STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045297	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manila Healthcare Center	2975 W State Highway 18 Manila, AR 72442

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review, observation, interview, and facility policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented for one (Resident #17) of two residents reviewed for EBP and failed to ensure hand hygiene was consistently implemented during incontinence care for one (Resident #46) of one resident reviewed for incontinence care.The findings include:Resident #17A review of Resident #17's Physician's Orders, dated 03/16/2026, revealed all medications were to be administered by way of (via) a Percutaneous Endoscopic Gastrostomy (PEG) tube, with a start date of 04/10/2024. The resident had an active order for EBP related to indwelling devices, with a start date of 06/24/2024. A review of Resident #17's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/18/2025, revealed a Staff Assessment for Mental Status (SAMS) score of 3, which indicated the resident was severely impaired and never/rarely made decisions. Resident #17's MDS also revealed the resident had a feeding tube while a resident.A review of Resident #17's Care Plan revealed the resident required tube feedings related to dysphagia, with interventions which included direction for staff to follow EBP, initiated on 04/21/2024.A review of Resident #17's electronic Medication Administration Record (eMAR) for 03/2026 revealed EBP related to indwelling devices with an order date of 06/24/2024. There were two 12-hour time slots listed on the eMAR:- On 03/18/2026, the first time slot of 12 hours, had a checkmark and Licensed Practical Nurse (LPN) #2's initials were in the box. The chart codes/follow up codes on the eMAR revealed a checkmark indicated administered.During an observation on 03/16/2026 at 1:40 PM, this surveyor observed there was no EBP signage posted, or Personal Protective Equipment (PPE), available outside of Resident #17's room. After entering the room, there was a feeding pump to the right of Resident #17's bed, that was not in use at this time.During an observation on 03/17/2026 at 12:33 PM, this surveyor observed there was still no EBP signage or PPE outside of Resident #17's room, nor any other indicator that the resident required EBP.During a concurrent observation and interview on 03/18/2026 at 12:26 PM, Registered Nurse (RN) #10 entered Resident #17's room to change Resident #17's percutaneous endoscopic gastrostomy (PEG) tube tubing. As the primary nurse, LPN #2 was busy at this time. RN #10 sanitized her hands and put on a pair of gloves. She then informed Resident #17 of the care she was about to perform and stated she needed to grab a cup of water, so RN #10 removed their gloves and exited the room. At 12:37 PM, RN #10 re-entered Resident #17's room and sanitized her hands and put on a new pair of gloves. She did not bring a gown into the resident's room to use and continued to perform the entire procedure of disconnecting the resident's previous enteral feeding bags and tubing with a new set of enteral feeding bags and tubing to Resident #17's PEG tube. During the procedure, RN #10 connected a 60 cubic centimeter syringe to Resident #17's PEG tube, to check for placement, without wearing a gown. RN #10 verified the resident was on EBP and stated that gloves were a part of EBP. When questioned if a gown was a part of EBP, RN #10 stated she had never worn a gown for hooking up a PEG tube. She then stated she was not informed that a gown was to be used when changing the lines on a PEG tube.During an interview on 03/18/2026 at 12:55 PM, LPN #2 stated Resident #17 should be on EBP, because the resident had a PEG tube and a [brand name] catheter. LPN #2 stated there was not a red dot by the resident's name (on the name placard next to the resident's door) to indicate (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #17 was on EBP. LPN #2 stated the Treatment Nurse was responsible for posting the signage for residents on EBP.During an interview on 03/19/2026 at 11:12 AM, the Treatment Nurse stated she was responsible for putting up the signage for residents on EBP. She stated when she ran her list to check everyone, Resident #17 was out to the hospital, and she missed putting Resident #17's EBP information [signage] in place. A review of an Enhanced Barrier Precautions policy with a revision date of 08/2022, revealed gown and gloves were to be applied prior to performing high-contact resident care activity (as opposed to before entering the room). This EBP policy indicated examples of high-contact resident care activities which included device care or use, such as a feeding tube.A review of an EBP Competency Checklist revealed RN #10 completed the following items on the EBP checklist on 11/17/2025: the PPE required for EBP, and conditions which required the use of EBP; a feeding tube was included on this list.Resident #46A review of Resident #46's admission Record indicated the facility admitted the resident on 08/22/2023, with diagnoses which included dementia and Parkinson's disease.A review of Resident #46's quarterly MDS with an ARD of 02/02/2026, revealed a SAMS score of 3, which indicated the resident was severely impaired and never/rarely made decisions. Resident #46's MDS also revealed the resident was dependent for toileting, personal hygiene, could shower/bathe self, and was always incontinent of bowel and urine. A review of Resident #46's Lab Results revealed a urine analysis was performed on 02/12/2026, which indicated Escherichia Coli (bacteria normally found in intestines that could cause infection when found in the urinary tract) and extended-spectrum beta-lactamase (enzymes produced by a bacteria that make them resistant to common antibiotics) in the resident's urine, which required treatment with an antibiotic.During an observation on 03/18/2026 at 1:49 PM, Nurse's Aide (NA) #6 and Certified Nursing Assistant (CNA) #7 entered Resident #46's room to perform perineal (peri) care to the resident. CNA #7 had sanitized her hands and put on gloves before performing care to Resident #46. During the care, CNA #7 stated she needed more wipes to provide care to Resident #46. NA #6 then exited the room and came back in after a few minutes with a green package of unopened wipes. Without changing gloves and sanitizing her hands, CNA #7 received the package of wipes from NA #6, opened the package of wipes, placed the package of wipes on the over-bed table, and began to remove clean wipes from the package with the same gloves that she was wearing while using previous wipes to cleanse urine from Resident #46's skin. CNA #7 continued to use those same pair of gloves to pick up a bottle of perineum (area of skin located between the genitals and the anus) wash, sprayed the liquid to Resident #46's gluteal area, removed wipes from the package and cleansed Resident #46's gluteal areas. CNA #7 picked up the bottle of perineum wash and sprayed some liquid on Resident #46's rectal area and proceeded to cleanse loose brown feces from Resident #46's rectum. After CNA #7 was done with peri-care to Resident #46, without changing gloves, she placed a clean adult brief under the resident's right side, rolled Resident #46 to the left side, and then pushed a blue lift pad under the resident's back. Then CNA #7 and NA #6 repositioned Resident #46 to their right side, and NA #6 removed the blue lift pad and pulled the clean adult brief under the resident's left side, and then the resident was positioned on their back. After peri-care was completed, CNA #7 placed a yellowish-gold bottle of powder, and the bottle of perineum wash inside Resident #46's drawer and before removing and discarding their soiled gloves in the trash can.During an interview with CNA #7 on 03/18/2026 at 2:05 PM, she verified she was to sanitize her hands before and after entering a resident's room who was incontinent of urine and feces, when providing peri-care. She then verified she was supposed to change her gloves when she provided peri-care to anterior parts of a resident's peri-area and change gloves when performing care to the resident's back side. CNA #7 verified she was not supposed to use the gloves that she cleansed feces from the resident's skin with to remove clean wipes from a package and then confirmed she did not change her gloves during peri-care to Resident #46, because she was moving too fast. CNA #7 also stated she knew she was supposed to sanitize her hands during peri-care when moving to Resident #46, but she did not. She stated she had received training on how to perform peri-care to residents by shadowing a CNA at the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility for two to three weeks. She stated she had not performed any skills-checkoffs before caring for residents on her own.During an interview on 03/19/2026 at 2:43 PM, the Director of Nursing (DON) stated the nurses were in-serviced on EBP either by the Infection Preventionist or the DON quarterly, and if there were any changes. She stated the Infection Preventionist was responsible for posting EBP signage, but nurses knew what to do and where things were, therefore could place EBP signage. The DON stated the red dot [placed by the resident's name on the door tag outside of the room] was for staff to be aware of who was on EBP. She stated her expectations regarding CNAs and nurses following EBP was for the staff to put on PPE and if they had any questions, to ask for clarification. She stated her expectations for staff on hand hygiene during peri-care were to follow hand hygiene, per the training, and to do hand hygiene appropriately because this could lead to further issues. The DON then stated CNA #7 did receive training and she was asked to provide a skills checkoff for CNA #7 regarding peri-care. As of 03/19/2026 at 4:57 PM, the DON had not provided any trainings/education on peri-care for CNA #7.A review of a Perineal Care policy, revised 02/2018, revealed the purposes of this procedure were to provide cleanliness and comfort for the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.A review of a Handwashing/Hand Hygiene policy, revised October 2023, revealed hand hygiene is the primary means to prevent the spread of healthcare-associated infections.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review the facility failed to ensure that one (Resident #95) of one resident reviewed for self-determination, had the opportunity to exercise autonomy in choosing when to have medication administered. The findings include: Review of an admission Record revealed Resident #95 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease with (acute) exacerbation, congestive heart failure, pneumonia, vitamin deficiency, dizziness, and gastroesophageal reflux disease (GERD). Review of Resident #95's admission Minimum Data Set (MDS) revealed that the MDS was in progress. Review of the CMT Medication Administration Record (MAR) dated 03/16/2026 revealed that Resident #95 refused the following medications: an antibiotic, a high blood pressure medication, an allergy medication, vitamin, an iron supplement, an anticholinergic, a probiotic, a blood thinner, an antacid, an oral steroid, an antitussive, a diuretic and an antivertigo. The medications were coded on the MAR with the number two. The number indicated the medications were refused. During an interview on 03/16/2026 at 12:05 PM, Resident #95 indicated they had not received morning medications at that time. Resident #95 indicated that the nurse brought the morning medications to the room around 7:30 AM and the resident informed the nurse that it was too early to take 11 pills. Resident #95 indicated that they told the nurse to bring the medications back after they had eaten breakfast, which was around 9:00 AM-9:30 AM. Resident #95 stated they could not remember the name of the nurse. During an interview on 03/16/2026 12:08 PM, Licensed Practical Nurse (LPN) #8 indicated that Medication Technician (Med Tech) #9 went in to give Resident #95 their medications at 8:30 AM. LPN #8 indicated that Resident #95 wanted to wait until 9:00 AM, after breakfast, to take the morning medications. LPN #8 indicated that Resident #95 was informed that medications had to be taken between 7:00 AM and 9:00 AM. LPN #8 indicated that she notified the Nurse Practitioner (NP) at 12:00 PM that Resident #95 refused the morning medications. During an interview on 03/16/2026 at 3:13 PM, Resident #95 indicated that they took an antibiotic every day. Resident #95 indicated that it was important that medication was taken every day. During an interview on 03/18/2026 at 9:26 AM, the NP indicated that Resident #95 should be accommodated if the resident chose to take medications later than scheduled. The NP indicated she received a message on 3/16/2026 at 12:07 PM from LPN #8 indicating that Resident #95 did not take the medications. The nurse practitioner indicated that Resident #95 did not receive the scheduled antibiotic on 03/16/2026. The NP indicated that Resident #95's last dose of antibiotic should have (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been Monday 3/16/2026, however the last dose was administered on 03/17/2026. The NP indicated that LPN #8 should have administered Resident #95's diuretic, iron supplement, and high blood pressure medications. During an interview on 03/18/2026 11:06 AM, the Director of Nursing (DON) indicated that if Resident #95 requested medication to be administered after breakfast the provider should be contacted to change the medication times. The DON indicated that the resident's preference on the time that they would like their medications administered should be accommodated. The DON indicated that Med Tech #9 should have notified the nurse if Resident # 95 requested medications at a time that was different from the scheduled time. During an interview on 03/18/2026 at 2:11 PM, the Administrator indicated that the facility was Resident #95's home. The Administrator also indicated that it was Resident #95's choice to take medication at a different time than the scheduled time. During an interview on 03/19/2026 at 12:40 PM, Med Tech #9 indicated that if a resident requested their medication after breakfast, she would usually inform the nurse. Med Tech #9 indicated that she informed LPN #8 that Resident #95 did not take the morning medications. Med Tech #9 indicated that she had to leave the facility to work transportation for other residents. Med Tech #9 indicated that she asked LPN #8 to give Resident #95 the medications when Resident #95 finished breakfast. Med Tech #9 indicated that LPN #8 agreed to give Resident #95 the medications. During a phone interview on 3/19/2026 at 04:00 PM, LPN #8 stated that Med tech #9 LPN via phone asked her to give Resident #95 her medication on 3/16/2026.LPN #8 indicated that Med Tech #9 offered Resident #95 her medications, and the resident wanted to wait until 9:00 AM. LPN #8 indicated that Med Tech #9 put a lid on the medications and put it in the top drawer of the medication cart. LPN #8 indicated on 3/16/2026 at 9:40 AM that Med Tech #9 left the facility to do transport. LPN #8 indicated that she assumed Med Tech #9 had administered Resident #95 her medications. LPN #8 indicated that around 11:00 AM she discarded Resident 95's medications. LPN #8 indicated that she talked to Resident #95 later that day on 3/16/2026, and Resident #95 indicated that she did not get her morning medications. Review of a policy titled Administering Medication indicated that staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. The policy indicated that medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include honoring resident choices and preferences.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review, interview and facility policy review, the facility failed to ensure a Comprehensive Care Plan was consistently implemented for one (Resident #17) of four residents reviewed. The findings include: Review of an admission Record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses which included epilepsy, restless leg syndrome and hemiplegia and hemiparesis (decreased sensation or mobility on one side of the body) affecting the right dominant side. Review of a quarterly Minimum Data Set with an Assessment Reference Date of 12/18/2025, revealed Resident #17 had a Staff Assessment for Mental Status score of 03, which indicated Resident #17 had severe cognitive impairment, never/rarely made decisions, and was dependent on staff for rolling left and right. Review of March 2026 Physician's Orders revealed Resident #17 was receiving comfort measures only. Review of a Care Plan with a revised date of 02/01/2020, revealed Resident #17 had an Activity of Daily Living (ADL) self-care performance deficit, with an intervention, dated as initiated 01/28/2020 and revised 02/01/2022, of bed mobility requiring extensive assistance times (x) 2 staff for repositioning and turning in bed every (q) 2 hours and as necessary. The Care Plan also revealed Resident #17 had an actual fall with minor injury on 02/05/2026 and one on one education was provided with staff to ensure using two persons assistance with bed mobility and care. Review of a Progress Note dated 02/05/2026 at 4:19 AM, revealed Resident #17 was found lying on the floor on the resident's side after rolling out of bed during briefs change. Review of an Incident and Accident (I&A) Report dated 02/05/2026 revealed Resident #17 was found on the floor lying on Resident #17's side after rolling out of bed while CNA [not named] was trying to smooth out the drawsheet. The incident report indicated Resident #17 did not have any injuries. During a telephone interview on 03/19/2026 at 3:22 AM, Licensed Practical Nurse (LPN) #12 stated knowing how to care for Resident #17 by looking at the resident's care plan and if there are changes the day shift nurse gives her those changes about the resident in report. She stated she was working 02/13/2026 when Resident #17's incident of falling out of the bed occurred and CNA #11 was the CNA working with Resident #17 that night. LPN #12 recalled CNA #11 notifying her that Resident #17 rolled down CNA #11's body to the floor after she noticed the bed moving and the wheels unlocked. LPN #12 stated 2 CNAs were required to turn and reposition Resident #17 while in bed. During a telephone interview on 03/19/2026 at 3:48 AM, CNA #11 stated she was familiar with what (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care Resident #17 required by reviewing the Closet Care Plan. She stated Resident #17 required two CNAs to turn and reposition the resident and admitted to moving the resident in bed with no help. She stated she did not check the wheels on the resident's bed before reaching under the resident to smooth the drawsheet because the wheels appeared to be locked to her. CNA #11 stated when she let go of the drawsheet that was under Resident #17, the bed moved and Resident #17 rolled out of the bed down her [CNA #11's] body to the floor. CNA #11 stated, because my arm length is long, I thought I could straighten the draw sheet under the resident on my own. She stated she does check the wheels on the resident's beds before providing care, but she was trying to handle many tasks that night and did not check the wheels on Resident #17's bed. During an interview on 03/19/2026 at 2:43 PM, the Director of Nursing (DON) stated she expected staff to follow the resident's Care Plan every time they provided care and if staff had any questions about the Care Plan to reach out to the charge nurse or nurse manager. She stated staff should check the wheels on the residents' bed before providing care and before exiting the room. Review of a facility policy titled Care Plans, Comprehensive Person-Centered revised March 2022, revealed A comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care plan policy also revealed the comprehensive, person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and reflects currently recognized standards of practice for problem areas and conditions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, interviews, record reviews and facility policy review, the facility failed to ensure nails were trimmed for one (Resident #4) of three residents reviewed for Activities of Daily Living (ADL) care. The findings include: Review of a facility policy on nail care titled Fingernails/Toenails, Care of revealed the propose of nail care is the clean the nail bed, keep nails trimmed, and prevent infections. The policy revealed that nail care included daily cleaning and regular trimming. The policy revealed that the condition of a resident's nails and nail bed should be documented in the resident's medical record. The policy revealed that proper nail care helps to prevent skin problems around the nail bed. The policy revealed nails should be trimmed and smooth to prevent the resident from accidentally scratching and injuring his skin and the nurse supervisor should be contacted if there is evidence of ingrown nails, or if the nails are too hard or too thick to cut with ease. Review of an admission Record revealed Resident #4 was admitted to the facility on [DATE] with diagnosis of type 2 diabetes with hyperglycemia. Review of a 5-day Minimum Data Set with an Assessment Reference Date of 12/26/2025 revealed Resident #4 had short and long term/memory problems according to a Staff Assessment of Mental Status (SAMS), the SAMS was not scored. Resident #4 was dependent on staff for personal hygiene. Review of an Order Summary Report for Resident #4 revealed an order with a start date of 12/23/2025 for diabetic nail care that should be provided by a Licensed Nurse as needed. Review of Resident #4's Care Plan, initiated on 12/30/2025, revealed the resident had an ADL self-care performance deficit related to dementia. Interventions indicated that the resident was totally dependent on one staff for personal hygiene. On 03/16/2026 at 2:49 PM, this Surveyor observed that Resident #4's toenails were long and curved. During an interview on 03/17/2026 at 9:15 AM, Nurse Aide (NA) #6, indicated that the facility had certain people to do nail care. NA #6 indicated that she does not clip Resident #4's toenails because she was not certified to perform nailcare for diabetic residents. NA #6 stated that she informed the nurse when a resident wanted their nails trimmed. During an observation and concurrent interview on 03/17/2026 at 1:13 PM, the Director of Nursing (DON) looked at Resident #4's toenails and indicated Resident #4's toenails were very long, jagged, and probably had fungus. The DON indicated that Resident #4's right big toenail was overlapping onto the second toe. The DON indicated that the nurse could trim Resident #4's toenails if they were a diabetic and that Resident #4's toenails should be trimmed weekly. The DON indicated that the podiatrist came to the facility at least monthly, and sometimes every 2-3 weeks. [The podiatrist saw (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents based off of a list provided by the facility] According to a podiatry list provided by the DON the last time the podiatrist came to the facility was in February 2026. Resident #4 was not on the list to be seen by the podiatrist. During an interview on 03/17/2026 at 1:21 PM, the Treatment Nurse (TN) indicated that the nurses and Certified Nursing Assistants (CNA s) were responsible for cutting Resident #4's toenails. The TN indicated that Resident #4 should be referred to podiatry if the nails were too thick. The TN looked at the treatment record and indicated the resident was a diabetic and the CNAs did not do diabetic nail care. The TN confirmed that she signed Resident #4's treatment record on 03/12/2026 indicating that Resident #4's nail care had been completed. The TN verified that the treatment record was signed after the care had been completed. During an observation on 03/17/2026 at 1:30 PM, the TN raised Resident #4's right foot. The right big toenail was curved overlapping the second toe. Resident #4's toenail on the third toe was severely curved, extending halfway under the toe. Doing an interview on 03/18/2026 at 9:36 AM, the Nurse Practitioner indicated that she was not sure who was responsible for cutting Resident #4's nails. She indicated that a Podiatrist could come if Resident #4's nails were thick. During an interview on 03/18/2026 at 3:47 PM, CNA #4 indicated that the nurses were responsible for cutting Resident #4's toenails since the resident was a diabetic. Review of a Podiatry Referral List for September 2025, October 2025, and February 2026 did not indicate that Resident #4 had been referred to see the Podiatrist.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Number of residents sampled: Number of residents cited: Based on observations, interviews, and record reviews, the facility failed to add oxygen to the Physician Orders for one (Resident #40) of two residents reviewed for oxygen orders. The findings include: Review of Resident #40's admission Record indicated that the facility admitted Resident #40 on 12/11/2025 with diagnoses which included pneumonia, shortness of breath, obstructive sleep apnea, and acute bronchitis. Review of a discharge return anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/28/2026 revealed Resident #40 had modified independence for daily decision according to a Staff Assessment of Mental Status (SAMS). Review of Residents #40's Physician Orders did not indicate that Resident #40 had an order for oxygen administration. Review of a form titled Standing Orders dated 02/08/2021, signed by the Nurse Practitioner (NP), indicated to administer oxygen at 2-4 liters per minute as needed for shortness of breath and/or a pulse oximetry less than 90%. Review of Resident #40's Care Plan did not indicate that Resident #40 was on oxygen. During an interview on 03/16/2026 at 12:45 PM, Resident #40 was sitting in a medical reclining chair in the dining room. Resident #40 indicated that they were supposed to have oxygen. Resident #40 indicated they were having difficulty breathing. During an interview on 03/16/2026 at 12:55 PM, Resident #40 asked this surveyor to raise their medical reclining chair. The surveyor informed Certified Nursing Assistant (CNA) #7 that Resident #40 needed assistance with reclining their chair. During an observation on 03/16/2026 at 12:57 PM, Resident #40 informed Certified Nursing Assistant (CNA) #7 that they needed oxygen. During an observation on 03/16/2026 at 1:02 PM, Resident #40 had their head covered crying. Resident #40 indicated that they were having trouble breathing. During an interview on 03/16/2026 at 1:02 PM, the Housekeeping Supervisor was informed that Resident #40 needed assistance. The housekeeping supervisor paged the nursing staff. During an observation and concurrent interview on 03/16/2026 1:03 PM, CNA #7 checked Resident #40's oxygen saturation. Resident #40's oxygen saturation was 90%. CNA #7 indicated Licensed Practical Nurse (LPN) #2 was informed that Resident #40 needed oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 03/16/2026 at 1:27 PM, LPN #2 administered oxygen to Resident #40. The oxygen was set on three liters per minute by nasal cannula. During an observation on 03/18/2026 at 8:40 AM, Resident #40 was in bed with oxygen on three liters per minute by nasal cannula. During an interview on 03/18/2026 at 9:14 AM, LPN #2 indicated that she was not sure how long Resident #40 had been on oxygen. LPN #2 indicated that Resident #40 was on another hall and recently moved to the 300 Hall. LPN #2 indicated that every resident had a standing order for two liters of oxygen as needed. During an interview on 03/18/2026 at 9:36 AM, the NP indicated that Resident #40 had been on oxygen since the resident was admitted to the facility. The NP indicated that if a resident required standing orders, the order must be added to the resident's active Physician Orders. The NP indicated that she had observed Resident #40 with oxygen on but she was not sure how often the resident should be administered oxygen. During an interview on 03/18/2026 at 11:03 AM, the Director of Nursing (DON) indicated that there was a standing order for oxygen, and she was not sure how long Resident #40 had been on oxygen. The DON indicated that if a standing order was used it must be added to the resident's active Physician Orders and Care Plan. The DON indicated that the oxygen dosage should also be added to the orders. During an interview on 03/18/2026 at 1:32 PM, Resident #40 confirmed that she had been on oxygen since admission to the facility. During an interview on 03/18/2026 at 2:11 PM, the Administrator indicated that residents should have an order for oxygen before it was administered. During an interview on 03/18/2026 at 2:28 PM, the MDS Coordinator indicated the nurses, or the CNAs would let her know if oxygen needed to be added to the Care Plan. The MDS Coordinator indicated that she knew Resident #40 was on oxygen because she observed oxygen on the resident. The MDS Coordinator indicated that she had not added oxygen to the Care Plan yet because she was behind on updating the Care Plans. The MDS Coordinator indicated that she had been updating Care Plans for three months independently. The MDS Coordinator indicated that oxygen should be added to the Care Plan as soon as an order was obtained for the resident. Review of a facility policy titled, Oxygen Administration with an effective date of 12/08/2005 revealed that oxygen should be administered under orders of the attending physician, except in the case of an emergency. In an emergency, oxygen may be administered without a physician's order, however, the order should be obtained immediately after the crisis is under control. The policy also revealed that a physician's order should be obtained for the rate of flow and route (tank, concentrator, nasal cannula, mask) of administration.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Number of residents sampled:Number of residents cited:Based on interview and record review the facility failed to ensure one (Resident #14) of one resident reviewed for pain management, received their pain medication when requested. The findings include: Review of an admission Record revealed the facility admitted Resident #14 on 10/18/2024 with diagnoses which included age-related osteoporosis with current pathological fracture. Review of a quarterly Minimum Data Set with an Assessment Reference Date of 1/20/2026, revealed Resident #14 had a Brief Interview of Mental Status score of 15 which indicated Resident #14 was cognitively intact. Review of Resident #14's Order Summary Report with a start date of 10/18/2024, revealed a Physician's Order for an opioid pain medication, to be given every eight hours as needed (PRN) for pain. Review of Resident #14's Care Plan, revised on 10/26/2024, revealed the resident had acute pain related to fracture of the back, and osteoporosis. The Care Plan interventions included to anticipate the resident's need for pain relief and respond immediately to any complaint of pain. During an interview on 03/17/2026 at 10:25 AM, Resident #14 complained of back pain. Resident #14 indicated they had not received their scheduled pain medication. Resident #14 indicated that the nurse should bring the scheduled pain medication between 7:00 AM- 9:00 AM. Resident #14 indicated that they asked Certified Nursing Assistant (CNA) #4 at approximately 9:56 AM to inform Licensed Practical Nurse (LPN) #2 that the residents pain medication was needed. During an interview on 03/17/2026 at 10:31 AM, LPN #2 indicated that she had finished passing all medications for the morning. LPN #2 indicated that Resident #14 received a PRN pain medication every eight hours. LPN #2 indicated that the resident usually requested the medication every morning. LPN #2 indicated that she had a hectic morning and could not remember if any of the staff informed her that Resident #14 wanted the pain medication. LPN #2 indicated that she did not assess Resident #14's pain because Med Tech #5 was assigned to pass medications to Resident #14. LPN #2 indicated that residents were to be assessed for pain every morning. LPN #2 confirmed that Resident #14 was not assessed for pain during the medication pass and the resident did not receive any pain medication. During an interview on 03/17/2026 at 10:38 AM, CNA #4 indicated that Resident #14 informed her that morning of the need for the PRN pain medication. CNA #4 indicated that LPN #2 was informed of Resident #14's request for pain medication. During an interview on 03/17/2026 at 12:57 PM, Resident #14 indicated that the pain medication was received approximately 45 minutes after this surveyor had talked with the resident that morning. Resident #14 indicated that the pain medication helped a little and Resident #14 reported a pain level of eight on a scale of 1-10. During an interview on 03/18/2026 at 9:20 AM, LPN #2 indicated that pain medication should be (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered when requested by a resident to ensure the resident was not uncomfortable. During an interview on 03/18/2026 at 9:23 AM, the Nurse Practitioner (NP) indicated that she expected pain medications to be administered within an hour after a resident requested the medication. The NP indicated that she felt pain medication should be administered as soon as possible so that pain could be controlled. During an interview on 03/18/2026 at 10:58 AM, the Director of Nursing (DON) indicated that a nurse should administer a PRN pain medication immediately after receiving the request from a resident. The DON indicated that if the nurse was in the middle of passing another resident their medications that the PRN medication should be administered immediately after. During an interview on 03/18/2026 at 2:08 PM, the Administrator indicated that if a resident requested a PRN medication it should be administered as soon as possible. Review of a facility document titled Inservice Education Report dated 11/2/2025 indicated that PRN (as needed) medications are documented and administered properly. The in-service indicated that a patient must ask for the PRN medication. The in-service indicated to assess pain for location and severity, then follow up and document. Review of a facility policy titled, Administering Medications with a revised date of April 2019 revealed that medication administration times are determined by the resident and need and benefit, and not staff convenience, resident's choices and preferences should be honored. The policy also revealed if a resident is unavailable to receive medication on medication pass the medication record should be flagged and after completing the medication pass the nurse should return the resident to administer the medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, record review and interviews, the facility failed to ensure the Medical Director (MD) or Nurse Practitioner (NP) were contacted for orders when two medications were unavailable for one resident (Resident #98) during medication pass. Specifically, this surveyor observed 2 of 37 opportunities for medication not administered in accordance with the physician orders by way of omission, resulting in a medication error rate of 5.41%. The findings include: Review of Resident #98's Medical Diagnosis revealed the facility admitted Resident #98 with diagnoses which included dementia, fibromyalgia (widespread chronic pain and fatigue) and polyneuropathy (widespread damage to peripheral nerves causing numbness, burning pain and weakness starting in the hands and feet). Review of an admission Minimum Data Set with an Assessment Reference Date of 12/10/2025, revealed Resident #98 had a Brief Interview for Mental Status score of 5, which indicated the resident had severe cognitive impairment. The MDS also revealed Resident #98 was on a scheduled pain management regimen and the resident used a wheelchair and was not assessed for ambulation due to their physical condition. Review of a Care Plan with initiated date of 12/29/2025, revealed Resident #98 had chronic pain related to arthritis, was at risk for thrombotic event related to a topical nonsteroid anti-inflammatory gel. Interventions included to watch for signs of heart attack, stroke, and gastrointestinal reactions including bleeding and ulcers. Review of Medication Pass Competencies for Licensed Practical Nurse (LPN) #1 revealed competencies were achieved on 02/16/2026 and completed by the Assistant Director of Nursing (ADON). Competencies were not provided for LPN #3. Review of a Progress Note dated 03/17/2026 at 8:13 AM, revealed LPN #1 indicated that an anti-inflammatory gel was on order, no documentation indicated that the Medical Director (MD) or the ADON was made aware. Review of a Progress Note dated 03/18/2026 at 9:11 AM, revealed LPN #1 indicated an oral non-steroidal anti-inflammatory drug (NSAID) was on order, no documentation indicated that the MD or the ADON was made aware. Review of a Progress Note dated 03/18/2026 at 9:21 AM, revealed LPN #1 indicated that an anti-inflammatory gel was on order, no documentation indicated that the Medical Director (MD) or the ADON was made aware. Review of a Progress Note dated 03/18/2026 at 10:23 PM, revealed LPN #3 indicated that the anti-inflammatory gel was not available and an electronic message was sent to the ADON. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a receipt from [Named] pharmacy showed the NSAID and the anti-inflammatory gel were delivered to the facility on [DATE] at 11:06 AM. On 03/18/2026 at 9:08 AM, LPN #1 was observed giving medication to Resident #98. LPN #1 revealed the facility was out of a NSAID and an anti-inflammatory gel, and the medication should arrive on 03/18/2026 from a pharmacy. During a telephone interview on 03/18/2026 at 10:34 AM, LPN #1 stated Resident #98's NSAID and an anti-inflammatory gel had arrived from the pharmacy. LPN #1 stated no the doctor was not notified the resident had not received the ordered doses were not administered, and LPN #1 also stated they did not give the missed dose of medication because Resident #98 would get it at the next dose period. During an interview on 03/19/2026 at 10:43 AM, LPN #1 stated that on 03/17/2026 the anti-inflammatory gel was emptied, and a note was made showing it was on order. The anti-inflammatory gel came from a pharmacy in the morning on 03/18/2026. LPN #1 confirmed Resident #98 did not get a dose of the topical gel until the evening of 03/19/2026. LPN #1 confirmed Resident #98's last dose of NSAID was on 03/17/2026, and Resident #98 did not get another dose until the morning of 03/19/2025. LPN #1 revealed the process for ordering medications was to make a list of medications low in stock and notify the ADON. Sometimes the medications were on back order and the ADON would call [Named] Pharmacy, and the facility would pick the medication up. LPN #1 stated the NSAID and the anti-inflammatory gel was now in stock. During an interview on 03/19/2026 at 11:00 AM, the ADON stated that if a medication was not in the facility nursing staff were to notify the pharmacy and make a note about the pharmacy response and then notify the MD or Nurse Practitioner (NP), and document in the nurse progress notes or administration note. The ADON confirmed Resident #98 was out of NSAID and anti-inflammatory gel on 03/18/2026 and [named] pharmacy delivered the medications. The ADON revealed how late the Pharmacy delivered the medication would determine when the next dose was administered. The ADON reviewed the electronic record and stated, It [electronic record] shows that Resident #98 did not get last night's dose of topical anti-inflammatory gel even though it was delivered the morning of 03/18/2026. LPN #3 documented in progress notes that the anti-inflammatory gel was not available. The ADON also confirmed Resident #98 did not get a dose of NSAID on 03/18/2026 according to the Medication Administration Record [MAR.] The ADON stated I do not see a note that the doctor was notified that Resident #98 missed a dosed of NSAID and two doses of anti-inflammatory gel. The ADON indicated that the MD or NP should have been notified. During an interview on 03/19/2026 at 11:15 AM, The MD stated the NP should have been notified that medications for Resident #98 were not available. During an interview on 03/19/2026 at 11:18 AM, The Administrator stated his expectation was that nurses would immediately call the care Physician and call [named] pharmacy and have medications delivered immediately. The Administrator stated the Physician should be notified when a resident does not have medication, because they need to know if the medication was delivered and was in the building. The Administrator also stated the medication should be given at the next dosing period unless the care Physician stated otherwise. The Administrator stated, I would anticipate that the resident would get the ordered medication if it were on the MAR. During an interview on 03/19/2026 at 4:00 PM, Resident #98 stated a nurse put the cream on me [feet and legs] this morning. Resident #98 revealed having some discomfort and pain going to and from the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doctor's office on 03/18/2026. I sure think it would have helped if I had gotten my pain cream yesterday. Resident #98 stated staff were not notified about residents' discomfort because there was nothing they could do about it due to not having the resident's prescribed medication. Review of a facility policy titled Administering Medications, revised on 04/2019, revealed medications are administered in accordance to prescriber orders, including any required time frame. The policy also revealed If medication is given at a time other than the scheduled time, the administrator of the medication should initial, and circle the MAR space provided for that drug and dose. Review of a facility in-service titled TX/IP dated 03/26/2025, revealed staff received medication administration training. LPN #1 signed the in-service which indicated LPN #1 attended training.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Number of residents sampled: Number of residents cited: Based on observation, record review, interviews and facility policy review, the facility failed to ensure required nurse staffing information (staff, census, date and location) was consistently provided on the Daily Staffing Log, to ensure nurse staffing information was documented in a readable format for visitors and staff. The findings include: During observation and concurrent interview on 03/17/2026 at 3:07 PM, Human Resources [HR] provided Daily Staffing Logs from 02/15/2026-03/15/2026. This Surveyor observed the Daily Staffing Logs were missing dates, resident census, staff names and work locations on some of the logs. HR stated, The Daily Staffing Logs are hanging on a whiteboard opposite the time clock and facing the common entry area for visitors. HR stated that they were responsible for dating the staffing log, hanging it up, recording the census, and writing down the total work hours and that staff were responsible for writing their names and their location worked on the Daily Staffing Log. If anything gets left off, I try to find the information and correct it the next morning. HR stated that they had gotten behind on completing the staffing logs and had not caught up. HR stated that she also printed out the time clock information and attached it to the Daily Staffing Log. Review of Daily Staffing Logs dated 02/15/2026-03/15/2026 and concurrent interview with HR on 03/17/2026 revealed the following:-02/15/2026 Day Shift had no resident census and specific units worked were not filled out for 3 CNAs.-02/15/2026 Evening Shift was not dated, had no resident census and Certified Nursing Assistants [CNAs] specific units worked were not filled out.-02/15/2026 Night Shift was undated, had no resident census, no Licensed Practical Nurse [LPN]/Registered Nurse [RN] staff and hours were documented, no specific units worked for any staff were documented.-02/16/2026 unknown shift documented a resident census of 77, 2 RN/2 LPN/2 MA-C and 7 CNA without a specific unit worked.-Unknown date, shift and resident census, with one LPN and 2 CNA with locations worked documented and 3 CNAs without a specific unit work location.-Unknown date, shift and resident census, with one LPN documented and 3of 4 CNAs not showing a specific unit worked.-02/17/2026 Day Shift documented a resident census of 78, 1 of 2 RN, 1 LPN, 2 Medication Administration Certified [MA-C], 1 Restorative CNA, and 8 of 9 CNAs without a specific unit worked.-02/17/2026 Evening Shift had no resident census, 1 LPN without a specific unit worked and one CNA documented on the log as having worked that shift.-02/17/2026 Night Shift had no resident census, 1 LPN and 3 of 4 CNAs documented on the log without a specific unit worked.HR confirmed that all the Daily Staffing Log sheets from 02/15/2026-03/15/2026 were missing required nurse staffing information. During an interview on 03/19/2026 at 12:01 PM, the Administrator confirmed that HR made sure the Daily Staffing Logs were filled out with nurse staffing information, and that the Daily Staffing Logs were put on the wall opposite the time clock to make sure staff filled in their name and location worked. The Administrator stated, The Director of Nursing should check the daily log sheet and make sure the staff names, resident census, shift and date were filled out. I also think that staff need to be in-serviced on how to fill this daily log sheet out because it is putting a lot of work on HR. The Administrator revealed the purpose of nurse staffing information being documented on the Daily (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Staffing Log were for visitors and families to know who was working in their family's area, and to know how many residents were in the building. Review of a facility policy titled Staffing, Sufficient and Competent Nursing, revised 08/2022, revealed the facility provides enough staffing with appropriate skills and competency. Staffing rations include an evaluation of disease, condition, physical or cognitive limitations of the population. Direct care daily staffing numbers are posted in the facility for every shift and include the number of nursing personnel responsible for providing direct care.