STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045176	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Woods, A Nightingale Community	1194 N Chester St Monticello, AR 71655

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, interview, and facility policy review, the facility failed to ensure safety straps were placed on all four wheels of a resident's wheelchair before being transported in the facility van which resulted in one resident falling backwards from the wheelchair for one (Resident #1) of three residents reviewed for accidents and hazards. The findings include: Review of Resident #1's Medical Diagnosis revealed Resident #1 had diagnoses that included end stage renal disease, acquired absence of right leg above the knee, type 2 diabetes with chronic kidney disease, dependence on renal dialysis, and acquired absence of left leg below the knee. Review of Resident #1's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/11/25, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS also revealed Resident #1 used a wheelchair for mobility. Review of Resident #1's Care Plan initiated on 02/24/25, revealed Resident #1 had a self-care performance deficit related to a right above the knee amputation and a left below the knee amputation. The care plan indicated Resident #1 required moderate assistance of one staff member with transfers and was dependent on renal dialysis three times weekly. Review of Resident #1's Physicians Orders dated 07/07/25, revealed Resident #1 should be transported to dialysis every Monday, Wednesday, and Friday. Review of Resident #1's Reportable revealed Resident #1 was being transported from dialysis on 09/20/2025 at 10:58 AM by Certified Nursing Assistant (CNA) #1. The document revealed that the wheelchair flipped backwards when the van driver accelerated after being stopped at a red light. Review of the facility's Incident and Accident Report revealed the wheelchair straps were secured to the back of the resident's wheelchair but not the front of the resident's wheelchair. Resident #1 had bilateral lower extremity amputations which contributed to the uneven weight balance and distribution during acceleration of the vehicle. Review of an Office of Long-Term Care (OLTC) Witness Statement Form dated 09/20/2025 at 10:58 AM, revealed CNA #1 secured the two back straps to Resident #1's wheelchair, but did not attach the two front straps to the resident's wheelchair. After sitting at a red light, the light turned green, and CNA #1 accelerated the vehicle, at which point the wheelchair went backwards. When CNA #1 looked back Resident #1 was still in the sitting position laying on their back in the wheelchair. The witness (continued on next page)

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement revealed CNA #1 called and notified the administrator, who instructed CNA #1 to call emergency medical personnel. Review of a Progress Note titled Post Incident with an effective date and time of 09/21/2025 at 6:13 PM, revealed Resident #1, went backwards in van. Description of injuries included a bump on the right forearm, discomfort in chest, and lower back. Review of an Individual In-Service Training dated 08/24/2024 and signed by CNA #1, revealed the subject as Resident and Wheelchair Securement Education. The document revealed CNA #1 was trained on how to properly secure a resident before transport with return demonstration provided with the Administrator. During an interview on 06/09/2026 at 11:54 AM, CNA # 1 stated that he and Resident #1 were talking when the resident was being loaded onto the facility van. CNA #1 stated that he attached the straps to the back of Resident #1's wheelchair while he and Resident #1 were still talking. CNA #1 then stated he closed the backdoor on the van and went around to the front to attach the straps to the front of Resident #1's wheelchair. CNA #1 stated he forgot to attach the secure straps to the front of the resident's wheelchair and while sitting at a red light, after the light turned green, he accelerated and heard a thump. CNA #1 then stated he saw Resident #1's wheelchair on its back with the resident laying across the wheelchair. CNA #1 stated he called the Administrator. CNA #1 stated the Administrator told him to call 911 and CNA #1 stated he stayed with the resident until Emergency Medical Services (EMS) arrived. CNA #1 stated he did not touch the resident until the resident was loaded onto the EMS stretcher. CNA #1 stated he did receive training on loading and transporting residents approximately two years before the incident occurred. CNA #1 stated that the incident could have been avoided by double checking his work. CNA #1 stated that it was the responsibility of the driver to inspect the straps to ensure they were working correctly. During an interview on 06/10/2026 at 12:33 PM, the Administrator stated CNA #1 was no longer transporting residents. The Administrator also stated that in-services and retraining were conducted by the facility after the incident. The Administrator stated that training in loading and transporting residents was outsourced to another entity, and she had spoken with the representative about conducting an in-service but was unsure when it would take place due to the in-service being conducted at the same time as sister facilities. The Administrator stated that as an intervention to prevent other incidents, two staff members were assigned to out-of-town trips to ensure resident safety. During an interview on 06/10/2026 at 2:18 PM, the Maintenance Director stated his responsibility for the van included using a checklist to conduct daily walk around inspections. This included checking the oil on the van and checking the air pressure in the van's tires. The Maintenance Director stated that inspecting the safety straps was not part of his assigned duties and that drivers had a checklist that they used before transporting a resident and checking the security straps for safety was included on the checklist. The Maintenance Director stated that if a resident was not secured properly while being transported, the wheelchair could turn over, the resident could fall out of the wheelchair, the wheelchair could roll around the back of the van, and someone could become seriously injured. Review of undated facility policy titled Fleet Management revealed, the facility strives to maintain a safe working environment to protect employees and residents from injury and property loss, and the facility is committed to promoting a heightened level of safety awareness and responsible driving behavior in its employees. Elements of this program include training standards and safety regulations. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The driver and all occupants are required to wear safety belts when the vehicle is in operation. The driver is responsible for ensuring passengers wear their safety belts. The facility re-educated CNA #1 on how to properly secure a resident before transport with return demonstration provided on 08/28/2024, the CNA was reassigned jobs and was suspended for three days during the time the facility investigated the situation. These actions were performed before the survey team entered the facility, resulting in this finding being cited at past non-compliance.