

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045222	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER Woodruff County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 139 West Highway 64 McCrary, AR 72101	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure the environment remained free from avoidable accident hazards, and that adequate supervision was provided during transfers for one (Resident #107) of eight residents reviewed for accidents and supervision. Specifically, the facility did not ensure staff followed safe transfer procedures using a mechanical lift, which resulted in injury to the resident.</p> <p>The findings include:</p> <p>A review of Resident #107's Face Sheet revealed Resident #107 was admitted to the facility on [DATE], with diagnoses that included a fracture of the right femur leg bone, a disease caused from narrowing blood vessels reducing the blood flow to the legs and feet, and dementia.</p> <p>A review of Resident #107's Care Plan, revised 04/28/2025, revealed the resident required assistance with activities of daily living and was to be transferred using a mechanical lift with two-person assistance. The Closet Care Plan also contained the same intervention.</p> <p>A review of a facility reported incident revealed that on 05/02/2025, at 6:18 PM, Certified Nursing Assistant (CNA) #3 reported to Licensed Practical Nurse (LPN) #4 that Resident #107 had sustained two skin tears on the right leg. LPN #4 assessed the resident and questioned CNA #3, who initially could not recall how the injuries occurred. Upon further questioning, CNA #3 admitted to transferring Resident #107 alone using a mechanical lift, without the assistance of a second staff member as required by the resident's care plan and facility policy. LPN #4 suspended CNA #3 pending investigation and notified the Director of Nursing (DON), the Administrator, Medical Director, and Resident #107's family representative.</p> <p>During an interview on 09/17/2025 at 10:25 AM, LPN #4 recalled the incident. LPN #4 confirmed that CNA #3 had admitted to transferring Resident #107 alone and reported the skin tears but could not identify what caused them. LPN #4 stated that CNA #3 was suspended, and the appropriate parties were notified.</p> <p>During an interview on 09/18/2025 at 11:08 AM, the Assistant Director of Nursing (ADON) stated that CNA #3 had performed the transfer alone. The ADON stated that all staff were trained on mechanical lift procedures upon hire and annually thereafter.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 09/18/2025 at 11:35 AM, the Director of Nursing (DON) stated that staff were trained and checked off on mechanical lift skills. The DON stated that adequate staff were available at the time of the incident and that CNA #3 did not request assistance. The DON indicated the skin tears may have resulted from improper placement of the lift pad during the transfer.</p> <p>During an interview on 09/18/2025 at 12:01 PM, the Administrator confirmed that CNA #3 admitted to transferring Resident #107 alone. The Administrator stated that CNA #3 was terminated following the outcome of the investigation.</p> <p>During an interview on 09/18/2025 at 1:09 PM, CNA #3, who was hired on at the facility on 9/02/2024 and in-serviced on lift transfers on 9/05/2024, indicated she had transferred Resident #107 without a second staff member, in violation of the care plan and facility policy. CNA #3 admitted to being aware all residents requiring a lift to transfer in this facility required two staff persons yet knowingly transferred Resident #107 independently. CNA #3 stated the transfer conducted on 05/02/2025, resulted in the termination of her employment following the facility investigation.</p> <p>Review of a facility policy titled Safe Lifting of Residents, revised 12/01/2013, indicated that resident safety, dignity, comfort, and medical condition would be incorporated into decisions regarding lifting and moving residents.</p> <p>This failure to follow safe transfer procedures placed Resident #107 at risk for injury and resulted in actual harm.</p> <p>Review of facility documentation revealed CNA #3 had been terminated on 05/05/2025 following the facility's investigation, and that all staff had been in-serviced following the event, completed 05/12/2025. Interviews with staff verified understanding of the training.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to implement infection control practices in accordance with Enhanced Barrier Precautions (EBP) requirements for two (Resident #1 and Resident #2) of five residents reviewed for infection control, and one (Resident #2) of one resident reviewed for trach care. Specifically, the facility did not ensure that staff put on appropriate personal protective equipment (PPE) while providing care to residents on EBP.</p> <p>The findings include:</p> <p>Resident #1</p> <p>A review of an admission Record indicated that the facility admitted Resident #1 on 05/11/2024, with diagnoses which included impaired brain function caused by metabolic disturbances, end stage kidney disease, and an encounter for attention to a feeding tube placed in the stomach.</p> <p>A review of Resident #1's Care Plan, revised 08/15/2025, revealed Resident #1 was on EBP. The Care Plan included interventions with a start date of 05/23/2024, to require PPE [gown, gloves, etc.] and, to provide face protection [face mask, goggles, or face shield] with activities for risk of splash or spray.</p> <p>During observation on 09/17/2025 at 2:51 PM, this surveyor observed Registered Nurse (RN) #2 touching medication bare handed and place the pill in the medication cup during preparation of one medication for Resident #1. RN#2 was observed to perform hand hygiene, then to touch the medication cart and medication cards, contaminating their hands, prior to touching the medication bare handed. This surveyor observed RN #2 administering medication via PEG [percutaneous endoscopic gastrostomy] tube without a gown.</p> <p>During the interview on 09/17/2025 at 2:51 PM with RN #2, she verbalized that she should have worn a gown. RN #2 also verified that she touched a medication without any gloves when preparing medication prior to administering them to the resident.</p> <p>During an interview on 09/18/2025 at 10:59 AM, the ADON (Assistant Director of Nursing) verified that residents who were on dialysis or had PEG tubes should be on EBP. The ADON confirmed that when someone had a PEG tube, a staff member should wear gown and gloves. She explained that wearing PPE was to protect the resident. She confirmed that it was not appropriate to touch medication bare handed. She stated, It is infection control. If they touch a pill they should have gloves on. The ADON verified that nursing administration did medication check offs with nurses. The ADON stated, So they know to not touch medication without gloves and we in-service about enhance barrier precautions.</p> <p>During an interview on 09/18/2025 at 11:19 AM, the DON (Director of Nursing) verified that residents who were on dialysis or had a PEG tube should be on EBP. The DON confirmed staff should dress with mask, gown, and gloves when performing care for residents who are on EBP. She explained that EBP was to prevent infection for the residents who were at risk, and attempt to prevent rehospitalization. The DON explained that it was not appropriate to touch medication bare handed due to cleanliness. She stated that there were in-services on EBP and medication administration.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/18/2025 at 11:40 AM, the Administrator verified that staff kept the supply of PPE outside the resident door, and it was re-stocked daily and as needed. She confirmed that individuals with a PEG tube would be on EBP. She stated the purpose behind EBP was to protect the resident from our germs. The Administrator verified that a nurse was not supposed to touch medication bare handed.</p> <p>During an interview on 09/18/2025 at 2:45 PM, the Infection Preventionist (IP) verified that nurses were supposed to wear gown and gloves when caring for someone with a PEG tube. The IP explained that using infection control practices with EBP decreased the risk of infection for the residents. She explained that nursing administration did visual observations, and PPE check offs to ensure staff followed EBP. The IP verified that it was not appropriate to handle medications without wearing gloves because, you never know what kind of germs are on your hands. She verified that even after a nurse washed their hands they are to not touch the medication bare handed because, the nurse could touch medication cards and the medication cart.</p> <p>Resident #2</p> <p>A review of Resident #2's Face Sheet revealed Resident #2 was admitted to the facility on [DATE] with diagnoses which included tracheostomy (trach) status.</p> <p>A review of Resident #2's Physician orders indicated daily trach care interventions which included: to cleanse the stoma daily, to change the disposable inner cannula daily, and to change the trach collar every other day. Resident #2's Physician Orders also indicated EBP precautions were ordered on 04/11/2024.</p> <p>On 09/17/2025 at 3:40 PM, Registered Nurse (RN) #1 was observed performing trach care for Resident #2, who was on EBP. RN #1 did not put on a gown or mask prior to initiating care. RN #1 had placed a disposable plastic barrier down on Resident #2's over the bed table which was parked to the left of the bed. The supplies were placed on top of the barrier. RN #1 stood between the table and the resident with the resident to the right side and table on the left. RN #1 gathered supplies from the table and would lean over Resident #2, who was in a supine position in the bed with head elevated at 35 degrees. RN #1's scrub top was in direct contact with the resident's bed linens while leaning over to perform trach care. RN #1's face was positioned less than an arm length away from Resident #2's face during treatment.</p> <p>During an interview on 09/17/2025 at 3:50 PM, RN #1, who was in-serviced on infection control 11/11/2024, stated that trach care required EBP and acknowledged that a gown should have been worn during the procedure. RN #1 confirmed that EBP was important to prevent residents from acquiring infections.</p> <p>During an interview on 09/18/2025 at 8:35 AM, RN #2 confirmed that EBP should be used during trach care and that training and skills checks were conducted with staff at the facility.</p> <p>During an interview on 09/18/2025 at 9:06 AM, CNA #15 stated that EBP was put in place to protect residents with open sites on the body.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 09/18/2025, at 11:18 AM, the ADON stated that trach care required gloves, gown, and mask under EBP. The ADON stated that breathing near the trach site without a mask would not be safe and that EBP was used to protect residents from infection.</p> <p>During an interview on 09/18/2025, at 11:25 AM, the DON stated that PPE should be donned outside the resident's room and that staff are required to wear gown, gloves, and mask when providing care to residents on EBP. The DON stated that EBP was used to prevent infections and rehospitalizations and that in-services were conducted to educate staff on EBP practices.</p> <p>During an interview on 09/18/2025, at 11:55 AM, the Administrator stated that PPE was stocked outside the rooms of residents on EBP and that charts were flagged to identify residents who require EBP. The Administrator stated that supervisors monitor staff compliance and that camera footage was reviewed to ensure adherence to infection control practices.</p> <p>During an interview on 09/18/2025, at 2:45 PM, the IP stated that trach care required a gown, gloves, and mask under EBP. The IP stated that staff were observed daily and received annual PPE competency checks to ensure proper donning and doffing procedures.</p> <p>A review of a Medication Administration in-service, dated 11/18/2024, indicated Do not touch oral medication.</p> <p>A review of a facility policy titled, Personal Protective Equipment, dated 09/2010, indicated When to use a mask: when performing a task that may involve the splashing of blood or body fluids into the mouth or nose. Gowns- Use gowns only when indicated or as instructed. When use of a gown is indicated, all personnel must put on the gown before treating or touching the resident.</p> <p>A review of the facility's undated policy titled, Tracheostomy Care, indicated, Put exam gloves on both hands; masks and eye wear should be worn if there is a likelihood of splashes and splattering.</p> <p>A review of a facility policy titled, Enhanced Barrier Precautions, dated 04/20/2024, revealed, it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. High-contact resident care activities include device care or use of feeding tubes and tracheostomy/ventilator tube.</p>		