STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045246	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perry County Nursing and Rehabilitation Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for one (Resident #58) of five residents reviewed for comprehensive person center care plans. The findings include: Review of an admission Record indicated the facility admitted Resident #58 on 09/25/2025 with diagnoses that included degeneration of the brain, dementia with mood disturbances, depression, anxiety, wandering and repeated falls. Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/02/2026, revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 4 which indicated the resident had severe cognitive impairment and was severely impaired for daily decision making. The MDS indicated Resident #58 was dependent on supervision of staff and touch assistance to walk 10 feet, to walk 50 feet with two turns and to walk 150 feet. Position changes from sitting to lying, lying or sitting on the side of the bed was supervision and touch assistance. The MDS indicated Resident #58's sit-to-stand motor skills required setup or clean up assistance and Resident #58 was frequently incontinent for bowels and bladder and falls with no injuries had occurred two or more times and one fall occurred with injury (except major). Review of Resident #58's Care Plan, initiated on 10/06/2025, revealed the resident required a secured/special care unit due to behaviors and the resident had a high risk for falls with actual falls documented. Interventions included placing Resident #58 on the memory unit of the facility. The Care Plan indicated Resident #58 exhibited behaviors such as wandering, verbal aggression, physical aggression, agitation, and confusion. Resident #58's Care Plan did not indicate the newly displayed behaviors of lying/sitting on the floor and the Care Plan did not indicate any interventions for this behavior. Review of Medication Administration Record and the Treatment Administration Record for March of 2026, revealed Resident #58 had the following medications administered: Allergy medication related to repeated falls, an antidepression medication, two antipsychotic medications for degeneration of the brain, two antianxiety medications, medication for dizziness, and a pain medication. Review of a Record for In-service Training dated 03/06/2026 and given by Licensed Practical Nurse (LPN) #1, indicated Resident #58 was lying on the floor sporadically throughout the day. The in-service encouraged staff to ensure Resident #58 was visible, location known and to encourage Resident #58 to sit in a chair or get in bed if tired. LPN#1 indicated to keep other residents safe from tripping or falling. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #58's Custom Progress Notes, provided by LPN #1 on 03/19/2026 at 12:09 PM, indicated behaviors of crawling, sitting and lying on the floor throughout the unit began on 12-09-2026. The Custom Progress Notes indicated the following: -On 12/09/2025 Resident #58 was observed crawling on the floor. -On 12/10/2025 Resident #58 was observed lying on the floor.-On 12/18/2025 Resident #58 was observed crawling around on the floor in other residents' rooms.-On 12/24/2026 Resident #58 was observed laying on the floor beside the staff while charting.-On 01/20/2026 and 01/21/2026 Resident #58 was observed taking a seat on the floor. -On 01/27/2026 Resident #58 was assisted up from the floor by staff and the Resident #58 laid back down on the floor unassisted. -On 01/30/2026 Resident #58 was observed laying and sitting on the floor and it was reported to the nurse. -On 02/07/2026 Resident #58 was observed gently sitting on the floor. Staff offered a chair for Resident #58 to sit in. -On 02/18/2026 Resident #58 observed taking a seat on the floor while staff assisting other residents. On 03/16/2026 at 12:02 PM, a surveyor observed Resident #58 lying on the floor in the middle of the hall on the memory care unit. The surveyor was advised by Certified Nursing Assistant (CNA) #2, lying on the floor was a known behavior of Resident #58. CNA #2 reported being advised to document the behavior when it was observed. During an interview on 03/19/2026 at 10:55 AM, CNA #3 indicated CNAs enter a stop and watch in the computer when they needed to document and alert the nurses for increased behaviors for Resident #58. During an interview on 03/19/2026 at 11:01 AM, CNA #2 indicated Resident #58 liked to crawl, sit, and lay on the floor. CNA #2 indicated she had voiced her concerns to the Administrator and the Director of Nurses (DON) and CNA#2 was advised the team of all the department heads would meet and come up with interventions for the behavior. CNA #2 indicated this was a recent behavior Resident #58 had started within the last two to three months. CNA #2 indicated staff documented behaviors for Resident #58 under custom notes in the electronic record. CNA #2 stated Residents #58's behavior was a fall risk to the other residents because Resident #58 would lie down in front of the other residents' doorways. During an interview on 03/19/2026 at 11:25 AM, CNA #4 indicated Resident #58 had a new behavior of sitting on the floor. CNA #4 stated Resident #58 was observed by her lying on the floor in front of a resident's room and while she was ambulating the other residents to the shower. During an interview on 03/19/2026 at 12:09 PM, LPN #1 indicated that she created and conducted an in-service related to Resident #58's behavior of lying on the floor. LPN #1 stated all department heads were assigned a hall, and they were to review all new or changed behaviors for that day. LPN #1 stated a new or changed behavior should be Care Planned. LPN #1 confirmed CNA #2 had notified her of Resident #58's behaviors. During an interview on 03/19/2026 at 1:05 PM, LPN #5 indicated that she was responsible for updating Care Plans. LPN #5 stated she was aware of Resident #58's behavior of sitting on the floor and stated, yes that is something that should be care planned. LPN #5 indicated if the information was not included in the Care Plan, then staff would not know how to care for the residents, and the behavior is a fall risk for the other residents. During an interview on 03/19/2026 at 1:09 PM, the DON indicated Resident #58 started the new (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors at the beginning of January. The DON stated CNAs were trained to enter custom alerts on residents and the nurses must do a follow-up note on the custom alert. The DON indicated the behaviors had been discussed and it was discussed to have the behaviors Care Planned. The DON indicated without the information listed in Resident #58's Care Plan, staff would not know how to care for the resident. The DON stated, the behaviors were a fall risk and caused mental anguish for the other residents. During an interview 03/19/2026 at 1:40 PM, the Administrator indicated Resident #58 had consistently been displaying the behaviors of lying and sitting on the floor since mid-December and it had not been consistently addressed. The Administrator stated that behaviors should be included in all Care Plans and that the Unit Coordinators and the Interdisciplinary Team (IDT) were responsible for making rounds every morning and checked for any changes with the residents and reviewed documentation for changes with the residents. The IDT consisted of all the department heads such as the Administrator, the DON, the MDS coordinator, the CNA Coordinator and the Treatment Nurse. The Administrator stated, the behavior was Care Planned now and that she updated the record herself. The Administrator reported that the nurses documented clinical alerts and the CNAs were trained to do stop and watch custom alerts. The Administrator stated once the alerts were received the information should be Care Planned then cleared and that apparently the staff had been clearing the alerts without the information being Care Planned. The Administrator was unsure which staff were assigned as Unit Coordinator for the hall Resident #58 resided on. During a follow-up interview on 03/19/2026 at 2:20 PM, the Administrator reported that she had spoken with the DON and was advised that LPN #1 was the nurse responsible for reviewing the hall Resident #58 resided on. The Administrator reported LPN #1 stated she was unaware that was her hall to cover for review. The Administrator also reported that the Unit Coordinators were responsible for making rounds every morning and checking for any changes with the residents and reviewing documentation for changes with the residents to discuss in the morning meetings. This surveyor requested a facility policy related to Care Plans. The Administrator stated the facility did not have a policy for Care Plans.