

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2026
NAME OF PROVIDER OR SUPPLIER  Gosnell Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  700 Moody Street Gosnell, AR 72315	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure safety straps were placed and secured to all four wheels of a resident's wheelchair before being transported in the facility van which resulted in the resident falling backwards from the wheelchair for one (Resident #65) of four residents reviewed for accidents.</p> <p>The findings include:</p> <p>A review of Resident #65's Physician's Orders dated 12/31/2024, revealed an order to admit to long-term care on 09/18/2024. Resident #65's Physician's Orders also revealed diagnoses which included hemiplegia (complete or near-complete paralysis on one side of the body) and hemiparesis (partial weakness on one side of the body) which affected the right dominant side, and an acquired absence of left leg below the knee. Resident #65's Physician's Orders further revealed a medication for pain was ordered on 09/18/2024, to be given as needed every six hours.</p> <p>A review of Resident #65's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 12/19/2024, revealed a Brief Interview for Mental Status score of 12, which indicated the resident had moderate cognitive impairment. Resident #65's MDS also revealed the resident had functional limitation in range of motion in the lower extremity on both sides and used a wheelchair for mobility.</p> <p>A review of Resident #65's Care Plan revealed an activity of daily living self-care performance deficit, with interventions which included limited assistance by one staff for transfers between surfaces as necessary, revised 11/06/2024. Resident #65's Care Plan also revealed the resident had an actual fall on 12/06/2024, with interventions which included staff education on how to properly transport in the van, initiated on 12/10/2024.</p> <p>A review of Resident #65's reportable revealed the following:</p> <ul style="list-style-type: none"> <li>- The date and time of the Incident &amp; Accident (I&amp;A) was 12/06/2024 at 3:45 PM, and the alleged perpetrator was a facility employee.</li> <li>- The Summary of Incident revealed Resident #65 was being transported in the facility van by the facility transporter [Certified Nursing Assistant (CNA) #3], when the driver noticed a dip in the road. As the driver navigated the areas in the road, Resident #65 indicated they were falling. Resident #65 was assisted to an upright position in the wheelchair and refused transport to the emergency room for evaluation and denied pain or discomfort at the time of the fall.</li> <li>- The Findings and Actions taken revealed CNA #3 was interviewed by the Administrator (Admin) #2 and she revealed to Admin #2 she did not use the correct number of straps to secure [Resident #65's] (continued on next page)</li> </ul>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>wheelchair in the van. The straps were used in the larger van the prior night for a resident outing. Admin #2's interview indicated the Maintenance Director removed the strap from the van to use in the larger van and did not replace the strap in the van it originated from. Admin #2's interview revealed the van driver was to make a pre-trip inspection to ensure all equipment was present and in working condition.</p> <p>A review of a CNA #3's OLTC [Office of Long-Term Care] Witness Statement Form, dated 12/06/2024, revealed CNA #3 placed the two back floor locks and one front floor lock to Resident #65's wheelchair, but did not indicate which front lock was not placed on Resident #65's wheelchair. During the drive, CNA #3 approached a deep hump in the road, and as she hit the brakes, Resident #65's wheelchair tilted backwards and Resident #65 stated, I'm falling back. After stopping the van, CNA #3 stated she found Resident #65 lying flat on their back with the wheelchair on the floor of the van.</p> <p>A review of a Professional Van and Mobility Service Invoice dated 12/10/2024, for the van used to transport Resident #65 on 12/06/2024, revealed four retractors in working order, one shoulder belt, and one lap belt (male and female).</p> <p>A review of a Termination of Employment/Leave of Absence form indicated CNA #3's last day worked was 12/06/2024, and the infraction was violation of policies/procedures.</p> <p>A review of Resident #65's Progress Notes revealed a nursing I&amp;A note dated 12/06/2024 at 5:30 PM, which indicated Resident #65 was being transported by a facility transport aide, and ended up falling backwards in the van as the wheelchair tumbled backwards.</p> <p>A review of Resident #65's Progress Notes revealed a neurologic focused evaluation dated 12/06/2024 at 6:31 PM, which indicated Resident #65 had a fall in the facility van and the resident voiced complaints of pain in the base on back of the skull. Resident #65 had a nodule on the back of the head and declined to go to the emergency room for evaluation.</p> <p>A review of two Inservice on Transportation Vans, dated as completed on 09/11/2024 and on 11/20/2024, revealed CNA #3 was shown how to properly secure the resident in the van 2.</p> <p>A review of two Transportation Program-Best Practice Recommendations for Van Safety forms revealed the resident being transported in a wheelchair will have the wheelchair securely attached to the body of the van and will maintain a center position in the van during transport. The forms included CNA #3's name and were dated 09/11/2024 and 11/20/2024.</p> <p>During an attempted telephone interview on 03/24/2026 at 7:35 PM, this surveyor called CNA #3's documented number, and an automated operator intercepted the call indicating the person called did not have a voicemail set-up yet and the call ended.</p> <p>During an attempted telephone interview on 03/24/2026 at 7:38 PM, this surveyor called Resident #65's documented number, and an automated operator intercepted the call indicating the destination voicemail box was full and the call was abruptly ended.</p> <p>During a telephone interview on 03/24/2026 at 8:00 PM, Admin #2 stated she did not recall much regarding the incident of Resident #65 falling out their wheelchair, while being transported in the facility van. She stated the Maintenance Director did some training with CNA #3 on how to properly (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>secure a resident in a wheelchair in the van straps. She stated CNA #3 had performed skills checkoffs for securing residents in the van properly before being allowed to transport residents. Admin #2 stated CNA #3 was immediately suspended after the incident of Resident #65's falling out of the wheelchair and did not recall the events surrounding CNA #3's termination.</p> <p>During a concurrent observation and interview on 03/25/2026 at 8:31 AM, CNA #4 and CNA #5 used an empty wheelchair and demonstrated how to secure a wheelchair to the floor in the smaller van, using the safety straps and seat belt. After all the straps and the seat belt were locked, CNA #4 shook the wheelchair, and the wheelchair did not move. CNA #5 stated if either of the front locks were not secured and loose, this could cause the wheelchair to move. CNA #5 loosened the locks on both front wheels and when she shook the wheelchair, the front wheels did move.</p> <p>On 03/25/2026 at 9:30 AM, Admin #1 voiced intent to provide the manufacture's guidance on the safety straps for both vans. Admin #1 provided a copy of van checkoffs for CNA #4 and CNA #5.</p> <p>During an interview on 03/25/2026 at 4:14 PM, Maintenance stated a hold down device that hooked up to the back of the wheelchair, to keep the wheelchair from moving, was missing from the van in which Resident #65 was transported in on 12/06/2024. He stated the big van had a shortage of one of the straps because the big van was being used to take residents to a parade. He stated CNA #3 did not get the tie down (safety strap), which he clarified was to hold the wheelchair down, and left without putting the tie down back in the van the strap was removed from. He stated the tie downs were interchangeable, and he was unaware if CNA #3 did not hook a tie down in the front or the back of the wheelchair. He stated there has been no other van incidents since December 2024.</p> <p>During an interview on 03/25/2026 at 5:30 PM, Admin #1 revealed she became the Administrator at the facility on 01/29/2025. She stated to decrease the likelihood of the incident, which happened to Resident #65 on 12/06/2024, from happening again, the following tasks had been put in place:</p> <ul style="list-style-type: none"> <li>- the new van driver will complete a skills check off and ride with a seasoned van driver before driving residents.</li> <li>- the new van driver will have a seasoned van driver with them when they drive for first time.</li> <li>- the new van driver will perform a return demonstration in front of the seasoned van driver.</li> <li>- van drivers will complete a quarterly training.</li> <li>- a professional van service will watch all van drivers load and unload a wheelchair and inspect the facility vans yearly.</li> <li>- all van drivers must ensure there are no frays in any restraints before driving the van.</li> </ul> <p>Admin #1 verified that not securing a wheelchair properly in the transport van could cause injury, death, or mental anguish, such as a resident being scared of the van. She stated her expectations regarding van drivers operating the vans and securing the resident's wheelchairs properly for transport included safety being forefront, and van drivers must do everything correctly, to ensure every step occurred.</p> <p>As of 03/25/2026 at 6:00 PM, Admin #1 had not provided the manufacture's guidance on the safety (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>straps for either van the facility used.</p> <p>A review of a Safety and Supervision of Residents policy, dated as revised July 2017, indicated the facility strives to make the environment as free from accident hazards as possible. The policy indicated employees should be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents.</p> <p>A review of facility documents including in-services and inspections of the van being used to transport residents revealed the facility had identified and addressed concerns by 12/10/2024, resulting in these findings being cited at past non-compliance.</p>		