resident was resistant to care such as showering and bathing. Further review of Resident #71’s Care Plan revealed interventions that directed staff to try different approaches such as another staff member attempting care, postponing care, attempting again at a later time, and/or notifying the nurse of the situation. A review of Resident #71’s Progress Note, revealed on 06/01/2025 at 10:21 AM, the resident was aggressive and combative with staff when staff entered into their room. A review of a facility incident report, dated 06/03/2025, revealed Resident #71 was fighting and cussing at staff while receiving a shower, and received a skin tear to the left arm/wrist area from fighting the girls. A review of an OLTC [Office of Long-Term Care] Witness Statement for Certified Nursing Assistant (CNA) #2 revealed, [Resident #71] didn’t want to take a shower from the start, so I started taking [pronoun] clothes off, [Resident #71] went to punching at me. During an interview on 07/31/2025 at 11:11 AM, CNA #2 revealed Resident #71 was cussing because they did not want to take a shower. CNA #2 confirmed she told the charge nurse Licensed Practical Nurse (LPN) #3 the resident was refusing, and LPN #3 said Resident #71 had to take a shower. CNA #2 explained the resident was fighting with the nurse the whole time they received a shower. CNA #2 stated they did not know how Resident #71 got a skin tear. During an interview on 07/31/2025 at 12:35 PM, LPN #3 stated Resident #71 was a very combative (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
	045440	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harris Health and Rehab	287 South Country Club Road Osceola, AR 72370

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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 - Minimal harm or potential for actual harm Residents Affected - Few	person. She also stated when she assessed Resident #71’s skin, she was not aware of the resident refusing care up to that point. LPN #3 revealed when Resident #71 started to get combative in the shower, she instructed the CNAs to get the resident back to their room, get them dressed, and let them calm down. During an interview on 07/31/2025 at 2:52 PM, CNA #2 revealed the timeline of the incident started in Resident #71’s room when, “we [the CNAs] were removing the resident’s clothes to get the resident into their shower chair. CNA #2 explained that while taking off Resident #71’s shirt in the shower, she noticed a skin tear and informed LPN #3. CNA #2 also verified that the resident had not been refusing care, prior to that day. She revealed the reason Resident #71 needed a shower was, They just got back from the hospital, they had thrown up and had poop all over them. We couldn’t just let them lay like that. During an interview on 07/31/2025 at 3:18 PM, CNA #2 was asked how she knew to care for a resident and stated, I went to school for it. I’m a CNA and I know how to do it. CNA #2 then verified that residents had a Care Plan on their door. During an interview on 07/31/2025 at 6:17 PM, LPN #3 revealed the way she knew how to care for a resident was by their Care Plan. LPN #3 explained she went into the shower room before the CNAs began the shower, and the CNAs could not shower Resident #71 because the resident started fighting. Then two CNAs took the resident back to their room. During an interview on 08/01/2025 at 11:25 AM, the Director of Nursing (DON) confirmed that if a resident was combative, then staff would need to report it to the charge nurse. The DON explained staff needed to find out why the resident was refusing and then attempt the shower at a different time and inform the family. During an interview on 08/01/2025 at 12:02 PM, the Administrator confirmed that if a resident refused, staff were to try again and pass the task to someone else to try to get the resident to take a shower. The Administrator verified the staff involved did not follow Resident #71’s person centered Care Plan. The Administrator stated if the resident was fighting prior to going to the shower, then the staff did not following the Care Plan. A review of a facility policy titled Resident Rights, dated February 2021 indicated, “Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: be treated with respect, kindness, and dignity, perform services for the facility if he or she chooses, or refuse to perform services for the facility.” A review of a facility policy titled Activities of Daily Living, dated March 2018 indicated, “If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time or having another staff member speak with the resident may be appropriate.”