STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045196	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Village Nursing and Rehab	400 Southridge Parkway Heber Springs, AR 72543

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Number of residents sampled: Number of residents cited: Based on record review, interview, and facility policy review, the facility failed to ensure the provider documented a rationale for the continuation of psychotropic medications on the Medication Regimen Review (MRR) form for three (Residents #2, Resident #7, and Resident #52) of five residents reviewed for unnecessary medications. The findings include: Resident #2 Review of an Order Summary Report revealed Resident #2 had diagnoses which included depression and anxiety and had an order for psychotropic medication which indicated to give the medication by mouth every six hours as needed for anxiety. Review of a significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/16/2025 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) Score of 9, which indicated the resident had moderate cognitive impairment. The MDS also revealed Resident #2 required partial to moderate assistance with toileting and personal hygiene, and to shower/bathe self. The MDS also indicated Resident #2 had an active diagnosis of anxiety disorder. Review of a Care Plan, with a review date of 02/13/2026, revealed Resident #2 used an anti-anxiety medication with interventions to administer the medication as ordered by the physician and monitor the resident for adverse reactions such as drowsiness, slurred speech, impaired thinking and judgement. Review of the Progress Notes from 11/16/2025 to 12/20/2025, has no rationales documented for the continued use of the prescribed antidepressant medication. Review of a Pharmacy MRR-Antidepressant form, with an effective date of 12/05/2025, revealed the Consultant Pharmacist notes indicated the resident has recent documented falls. The provider chose to continue the dose of the medication, and the rationale was blank. The provider electronically signed (e-signed) the document on 12/11/2025. The Director of Nursing (DON)/Designated RN (Registered Nurse) section indicated continue POC (plan of care). Given as needed for seizure. The DON e-signed the form on 12/11/2025. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #7 Review of an admission Record indicated the facility admitted Resident #7 on 01/28/2024 with diagnoses which included dementia, Alzheimer's disease (disorder affecting memory, thinking, language and behavior) and anxiety. Review of an Order Summary Report revealed Resident #7 had an order for an antipsychotic medication to be administered in the morning and in the evening. Review of a quarterly MDS with an ARD of 01/26/2026, revealed Resident #7 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. The MDS also revealed Resident #7 required supervision or touching assistance with personal hygiene, and tub/shower transfer; partial to moderate assistance with shower/bathing self and that Resident #7 was taking a high-risk drug classed as an antipsychotic. Review of a Care Plan, with a review date of 02/13/2026, revealed Resident #7 used a psychotropic medication and had an intervention to monitor/document/report as needed for adverse reactions such as unsteady gait, frequent falls and behavior symptoms not usual to the person, and there was a black box warning for the psychotropic medication and to see MAR [Medication Administration Record]. Review of Resident #7's Progress Notes for 01/20/2026 to 02/18/2026 did not include any rationales from the provider for the continuation of the antipsychotic medication. Review of a Pharmacy MRR-Antipsychotic form, with an effective date of 02/06/2026 for Resident #7, revealed the antipsychotic recommendation was for a gradual dose reduction (GDR) of the medication. The consultant pharmacist notes were blank. The provider chose to continue the medication with no changes and did not document a rationale. The DON chose the response provider response received and accepted. The DON e-signed the form on 02/06/2026. Resident #52 Review of an admission Record indicated the facility admitted Resident #52 on 07/02/2024 with diagnoses which included dementia (disorder affecting memory, thinking, language and behavior), anxiety and depression. Review of an Order Summary Report revealed Resident #52 had an order for psychotropic medication to be given at bedtime related to depression. Review of a quarterly MDS with an ARD of 01/13/2026 revealed Resident #52 had a Staff Assessment for Mental Status (SAMS) score of 3, which indicated Resident #52 had severe cognitive impairment, never/rarely made decisions of daily living, was dependent on staff for eating, toileting personal hygiene and to shower/bathe self. The MDS also indicated Resident #52 was taking a high-risk drug classed as an antidepressant. Review of a Care Plan, with a review date of 01/14/2026, revealed Resident #52 used an antidepressant medication with interventions that included to monitor, document and report as needed for adverse reactions such as a change in behavior, mood, cognition or gait changes. Review of a Pharmacy MRR- Antidepressant form for Resident #52, with an effective date of (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	06/05/2025, revealed the antidepressant recommendation was for a taper/GDR of the psychotropic medication. The Consultant Pharmacist notes were blank. The provider chose to continue the medication with no changes and documented the resident was stable on the current dose but did not document any evidence or specific behaviors. The DON chose the option of 'MD response received and accepted' and e-signed the form on 06/08/2025. Review of Progress Notes for 05/01/2025 to 07/01/2025 for Resident #52 did not reveal any provider documentation to indicate a rationale for continuing the psychotropic medication. During an interview with the DON on 02/20/2026 at 5:03 PM, she stated she was typically on the receiving end of the MRR or the Assistant Director of Nursing (ADON) when asked who follows up with the provider if there was no rationale on the MRR. She stated she reviewed the MRR after the provider completed his/her sections on the form. She stated she was fairly new and still learning the gradual dose information but was familiar with the Centers for Medicare and Medicaid Services (CMS) guidelines for GDR. In an earlier conversation in the conference room on 02/20/2026, the DON stated she had just spoken with the provider on the telephone about the concern of not documenting a rationale for continuing psychotropic medications, and the provider was new and did not know he was supposed to document a rationale for continuing psychotropic medications. The DON stated during this interview at 5:03 PM, the provider had started January of this year (2026). Review of a facility policy titled Medication Regimen Review revised date of April 2007, indicated the purpose of the MRR is to help the facility maintain each resident's highest practicable level of functioning by helping them utilize medications appropriately and prevent or minimize adverse consequences related to medication therapy to the extent possible. This policy also revealed the consultant pharmacist will provide a written, signed and dated copy of the report with the irregularities found and recommendations for their solution to the DON and medical doctor for each resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, interviews, record review, facility policy review, it was determined that the facility failed to ensure personal items were not stored in Personal Protective Equipment (PPE) container to prevent contamination of clean PPE for one of four PPE storage cabinets; failed to ensure the door to a biohazard room was secured to prevent access by residents or visitors; failed to ensure staff performed hand hygiene when entering and exiting resident rooms during clean laundry delivery to prevent cross contamination from resident to resident on one of one hall observed during laundry delivery; and failed to ensure staff performed hand hygiene and glove changes during medication administration via a central line to prevent the potential introduction of infection for one (Resident #37) of one resident reviewed for central line medication administration. The findings include: Incident #1 During an observation on 02/17/2026 at 11:35 AM, on 200-Hall, enhanced barrier precautions (EBP) signage was located outside rooms [ROOM NUMBER]. A plastic 3-drawer cabinet, on wheels, containing PPE was located to the right of room [ROOM NUMBER]. The top drawer of the cabinet contained a hairbrush, personal care wipes, an empty glove box, masks, and mask/face shield combo. During a concurrent observation and interview on 02/17/2026 at 11:40 AM, Medical Records (Med Rec) #2, opened the top drawer of the EBP cabinet, removed the empty glove box. Med Rec #2 identified the open container of wipes as partially used pack of personal care wipes, not disinfectant wipes, and stated the wipes and hairbrush should not be in drawer, because the drawers were clean areas and the brush and wipes were not clean due to use. Med Rec #2 removed the wipes and brush from the drawer. Med Rec #2 stated, PPE cabinets were not at each door as PPE was located so it was accessible for anyone that may need it. Review of a facility policy titled, Enhanced Barrier Precautions, dated August 2022, indicated, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. The policy further indicated, Signs are posted in the door or wall outside the resident room indicting the type of precautions and PPE required. PPE is available close to or inside of the resident room. Incident #2 During an observation on 02/17/2026 at 11:44 AM, a sign indicated Dirty Utility was hanging next to a door, with a push button keypad lock, labeled Biohazard. The Door was not secured and opened when pulled. The Dirty Utility Room contained two gray barrels on wheels, labeled as soiled linens: one yellow barrel on wheels, and one red barrel on wheels. During an interview on 02/17/2026 at 11:49 AM, Certified Nursing Assistant (CNA) #3 was asked if the door marked BIOHAZARD was secured. CNA #3 pushed the door and heard a click and stated, No it (continued on next page)

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	045196	A. Building B. Wing	02/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	must not have shut all the way. CNA #3 stated the door was secured, to keep residents out, due to trash, chemicals and dirty bedding. CNA #3 indicated the yellow barrel was used for trash and confirmed a bag of trash was in the barrel. The gray barrel was used for soiled bedding and had recently been picked up. The red barrel was a biohazard barrel and was currently empty. During an interview on 02/17/2026 at 11:52 AM, Environmental Supervisor stated, the biohazard room should not be open due to the chemicals and other hazards, and residents could get hurt [if they entered]. Incident #3 During an observation on 02/17/2026 at 2:03 PM, Environmental (Enviro) #4 was delivering clean laundry on 400-hall. Clothing was not covered to prevent contamination. The cart contained clothes hanging on hangers and folded laundry in an attached open metal basket below the hanging clothing. Enviro #4 entered and exited Rooms 407, 408, 409, 410, 411, 413, 415, 416, 417 and 418 without performing hand hygiene. Enviro #4 did not perform hand hygiene when entering or exiting room [ROOM NUMBER]which had an EBP sign on the name plate This surveyor also observed Enviro #4 hang dirty hangers on the metal basket with clean laundry upon exiting each room and draped clean blankets over their arm to deliver into rooms without a barrier. During an interview on 02/17/2026 at 2:11 PM, Enviro #4 stated, the cover for the clean laundry cart should have been utilized to prevent contamination of clean laundry and I should have performed hand hygiene when going from room to room to prevent cross contamination. Enviro #4 stated they did not know why the resident in room [ROOM NUMBER] was on EBP. Enviro #4 stated training was provided on how to deliver laundry. During an interview on 02/18/2026 at 12:14 PM, the Assistant Director of Nursing (ADON) stated Environmental Services was responsible for training their employees on infection control. During an interview on 02/20/2026 at 9:05 AM, Enviro #9 stated the process for delivering clean was as follows: clean laundry cart was loaded, the cover was put over the clean laundry, (Enviro #9 used an empty clean laundry cart to demonstrate placing the cover over clean laundry) and the cart would be taken to the hall for delivery. Upon arrival at the hall, cover pulled back, hands sanitized, clean laundry removed, cover pulled back over clothes, laundry taken into residents' room and put away (in drawer or closet), dirty hangers picked up and hung on outside of basket at the bottom of the cart. Hands would be sanitized, cover lifted, clean laundry removed and delivered to the next resident. Enviro #9 stated placing dirty hangers on the outside of the basket was not a concern if the hangers did not touch clean laundry but that it may be possible for hangers to touch laundry in basket. During an interview on 02/20/2026 at 9:19 AM, Environmental Supervisor stated Enviro #4 had worked in three positions at the facility and when moved to laundry Enviro #4 received three days of training on how to handle clean laundry during orientation. Staff were trained on the shift they were hired for. Environmental Supervisor stated she did infection control training by verbal, demonstration and had Enviro #4 do return demonstration to allow for concerns to be corrected. Environmental Supervisor could not remember if correction of Enviro #4 was required. Environmental Supervisor stated cart covers were used to prevent cross contamination and could cause residents to become sick if laundry became contaminated. Due to concern with dirty hangers being hung on cart with clean laundry, Environmental Supervisor stated, late night shift was going to pick up all hangers and sanitize them. (continued on next page)

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	045196	A. Building B. Wing	02/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a personnel file indicated Enviro #4 was employed in Housekeeping, Environmental, and Dietary departments. Review of a facility document titled, Code of Conduct, dated as signed by Enviro #4 on 05/09/2025, advised All personnel shall follow safe work practices and comply with all applicable safety standards and health regulations. Review of a facility document titled, General Orientation Checklist, 05/09/2025, revealed Enviro #4 received education in Housekeeping/Laundry, on linen cleaning, and disposal cart care, safety, and cart storage by Environmental Supervisor. Education overview of the nursing department included Infection control procedures/protocol (handwashing etc.) was done by the ADON. Review of a facility document titled, Hand Hygiene Competency, dated 05/09/2025, indicated Enviro #4 was competent in handwashing with soap and water and hand hygiene with alcohol-based gel. Review of a facility document titled, Job Description Housekeeper/Floor Technician, dated as signed by Enviro #4 on 05/09/2025, outlined duties and responsibilities, Safety and Sanitation Functions as following facility policies and procedures that included infection control and hand sanitation. No other job descriptions were contained in the employee file. Review of a facility policy titled, Handwashing/Hand Hygiene, revised on October 2023, indicated This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Administrative Practices to promote hand hygiene included training of personnel on the importance of hand hygiene to prevent spread of infections and All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Indications for hand hygiene included after touching a resident's environment. A policy and procedure for clean laundry handling were requested, the facility provided policies and procedures titled Laundry and Bedding, Soiled and Departmental (Environmental Services) – Laundry and Linen, and stated no other policy was available. The policies provided did not directly address transport of clean clothing, handling of clean laundered clothing, or dirty hangers. Review of a facility policy titled, Departmental (Environmental Services) – Laundry and Linen, revised January 2014, indicated to cover linen carts to keep linen hygienically clean and free of pathogens, to protect it from environmental contamination. Review of a facility policy titled, Laundry and Bedding, Soiled, revised September 2022, indicated, Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. Incident #4 Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/17/2026, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact, and received antibiotics by Intravenous (IV) access. Review of an admission Record indicated the facility admitted Resident #37 with diagnoses that included osteomyelitis (bone infection); chronic osteomyelitis with draining sinus right humerus (arm); muscle wasting and atrophy; difficulty walking; infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts; chronic atrial fibrillation (irregular (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	heartbeat); difficulty swallowing; and diabetes mellitus type 2. Review of an Order Summary Report revealed active orders dated 02/20/2026, which included Peripherally Inserted Central Catheter (PICC) line tubing changes; PICC line dressing changes; flush orders; and [name brand antibiotic] orders. Review of a Medication Administration Record (MAR) dated 02/01/2026-02/28/2026, revealed IV tubing was scheduled to be changed every four days, and documented as changed on 02/18/2026; dressing was scheduled to be changed weekly on Thursdays, and last documented change prior to 02/18/2026 was 02/12/2026; and [name brand antibiotic] was scheduled to be received three times daily, and last administration was documented as 09:00 AM on 02/18/2026. Review of a Care Plan Report, revised on 01/16/2026, indicated Resident #37 had an Activities of Daily Living self-care performance deficit related to a left femur (leg) fracture and limited mobility; altered cardiovascular status related to chronic atrial fibrillation; and potential nutritional problem related to osteomyelitis. Review of a Nsg [Nursing] Admit/Readmit Assessment and Care Plan, with an effective date of 01/15/2026, indicated Resident #37 had a PICC line in the left antecubital (inner elbow area.) Review of a Nsg Every Shift Skilled Charting, with an effective date of 02/17/2026, indicated Resident #37 had a PICC line and was receiving antibiotic medications. During an observation on 02/18/2026 at 1:33 PM, Resident #37 was observed self-propelling their wheel chair and exiting the restroom. Licensed Practical Nurse (LPN) #1 entered Resident #37's room spoke with resident about medication to be administered. Medicare Manager (MC Manager) came to the doorway of resident's room with a yellow gown and gloves, LPN #1 placed a 100 ml Normal Saline (NS) fluid bag and a vial of un-constituted powdered [name brand antibiotic] with attached adapter on the overbed table, did not clean of the table prior to setting down supplies, and stepped out of the room. Resident #37 was sitting in wheelchair on the right side of the lower end of the bed. LPN #1 re-entered Resident #37's room, with the yellow gown and gloves provided by MC Manager and did not perform hand hygiene. LPN #1 donned the yellow gown and right-hand glove, dropped second glove on floor, donned a clean glove on left hand and with right gloved hand picked up dirty glove from floor and placed the dirty glove on overbed table next to the NS bag. LPN #1 then walked to the left side of the bed, placed gloved left hand on IV pole and moved pole supporting IV pump to end of bed near resident. No hand hygiene or glove change was performed. LPN #1 removed the cover of connected vial adapter attached to antibiotic vial and cap from the 100 ml NS bag and spiked the bag, squeezed fluid bag injecting NS into powdered [name brand antibiotic] vial and vigorously shook vial until fluid and powder were incorporated. LPN #1 removed the empty IV bag setup, used in previous medication administration, hanging on IV pole, from the IV tubing dated 02/18/2026. LPN #1 stated the IV tubing was hung with morning dose of medication. LPN #1 removed spike access port protective cover, from the medication bag, and inserted spike end of IV tubing, squeezed the drip chamber to fill with fluid, and hung the bag on the IV pole. LPN #1 reached into their scrub pocket with right gloved hand, removed alcohol prep pad, removed the disinfection cap from single lumen PICC line, located in left arm, opened alcohol pad package, scrubbed PICC needleless connector for 30 seconds, attached 10 milliliter (ml) syringe of normal saline, released clamp, received blood return, and flushed with 10 ml of normal saline. LPN #1 then removed the end cap from IV tubing, attached the tubing to the PICC line , and started the IV pump - set at 200 milliliters per hour (ml/hr), volume to be infused set at 100 ml to run over 30 minutes. IV Pump did not immediately start, LPN #1 pressed prime line, PRIME (continued on next page)

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	045196	A. Building B. Wing	02/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appeared on pump and infusion started. No air was visible in the IV line. LPN #1 gathered used supplies, removed gown and gloves, disposed of items and performed hand hygiene. During an interview on 02/18/2026 at 1:48 PM, LPN #1 stated IV tubing was changed every four days and new tubing was hung when LPN #1 administered morning dose of medication. LPN #1 stated gown and gloves were used when accessing a single lumen PICC to prevent outside pathogens from entering the system and causing infection that could affect the resident's heart. LPN #1 stated she performed hand hygiene prior to entering the resident's room using hand sanitizer on the wall. LPN #1 stated the table should have been cleaned prior to the medications and supplies being placed on the table, the glove dropped on the floor should not have been picked up and placed on the overbed table near the medication, gloves should have been changed and hands sanitized after picking up the glove from the floor, and touching the IV pole, before cleaning the lumen and accessing the PICC. LPN #1 stated the break in infection control procedures could have caused cross contamination and the resident to develop an infection. During an observation and concurrent interview on 02/18/2026 at 2:15 PM, LPN #1 sanitized hands, stopped the IV pump, clamped the PICC line, disconnected the IV tubing and cleaned the lumen with alcohol prep pad for 30 sec, attached 10 ml syringe of NS flush, opened clamp, flushed with 9.5 ml NS, removed NS syringe, removed [anticoagulant] syringe from package, expressed air, attached syringe and flushed PICC with [anticoagulant] and engaged clamp. LPN #1 stated 10 ml of NS was used to flush the PICC line followed by 5 ml of [anticoagulant]. LPN #1 removed an orange cap from a sealed package and placed it on the PICC access port, disposed of supplies, removed gown, gloves, and performed hand hygiene. Review of a facility document titled, Job Description, unsigned by LPN #1, with a date of hire 09/16/2025, outlined the purpose of the job position, The primary purpose of your job position is to provide direct nursing care to the patient and to ensure that the highest degree of quality care is maintained at all times. Drug administration functions indicated Prepare and administer medications as ordered. Personnel functions indicated to ensure all departmental policies and procedures are followed at all times. Safety and sanitation functions indicated to monitor for adherence to all safety and infection control policies and procedures. Specific requirements indicated must not pose a direct threat to the health or safety of other individuals in the workplace. Review of a document titled, Code of Conduct 2025, signed by LPN #1 on 09/16/2025, instructed All personnel shall follow safe work practices and comply with all applicable safety standards and health regulations. Review of a facility document titled, Arkansas Patient Rights, signed by LPN #1 and dated 09/16/2025, indicated The right to receive adequate and appropriate health care. with established and recognized practice standards. Review of a facility document titled, General Orientation Checklist, dated 09/16/2025, indicated LPN #1 received overview of responsibilities and duties related to blood borne pathogens and infection control procedures/protocol (handwashing). Review of a facility document titled, Infection Prevention and Control Program, signed by LPN #1 on 09/16/2025, indicated Prevention – use standard precautions for every resident, sanitize hands often, use gloves, and hand hygiene was to be completed anytime hands become soiled, upon entering or exiting any patient room or care area, anytime a resident is touched. (continued on next page)

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	045196	A. Building B. Wing	02/20/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility document titled, Hand Hygiene Competency, dated 09/16/2025 indicated LPN#1 was competent with handwashing and use of alcohol-based hand rub. Review of a policy and procedure titled, Guidelines for Preventing Intravenous Catheter-Related Infections, with a revised date of August 2014, stated the purpose of the procedure was to maximally reduce the risk of infection associated with indwelling intravenous (IV) catheters. The general guidelines included Facility staff who manage infusion catheters will have training and demonstrated clinical competency in intravenous therapy, including appropriate infection control measures to prevent IV catheter-related infections. When working with IV equipment aseptic techniques shall be observed. Nursing Practice Guidelines to Prevent Catheter-Related Infections included observing proper hand hygiene procedures of handwashing or alcohol-based hand rubs, before and after accessing the site. Review of the policy and procedure titled, Central Venous and Midline Catheter Flushing, with a revised date of April 2016, indicated the purpose of the procedure included to maintain patency of midline and central venous catheters and ensure entire dose of medication was administered. General guidelines indicated no physician order was needed for the procedure. The Saline, Administer, Saline (SAS) method included flushing with 10 ml syringe of normal saline (NS) amount as ordered or per facility protocol. During an interview on 02/20/2026 at 2:25 PM, the Director of Nursing (DON) stated all employees are expected to follow infection prevention protocols. Education was provided upon hire and included handwash check offs and donning/doffing PPE. PPE bins (storage containers) should contain only basic PPE, gloves, face protectors, masks, gowns, and not hairbrushes, or personal wipes due to the infection risk to residents. Staff are expected to perform hand hygiene during laundry delivery when going in and out of resident rooms, entering EPB room with clean laundry and exiting with empty dirty hangers, picking up clean laundry and entering another resident room should not be done for safety of residents and the risk of bringing infection to the secondary resident. Staff should not drape clean laundry over their arms. During an interview on 02/20/2026 at 6:20 PM, the Administrator stated staff were expected to abide by infection prevention practices, use sanitizer, wash hands, and abide by all isolation guidelines if on EBP, contact, droplet, or other type of isolation. The Administrator also stated they expected nurses to change gloves and wash hands during resident care abide by all policies to prevent spreading infections and to keep residents safe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045196	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southridge Village Nursing and Rehab	400 Southridge Parkway Heber Springs, AR 72543

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review and facility policy review, it was determined that the facility failed to ensure education was provided when a pneumococcal vaccine was offered for one (Resident #41) of one resident. The findings include: Review of an admission Record indicated the facility admitted Resident #41 with diagnoses that included hemiplegia (loss of movement on one side of the body) and hemiparesis (muscle weakness of one side of the body) following cerebral infarction (stroke) affecting the right dominate side, cognitive communication deficit, aphasia (language disorder), and malignant neoplasm (cancer) of colon. Resident #41's family member was listed as the responsible party. Review of an Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/09/2025, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. The MDS also indicated Resident #41's pneumococcal vaccine was not up to date; vaccine was offered and declined. Review of Resident #41's Care Plan Report, revised on 12/23/2025, did not address vaccinations. Review of an Order Summary Report, for February 2026, revealed Resident #41 had no orders for vaccines. Review of a form titled, Participation in Immunization Programs, revealed Resident #41 agreed to participate in the immunization program, Consent to Vaccination/Permission to Administer Vaccines, had no last known vaccination for pneumonia. The document further indicated, I authorize the facility to administer a one-time pneumococcal vaccine to me. The document further outlined an understanding that Resident #41 had the legal right to refuse administration of these vaccines at the time of administration and was E-signed by Resident #41's responsible party. Review of Clinical Immunizations report dated 02/20/2026, revealed Resident #41 refused the Pneumococcal conjugate vaccine (PCV) and the Pneumococcal polysaccharide vaccine(PPSV) vaccines. Review of Clinical Immunizations View Immunization PPSV, dated 02/17/2023, indicated Resident #41 refused the PPSV vaccine and education was provided. Review of Clinical Immunizations View Immunization, dated 06/29/2023, indicated Resident #41 refused the PCV vaccine and education was not provided. During an interview on 02/18/2026 at 12:14 PM, the Assistant Director of Nursing (ADON) stated immunizations were offered on admission and annually. Pneumonia was reoffered yearly if the resident had not previously received the vaccine, and verbal education included risks and benefits of receiving the vaccine. Vaccines received or refused, were documented in the resident's electronic health record. To ensure flu and pneumonia vaccines were offered annually, the ADON ran an audit annually for residents who admitted to the facility outside the flu season and those who previously refused. Residents, responsible parties, or Power of Attorney's (POA) would be contacted for (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents who could not consent or decline. The ADON confirmed Resident #41's responsible party had refused the influenza and COVID vaccines when offered upon admission, in 2023. The ADON confirmed Resident #41 was offered and refused the PPSV23 pneumonia vaccine, with education, on 02/17/2023, upon admission, and the PCV20 vaccine on 06/29/2023, without education. The ADON could not provide the information Resident #41 was offered or declined regarding the pneumonia vaccine with education since 2023. During an interview on 02/20/2026 at 9:45 AM, the ADON provided a document titled Participation in Immunization Programs, signed by Resident #41's responsible party on 02/06/2023, and stated the pneumonia vaccine had not been reoffered to the resident since 2023. During an interview on 02/20/2026 at 2:25 PM, the Director of Nursing (DON) stated their expectation was all nurses would follow infection prevention protocols. During an interview on 02/20/2026 at 6:20 PM, the Administrator stated, we don't want to spread infections, and expected staff to abide by all policies to keep residents safe. Infection Prevention staff were expected to follow CMS guidance on offering resident's vaccinations. Flu vaccines were offered yearly, and residents were offered pneumonia vaccines as long as no contraindications, to control the spread of pneumonia and flu. Review of a facility policy titled, Pneumococcal Vaccine, revised August 2016, indicated, All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy also states Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) and resident/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicting the date of the refusal of the pneumococcal vaccination. The policy adopts and incorporates by reference, OBRA (Omnibus Budget Reconciliation Act) Regulatory Reference numbers included 483.80(d). Other references included Centers for Disease Control and Prevention (CDC) 2014, Use of 13-valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine among adults ≥65 years: Recommendations of the Advisory Committee on Immunization Practices (ACIP). Morbidity and Mortality Weekly Report 63(37) Related documents included the vaccine information statements for Pneumococcal Conjugate Vaccine (PVC-13) and Pneumococcal Polysaccharide Vaccine (PPSV). Review of the adopted and incorporated by reference OBRA Regulatory Reference 483.80 document titled, Title 72-Public Health Chapter IV – Centers for Medicare & Medicaid, Department of Human Services, Subchapter G-Standards and Certification, Part 483-Reqirements for State and Long Term Care Facilities, Subpart B-Requirements for Long Term Care Facilities up to date as of 02/23/2026, indicated .(d)(2) Pneumococcal disease . (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or resident's representative has the opportunity to refuse immunization; and (iv) the resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding benefits and potential side effects of pneumococcal immunization, and (B) That the resident either received the pneumococcal immunization, or did not receive the pneumococcal immunization due to medical contraindication or refusal. Review of the adopted and incorporated by reference document titled, CDC 2014 Use of 13-valent pneumococcal conjugate vaccine and 23-valent pneumococcal polysaccharide vaccine among adults (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	≥65 years: Recommendations of the Advisory Committee on Immunization Practices (ACIP), dated 11/22/2019, indicated New Pneumococcal Vaccine Recommendations for Adults Ages ≥[AGE] years old, PCV13 [13 refers to the protection from the number of bacterium types that cause pneumococcal disease] vaccination recommended based on risk for pneumococcal disease as a result of underlying medical conditions. ACIP recommends one dose of PPSV23 [23 refers to the protection from the number of bacterium types that cause pneumococcal disease] for all adults ≥65 years, unless the dose was received before age [AGE], should receive additional dose, 5 years after previous dose. Review of the adopted and incorporated by reference document titled, Morbidity and Mortality Weekly Report, dated 01/09/2025, summarized what was known on the pneumococcal vaccine topic before October 2024, included single dose of 15-valent, 20-valent or 21-valent PVC was recommended for all adults aged ≥65 years. Additions to the report made by the committee 10/23/2024 included a single dose of PCV for all adults aged ≥[AGE] years old who are PCV naïve [have never had the vaccine] or who have an unknown vaccination history. Review of the adopted and incorporated by reference document titled, Vaccine Information Statement, Pneumococcal Conjugate Vaccine, dated 05/29/2025, recommendation included, 2. Pneumococcal conjugate vaccine .Adults 50 years or older who have not previously received PCV should receive a PCV vaccine. Review of the adopted and incorporated by reference document titled, Vaccine Information Statement, Pneumococcal Polysaccharide Vaccine (PPSV23), dated 05/29/2025, indicated PPSV23 was recommended for adults following a dose of PCV15 pneumococcal conjugate vaccine. Review of a document titled, Arkansas Code of 1987 (2024), Chapter 10, Subchapter 13 Nursing Home Resident and Employee Immunization, Section 20-10-1301, indicated It is recognized that: .(3) The CDC recommends that individuals over the age of sixty-five (65) years have .a pneumococcal vaccine one (1) time; .(6) The elderly living in an institutional setting, where disease may be more readily transmitted, are less protected than those living in the community. As used in this subchapter: .(4)(b) Each nursing home facility in this state shall: (3) Document and report annually immunizations against; .(B) Pneumococcal disease for residents.