STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045413	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Methodist Health and Rehab	7425 Euper Lane Fort Smith, AR 72903

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, interviews and facility document review, it was determined that the facility failed to ensure the survey results were readily available for residents and families to easily view, with the potential to affect all 120 residents who resided in the facility. The findings include: Review of the facility admission Packet provided by the facility to residents and their representatives at admission did not reference the resident's right to ready access to survey results. Review of the Resident Council meeting minutes did not contain any record of the residents' right to survey being provided to the residents. During an observation on 06/11/2026 at 4:26 PM, this surveyor observed that the posted resident rights displayed on the wall of the facility did not include the right to see the results of previous surveys. During an interview while present in a resident council meeting on 06/10/2026 at 2:02 PM, Resident #71 indicated they did not know where the survey results were kept and had not seen it. Resident #61, Resident #86, Resident #88, Resident #92, Resident #106, and Resident #123 who were also present in the resident council meeting relayed that they did not know about any survey results or their location either. All residents present were cognitively intact per BIMS scores. During an observation and interview on 06/10/2026 at approximately 2:30 PM, this surveyor searched the common areas of the facility that were easily accessible by residents and visitors and was unable to locate the documentation that included the survey results. The Director of Nursing (DON) was asked for the location of the results that were available to residents and visitors, was initially unsure of their location, but left to search before returning with a survey results book. During a follow-up observation and interview on 06/10/2026, at 2:45 PM, this surveyor observed the DON return the survey results book to the security officer (SO) who replaced it in the drawer to the left of his desk. The SO desk was located near the 24-hour coded guest and employee entrance at the side of the facility. The DON was asked to confirm this copy of the survey results was the only one available for review and stated the book that had been provided was the only copy maintained for this purpose. There was no survey results book located near the front entrance. The area the desk was located in was accessible to employees, staff, and visitors, but the book was stored in a drawer; anyone needing access to the book to review the survey results would have to ask facility staff to provide the results in order to view them.

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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record review and interview, the facility failed to ensure one (Resident #101) of two residents reviewed was free from abuse that had the potential to cause mental anguish and/or physical harm. The findings include: Review of Medical Diagnosis Report revealed Resident #101 was admitted to the facility with diagnoses which included dementia, osteoporosis and epilepsy. Review of the annual Minimum Data Set [MDS] with an Assessment Reference Date [ARD] of 04/27/2026, and a Staff Assessment for Mental Status [SAMS] score of 3, which indicated the resident was severely impaired for daily decision making. Review of Resident #101's Care Plan revealed the resident was dependent on staff for intellectual, emotional and social needs related to cognitive impairment with an initiation date of 04/27/2022. The care plan included interventions to encourage Resident #101 to participate in activities: pets, parties, and to be one to one when Resident #101 became non-verbal or confused. Review of Resident #101's reportable with a discovery date of 04/04/2025 at 2:25 AM and submitted to the Office of Long-Term Care [OLTC] on 4/04/2026 at 10:38 AM, revealed a security officer was monitoring cameras and DON was alerted to come view cameras. At 2:20 AM it was noted a female CNA (identified as CNA #9) was seated on the couch in the closed unit next to Resident #101 and resident was trying to get up off the couch. CNA #9 appeared to pull Resident #101 back down to a sitting position on the couch by grasping the back waist of the pants and pulling Resident #101 down several times. CNA #9 was described as grasping Resident #101's left arm, then bending the arm and pushing it away when resident reached for CNA #9. The document indicated that the police, family, administration and physician were notified. No injuries were documented, and two cognitive residents interviewed denied abuse. Review of CNA #9's employee file contained a job description for CNA #9 titled , Job Title: CNA with a description on page 13 that included [the CNA] must be able to be tactful with residents, possess integrity and ethical awareness and cannot possess a direct threat to residents in the facility. Residents must be treated with kindness, dignity and respect per Resident Rights. CNA #9 signed the job description on 02/12/2025. CNA #9's employee file contained documents for Employee Orientation Day 2 signed on 02/17/2025 by CNA #9 which addressed reporting and preventing abuse. During an interview on 06/10/2026 at 3:17 PM, the Director of Nursing [DON] stated that while working late the security officer called the DON to the security office. The DON revealed watching a video that showed Certified Nursing Assistant [CNA] #9 pulling Resident #101 down to a couch in the closed unit and pushing Resident #101's arm away several times. The DON said, I immediately went to assess Resident #101. The DON said Resident #101 appeared to display increased agitation. CNA #9 was taken off hall and informed could not work with Resident #101. CNA #9 denied abusing Resident #101 and was told there was video footage of the abuse taking place. The DON stated the different types of abuse were physical, mental, financial, and neglect. The DON stated they considered pulling Residents down by their clothing and bending and pushing residents away by the arm to be abuse. The DON stated, CNA #9 was suspended then terminated. The DON revealed staff were trained on (continued on next page)

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	abuse on hire and multiple times a year, but that CNA #9 had not worked at the facility long. The DON indicated that as the Assistant Director of Nursing [ADON] at the time of the incident, the DON did not personally report to the Office of Long-Term Care and RN #12 was notified immediately. During a telephone interview on 06/10/2026 at 5:00 PM, CNA #9 stated Resident #101 had gotten extremely agitated including hitting CNA #9, despite multiple attempts to calm the resident down. CNA #9 stated I was trying to get safe, but the resident was 1:1. CNA #9 revealed she had been trying to keep Resident #101 on the couch until her partner came out of another room because CNA #9 was not feeling well. CNA #9 denied pulling Resident #9 down by their clothing and said, I was just redirecting [the resident]to stay on the couch. CNA #9 denied any abuse and stated that when the DON told CNA #9 not to care for the resident any longer CNA #9 left and went to her car. CNA #9 said she was called to return to the facility to fill out a witness statement. During an interview on 06/11/2026 at 9:33 AM, the Security Officer [SO] revealed working the night CNA #9 had an incident with Resident #101 in April of 2025. SO said, I was watching video and noticed a quick flash of white, so I went back to the camera and there was a CNA (identified as CNA #9) wearing a white sweater sitting on the couch in the closed unit with Resident #101. The Administrator asked SO to play video footage from that night and for the SO to narrate. SO revealed Resident #101 was seen repeatedly trying to get up and was being pulled down several times from the back of the pants and/or shirt. SO pointed out several times where Resident #101 tried to reach out to CNA #9 and was violently pushed away. SO indicated security had no contact with CNA #9. During an interview on 06/11/2026 at 10:00 AM, Registered Nurse [RN]/CNA class instructor, and former administrator until 12/08/2025 stated, CNA #9 claimed to be protecting herself and her unborn child because Resident #101 was coming at her, but video showed CNA #9 kept grabbing the back of Resident #101 pants or shirt and pulling resident down to the couch in the closed unit. RN/CNA class instructor revealed the incident occurred on the 11 PM-7 AM shift, on 04/04/2025. RN/CNA instructor indicated CNA #9 was trained on how to deal with dementia residents and was terminated because CNA #9 did not show any remorse. RN/CNA class instructor revealed that this incident was abuse and should have been reported within hours of discovery. RN/CNA Class Instructor stated it was a sad situation and Resident #101 could not understand. On 6/11/2026 at 10:38 AM, the DON revealed that witness statements were started right away and all residents on the closed unit were checked on with no concerns found. Reviewed abuse in-service signature sheet showing all staff were in-serviced on abuse from 5/05/2026-6/03/2026. Reviewed in-service education material titled Abuse Recognizing, Reporting and Preventing, revealed residents have the right to be free from abuse, neglect and exploitation. Unreasonable confinement, punishment causing harm or mental anguish is considered abuse. Abuse can come from caregivers, spouses, visitors and family. Placing someone in a secluded spot and hitting or slapping could be considered physical abuse. Review of a facility policy titled, Abuse Prevention and Procedure & Abuse Investigation Procedure, with a review date of 03/02/2020, revealed, residents have the right to be free of abuse. Abuse includes the willful infliction of injury and unreasonable confinement, intimidation and mental anguish. Physical abuse includes placing a resident in a secluded spot as punishment. Abuse should be reported immediately. Report to the charge nurse immediately and they will contact administration (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and start witness statement; alleged perpetrator should be suspended during the investigation. The survey team verified the termination of CNA #9, the facility's investigation, and the facility's retraining on the topic of abuse that to include all staff, resulting in this incident being cited as past non-compliance.

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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. Based on observation, record review and interviews, the facility failed to ensure an allegation of abuse was reported in a timely manner to ensure accountability, preserve evidence, and prevent further harm for one (Resident #101) of two residents reviewed. The findings include: Review of Medical Diagnosis Report revealed Resident #101 was admitted to the facility with diagnoses that included dementia, osteoporosis and epilepsy. Review of an annual Minimum Data Set [MDS] with an Assessment Reference Date [ARD] of 04/27/2026, and Staff Assessment for Mental Status [SAMS] score of 3, which indicated the resident was severely impaired for daily decision making. Review of Resident #101's Care Plan revealed the resident was dependent on staff for intellectual, emotional, and social needs related to cognitive impairment with an initiation date of 04/27/2022. The care plan also included interventions to encourage Resident #101 to participate in activities: pets, parties. The care plan indicated Resident #101 was one to one (indicating one staff member should be designated to provide care solely to this resident) when the resident became non-verbal or confused. Review of Resident #101's reportable with a discovery date of 4/04/25 at 2:25 AM, was submitted to the Office of Long-Term Care [OLTC] on 04/04/2026 at 10:38 AM. The reportable indicated police, family, administration, and physician were notified [of the incident]. On 06/09/2026 at 3:04 PM, Certified Nursing Assistant [CNA] #10 confirmed working in the closed unit and said suspected abuse should be reported to the Administrator and Director of Nursing [DON] immediately. CNA #10 was not aware of any employee to resident abuse and stated the types of abuse were physical, verbal and sexual. During an interview on 06/09/2026 at 3:11 PM, Licensed Practical Nurse [LPN] #11 stated she was not aware of any residents being pushed or shoved by staff and was not aware of any resident being pulled down by the back of their shirt or pants because it would not be appropriate. LPN #11 stated, Suspected abuse should be reported to the Administrator and DON, and after hours, staff should call the on-call nurse immediately. LPN #11 stated the different types of abuse were verbal, emotional and physical. During an interview on 06/10/2026 at 3:01 PM, the Administrator stated they were not here when a CNA pulled Resident #101 down by the back of their clothing, but it was not appropriate because it was a dignity issue and could have caused Resident #101 to fall and become injured. The Administer revealed CNA #9 was terminated [following the incident]. The Administrator stated that for abuse or suspected abuse, the administrator was to be called right away regardless of the time, the victim should be assessed and separated from the alleged perpetrator. The Administrator revealed that the alleged perpetrator should be suspended during investigation, and Office of Long-Term care contacted within two hours. The Administrator revealed staff are in-serviced on abuse several times a year and they know to call me right away. The Administrator revealed that the incident [with CNA #9 and (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #101] was not reported in a two-hour period. During an interview on 06/10/2026 at 3:17 PM, the DON stated that while working late the security officer called the DON to the security office. The DON revealed watching a video that showed CNA #9 pulling Resident #101 down to a couch in the closed unit and pushing Resident #101's arm away. DON said, I immediately went to assess Resident #101. DON stated it was time for CNA #9 to leave for the day, CNA #9 was taken to off the hall and told she could not work with Resident #101. The DON stated the different types of abuse were physical, mental, financial, neglect. The DON stated she considered pulling residents down by their clothing and bending and pushing residents away by the arm to be abuse. The DON stated, CNA #9 was suspended then terminated. The DON revealed staff were trained on abuse when hired, and multiple times a year, but CNA #9 had not worked at the facility long. The DON stated that as the Assistant Director of Nursing [ADON] at the time of the incident, the DON did not personally report to the Office Long-Term Care. During a telephone interview on 06/10/2026 at 5:00 PM, CNA #9 stated Resident #101 had gotten extremely agitated including hitting CNA #9, despite multiple attempts to calm the resident down. CNA #9 stated, I was trying to get safe, but she was one to one. CNA #9 revealed trying to keep Resident #101 on the couch until her partner came out of another room because CNA #9 was not feeling well. CNA #9 denied pulling Resident #9 down by resident's clothing and said, I was just redirecting [the resident] to stay on the couch. CNA #9 denied any abuse and stated that when the DON told her she could not care for the resident, CNA #9 left and went to their car. During an interview on 06/11/2026 at 9:33 AM, the Security Officer [SO] revealed working the night CNA #9 had an incident with Resident #101 in April of 2025. The SO stated, I was watching video and noticed a quick flash of white, so I went back to the camera and there was a CNA (identified as CNA #9) wearing a white sweater sitting on the couch in the closed unit with Resident #101. The Administrator asked SO to play video from that night and SO to narrate. The SO revealed Resident #101 was seen repeatedly trying to get up and was being pulled down several times from the back of their pants and/or shirt. The SO pointed out several times where Resident #101 tried to reach out to CNA #9 and was violently pushed away resulting in a scratch on one of residents arms. The SO stated security had no contact with CNA #9. During an interview on 06/11/2026 at 10:00 AM, Registered Nurse [RN]/CNA class instructor, and former administrator until 12/08/2025 stated, CNA #9 claimed to be protecting herself and unborn child because Resident #101 was coming at her. The video showed CNA #9 kept grabbing the back of Resident #101 pants and pulling [the resident] down to the couch in the closed unit. RN/CNA class instructor revealed the incident occurred on the 11PM-7AM shift. She stated, CNA #9 had been trained on how to deal with dementia residents and was terminated because the CNA showed no remorse for the situation. RN/CNA class instructor revealed that this incident was abuse and should have been reported in two hours from discovery. RN/CNA class instructor asked to resume the interview after review of the reportable. During a follow up interview on 06/11/2026 at 10:38 AM, the DON (ADON at the time of the incident) revealed reporting the incident to RN #12 and was not sure when RN/CNA class instructor was notified. The DON stated after watching the video CNA #9 was suspended and witness statements were taken. During an interview on 06/11/2026 at 10:46 AM, RN/CNA instructor, who was the administrator at the time of the incident, stated after reviewing the reportable she remembered that notification was made (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when she arrived to work about 6:58 AM on 04/04/2025. RN/CNA instructor stated she thought since there was no injury she had more than a 2-hour window to report. RN/CNA class instructor stated staff should have made the notification immediately, but I thought there was 2 hours when there was an injury. RN/CNA class instructor stated the incident should have been submitted in a 2-hour window because you would want to prevent anything from happening to anyone else. Review of CNA #9's employee file contained a document titled, Job Title: CNA which indicated on page 13 that the CNA must be able to be tactful with residents, possess integrity and ethical awareness and cannot possess a direct threat to residents in the facility. Residents must be treated with kindness, dignity and respect. CNA #9 signed the document on 02/12/2025. CNA #9's employee file contained a document titled, Employee Orientation Day 2 signed on 02/17/2025 by CNA #9 which addressed reporting and preventing abuse. Review of a facility policy titled, Abuse Prevention and Procedure & Abuse Investigation Procedure, reviewed 03/02/2020, indicated a residents have the right to be free of abuse. Abuse includes the willful infliction of injury and unreasonable confinement, intimidation and mental anguish. Physical abuse includes placing a resident in a secluded spot as punishment. Abuse should be reported immediately. Report to the charge nurse immediately and they will contact administration and start witness statement; alleged perpetrator should be suspended during the investigation. Review of a facility policy titled Abuse, Neglect, misappropriation and Exploitation, revised 10/18/2022, revealed all personnel including staff, physician, administration and owners will report all allegations of witnessed or suspected abuse or neglect to the designee (administrator) immediately so a report can be made according to state laws and regulations.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure Resident #67 received the proper assistive device to prevent accidents and safely transfer from bed to wheelchair using a lift. Specifically, staff utilized a bariatric size sling to transfer Resident #67, when the resident required a medium sized sling, resulting in the resident sliding out of the sling and falling to the floor. The findings include: A review of admission Record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, type 2 diabetes mellitus, peripheral vascular disease, left knee osteoarthritis, severe protein calorie malnutrition and affective mood disorder. Review of the admission Minimum Data Set (MDS) with an Assessment Reference Date of 05/12/2026 revealed Resident #67 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was independent in daily decision making. Further review indicated the resident had impairment of both sides of the upper and lower extremities. The MDS also indicated Resident #67's functional ability for mobility was dependent on staff for chair/bed to chair transfer. Review of a Progress Note dated 05/29/2026 at 10:21 AM, indicated that during transfer with a mechanical sit to stand lift, Resident #67 slid out of lift pad down to the floor onto buttocks. The progress note also revealed lift pad being used does appear large for resident's size. Review of Resident #67's Care Plan with a revision date of 06/02/2026 indicated the resident was a high risk for falls related to gait/balance problems. The care plan interventions indicated the resident had a fall on 05/29/2026 and all staff were in-serviced on ensuring the lift pad is the correct size for the resident prior to any transfer as well as ensuring residents have proper footwear prior to any transfer. A review of Resident #67's Order Summary revealed an order dated 05/29/2026 that indicated the resident had a potential for injury due to fall without head injury. Interventions for the order were as follows: 1) Vital Signs every shift times 48 hours, and 2) Examine for injuries two times a day for 2 days. An order dated 05/29/2026 indicated redness to left shoulder post fall on 05/29/2029, Interventions for the order were as follows: monitor for injury, pain, or decreased ROM [range of motion] to LUE [left upper extremity] two times a day. During an interview on 06/09/2026 at 2:42 PM Resident #67 stated CNA #3 was transferring the resident using a mechanical sit to stand lift from the resident's bed to the wheelchair. The resident reported the sling CNA #3 used was like an oversized sheet. Resident #67 stated she was not the only one who used it. The resident also reported several of the CNAs had said the sling was too big, but they would adapt the sling and use it anyway. Resident #67 stated [after the fall] the resident was sore for a couple of days and stated regarding the fall it did not feel good. During a phone interview on 06/11/2026 at 11:28 AM, CNA #3 stated she was not sure how it was described but the resident's care plan would indicate to her which sling should be used to transfer Resident #67. She reported the sling she used to transfer the resident was too big so she took it off and tightened it up and it felt right. She indicated Resident #67 was being transferred from the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's bed to the wheelchair and before arriving at the wheelchair the resident started slipping out of the sling and went to the floor. During an observation and interview on 06/09/2026 at 9:43 AM, CNA #13 indicated resident information such as transfer status and which sling to use could be found on the resident sheet in the worksheet binder that was at the nurses' station. She added that the CNAs should look at the worksheet binder daily for resident information. During an interview on 06/11/2026 at 9:52 AM, the Director of Nursing (DON) indicated the facility had recently started a color-coded system for identifying correct sling sizes. She reported Resident #67 did not have a specific sling size at the time of the fall. The DON indicated that CNA #3 stated to the DON that the sling looked too big and other slings were available on the hall and in the laundry room. During an interview on 06/11/2026 at 12:11 PM, the Administrator reported we had a hole in the system, we did not know we had different sizes of slings. She reported before Resident #67 fell from the sling the staff thought there was one sling size. She reported the staff did not even know where the bariatric sling came from. The Administrator stated, upper management did not know to teach anything different because we did not know there was more than one [sling]. She reported that since the incident the facility has started a color-coded system for identifying correct sling sizes. She indicated a mandatory check-off for proper sling and lift use would conclude later this week for all CNAs. A review of Instructions for use of [name brand] sling, revealed on pages 2 and 3 that the right type and size of slings should be used after proper assessment of each patient/resident's size, condition and the type of lifting situation. Page 11 of the instructions also revealed, before approaching the resident, the caregiver shall always tell the resident what they are going to do and have the correct size sling ready. A review of a facility policy titled, Transfers, with a revised date of 05/29/24, indicated all transfers will be done as per the resident's individualized care plan unless otherwise contraindicated to ensure safe transfers of residents between surfaces. The policy also indicated mechanical lifts require two persons, and manufacturer guidelines should be followed.