STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045439	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gosnell Health and Rehab	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)
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. Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for one (Resident #5) of five residents reviewed for the resident's comprehensive assessment. Specifically, the facility failed to ensure Resident #5's comprehensive care plan included information that would require staff to provide care and monitor for resident safety. The findings include: A review of Resident #5's admission Record indicated the facility admitted the resident on 01/16/2026, with diagnoses which included nerve damage, muscle weakness, limitation of activities, type 2 diabetes mellitus, difficulty walking, inflammation of the spine, urinary tract infections, constipation, adjustment disorder, anemia, thyroid disorder, high cholesterol, sleep apnea, high blood pressure, irregular heartbeat, arthritis, chronic kidney disease, shortness of breath, fatigue, and stomach paralysis. A review of Resident #5's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/23/2025, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #5's MDS also revealed the resident was independent for daily decision making. The MDS indicated Resident #5 utilized a wheelchair and had impairment to both legs. Resident #5 was dependent on care for personal hygiene, toileting hygiene, showering, upper and lower dressing, and putting on and taking off shoes. Resident #5 was completely dependent of staff on mobility for rolling left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair-bed transfers, toileting transfers, and tub/shower transfers. A review of Resident #5's Physician's Orders revealed Resident #5 had orders for occupational, physical and speech therapy to evaluate and treat, resident and or family have been informed of medical conditions/diagnosis and plan of care, resident may participate in activity as tolerated, do not resuscitate orders, foley catheter care, occupational therapy for skilled interventions 3-5 times per week for the next 8 weeks, and enhanced barrier precaution. A review of Resident #5's Medication Administration Record for March of 2026, revealed Resident #5 was given oral medications for insomnia, three oral medications for diabetes, two injections to assist in controlling the diagnosis of diabetes, medication that promoted wound healing, antibiotic for a urinary tract infection, blood thinner medication, medications that assisted in controlling heart rate and rhythm, stomach acid medication, medication for nerve pain, monitoring of urinary output from a foley catheter, and pain medication. A review of Resident #5's Treatment Administration Record for March of 2026 indicated Resident #5 (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received an ointment applied every shift to promote wound healing to the buttocks, orders on how to cleanse, dry and cover a pressure ulcer to Resident #5's right buttocks, and for foley catheter care at bedtime. A review of Resident #5's Care Plan on 03/24/2026 at 11:07 AM, with an earliest initiation date of 01/19/2026, revealed the following care areas/interventions were not addressed: -The care plan did not address the resident's dependence on staff related to self-care performance deficits; there were no interventions listed to inform staff of the level of care required. -The care plan did not address the resident's impaired mobility related to impaired function in both legs; there were no interventions addressing the resident's need for mobility devices (wheelchair) or the prevention of falls. -The care plan did not address the resident's prescribed medications; there were no interventions listed to inform staff how to monitor for signs/symptoms of complications related to the resident's prescribed medications, which included an anticoagulant, antidepressant, an opioid pain medication, and medications for managing diabetes mellitus. There were no black-box warnings for Resident #5's prescription of an antidepressant medication which posed a risk for suicidal thoughts and ideations. There were no black-box warnings for Resident #5's prescription of an opioid pain medication, or guidance for staff to follow in responding to the resident's pain. -The care plan did not address the resident's impaired skin integrity; there were no interventions to guide staff in addressing current wounds, or the prevention of additional wounds. During an interview on 03/26/2026 at 10:06 AM, Certified Nursing Assistant (CNA) #6 indicated she did not access the kiosk to look at the care plan for any residents. She indicated she utilized the closet care plan. CNA #6 reported she only knew how to care for Resident #5 from their closet care plan. During an interview on 03/26/2026 at 10:30 AM, CNA #7 indicated the only way she knew how to care for Resident #5 was by the closet care plan as well. A review of Resident #5's Closet Care Plan, printed date 03/16/2026, revealed assistive devices, functional mobility, and pressure reducing devices were referenced, but no guidance referencing medications, wound care, or monitoring related to the resident's diagnoses or medications was present. During an interview on 03/26/2026 at 11:15 AM, the MDS Nurse indicated that care plans were updated quarterly, every three months. The MDS Nurse revealed information that should be included on a care plan consisted of medications, new antibiotics, advanced directives, any black box warning for medications, falls, skin assessments, and treatments. She stated the care plan identified how to care for the residents. No interventions were documented on the closet care plans. The MDS Nurse indicated that Resident #5's initial care plan was completed on 01/16/2026, and that comprehensive care plans should be completed within seven days and no later than 21 days after admission or change. She verified Resident #5's care plan was not comprehensive, and without a comprehensive care plan with interventions, one would not know how to care for their resident. The MDS Nurse stated she was the one who created and updated the care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/26/2026 at 11:58 AM, the Director of Nursing (DON) indicated the facility had seven days after admission to complete a comprehensive care plan. She indicated the care plans included all the information needed to properly care for a resident, such as social activities, nutrition, levels of care, falls, black box warnings for medications, foley catheter care, pain medications, diagnoses, and interventions. The DON stated, If a care plan was not complete, then you will not know how to care for a resident. The DON continued to state, The CNAs cannot see the care plan and the Kardex does not include care interventions. During an interview on 03/26/2026 at 1:04 PM, the Administrator indicated that a care plan was to be completed within the first seven days of being at the facility. She then indicated that a base line care plan was completed first and then a comprehensive care plan. The Administrator stated, If a care plan is not completed then the facility would not know how to care for the resident, the care plan is how we know how to take care of our resident and what interventions have been put into place. The Administrator indicated the closet care plans were generic and she did not think they listed any interventions. A review of the policy titled Resident Rights with a revision date of 02/2021 states, Residents are, to be informed of, and participate in, his or her care planning and treatment. A review of a facility policy titled, Care Plans, Comprehensive Person-Centered, revised on March of 2022, indicated, The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant change in Status), and no more than 21 days after admission. The comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment, any specialized services to be provided as a result of PASARR recommendations; and which professional services are responsible for each element of care, includes the resident's stated goals upon admission and desired outcomes, builds on the resident's strengths and reflects currently recognized standards of practice for problem areas and conditions. And reviews and updates are made to the care plan are significant changes in the resident condition, when the desired outcome is not met, when the resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunction with the required quarterly MDS assessment.