

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Perry County Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1321 Scenic Drive Perryville, AR 72126	
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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report to the State Survey Agency a major injury of unknown origin for one (Resident #1) of three residents reviewed for accidents with major injuries. The findings include: A review of Resident #1's admission Record revealed the facility admitted Resident #1 on 06/10/2024, with diagnoses which included hemiplegia and hemiparesis following a cerebral infarction affecting the dominant right side, and gout. A review the discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated on 07/04/2026 revealed a Staff Assessment of Mental Status (SAMS) code of 1, which indicated that Resident #1 had short term memory problems, and 3, which indicated their cognitive skills for daily decision making were severely impaired. The MDS revealed Resident #1 was dependent on staff for toileting hygiene, showering, upper and lower body dressing, personal hygiene, bed to chair transfer, and car transfers. The MDS also revealed Resident #1 was always incontinent with bowel and bladder. A review of the Care Plan initiated on 06/12/2024 indicated Resident #1 was at risk for falls. Interventions indicated to be sure Resident #1's call light was within reach and for Resident #1 to be encouraged to use for assistance as needed. The Care Plan also indicated Resident #1 required prompt response to all requests for assistance and required a mechanical lift with two staff for transfers. A review of a Release of Responsibility for Leave of Absence indicated that Resident #1 was signed out of the facility to attend a funeral on 06/02/2026 at 10:15 AM and returned to the facility on [DATE] at 3:30 PM. A review of a form titled Telemed Visit electronically signed by the APRN on 07/04/2026, revealed, [Resident #1], is evaluated for right lower extremity pain. Resident #1 was not able to participate in the telehealth visit related to cognitive impairment and not being able to speak (resident was non-verbal). Resident #1 complained of pain to the right lower extremity. An x-ray was obtained, revealing a fracture. Resident #1 was total care requiring a mechanical lift, family transferred the resident to a personal vehicle at max assist. On the return trip, the original vehicle broke down, (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 045246	Facility ID: 045246 If continuation sheet Page 1 of 4

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requiring the family to transfer the resident from one vehicle to a smaller vehicle at max assist Resident #1 reports that the pain had been present since the funeral. Review of hospital records with an admission date of 07/04/2026, signed by the emergency room doctor indicated Resident #1 usually transfers from bed to wheelchair and back and had gone to a funeral and got moved around a lot. The ER doctor indicated that when he talked to Resident #1 most of the resident's answers were Nay Nay. Resident #1 was able to answer some questions with yes. The ER doctor indicated that Resident #1 answered Yes when asked if in pain, and if the resident had fallen. He indicated that there was no family or staff at bedside, and he couldn't understand what the resident's further response was. The ER doctor indicated that Resident #1 had a severe type of broken bone where the bone shatters or breaks into three or more pieces. The ER doctor indicated that Resident #1 had a fracture that was usually caused by high impact trauma such as a car crash, a heavy fall, or a severe sports injury. A review of an OLTC Witness Statement Form dated 07/08/2026 signed by Licensed Practical Nurse (LPN) #1, indicated that she was informed by CNA #2 that Resident #1 seemed off. LPN #1 indicated that Resident #1's face, right arm, abdomen, and right leg appeared swollen. LPN #1 assessed Resident #1 who had two plus pitting edema to the right leg, and non-pitting edema to their right arm. Resident #1 stated Ow when their arm, abdomen, and leg were palpated. A review of an OLTC Witness Statement Form dated 07/08/2026 signed by Certified Nurse Aide (CNA) #2 indicated, she noticed swelling to Resident #1's leg, and Resident #1 grabbing their leg. CNA #2 indicated that she reported the incident to LPN #1, and LPN #3. A review of an OLTC Witness Statement Form dated 07/08/2026 signed by Certified Nurse Aide (CNA) #4, revealed she worked with Resident #1 on 07/05/2026. CNA #4 indicated she reported it to the nurse and performed a stop and watch. CNA #4 did not indicate what she reported to the nurse. During an interview on 07/20/2026 at 12:10 PM the Administrator indicated that Resident #1's fracture was not observed by any person, and the resident was not able to inform staff of how they were injured. During an interview on 07/20/2026 at 4:00 PM, the Administrator indicated that an injury of unknown source was an injury where the source of how the fracture occurred was unknown. The Administrator indicated the Director of Nursing (DON) informed her of Resident #1's fracture when the X-rays came in. The Administrator indicated that an injury of unknown origin should be reported to the Office of Long-Term Care (OLTC) immediately. The Administrator indicated that she was responsible for reporting resident's injuries of unknown origin to OLTC. The Administrator indicated that OLTC was not notified of the fracture that Resident #1 sustained on 07/04/2025 because Resident #1 was having more stiffness when Resident #1 returned from the funeral, she could not recall the date of the funeral. She indicated Resident #1 was a total care patient and always had pain. The Administrator indicated she believed that Resident #1's history and medication caused the pathological fracture, and it was the reason OLTC was not notified. The Administrator indicated that she did not believe that anyone had abused Resident #1. Therefore, she did report the fracture to the police or the Medical Director. During an interview on 07/21/26 at 1:00 PM, LPN #5 indicated when she arrived for her shift the (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/22/2026 at 7:31 AM, CNA #9 indicated Resident #1 transferred using a lift with two people. CNA #9 indicated that she did not know how Resident #1 got a fracture. During an interview on 07/22/2026 at 8:10 AM, the Administrator indicated that she completed an internal investigation although she thought Resident #1's fracture was pathological. The Administrator indicated the investigation started when the DON called her on 07/04/2026. During a follow up interview on 7/22/2026 at 8:55 AM, the Administrator indicated she determined the fracture was pathological based on Resident #1 being bed bound, did not walk, and took medications such as: steroids, anti-epileptics, diuretic, and an anti-depressant. The Administrator indicated she was not at the facility when she started the investigation but read Resident #1's chart and everything the DON sent to her. The Administrator indicated she returned to the facility from vacation on 07/07/26 and spent most of the day (07/08/2026) completing staff interviews. The Administrator indicated after she received the hospital records on 07/09/2026 it helped conclude her findings and gave confirmation that she was correct. The Administrator indicated she did not report the fracture to OLTC because she thought immediately the fracture was pathological after she received the phone call from the DON. During a phone interview on 07/22/2026 at 3:10 PM, the Medical Director (MD) indicated Resident #1 was losing bone mass, immobile, and a fracture was more likely. These factors made it much more likely to get a fracture. The MD indicated he did not see anything suspicious from his standpoints. As far as the fall , the MD indicated, he did not recall any bruising on the arms noted on records, and it looked like Resident #1 may have had some difficulty getting in and out of the car. The MD indicated he would not be surprised if the fracture had not come from Resident #1 getting in and out of the car when Resident #1 was out with family, but that he was not 100% sure how Resident #1 got the fracture. The MD indicated he was not sure of the rules with OLTC and when they should be contacted. The MD indicated it was hard to tell with a resident who has cognitive impairment when they are in pain. He indicated Resident #1 had a board that was used for communication, but even with the board Resident #1 did not give purposeful information. The MD indicated that it was hard to determine when the fractures were acquired, and how much pain Resident #1 was in at the facility. During a phone interview on 07/23/2026 at 4:30 PM, the Radiology Director indicated Resident #1's bone fracture could relate to Resident's #1 medical condition, and the fact that Resident #1 was immobile. The Radiology Director indicated he was not 100% sure if Resident #1's fracture was from their diagnosis, medical condition, transferring, or a fall. Review of the in-service training sheet indicated an Abuse In-service was conducted on 06/22/2026 by the administrator. Review of an Abuse Policy indicated that injuries of unknown source is when the injury was not observed by anyone, or the injury could not be explained by the resident. The injury is suspicious because of the extent and location of the injury.		