STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045351	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Manor Nursing and Rehab	804 Burnett Drive Mountain Home, AR 72653

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Number of residents sampled: Number of residents cited: Based on document review, interviews and policy review the facility failed to prevent abuse for one (Resident#12) of five residents reviewed for abuse. The findings include: Resident #62 A review of Resident #62’s “Quarterly Minimum Data Set” (MDS) with Assessment Reference Date (ARD) of 07/05/2025, indicated that Resident #62 had a Brief Interview of Mental Status (BIMS) with a score of two, which indicated the resident had severe cognitive impairment. A review of Resident #62’s “Care Plan” revealed that Resident #62 has decreased physical mobility related to muscle wasting and weakness. A review of Resident #62 “Physician Order Summary” revealed the facility admitted Resident #62 on 01/02/2025, with medical diagnoses which included decreased cognition without behavioral disturbance, loss of touch with reality, mood disturbance or anxiety, irregular heartbeat, muscle wasting and weakness, and assault by unspecified means. Resident #62’s medications included Aspirin EC 81 mg daily. Resident #12 A review of Resident #12’s “Quarterly MDS” with ARD of 06/06/2025 indicated that Resident #12 had a Brief Interview of Mental Status (BIMS) with a score of four, which indicated the resident had severe cognitive impairment. No behaviors were documented in the look back period. A review of Resident #12’s “admission Record” revealed that the facility admitted Resident #12 on 10/01/2025 with medical diagnoses which included decline in cognition without behavioral disturbance, loss of touch with reality, mood disturbance and anxiety, and other symptoms of appearance and behavior, with a major depressive disorder. Incident 1 (continued on next page)

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
	045351	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Manor Nursing and Rehab	804 Burnett Drive Mountain Home, AR 72653

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of Resident #12’s “Nursing Progress Note” dated 06/24/2025 at 10:45 AM indicated that the Director of Nurses (DON) responded to the secured unit where Resident #12 was threatening Resident #62. Resident #12 threatened that if roommate (Resident #62) opened [pronoun] mouth [pronoun] was not going to like what happened and Resident #12 had put up with enough of [Resident #62’s [expletive] and was not going to put up with it anymore. The DON informed Resident #12 that they could not touch their roommate. Resident #12 replied with “I will knock [Resident #62’s] [expletive] head off.” The Nursing Progress Note revealed that Resident #12 continued to yell and threaten Resident #62 and curse at the DON. The Progress Note revealed that Resident #12 also continued to yell and cuss at other residents in the hallway. A review of a “Nursing Progress Note” dated 06/24/2025 at 11:05 PM indicated a urine specimen was obtained from Resident #12. A review of “UA results” dated 06/24/2025, was with in normal limits. A review of “Every (Q) 15 Minute (Min) Monitoring” form, dated 06/24/2025, revealed Resident #12 was monitored every 15 min from 11: 00 am to 2:00 pm. Incident 2 A review of Resident #62’s “Nursing Progress Notes” dated 08/21/2025 at 8:05 PM, revealed staff heard yelling from Resident #12 and Resident #62’s room and staff went to observe. Resident #62 was lying in bed and Resident #12 was standing over Resident #62 holding a remote with their hand raised. Resident #62 was observed with blood on their left forehead. Resident #62 reported “they are beating the [expletive] out of me with something hard and I didn’t even do anything. ” Resident #12 was moved to the other side of the room, while treatment was provided to Resident #62’s area on the left forehead. A Skin Audit was completed for Resident #62, and no other injuries were observed by staff. Neuro checks were also initiated. A review of Resident #12’s “Nursing Progress Note” dated 08/21/2025 11:37 PM, indicated yelling was heard coming from Resident #12 and Resident #62’s room and staff responded. Staff reported upon entering the room, Resident #12 was standing at the foot of the bed where Resident #62 was lying on the bed. Resident #12 was observed standing with their right hand upholding a remote in their hand. Blood was dripping from Resident #62’s forehead from being struck with a remote control by Resident #12. Resident #12 admitted hitting Resident #62 after being cursed by Resident #62. Resident #12 was agitated, the APRN (Advanced Practice Registered Nurse) gave orders to send Resident #12 to the emergency room for a psychiatric evaluation. Resident #12 was placed on one-on-one with a staff member until the ambulance arrived. During an interview on 08/26/2025 at 12:32 PM, Resident #62 stated the incident occurred about a week ago, the room was shared with Resident #12, and they were not together in the room often. Resident #62 reported that they were sleeping and were woken up by Resident #12 hitting them on the head with a remote. Resident #62 could not recall threatening behavior prior to the incident on 08/24/2025 and did remember that Resident #12 had not being in the room since the incident. During an interview with Certified Nursing Assistant (CNA) #11 on 08/26/2025 at 12:55 PM, she indicated Resident #12 had threatened other residents on 08/20/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045351	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Manor Nursing and Rehab	804 Burnett Drive Mountain Home, AR 72653

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 08/26/2025 at 1:01 PM, CNA #10 revealed Resident #12 threatened to beat up Resident #62 a couple of times and it was reported to the nurse. During an interview on 08/26/2025 at 1:22 PM, the DON read the Nursing Progress Note dated 06/24/2025 to this surveyor. Then it was revealed that CNA #10, remained one on one with Resident #12 until they wanted to get up and go to the dining room, in which Resident #12 had calmed down at that point, a urinalysis was obtained for Resident #12, and the results were negative. The DON stated there were no further incidents of threatening behavior. A room change was not done because the DON was not aware of threatening behavior on 08/20/2025. The APRN was notified on 06/24/2025, no psych consultation was obtained at that time. The DON revealed that on 08/21/2025 Resident #62 got up and hit Resident #12 in the head with the remote. The injury did not require sutures or stitches. During an interview on 08/26/2025 at 1:32 PM, the Administrator stated there were no beds open to move Resident #12 to, except the opposite gender had two beds open, and would not be able to move Resident #12 or Resident #62 into those beds. The Administrator stated Resident #62 curses at times and had threatened other residents before, but had not hit anyone. The Administrator believes Resident #12 hallucinates things and then gets agitated with others. The Administrator did not remember the incident on 06/24/2025. During an interview on 08/26/2025, the DON was asked to provide one on one documentation for the time period after the incident on 08/21/2025 until Resident #12 went to hospital. The documentation was not provided. During an interview on 08/26/2025 at 1:58 pm, the Social Director revealed a follow up was completed with Resident #12 after the incident on 06/24/2025, and Resident #12 did not remember saying anything to Resident #62. On 06/25/2025 she returned to Resident #12, and Resident #12 was calm and had no threatening behaviors. During a visit with Resident #62 on 08/22/2025, Resident #62 reported feeling safe with staff however, they did not feel safe with Resident #12. During a follow-up visit on the following Monday, Resident #62 reported feeling safe. Resident #12 was admitted to Geri-psych unit and was not in the facility. The Social Director could not recall discussions from the administration of moving either resident to new rooms to separate them or interventions put in place after the incident on 06/24/2025, During an interview on 08/27/2025 at 9:51 AM, CNA #10 revealed on 06/24/2025, from the time of the altercation to the end of the shift at 2 PM, CNA #10 completed 15-minute checks on Resident #12. CNA #10 did not recall any other physical altercations. CNA #10 did recall yelling and screaming by Resident #12 at times, and Resident #12 made threats to beat up Resident #62, which was reported to the nurse. CNA #10 did not recall which nurse the threats were reported to. CNA #10 reported that Resident #62 would yell out at times in the shared room with Resident #12. Resident #12 would walk over to Resident #62, but the staff would redirect Resident #12 before a physical altercation took place. The threatening behavior happened about 4 to 5 times over a month or two period. During an interview on 08/27/2025 at 1:18 PM, LPN #12 indicated she was aware of one verbal altercation involving Resident #12 and Resident #62 escalating to Resident #12 swinging at Resident #62 but did not make physical contact. The residents were separated for the night. LPN #12 could not indicate the date or time that altercation occurred. LPN #12 stated Resident #12 cursed while adjusting to the secure unit. Resident #12 becomes confused when not wearing oxygen and staff monitors for oxygen needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045351	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Manor Nursing and Rehab	804 Burnett Drive Mountain Home, AR 72653

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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 08/28/2025 at 3:06 PM, the APRN revealed she was made aware of the verbal altercation and had ordered one dose of anxiety medication. The APRN conducted a follow-up visit within 24 hours and Resident #62 stated there was no intent to hurt anyone. The APRN stated she would have ordered a Geri-psych consult if she was made aware of further threatening behavior prior to the 08/21/2025 altercation. During an interview on 08/29/2025 at 9:19 AM, the APRN reported a decrease in Resident #62’s dose of [an anticonvulsant and mood-stabilizing medication used to treat epilepsy and bipolar disorder] was done in November of 2024, but due to staff reports of Resident #62 becoming agitated and threatening, the dose was increased, and a Gradual Dose Reduction was declined due to reported behaviors. She reported that Resident #62 had been roommates with all the same genders but couldn’t get along with them. She was aware of verbal aggression but no physical aggression to other residents. She reported that she had questioned if they were going to move the rooms, but it didn’t happen. She reported that LPN # 12 had reported to her that Resident #62 couldn’t room with other residents due to yelling and screaming. A review of a policy titled, “Abuse, Neglect, Exploitation and Misappropriation Prevention Program” dated (enter date or if undated state undated) indicated that residents have the right to free from abuse, the facility will protect residents from abuse by other residents, and the facility will handle other residents’ aggressive behaviors.