STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045384	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbriar Nursing Home	204 Catherine St Harrisburg, AR 72432

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interview and facility policy review, it was determined that the facility failed to ensure the Minimum Data Set (MDS) was accurate and complete to facilitate the ability to plan and provide necessary care and services for three (Residents #4, #17 and #64) of three residents reviewed. The findings include:Resident #4Review of an admission Record indicated the facility admitted Resident #4 with diagnoses that included atherosclerotic heart disease (a buildup of fats and cholesterol in the artery walls, leading to narrowed or hardened arteries) and cerebral infarction (a stroke caused by blockage in an artery supplying blood to the brain).Review of a quarterly MDS with an Assessment Reference Date (ARD) of 02/09/2026 for Resident #4 revealed that the resident was taking medications that included an anticoagulant (medication that prevents or reduces the formation of blood clots) and an antiplatelet (medication that prevents blood platelets from sticking together. Review of an admission MDS dated [DATE] revealed, Resident #4 was not taking an anticoagulant but was taking an antiplatelet. Review of Resident #4's Order Summary dated 04/06/2026, revealed an order with a start date of 09/13/2022 for an antiplatelet to be given one time a day related to atherosclerotic heart disease.Review of Resident #4's Care Plan initiated on 12/05/2025 revealed the resident was on anticoagulant therapy as ordered by Medical Doctor. Care Plan interventions included: see black box warnings, take anticoagulant medication as ordered.During an interview on 04/09/2026 at 10:10 AM, the MDS Coordinator stated she was familiar with Resident #4. She reviewed the quarterly MDS with an ARD of 02/09/2026 and quarterly MDS with an ARD of 11/17/2025 and stated, they were coded as an anticoagulant, but the resident was taking an antiplatelet and they are not the same medication. I coded it wrong. The MDS Coordinator stated she used the Resident Assessment Instrument (RAI) Manual to code MDSs. She stated, I will fix those and submit them.During an interview on 04/09/2026 at 11:51 AM, the Assistant Director of Nursing (ADON) stated she was familiar with Resident #4. The ADON stated she did not believe the resident was taking an anticoagulant but that an anticoagulant and antiplatelet should be on the MDS because resident should be monitored for bleeding. Review of the RAI Version 3.0 Manual dated October 2025, page N-9, documented N0415: High-Risk Drug Classes: Use and Indication - do not code antiplatelet medications such as aspirin/extended release, dipyridamole or clopidogrel as N0415E, Anticoagulant. Resident #17Review of an admission Record indicated the facility admitted Resident #17 on 05/22/2025 with diagnoses that included depression, anxiety, a stroke (blockage in an artery supplying blood to the brain), a lung disease, bipolar disorder, adult failure to thrive, fatigue, a history of falling and a right hip fracture. Review of a quarterly MDS, with an ARD of 02/16/2026, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #17 was cognitively intact. The MDS indicated Resident #17 had an acute onset mental status change with behaviors present of inattention that comes and goes. The MDS also revealed Resident #17's functional abilities indicated no impairment to arms or legs, and a wheelchair was used for mobility. Resident #17 required substantial to maximal assistance for lower body dressing and putting on or taking off shoes and partial to moderate assistance with transfers. The MDS also revealed Resident #17 had no falls since admission and restraints and alarms indicated that there were no alarms on Resident #17's bed (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or chair. Review of Resident #17's Care Plan initiated on 12/08/2025, revealed Resident #17 had actual falls on 12/23/2025, 12/31/2025, and 02/06/2026. Care Plan interventions included floor mat at bedside, assessing reasons for falls and pressure alarm in place to wheelchair, initiated02/06/2026; added bed alarm and chair alarm, initiated12/21/2025; and electronic chair/bed alarm initiated 12/24/2025. Review of Clinical Physician Orders revealed Resident #17 had an order for a wheelchair alarm to alert staff when rising unassisted with a start date of 01/01/2026 and bed alarm to alert staff when rising unassisted with a start date of 01/01/2026. Review of Medical Administration Record-Treatment Administration Record (MAR-TAR) dated 04/2026, revealed documentation by day shift and night shift staff to monitoring the bed/chair alarm. The MAR-TAR revealed an order for bed alarm to alert staff when rising unassisted, every shift for safety and when rising unassisted, order dated 01/01/2026 and an order for wheelchair alarm to alert staff when rising unassisted every shift for safety and to alert staff when rising unassisted, order dated 01/01/20226.During an observation on 04/06/2026 at 11:00 AM, Resident #17 was observed sitting in a wheelchair in Resident #17's room, chair alarm in place on the wheelchair. During an observation on 04/09/2026 at 10:30 AM, Resident #17 was observed sitting in a wheelchair in Resident #17's room, chair alarm in place on the wheelchair. During an interview on 04/09/2026 at 12:16 PM, the MDS Coordinator indicated the information needed to update and complete the MDS assessment was obtained through chart review, resident assessment and staff relayed information through verbal report or secure communication text. The MDS Coordinator reviewed Resident #17's electronic chart and verified orders for a bed and wheelchair alarm dated 01/01/2026. The MDS Coordinator reviewed the quarterly MDS completed on 02/16/2026 and stated, no alarms had been marked, and that is an MDS discrepancy. The MDS Coordinator indicated a discrepancy could result in federal, state or the facility not being compensated correctly, could cause an issue in the payment process and a difference in the quality care measures. Review of a RAI Version 3.0 Manual dated October 2025, revealed An alarm is any physical or electronic device that monitors resident movements and alerts the staff, by either audible mean, when movement is detected, and my include bed, chair and floor. The coding instructions revealed, Identify all alarms that were used at any time (day or night) during the 7-day look back period. After determining whether or not an item listed in P0200 was used during the 7-day look back period, code the frequency of use: Code 0, not used, Code 1, used less than daily, and Code2, used daily. Coding tips revealed, Bed alarm includes devices such as sensor pad placed on the bed or a device that clips to the residents clothing. Chair alarm includes devices such a as a sensor pad placed on the chair or a wheelchair or a device that clips to the resident's clothing. Resident #64Review of an admission Record indicated the facility admitted Resident #64 on 12/09/2016 with diagnoses that included chronic kidney disease stage three (irreversible loss of kidney function, preventing the kidneys from filtering waste effectively), unspecified Escherichia coli (E. Coli) (an infection where E. Coli has been identified as the cause), retention of urine (the bladder cannot empty completely or at all).Review of a quarterly MDS with an ARD of 02/16/2026, revealed that Resident #64 had an indwelling catheter (a flexible tube inserted through the urethra into the bladder to drain urine continuously into a collection bag). The MDS also revealed the resident was on intravenous (IV) medications (medications that were given through a vein).Review of Resident #64's Order Summary revealed an order with a discontinued date of 09/30/2025 to change foley monthly on last day of the month for retention/incontinence. The Order Summary also revealed an order for an IV antibiotic every 24 hours for infection with a start date of 11/13/2025 and end date of 11/17/2025.During an interview on 04/09/2026 at 12:30 PM, the MDS Coordinator stated she was familiar with Resident #64. She reviewed the quarterly MDS with an ARD of 02/16/2026 and stated that IV medication information would have come from the Medication Administration Record (MAR). The MDS Coordinator revealed that IV medication was entered on the MDS in error. The MDS Coordinator revealed that when she coded the MDS, she would look at the MAR and Treatment Administration Record (TAR) and go back 14 days for the look back period. The MDS Coordinator (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that [name brand] catheter was not listed in the MAR and TAR, so marking indwelling catheter on the quarterly MDS was in error. The MDS Coordinator stated she used the RAI to code MDSs.During an interview on 04/09/2026 at 11:51 AM, the Assistant Director of Nursing (ADON) stated she was familiar with Resident #64. The ADON revealed that Resident #64 did not currently have a foley catheter and had not had a foley catheter for several months. Review of a RAI Version 3.0 Manual dated October 2025, revealed to code any drug or biological given by intravenous push epidural pump, or drip through a central or peripheral port in this item. During an interview on 04/09/2026 at 2:00 PM, the Administrator indicated the job of the MDS Coordinator was to process new, added, and continued orders for the residents. The Administrator stated, When it is time for a new MDS to be completed, all orders should be reviewed, and you should see what is actually happening right now with the resident. You should look at the orders and look at the patients for information. The Administrator indicated if a new order was received it was to be included in the next MDS assessment.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to protect a resident's right to be free from verbal and mental abuse for one (Resident #38) of four residents reviewed. The findings include: Review of Resident #38's admission Record revealed the facility admitted Resident #38 on 04/12/2022 with diagnoses that included dementia, mood disorder, bipolar disorder, limitations of activities due to disabilities, altered mental status, a sleeping disorder, and an excessive persistent thirst with an insatiable urge to drink fluids. Review of an annual Minimum Data Set with an Assessment Reference Date of 01/12/2026, revealed Resident #38 had a Brief Interview for Mental Status (BIMS) score of 10 which indicated the resident had moderate cognitive impairment. The MDS indicated no acute altered mental status present, no behaviors had been displayed towards others, and no impairment to arms or legs. The MDS also revealed Resident #38 used a wheelchair for mobility and Resident #38's eating skills were indicated as independent once the meal was placed in front of the resident. Review of Resident #38's Care Plan initiated on 04/18/2022 revealed the resident had an Activities of Daily Living (ADL) deficit, had impaired cognitive function and impaired thought process due to mental diagnosis. Care Plan interventions included Resident #38 required moderate assistance of one staff with ADLs, required a sippy cup for meals, and was able to feed self after set up. Staff were required to give cues and reminders for dehydration. Resident #38 required weighted utensils and divided plate at mealtime and was encouraged to participate to the fullest extent possible with each interaction. Review of Clinical Physician Orders revealed Resident #38 was allowed to reside on the Special Care/Memory Unit per request. Review of an undated facility Resident admission Packet revealed Federal law specifies that nursing homes protect and promote the following rights of each resident: Be treated with respect: You have the right to be treated with dignity and respect. Be free from abuse and neglect: You have the right to be free from verbal, sexual physical and mental abuse. Review of Resident #38's Reportable included documentation signed by Certified Nursing Assistant (CNA) #4 on date of hire 02/25/2021. A document titled Suspected abuse and neglect revealed, The resident has the right to be free from abuse. The resident has the right to be free from verbal, physical and mental abuse, corporal punishment and involuntary seclusion. A document titled Abuse Prohibition Program revealed, The facility is responsible to provide a safe and secure environment for residents at all times. Review of a facility document titled Residents Rights signed by CNA #4 on 02/25/2021 revealed, Each and every resident in this facility has the right to: Be treated at all times courteously, fairly, and with the fullest measure of dignity and to be free of verbal, psychological, physical, and sexual abuse. Review of an OLTC Witness Statement Form dated 03/01/2026 at 8:10 AM, revealed Licensed Practical Nurse (LPN) #1 was passing medications and heard CNA #4 screaming and cussing at (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #38. LPN #1 indicated CNA #4 stated, Why did you drink my protein shake, don't touch any [expletive] thing that is not yours. LPN #1 indicated CNA #4 proceeded to yell at Resident #38 for a minute. Review of an OLTC Witness Statement Form dated 03/01/2026 at 8:33 AM, revealed CNA #2 was serving trays in the dining area where the incident occurred. CNA #2 indicated that CNA #4 had sat a protein shake down on the table where she was serving trays at for residents. CNA #2 stated, CNA #4 screamed at Resident #38 saying [expletive] [Resident #38], why are you touching stuff that don't [expletive] belong to you? CNA #2 indicated that Resident #38 took a drink of CNA #4's drink. Review of an OLTC Witness Statement Form dated 03/01/2026 at 8:45 AM, revealed CNA #3 was in the bathroom with a different resident and heard CNA #4 yell at Resident #38, Why did you touch my [expletive] stuff. After CNA #3 completed resident care in the bathroom, she walked into the dining room where CNA #4 and Resident #38 were. CNA #3 indicated that she heard CNA #4 call Resident #38, a [expletive] and that CNA#4 then told Resident #38 she would drink Resident #38's milk since Resident #38 drank her protein shake. Review of an OLTC Witness Statement Form dated 03/01/2026 at 8:20 AM, revealed CNA #4 indicated she did get upset and cuss at Resident #38. CNA #4 indicated she told Resident #38 That is not yours, leave [expletive] stuff alone that is not yours. Review of an Employee File for CNA #4 revealed she was terminated on 03/04/2026. There was no reason indicated for the termination. During an interview on 04/08/2026 at 10:26 AM, LPN #1 stated she was on 500 hall passing medications when she heard CNA #4 yelling at Resident #38. LPN #1 indicated CNA #4 stated that Resident #38, She drank my [expletive] shake. LPN #1 stated CNA #4 was verbally cussing Resident #38. LPN #1 stated she notified the administrator, and obtained witness statements from CNA #2, CNA #3 and CNA #4. CNA #4 was made to clock out and leave the facility. LPN #1 indicated there were lockers and a closet located on the unit for staff to store all of their personal items. LPN #1 stated they received an in-service for abuse/neglect training on 03/02/2026. During an interview on 04/08/2026 at 2:28 PM, CNA #2 stated while the CNAs were passing breakfast trays in the dining room, CNA #4 sat her weight loss protein shake on the table beside Resident #38's tray. CNA #2 indicated Resident #38 opened and drank some of CNA #4's drink. CNA #2 indicated CNA #4 stated to Resident #38, What the [expletive] are you doing? Are you [expletive] kidding me? CNA #2 indicated that CNA #4 snatched the drink from Resident #38's hand. CNA #2 stated the facility gave an in-service on abuse/neglect after the incident on 03/02/2026. During an interview on 04/08/2026 at 10:41 AM, CNA #3 indicated she was in the bathroom assisting another resident when she heard CNA #4 yelling at Resident #38. CNA #3 indicated that Resident #38 had drank CNA #4's drink and then CNA #4 called Resident #38 a stupid [expletive]. CNA #3 indicated that Resident #38 then stated, No. You are a stupid [expletive]. CNA #3 indicated that after that CNA #4 took Resident #38's sippy cup and put water in it and CNA #4 told Resident #38, since you drank mine, you can drink water. During an interview on 04/09/2025 at 12:35 PM, RN #5 indicated she had just entered into the facility, from the back door on the memory unit which leads into the dining room that morning, when she heard the word [expletive]. RN #5 indicated after entering the unit she noticed it was CNA #4 hollering at (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #38. RN #5 stated she assessed Resident #38 after the incident and all Resident #38 would say was Bad. RN #5 indicated there were certain places for staff to store their personal items. RN #5 stated she received in-service training on abuse and neglect after the incident on 03/02/2026. During an interview on 04/09/2026 at 2:00 PM, the Administrator indicated CNA #4 was terminated for cussing Resident #38. The Administrator stated, CNA #4 admitted to cussing Resident #38. The Administrator indicated that her expectation of her staff was that there was no abuse in the facility. The Administrator listed forms of abuse as verbal, mental, sexual, physical and seclusion. The Administrator indicated there were multiple lockers and closets designated for staff to keep their personal belongings. The Administrator indicated the last in-service was completed on 03/02/2026 after the incident occurred. Review of a facility in-service titled, Abuse –Intent, Interpretive Guidelines, revealed that an all department, all staff in-service presented by the Administrator was completed on 03/02/2026, with a total of 62 signatures of attendees. The intent of the in-service indicated Each resident has the right to be free from abuse, corporal punishment and involuntary seclusion. Residents must not be subject to abuse by anyone including but not limited to, facility staff. Interpretive guidelines listed the forms of abuse as verbal, sexual, physical, mental and involuntary seclusion. The definition of all 5 categories is listed. Verbal abuse was defined as, the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend, or disability. Review of a facility in-service titled In-Service Training Report, Dignity and Respect, Regulations and Meaning of Being Respectful to Residents, dated 08/15/2025 for all staff included, Dignity, Respect and Speaking to the Resident effective 11/28/2017 revealed The resident has the right to a dignified existence, self-determination and communication, with access to persons inside and outside of the facility. and A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. An insert in the in-service stated, This means you should always be respectful to all residents. You should speak to and treat them as you would expect a care giver to treat and speak to your mother, father, or grandparents. Review of an undated facility policy titled Resident Abuse, revealed The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. The policy defines verbal abuse as, Any use of oral, written, or gestures language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance. The facility re-educated all staff on abuse, following the incident on 03/01/2026, per an in-service initiated on 03/02/2026. In addition, CNA #4 was terminated after the incident involving Resident #38. These actions were performed before the survey team entered the facility, verified by document review and staff interview resulting in this finding being cited at past non-compliance.