STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045416	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Timberlane Health & Rehabilitation	2002 Timberwood Road El Dorado, AR 71730

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility document review, it was determined the facility failed to ensure staff administered medication according to accepted professional standards and failed to follow physician orders for one (Resident #4) of one resident reviewed The findings include: Review of Resident #4's admission Record, revealed Resident #4was admitted on [DATE] with medical diagnoses that included: disorder of circulatory system, type-2 diabetes mellitus, morbid obesity, essential hypertension, peripheral vascular disease, chronic kidney disease, dependence on renal dialysis, and depression. Review of Resident #4's Care Plan initiated on 04/17/2026, revealed Resident #4 had hypertension, depression, used an antidepressant, and was dependent for hemodialysis for End Stage Renal Disease (ESRD). Review of [the local hospital] After Visit Summary, dated 06/05/2026, revealed Resident #4 was discharged from the hospital and back to the facility with a prescription for an antihypotensive medication to be given three times (TID) a day. The local hospital's After Visit Summary gave instructions to HOLD the antihypotensive medication if the systolic blood pressure (SBP) was greater than 120. Review of the Medication Order Summary dated 06/05/2026 showed the antihypotensive medication was given TID with a note: added greater than to the order. This order was discontinued on 06/11/2026. A new order dated 06/11/2026 revealed the antihypotensive medication was to be given TID and HELD IF SBP was greater than120. Review of the [name brand antihypotensive medication] Package Insert, with a revision date of 01/2017 indicated, it was used for the treatment of symptomatic orthostatic hypotension and could cause marked elevation of supine blood pressure. Review of Resident #4's Medication Administration Record (MAR) dated June 2026, indicated the following date, times, administration or held medication, and blood pressure readings at the time of the administration of medication. 06/06/2026 at 8:00 AM- blood pressure (BP) 157/77- medication was administered by LPN #2. 06/06/2026 at 1:00 PM- BP was 157/77- medication was administered by LPN #2. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/06/2026 at 8:00 PM- BP was 136/79- medication was administered by LPN #5. 06/07/2026 at 800 AM- BP 127/69- medication was administered by LPN #2. 06/07/2026 at 1:00 PM- BP 127/69- medication was administered by LPN #2. 06/07/2026 at 8:00 PM- BP 136/91- medication was administered by LPN #5. 06/08/2026 at 8:00 AM- BP 142/86 - medication was administered by LPN #5. 06/08/2026 at 1:00 PM- BP not taken due to resident not in facility 06/08/2026 at 8:00 PM- BP 110/68 medication held due to vitals outside of parameters for administration by LPN #5. 06/09/2026 at 8:00 AM- BP 109/67- medication was administered by LPN #2. 06/09/2026 at 1:00 PM- BP 113/69- medication was administered by LPN #2. 06/09/2026 at 8:00 PM-BP 91/90- medication held due to vitals outside of parameters for administration by LPN #6. 06/10/2026 at 8:00 AM- BP 137/75- medication held due to vitals outside of parameters for administration. 06/10/2026 at 1:00 PM- BP not taken due to resident not in facility 06/10/2026 at 8:00 PM- BP 166/88, medication was administered by LPN #6. 06/13/2026 at 8:00 AM-BP 136/72, medication was administered by LPN #2. The medication was administered by staff nine times when Resident #4's BP was greater than 120 and failed to administer the medication two times when Resident #4's systolic blood pressure BP was less than120, totaling eleven medication errors for the antihypotensive medication. During an interview on 06/29/2026 at 12:15 PM a family member of Resident #4 stated during a care plan meeting, the family asked what medications Resident #4 was currently taking. The family members questioned the facility staff and why the antihypotensivie was being administered when the order was to hold if SBP was greater than120. The family member stated, The Director of Nursing (DON) informed them it was a medication error, and it would be addressed. The DON further stated, Disciplinary action would be taken on the staff who administered the medication. The family member stated, There is no telling how long the medication error would have occurred if I wouldn't have questioned them in that care plan meeting. During an interview on 06/30/2026 at 1:30 PM the Advanced Practice Registered Nurse (APRN), explained when a resident was readmitted to the facility from the hospital, the resident's orders were reviewed either the next day or on Monday if it occurred on a weekend. The APRN stated, The discharge orders from the hospital are reviewed and are entered by either the Unit manager or the Admitting Nurse. The APRN also stated, The [antihypotensive medication] is used for hypotensive (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	episodes and is prescribed to a lot of the dialysis residents and the nurse should always get a BP reading before administering the medication. The APRN indicated if the medication was not administered for a BP reading of less than 120, the BP would continue to drop. The APRN explained he did do not participate in the care plan meetings but the [resident's] family is more concerned with medications. During an interview on 06/30/2026 at 3:24 PM, the Director of Nursing (DON) indicated [NAME] a resident was readmitted from the hospital, the unit manager or nurse entered the hospital discharge orders. The following weekday, the clinical team reviewed orders that were entered. The clinical team consisted of the Minimum Data Set (MDS) Coordinator, the unit manager, the DON, and the Assistant Director of Nursing (ADON). The DON stated, When a medication error happened in the facility, medication error incident and accident (I&A) was completed, an in-service was conducted with the staff, disciplinary action occurred if needed, and the family and provider were notified. During a follow up interview on 07/01/2026 at 8:27 AM, the DON stated the medication error was identified on 06/10/2026 at 9:15 PM by the nurse and addressed on 06/11/2026. The on-call physician was notified, and the staff was instructed to monitor the BP every two hours for eight hours. LPN #2, LPN #5, and LPN #6 were disciplined, and an in-service was immediately done. The DON provided the [name brand antihypotensive medication] internal investigation documents for review. Review of [the antihypotensive medication] Internal Investigation document revealed a medication error form was completed for Resident #4, and LPN #2, LPN #5, and LPN #6 disciplinary action forms were completed and signed by the staff and DON. The investigation documents also included an in-service that had been completed on 06/11/2026 over the topics of Medication administration, Six Rights of Medication Administration and Medications with Parameters. During an interview on 07/01/2026 at 12:15 PM, the Medical Director (MD) stated, The antihypotensive medication was used to increase BP and the expectation of staff at the facility was to follow orders. If the order was to hold the medication for SBPg120, the staff should have held it. The MD stated, With renal residents, medication works differently, and the nephrologist was the one to make changes. The MD also stated, We follow the guidance of the nephrologist. The MD stated he participated in the Quality Assessment & Assurance (QAA) meetings monthly and this had been discussed at length at the meetings. Review of a [antihypotensive medication] Package Insert from the Food and Drug Administration (FDA) reference identification (ID) indicated [antihypotensive medication] was indicated for the treatment of symptomatic orthostatic hypotension. It could cause marked elevation of supine blood pressure. [antihypotensive medication] should not be used in patients with persistent and excessive supine hypertension.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interviews, record review and facility policy review , it was determined the facility failed to ensure multi-dosed insulin vials were labeled in accordance with currently accepted professional standards specifically insulin was not labeled with the date the vial was first accessed for five (Residents #1, #6, #7, #8, and #9) of seven residents reviewed. The findings include: During an observation of insulins and concurrent interview on 06/30/2026 at 11:05 AM, Licensed Practical Nurse (LPN)#1 indicated Resident #9's multi-dose [fast-acting insulin] vial was not labeled with the opened date. She stated with the vial not being properly labeled, she could not access it. LPN #1 stopped with the administration process and took the unlabeled insulin bottle to the Director of Nursing (DON) to report it. LPN #1 and the DON went to dispose of the insulin vial and obtained a new vial of insulin. LPN #1 labeled the new vial and withdrew four units to administer to Resident #9. During a concurrent observation and interview on 06/30/2026 at 11:42 AM, LPN #1 indicated Resident #7's [rapid-acting] multi-dose insulin vial was not properly labeled with the opened date. She stated with the vial not being properly labeled, she could not access it. LPN #1 stopped with the administration process and took the unlabeled insulin bottle to the Director of Nursing (DON) to report it. LPN #1 and DON went to dispose of the insulin vial and obtained a new vial of insulin. During an observation on 06/30/2026 at 11:58 AM, this surveyor with the Assistant Director of Nursing (ADON) present, observed LPN #1 check all remaining insulin in the medication cart. Five (Residents #1, #6, #7, #8, and #9) of seven resident's multi-dose insulin vials were not labeled with an opened date. Review of a facility provided Medication Administration Record (MAR) printout of Resident #1's Insulin Administration dated June 2026 highlighted by facility staff to indicate that the [second rapid acting insulin] multi-dosed vial was opened, and unlabeled with pharmacy date of delivery as 06/02/2026 and was administered to Resident #1 31 times after the printed date of delivery from the facility pharmacy. Review of a facility provided MAR print out of Resident #6's Insulin Administration dated June 2026, highlighted by facility staff to indicate the [fast acting insulin] multi-dosed vial was opened, and unlabeled with pharmacy date of delivery as 06/26/2026 and was administered to Resident #6 six times after the printed date of delivery from the facility pharmacy. Review of a facility provided MAR print out of Resident #7's Insulin Administration dated June 2026, highlighted by facility staff to indicate the [long-acting insulin] multi-dosed vial was opened, and unlabeled with a pharmacy date of delivery as 06/15/2026 and was administered to Resident #7 31 times after the printed date of delivery from the facility pharmacy. Review of a facility provided MAR print out of Resident #7's Insulin Administration dated June 2026, highlighted by facility staff to indicate the [rapid-acting insulin] multi-dosed vial was opened, and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unlabeled with pharmacy date of delivery as 06/19/2026 and was administered to Resident #7 25 times after the printed date of delivery from the facility pharmacy. Review of a facility provided MAR print out of Resident #8's Insulin Administration dated June 2026, highlighted by facility staff to indicate the [second rapid-acting insulin] multi-dosed vial was opened, and unlabeled with a pharmacy date of delivery as 06/22/2026 and was administered to Resident #8 11 times after the printed date of delivery from the facility pharmacy. Review of a facility provided MAR print out of Resident #8's Insulin Administration dated June 2026, highlighted by facility staff to indicate the [long-acting insulin] multi-dosed vial was opened, and unlabeled with a pharmacy date of delivery as 06/26/2026 and was administered to Resident #8 four times after the printed date of delivery from the facility pharmacy Review of a facility provided MAR print out of Resident #9's Insulin Administration dated June 2026, highlighted by facility staff to indicate the [long-acting insulin] multi-dosed vial was opened, and unlabeled with a pharmacy date of delivery as 06/17/2026 and was administered to Resident #9 13 times after the printed date of delivery from the facility pharmacy. Review of a [rapid-acting insulin] Package Insert revised 01/2026, revealed the subcutaneous insulin may be stored for 28 days when refrigerated at 41 degrees (*) Fahrenheit (F) and for 14 days at room temperature up to 86*F. Review of a [long-acting insulin] Package Insert revised 05/2025, revealed the multi-dose vial opened should be used within 28 days refrigerated or room temperature. Review of a[a second rapid-acting insulin] Package Insert revised 06/2025, revealed the subcutaneous insulin may be stored for 28 days when refrigerated at 41* F and for 14 days at room temperature up to 86*F. Review of a [fast-acting insulin] Package Insert revised 02/2023, revealed the multi-dose vial opened should be used within 28 days refrigerated or room temperature. During an interview on 06/30/2026 at 12:42 PM, the Pharmacist revealed the printed date on the bottom of the multi-dose vial is the date the order was completed and delivered to the facility. The Pharmacist stated, I am unsure when the vials were opened, that it was the facility's responsibility to write the opened date on the vial for staff's awareness. The pharmacist also stated, The four insulins that the manufacturer package inserts were requested for were insulins that could only be opened and used up to 28 days, then must be discarded. The Pharmacist further stated, There are some insulins that can be used to the expiration date but not these four [referring to the insulins found unlabeled in the cart]. During an interview on 06/30/2026 at 2:14 PM, LPN #2 verbalized, Multi-dose insulin vials must have the opened date on the vial and not just on the outside of the bag. She stated, if not, nurses would not know when the 28 days ended. Insulin does not work as it should past the 28 days. During an interview on 06/30/2026 at 2:47 PM, the ADON stated, The expectation of a nurse when opening an insulin vial was to write the opened date on the vial, check the expiration and make sure the insulin was in the vial. The ADON stated once the insulin goes past 28 days, the insulin would be ineffective. The open date should be written on the vial, and not the bag the insulin is kept in. The (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADON further stated, In-services had been completed but with her being so new, she could not give dates. During an interview on 06/30/2026 at 3:24 PM, the DON stated, The expectation of nurses were to date the bag and vial when opened and new bottles of insulin were to be stored in the refrigerator until used. The DON also stated, If staff found a vial that did not have the date, they were to notify the DON. The DON stated, The pharmacy gets the medications in the facility quickly when they run out. If insulin is not disposed of after 28 days; the insulin potency is affected. During an interview on 07/01/2026 at 9:00 AM, LPN #4 stated, When administering insulin to a resident, LPN #4 looked for the opened date, expiration date, name of resident, resident date of birth and how much was being administered. LPN #4 stated, If the insulin vial did not have an open date, LPN #4 would not administer insulin from the vial due to not knowing when it was opened. During an interview on 07/01/2026 at 12:15 PM, the Medical Director (MD) stated, If insulin was used past the 28 days, the insulin may lose effectiveness and that is why it is restricted past that time. Nurses have to follow policies and procedures 100%, that is not an option. During an interview on 07/01/2026 at 12:51 PM, the Administrator stated, It is very important for insulin to be labeled with the open date. The dates are there for a reason and I'm sure it has some interference with the insulin. Review of facility policy titled Medication Labeling and Storage revised February 2023 indicated multi-dose vials that have been opened or accessed are discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.