

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 02/27/2025
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)
<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>37925</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure the required staffing data was posted daily as evidenced by the daily staffing logs did not display the total number and actual worked hours for Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nursing Assistants (CNAs) and resident census.</p> <p>The findings are:</p> <p>On 02/24/2025 at 9:38 AM, a review of the nursing schedules posted in the clear glass of the Director of Nursing (DON) office, which was to the right of the nursing station, was dated February 20, 2025, through March 05, 2025. The RN and LPN schedule; 7/3 (7:00 AM to 3:00 PM) shift CNA and [NAME] Clerk schedule; and the 3/11 (3:00 PM to 11:00 PM) and 11/7 (11:00 PM to 7:00 AM) schedule, had an x in some boxes, but the x did not have a number value to indicate the number of hours the x indicated. Some boxes on the RN and LPN schedule had numbers such as 7-3 (7:00 AM to 3:00 PM), 3-7 (3:00 PM to 7:00 PM), 4p-11p (4:00 PM to 11 PM), 3-11 (3:00 PM to 11:00 PM) and 7-11 (7:00 AM to 11:00 PM). The total actual hours were not indicated on the schedule. The 7-3 shift CNA and [NAME] Clerk schedule had an x in the box to indicate the date to be worked and dashes to indicate when the staff member was off.</p> <p>On 02/24/2025 at 10:54 AM, the daily staffing log sheets were observed on a table in the front lobby for the day shift, evening shift, night shift, housekeeping/maintenance and dietary and no census was indicated on any of the staffing logs. There were no staffing logs for the prior day, 02/23/2025, to show the total number of hours worked by the staff.</p> <p>On 02/25/2025 at 9:36 AM, the daily staffing log sheets were observed on a table in the front lobby for the day shift, evening shift, housekeeping/maintenance and dietary and no census was indicated on any of the staffing logs. The staffing log for the night shift for 02/24/2025 was on the table but the total number of hours worked by the staff was not indicated on the staffing log.</p> <p>On 02/26/2025 at 9:44 AM, the daily staffing log sheets were observed on a table in the front lobby for the day shift, evening shift, night shift, housekeeping/maintenance and dietary and no census was indicated on any of the staffing logs. There were no staffing logs for the prior day, 02/25/2025, to show the total number of hours worked by the staff.</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
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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 02/26/2025 at 3:09 PM, the Director of Nursing (DON) was interviewed with concurrent observations, and she indicated everyone signs in when asked who was responsible for filling out the staffing logs. She stated the night shift nurse placed the sheets out for the next day. When she was asked if the night nurse was trained in what information needed to be put on the staffing logs, she stated she needed to look at the sheet. After reviewing the daily staffing log sheet on the table dated February 26, 2025, the DON stated the daily census was on a separate sheet that was printed out of their electronic computer system, attached to the staffing log and placed in the collection box on business office door and was not visible to the public. The DON stated she thought the Business Office Manager (BOM) placed the total hours worked on the daily staffing logs.</p> <p>On 02/27/2025 at 9:27 AM, the daily staffing log sheets were observed on a table in the front lobby for the day shift, evening shift, night shift, housekeeping/maintenance and dietary and no census was indicated on any of the staffing logs. There were no staffing logs for the prior day, 02/26/2025, to show the total number of hours worked by the staff.</p> <p>On 02/27/2025 at 9:42 AM, LPN #9 was interviewed by telephone and stated she filled out the staffing log, printed off a census after midnight, indicated if a resident was in the hospital or rehab and placed the sheets in the front door for the front office staff to do the count. She stated she had not been instructed on placing the census on the daily staffing log labeled census and did not total the hours worked for each staff member. She stated she placed the daily staffing logs in the front lobby for each to sign in and out on.</p> <p>On 02/27/2025 at 2:57 PM, the BOM was interviewed and stated once she received the daily staffing logs, she used the census sheet attached to the staffing logs to ensure residents who were out of the facility were reflected in the electronic computer system and the staffing logs and census was given to Human Resources (HR).</p> <p>On 02/27/2025 at 2:58 PM, HR was interviewed and stated once she received the daily staffing logs, she reviewed the staff times in the electronic system to ensure the staff member clocked in and did not have any missed punches. She reviewed the daily staffing log for 02/27/2025 and stated she had not been totaling the hours for staff or placing the daily census on the sheets.</p> <p>A review of a Staffing, Sufficient and Competent Nursing policy, dated as revised August 2022, revealed direct care daily staffing numbers (the number of nursing personnel responsible for providing direct care to residents) are posted in the facility for every shift.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 2 of 2 meals observed. This failed practice had the potential to affect 21 residents who received mechanical soft diets from 1 of 1 kitchen.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. The menu for lunch documented residents on pureed diets were to receive a #6 scoop (2/3) cup of pureed chicken and dumplings. <ol style="list-style-type: none"> a. On 02/24/2025 at 12:49 PM, Dietary [NAME] (DC) #3 was observed using a #8 scoop (1/2) cup to serve a single portion of chicken and dumplings to the residents who required pureed diets, instead of a #8 scoop (2/3) cup. b. On 02/24/2025 at 12:59 PM, DC #3 was interviewed and was asked what scoop she had used to serve pureed chicken and dumplings and how many servings she gave to each resident and if she had looked at the menu before serving. She stated she used a #8 scoop, gave one serving each, and did not look at the menu. 2. On 02/24/2025 at 12:51 PM, the kitchen ran out of cornbread and served regular bread to seven residents. DC #1 was interviewed and was asked how many residents received bread and the reasons those residents were served bread. She stated because the kitchen ran out of cornbread. DC #2 stated the kitchen ran out of cornbread because she fed the employees first. 3. On 02/24/2025 at 1:10 PM, Resident #15 was interviewed and asked if she liked cornbread. She stated she loved cornbread. Residents #25 and #31 were interviewed and asked if they liked cornbread. Both confirmed that they liked cornbread. 4. The menu for supper documented residents on pureed diets were to receive a #8 scoop (1/2) cup of pureed baked beans. <ol style="list-style-type: none"> a. On 02/24/2025 at 06:21 PM, during the supper meal service residents who required pureed diets were not served pureed baked beans. 5. On 02/24/2025 at 6:23 PM, the Dietary Manager and DC #3 were asked the reason residents on pureed diets were not served pureed baked beans. The Dietary Manager stated she had wasted the pureed baked beans after the DC #3, using the same gloved hand she had used to open a drawer, removed a #8 scoop, contaminating it in the process. The same #8 scoop, then fell into the pureed baked beans prepared for the residents on pureed diets, leading to cross contamination. The residents on pureed diets were supposed to have pureed baked beans like everyone else. DC #3 stated she gave the residents pureed diets mashed potatoes, pureed corn dogs, and tomato juice, and did not give pureed beans since spoon fell in it. 		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure dietary staff washed their hands and changed their gloves before handling food items; foods stored in the dry storage area, refrigerator, and freezer were covered and sealed; expired food items were promptly removed from stock; 1 of 2 ice machines was maintained in clean and sanitary condition; hot food items were maintained at or above 135 degrees Fahrenheit on the steam table.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. On [DATE] at 8:11 AM, an ice scoop holder on the wall in the kitchen by the ice machine had a wet black and beige residue on it. The Dietary Manager was interviewed and was asked if she could wipe the area. The black and beige residue easily transferred to the tissue. She stated, It was black and beige residue. The surveyor asked the Dietary Manager who uses the ice from the ice machine and how often she cleans it. She stated she cleaned it every day and the kitchen used it to fill beverages served to the residents at mealtimes. 2. On [DATE] at 8:41 AM, the following observations were made on a shelf in the walk-in refrigerator: <ol style="list-style-type: none"> a. A container of cottage cheese in a box had an expiration date of [DATE]. b. An opened box of bacon. The box was not covered or sealed. 3. On [DATE] at 08:53 AM, the following observations were made on the walk-in freezer shelf: <ol style="list-style-type: none"> a. An opened box of catfish patties. The box was not covered or sealed. b. An opened box of hamburger patties. The box was not covered or sealed. c. An opened box of garlic bread. The box was not covered or sealed. d. An opened box of dinner rolls. The box was not covered or sealed. e. An opened box of biscuits. The box was not covered or sealed. f. An opened box of hash browns. The box was not covered or sealed. g. An opened box of corn dogs. The box was not covered or sealed. h. An opened box of cheese filled tortillas. The box was not covered or sealed. 4. On [DATE] at 9:03 AM, Dietary [NAME] (DC) #2 was touching a box of plastic sheets while pulling plastic wrap out of the box. Without washing her hands, DC #2 picked up glasses that contained beverages to be served to the residents by their rims and covered each with a piece of plastic wrap. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>5. On [DATE] at 9:11 AM, an opened box of raisin bran cereal was on a shelf in the nourishment refrigerator. The box had no received date.</p> <p>6. On [DATE] at 9:13 AM, an opened container of vanilla ice cream on a shelf in the walk-in freezer, had particles of icicles on it. The Dietary Manager was interviewed and was asked to describe the appearance of the ice cream. She stated it had icicles on the inside and looked like it had been defrosted and refrozen.</p> <p>7. On [DATE] at 11:49 AM, DC #3 removed fresh tomatoes, cucumbers, and onion from the original box. Without rinsing the tomatoes and cucumbers she placed them on the cutting board. Without rinsing, DC #3 sliced the tomato, cucumber, and onion, and placed the pieces in a container for the vegetable salad to be served to the residents for the supper meal. DC #3 was interviewed and was asked what she should have done before slicing the tomatoes, onion, and cucumbers. She stated she should have rinsed them. DC #3 was then asked if she had rinsed the tomatoes, onion, and cucumbers. She stated that she had not.</p> <p>8. On [DATE] at 12:28 PM, the temperatures of the food items when checked and read on the steam table by the DC# 2 were as follows:</p> <p>a. Pureed chicken and dumplings - 123.9 degrees Fahrenheit.</p> <p>b. Pureed cut green beans - 129 degrees Fahrenheit.</p> <p>c. Pureed bread with warm milk - 99.5 degrees Fahrenheit.</p> <p>The above food items were not reheated before being served to the residents.</p> <p>9. On [DATE] at 12:48 PM, DC# 2 was on the tray line serving the lunch meal. She picked up tray cards and placed them on the trays. Without washing her hands, she picked up plates and bowls to be used in portioning food items to be served to the residents and placed them on the trays with her fingers inside the plate and bowls. At 1:06 PM, DC# 2 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment. She stated she should have washed her hands.</p> <p>10. On [DATE] at 5:07 PM, DC #3 was wearing gloves on her hands when she touched the handle of the deep fryer basket that contained corn dogs. After that, DC #3 opened the cabinet, took out a spray bottle, and sprayed inside a pan, contaminating the gloves. Without changing gloves and washing her hands, DC #3 picked a clean blade and attached it to the base of the blender to be used in pureeing foods to be served to the residents who required pureed diets.</p> <p>11. On [DATE] at 5:37 PM, DC #3 was wearing gloves on her hands while sorting tray cards, contaminating the gloves. Then, without changing gloves and washing her hands, DC #3 picked up the tray cards and placed them on the trays. With the same gloves, DC #3 picked up corn dogs and placed them on plates. DC #3 then received a bag of bread from the Dietary Manager. Without changing gloves and washing her hands, DC #3 opened the bag of bread, removed slices of bread, and placed them on the plates to be served to the resident who did not receive baked beans.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12. On [DATE] at 5:47 PM, the temperatures of the following food items before been served to the residents were:</p> <p>a. The chicken and dumplings temperature from the container by the steam table was 105 degrees Fahrenheit.</p> <p>b. Ground corn dogs - 106 degrees Fahrenheit.</p> <p>The above food items were not reheated before being served to the residents.</p> <p>13. A review of facility policy titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary, initiated 2022, provided by the Compliance Officer on indicated, employee should wash their hands during food preparation, as often as necessary and after engaging in other activities that contaminates the hands.</p>		

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<p>F 0917</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space.</p> <p>48977</p> <p>Based on observations, interviews, record review, and policy review, the facility failed to provide appropriate bedding for 1 (Resident #1) of 1 sampled resident observed for bedding.</p> <p>The findings include:</p> <p>A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/06/2024 revealed Resident #1 had short-term and long-term memory problems.</p> <p>A review of the plan of care for Resident #1 (revised on 09/08/2023) revealed Resident #1 required total assistance to turn and reposition in the bed and the resident could use rail with left hand to assist with turning and repositioning.</p> <p>On 02/24/2025 at 09:15 AM, this surveyor observed Resident #1 lying on [pronoun] back in bed without a pillow. Resident #1 was holding [pronoun] head up from the mattress. This surveyor did not see a pillow on or around the bed.</p> <p>On 02/24/2025 at 02:54 PM, this surveyor observed Resident #1 in bed lying on [pronoun] left side without a pillow. Resident #1's head was resting on the left hand folded into a fist. This surveyor did not see a pillow on or around the bed.</p> <p>On 02/25/2025 at 08:30 AM, this surveyor observed Resident #1 lying in bed on the [pronoun] right side without a pillow. Resident #1 was resting [pronoun] head on the mattress, and this surveyor noted a bend in the neck. This surveyor did not see a pillow on or around the bed.</p> <p>On 02/25/2025 at 03:40 PM, this surveyor observed Resident #1 lying in the bed on [pronoun] left side without a pillow. Resident #1 was resting [pronoun] head on [pronoun] hand folded into a fist. This surveyor did not see a pillow on or around the bed.</p> <p>On 02/25/2025 at 03:55 PM, this surveyor observed Licensed Practical Nurse (LPN) #7 search for Resident #1's pillow, but she was unable to locate a pillow on, under, or near the resident's bed. LPN #7 was also unable to locate a pillow in the resident's closet.</p> <p>On 02/25/2025 at 03:49 PM, during an interview Certified Nursing Assistant (CNA) #5 stated the position in which Resident #1 was lying, did not appear comfortable. CNA #5 stated Resident #1 was not capable of positing alone and was dependent on staff. CNA #5 stated Resident #1 was not capable of voicing discomfort or desired position. CNA #5 stated if she herself was lying in bed she would want a pillow for comfort. CNA #5 stated the resident removes the pillow, but the facility has done nothing to her knowledge differently to ensure the resident was comfortable.</p> <p>(continued on next page)</p>		

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<p>F 0917</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 02/25/2025 at 03:55 PM, during an interview LPN #7 stated Resident #1 did not have a pillow on the bed, around bed, or in the room. LPN #7 stated she thinks she knows where the pillow was and looked over to the resident in Bed A who had 2 pillows. When asked if that resident was ambulatory or able to self-propel, LPN #7 stated no. LPN #7 stated Resident #1 did not look comfortable in the current position. LPN #7 stated the absence of a pillow can affect the resident by preventing the resident from having proper neck alignment.</p> <p>On 02/27/2025 at 11:32 AM, during an interview the Administrator stated Resident #1 was unable to position self and was dependent on staff for positioning, and the resident was not capable of voicing discomfort. The Administrator stated the absence of a pillow can cause contracture if the resident is not position right.</p> <p>On 02/27/2025 at 11:41 AM, during an interview the Director of Nursing (DON) stated Resident #1 was unable to position self and was dependent on staff for positioning. The DON stated the absence of a pillow could affect the resident's neck posture.</p> <p>A policy titled Repositioning, with a revision date of May 2013 noted, The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care pian for repositioning, to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents .</p>