

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 03/12/2025
NAME OF PROVIDER OR SUPPLIER Johnson County Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure residents were free from elopement for 1 (Resident #1) of 3 sampled residents reviewed for elopement risks. Specifically, Resident #1 was admitted on [DATE] with diagnoses of dementia and psychotic disorder and was severely cognitively impaired. When the resident exited the facility an alarm sounded, and within one minute, an office aide turned the alarm off. The office aide did not notify any other staff that the alarm had sounded and continued working. On 02/28/2025 at 08:06AM, staff confirmed Resident #1 eloped by video, called a Code Green, and notified the Administrator. At 08:26AM the Certified Nursing Assistant (CNA) Supervisor located Resident #1 at a park, 1.25 miles away, and returned Resident #1 to the facility.</p> <p>It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 at a scope and severity of J.</p> <p>The IJ began on 02/28/2025 at 07:38AM, when Resident #1 eloped from the facility, and an office aide turned the alarm off and did not notify any other staff that the alarm had sounded.</p> <p>The Administrator was notified of the past noncompliance (PNC) IJ on 03/12/2025 at 1:46 PM. The facility implemented corrective actions which were completed prior to the State Agency's completion of its survey, thus it was determined to be a Past Noncompliance citation.</p> <p>Findings include:</p> <p>Review of a policy titled, Elopement and Wandering, revised 11/12/2017, revealed all employees are trained about elopement on hire and annually, and all employees were responsible for immediately reporting any suspicion or attempt of resident elopement to the charge nurse or Director of Nursing (DON).</p> <p>Review of the admission Record revealed Resident #1 admitted to the facility on [DATE] with diagnoses of dementia, delirium, and brief psychotic disorder.</p> <p>Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/01/2024 revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment.</p> <p>(continued on next page)</p>		

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: 045168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Johnson County Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Order Summary Report indicated on 11/01/2024 Resident #1 had an order for an antipsychotic 25mg (milligrams) tablet twice a day. On 01/08/2025, the antipsychotic was reduced to 25mg at bedtime, reduced to 25mg, 0.5 tablet on 01/20/2025, and discontinued on 01/27/2025.</p> <p>Review of Resident #1's Care Plan, dated 11/19/2024, revealed Resident #1 was at risk for elopement, with interventions to offer pleasant diversions, food, activities, television, and conversation. Resident #1 was at risk for falls, and on 12/23/24 had an unwitnessed fall, with an intervention to toilet every two hours.</p> <p>A review of the Nursing Admit Readmit Quarterly Assessment, dated 02/06/2025, section M2, revealed Resident #1 had a diagnosis of dementia, did not wander, and was able to follow direction. An elopement risk assessment for Resident #1 revealed a score of 9, indicating the resident was at risk to wander.</p> <p>A review of the Nursing Elopement Risk with Care Plan revealed on 02/28/2025 Resident #1 had a history of wandering, a diagnosis of dementia, had eloped from the facility, and had an elopement risk assessment score of 13, which indicated the resident was at high risk for elopement.</p> <p>A review of the Soc/Act Social Services Resident Room Change, effective date 2/20/2025, indicated on 02/20/2025 Resident #1 was moved from the closed unit to 100 [NAME] Hall.</p> <p>On 02/28/2025 at 07:38 AM, a facility video of the front door showed Resident #1 approaching the door, pressing the release bar of the door until the door opened, setting off an alarm. Resident #1 was visible on video exiting the front door.</p> <p>On 02/28/2025 at 07:39 AM, the Office Aide was seen on video walking to the front door, turning off the alarm, and glancing out the front door through the glass before walking to the front desk, sitting down, and picking up a cellphone.</p> <p>On 02/28/2025 at 07:41 AM, the Office Aide took a telephone call on the facility phone, with the call ending at 07:42 AM. The Office Aide walked from behind the desk and to the window on the right side of the lobby.</p> <p>On 02/28/2028 at 07:42 AM, the Office Aide walked to the front entrance and exited the building.</p> <p>On 02/28/2025 at 07:43:59 AM, the Office Aide walked back into the building and sat at the front desk.</p> <p>On 02/28/2025 at 07:44 AM, the Office Aide picked up a cell phone and looked toward the front entrance.</p> <p>Review of the (named area) Communications dispatch call log showed on 02/28/2025 at 08:23:36 AM, a call was received from Licensed Practical Nurse (LPN) #3 reporting an older resident (Resident #1) had gotten out of the facility and was walking toward the hospital, description given. Resident #1 left the facility at 07:38 AM. At 08:26:30 AM, LPN #3 advised the dispatcher Resident #1 had been found. At 08:27 AM, police units were advised Resident #1 had been found.</p> <p>(continued on next page)</p>		

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 03/12/2025
NAME OF PROVIDER OR SUPPLIER Johnson County Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/10/2025 at 04:49 PM, Resident #1 confirmed the resident left the facility unsupervised, but did not remember when or why the resident left. Resident #1 reported the resident just went for a long walk.</p> <p>On 03/11/2025 at 08:30 AM, the Maintenance Director provided Weekly Exit Door Inspections since January and indicated the front door was in good working condition. He revealed that the front door would open if the door bar was held down for 15 seconds.</p> <p>In an interview on 03/11/2025 at 10:35 AM, the Office Aide stated on 2/28/2025 she rushed from the bathroom because she heard the front door alarm, turned off the door alarm, looked out the windows, the side first then the front windows, and did not see any residents, went to the desk and answered the facility phone. The Office Aide said that she failed to tell staff the door alarm went off so they could count residents and failed to notify the Director of Nursing (DON) or Administrator right away. The Office Aide revealed a family member had previously informed her Resident #1 was a wanderer. The Office Aide revealed she was in-serviced on elopement when she was hired, and with yearly competencies.</p> <p>In an interview on 03/11/2025 at 11:00 AM, the CNA Supervisor stated on 2/28/2025 Resident #1 left the building without supervision. CNA #8 told the CNA Supervisor Resident #1 could not be located. The CNA Supervisor and CNA #8 searched 100-Hall, East and [NAME] side of the building, and were unable to locate Resident #1. The CNA Supervisor notified the DON and called a Code Green for elopement. The CNA Supervisor stated she got into her car and drove away from the facility to search for Resident #1 and located Resident #1 walking near the ballfields at (specific location) Park, approximately 1.25 miles away from the facility. The CNA Supervisor described Resident #1 as being exhausted, dragging, and easily directed into her car to return to the facility. The CNA Supervisor said facility policy was not followed, when the alarm was turned off and no notification was made to other staff in the building so all residents could be accounted for.</p> <p>On 03/11/2025 at 12:45 PM, the surveyor reviewed front door video with the Administrator. The Administrator identified Resident #1, wearing a red beanie, pressed down on the bar of the door until it opened, and the alarm sounded. The Administrator identified the Office Aide, who walked to the front door and turned the alarm off, returned to the desk, picked up her cellphone, and answered the facility phone. The Administrator stated when she pulled up to facility at 08:06 AM and staff called and told her Resident #1 had left the building, she immediately searched the grounds, and went to the back of the facility because there is a large drop off to the rear of the building and she wanted to check for herself that Resident #1 had not fallen at the drop off. The Administrator stated the facility failed when the Office Aide turned off the alarm and did not physically go outside and look immediately to see if a resident went out the front door. The Administrator revealed walking down the road between the facility and (the park where Resident #1 was found) was a concern because of traffic. The Administrator was not sure if any waterways were between the facility and (the park), and confirmed staff were in-serviced for elopement on hire, and with a yearly in-service.</p> <p>During a second interview on 03/11/2025 at 1:15 PM, the Office Aide said that it took her about one minute to get to the front door, and if someone was at the nurse's station it would show them what door was alarming. I glanced out the front glass doors and did not see anyone. The Office Aide stated that after talking on the phone she thought two minutes had passed and went outside to check more thoroughly. The Office Aide did not see anyone and came back inside the facility. The Office Aide did not notify the staff, charge nurse, DON, or Administrator of the alarm sounding.</p> <p>(continued on next page)</p>		

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 03/12/2025
NAME OF PROVIDER OR SUPPLIER Johnson County Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 03/11/2025 at 01:30 PM, LPN #3 confirmed Resident #1 resided on [NAME] Hall, and stated she was notified by CNA #8 that Resident #1 could not be located. LPN #3 checked around the building, could not find Resident #1, and called the police. LPN #3 stated the [NAME] nurse 's station panel did not have an indicator for the front door alarm. LPN #3 stated if an alarm was heard, LPN #3 would check the panel to see what door it was and would turn off the alarm if a resident was not observed outside the facility glass door. LPN #3 stated she would not go outside to check because in the past staff set the alarms off taking too long to put in the code, or when taking residents out to smoke. The surveyor asked LPN #3 to confirm when an alarm went off, she would turn it off and would not have gone outside to look around because staff were setting off alarms taking too long to put in the code, and when taking residents out to smoke, which LPN #3 confirmed. LPN #3 stated training was provided yearly on elopement.</p> <p>In an interview on 03/11/2025 at 01:49 PM, LPN #7 stated the front door alarm sounded on the East panel and confirmed Resident #1 left the building unsupervised on 02/28/2025, that she did not hear the alarm sound, but may not have been at the nurse's station to hear the alarm.</p> <p>In a phone interview on 03/11/2025 at 04:18PM, CNA #8 revealed that she was familiar with Resident #1 and confirmed the resident eloped on 02/28/2025. CNA #8 said that Resident #1 was a good eater and the morning of 02/28/2025 she noted that Resident #1's breakfast tray was still on the rack. She looked in the bathroom and started searching for the resident. Resident #1 was not in the dining room, and she became concerned and started asking everyone to please help her look for him. Housekeepers #9 and #10 thought Resident #1 had gone to smoke. We looked everywhere, and a Housekeeper and I went out the front door and split up and ran around the building, but did not find (Resident #1). I heard someone call Code Green, and it was not long after Resident #1 was found and returned to the facility. Resident #1 was described as very tired when (the resident) came back, walking slower than usual, and staff got a wheelchair and took Resident #1 to the locked unit.</p> <p>On 03/12/2025 at 08:27AM, Housekeeper #9 said she was aware Resident #1 left the building without supervision. She said Resident #1 left (the resident's) room that morning and said (the resident) was leaving and would see us later, I assumed (pronoun) went outside to smoke. Housekeeper #9 said she was in-serviced on elopement a few weeks ago when she was hired, and after the incident.</p> <p>In an interview on 03/12/2025 at 08:29AM, Housekeeper #10 revealed she was training Housekeeper #9 on 2/28/25 and saw Resident #1 come out of the resident's room and was given permission to clean resident's room. Resident #1 said (the resident) was leaving and I assumed (pronoun) was eating breakfast or smoking. Had the resident said (the resident) was leaving the facility Housekeeper #10 said she would have notified the nurse. Housekeeper #10 confirmed everyone was in-serviced about elopement on hire, after the incident, and with yearly competencies.</p> <p>On 03/12/2025 at 11:40 AM, the Administrator provided a missing in-service signature sheet dated 2/28/2025. The Administrator said that she and nursing immediately started educating everyone in the facility, the morning of 02/28/2025 and calling staff to come be in-serviced. She revealed that signatures were done over second and third shift with the help of nursing services, suggesting an end date of 03/01/2025. The Administrator provided a copy of in-services on Code Green dated 02/28/2025.</p> <p>(continued on next page)</p>		

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 03/12/2025
NAME OF PROVIDER OR SUPPLIER Johnson County Health and Rehab, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 3/12/2025, the route Resident #1 followed to travel from the facility to the park where the resident was found was examined by the surveyor. Resident #1 would have traveled approximately 3,588 feet westward on Arkansas Highway 123, passing a densely wooded plot of land on the left. Resident #1 then turned north on a local street, traveling approximately 1500 feet. On this street the resident would have transversed a bridge spanning a creek before arriving at the park.</p>		