STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045305	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER: Southern Trace Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 22515 I 30 Bryant, AR 72022	

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49596 Based on observations, interviews, and record review, the facility failed to ensure residents were free from resident-to-resident abuse for 4 (Resident's #4, # 9, #13 and #14) of 14 sampled residents reviewed for abuse. The lack of effective behavior monitoring resulted in Resident #4 having resident to resident abuse that occurred on [DATE]; Resident #9 having resident to resident abuse that occurred on [DATE] and [DATE]; Resident #13 having resident to resident abuse that occurred on [DATE]; and Resident #14 having resident to resident abuse that occurred on [DATE] and [DATE]. Of these incidents, Resident #5 was the physical aggressor. The findings are: 1. A review of an Incident and Accident report dated [DATE] revealed Resident #5 shoved Resident #9 out into the hallway because Resident #9 was in Resident #5's room. The nurse caught Resident #9 to prevent a fall. 2. A review of an Incident and accident report dated [DATE] revealed Resident #5 was sitting in the dining room and struck Resident #13, who was seated at the same table. 3. A review of an Incident and Accident report dated [DATE] revealed Resident #14 was standing in front of Resident #5 talking when Resident #5 slapped Resident #14 on the arm. Resident #14 began to cry after being struck. 4. A review of the Incident and Accident report dated [DATE] revealed Resident #5 walked up to Resident #9 and struck Resident #9 in the face twice. 5. A review of the Incident and Accident report dated [DATE] revealed Resident #5 pulled Resident #14, by the wrist, off the sofa. 6. A review of an Incident and Accident report dated [DATE] revealed Resident #5 pushed Resident #4, causing the resident to fall. Resident #4 was described as crying hysterically. (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	a. A review of OLTC [Office of Long Term Care] Incident and Accident Reports (I&A) indicated on [DATE] Certified Nursing Assistant (CNA) #1 heard Resident #4 yelling for Resident #5 to get out of my room. CNA #1 witnessed Resident #4 falling out of the doorway of Resident #4's bedroom, into the hall, landing on the resident's bottom and falling onto their back. Resident #4 stated, (Resident #5) came into my room and pushed me. Resident #4 reported pain to their tailbone. b. A review of the radiology results report dated [DATE] reflected findings L2 (lumbar disc #2) compression fracture appears acute. L1 compression deformity age unknown. Minimal anterolisthesis of L4 and L5. Impression: L2 compression fracture with age unknown, L1 compression deformity. c. A review of a skin audit report dated [DATE] at 3:23 PM, reflected Resident #4 to have a pain level of 6 on a scale of ,d+[DATE]. d. A review of a skin audit report dated [DATE] at 3:27 PM identified Resident #4 to continue to complain of pain to the back, with [opioid analgesic medication name] (pain medication) given as ordered. e. A review of a Hot Rack Charting form dated [DATE] at 2:34 PM, reflected item 1. Reason for Hot Rack Charting: Physical Aggression Received [DATE]. Item 3. Narrative Note: Patient still visibly shaken when I opened the door - fearful. Gave pain pill [opioid analgesic medication name] as ordered and sat and comforted the patient. f. During an interview on [DATE] at 1:33 PM, the Minimum Data Set Coordinator (MDS)/Licensed Practical Nurse (LPN) for the Secure Unit, stated the facility did have residents that tend to hit others and that wander in/out of other resident's rooms. She stated Resident #5 had initiated several incidents. The MDS Coordinator provided this surveyor with a list of Resident #5's Physical Aggression Initiated incidents. The list showed 7 incidents in which Resident #5 had initiated physical aggression toward other residents. The MDS Coordinator said Resident #5 tried to climb over the back fence, hit staff, and they were scared [pronoun] might escalate even further. g. During an interview on [DATE] at 12:55 PM, the Administrator stated they did not have a reportable on Resident #5 for the incidents dated [DATE]; [DATE]; [DATE], or [DATE] because there were no injuries. h. During a phone interview on [DATE] at 2:04 PM, CNA #5 said, All I know is what I already provided on my witness statement, and did not provide any additional information. i. During an interview on [DATE] at 2:05 PM, CNA #3 stated that in days leading up to the incident with Resident #4, Resident #5 had not been sleeping. She had brought Resident #5 to the nurse ' s attention. She said Resident #5 had been pacing and yelling at another resident who was clueless. CNA #3 distracted Resident #5, and she thought it was the following day the incident occurred with Resident #4. CNA #3 stated she could not get Resident #5 to lay down, but that [Resident #5] would nod off on the couch. Resident #5 had done this for about three (3) days. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	j. During a phone interview on [DATE] at 2:07 PM, CNA #1 said, I was working over. I was watching the hall for another nurse. I thought all residents were in bed. I looked out of the door, and Resident #5 was sticking the resident's head out of the doorway. Since it was 11:00 PM, I told Resident #5 to go back to bed. Next, I heard Resident #4 yell and when I looked, Resident #4 fell out of the door and landed on Resident #4's bottom. I got in between Resident #4 and Resident #5 to protect Resident #4. Then the 200 Hall nurse yelled out, Are you alright? and I said, No. So, the 200-Hall nurse went and got the nurse, and we made sure Resident #4 was safe. And that is all I know. k. During a phone interview on [DATE] at 2:11 PM, LPN #4 said, I was on my lunch break, my nurse came and got me and told me another resident had picked Resident #4 up and thrown Resident #4, and later I was told Resident #5 had pushed Resident #4. We got an x-ray. The aggressor was taken off the hall for a while, and the family was notified. I think I talked with the son. We calmed Resident #4 down and followed the doctor's orders. l. During an interview on [DATE] at 3:00 PM, the Administrator reviewed the incident reports with this surveyor and said if there was no injury, no pain, no crying, nobody hurt, then they did not file a report with the Office of Long-Term Care. This surveyor asked if the facility conducted an investigation for the incidents, and if she had a file on the investigations. The Administrator said she was sure the incidents were discussed in Quality Assurance (QA) meetings. m. On [DATE], the Administrator provided a written form that outlined dates QA was reviewed. The form indicated QA reviewed: i. [DATE]: for [DATE] incident with Resident #5 and a female resident. Occurred at 7:32 a.m. Trigger identified: Demented female resident standing close to Resident #5 speaking in word salad. Resident #5 slapped at female resident's arm to make her move. When questioned, neither resident could recall the incident. ii. [DATE]: For [DATE] incident with Resident #5 and a female resident in [DATE], occurred ,d+[DATE] shift. Unknown trigger - Access Medical Behavioral Telehealth visit- transferred to ER for evaluation. Returned with new order for Depakote. iii. [DATE]: For [DATE] incident with Resident #5 and a female resident in November. Occurred 5:44 PM. Trigger: Resident #5 reacted to being kicked at. iv. [DATE]: For [DATE] incidents with Resident #5 and 2 different females in [DATE]. Both happened between the hours of 2:30 a.m. and 6:15 a.m. Unknown trigger - possible restlessness and not sleeping. Unit was quiet prior to both incidents. Labs were drawn; urinalysis and CBC: subtherapeutic Depakote level. v. Summary: Prior to September there was no pattern of behaviors to initiate a root cause analysis. Resident #5 is [AGE] years old with severe dementia, psychotic disturbances and Alzheimer's. Two of the incidents listed above were triggered by females in Resident #5's personal space. There was no pattern of targeting specific residents on the 200 Hall. On [DATE] there was an incident of extreme behavior that did not involve any residents. It was decided, at that moment, that [facility name] could no longer meet Resident #5's needs. Resident #5 was sent to [hospital name]. Alternate placement was found at [alternate facility name]. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	7. A review of the State Operations Manual Appendix PP, F600 indicated, Willful actions include, but are not limited to, the following: hitting, slapping, punching, choking, pinching, biting, kicking, throwing objects, grabbing, shoving . The action itself was deliberate or non-accidental, not that the individual intended to inflict injury or harm . Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. 8. A review of Resident #5's Care Plan Report indicated Resident #5 had the potential targeted behavior related to dementia, with the following interventions listed: Administer medications as ordered date initiated [DATE], Anticipate resident's needs date initiated [DATE], Identify times of day, places, circumstances, triggers, and what de-escalates behavior - date initiated [DATE], Resident #5 has thicker accent and paces usually before behavior. Resident #5 behaviors are de-escalated by time outside and reggae music calms him date initiated [DATE], when Resident #5 becomes agitated, attempt to intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive, staff to walk away calmly and approach later, date initiated [DATE]. Care Plan identified Resident #5 to have a BIMS of 3. The Care Plan did not reflect any incidents this resident had during Resident #5's stay at the facility. Resident #5 exhibited aggressive behaviors toward Residents #9, #13, and #14 prior to the implementation of the behavior care plan being developed. 9. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 09 which indicated moderate cognitive impairment. Resident #4 was identified to have disorganized or incoherent thinking. The MDS does not identify Resident #4 to have behavioral symptoms. a. A review of Resident #4's physician orders dated [DATE], identified Resident #4's diagnoses as Alzheimer's disease, cerebral infraction, dementia with other behavioral disturbance, type 2 diabetes mellitus, insomnia, atherosclerotic heart disease, osteo-arthritis, low back pain, pain in arm, intervertebral disc degeneration, lumbosacral region with discogenic back pain, and a wedge compression fracture of second lumbar vertebra initial encounter for closed fracture. An order on [DATE] stated [analgesic opioid agonist medication name] 50 milligrams for other lower back pain. b. A review of Resident #4's Care Plan Report indicated Resident #4 has requested that Cardiopulmonary Resuscitation (CPR) measures be performed, resident is a very sociable person, resident has a potential for Activities of Daily Living (ADL) self-care performance deficit secondary to dementia and Alzheimer's. Resident #4 was not care planned for behaviors. 10. A review of Resident #9's Care Plan Report revealed Resident #9 was not care planned for behavior issues. a. A review of Resident #9's Medical Diagnosis report reflected the resident had diagnoses that included Alzheimer's disease, chronic kidney disease stage 3A, osteoarthritis of knee, pain to the right knee, sciatica, alcohol dependence induced persisting dementia, Wernicke's encephalopathy, and Raynaud's syndrome. b. The quarterly MDS with an ARD of [DATE], revealed Resident #9 had a BIMS score of 07 which indicated severe cognitive impairment. The MDS did not identify Resident #9 to have behavioral symptoms. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	11. A review of Resident #13's physician Order Summary Report reflected the resident had diagnoses that included dementia, with other behavioral disturbances, Alzheimer's disease, anxiety disorder, chronic pain, major depressive disorder, restlessness and agitation, and insomnia. a. The quarterly MDS with an ARD of [DATE], revealed Resident #13 had a BIMS score of 03 which indicated severe cognitive impairment. The MDS identified Resident #13 to sometimes have behavioral symptoms, inattention, difficulty focusing attention, disorganized thinking, disorganized physical behavioral symptoms and verbal behavioral symptoms. 12. A review of Resident #14's Care Plan Report indicated Resident #14 had the potential to be verbally aggressive related to cognition and cognitive status. Resident will often cry when upset. Date initiated [DATE]. a. A review of Resident #14's Medical Diagnosis report reflected the resident had diagnoses that included dementia, with other behavioral disturbances, insomnia, atherosclerotic heart disease, restlessness and agitation, and palliative care. b. The significant change MDS with an ARD of [DATE], revealed Resident #14 had a BIMS score of 00, which indicated severe cognitive impairment. The MDS did not identify Resident #14 to have behavioral symptoms, inattention, difficulty focusing attention, disorganized thinking, disorganized, and altered level of consciousness, indicating behavior not exhibited.