STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045151	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Green House Cottages of Walnut Ridge	1500 West Main Street Walnut Ridge, AR 72476

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to provide the resident with needed medical services for one (Resident #24) of one resident reviewed. Specifically, the facility failed to enter a treatment order on the Treatment Administration Record (TAR), which resulted in an open wound to Resident #24's chest not being treated or assessed for one month. The findings include: Review of Resident #24's admission Record revealed the facility admitted Resident #24 on 01/19/2026 with diagnoses which included heart failure, muscle weakness, diabetes, protein calorie malnutrition, muscle wasting and atrophy, reduced mobility. Review of Resident #24's Care Plan initiated on 05/11/2026 revealed the resident had a skin tear/potential for skin tear of the right chest and the right elbow. Interventions included if a skin tear occurred to obtain an order, staff were to treat the skin tear as ordered and identify causative factors. Review of an Office of Long-Term Care (OLTC) Incident and accident (I&A) Report initiated on 04/30/2026 revealed Resident #24's family member made the facility staff aware that an outdated bandage was found on Resident #24's chest at the time of transfer to the local hospital on [DATE]. Review of images observed from Resident #24's family member revealed a dressing dated 03/29/2026 with the initials of Licensed Practical Nurse (LPN) #8 that was found on Resident #24 when being admitted to the hospital on [DATE]. The images show Resident #24's face, allowing the resident to be identified, as well as the initials of LPN #8 and date of 03/29/2026. Review of an OLTC Witness Statement Form, completed on 05/01/2026, revealed LPN #5 indicated that on 03/25/2026 she was training LPN #8 when Resident #24 returned to the facility. LPN #5 and LPN #8 completed the readmission body audit and removed the dressing from the hospital. Assessed that Resident #24 had a skin tear to the right chest area. LPN #5 then informed LPN #8 they would be using standing orders per facility protocol for treating Resident #24's wound. A dressing was applied to the wound on Resident #24's chest by LPN #5 and LPN #8. Review of an OLTC Witness Statement Form completed on 05/01/2026, revealed RN #9 documented she performed the body audit with the resident sitting in the chair, I pulled up [Resident #24's] shirt .I did not see any patch on [Resident #24's] front, possibly due to me bunching up [the resident's] shirt when I pulled it up (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's TAR dated March 2026 revealed Resident #24 had a treatment order for a skin tear to the right forearm, but no treatment order for the skin tear to the chest. Review of the facility's TAR dated April 2026 revealed Resident #24 had a treatment order for a skin tear to the right forearm, but no treatment order for the skin tear to the chest. Review of Resident #24's Progress Notes revealed Resident #24 returned to the facility on [DATE] from the hospital. A skin tear to the chest was documented. The Progress Note also revealed that yes there were new areas of concern, and no documentation was included of a treatment or dressing change being completed by LPN #5 to the chest. Review of a facility document titled re-admission Evaluation dated 03/25/2026 and signed by LPN #5, revealed Resident #24 returned to the facility from the hospital on [DATE]. The re-admission Evaluation also revealed Resident #24 had a skin tear to the chest measuring 2.5 centimeters (cm) by 1 cm. Review of a facility document titled Follow-up Question Report dated from 03/03/2026 through 04/29/2029, revealed Resident #24 had showers on the following dates:-03/27/2026 by Certified Nursing Assistant (CNA) #6.-03/31/2026 by CNA #7.-04/05/2026 by CNA #6.-04/08/2026 by CNA #6.-04/12/2026 by CNA #7-04/15/2026 by CNA #7.-04/20/2026 by CNA #7.-04/29/2026by CNA #6.A total of 8 showers were documented from 03/25/2026 until 04/29/2026, all administered by CNA #6 and CNA #7. Review of facility documents titled Body Audit for Resident #24 revealed the following:-03/27/2026 completed by RN #8 front torso was clear. -04/03/2026 completed by LPN #10 front torso was clear. -04/10/2026 completed by the Treatment Nurse (TN) revealed front torso was clear. -04/17/2026 completed by the TN revealed front torso was clear.-04/24/2026 completed by the TN revealed front torso was clear.-05/03/2026 completed by the TN revealed Resident #24 had discoloration to upper front torso, open area on the right side of the chest, signs of healing are shown. During an interview on 05/13/2026 at 1:21 PM, CNA #6 stated that Resident #24 was a two-person assist for showers so there always had to be two staff present for showers. CNA #6 stated that shower days were easy, and he and CNA #7 or another staff member completed the showers together. CNA #6 stated he, had never seen any dressings at all on Resident #24. CNA #6 stated he did not assist the nurses with body audits unless it was to assist the resident to bed. During an interview on 05/13/2026 at 1:37 PM, LPN #5 stated that standing orders were orders the doctor had already approved the nurses to use for all residents. LPN #5 stated all standing orders were entered into the Medication Administration Record (MAR) or TAR. LPN #5 stated she was training LPN #8 on 03/25/2026 when Resident #24 returned to the facility. LPN #5 and LPN #8 completed a full body audit and noted a skin tear to Resident #24's right chest. LPN #5 stated that she and LPN #8 put the dressing on Resident #24's chest. LPN #5 recalled telling LPN #8 they would need to enter the orders into the TAR for Resident #24. LPN #5 stated, I think I put it in. It would still be there if I did it correctly. LPN #5 accessed the electronic medical record for Resident #24. LPN #5 confirmed that no treatment orders were present for the chest wound on the Resident #24's for March 2026 or April 2026 . LPN #5 stated that if a treatment order was not placed on the TAR the other nurses would not know a treatment was needed and it would not get done. During an interview on 05/13/2026 at 2:12 PM, the Assistant Director of Nursing (ADON) stated that (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	even if a standing order was used for treatment of a wound, it would have to be put on the TAR. The ADON stated that orders were to be entered before, you ever even do the treatment and then documentation of the completed task was recorded on the TAR as well. The ADON stated there should not have been a dressing placed on any resident without an entered order or the documentation to follow. The ADON stated if an area was marked clear then there was nothing abnormal there. The ADON stated, I do not think the body audit was done thoroughly if there was documentation the area was clear but there was an actual dressing in place on the body. The ADON stated potential outcomes of a dressing going unchanged could be skin damage, skin deterioration and infection. During an interview on 05/13/2026 at 3:00 PM, the TN stated body audits on Resident #24 were hard. The TN stated Resident #24 would lift their shirt for her to assess and that she did not get a clear view of [Resident #24]. She stated she would ask staff such as CNA's and other nurses if any residents had any issues as well. The TN stated No, that is not a complete skin assessment if I did not look under Resident #24's shirt. I missed the dressing on Resident #24's right upper chest. The TN stated, there should always be an order entered for a dressing change because that is where you document it and that is how the other nurses know that treatment is due. During an interview on 05/13/2026 at 3:25 PM, the Director of Nursing (DON) stated, a report was made that the facility potentially missed a 'patch' on a resident. The DON stated that the nurses that completed the body audits did not see the patch and the CNA's reported not seeing a patch either. The DON confirmed no orders we placed on the TAR. The DON stated, the initials on the patch were LPN #8's initials and it was dated 03/29/2026. The DON confirmed that LPN #8 had been precepting under LPN #5 on 03/29/2026. The DON stated, LPN #5 was responsible for documenting the dressing change. The DON stated, They would not be able to identify that there was a treatment needed if it were not entered on their body audits or the TAR. During an interview on 05/13/2026 at 10:15 PM, LPN #8 stated LPN #5 was her preceptor during that time, and she was shown how to put the treatment order in the system, and the order was placed in the system for Resident #24. LPN #8 indicated she did not recall if the dressing change had been documented but that she knew she changed the dressing on 03/27/2026, so she knew a dressing change was due. LPN #8 stated it had not been changed since I changed it last on 3/27/2026. LPN #8 reported changing the dressing on 03/29/2026 and initialing and dating the dressing. During an interview on 05/14/2026 at 11:40 AM, the Administrator stated she expected all body audits to be done completely by removing all clothing. The Administrator stated when Resident #24 returned to the facility there was a standing order given and the area to Resident #24's upper chest was applied by LPN #5 and the precepting LPN #8. She stated all orders were to be placed in the TAR. The Administrator stated, LPN #5 and LPN #8 stated they put an order in but there must have been a glitch in the system. Review of an OLTC I&A Report revealed in-person in-services were conducted by the DON on 04/30/2026 on Abuse/Neglect, Charting, Body Audits, Admissions, Treatments, and Skin Concerns. -The Skin and Wound in-service dated 04/30/2026 revealed New Admits/Re-Admits will receive a complete body audit within 4/HRS of admitting any wounds, skin tears, bruises, abrasions, or pressure ulcers, with description/measurement. Any resident with a wound will have a care plan identifying wounds and interventions for resolving. The in-service also indicated, New treatment orders will be monitored daily, to ensure all components of order are present and TARs will be reviewed daily for compliance.The in-service on Shower Completion dated 04/30/2026 revealed CNAs were required to complete a shower form, and all skin concerns and observations must be reported to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the charge nurse. Review of a facility undated policy titled Abuse, Neglect and Maltreatment Investigating and reporting revealed, This facility will endeavor to protect residents from maltreatment, which means adult abuse, exploitation, neglect, physical abuse, sexual abuse and misappropriation of property. Review of a facility undated policy titled Care and Prevention of Pressure Ulcers and Skin Condition indicated its purpose was to prevent and treat further breakdown of pressure sores; to promote healing of pressure sores that are present; and to identify and treat other skin conditions.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, record reviews and facility policy review, it was determined that the facility failed to notify staff that a resident who had a Peripherally Inserted Central Catheter (PICC) line in place was on Enhanced Barrier Precautions (EBP), resulting in a staff member transferring the resident without appropriate Personal Protective Equipment, and to ensure staff followed EBP when the requirement was posted for one (Resident #99) of one resident reviewed.ˆ The findings include: Review of Resident #99's admission Record revealed the resident was admitted by the facility on 04/08/2026 with an open wound to the lower left leg. Review of Resident #99's admission Minimum Data Set (MDS) with an Assessment Reference Date of 04/09/2026, revealed Resident #99 had a Brief Interview for Mental Status score of 10, which indicated Resident #99 had moderate cognitive impairment. The MDS also revealed that Resident #99 received intravenous (IV) medications and antibiotics via midline IV access.Review of Resident #99's Care Plan initiated 04/09/2026, revealed Resident #99 received IV antibiotic therapy with an intervention for EBP precautions due to PICC line. Review of Resident #99's Medication Administration Record (MAR) dated 05/01/2026 - 05/31/2026, revealed an order for EBP every shift with a start date of 04/10/2026. Review of Resident #99's Physician Order dated 04/10/2026, revealed an order for an IV antibiotic two times a day, until 05/16/2026. Review of Resident #99's Clinical Physician Orders dated 04/10/2026, revealed an order for EBP every shift with a start date of 04/10/2026 and end date of 05/12/2026. Review of Resident #99's Progress Notes for May 2026, revealed indicated Resident had a PICC line on 05/01/2026-05/12/2026. During an interview on 05/11/2026 at 1:25 PM, Resident #99 stated they received antibiotics through an IV port because they had a wound on their foot. Resident #99 stated they were to be discharged home after they completed their IV antibiotics. Resident stated the antibiotics would be completed on Saturday and then the resident would be discharged on Sunday. An IV pump was observed sitting in Resident #99's room. While Resident #99 was being interviewed, an identified staff member entered Resident #99's room and put on a pair of gloves, then took the resident's urinal to the bathroom. A few minutes later the staff member entered the resident's room, wearing a pair of gloves and no other form of PPE, and transferred the resident from their bed to their wheelchair. Resident #99's door did not have signage or supplies hanging on the door or in the hallway outside the resident's door that notified staff, visitors, or other residents that Resident #99 was on EBP. During an observation on 05/12/2026 at 3:30 PM, there was no signage for EBP noted on Resident #99's door or outside the room and no PPE was noted hanging on Resident #99's door or in the hallway just outside the door. During an interview on 05/12/2026 at 3:31 PM, Certified Nursing Assistant (CNA) #1 stated they had worked at the facility for seven years. CNA #1 stated, EBP was what we use when a resident has an infection, it was [Personal Protective Equipment]PPE stuff, like gowns, mask and gloves we dress out before going into the resident's room. CNA #1 stated, I am responsible for the residents residing on 600 Hall, on which Resident #99 resided. CNA #1 stated there were no residents on the hall on EBP. CNA #1 stated if a resident was on EBP, the facility's method of informing staff included signage on the door that the resident was on EBP, and the supplies would be hanging in a caddy on the resident's door. CNA #1 stated EBP was to protect the resident, visitors and staff. CNA #1 stated, it was important that the signage be in place, so everyone knew something was going on with the resident. CNA #1 stated urinary tract infections (UTIs), shingles, something in the resident's urine or blood, and wounds would require EBP. During an interview on 05/12/2026 at 3:47 PM, CNA #2 stated they had worked at the facility for almost 4 years. CNA #2 stated, EBP was where you wear gloves, PPE, sanitize your hands and clean. CNA #2 stated a resident was placed on EBP precautions if they had an infection like a UTI or something in their urine or stool. CNA #2 stated, they [the facility] put a sign on the resident's door telling us if a resident was on EBP and they put the supplies outside the door in a container that has drawers for the gowns, gloves, eye wear, shoe booties, or any other thing we need to use for the isolation. CNA #2 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated they were working Resident #99's hall and they did not have a resident on this hallway on EBP. During an interview on 05/12/2026 at 3:56 PM, Registered Nurse (RN) #3 stated they had been working at the facility since December 24, 2025. RN #3 stated they had received training on EBP, and EBP was for the protection of the patient from us and things we could bring in. RN #3 stated the facility would post a sign on the resident's door and hang a caddy over the resident's door with PPE supplies such as masks, gowns, gloves and things needed to care for the resident. RN #3 stated it was important to let staff know and identify who was on EBP because they were at higher risk of infections and you don't want to bring something from outside into them. RN #3 stated Resident #99 was on EBP due to the resident having a PICC line access. During an interview on 05/12/2026 at 4:07 PM, the Director of Nursing (DON) stated the Assistant Director of Nursing (ADON)/Infection Control Preventionist (ICP) was the designated person that trained staff on EBP. The DON stated EBP was used when a resident had an indwelling medical device, PICC lines, catheters, any indwelling device, or feeding tube. The DON stated the staff knew when a resident was placed on EBP because it was in the resident's Care Plan and the facility also put signage on the resident's door and put EBP supplies in a caddy over the door or at the doorway. The DON stated it was important that staff were aware if someone was on EBP to try to cut down on infections in the facility and to let the staff know the resident had an infection in their body; to protect them and others. The DON stated they had a list of all residents who were on EBP in their IP module in the electronic record. The DON also stated that the department heads monitor assigned hallways to ensure the EBP was in place for residents on the department heads assigned hall. Review of an undated facility EBP List revealed Resident #99 was not listed as being on EBP. During an interview on 05/12/2026 at 4:15 PM, the ADON/ICP stated, it was important to identify a resident who required EBP because the facility was trying to cut down on infections and if a resident had an infection in their body, EBP was to protect them and protect others. The ADON/ICP stated it was best practice, and it was pushed out through the Centers for Disease Control (CDC). The ADON/ICP stated they help maintain the program and make sure the facility was effective in making sure that nothing goes from one resident to another. The ADON/ICP stated all staff were trained the same on EBP whether they work in the cottages or in the traditional nursing home setting. The ADON/ICP stated staff were trained upon hire and quarterly on EBP and if the staff seemed to be struggling then they will work with that staff 1 to 1 followed by a teach back method to ensure they understand. The ADON/ICP reviewed the electronic record and stated Resident #99 was on EBP related to wounds. The ADON/ICP stated Resident #99 also had a PICC line. During an interview on 05/12/2026 at 4:19 PM, the Administrator stated it was important to ensure staff were aware of EBP because it kept germs from spreading around to other residents and staff members. The Administrator stated staff were aware of who was on EBP by signs posted on the residents' door and the PPE supplies were in the hangers over the outside of the resident's door. The Administrator stated staff were trained upon hire and quarterly on EBP to ensure staff understood when and where they should wear PPE. On 05/12/2026 at 4:32 PM, the Administrator, ADON/ICP and DON walked to Resident #99's room with this surveyor and verified Resident #99's room was not set up for EBP, no signage or PPE supplies were in place. The ADON/ICP stated they would get the signage and supplies put into place. During an observation on 05/13/2026 at 12:15 PM, LPN #4 did not put on PPE before administering an IV antibiotic through Resident #99's PICC line. EBP signage was noted on Resident 99's door with PPE hanging on the residents' door. LPN #4 stated I should have put on a gown before using the PICC line. During an interview on 05/14/2026 at 8:54 AM, Physician Assistant (PA) stated they were at the facility every day Monday-Friday. The PA stated the ADON/ICP monitored the infection control procedures in the facility and if they had any questions they will bring their concerns to me. The PA stated if they see a lot of UTIs, or other issues, in a specific cottage they would bring it to the ADON/ICP's attention and see if there was an infection control problem. The PA stated, a resident should be placed on EBP if they had something like multi-resistant staphylococcus aureus (MRSA), an infection that was easily spreadable, anything that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had increased infectious contact, UTIs, if a resident had a catheter, to prevent sources into the body and other devices that provide an extra route that could cause an infection concern needed to be on EBP. The PA stated the facility would post signs outside the resident's door along with any PPE in a cart that was needed for EBP. The PA stated it was important to ensure the staff were aware of a resident being on EBP because they did not want to cause any extra infections, or harm to the patient. The PA stated a resident should be placed on EBP if they come to the facility with a device such as a catheter, PICC line, a new order and certain infections. The PA stated the resident should be placed on EBP as soon as the facility was notified, for example if a lab notified the facility or when the resident came back from a procedure such as getting PICC line EBP should be set up for them. Review of facility Policy Enhanced Barrier Precautions dated 2022, revealed Enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident activities for residents know to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). The policy also revealed clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves.