STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045318	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chambers Health and Rehabilitation	1001 East Park Street Carlisle, AR 72024

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Number of residents sampled: Number of residents cited: Based on observation, record review, interview and facility policy review, the facility failed to ensure a nurse demonstrated competency in the administration of an intramuscular (IM) injection for one (Resident #6) of one resident reviewed for administration of an IM injection. The findings include: During an observation of an 8:00AM medication administration pass on 12/10/2025, Licensed Practical Nurse (LPN) #1 took a one-gram (gm) vial of antibiotic injection powder and injected 3.2 milliliters (ml) of a local numbing agent into the vial of antibiotic powder to reconstitute the medication for use. After the medication was completely dissolved in the local numbing agent, LPN #1 took a five cubic centimeter (cc) syringe with a 23 gauge (g) (x) 1 inch needle attached and withdrew the liquid medication from the antibiotic vial. After LPN #1 put on Personal Protective Equipment (PPE), she entered Resident #6's room to administer the medication. LPN #1 held a 5-cc syringe with a 23 g x 1 inch needle attached, in her hand and was preparing to inject the needle into the back of Resident #6's left arm. LPN #1 was asked to show the syringe to this surveyor as well as an accompanying surveyor in Resident #6's room. This surveyor as well as the other surveyor observed 1 cc [1 cc=1 ml] of a clear liquid inside the syringe. LPN #1 was asked to verify the amount of liquid in the syringe, and she stated 1 cc. This surveyor then asked LPN #1 if she was about to administer 1 cc of medication to Resident #6 and she stated, Yes. LPN #1 used an alcohol wipe and swabbed the back of Resident #6's left arm, removed the cap from the needle and injected the needle into the back of Resident #6's arm in the center area below the shoulder and above the elbow and administered 1 cc of medication to the resident. Review of Resident #6's Physician Orders dated 12/07/2025 revealed an order for antibiotic injection solution reconstituted 1 gm and inject 1 gram Intramuscularly (IM) one time a day for a Urinary Tract Infection (UTI) for 5 days. Review of a copy of an Order Sheet on 12/11/2025 for Resident #6 revealed, supply medication/directions of antibiotic 1 gram vial recon (reconstitute) w/ (with) 3.2 millimeters (ml) of local numbing agent & (and) inject 1 g IM every day for 5 days. Review of an Electronic Medication Administration Record (eMAR) for Resident #6 indicated, antibiotic injection solution reconstituted 1 gm inject 1 gram intramuscularly one time a day for UTI for 5 days. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/2025 at 10:30 AM, LPN #1 was asked to look at Resident #6's medication order for the antibiotic injection in the resident's Electronic Health Record (EHR) and state the Physician's Order. The LPN located Resident #6's order for the antibiotic injection in the EHR and stated, reconstituted with 3.2 ml of local numbing agent and inject 1 gm IM for 5 days. The nurse verified the antibiotic vial contained 1 gm of medication and that she used 3.2 ml of local numbing agent to reconstitute the powder in the vial. She stated she did not remember how many ml of antibiotic she administered to the resident. She admitted 3.2 ml of medication should have been administered to Resident #6 and that she did not administer 1 gm of antibiotic to Resident #6. LPN #6 stated, I knew the Kleenex and stuff was wet when I laid down the barrier [on top of the medication cart], but I didn't notice it. I should have noticed when you asked me how much was in there (the syringe), but I didn't catch it. During a later interview on 12/11/2025 at 3:28 PM, LPN #1 stated IM injections could be administered in the hip or upper arm of a resident depending on how much is in it [a syringe]. LPN #1 was asked if the back of the arm where she administered the injection on Resident #6 was used for subcutaneous (SQ) injections and she stated, Not in the muscle. LPN #1 was asked to name the muscle where she administered Resident #6's IM injection and she stated she would have to look it up and get back to this surveyor. LPN #1 stated she could not remember if she had received any training on administering injections at the facility but did receive training in nursing school and prior to working at this facility. LPN #1 was asked what the outcome could be if an IM injection was administered in the wrong site and she stated she needed to look it up and get back to this surveyor. LPN #1 returned to this surveyor a few minutes later and stated some outcomes of giving an IM injection in the wrong site were tissue damage, nerve damage and a blood vessel could be hit. LPN #1 never stated the name of the muscle where she placed the IM injection in Resident #6's left arm. During an interview on 12/11/2025 at 4:40 PM, the Director of Nursing (DON) confirmed if a nurse inserted 3.2 ml of a local numbing agent into a 1 gm vial of medication which per Physician Orders required 3.2 ml to be reconstituted, the minimal amount expected to be withdrawn from the vial was 3.2 ml. She admitted if a nurse had 1 ml of medication in a syringe after withdrawing the liquid from a vial which 3.2 ml was used to reconstitute, the full dose of medication would not be in the syringe. The DON stated when giving an IM injection to a resident, 1 ml can be given in the deltoid muscle, and if the amount was more than 1 ml, she would give the IM injection in the gluteus maximus muscle. The DON stated the nurse should have used 2 syringes, with one syringe containing 3 ml and the second syringe containing 0.2 ml. She stated the nurses do complete skills checkoffs for IM and intravenous (IV) injections upon hire and yearly. The DON stated her expectations of nurses giving IM medications were to be confident in their skill set and to let her know if further education was needed. The DON stated giving an IM injection in the wrong site could cause some site irritation and absorption issues. During an interview on 12/11/2025 at 5:01 PM, the Advanced Practice Registered Nurse (APRN) stated LPN #1 did call and let her know Resident #6 did not receive the full dose of antibiotic medication. She stated LPN #1 told her some medication had leaked out, but she was not told by LPN #1 the amount that leaked out. She stated her expectations for nurses administering IM injections were to make sure residents were getting the appropriate amount of medication and dosage in the appropriate area and there was no pain for the residents. Review of a Nurse Competency Skills Check Off for LPN #1 indicated medication check off and reorder meds was completed on 02/13/2025 but it does not specify what was included in the medication check off. A Departmental Orientation Nursing LPNs, RNs form dated as completed 09/25/2023 indicated the following, Supervisor- check off each item as completed. Each item is to be (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fully explained, examples shown, and employee in-serviced on nursing responsibilities regarding: . Medications- Administration of (oral, crushed, IV, IM, sub-cutaneous, eye, ear, NG) . and there was a check mark next to this item. Review of the Food and Drug Administration (FDA) label for the antibiotic powder revealed, reconstitute contents of a 1g (gram) vial of antibiotic powder with 3.2 ml of local numbing agent. Shake vial thoroughly to form solution and immediately withdraw a volume, not to exceed 1 g/day, and administer by deep intramuscular injection into a large muscle mass (such as the gluteal muscles (buttocks) or lateral (side) part of the thigh). Review of an Administering Medications policy, with a revision date of April 2019, revealed medications are administered in accordance with prescriber orders, including the time frame. This policy also revealed the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administering before giving the medication. Review of an Intramuscular Injections police, with a revision date of March 2011, revealed to verify the order for the resident's name, drug name, time, and route of administration. This policy indicated selecting an appropriate injection site and assisting the resident to a comfortable position depending on the site chosen for the injection. A few sites listed were vastus lateralis (lateral side of the thigh), ventrogluteal (area on the hip), dorsogluteal (upper outer area of the buttock) and deltoid (triangular shaped muscle in the shoulder).

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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. Number of residents sampled: Number of residents cited: 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 of one (Resident #6) of seven residents who received medications from three Licensed Practical Nurses (LPNs). Twenty-six opportunities of medication administration were observed, and two errors were observed, resulting in a medication error rate of 7.69%. The findings include: During an observation on 12/10/2025 at 8:00AM, Licensed Practical Nurse (LPN) #1 took a one-gram (gm) vial of antibiotic injection powder and injected 3.2 milliliters (ml) of a local numbing agent into the vial of antibiotic powder to reconstitute the medication for use. After the medication was completely dissolved in the local numbing agent, LPN #1 took a five cubic centimeter (cc) syringe with a 23 gauge (g) (x) 1 inch needle attached and withdrew the liquid medication from the antibiotic vial. After LPN #1 put on Personal Protective Equipment (PPE), she entered Resident #6's room to administer the medication. LPN #1 held a 5-cc syringe with a 23 g x 1 inch needle attached, in her hand and was preparing to inject the needle into the back of Resident #6's left arm. LPN #1 was asked to show the syringe to this surveyor as well as an accompanying surveyor in Resident #6's room. This surveyor as well as the other surveyor observed 1 cc [1 cc=1 ml] of a clear liquid inside the syringe. LPN #1 was asked to verify the amount of liquid in the syringe, and she stated 1 cc. This surveyor then asked LPN #1 if she was about to administer 1 cc of medication to Resident #6 and she stated, Yes. LPN #1 used an alcohol wipe and swabbed the back of Resident #6's left arm, removed the cap from the needle and injected the needle into the back of Resident #6's arm in the center area below the shoulder and above the elbow and administered 1 cc of medication to the resident. Review of Resident #6's Physician Orders dated 12/07/2025 revealed an order for antibiotic injection solution reconstituted 1 gm and inject 1 gram Intramuscularly (IM) one time a day for a Urinary Tract Infection (UTI) for 5 days. Review of a copy of an Order Sheet on 12/11/2025 for Resident #6 revealed, supply medication/directions of antibiotic 1 gram vial recon (reconstitute) w/ (with) 3.2 millimeters (ml) of local numbing agent & (and) inject 1 g IM every day for 5 days. Review of an Electronic Medication Administration Record (eMAR) for Resident #6 indicated, antibiotic injection solution reconstituted 1 gm inject 1 gram intramuscularly one time a day for UTI for 5 days. During an interview on 12/10/2025 at 10:30 AM, LPN #1 was asked to look at Resident #6's medication order for the antibiotic injection in the resident's Electronic Health Record (EHR) and state the Physician's Order. The LPN located Resident #6's order for the antibiotic injection in the EHR and stated, reconstituted with 3.2 ml of local numbing agent and inject 1 gm IM for 5 days. The nurse verified the antibiotic vial contained 1 gm of medication and that she used 3.2 ml of local numbing agent to reconstitute the powder in the vial. She stated she did not remember how many ml of antibiotic she administered to the resident. She admitted 3.2 ml of medication should have been (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered to Resident #6 and that she did not administer 1 gm of antibiotic to Resident #6. LPN #6 stated, I knew the Kleenex and stuff was wet when I laid down the barrier [on top of the medication cart], but I didn't notice it. I should have noticed when you asked me how much was in there (the syringe), but I didn't catch it. During an interview on 12/11/2025 at 4:40 PM, the Director of Nursing (DON) confirmed if a nurse inserted 3.2 ml of a local numbing agent into a 1 gm vial of medication which per Physician Orders required 3.2 ml to be reconstituted, the minimal amount expected to be withdrawn from the vial was 3.2 ml. She admitted if a nurse had 1 ml of medication in a syringe after withdrawing the liquid from a vial which 3.2 ml was used to reconstitute, the full dose of medication would not be in the syringe. She stated if a resident being treated for a UTI does not receive the full dose of antibiotic medication, the treatment may be ineffective. During an interview on 12/11/2025 at 5:01 PM, the Advanced Practice Registered Nurse (APRN) stated LPN #1 did call and let her know Resident #6 did not receive the full dose of antibiotic medication. She stated LPN #1 told her some medication had leaked out, but she was not told by LPN #1 the amount that leaked out. She stated her expectations for nurses administering IM injections were to make sure residents were getting the appropriate amount of medication, dosage in the appropriate area and there was no pain for the residents. Review of the Food and Drug Administration (FDA) label for the antibiotic powder revealed, reconstitute contents of a 1g (gram) vial of antibiotic powder with 3.2 ml of local numbing agent. Shake vial thoroughly to form solution and immediately withdraw a volume, not to exceed 1 g/day, and administer by deep intramuscular injection into a large muscle mass (such as the gluteal muscles (buttocks) or lateral (side) part of the thigh). Review of an Administering Medications policy, with a revision date of April 2019, revealed medications are administered in accordance with prescriber orders, including the time frame. This policy also revealed the individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administering before giving the medication.