

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045301	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER Oak Manor Nursing and Rehabilitation Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Morton Avenue Booneville, AR 72927	

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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Number of residents sampled:</p> <p>Number of residents cited:</p> <p>Based on observation, record review, interview and facility policy review, the facility failed to ensure the medication error rate was less than five percent during the medication administration observation for two (Residents #57 and Resident #60) of four residents. This surveyor observed 31 opportunities for medication administration and four of the 31 medications were not administered in accordance with the Physician's Orders, resulting in a medication error rate of 12 percent.</p> <p>The findings include:</p> <p>Resident #57</p> <p>Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/23/2026 for Resident #57 revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #57 was cognitively intact.</p> <p>On 04/16/2026 at 11:47 AM, after preparing medications for Resident #57, this surveyor observed LPN #8 administer Resident #57's oral medications with a cup of water. LPN #8 sanitized her hands, donned a pair of gloves and administered one drop from a small bottle of eye medication into the resident's left eye.</p> <p>Review of the most recent Physician's Orders for Resident #57 revealed an order to administer an 80 mg oral chewable tablet three times a day for gas/bloating, and the order start date was 01/22/2026.</p> <p>Review of the most recent electronic Medication Record (eMAR) for Resident #57 revealed a 125 mg oral chewable tablet for gas/bloating was scheduled for 8:00 AM. There was a checkmark in the box next to the medication and LPN #8's initials. The chart codes revealed a checkmark indicated the medication was administered.</p> <p>During an interview with concurrent observations on 04/16/2026 at 2:05 PM, LPN #8 retrieved the bottle of the gas medication she used during the morning medication administration pass for Resident #57. LPN #8 reviewed the eMAR and stated the dose ordered for the gas medication was 125 mg. She then looked at the bottle and stated the bottle indicated 80 mg. She stated she normally tried to read and match the MAR with the medication she was giving but she missed this, referring to the difference in the dose of the medication in comparison to the order. LPN #8 stated the nurse, or the MA-C restocked the over the counter (OTC) medications in the medication cart. She stated before administering medication to a resident, the name and dose of the drug should be checked. She was (continued on next page)</p>

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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>asked if she would check for any other information and stated she could check the residents' order in the chart, and the time and route for accuracy. She stated she had received training on medication administration during an in-service, but she did not recall the date of when the last training was provided. She stated it was important for residents to receive the correct dose of medication to treat their symptoms. This surveyor asked if extended-release medications should be crushed and she stated no. She added the reasons for not crushing extended-release medications were, those medications were to be released at a slow and steady rate to work and were meant to be long lasting.</p> <p>Resident #60</p> <p>Review of an annual MDS with an ARD of 01/22/2026 for Resident #60 revealed a BIMS score of 09, which indicated the resident had moderate cognitive impairment.</p> <p>On 04/16/2026 at 8:15 AM, this surveyor observed Medical Assistant-Certified (MA-C) #7 crush all the oral medications for Resident #60. MA-C #7 placed the powder in a pill cup with a small amount of applesauce. At 8:25 AM, MA-C #7 entered Resident #60's room, put on (donned) a pair of gloves, shook a bottle of nasal spray and administered one spray into Resident #60's nostrils. MA-C #7 removed the gloves, sanitized her hands, administered the resident's inhalation medication and then administered the oral medications with a cup of liquid.</p> <p>Review of the Physician's Orders for Resident #60 revealed the following:</p> <p>-May crush and administer all meds concurrently unless clinically contraindicated with an order date of 02/17/2025.-A nasal steroid spray with two applications to be given in each nostril one time a day for nasal congestion with an order date of 12/01/2025.-An extended-release blood pressure medication to be given by mouth one time a day with an order date of 01/20/2026.-An extended-release chest congestion medication to be given by mouth two times a day with an order date of 02/19/2025.</p> <p>Review of Resident #60's eMAR revealed a nasal steroid spray, an extended-release blood pressure tablet and an extended-release chest congestion tablet were scheduled for 8:00 AM on 04/16/2026. There was a checkmark and MA-C #7's initials in a box next to the medication. The chart codes revealed a checkmark indicated the medication was administered.</p> <p>During an interview on 01/16/2026 at 2:20 PM, MA-C #7 stated she administered one spray of Resident #60's nasal spray in each nare. She reviewed the eMAR for Resident #60 and stated, Oh I see what I did. It [the dose ordered] was one and they [provider] increased it. She stated extended-release medications should not be crushed because it was an accelerated medication. She stated she did perform a skills check-off for medication administration but did not provide a date, or with whom the check-off was completed. MA-C #7 stated before administering medications to a resident, she would make sure she had the right resident, right medication, and she would make sure everything was right before giving the medication. She stated giving the wrong form and wrong amount of a medication was considered a medication error. MA-C #7 stated she was told by another nurse that Resident #60 requested the medications to be crushed. She stated she could not remember the name of the nurse and only recalled she had been crushing Resident #60's medications since she was made aware of the resident's request about a month prior to 04/16/2026. She stated she did not know if the provider was informed of Resident #60's request to have the oral medications, including the extended-release medications, be crushed.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 01/16/2026 at 2:31 PM, Licensed Practical Nurse (LPN) #8 went to Resident #60's room and checked the blood pressure (B/P) using a manual cuff on the left arm. She stated the residents' B/P was 152/68 at that time. Resident #60 stated feeling ok at that time. LPN #8 checked Resident #60's electronic health record and stated the B/P was 129/64 at 8:21 AM [on 04/16/2026].</p> <p>During a telephone interview on 04/16/2026 at 7:03 PM, the Medical Director (MD) stated no extended-release medication should be crushed. He stated crushing an extended-release medication would cause all the medication to be given at once, instead of overtime. He stated due to the low dose of the blood pressure medication, he would not expect any harm to Resident #60, but the medication should not have been crushed. The MD indicated if a higher dose of 100 mg was given, then he would be concerned about possible harm to Resident #60. The MD was informed that the medication for chest congestion was also crushed, and he stated, no medication that was extended release should be crushed. The MD stated he did not recall being made aware of Resident #60's request to crush the [oral] medications.</p> <p>Review of a guideline on the extended-release blood pressure medication, provided by the Director of Nursing (DON) on 04/16/2026, revealed the medication should not be crushed or chewed. The key safety guidelines revealed signs of low blood pressure or very slow heart rate should be monitored.</p> <p>Review of a guideline on the extended-release congestion medication, provided by the DON on 04/16/2026, revealed this medication should be swallowed whole without crushing.</p> <p>Review of a guideline on the nasal steroid spray, provided by the DON on 04/16/2026, revealed adults usually take two sprays in each nostril daily for one week, reducing to one to two sprays directly thereafter, and must be used consistently.</p> <p>During an interview on 04/16/2026 at 2:43 PM, the DON stated when MA-C #7 started, she would have received three weeks of training with a nurse and then as needed. She stated if a resident requested their medication be crushed, the provider would be called and informed of the resident's request and asked, if the medication needed to be switched. She stated extended-release medications should not be crushed because those medications were meant to enter the body slowly over the day. She stated if the extended-release medication, such as a blood pressure medication, were crushed, the resident's blood pressure could drop too fast. She stated crushing the medication for chest congestion could cause the resident to receive a higher dose at one time rather than throughout the day. She stated her expectation of nurses and MA-Cs for medication administration was that they would follow the Physician's Order, treat the residents with respect and answer any questions the residents may have about their medications.</p> <p>Review of a facility policy titled, Medication, General Administration of, revised on 11/22/2016, revealed the procedure included, should there be any doubt concerning the administering of medications, the physician's order must be verified before the medication is administered.</p>		