STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045339	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atkins Nursing and Rehabilitation Center	605 Northwest 7th Street Atkins, AR 72823

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Number of residents sampled: Number of residents cited: Based on record review and interviews it was determined the facility failed to send a written notice of transfer or discharge to the Ombudsman for one (Resident #59) of one resident, upon discharge. The findings include: Review of Resident #59's admission Record revealed the facility admitted Resident #59 on 02/10/2026 from a local hospital. Review of Resident #59's Medical Diagnosis report revealed Resident #59 had diagnoses which included acute kidney failure, encephalopathy, hypothyroidism, dementia, hypertension and congestive heart failure. Review of Resident #59's discharge, return anticipated Minimum Data Set with an Assessment Reference Date of 02/12/2026 revealed the discharge status was discharged to an inpatient rehabilitation facility. The MDS coded the discharge as a planned discharge. Review of Resident #59's Care Plan dated 02/12/2026 revealed Resident #59 wished to discharged . Review of Resident #59's Progress Notes dated 02/12/2026 at 10:57 PM revealed Resident #59 had discharged to a local rehab. Review of a facility Ombudsman Notification Report dated February 2026, provided by the Administrator, did not include Resident #59. During an interview with the Business Office Manager (BOM) and the BOM Consultant on 04/15/2026 at 2:20 PM, the Business Office Manager (BOM) stated she was responsible for notifying the Ombudsman at the end of each month of emergency discharges. The BOM stated the Ombudsman should be notified when there was an emergency transfer or discharge. The BOM stated she did not notify the Ombudsman of Resident #59's discharge and she was not aware of anyone else at the facility notifying the Ombudsman. The BOM reviewed the Emergency Transfer Report dated February 2026 and confirmed the list was the report sent to the Ombudsman for residents who had discharged in February 2026. The BOM stated they, did not notify the Ombudsman of non-emergency discharges. The BOM Consultant stated the purpose of notifying the Ombudsman was to let the Ombudsman know about a resident's discharge so the Ombudsman could call and talk to the resident if the Ombudsman (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had any concerns. The BOM Consultant stated they had been notifying the Ombudsman of the emergency discharges. During an interview on 04/15/2026 at 3:02 PM, the Administrator stated Resident #59 had been discharged to a local rehab facility. The Administrator stated the facility should be notifying the Ombudsman of all discharges to ensure they were aware a resident had left the facility and if there were any needed services, as the patient advocate, and so the Ombudsman would know the location of the discharged resident. During an interview on 04/15/2026 at 3:07 PM, the Director of Nursing (DON) stated Resident #59 admitted to the facility from the local hospital with plans to return to that same local hospital's rehabilitation unit for rehabilitation [therapy]. The DON stated Resident #59 discharged to the local hospital rehabilitation unit on 02/12/2026. During an interview on 04/16/2026 at 8:30 AM, the Ombudsman stated they had not been notified regarding Resident #59's discharge from the facility. This surveyor requested a facility policy regarding notification of the Ombudsman. The facility provided an Admission, Transfer and Discharge of Resident policy dated 11/22/2016, but did not have a policy covering notification of the Ombudsman.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observations, record review, interviews and facility policy review, the facility failed to ensure an indwelling catheter was stored off the floor to reduce the risk of infection, cross contamination and injury for one (Resident #3) of one resident reviewed. The findings include:Review of Resident #3's Medical Diagnosis revealed Resident #3 had diagnoses which included urine retention, overactive bladder, chronic kidney disease, tubulointerstitial nephritis (inflamed kidney tubules) and anxiety.Review of an admission Minimum Data Set (MDS) with an Assessment Reference Date of 03/30/2026 revealed, Resident #3 had a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact. The MDS also revealed Resident #3 had a catheter and had not had a UTI in the last 30 days. Review of Resident #3's Care Plan revealed Resident #3 had potential/actual impaired skin integrity related to catheter, poor mobility, and use of anticoagulant with an initiated date of 03/31/2026. Care Plan interventions included to keep the residents' nails short, and encourage no scratching, prevent excessive moisture to body parts and to provide [name brand indwelling catheter] care with soap and water.Review of Resident #3's Physician Orders dated 03/30/2026, revealed staff were to check [name brand indwelling catheter] [name brand securement device] for placement every shift related to benign prostatic hyperplasia with lower urinary tract symptoms.Review of Resident #3's Physician Orders dated 03/25/2026 revealed Resident #3 had an order for an anticoagulant to be given twice a day related to stroke.Review of a Urinary Analysis (UA) dated 04/10/2026, revealed results of a positive urinary tract infection (UTI) with blood in the urine and was positive for gram-negative bacteria.Review of Resident #3's Progress Notes on 04/13/2025 at 7:21 PM, revealed the physician was notified of worsening confusion, blood in urine and Resident #3 was started on antibiotics for 10 days. Review of Resident #3's Physician Orders dated 04/13/2026, revealed an order for an antibiotic to be given for 10 days.Review of Resident #3's Physician Orders dated 04/14/2026 revealed an order for contact isolation for gram-negative bacteria in the urine, may discontinue when antibiotics are complete. Review of Resident #3's lab results from [local hospital] dated 04/14/2026 revealed low hemoglobin and hematocrit levels. On 04/13/2026 at 10:43 AM, Resident #3 was observed sitting in a wheelchair on the left side of the bed facing the open door. The front right wheel had rolled over the covered catheter bag hanging below the right arm of Resident #3's wheelchair. Red urine was observed in the catheter tubing. This surveyor observed Resident #3 wearing a leg strap in place on the right leg and the catheter tubing was stretched. Resident #3 stated I do not know why my pee is red and did not know if the catheter tubing had been pulled. This surveyor exited the room, stood in the hallway and observed Resident #3 rolling back and forth over the catheter bag with the wheelchair. Resident #3 was visible to two staff walking in the hallway.During an interview on 04/13/2026 at 10:56 AM, Certified Nursing Assistant (CNA) #1 stated Resident #3 had a UTI and pneumonia in the past but not at this time. CNA #1 stated Resident #3's catheter was resting on the floor and urine appeared red with sediments in the tubing.During an observation and concurrent interview on 04/13/2026 at 11:31 AM, CNA #1 confirmed Resident #3 had red urine in the catheter tubing and stated, Licensed Practical Nurse (LPN) #3 told me it was caused by Resident #3's medicine. CNA #1 stated catheter bags were not supposed to be on the floor because it was dirty and an infection risk. This surveyor observed CNA #1 put on a yellow gown, wash their hands, put on gloves, and hung the catheter bag under the wheelchair, off of the floor. CNA #1 revealed there was an infection control in-service in February or March of 2026.During a telephone interview on 04/13/2026 at 1:30 PM, Resident #3's family member stated the resident had gotten a sore around the penis and an unknown nurse applied cream and changed out the catheter and it improved rapidly. The family member stated Resident #3 had a UTI, was going to see a urologist and felt that the facility was doing everything they could to help Resident #3 heal from the UTI. The family member also stated someone called today and notified them a culture had come back and Resident #3 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	may be starting an antibiotic. On 04/14/2026 at 1:17 PM, Resident #3 was observed resting quietly. Turbid, red urine with sediment was observed in the catheter tubing draining in a blue covered catheter bag. A lunch tray with fluids were sitting on the over bed table, untouched. Resident #3's roommate had been moved out of the room, contact precautions were in place with signage and Personal Protective Equipment (PPE) was stored outside the door. During an interview on 04/14/2026 at 2:24 PM, LPN #3 stated Resident #3 had a UTI positive for gram-negative bacteria and Resident #3 had increased urine with blood in the catheter. LPN #3 stated blood was discovered in the catheter tubing yesterday morning and Resident #3 had been on a pain reliever that treated urinary symptoms. LPN #3 stated, Antibiotics were started last night, and the gram-negative bacteria is new. LPN #3 stated a catheter should be in a privacy bag and stored off the floor. LPN #3 indicated no CNAs had told her that Resident #3 was rolling over the catheter bag while it rested on the floor. LPN #3 stated it was all around bad because, it could have pulled on the tube and created more bacteria and Resident #3 could have gotten a hole in the catheter bag. LPN #3 stated again If a CNA sees a resident with bloody urine in the catheter tube and the resident was rolling on it with the wheelchair the CNA should have reported that to the nurse.During an interview on 04/15/2026 at 9:39 AM, LPN #2 stated that he worked on 04/14/2026 and the Medical Director (MD) was called about red urine, a culture was taken during the night and the MD stated to wait for results. LPN #2 stated there was a hook under Resident #3's wheelchair to hang the catheter bag from and it would not be appropriate for the catheter bag to be on the floor. LPN #2 stated, I would have changed out and assessed the entire catheter system since Resident #3 was rolling over the bag to check for holes, pulling and injury. Resident #3 stated a 10 [on a pain scale of 1-10] when asked by LPN #3 if the resident was in pain, and LPN #3 stated he would give Resident #3 a non-steroidal anti-inflammatory for the pain.During an interview on 04/15/2026 at 2:15 PM, with the Director of Nursing [DON] and Administrator, the DON stated her expectation was that catheters would be stored under wheelchairs and off the floor when the resident was not in bed. The Administrator confirmed that there was a place to hang the catheter under the wheelchair. The DON and Administrator confirmed catheter bags on the floor being rolled over by residents would not be appropriate because it could cause pulling. The DON revealed that staff made her aware of Resident #3's catheter bag being on the floor and confirmed Resident #3 had been diagnosed with gram-negative bacteria in the urine and was placed on contact precautions and started on antibiotics. The DON revealed if a CNA found a resident sitting in their wheelchair and noticed red fluid in the catheter tubing, or a resident rolling on the catheter tubing, they expected the CNAs to tell a nurse. Review of a facility in-service document dated 02/17/2026 revealed a handwritten subject as mandatory in-service, with multiple areas of reference of which included infection control. LPN #2, LPN #3 and CNA #1's signature indicated they attended the mandatory in-service. This surveyor did not locate infection control training in this document. Review of a facility policy titled Catheter Care, Urinary revised on 11/22/2016, revealed staff are to report any abnormal findings to the charge nurse.Review of a facility policy titled Infection Prevention and Control Program dated 11/22/2017, revealed the facility must have a surveillance program to identify infections before they can spread. Nursing staff monitors residents for signs and symptoms that suggest infection and will report suspected infections to the charge nurse as soon as possible. Surveillance includes monitoring, documentation, reporting, education, data analysis, and antibiotic review. Charge nurse will notify the doctor and infection control nurse as soon as possible.