STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045301	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Manor Nursing and Rehabilitation Center Inc	150 Morton Avenue Booneville, AR 72927

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. Number of residents sampled: Number of residents cited: Based on record review and interviews, it was determined that the facility failed to ensure a Certified Nurse Aid (CNA #1) followed the Care Plan for the safety of one (Resident #3) of one resident whose Care Plans were reviewed. Specifically, the resident was transferred by one staff member instead of the required two, resulting in a fall. The findings include: Review of an admission Record revealed the facility admitted Resident #3 with diagnoses which included type 2 diabetes, atrial fibrillation, congestive heart failure (CHF), peripheral vascular disease, difficulty walking and history of falling. Review of an annual Minimum Data Set (MDS) with an Assessment Reference Date of 06/10/2025, revealed Resident #3 had a Brief Interview of Mental Status score of 3 which indicated the resident had severe cognitive impairment. The MDS also revealed Resident #3 required partial/moderate assistance for shower/bathing and was dependent on staff for tub/shower transfers. Review of Resident #3's Care Plan initiated on 03/24/2025 revealed Resident #3 had an activity of daily living self-care performance deficit related to repeated falls. Care Plan interventions included that Resident #3 required a mechanical lift and two staff assistance for transfers. The Care Plan also revealed a revision on 06/12/2025 that the mechanical lift had been discontinued and the resident was now dependent on two staff with gait belt for transfers. Review of a Facility Incident Report dated 08/13/2025 revealed an investigation was completed by the Administrator due to Resident #3 falling on 08/13/2026. CNA #1 verified in a witness statement, that he was transferring Resident #3 to a wheelchair (w/c) from a shower chair when the resident's knees went weak and he helped lower resident to the floor in the shower room. An assessment provided by Licensed Practical Nurse (LPN) #8 revealed Resident #3 had a small scratch below each knee. The Administrator reviewed Resident #3's Care Plan and Closet Care Plan and confirmed that Resident #3 was a two-person transfer. During a phone interview CNA #1 told the Administrator he thought resident was a one-person transfer. The Administrator asked CNA #1 if he had checked Resident #3's Closet Care Plan and CNA #1 stated, not in a while. Review of facility in-services dated 09/18/2024, 12/18/2024, 03/19/2025, and 06/06/2025, revealed CNA #1 was trained on abuse and neglect as well as patient transfers, use of gait belt and mechanical (continued on next page)

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	lift per verbal training and/or demonstration. The facility in-serviced nursing [direct care] staff that were present in the facility the day of the incident on 08/13/2025 and as they became available, to reiterate nursing staff should check the Closet Care Plan regarding resident transfer status. CNA #1 was terminated from duties on 08/14/2025 by the Administrator. Review of CNA #1's Personnel Chart revealed that CNA #1 documented he attended/read in-services on 03/19/2025 with topics of Abuse/Neglect, Resident Rights/Dignity/Civil Rights and Transfers/gait belts/mechanical lifts, educated. Review of a Progress Note by LPN # 8 dated 08/14/2025 revealed Resident #3 had one superficial scratch to the right knee with a scabbed area, no bruising to the area and one superficial scratch to the left inner knee that was approximately one centimeter in length with a scabbed area and no bruising to the area. Resident #3 denied pain to both knees and stated, I am fine. This surveyor attempted to contact CNA #1 two times by phone for interview on 04/15/2026 at 8:47 AM and on 04/15/2026 at 5:50 PM but was unsuccessful. During an interview on 04/15/2026 at 10:21 AM, CNA #3 reported the CNAs go by the Closet Care Plan if they did not know how to take care of a resident. CNA #3 reported she could also ask the nurse or a co-worker, but she always checked the Closet Care Plan first. CNA #3 also indicated that Care Plans were updated often, so she looked at the Closet Care Plan every time she worked a hall, because it may have changed. During an interview on 04/15/2026 at 11:00 AM, CNA #4 reported if she was not familiar with a resident, she checked the Closet Care Plan. The Closet Care Plan may be updated at least once a month, but she checked them every day because if something had changed with a resident, it should be updated then. During an interview on 04/15/2026 at 11:57 AM, Medication Assistant – Certified (MA-C) #5 reported she checked the Closet Care Plan when she took care of a resident she was not familiar with. If she felt uncomfortable with the information on the Closet Care Plan, then she would go to the nurse for more information. MA-C #5 reported The Closet Care Plan was updated every time it is needed. During an interview on 04/16/2026 at 8:27 AM, CNA #2 reported that she did not really know what happened with Resident #3. CNA #2 indicated she had assisted getting the resident up from the shower floor and into the w/c via mechanical lift. She was told by CNA #1 that he was transferring Resident #3 from the shower chair to the w/c and the resident's knees went weak. CNA #2 stated, I had told CNA #1 that when he was ready to transfer Resident #3, that I would help him, because Resident #3 was listed as two-person assistance for transfers. CNA #2 reported after the incident, staff immediately had an in-service/re-training that if a resident was a two person assist, that two people needed to assist, and to check the Closet Care Plan regularly because resident's needs could change daily and were updated as needed. During a phone interview on 04/16/2026 at 9:42 AM, CNA #6 stated she was working in the hall when she heard the emergency call light from the shower room. CNA #1 was attempting to transfer Resident #3 from shower chair to the w/c and the resident slipped down on their knees. CNA #1 had asked CNA #6 to assist him getting Resident #3 up to the w/c. CNA # 6 assisted with the gait belt, then CNA #6 told LPN #8 what happened. CNA #6 stated that each resident had a Closet Care Plan (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and that was how the CNAs knew how to take care of the residents, but the Closet Care Plans could change every day, and CNAs needed to review them daily. During an interview on 04/16/2026 at 1:20 PM, the Administrator reported that all residents had a Closet Care Plan, and that the Care Plan could change daily, or several times a day. She stated every morning, she looked at her dashboard (communication board), the morning of 08/14/2026, she had seen where it was reported on 08/13/2026 that CNA #1 attempted to transfer Resident #3 alone. She knew that Resident #3 was listed as needing two-person assistance, and the problem was when CNA #1 tried to transfer Resident #3 from shower chair to w/c alone. She stated she double checked, before she said anything to CNA #1, and the Closet Care Plan did indicate two-person assistance was required. The Administrator stated, I called [CNA #1] so he could tell me what happened and he said that he transferred Resident #3 by himself. The Administrator stated CNA #1 told her that he had not reviewed the Closet Care Plan in a while. The Administrator stated the she went over Abuse and Neglect approximately every three months and let staff know that if they did not use two people for two person assisted transfers, that was neglect. The facility terminated CNA #1 on 08/14//2025 after facility investigation per review of the employee's personnel file and verification by the Administrator. All nursing [direct care] staff were retrained immediately after the incident on 08/14/2026 that if a resident was a two person assist, that two people needed to assist, and to check the Closet Care Plan regularly because resident's needs could change daily and were updated as needed after the incident before returning to work. These actions were performed before the survey team entered the facility and understand of in-services verified via interview of direct care staff resulting in this finding being cited at past non-compliance.