

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045172	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2026
NAME OF PROVIDER OR SUPPLIER Dermott City Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 702 West Gaines St Dermott, AR 71638	
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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This failed practice resulted in actual harm for one (Resident #1) of three sampled residents reviewed for neglect. It was determined the facility's noncompliance 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 CFR 483.25 (Quality of Care) at a scope and severity of J. The IJ began on [DATE], when facility staff failed to identify and properly respond on behalf of a resident experiencing a medical emergency resulting in avascular necrosis and subsequent death. The Administrator was notified of the IJ on [DATE] at 1:22 PM. A removal plan was requested and received on [DATE] at 4:35 PM. The facility's removal plan was completed on [DATE] and verified on [DATE] at 2:58 PM. The findings include: A review of Resident #3's Medical Diagnosis indicated the facility admitted the resident on [DATE] with diagnoses of unspecified fracture of the sacrum, (fracture of lower back) cerebrovascular disease (condition that effects blood flow in the brain), heart disease, chronic obstructive pulmonary disease (condition that causes severe breathing difficulty) and chronic kidney disease. A review of Resident #3's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. A review of Progress Notes dated [DATE] revealed Resident #3 was being treated for Covid-19. A review of Progress Notes dated [DATE] revealed Resident #3 was evaluated by nursing staff, and Resident #3's skin was warm and pink with capillary refill less than 3 seconds, with no swelling present. A review of Progress Notes dated [DATE] revealed Resident #3 was complaining of pain to the left (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
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	inner foot. Stated left great toe area is really sore to touch. Denies any recent injuries to foot. Slight swelling and purple/red discoloration noted. Pedal pulse to left foot positive. Orders per Advanced Practice Registered Nurse (APRN) [to administer] a steroid injection if resident continues to complain of pain may get x-ray. A review of Progress Notes dated [DATE] revealed Resident #3 was, complaining of pain to left foot area. Slight swelling and purple/red discoloration noted. Has edema noted to left foot. Discoloration and edema to left great toe area. X-ray of left foot, and steroid injection. A review of Health Status Note/Nurses Note dated [DATE] revealed staff were, called to room. Resident complaining of leg pain. Says it is shooting all the way to the [resident's] toes. Requesting pain meds at this time. 1 [prescription opioid pain medication]- tab given at this time. A review of Health Status Note/Nurse Note dated [DATE] revealed, Resident has remained in room most of time. Had X-ray of left foot due to complaints of pain. Impressions: No acute fracture. No discoloration noted to left foot but complaints of pain. Resident taking as needed pain medication. A review of Long -Term Care Evaluation: Look back note: dated [DATE] revealed the resident had discoloration of left great toe across base of toes persists, physician aware. No anti-embolic treatment prescribed. Denies calf tenderness. Left pedal pulse weak and thready. Right pedal pulse weak and thready. Discoloration left great toe/base of toes of left foot. Tissue: Cool. A review of Health Status Note dated [DATE] revealed Resident pain to foot, has discoloration noted to foot when sitting up. When foot is elevated normal color, cool to touch. Gait and balance unsteady. Continue to check on often. Family called and concerned about resident complaining of feet and legs hurting. No progress notes or Physicians orders were noted in Resident #3's medical record through the dates of [DATE] through [DATE]. A review of Orders-Administration Note dated [DATE], revealed [prescription opioid pain medication] oral tablet 50 mg give 1 tablet by mouth every 8 hours as needed for pain. A Health Status Note/Nurses Note dated [DATE] revealed [Family member] here and helped [Resident #3] into wheelchair and to private car for transport. [Resident #3] assisted to get in car. Can move self about, but yells when stepping on [affected extremity]. A review of a local hospital Emergency Department (ED) note dated [DATE] at 7:45 AM revealed, left foot pain and discoloration for the past week. Palpable pulse not present on exam. A review of Radiology results dated [DATE] at 11:36 AM revealed significant blockage to the artery above the left knee and significant blockage to the resident's blood vessels, also moderate blockage of the left femoral artery. Final diagnosis/clinical impression: dated [DATE] at 2:00pm revealed, transfer to another facility for specialty care; vascular. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #3's hospital records dated [DATE] at 12:10 PM, revealed a final report that showed a CTA)a non-invasive imaging test that combines a standard CT scan with an injection of contrast dye to produce highly detailed 3D pictures of blood vessels and tissues throughout the body) was performed that revealed bilateral aortoiliac occlusion with a popliteal occlusion in the left leg (indicates blockages in the major blood vessels supplying the pelvis/both legs (the aorta and iliac arteries) as well as a blockage behind the left knee (the popliteal artery)). Resident #3 was described as writhing in bed, speaking incoherently. The left leg was cyanotic (blue) from the foot to midway up the lower leg. Both feet were very cold to touch, and the left foot appeared to be without sensation and paralyzed. The record also stated that Resident #3's left leg was without sensation and paralyzed consistent with a left leg that could not be saved. Based on review by the medical doctor (MD), it appeared the left leg had been critically ischemic (lacking in adequate blood flow and oxygen) for at least two days. The MD informed the family that Resident #3 had sustained an occlusion most likely a week ago, and that the left leg was no longer viable. The option provided to the family was an above-knee amputation, which was described as very high risk, with a 30-day mortality as conservatively 60 to 70% but very well may be approaching 100%. The MD recommended palliative care in-patient hospice as an option. In an interview conducted on [DATE] at 8:41 AM, Resident #3's family member stated that Resident #3 was admitted to the facility for rehab after a fall suffered at home. The resident's family member stated that within being in the facility for two weeks Resident #3 had been complaining of left foot pain. The resident's family member also stated that Resident #3 had been calling complaining of pain to their left foot. The family member stated that the facility was called, and reported speaking to nursing staff to relay what Resident #3 was saying regarding the pain. Resident #3's family member stated that after speaking to nursing staff at the facility, they were informed that the resident's leg would have discoloration when sitting but then return to normal color when standing or when the leg was elevated. Facility staff informed the family member that pain medication was provided, and an x-ray were performed which showed no fracture. Resident #3's family member stated that on [DATE] the facility was called and informed them that the family was taking the resident to the hospital. While at the hospital Resident #3 was started on a blood thinner, and then the family member was informed by hospital staff that Resident #3 was being transferred to another hospital for a consultation with a vascular surgeon. Resident #3's family member stated that they were informed by the vascular surgeon that Resident #3's artery was blocked, and the vascular surgeon informed them that if Resident #3 had gotten to the hospital sooner [the surgeon] might have been able to save Resident #3's leg. The vascular surgeon relayed at the time, there was no hope of saving Resident #3's leg due to the procedure being a high-risk surgery. Resident #3's family member stated the family collectively made the decision to not pursue the surgery but elected to place the resident on hospice. Resident #3 expired on [DATE]. A review of Resident #3's Death Certificate, dated [DATE], revealed that the cause of death was due to infection and dead tissue. In an interview with Licensed Practical Nurse #1 (LPN 1) [DATE] at 8:57 AM, it was revealed that Resident #3's left foot was red and purple at times and was consistently hurting. LPN #1stated that the resident had been complaining of pain off and on for at least two weeks. LPN #1 stated that Resident #3 had an X-ray performed on their left foot and the results were negative for fractures. LPN (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	#1 stated that a steroid injection was ordered by the APRN and the Physician ordered [prescription opioid pain medication] for pain which was given to the resident when they complained of pain. In an interview with the APRN on [DATE] at 1:41 PM, it was revealed that the resident was seen once by the APRN in February before the symptoms began, where Resident #3 was treated for allergies. The APRN stated that the resident had not seen Resident #3 since February due to making rounds at the facility on a monthly basis, but that she had planned on seeing Resident #3. The APRN stated that the only order they had given for Resident #3 was to refill Resident #3's medication due to the Physician being out of his office, and another for the X-ray. The APRN stated that her expectations were to be notified by staff from the facility if a resident's condition worsened so a determination could be made if the resident needed further treatment or to be sent out to the hospital. During an interview conducted with the Director of Nursing (DON) on [DATE] at 1:46 PM, it was revealed that the DON's expectation from the nursing staff was to perform thorough assessments on each resident, and if a resident's condition worsened the nursing staff were to notify the Physician or the APRN for further instructions. The DON also stated that if the nursing staff inform the Physician or APRN about a resident's condition and they do not receive any orders, the staff should inform the DON and she would intervene. The DON also stated that a resident with a possible emergency situation should be sent to the hospital immediately. The facility's plan of removal was received on [DATE] at 4:35 PM. The facility's removal plan was completed on [DATE] and verified by surveyors onsite on [DATE] at 2:58 PM. Plan of Removal: 1. Corrective Action a. All licensed nursing staff were in-serviced beginning on [DATE] (and will continue until all facility staff have been in-serviced prior to start of their shift on common signs and symptoms of deterioration in a resident. Examples of these signs and symptoms included but was not limited to complaints of pain, swelling, discoloration of skin, out of normal range of vital signs, weight loss or gain, grimacing, being lethargic, lack of pedal pulses, coolness of extremities to touch. Who to notify in case any of these and other signs and symptoms were visually or audially observed. Staff were in serviced to notify upon observation the PCP/attending physician, family/POA, Care giver DON (Director of Nursing) and Administration. And to notify the ambulance of choice if sending resident out to the hospital. Nursing staff were also in serviced that if the PCP/attending physician gave an order for x-ray, lab work, or any other service that the order was to be carried out immediately, not passed on to the next shift, but was to be during the shift of the nurse taking the order. b. All current residents and any future resident who have a current BIMS score of 10 or higher were/will be in serviced 1:1 on the Resident's Right to seek medical care or to refuse any or all medical care. This includes medication orders, medication treatment, going to the hospital of their choice, having the facility transport them to the doctor, hospital of choice. Any resident currently in the facility who had a current BIMS score of 10 or less the facility will seek out the resident's POA, responsible party, family, and/or caregiver and educate them on the rights to self- choose if, when (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	and where treatment is accepted or rejected. These tasks will be completed by [DATE]. Resident #3 no longer resides in the facility. 2. Identification of other residents: [DATE], the RN Compliance Officer obtained a roster of all current residents who were in the facility via electronic health record or a resident census report and assessed each resident both visually and verbally inquiring as to their pain, what level on a scale of 0-10, any visual signs of pain, swelling, or mottling. Any negative outcomes verbally or visually were immediately addressed including providing pain medication, notification to PCP/attending physician, family/caregiver. This identification of other residents was completed on [DATE]. All outcomes were documented on the Compliance Officer's roster. 3. Measures put into place: a. Beginning [DATE], the compliance RN began in servicing all staff on change of condition in health or mental status change, physician notification and to ensure they are transferred out in a timely manner. b. On [DATE], the DON in serviced all nursing staff on the use of the new facility nursing tools of the SBAR Communication Form and Progress Note, the new facility nursing tool, the STOP AND WATCH, the STOP AND WATCH EARLY WARNING TOOL. How to use, when to use to whom to notify if there is a change of condition, sending a resident to the hospital, why we are sending the resident and when to notify family/caregivers, DON and administrator. No staff will be allowed to begin their shift without being in serviced prior to completion of in-servicing. The staff will be completed by [DATE], for all staff who are on the facility schedule. 4. Facility Monitoring: a. Beginning on [DATE], the DON or her designee will assess all residents; report changes of condition, and/or transfer resident to higher level of care for evaluation and possible treatment for all residents who are exhibiting declining signs and symptoms to prevent serious harm, serious impairment, serious injury or death. All newly hired staff will have a notification in their hire pack of this policy and new documents. All new documents will be available in the facility's electronic health record. An in-service will also be conducted upon hiring of the location of these new documents in the electronic health record. b. The DON or her designee will monitor 2 random residents 3 times a week (total of 6) for 3 weeks, then 2 random residents 2 times a week (total of 4) and then 1 random resident 1 time a week for 1 week or until compliance is achieved. All completed documentation upon completion will be placed in the 2567 notebook placed in the administrator's office for any review by required agency. 5. QA (Quality Assurance) (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. The DON or her designee will provide all monitoring documentation to the QA of any negative outcome, issues, requesting suggestion or improvements on current actions. This interaction with the QA committee will be conducted weekly until compliance is achieved.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interviews, record review and facility document review, it was determined the facility failed to ensure that a resident's transfer or discharge was reported to the ombudsman for one (Resident #3) of one resident reviewed for discharge process. The findings include: A record review of admission Record revealed Resident #3 was admitted on [DATE], was discharged on [DATE] to an acute care hospital and did not return to the facility. A record review of Medical Diagnoses indicated Resident #3 was admitted to the facility with the diagnoses of fracture of sacrum, cerebrovascular disease, atherosclerotic heart disease, chronic obstructive pulmonary disease, chronic kidney disease stage 3, hypertension, and benign prostatic hyperplasia. A review of admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of [DATE] indicated Resident #3 had a Brief Interview for Mental Status (BIMS) score of 10, indicating Resident #3 was moderately cognitively impaired. Resident #3 was not receiving scheduled or as needed pain medication. Resident #3 had a fall in the past month with a fracture. A review of facility policy, Transfer or Discharge dated [DATE], indicated the facility would send a copy of the notice of transfer or discharge to the Office of the State Long-Term Care Ombudsman when practicable (in a monthly list of residents that includes all notice content requirements) and to the resident and representative as soon as practicable before the transfer. A review of facility document, Notice of Resident Transfer or Discharge dated [DATE], indicated the Ombudsman was notified of two residents during the month of [DATE] with Resident #3 not included on the list. During an interview on [DATE] at 10:45 AM, the Social Services Director (SSD) stated there were only two residents that were on the ombudsman's list for [DATE]; Resident #3 was not on the list. During an interview on [DATE] at 2:25 PM, the Administrator stated she considered an emergent situation where the facility would need to send a resident out included: a fall, blood, head injury from the fall, if the resident had a bone sticking out, signs and symptoms of an infection, running a fever, nausea and/or vomiting, not eating and weight loss, and anything else the staff thought a doctor should see the resident. The staff cannot diagnose or treat but they can send them out to obtain those services. She stated, The staff should listen to residents when they complain and send them out for that, things that are not normal. During a follow-up interview on [DATE] at 9:19 AM, the SSD stated, it was the nurse's responsibility to fax the discharge/transfer form to the ombudsman at the time of discharge or transfer, then the (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse would give me a copy. She indicated the nurses get a confirmation fax when it goes through. The SSD stated, When I get the copy, I send it via email to the family so they can sign it and return it to me. The SSD stated that any resident that goes to the hospital would be put on the list. She indicated that a resident that goes home would not, but she would do a post discharge on that resident. The SSD stated if a resident was taken to the hospital from the facility by a family member, a notice of transfer/discharge would be sent to the ombudsman for that resident by the nurse. She stated her only interaction with the forms were in making sure the signatures were valid. During an interview on [DATE] at 9:34 AM, the Director of Nursing (DON) indicated the nurse on the floor was responsible for preparing the Notice of Discharge/transfer form for the ombudsman and sending it in. She stated the nurse would fill the form out, fax it, get a confirmation fax, then leave a copy of the form in (the DON's) door tray. The DON stated, Any resident that is being sent out to the Emergency Department (ED), transfers to another facility, and discharged from the facility would have the notice completed and sent in. During an interview on [DATE] at 10:23 AM, the Administrator indicated the SSD was the person that was responsible for preparing the discharge/transfer list that is submitted to the ombudsman. She stated that any resident that goes to the hospital, discharged home with family, expired, and/or transferred to another facility would be included on the list. The Administrator stated that a resident that is taken to the ED and stayed at the hospital would be included on the ombudsman list. We would call to check on them. She indicated if a resident that was leaving the facility for a family day, out to eat, to church, fishing, or family taking them to the doctor would not be on the list.		