STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045340	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Russellville Nursing and Rehabilitation Center	215 South Portland Avenue Russellville, AR 72801

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and facility policy review, the facility failed to ensure Minimum Data Sets (MDS) were completed in a timely and accurate manner for two (Resident #106 and Resident #70) of two residents reviewed; specifically, that a quarterly MDS was accurately completed for (Resident #70) to indicate an appropriate smoking status, and that an admission MDS was completed within 15 days of admission for Resident #106. The findings include: Resident #106 A review of Resident #106's Care Plan revealed the facility admitted the resident on 02/05/2026, with diagnoses which included alcohol use, unspecified intoxication, cardiac arrythmias, and spinal stenosis. A review of the MDS portion of Resident #106's electronic record on 02/24/2026 revealed an in progress status with a start date of 02/09/2026 for the admission MDS. During an interview on 02/24/2026 at 3:45 PM, MDS Coordinator #9 confirmed Resident #106's admission MDS was delinquent, due to MDS Coordinator #9 having an extended medical leave that started in October 2025. During an interview on 02/25/2026 at 11:43 AM, the Administrator and Assistant Administrator stated because they had two MDS Coordinators, when one MDS coordinator was absent, the other was expected to complete all assessments within the allotted timeframe, which was within a15 days after admission. During an interview on 02/26/2026 at 9:17 AM, the Director of Nursing (DON) stated that if admission assessments were delinquent, information would not be relayed to the appropriate people and correct treatments could be delayed. The DON stated that the DON should oversee the MDS Coordinators but had not yet reached that point in training. During an interview on 02/26/2026 at 9:26 AM, the Assistant Director of Nursing stated that a failure to complete assessments could result in a resident decline or change not being relayed to staff, leading to a delay in proper care. During an interview on 02/26/2026 at 10:58 AM, Medical Director (MD) #10 stated her expectation for facility staff was that assessments were completed in a timely manner. MD #10 then reported if (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessments were not completed timely, it could result in resident's not receiving proper care and having missed appointments. MD #10 then reported that she strived for completing [MDS assessments] in the 48-hour window but definitely no longer. During an interview on 02/26/2026 at 12:56 PM, MDS Coordinator #9 reported the Resident Assessment Instrument (RAI) manual was used for guidance when coding to the MDS. This surveyor requested a copy of section in the RAI manual that indicated a time frame for completing admission MDS assessments from the MDS coordinator. On 02/26/2026 at 1:12 PM, this surveyor received a document regarding the time frame for completing admission MDS assessments from the RAI Manual dated [DATE] chapter 2: section 2-6The RAI Manual indicated the time frame for an MDS to be completed upon admission was 15 days post admission. Resident #70 During an observation on 02/24/2026 at 1:50 PM, Resident #70 was smoking while wearing a protective apron and staff provided the resident with cigarettes and the lighter. A review of Resident #70's Medical Diagnosis revealed the resident had diagnoses which included right side hemiplegia, heart disease with heart failure, wheezing, cerebral infarction (stroke), depression, hypertension (high blood pressure), and chronic obstructive pulmonary disease. A review, conducted on 02/23/2026 at 2:15 PM, of Resident #70's Care Plan, revised 01/07/2026, revealed there was no documentation of the resident's smoking status. Resident was initially admitted on [DATE] and review of records indicate that resident was assessed for smoking on 07/29/2025. A review of Resident #70's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/01/2026 did not indicate the resident smoked. A review of Resident #70's quarterly smoking safety evaluation revealed the evaluation was 19 days past the required completion date of 02/05/2026. A review of resident's medical record indicated that Resident #70's last quarterly smoking assessment was completed on 11/05/2025. The next scheduled assessment should have been 90 days after the last quarterly assessment. A review of Resident #70's closet Care Plan on 02/26/2026 at 11:49 AM, revealed the resident was listed as a smoker, despite the official Care Plan lacking the information. During an interview on 02/24/2026 at 2:06 PM, Licensed Practical Nurse (LPN) #3 stated that smoking assessments were required upon admission, quarterly, or with a significant change in condition by any charge nurse for admissions. LPN #3 stated MDS Coordinators #8 and #9 were responsible for the residents' quarterly and significant change assessments. During an interview on 02/25/2026 at 9:05 AM, MDS Coordinators #8 and #9 stated the assessments, both smoking and quarterly MDS, were not completed in the allotted timeframe due to MDS Coordinator #9 being off work for an extended period. MDS Coordinators #8 and #9 confirmed the assessments fell behind and that had any incidents occurred, updates would have been made. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/25/2026 at 11:43 AM, the Administrator acknowledged that if the condition of a resident changed without a new assessment, the facility might not identify new safety risks. During an interview on 02/26/2026 at 8:31 AM, LPN #3 stated that the floor nurses did not perform smoking assessments, as this task was assigned to the MDS Coordinators, unless it was an admission assessment. During an interview on 02/26/2026 at 11:48 AM, CNA #1 stated that a closet Care Plan was used to identify smokers and confirmed the need for a smoking apron.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review, interview, and facility document review, the facility failed to ensure that quarterly Minimum Data Set (MDS) assessments were completed within the 90-day regulatory timeframe for 11 (Residents #25, #36, #38, #50, #60, #62, #67, #69, #73, #76, and #83) of 15 residents reviewed for quarterly assessments. The findings include: During a review of the resident's quarterly MDS assessments on 02/24/2026 at 11:01 AM, the following past due quarterly assessments were identified: - Resident #25's last quarterly MDS was completed on 10/16/2025, their next assessment was due on 01/16/2026.- Resident #36's last quarterly MDS was completed on 10/21/2025, their next assessment was due on 01/21/2026.- Resident #38's last quarterly MDS was completed on 10/10/2025, their next assessment was due on 01/10/2026.- Resident #50's last quarterly MDS was completed on 10/15/2025, their next assessment was due on 01/15/2026.- Resident #60's last quarterly MDS was completed on 10/17/2025, their next assessment was due on 01/17/2026.- Resident #62's last quarterly MDS was conducted on 10/17/2025, their next assessment was due on 01/17/2026.- Resident #67's last quarterly MDS was conducted on 10/10/2025, their next assessment was due on 01/10/2026.- Resident #69's last quarterly MDS was conducted on 10/07/2025, their next assessment was due on 01/07/2026.- Resident #73's last quarterly MDS was conducted on 10/14/2025, their next assessment was due on 01/14/2026.- Resident #76's last quarterly MDS was conducted on 10/14/2025, their next assessment was due on 01/14/2026.- Resident #83's last quarterly MDS was conducted on 10/15/2025, their next assessment was due on 01/15/2026. During an interview on 02/24/2026 at 3:35 PM, Minimum Data Set (MDS) Coordinator #8 stated that assessments were the responsibility of the MDS department and must be completed every 90 days. MDS #8 acknowledged that many assessments were delinquent, because the other MDS Coordinator [MDS Coordinator #9] was absent for six weeks and no backup was provided to assist with the workload. During an interview on 02/24/2026 at 3:45 PM, MDS Coordinator #9 confirmed that the assessments for several residents were delinquent, due to MDS Coordinator #9 having an extended medical leave that started in October of 2025. MDS Coordinator #9 stated that no staff filled the position during the absence. During an interview on 02/25/2026 at 11:43 AM, the Administrator and Assistant Administrator stated that if one MDS Coordinator was absent, the other MDS Coordinator was expected to complete all assessments within the required timeframe. Both the Administrator and Assistant Administrator further acknowledged being unaware that the facility's quarterly assessments were delinquent at that time. During an interview on 02/26/2026 at 9:17 AM, the Director of Nursing (DON)—employed at the facility for nearly a year—stated that delinquent quarterly assessments could prevent the relay of information to the appropriate people and may cause delays in correct treatments. The DON further noted that the DON was responsible for overseeing MDS Coordinators, but the DON had not yet reached the required point in training to fulfill this duty. (continued on next page)

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	045340	A. Building B. Wing	02/26/2026

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/26/2026 at 9:26 AM, the Assistant Director of Nursing stated that a failure to complete quarterly assessments could result in a resident decline or change not being relayed to staff, which could lead to a delay in proper care. During an interview on 02/26/2026 at 10:58 AM, Medical Director (MD) #10 stated that failure to complete quarterly assessments accurately and on time could result in negative outcomes, improper care, and missed appointments. MD #10 stated that the facility's expectation was that assessments would be completed 100% of the time and no more than a 48-hour window for delays. During an interview on 02/26/2026 at 12:30 PM, the Administrator stated that changes and incidents were discussed every morning during morning meetings. The Administrator further noted that if any situation required an immediate update, the update was completed once the meeting concluded. During a review of facility documents on 02/26/2026 at 9:59 AM, the Administrator provided this surveyor with the Policy and Procedure for Resident Assessment, which utilized the Resident Assessment Instrument (RAI) manual, dated 10/20/2025. The RAI manual required three quarterly assessments to be completed within the year, between comprehensive assessments, to ensure timing requirements were met.

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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. Based on observations, record reviews, and interviews, the facility failed to ensure hand hygiene and gloving were appropriately performed for one (Resident #57) of one sampled resident observed during perineal care, and the facility failed to ensure appropriate Personal Protective Equipment (PPE) was worn when administering medication and water flushes through a feeding tube for one (Resident #11) of one sampled resident, to prevent the risk for infection. Specifically, LPN #11 wore gloves and no gown when administering medication and flushes through a feeding tube, a high-contact care activity. The findings include: Resident #57 A review of Resident #57's Medical Diagnosis revealed the resident had diagnoses which included Huntington's disease (rare disorder associated with progressive loss of brain and muscle function), bipolar disorder, and anxiety disorder. A review of Resident #57's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/05/2025, revealed a Brief Interview for Mental Status (BIMS) score of 02, which indicated the resident had severe cognitive impairment. Resident #57's MDS also revealed the resident was frequently incontinent of urine, always incontinent of bowel, and was dependent on staff for toileting. During an observation on 02/23/2026 at 12:25 PM, this surveyor entered Resident #57's room and observed Certified Nursing Assistant (CNA) #13 providing perineal care to the resident. CNA #13 leaned forward and dropped a wet brief into a trash can resting on the left side of the resident's bed. CNA #13 appropriately wiped Resident #57's perineal area with wipes, closed the lid to the wipes, and leaned forward to place the package of wipes on the bedside table, with their contaminated gloves still on. CNA #13 picked up a clean brief and rolled it onto Resident #57 and attached the brief, without changing gloves. CNA #13 revealed they normally changed Resident #57 as a team of two staff members. CNA #13 did not address why she chose to provide perineal care alone at this time. CNA #13 confirmed no she did not change out of dirty gloves before touching a clean brief that was placed on Resident #57. CNA #13 also verified that not doing so could spread germs. During an interview on 02/24/2026 at 1:54 PM, Licensed Practical Nurse (LPN) #11 confirmed CNA #13 was working under her charge and revealed she expected CNAs to wipe residents front to back, not use the same side of a washcloth, be as clean as possible, ensure CNAs were wearing gloves, and provided privacy and dignity during perineal care. LPN #11 stated they would expect staff to change their gloves during perineal care, so they were not transferring bacteria or causing a urinary tract infection. During an interview on 02/24/2026 at 2:10 PM, CNA #14 stated that during perineal care, she took several pairs of gloves, bags, and a clean brief to the resident's room. CNA #14 revealed they would perform hand hygiene and puts on gloves, pull down linens and remove the resident's brief, after wiping the resident. CNA #14 stated they would then sanitize their hands and replace their gloves throughout perineal care. CNA #14 revealed they would remove the gloves and make sure their hands are clean before touching the residents' call light or blankets. CNA #14 stated they would wash their hands again when finished with perineal care. (continued on next page)

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	045340	A. Building B. Wing	02/26/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/24/2026 at 3:54 PM, the Director of Nursing (DON) said staff were expected to have one clean and one dirty CNA during perineal care. The DON also stated that they should change their gloves throughout the process. They [the CNAs] were to wipe the resident at least three times, deglove and wash hands and put on clean gloves to reduce the risk for infection. During an interview on 02/24/2026 at 3:55 PM, the Administrator revealed that during perineal care, they expected there to be a clean and dirty person and for them to change gloves during perineal care, to prevent cross contamination and perform hand hygiene after the task was completed. A review of policy and procedure titled Perineal/Catheter Care, revised, 11/22/2016, revealed staff would need two plastic bags and 3-5 pairs of gloves for perineal care. After removing the wet brief and wiping the resident, then staff were expected to change gloves. Staff would then place a clean incontinent brief pad under the resident and replace the sheet and blanket. A review of an in-service dated 10/09/2025, using a policy titled Perineal/Catheter, revised 11/22/2016, revealed LPN #11 and CNA #14 attended the in-service. The name of the in-service instructor was not documented. A review of an in-service dated January, the year provided confirmed by the administrator as 2026, using a policy titled Perineal/Catheter, revised 11/22/2016, revealed LPN #11 attended the in-service, but CNA #13 and CNA #14 were not in-serviced. CNA #13 did not attend this in-service. The name of the in-service instructor is not documented. Resident #11 During an observation on 02/25/2026 at 9:26 AM, LPN #11 arrived at Resident #11's bedside and stated LPN #11 was going to give a laxative, an anti-gas medication, an anti-heartburn medication, and a protein supplement through Resident #11's feeding tube. LPN #11 was wearing gloves, without a gown for PPE. LPN #11 then revealed the resident's feeding pump was off, because Resident #11 was vomiting on 02/24/2026. LPN #11 pulled down the blanket and raised Resident #11 shirt to reveal a closed Percutaneous Endoscopic Gastrostomy (PEG) tube. LPN #11 flushed Resident #11's PEG tube with 30ml of water and verbalized to the resident she would be giving Resident #11 100cc of water. LPN #11 then opened the resident's feeding tube and administered what she said was medication through the feeding tube. This surveyor observed LPN #11 administer a 30cc water flush, then another 100cc of water through Resident #11's PEG tube to prevent dehydration. LPN #11 did not wear a gown throughout care. During an observation on 02/25/2026 at 9:41 AM, LPN #11 was standing outside Resident #11's room, near a small EBP sign posted outside the door. LPN #11 revealed she had gloves on for infection control measures and did not think nursing staff had to wear gowns when putting anything through a feeding tube. LPN #11 read off wear gloves and gown for the following high-contact resident care activities from the EBP sign and said, I think I should have worn a gown and gloves, to reduce the risk for infection. PPE was available at Resident #11's door. A review of Resident #11's Medical Diagnosis revealed the resident had diagnoses which included stroke, heart failure and respiratory failure. A review of Resident #11's quarterly MDS with an ARD of 11/14/2025, revealed the resident received tube feedings via PEG tube, while a resident. (continued on next page)

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	045340	A. Building B. Wing	02/26/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #11's Care Plan revealed the resident had a feeding tube for all food and nutrition (revised 09/11/2018). Resident #11's Care Plan specified interventions for staff to administer tube feeding as ordered, and the head of the bed should be at 30-45 degrees. Lastly, Resident #11's Care Plan revealed the resident was on EBP, initiated 03/29/2024, and that staff were to gown and glove during high-risk resident care activities. A review of Resident #11's Physician Orders dated 05/21/2025, revealed Resident #11 was on EBP, related to feeding tube. A review of Resident #11's Physician Orders dated 01/15/2026, revealed Resident #11 was on bagged nutrition at 34 ml/hour, with water flushes every two hours. During an interview on 02/25/2026 at 10:00 AM, RN #12 stated staff should gown and glove during high contact resident care and revealed signage was placed on the door and closet. RN #12 confirmed EBP signage should always be on the resident's door. During an interview on 02/25/2026 at 9:47 AM, the Assistant Director of Nursing (ADON) said nurses should prepare medications, wear a gown and gloves then follow the proper procedure for administering medications through a feeding tube. The ADON then revealed that gowning and gloving was part of the enhanced barrier process, to keep us from transferring germs to the resident. Infection Preventionist [IP] revealed that staff were in-serviced on infection control at least yearly. The ADON revealed a Centers for Medicare and Medicaid Services (CMS) document titled, Enhanced Barrier Precautions in Nursing Homes, dated 03/20/2024, was used for policy and EBP guidance at the facility. During an interview on 02/26/2026 at 4:00 PM, the Administrator stated that he expected staff to follow policy when administering medications through a feeding tube. A review of a CMS document titled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/2024, revealed EBPs were designed to reduce the transmission of Multi-Drug-Resistant Organisms [MDRO] that may target gown and gloves in high contact resident care activities including PEG or feeding tubes. MDROs were common in nursing home facilities and could contribute to resident mortality. A review of an Infection Control in-service, dated 02/2025, revealed although EBP were not directly addressed, staff were to perform all procedures in a way that cut down on splashing, spraying or splattering. Wear disposable gloves and gowns whenever providing care where body fluids could splash. RN #12 did not sign the attendance sheet, and LPN #11 was marked as PRN [as needed], without a signature to indicate attendance.

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	045340	A. Building B. Wing	02/26/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure wounds were identified, documented, accurately reported to the physician, and treated for one (Resident #20) of four sampled residents reviewed. Specifically, an undated, unsigned, and undocumented dressing was discovered by staff on the lower right extremity of Resident #20, which had been applied without physician orders, and Resident #20 was found to have a small fist sized wound under the dressing, with myiasis [a parasitic infection of maggots in human tissue], which was not reported to the resident's physician. The findings include:ˆ A review of Resident #20's Medical Diagnosis revealedˆthe resident hadˆdiagnoses which included osteoarthritis, major depressiveˆdisorder,ˆand anxiety. A review of Resident #20's annualˆMinimum Data Set (MDS)ˆwith anˆAssessment Reference Date ofˆ[DATE],ˆrevealedˆan admission date of [DATE] and Brief Interview for Mental Statusˆscore of 14,ˆwhichˆindicated the resident was cognitively intact. Resident #20's MDS also revealed the resident hadˆan open lesion, requiredˆset-upˆassistanceˆwith meals,ˆtoileting,ˆand bathing, andˆwas independent for dressing and personal hygiene.ˆˆ A review of Resident #20's Care Planˆindicated the resident had aˆpotential and actual risk for skinˆintegrityˆrelated to weakness, fragile skin, decreased mobility, history of healed open lesion to the right lower leg. Resident #20's Care Plan included interventions, with an initiated date of [DATE], to encourageˆgoodˆnutrition and hydration, keep skin clean and dry. Other interventions, with an initiation date of [DATE], included to avoid scratchingˆskinˆand to keep hands and body parts from excessive moisture, educate family and caregivers of causative factors, monitor and document size and location of skin injury, and report failure to heal maceration and signs and symptoms of infection. Lastly, Resident #20's Care Plan specified that treatment should be completed perˆMedical Director (MD)ˆorders, initiated on [DATE]. A review of Resident #20's Weekly Skin Assessment, dated [DATE] at 1:14 PM, revealed the resident's skin was intact, with noˆbreakdown.ˆLPN/Treatment Nurse revealed that he alone assessed Resident #20 and denied finding any skin breakdown. ˆ During an interview onˆ[DATE]ˆatˆ2:59 PM,ˆCertified Nursing Assistant (CNA) #19ˆrevealedˆseeingˆ2-3 fliesˆat the foot ofˆResident #20'sˆbed on the night of [DATE] and stated,ˆI thought that looked unusual to me, for flies to sit in one area. CNA #19ˆrevealed uncovering Resident #20 for toiletingˆat the beginning of the shift and there was drainage leaking from the resident's lower right leg, CNA #19 stated, it was aˆlot.ˆCNA #19 said she had not workedˆwithˆResidentˆ#20ˆin aˆwhile,ˆandˆimmediatelyˆcalled and toldˆLPN #15ˆthe bandage needed to be changed.ˆCNA #19 revealed there was soˆmuchˆdrainage,ˆCNA #19ˆthought it had gone theˆwhole dayˆwithout being changed.ˆCNAˆ#19ˆdescribed theˆbandageˆas undated, wrapped, saturatedˆandˆthe white wrapping was a yellow green color.ˆThere was a strong smell, like something died.ˆCNA #19 statedˆthey and LPN #15 gownedˆup,ˆdue to Enhanced Barrier Precautionsˆ(EBP)ˆand the large amount of drainage.ˆWe did not know what was going on.ˆLPN #15ˆstarted unwrapping theˆdressingˆand maggots started falling out, there was so many, way too many.ˆCNA #19 revealed CNA #19ˆwas askedˆtoˆgoˆgetˆLPNˆ#17ˆto comeˆassist.ˆLPN #17ˆcame over and helped remove the dressing and examined the area.ˆCNA #19 stated the wound was fist size (continued on next page)

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	045340	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and it looked like raw skin with holes, and it had the texture of ground meat, and it was pink and red. CNA #19 confirmed maggots could be seen on the wound and they were removed and bagged up in a red bag and tied off and we threw the bag away. Resident #20, who sometimes refused care, did not want us to clean the wound, and we told them it was best that they let us work on their leg, so that it would get better. CNA #19 revealed interventions for Resident #20 were explain what we need to do and why, leave and come back later, we will try to get another to come and see if talking to the resident will allow them help. Sometimes [the resident] will refuse and will be persistent. CNA #19 said to her knowledge none of the residents ever had maggot therapy to clean wounds. During an interview on [DATE] at 11:23 AM, LPN #15 called via phone and confirmed that when providing care for Resident #20, on the [DATE] 11-7 PM shift a fist sized open lesion was found on the posterior right calf with maggots. LPN #15 said a CNA called LPN #15 to Resident #20's room, because the resident's leg was weeping and their dressing was saturated. LPN #15 had not been told in report that Resident #20 had any wounds or dressings and knew both legs wept the previous weekend, and the PA had said to leave it open to air. LPN #15 then revealed they raised Resident #20's pant or pajama leg and a few maggots fell out, unrolled the bandage three times and more maggots fell out, so I asked LPN #17 to come assist. LPN #15 and LPN #17 used supplies from the treatment cart to clean up the wound and a lot of maggots were removed. LPN #15 said she texted the DON, Administrator, Medical Director or PA, LPN or RN Treatment Nurse, and Assistant Director of Nursing (ADON). LPN #15 revealed that Resident #20 did not have an order for a dressing on the lower right leg. LPN #15 stated that it was nighttime and she did not hear back from her text right away, so she talked to the ADON and DON the next morning and was told they would investigate it. LPN #15 stated she did not know who put an undocumented dressing on Resident #20, how long the dressing was on Resident #20, or why a dressing was placed on the lower right calf. During an interview on [DATE] at 9:14 AM, LPN #17 confirmed that LPN #15 called for help cleaning and bandaging a wound because maggots started falling out when LPN #15 started unwrapping a bandage. LPN #17 said, The more we removed the more maggots we found. LPN #17 stated they cleaned and rebandaged the wound, maggots were put in a clear bag, then placed in a biohazard bag. LPN #17 stated the ADON contacted LPN #15 and told her to throw out the bag of maggots. LPN #17 stated the smell was pretty bad. Resident #20's legs had been weeping so the bandages were wet and yellow. The area was the size of a small fist. LPN #15 sent a text to Administrator, DON, ADON, MD, and PA. LPN #17 stated they were working on a new system now to take pictures, but the facility did not have it at that time. LPN #17 said the process following discovery of a wound was to call the doctor and family, ADON/DON, and staff were to clean and address the wound until the doctor or wound care nurse can look at it. During an interview on [DATE] at 12:01 PM, the LPN/TX nurse stated, we go in resident rooms to do body audits. The LPN/TX Nurse did not remember seeing anything on Resident #20's right lower leg, and revealed that on the [DATE] weekly skin audit for Resident #20, there was not a dressing on Resident #20's right leg, and it would have been noted on the skin assessment. The LPN/TX Nurse, when asked how staff would respond to discovering an unexpected dressing, revealed nurses would ask around to see if anyone knew what the dressing was for and then would remove the dressing to see what was underneath. The nurse or I would contact the doctor. The LPN/TC Nurse did not reference checking orders. The LPN/TX Nurse stated at no time did staff tell him they were putting a dressing on Resident #20. The RN/TX Nurse said, I did not even know [Resident #20's lower extremity] was weeping. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045340	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Russellville Nursing and Rehabilitation Center	215 South Portland Avenue Russellville, AR 72801

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #20's Progress Notes on [DATE] at 12:20 PM, revealed that on [DATE] at 12:00 PM, Resident #20 was observed with 2+ edema (moderate pitting edema, characterized by a 3–4 mm indentation in the skin that takes up to 15 seconds to disappear), redness, and weeping with an open lesion to the left posterior thigh related to a ruptured blister, an open lesion to right medial calf, and that the PA was notified. The PA initiated the following: 1.ˆReinflate [Name Brand air filled support cushion] to bedside chair everyˆThursdayˆand as needed.ˆˆ 2.ˆChange to an inflatable ˆcushionˆinˆsitting chair at the bedside at all timesˆas tolerated for pressure relief.ˆ 3.ˆTreat open lesion to right medial calf, cleanse with wound cleanser, pat dry, apply foam, cover with 1-2ˆpads,ˆand wrap withˆdressingˆfor drainage.ˆTreatment provided twice a day per LPN or RN Treatment Nurse, floor nurse to dressˆon 11-7 shift, due to weeping.ˆ 4.ˆTreatment for protection of left medial ankle, cleanse, apply skin prep, wrap in rollˆgauzeˆor left lower extremity twice a day as needed.ˆˆ 5.ˆCleanse ruptured blister on left upper posterior thigh with wound cleanser, applyˆmedical grade honey dressing, cover withˆan antimicrobial dressing,ˆand cover with a foam dressing. Changeˆdressingˆon Monday/Wednesday/Friday, and as needed.ˆˆ 6.ˆVenous and arterial ultrasound of both lower extremities related to wounds.ˆˆ 7.ˆAntibioticˆone capsule by mouth, 300mg twice a day, for cellulitis.ˆ A review of Wound Provider New Order, datedˆ[DATE]ˆindicatedˆResident #20 had a wound to the right medial calf, with instructions to cleanse wound, change to a water insoluble dressing daily and as needed. Resident #20 to be seen by wound care provider weekly, encouraged both legs to be elevated to reduce edema and weeping. A review of Resident #20's Clinical Notes, datedˆ[DATE],ˆindicatedˆResident #20ˆwasˆseen with rash, lesions and weeping consistent with cellulitis [bacterial infection of the skin] on the right lower extremity, withˆan open areaˆposterior to the right lower extremity measuring length 11 centimeter [cm], width 3.4cm x depth 0.1cm.ˆLeft inner ankle had a full thickness venous ulcer measuring length 1.9cm x width 1.3cm and depth unable to determine. During an interview onˆ[DATE]ˆatˆ8:54 AM,ˆthe ADONˆsaidˆthatˆ[on [DATE]] the morningˆafter being notified via text that a dressing was found on Resident #20, the facilityˆstarted checking to see who put a dressing onˆResident #20ˆand why,ˆbecauseˆthere wasˆnotˆan order for a dressing.ˆThe ADON confirmed no longer having text records andˆcould not rememberˆhow LPNˆ#15 describedˆthe woundˆbut,ˆI did tell her if there wereˆmaggots in the building, then the trash needed to be taken out, and I made sure the PA was notified.ˆThe ADON saidˆshe called LPN #15 just after midnight, and the PA was at Resident #20's bedsideˆas soon as she got to the facility that morning to assess the right calf wound. According to the ADON, the staff processˆwhen finding a skin problemˆwasˆtoˆnotify the ADON/DON, the PA, andˆtoˆput in a general order to clean the wound until the PA or doctor couldˆcome and lookˆat it. The facility could not take pictures at that time. The IP informed the ADON she believedˆit was on the 11-7 shift on [DATE]ˆbecause,ˆIˆdid a skin audit the next day.ˆA skin (continued on next page)

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	045340	A. Building B. Wing	02/26/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview onˆ[DATE]ˆatˆ11:14ˆAM,ˆthe Administratorˆ(Admin)ˆwasˆtold Residentˆ#20 hadˆdevelopedˆmaggotsˆinˆaˆwoundˆbut could not recall the nurse who made the discovery.ˆThe Admin stated, I know that the LPN and RN Treatment nurses and PA looked [the following day] and did not see any maggots.ˆThe Admin then provided an investigationˆfile, which revealed body audits were done, and daily skinˆchecks were doneˆfor two weeks, [DATE]-[DATE], on Resident #20.ˆResident #20's body audit showed a right hip open area with redness and edema up to the hip, both legs weeping, open area to the right ankle, open area to the back of the left thigh, and wounds and red area to both lower extremities. The file included an in-service dated [DATE] was given to the LPN Treatment Nurse on Body Audit Review and Nursing Weekly Skin Audit given by Wound Consultant.ˆ During an interview onˆ[DATE]ˆatˆ10:48 AM,ˆthe PAˆsaidˆshe was asked to assess a wound onˆResident #20ˆ's posterior right calf but could not remember when this was.ˆThe PA described the wound as appearingˆvascular,ˆarterialˆor venous, and weeping.ˆThe PA then revealed the wound had already been cleaned by LPN #15 and she did not see maggots.ˆˆˆ During an interview on [DATE] atˆ3:00 PM, the Medical Doctor (MD) revealed she was told Resident #20 had a woundˆinˆJuneˆ2025 but was not told nursing had reported maggots were found in the wound.ˆThe MD revealed that Resident #20 was seen by the PA, and the LPN and RN Treatment Nurses the next day.ˆThe MD revealed that had she known about the existence of myiasis, sheˆdefinitely wouldˆhave made sure Resident #20's right calf wound was cleaned very well and would have met and had a conversation with leadership to discuss how theˆwound got there. We would have had aˆdiscussion about wound care.ˆThe MD revealedˆsheˆoperatesˆa wound clinicˆand depending on the stage, sheˆwould expectˆstaff to notify her forˆtreatment recommendations and try to healˆthe wound.ˆShe then stated thatˆdepending on how bad a woundˆwas,ˆthe MDˆwould see them in the wound clinic orˆcome by [the facility]. The MDˆstatedˆsheˆdefinitelyˆexpectedˆto be notified if maggots were found in a wound.ˆThe MD revealed it would beˆdifficult for a nursing home resident to get maggots in a wound, butˆnot impossible.ˆLarvae are very tiny and might not be seen, it wouldˆdepend onˆif they were getting ready to hatch.ˆˆ ˆ A review ofˆa policyˆtitled, WoundˆDressingˆChange,ˆSterile, revised [DATE], revealedˆto cleanse wound per order. The policy did not address the procedure to follow with new skin findings.ˆˆˆ A review of an article titled About Myiasis, dated [DATE], by the Centers Disease Control revealed myiasis was a parasitic infection of fly larva or maggots in human tissue. People who had untreated open wounds were at high risk for getting myiasis, and it could be spread by ticks, mosquitos, and flies. A person with myiasis would normally develop a lump in their tissue that may begin to move as the larvae grows. The areas would likely to become infected without treatment. Some larvae move deep into the body, and some flies dropped their eggs on or near a person's wound, sores, or nose. Treatment was removal of larvae, and daily wound care is important for healing.ˆˆ

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	045340	A. Building B. Wing	02/26/2026

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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. Based on observation, record review, interview, and facility policy review, it was determined the facility failed to ensure one (Resident #8) of one resident reviewed for respiratory care, had an order for oxygen. The findings include: During an observation on 02/23/2026 at 11:49 AM, this surveyor observed Resident #8 resting with their mouth open, while receiving oxygen (O2) at two liters per minute (L/M) via Nasal Cannula (NC) with a Continuous Positive Airway Pressure (CPAP) device stored on the left bedside table. During a concurrent observation and interview on 02/24/2026 at 11:32 AM, this surveyor observed that Resident #8 remained on O2 at two L/M via NC. Resident #8 was alert and oriented. The resident revealed that they were on oxygen for COPD [Chronic Obstructive Pulmonary Disease]. A review of Resident #8's Medical Diagnosis revealed the resident had diagnoses which included anemia, heart disease, and wheezing. There was no diagnosis of COPD listed. A review of a Resident #8's quarterly Minimum Data Set (MDS) with an assessment reference date of 01/02/2026, revealed a Brief Interview for Mental Status score of 12, which indicated the resident had moderate cognitive impairment. Resident #8's MDS also indicated the resident was on oxygen while a resident [at the facility]. A review of Resident #8's Order Summary Report, dated 11/22/2023, revealed a discontinued order with no end date specified, for O2 at 2 L/M via Nasal Cannula PRN [as needed] to keep O2 sat [saturation] above 90%. A review of Resident #8's Oxygen Saturation Summary, dated 11/30/2025-02/22/2026, revealed the resident had no documentation of hypoxia, and demonstrated Resident #8 had saturations above 90% while on and off oxygen therapy. During an interview on 02/24/2026 at 1:37 PM, Licensed Practical Nurse (LPN) #11 checked Resident #8's electronic record and confirmed, [Resident #8] does not have an order for oxygen. LPN #11 called the Assistant Director of Nursing (ADON) via phone and asked, where to find oxygen orders. LPN #11 then stated, I am not seeing it. LPN #11 revealed the Medication Assistant-Certified (MA-C's) were responsible for checking to make sure oxygen was ordered and that tubing and water were changed. LPN #11 revealed she was not sure if oxygen orders were on the MAR or not, and when Resident #8 was sent to the hospital it looked like the order for oxygen was not put back in the electronic record by admissions. LPN #11 stated, It [O2] is technically a medication, so it requires an order. LPN #11 spoke with the ADON via telephone with this surveyor present and revealed the ADON was unable to locate an oxygen order. During the call, the ADON also verified that oxygen was a medication and a resident should not get oxygen without an order. During an interview on 02/24/2026 at 3:47 PM, the Director of Nursing (DON) stated, floor nurses should make sure they have oxygen orders, and new orders should be compared to the old orders when a resident returns from the hospital. The DON revealed that nurses should be monitoring a resident with oxygen. The DON stated, Nursing should set up the oxygen when the resident comes in, make sure it is at the right flow and check the rate when doing medication pass. The DON also stated (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing was responsible for oxygen [administration and set up]. MA-C 's were responsible for checking tubing and water each shift. The DON confirmed MA-C's just put eyes on oxygen, but they do not check the order. During an interview on 02/24/2026 at 3:50 PM, the Administrator stated, If a resident is on oxygen, the orders should be checked to see if they have new orders to make sure the orders are in place. Staff are expected to follow policy. This surveyor requested an oxygen policy/procedure and any in-services provided to staff. The Administrator provided a policy, but no oxygen in-service documentation. A review of a facility policy titled Oxygen Safety, revised on 11/22/2016, revealed oxygen is administered to the resident only upon the written order of a licensed physician. The facility would properly handle oxygen and flammable gases.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility policy review, the facility failed to ensure expired medication was not stored in the medication cart for one (300-Hall) of two medication carts observed. The findings include: During an observation on 02/24/2026 at 10:50 AM, this surveyor observed 10 vials of [Brand Name] eye drops stored in the bottom drawer of a medication cart on the 300-Hall, with a manufacturer's expiration date of August 2025. During an interview on 02/24/2026 at 10:53 AM, Medication Assistant (MA-C) #21 confirmed that the 10 closed vials of eye drops stored in the medication cart were expired, and that expired medications should be stored in the medication room, in a box. MA-C #21 indicated that the expired eye drops were not being administered to any of the residents. During an interview on 02/24/2026 at 10:54 AM, Licensed Practical Nurse #11 indicated that expired medications were kept in a box in the medication room. During an interview on 02/26/2026 at 1:45 PM, the Administrator indicated that the last medication in-service was completed with all the staff. The Administrator indicated that there was not a medication pass in-service with just the nurses. The Administrator then stated that the in-service was verbal, and there was no documentation on the specific information that was presented. During an interview on 02/24/2026 at 2:05 PM, the Director of Nursing indicated that the nurses were supposed to dispose of expired medications in a box that was in the locked medication room. Review of a facility policy titled Medication Ordering, Receiving and Storage Policy indicated the facility shall store all medications in a safe, secure, and orderly manner. The policy also indicated, if the facility had discontinued, or outdated medication the dispensing pharmacy should be contacted for instructions regarding returning or destroying the items.