STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045148	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cave City Nursing Home Inc	442 Taylor Circle Cave City, AR 72521

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on record review, interview, and facility policy review, the facility failed to ensure medications were administered according to physician's orders for one (Resident #40) of five residents reviewed. The findings include: A review of Resident #40’s quarterly Minimum Data Set with an Assessment Reference Date of 06/26/2025, indicated the resident had a Brief Interview for Mental Status score of 14, which indicated Resident #40 was cognitively intact. A review of Resident #40's active Physician's Orders, as of 07/01/2025, revealed the resident had diagnoses which included post-traumatic stress disorder, osteoarthritis, and generalized anxiety disorder. The resident’s Physician’s Orders also revealed the resident had medication orders, with an order date of 04/23/2025, for one benzodiazepine tablet for generalized anxiety disorder, to be given at bedtime, and one compound opioid pain medication tablet for pain, to be given every eight hours as needed. Resident #40’s Physician’s Orders also revealed not to administer either medication within two hours of each other. A review of Resident #40’s Administration History Report, from 06/06/2025 through 06/21/2025, revealed a compound opioid pain medication was administered four times, within the restricted period, with a benzodiazepine. Below are the findings: On 06/06/2025, one benzodiazepine tablet was documented as administered by Licensed Practical Nurses (LPN) #2 at 8:00 PM, and one compound opioid pain medication tablet was documented as administered at 8:01 PM. On 06/12/2025, one benzodiazepine tablet and one compound opioid pain medication tablet were documented as administered by LPN #4 at 8:05 PM. On 06/15/2025, one benzodiazepine tablet was documented as administered at 8:13 PM, and one compound opioid pain medication tablet was documented as administered by LPN #3 at 8:14 PM. On 06/21/2025, one benzodiazepine tablet and one compound opioid pain medication tablet were documented as administered by LPN #4 at 7:19 PM. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #40’s Psychiatric Clinic Progress Note, dated 04/23/2025, revealed for Medication safety: Instruct nursing home staff to separate administration of pain medication and [benzodiazepine] by a minimum of two hours for patient safety. A review of a Psychiatric Clinic Visit Sheet for Resident #40, dated 04/23/2025, and signed by the provider, read in part, be sure there is a two-hour window between opioid pain pill, and benzodiazepine. During a phone interview on 07/01/2025 at 9:34 AM, with LPN #1 at Resident #40's psychiatric clinic, LPN #1 confirmed the prescriber would routinely write the order as indicated with benzodiazepines and opioids. The medications were not to be administered together, which was why the prescriber ordered not to administer the medications within two hours of each other. During a phone interview on 07/02/25 at 10:02 AM, LPN #2 confirmed her initials were on Resident #40’s electronic medical record for administration of the compound opioid pain medication on 06/06/2025 at 8:00 PM. LPN #2 indicated Resident #40 often voiced complaints of pain, usually in the evening. LPN #2 confirmed the resident would receive pain medication with anxiety medication, and they were usually given at the same time, at the resident’s request. She then confirmed the facility’s expectation of the staff was to administer medications according to the physician's order and to comply with the medication administration policy. LPN #2 was asked to confirm the meaning of an order that specifically stated not to administer a medication within two hours of another medication. LPN #2 confirmed that a physician's order with those parameters would not be administered within the time period specified. She then reported that the purpose of not combining the two medications would be for complications such as oversedation, overdose, and kidney problems. LPN #2 confirmed when administering medications, she compared the medication with the physician's order to ensure the correct rights were observed. LPN #2 confirmed that if Resident #40 had an order not to administer a benzodiazepine and a compound opioid pain medication together, then they should not be administered together. During an interview on 07/02/2025 at 10:15 AM, the Medical Director confirmed he was familiar with Resident #40’s specific medication order not to administer their benzodiazepine and compound opioid pain medication at the same time, and to wait at least two hours between the administrations. The Medical Director indicated he expected staff to administer medications as written by the prescriber, and he had not been notified of a medication error with Resident #40. During an interview on 07/02/2025 at 10:20 AM, the Assistant Director of Nursing (ADON) confirmed Resident #40 often voiced complaints of pain and was medicated with as needed pain medications. The ADON confirmed the expectation of staff was to follow the Physician's Orders as written, and if the order was written as do not administer medications within two hours of each other, then they should not be administered. The ADON confirmed that the order for Resident #40, written by the practitioner, was not to administer the benzodiazepine and compound opioid pain medication within two hours of each other. She then stated the purpose of waiting between benzodiazepines and opioids was the possibility of respiratory depression. The ADON confirmed the facility’s expectation of staff was to follow the facility’s medication administration policy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/02/2025 at 10:28 AM, the Director of Nursing (DON) confirmed Resident #40 occasionally had complaints of pain and was medicated with as needed medications. The DON confirmed Resident #40 had routine orders for an antianxiety medication, a benzodiazepine, and a compound opioid for pain. He then confirmed the benzodiazepine was given at 8:00 PM. The DON reported the expectation of the facility, was for staff to follow facility policies, and to administer medications as written by the provider. If orders were written not to administer two medications within two hours of each other, then they should not be administered within the restricted time. The DON reported that benzodiazepines and opioids were not given together to avoid respiratory depression. During a phone interview on 07/02/2025 at 5:04 PM, LPN #3 confirmed familiarity with Resident #40. LPN #3 had provided care and administered medications to the resident. LPN #3 confirmed Resident #40 often voiced complaints of pain and was medicated, if it was within the parameters of the physician's order. LPN #3 confirmed the pain medication that Resident #40 often received was an opioid. LPN #3 confirmed Resident #40 had physician's orders for a benzodiazepine antianxiety medication. LPN #3 confirmed the physician's orders should be administered, as written. LPN #3 stated if the order specifically was written not to give medications together, then they should not be given together. LPN #3 confirmed knowledge of the medication administration policy, and to administer medications as written. LPN #3 denied knowledge of the two-hour restriction between Resident #40’s benzodiazepine and compound opioid pain medication. A review of a facility policy, Medication Administration, with a review date of 12/02/2024, revealed medications were to be administered as ordered by the physician. Policy Explanation and Compliance Guidelines ensure that the six rights of medication administration are followed: Right Time, Compare medication with medication administration record to verify the correct time. Administer within one hour before or after the scheduled time unless otherwise ordered by the physician. Administer medication as ordered in accordance with manufacture specification. A review of the National Institute on Drug Abuse, with a review date of 11/07/2022, indicated taking opioids in combination with other central nervous system depressants like benzodiazepines increased the risk of life-threatening overdose.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to provide Provider Enhanced Reporting Payroll Based Journal (PBJ) mandatory staffing data to the Center for Medicare and Medicaid Services (CMS) for the 2nd Quarter of 2025. The findings include: Upon review of the PBJ Monthly Data Report provided by the facility, PBJ data was submitted for January 2025, February 2025, and March 2025 to the state, but not to CMS. During an interview on 06/30/2025 at 2:30 PM, the Administrator confirmed being responsible for completing the staffing reports and sending the PBJ data to the state and to CMS. When asked about the process for submitting the PBJ report, the Administrator stated, I was submitting the information in the QuickBase program monthly. I was unaware the data wasn't going to CMS due to not being trained properly and not being notified by CMS that they were not receiving the data. I didn't know until you notified me that they did not have the data. We called them after notification to see if they would take it, and they said they would not at this point. It's now fixed and will be submitted correctly for this next quarter. This surveyor requested a policy or procedure on reporting PBJ data, and the Administrator stated, “We do not have a policy or procedure regarding PBJ data and reporting.”