



Division of Provider Services & Quality Assurance P.O. Box 8059, Slot S404 Little Rock, AR 72203-8059 P: 501.320.6182 F: 501.682.6159

July 22, 2021

Charlotte Lockhart, CEO Woodridge Of Forrest City, Llc 1521 Albert St Forrest City, AR 72335

Dear Ms. Lockhart:

On July 8, 2021 a Complaint Investigation survey was conducted at your facility by the Office of Long Term Care to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid (Title XIX) Program. This survey found that your facility had deficiencies requiring correction/substantial correction prior to a revisit as specified in the attached CMS-2567.

Plan of Correction

A POC must be submitted within 10 calendar days of you receipt of the Statement of

Deficiencies. Failure to submit a POC may result in termination. Include a completion date for each deficient cited.

Amanda M Smith, RN Manager OLTC, Survey & Certification Section PO Box 8059, Slot S404 Little Rock, AR 72201-4608 (501) **320-3963** email to amanda.m.smith@dhs.arkansas.gov@dhs.arkansas.gov.

Your Plan of Correction must also include the following:

a. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice;

b. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

c. Address what measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur;

d. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.

e. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. Your facility is ultimately accountable for its own compliance. The plan of correction will serve as the facility's allegation of compliance. Unless otherwise stated on the PoC, the last completion date will be the date of alleged compliance.

Informal Dispute Resolution

In accordance with 42 CFR § 488.331, you have one opportunity to question deficiencies through an informal dispute resolution (IDR) process. To obtain an IDR, you must send your written request to Health Facility Services, Arkansas Department of Health within ten (10) calendar days from receipt of the Statement of Deficiencies. The request must state the specific deficiencies the facility wishes to challenge. The request should also state whether the facility wants the IDR to be performed by a telephone conference call, record review, or a face-to-face meeting.

An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

Please submit your request to:

IDR/IIDR Program Coordinator Health Facilities Services 5800 West 10th Street, Suite 400 Little Rock, AR 72204 Phone: 501-661-2201 Fax: 501-661-2165 <u>ADH.HFS@Arkansas.gov</u>

If you have any questions, please call Sandra Broughton, Program Administrator at 501-320-6182.

Sincerely,

fmande mesmith

RN Manager DPSQA/Office of Long Term Care Survey & Certification Section

ams

cc:

DRA

	-	ID HUMAN SERVICES					APPROVED
							0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	PLETED
						(c
		04L115	B. WING			07/	08/2021
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIE	GE OF FORREST CITY,			152	21 ALBERT ST		
WOODKIL				FO	ORREST CITY, AR 72335		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	-	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE
		,			DEFICIENCY)		
N 000	Initial Comments		N 0	00			
	Note: The CMS-2567	7 (Statement of Deficiencies)					
		cument. All information must					
		cept for entering the plan of					
	correction, correction	dates, and the signature					
		icy in the original deficiency					
		orted to the Dallas Regional					
	Office (RO) for referra						
		IG) for possible fraud. If					
		tently changed by the State Survey Agency (SA)					
	should be notified imr						
		neulatory.					
	The facility was not in	compliance with §483,					
	Subpart G - Conditio	ns of Participation for					
	Psychiatric Residentia						
	A complaint survey w						
	06/29/2021 through 0	17/08/2021.					
	Complaint #AR00026	765 was unsubstantiated.					
		766 was unsubstantiated.					
	· ·	840 was unsubstantiated.					
	- ·	804 was substantiated, all					
		ncies cited at N128, N202					
	and N214.						
		832 was substantiated, all					
		ncies cited at N128, N202					
NI 400	and N214.			~			
N 128	PROTECTION OF RE CFR(s): 483.356(a)(3		N 12	28			
)					
	Restraint or seclusion	n must not result in harm or					
		and must be used only-					
		-					
		t met as evidenced by:					
		n, interview and record					
		ed to ensure an injury did					
	not occur during an E	mergency Safety					
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.

	-	ID HUMAN SERVICES				FORM	APPROVED	
	S FOR MEDICARE & I	MEDICAID SERVICES	(X2) MU	TIPI	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				LETED	
						(C	
		04L115	B. WING			07/	08/2021	
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODRID	GE OF FORREST CITY,	LLC			1521 ALBERT ST FORREST CITY, AR 72335			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE	
					DEFICIENCY)			
N 128	Continued From page		N	128	3			
		olving a physical restraint for of 4 (Clients #1, #2, #3 and						
	#4) sampled clients re	•						
	findings are:							
	1 Client #2 was admi	ittad on 02/10/2021 and had						
	diagnoses of Major D	itted on 03/19/2021 and had						
	• •	thout Psychosis, and Rule						
	out Attention Deficit H	lyperactivity Disorder.						
	a. The Emergency Sa	afety Intervention						
		ated 6/30/21 documented,						
	"Date & Time actua							
		ime- 1745 [5:45 PM]Date						
	& Time removed from 1750 [5:50 PM]"	n Restraint:6/30/21 Time-						
	1700 [0.00 T MJ							
	b. The Emergency Sa							
		Restraint/Seclusion Body ed 6/30/21 documented,						
	"Description of Injur							
		of Treatment: R [Resident]						
	•	ody hurt d/t [due to] ESI.						
		abnormalities found. R						
	mouth) for pain" The	10. Ibuprofen given po (by e form was signed by						
	Registered Nurse (RN							
		I:13 pm, RN #3 was asked, er the ibuprofen? Reassess						
	•	sure it [the ibuprofen] worked						
	and he wasn't still in p	pain? Or showing other						
		ed, "No ma'am. I told the						
	clock out time."	ESI. It was right before my						
		10:30 am, the video of the iewed and showed, during						
		s thrown to the floor, landing						

If continuation sheet Page 2 of 27

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		04L115	B. WING				C 108/2021
NAME OF PROVIDER OR SUP	PPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRIDGE OF FORRI	EST CITY,	LLC			1521 ALBERT ST FORREST CITY, AR 72335		
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
Quality Risk documentat Client #3's of he was give and Risk state of Nursing for The Director documentat July 8, 20212. Client #4 diagnoses of Disorder, and Disorder, and Disorder.a. The Emery Justification documented Restraint:? Time remove 1420 [2:20 Fb. The Emery Justification Assessment indicated, si Licensed Pr "Description of] [decreass [Right] wrist eval [Evaluation]c. The ER refer	on his left /2021 at 2 was aske ion of a re- complaint n ibuprofe ated she v or any oth r of Qualiti ion of a re- was adm f Disrupti ad Attentic rgency Sa Packet d I, "Date 7/5/21 Tim ed from F PM]" rgency Sa catical Nu on of injur of Treatm ed] ROM - sent to atton]/tx [T ecord date		N	128	3		

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/22/2021 MAPPROVED). 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		04L115	B. WING					C 08/2021
NAME OF PRO	OVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZI	P CODE		
WOODRIDO	GE OF FORREST CITY,	LLC			1521 ALBERT ST FORREST CITY, AR 72335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD B		(X5) COMPLETION DATE
N 143	splint to the right wrist occurred during the re- squirming around on t is pushing my arm ag wrist down, pushing m to dislocate my elbow ORDERS FOR USE (SECLUSION CFR(s): 483.358(d) If the order for restrain verbal order must be to nurse or other license practical nurse, while intervention is being in immediately after the ends. The physician or permitted by the state restraint or seclusion in a signed written for The physician or othe permitted by the state restraint or seclusion consultation, at least I period of the emerger This ELEMENT is no Based on record revi failed to ensure a phy restraint was docume 1 of 1 (Client #2) sam the use of a chemical 1. Client #2 was adm diagnoses Major Dep	1:59 am, Client #4 had a t. He indicated the injury estraint, and stated, "I was the ground. Then [Staff #8] ainst the ground, pushing hy elbow up. He was trying or something" DF RESTRAINT OR The or seclusion is verbal, the received by a registered d staff such as a licensed the emergency safety		128				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			C
		04L115	B. WING				08/2021
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRID	GE OF FORREST CITY,	LLC			1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 143	Packet dated 6/21/21 "Justification Progre Justification Criteria: I Self Staff Member Give Detailed Justifica [Patient] attacked star Benadryl- Dosage: 22 [intramuscular] Media Thorazine- Dosage: 22 Administering Med [M Med Administered: In was no Physician's or Thorazine documenter b. On 6/29/21 at 3:46 Nursing (DON) was a Physician's order for f in the chart?" She sta 2. The Emergency S received from the Dire 6/30/21 at 10:04 a.m. Physical Restraint: 1. physician is required restraint or chemical in Restraint Evaluation/f Activities: 1. The Dire each episode of restra	er. fety Intervention Justification documented, ess Note: Restraint Prevent Assault/Injury to: Patient Behavior: Please ation For Restraint: Pt ffMedication Administered: 5 mg (milligrams); Route: IM cation Adminstered: 25 mg; Route: IM; Nurse Medication]: [RN #2]; Time : 2335 [11:35 p.m.]" There rder for the Benadryl and ed in the client's chart. 6 p.m., the Director of sked, "Did you see the the Thorazine and Benadryl ated, "No, it's not there." afety Intervention policy ector of Quality Risk on , documented, "B. A written order from the for the use of a physical restraintH. Physical Performance Improvement ctor of Nursing shall assess aint documentation for Director of Nursing must te documentation" OF RESTRAINT OR		14:	3		
		, include] the name of staff					

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CENTERS FOR MEDICARE & MEI	HUMAN SERVICES				FORM): 07/22/2021 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· <i>`</i>		CONSTRUCTION	(X3) DATE	
	04L115	B. WING _				C 08/2021
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRIDGE OF FORREST CITY, LLC	~		15	521 ALBERT ST		
	<i>.</i>		F	ORREST CITY, AR 72335		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
 failed to ensure the name participating in or providir an Emergency Safety Inte documented in the client' #2, #3, and #4) of 4 (Clie clients reviewed for ESI. 1. Client #3 was admitted diagnoses of Major Depre Recurrent, Severe withou out Attention Deficit Hype a. The Emergency Safety Justification Packet dated document the Director of providing an assessment physically participating in b. On 07/07/2021 at 9:04 Quality Risk was asked, ' night [Staff #11] restraine stated, "Yes ma'am. I hap and saw [Staff #11] had [et as evidenced by: record review, the facility es of all staff physically ng assessments during tervention (ESI) were 's record for 3 (Clients ents #1- #4) sampled The findings are: d on 03/19/2021 and had ressive Disorder ut Psychosis, and Rule eractivity Disorder. y Intervention d 06/30/2021 did not f Quality Risk as t, or Staff #7 as n the ESI. 4 AM, the Director of "Were you there the ed [Client #3]?" She ppened to be passing by [Client #3] in containment o see if he was positioned there, and the client was 80 AM, a video of the ESI 7:45 [5:45 PM] was or of Quality Risk. It ng an ESI on Client #3 food tray into the Staff	N	154	DEFICIENCY)		

Facility ID: 3012

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/22/2021 MAPPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		LETED
		04L115	B. WING				C 08/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRIE	GE OF FORREST CITY,	LLC			1521 ALBERT ST		
					FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 154	chair. Client #3 went if the floor on his bottom him, and Staff #11 sta then proceeded to pic level, holding Client # and then appeared to with the client landing identified by the Direct initially starting to hely she proceeded to rem area. 2. Client #2 was admid diagnoses Major Dep Severe without Psych Dysregulation Disorde a. The Emergency Sa Justification Packet di document Staff #5 an restraint, or Therapist monitoring/counseling b. On 07/07/2021 at 3 on 07/05/2021 was re Quality Risk. She was to provide the names involved in the ESI. S #3, Staff #4, Staff #5, (monitoring/counselin Nurse (LPN) #1 (mon c. On 07/07/2021 at 4 Quality Risk was aske in the ESI on [Client # Justification Packet at She answered "No."	from the chair to sitting on in with his feet in front of anding behind him. Staff #11 & Client #3 up to his chest 3 horizontally to the floor, throw Client #3 to the floor, on his left side. Staff #7, tor of Quality Risk, is seen to with the restraint, but then have all clients from the tted on 06/16/21 and had ressive Disorder Recurrent, toosis, and Disruptive Mood er. affety Intervention ated 07/05/2021 did not d Staff #10 assisted in the #1 was g during the ESI. 3:31 PM, the video of the ESI viewed with the Director of a asked during the viewing, of the staff members he named: Staff #2, Staff Staff #10, Therapist #1 g) and Licensed Practical itoring). :16 PM, the Director of ed, "Are all the staff involved	N	154			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/22/2021 APPROVED . 0938-0391	
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		04L115	B. WING				; 08/2021	
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
WOODRIE	DGE OF FORREST CITY,	LLC		521 ALBERT ST FORREST CITY, AR 72	335			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE INCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
N 154	 diagnoses of Disruptiv Disorder, and Attentio Disorder. a. The Staff Emergen Debriefing Form dated PM], documented the #8, and Staff #9, as in debriefing. b. On 07/08/2021 at 1 asked, "Did you assis #4] on 7/5?" She state included or document restraint of Client #4. 4. On 07/07/2021 at 4 Quality Risk was aske assisted in the restrai #4] included in the ES those who did assess thinking no, looking at "Since you observed you have been includ situation?" She stated not usually." 5. The facility Emerge policy, received from on 06/30/2021 at 10:00 Documentation for Em Interventions: 5. The the emergency safety Restraint Evaluation/F Activities: 1. The Dire each episode of restra 	ve Mood Dysregulation on Deficit Hyperactivity acy Safety Intervention d 07/05/2021 at 1430 [2:30 e signatures of LPN #1, Staff nvolved in the staff 10:01 AM, Staff #2 was at in the restraint on [Client ed, "Yes." Staff #2 was not ted as participating in the 4:16 PM, the Director of ed, "Were all the staff who nt for [Clients #2, #3, and SI documentation including sments?" She stated, "I'm t it." She was then asked, [Client #3's] restraint should ed since you assessed the d, "Should I have been? I'm ency Safety Intervention the Director of Quality Risk 04 AM, documented, "F. mergency Safety e name of staff involved in <i>r</i> situation H. Physical Performance Improvement ctor of Nursing shall assess aint documentation for Director of Nursing must	N 154					

Facility ID: 3012

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE COMF	SURVEY PLETED
		04L115	B. WING				C /08/2021
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRI	OGE OF FORREST CITY,	LLC			1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
N 155 N 155	ORDERS FOR USE of SECLUSION CFR(s): 483.358(i) The facility must mair emergency safety situ used, and their outcoor This ELEMENT is no Based on interview a failed to ensure a cum for each Emergency S for 4 (Clients #1, #,2, clients. The findings 1. Client #1 was admid diagnoses of Disruptin Disorder and Major D Recurrent, Severe Wi a. An Emergency Sa Packet was dated 6/2 c. An Emergency Sa Packet was dated 6/2 d. An Emergency Sa Packet was dated 6/2 d. An Emergency Sa Packet was dated 6/2 2. Client #2 was admid diagnoses of Major D Recurrent, Severe wit Disruptive Mood Dyst	OF RESTRAINT OR tain a record of each uation, the interventions mes at met as evidenced by: and record review, the facility nulative log was maintained Safety Interventions (ESIs) #3, and #4) of 4 sampled are: itted on 2/3/21 and had ve Mood Dysregulation repressive Disorder ith Out Psychosis. fety Intervention Justification 7/21. fety Intervention Justification 24/21. fety Intervention Justification 25/21. itted on 06/16/21 and had epressive Disorder thout Psychosis, and regulation Disorder. fety Intervention Justification		155			

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		04L115	B. WING _				C 08/2021
NAME OF PI	ROVIDER OR SUPPLIER		·		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODRIE	GE OF FORREST CITY,	LLC			1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
N 155	Continued From page	9	N [·]	155			
	b. An Emergency Sa Packet was dated 6/1	fety Intervention Justification 9/21.					
	c. An Emergency Sa Packet was dated 6/2	fety Intervention Justification 1/21.					
	d. An Emergency Sa Packet was dated 7/0	fety Intervention Justification 5/21.					
	diagnoses of Major D	hout Psychosis, and Rule					
	a. An Emergency Saf Packet was dated 6/3	ety Intervention Justification 0/21.					
	diagnoses of Disruptiv	tted on 04/26/2021 and had ve Mood Dysregulation on Deficit Hyperactivity					
	a. An Emergency Saf Packet was dated 7/0	ety Intervention Justification 5/21.					
		9:04 a.m., the Director of ed for the facility's ESI log					
	Director was asked, " does the facility keep stated, "Yes, we do ke then asked, "Does it i outcomes?" He answ indicate that in the ch	11:15 a.m., the Clinical Do you keep a log of ESIs, a cumulative log?" He eep track of them." He was nclude injuries? Other ered, "I don't know, we art." The Clinical Director of the June and July log at					

Facility ID: 3012

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	-	D HUMAN SERVICES MEDICAID SERVICES			F	FORM APPROVED B NO. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		04L115	B. WING _			C 07/08/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRID	OGE OF FORREST CITY,	LLC		1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 155	Continued From page	9 10	N 1	155		
	a copy of the cumulat While the surveyor wa the Director of Nursin 8. The log form "Rest the CEO on 07/08/20 include the outcome of any of the clients inclu- include information co that were used.	a asked to show the surveyor ive log for June and July. as in her office, she called g for the log. raint for May" received from 21 at 2:30 PM, did not of any of the restraints for uded on the log and did not oncerning the interventions				
N 188	CFR(s): 483.370(a) Within 24 hours after seclusion, staff involv intervention and the r face-to-face discussion include all staff involv when the presence of may jeopardize the w Other staff and the re guardian(s) may parti when it is deemed ap facility must conduct s language that is under by the resident's pare The discussion must and staff the opportur circumstances result seclusion and strateg	the use of the restraint or ed in an emergency safety esident must have a on. This discussion must ed in the intervention except a particular staff person ellbeing of the resident. sident's parent(s) or legal cipate in the discussion propriate by the facility. The such discussion in a rstood by the resident and nt(s) or legal guardian(s). provide both the resident nity to discuss the ng in the use of restraint or ies to be used by the staff, a that could prevent the	N 1	188		

Facility ID: 3012

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					CONSTRUCTION	(X3) DATE COMP	
		04L115	B. WING _				。 08/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WOODRIE	OGE OF FORREST CITY,	LLC			21 ALBERT ST DRREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
N 188	Continued From page	9 11	N 1	88			
	Based on record revi failed to ensure all sta Safety Intervention (E client debriefing for 4 of 4 sampled clients r findings are: 1. Client #1 was adm diagnoses Disruptive Disorder and Major D Recurrent, Severe wit a. An Emergency Sa Packet dated 6/17/21 Progress Note: Restra Prevent Assault/Injury Please Give Detailed Staff reported that R chairs and behind oth the chairs and could r observed on left side during holdDate & [] restraint: Date 6/17/21 A Patient Emergency Form, dated 6/17/21 a names of staff present documented. b. On 6/29/21 at 3:52 Nursing (DON) was a ESI on 6/17/21 starter the client debriefing I named, are there any	A titled on 2/3/21 and had Mood Dysregulation epressive Disorder thout Psychosis. fety Intervention Justification , documented, "Justification aint; Justification Criteria: (to selfPatient Behavior: Justification For Restraint: resident] was on top of er NS [Nurse's Station] on not control himself. R upon entry of this writer and] time actually placed in 1 Time 1750 [5:50 p.m.]" Intervention Debriefing at 1816 (6:16 p.m.), had no it or those excused P. p.m., the Director of sked, "[Client #1] had an d at 1758 (5:58 p.m.). On did not see where staff were staff names or signatures ated, "No, he filled out the					

Facility ID: 3012

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		04L115	B. WING				C 08/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
WOODRIE	OGE OF FORREST CITY,	LLC			521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 188	 c. An Emergency Sa Packet dated 6/21/21 "Justification Progress Justification Criteria: I selfPatient Behavio Justification For Rest to attack staff/began s Time Actually Placed Time: 1840 [6:40 p.m Emergency Interventi 6/21/21 at 1945 (7:45 "Names of Staff Pre Note Any Who Were Nurse (RN) #2]" Th signatures documented d. On 6/29/21 at 4:08 "On the ESI report on do you see where the signed the client debr RN signed it." The D of the staff involved in "No." e. An Emergency Sa Packet dated 6/24/21 documented, "Justific Restraint; Justification Assault/Injury to: Staff Behavior: Please Giv Restraint: throwing ch to self regulate" A II Intervention Debriefin 1735 (5:35 p.m.), doc Present for the Debrie Were Excused)" Th staff present or excus 	fety Intervention Justification at 6:40 p.m., documented, s Note: Restraint; Prevent Assault/Injury to: r: Please Give Detailed raint: Pt [Patient] attempted self harmingDate & [and] Into Restraint: 6/21/21 .]" The Patient on Debriefing Form, dated p.m.), documented, esent for the Debriefing (Also Excused): [Registered here were no other staff ed. 8 p.m., the DON was asked, 6/21 at 1840 (6:40 p.m.), e staff involved in the ESI iefing?" She stated, "The ON was asked, "Was that all in the ESI?" She stated, fety Intervention Justification at 1705 (5:05 p.m.) ation Progress Note: in Criteria: Prevent	N	188			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		04L115	B. WING				C 108/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
WOODRIE	GE OF FORREST CITY,	LLC			521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 188	 Packet dated 6/25/21 documented, "Justific Restraint; Justificatio Assault/Injury to: Staff Behavior: Please Give Restraint: Attempting Emergency Safety Int dated 6/25/21 at 2020 "Names of Staff Prese Note Any Who Were I signature was presen signatures of staff prese client debriefing. Client #2 was adm diagnoses Major Dep Severe Without Psych Dysregulation Disorder a. An Emergency Sa Packet dated 6/19/21 "Justification Progress Justification Criteria: I Self, Staff Member Give Detailed Justifica [Resident] was upset attempted to process aggressive and starte nurse's station, Staff then started kicking d safety" A Patient E Intervention Debriefin 1650 (8:50 p.m.), doc Present for the Debriefin Staff present or excuss b. An Emergency Sa 	at 1958 (7:58 p.m.), ation Progress Note: n Criteria: Prevent f MemberPatient e Detailed Justification For to hit staff" The Patient cervention Debriefing Form, 0 (8:20 p.m.) documented, ent for the Debriefing (Also Excused)" The RN's t. There were no other essent or excused for the witted on 6/16/21 and had ressive Disorder Recurrent hosis, and Disruptive Mood er. fety Intervention Justification at 7:10 p.m. documented, s Note: Restraint; Prevent Assault/Injury to: Patient Behavior: Please ation For Restraint: R about being at facility. Staff [with] R. R became more d kicking lid from cooler at attempted to redirect. R oor. ESI initiated for	N	188			

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/22/2021 MAPPROVED). 0938-0391
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		04L115	B. WING				C 08/2021
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
					1521 ALBERT ST		
WOODRIL	GE OF FORREST CITY,			1	FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 188	SelfPatient Behavio Justification For Restr himself [with] piece o Emergency Safety Int dated 6/19/21 at 2205 "Names of Staff Pre Note Any Who Were I signatures of staff pre client debriefing. c. An Emergency Saf Packet dated 6/21/21 "Justification Progress Justification Progress Justification Criteria: I Self, Staff MemberF Give Detailed Justifica [Patient] attacked staf Safety Intervention De 6/21/21 at 2354 (11:5 "Names of Staff Pre Note Any Who Were I were no other signatu excused for the client d. An Emergency Sa Packet dated 07/05/2 documented the signa Practical Nurse (LPN) member present for th staff documented as e e. On 07/07/2021 at 3 the 07/05/2021 ESI w Director of Quality Ris the viewing, to tell the staff members involve	s Note: Restraint; Prevent Assault/Injury to: r: Please Give Detailed aint: R threatening to kill f floor tile"A Patient ervention Debriefing Form, 5 (10:05 p.m.), documented, sent for the Debriefing (Also Excused)" There were no sent or excused for the fety Intervention Justification at 10:50 p.m., documented, s Note: Restraint; Prevent Assault/Injury to Patient Behavior: Please ation For Restraint: Pt ff" A Patient Emergency ebriefing Form, dated 4 p.m.) documented, esent for the Debriefing (Also Excused) [RN #2]" There ires of staff present or debriefing. fety Intervention Justification 021 at 1330 (1:30 p.m.) ature of one nurse, Licensed 0 #1, as the only staff ne client debriefing, with no excused. 3:31 p.m., the video from	N	188			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		04L115	B. WING			C 07/08/2021		
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODRIE	OGE OF FORREST CITY,	LLC			1521 ALBERT ST FORREST CITY, AR 72335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
N 188	Therapist #1 (monitor Licensed Practical Nu f. On 07/07/2021 at 4 Quality Risk was aske in the ESI on [Client # Justification Packet a debriefing?" She answ 3. On 6/29/21 at 4:16 "On the client debriefin present at the ESI sig debriefing?" She stat 4. Client #3 was adm diagnoses of Major D Recurrent, Severe wit out Attention Deficit H a. An Emergency Sa Packet dated 6/30/20 documented the signa member, Staff #11, as debriefing. b. On 07/07/2021 at was reviewed with the showed Staff #11 initi Staff #7, identified by is seen initially startin but then she proceed the area. c. On 07/07/2021, the was asked, "Looking it look like all the staff [Client #3] were includ debriefing?" She state	ing/counseling) and urse (LPN) #1 (monitoring). 4:16 p.m., the Director of ed, "Are all the staff involved #2] named on the ESI s being in the client wered "No." 6 p.m., the DON was asked, ing, should all staff that were in they were at the ted, "Yes." hitted on 03/19/2021 and had epressive Disorder thout Psychosis, and Rule lyperactivity Disorder. fety Intervention Justification 21 at 1:55 p.m., ature of RN #3 and one staff	N	188	3			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/22/2021 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	
		04L115	B. WING				C 08/2021
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODDI					1521 ALBERT ST		
WOODRIL	GE OF FORREST CITY,	LLC			FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
N 188	 She was also asked, been included in the orstaff debriefing?" She [Staff #7] only helped 5. Client #4 was adm diagnoses of Disruptive Disorder, and Attention Disorder. a. An Emergency Sa Packet dated 07/05/2 documented the signates as the only staff mem debriefing. Two staff mem debriefing. Two staff mem debriefing. b. On 7/08/21 at 10:00"Did you assist in the 7/5?" She stated, "Ye 6. The facility policy of Interventions, receive Quality Risk on 6/30/2 documented, "G. Pf Within 24 hours from all staff involved in the Intervention) will mee conference to discuss feedback to one anoth took placed and poss which could be used to 7. The facility Emergipolicy, received from Risk on 6/30/21 at 10 Physical Restraint Ev 	"Should [Staff #7] have debriefing, either the client or e answered, "I don't know for a second or two." hitted on 04/26/2021 and had we Mood Dysregulation on Deficit Hyperactivity fety Intervention Justification 021 at 1435 [2:35 p.m.], ature of one nurse, LPN #1, ber present for the client members, Staff #8 and Staff I as excused from the client 01 a.m., Staff #2 was asked, restraint on [Client #4] on s." for Emergency Safety d from the Director of 21 at 10:04 a.m., hysical Restraint Debriefing: the initiation of the restraint, e ESI (Emergency Safety t in a post-intervention s the event and offer her concerning events that ible alternate methods to change behaviors" ency Safety Intervention the Director of Quality and :04 a.m., documented, "H.	N	188	8		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		04L115	B. WING				。 08/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WOODRIE	GE OF FORREST CITY,	LLC			21 ALBERT ST DRREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 188	Nursing must resolve documentation"	sode of restraint mpleteness. The Director of any incomplete		188			
N 189	safety intervention, ar and administrative sta debriefing session tha review and discussion 483.370(b)(1) The em that required the inter	the use of restraint or olved in the emergency nd appropriate supervisory aff, must conduct a at includes, at a minimum, a n of -	N	189			
	Based on observation interview, the facility f involved in an Emerge (ESI) were present du 3 (Clients #2, #3 and sampled clients who h restrained. The findir 1. Client #2 was adm diagnoses of Major D Recurrent, Severe with Disruptive Mood Dysr a. A Staff Emergency Debriefing Form date	Failed to ensure all staff ency Safety Intervention uring the staff debriefing for #4) of 4 (Clients #1 - #4) had been physically figs are: witted on 06/16/21 and had epressive Disorder thout Psychosis, and regulation Disorder.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		04L115	B. WING			07	C 7/ 08/2021
NAME OF PI	ROVIDER OR SUPPLIER	L		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRIE	OGE OF FORREST CITY,	LLC			1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
N 189	Staff #5 as involved in b. On 07/07/21 at 3:3 07/05/2021 ESI was in Quality Risk. She was to tell the surveyor the members involved in #2, Staff #3, Staff #4, Therapist #1 (monitor Licensed Practical Nu c. On 07/07/21 at 4:1 Quality Risk was aske in the ESI on [Client # Justification Packet a debriefing?" She answ 2. Client #3 was adm diagnoses of Major D Recurrent, Severe wi out Attention Deficit H a. A Staff Emergency Debriefing Form date documented the signa (RN) #3 and the signa Staff #11, as involved b. On 07/07/21 at 9:0 Quality Risk was aske night [Staff #11] restra stated, "Yes ma'am. I and saw [Staff #11] h containment in an ES) #1, Staff #2, Staff #4, and h the staff debriefing. B1 p.m., the video from the reviewed with the Director of a asked during the viewing, e names of the staff the ESI. She named: Staff Staff #5, Staff #12, ing/counseling) and urse (LPN) #1 (monitoring). B6 p.m., the Director of ed, "Are all the staff involved #2] named on the ESI s being in the staff wered "No." hitted on 03/19/2021 and had epressive Disorder thout Psychosis, and Rule Hyperactivity Disorder. / Safety Intervention d 6/30/21 at 1:55 p.m., ature of Registered Nurse ature of one staff member, in the staff debriefing. D4 a.m., the Director of ed, "Were you there the ained [Client #3]? She happened to be passing by 	N	189			
	and the client was alr c. On 07/07/21 at 10	:30 am, the video of the ESI					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/22/2021 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		04L115	B. WING				C 1 08/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRIE	DGE OF FORREST CITY,	LLC			521 ALBERT ST ORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 189	 initiated on 06/30 at 1 reviewed with the Dires showed Staff #11 initia after Client #3 threw h Member's face. The V struggled with the Clie chair. Client #3 went f the floor on his botton him, and Staff #11 stat then proceeded to pic level, holding Client # and then appeared to with the client landing identified by the Direct initially starting to help she proceeded to remarea. d. On 07/07/21, the E asked, "Looking at the look like all the staff w [Client #3] were inclue stated, "[Staff #11] init was the nurse who masked, "Should [Staff the debriefing, either the debriefing?" She answ #7] only helped for a s 3. Client #4 was adm diagnoses of Disruption Disorder, and Attention Disorder. a. A Staff Emergency Debriefing Form dates p.m.], documented the 	740 [5:40 p.m.], was ector of Quality Risk. It ating an ESI on Client #3 his food tray into the Staff //ideo shows Staff #11 ent, who was sitting in a from the chair to sitting on in with his feet in front of anding behind him. Staff #11 ck Client #3 up to his chest f3 horizontally to the floor, o throw Client #3 to the floor, o on his left side. Staff #7, ctor of Quality Risk, is seen p with the restraint, but then hove all clients from the Director of Quality Risk was e documentation, does it who were in the ESI on ded in the debriefing?" She tiated the restraint, [RN #3] onitored." She was also #4] have been included in the client or staff wered, "I don't know[Staff second or two." hitted on 04/26/2021 and had ve Mood Dysregulation on Deficit Hyperactivity / Safety Intervention d 07/05/2021 at 1430 [2:30 e signature of one nurse, es of two staff members,	N	189			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		04L115	B. WING				C 08/2021
NAME OF PF	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODRID	GE OF FORREST CITY,	LLC			1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 189		:01 a.m., Staff #2 was asked restraint on [Client #4] on	N	189			
N 202	Within 24 hours from all staff involved in the Intervention) will mee conference to discuss feedback to one anoth took placed and poss which could be used to Physical Restraint Ev Improvement Activitie shall assess each epi documentation for con Nursing must resolve documentation" MEDICAL TREATMEI CFR(s): 483.372(c)	d from the Director of 21 at 10:04 a.m., hysical Restraint Debriefing: the initiation of the restraint, e ESI (Emergency Safety t in a post-intervention a the event and offer her concerning events that ible alternate methods to change behaviorsH. aluation/Performance s: 1. The Director of Nursing sode of restraint mpleteness. The Director of any incomplete	N	202	2		
	that results in an injur meet with supervisory	mergency safety intervention y to a resident or staff must v staff and evaluate the aused the injury and develop re injuries.					
	Based on observation failed to ensure staff i Safety Interventions (t met as evidenced by: n and interview, the facility nvolved in Emergency ESI) resulting in client rvisory staff to evaluate the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/22/2021 MAPPROVED D. 0938-0391
	DF DEFICIENCIES	DENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L115	B. WING				C 108/2021
NAME OF PF	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODRID	GE OF FORREST CITY,	LLC			1521 ALBERT ST		
			1		FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG N 202	Continued From page circumstances causin a plan to prevent injur #3 and #4) of 4 (Clien who were reviewed for 1. Client #3 was adm diagnoses of Major D Recurrent, Severe wit out Attention Deficit H a. The Emergency St Justification Packet de "Date & Time actua Restraint:6/30/21 Ti & Time removed from 1750 [5:50 PM]" b. The Emergency St Justification Packet R Assessment form date "Description of Injur injuries Description reported left side of b Upon assessment no rated pain a 7 out of 1 mouth) for pain" The Registered Nurse (RN c. On 07/07/2021 at ESI restraint was revi the ESI, Client #3 was on the floor on his left 2. Client #4 was adm diagnoses of Disruption	e 21 g the injury and to develop y in the future for 2 (Clients its #1-#4) sampled clients or ESI. The findings are: hitted on 03/19/2021 and had epressive Disorder thout Psychosis, and Rule lyperactivity Disorder. afety Intervention ated 6/30/21 documented, ly placed into me- 1745 [5:45 PM]Date r Restraint:6/30/21 Time- afety Intervention estraint/Seclusion Body ed 6/30/21 documented, ies (4-Pain) No of Treatment: R [Resident] ody hurt d/t [due to] ESI. abnormalities found. R I0. Ibuprofen given po (by e form was signed by N) #3.		202	DEFICIENCY)	ATE	
	Disorder. a. The Emergency S	afety Intervention					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE	
		04L115	B. WING				C 08/2021
NAME OF PI	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	1521 ALBERT ST		
WOODRIE	GE OF FORREST CITY,	LLC		F	FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 202	Justification Packet de documented, "Date Restraint:7/5/21 Tim Time removed from R 1420 [2:20 PM]" b. The Emergency Sc Justification Packet R Assessment form date indicated, signed by S Licensed Practical Nu "Description of injur Description of Treatm of] [decreased] ROM [Right] wrist - sent to eval [Evaluation]/tx [T c. The ER record dat documented, "Sprate and hand." d. On 07/08/2021 at a splint to the right wrist occurred during the re- squirming around on is pushing my arm ag wrist down, pushing m to dislocate my elbow 3. On 07/08/2021 at a Director was shown th Client #3 and Client # section on the body a follow up with staff fol He was asked, "Is sta meeting with supervise caused the injury and	ated 07/05/2021 & Time actually placed into ne- 1352 [1:52 PM]Date & Restraint:7/5/21 Time- afety Intervention Restraint/Seclusion Body ed 7/5/21, with no time Staff #9, Staff # 8, and urse (LPN) #1 documented, iesNo visible injuries. ent: [Resident] [Complains [Range of Motion] to Rt ER [Emergency Room] for reatment]" reatment]" read July 5, 2021 in of other part of right wrist 8:59 am, Client #4 had a t. He indicated the injury estraint, and stated, "I was the ground. Then [Staff #8] ainst the ground, pushing ny elbow up. He was trying or something" 2:30 pm, the Clinical he ESI documentation for f4, specifically the blank ssessment page regarding lowing a restraint with injury. off involved in an ESI sory staff to talk about what to talk about a plan for ry?" The Clinical Director	N	202			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		04L115	B. WING _				C 08/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRID	GE OF FORREST CITY,	LLC			521 ALBERT ST		
				F	ORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 202	Continued From page meetings when we re- we do it." He was ther in the ESI included?" supposed to? Are we up here when a kid co- later or pull them out of short staffing? We do meetings, that is how asked, "Is there any do that changed, or staff the two injuries?" He is show you what we have received prior to exit. EDUCATION AND TF CFR(s): 483.376(a) The facility must requi- education, training, and of - This STANDARD is in Based on interview a failed to ensure staff E Intervention (ESI) re-tr resulted in injury for 2 (Clients #1-#4) sampli reviewed for ESI. The 1. Client #3 was admin diagnoses of Major Do Recurrent, Severe witt out Attention Deficit H a. The Emergency Sa Justification Packet da "Date & Time actual	e 23 view restraints, that's how n asked, "Are staff involved He stated, "Are we supposed to call them back omplains of an injury a day of staff that would lead to it in administrative we do it here." He was then documentation of procedures training required following stated, "We have it, I can we." No documentation was RAINING irre staff to have ongoing nd demonstrated knowledge not met as evidenced by: und record review, the facility Emergency Safety training was done after ESI (Clients #3 and #4) of 4 led clients who were e findings are: nitted on 03/19/2021 and had epressive Disorder thout Psychosis, and Rule typeractivity Disorder. afety Intervention ated 6/30/21 documented, lly placed into	N 2	202		IE	
		ime- 1745 [5:45 PM]Date n Restraint:6/30/21 Time-					

Facility ID: 3012

If continuation sheet Page 24 of 27

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		04L115	B. WING				。 08/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRIE	GE OF FORREST CITY,	LLC			521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 214	Assessment form dat "Description of Injur injuries Description reported left side of b Upon assessment no rated pain a 7 out of 7 mouth) for pain" The Registered Nurse (RN c. On 07/06/2021 at "Did you follow up aft his left side to make s and he wasn't still in p injuries?" RN #3 state other nurse about the clock out time." d. On 07/07/2021 at ESI restraint was revi the ESI, Client #3 was on the floor on his left e. On 07/07/2021 at Quality Risk was aske documentation of a re Client #3's complaint he was given ibuprofe and Risk stated she v of Nursing for any oth The Director of Qualit documentation of a re July 8, 2021. 2. Client #4 was adm	afety Intervention Restraint/Seclusion Body ed 6/30/21 documented, ries (4-Pain) No of Treatment: R [Resident] ody hurt d/t [due to] ESI. abnormalities found. R 10. Ibuprofen given po (by e form was signed by N) #3. 4:13 pm, RN #3 was asked, er the ibuprofen? Reassess sure it [the ibuprofen] worked pain? Or showing other ed, "No Ma'am. I told the ESI. It was right before my 10:30 am, the video of the ewed and showed, during s thrown to the floor, landing t side. 11:00 am, the Director of	N	214			

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/22/2021 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	ING _			C
		04L115	B. WING				08/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRI	OGE OF FORREST CITY,	LLC			1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
N 214	 Disorder, and Attentic Disorder. a. The Emergency S Justification Packet d documented, "Date Restraint:7/5/21 Tim Time removed from F 1420 [2:20 PM]" b. The Emergency S Justification Packet R Assessment form dat indicated, signed by S Licensed Practical Nu "Description of injur Description of Treatm of] [decreased] ROM [Right] wrist - sent to eval [Evaluation]/tx [T c. The ER record dat documented, "Spra and hand." d. On 07/08/2021 at splint to the right wris occurred during the re squirming around on is pushing my arm ag wrist down, pushing m to dislocate my elbow e. On 07/06/2021 at Director was asked, " training since the inci #3]?" He answered, " incident with this staff 	afety Intervention ated 07/05/2021 & Time actually placed into ne- 1352 [1:52 PM]Date & Restraint:7/5/21 Time- afety Intervention Restraint/Seclusion Body ed 7/5/21, with no time Staff # 9, Staff # 8, and urse (LPN) #1 documented, tiesNo visible injuries. tent: [Resident] [Complains [Range of Motion] to Rt ER [Emergency Room] for treatment]" ted July 5, 2021 in of other part of right wrist 8:59 am, Client #4 had a t. He indicated the injury estraint, and stated, "I was the ground. Then [Staff #8] tainst the ground, pushing my elbow up. He was trying or something"	N	214			

If continuation sheet Page 26 of 27

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 07/22 FORM APPRO OMB NO. 0938-	OVED
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		04L115	B. WING _		_	C 07/08/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WOODRII	OGE OF FORREST CITY,	LLC		1521 ALBERT ST FORREST CITY, AR 723	335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		TION
N 214	training or any monitor restraints or reporting the complaint survey stated, "No." f. On 07/08/2021 at 2 was asked, "Is there a procedures that chan required following the	g." He was then asked, "Any oring done with staff on since this incident or since started last week?" He 2:30 pm, the Clinical Director any documentation of ged, or staff training two injuries?" He stated, bw you what we have." No	N 2				

Facility ID: 3012

If continuation sheet Page 27 of 27





Division of Provider Services & Quality Assurance P.O. Box 8059, Slot S404 Little Rock, AR 72203-8059 P: 501.320.6182 F: 501.682.6159

August 5, 2021

Charlotte Lockhart, Administrator Woodridge Of Forrest City, Llc 1521 Albert St Forrest City, AR 72335

Dear Ms. Lockhart:

On July 8, 2021, we conducted a Complaint survey at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and have approved your plan of correction and presume that you will achieve substantial correction by August 13, 2021.

We will be conducting a revisit of your facility to verify that substantial correction has been achieved and maintained.

If you have any questions, please contact your reviewer: Amanda Smith at 501-320-3963 or email to Amanda.Smith@dhs.arkansas.gov.

Sincerely,

Daubra Beaughter for

Amanda Smith, Reviewer DPSQA/Office of Long Term Care Survey & Certification Section

as

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Approved 8/5/2021 SGB

PRINTED: 07/22/2021
FORM APPROVED
OMB NO 0029 0204

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN		(X3) DAT	IO. 0938-03	
		04L115 B. WM		<u>ــــــ</u> ز		COMPLETED	
NAME OF PROVIDER OR SUPPLIER		D, 141140	STREET ADDRESS, CITY, STATE, ZIP CO		7/08/2021		
WOODRI	DGE OF FORREST CITY,	LLC		1521 ALBERT ST FORREST CITY, AR 72335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE	
N 000	Initial Comments		N 00	0			
	is an official, legal doo remain unchanged ex correction, correction space. Any discrepan citation(s) will be repo Office (RO) for referra Inspector General (OI information is inadvert provider/supplier, the should be notified imm	G) for possible fraud. If tently changed by the State Survey Agency (SA) nediately. compliance with §483, ns of Participation for I Treatment Center. as conducted from					
	Complaint #AR000267 Complaint #AR000268 Complaint #AR000268 or in part, with deficien and N214. Complaint #AR000268 or in part, with deficien and N214. PROTECTION OF RE CFR(s): 483.356(a)(3)	must not result in harm or	N 128	3			
	not occur during an Em	, interview and record d to ensure an injury did nergency Safety					
Ch	alletter 9	POUER REPRESENTATIVE'S SIGNATURE		CED excused from correcting providing it is o	8-	(X6) DATE	

other safeguards provide sufficient protection to the patients. () 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04L115		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (A. BUILDING	C OMB NO: 0938-0 (X3) DATE SURVEY COMPLETED		
		B. WING	07/08/2021			
	ROVIDER OR SUPPLIER		152	REET ADDRESS, CITY, STATE, ZIP CODE 21 ALBERT ST DRREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
N 128	Intervention (ESI) inv 2 (Clients #3 and #4) #4) sampled clients of findings are: 1. Client #3 was adm diagnoses of Major D Recurrent, Severe wi out Attention Deficit F a. The Emergency Sa Justification Packet of "Date & Time actua Restraint:6/30/21 T & Time removed from 1750 [5:50 PM]" b. The Emergency Sa Justification Packet F Assessment form dat "Description of Injut injuries Description reported left side of b Upon assessment nor rated pain a 7 out of mouth) for pain" Th Registered Nurse (RI c. On 07/06/2021 at 4 "Did you follow up aff his left side to make s and he wasn't still in injuries?" RN #3 state other nurse about the clock out time."	olving a physical restraint for of 4 (Clients #1, #2, #3 and eviewed for ESI. The itted on 03/19/2021 and had eepressive Disorder thout Psychosis, and Rule typeractivity Disorder. afety Intervention fated 6/30/21 documented, illy placed into ime- 1745 [5:45 PM]Date in Restraint/Seclusion Body ted 6/30/21 documented, ries (4-Pain) No of Treatment: R [Resident] ody hurt d/t [due to] ESI. e abnormalities found. R 10. Ibuprofen given po (by e form was signed by N) #3. 4:13 pm, RN #3 was asked, ter the ibuprofen? Reassess sure it [the ibuprofen] worked pain? Or showing other ed, "No ma'am. I told the e ESI. It was right before my 10:30 am, the video of the iewed and showed, during	N 128	Staff responsible for improper ES technique resulting in resident inj client #3 was suspended immedi subsequently terminated on 7/6/2 CEO. Staff responsible for improj technique resulting in resident inj client #4 was suspended immedi subsequently terminated on 7/7/2 CEO. This staff member was also instructor and program manager. Due to the nature of these incide the potential to impact all current residents, all direct care staff con refresher on our chosen Emerge Behavior Management technique with return demonstration of corr technique and use of de-escalati techniques with our sister facilitie on 7/26/21 and 7/31/21. (We hav members out of sick leave that w training prior to working directly w residents). Re-education will be completed by company Nurse Executive wi DON/ Nurse Executive to review ESI packets with an accompany physician order for completeness For ongoing compliance, DON/N Executive will report compliance in morning administration meetir follow up on any delinquent documentation. It will also be rep monthly in Quality/Patient Safety	ury for ately and 21 by per ESI ury for ately and 21 by 5 our ESI on ts and and future appleted a ancy 6 (SAMA) ect on s' trainers e 3 staff ill receive with by 8/7/21 th current 100% of ng s. lurse rate daily ng and borted	8/7/21

ND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA	NO: 0938-0 TE SURVEY MPLETED		
04L115		B. WING	a	C 07/08/2021				
WOODRIDGE OF FORREST CITY, LLC			15	STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST FORREST CITY, AR 72335				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X\$) COMPLET DATE		
	 on the floor on his le e. On 07/07/2021 at Quality Risk was ask documentation of a r Client #3's complaint he was given ibuprof and Risk stated she of Nursing for any ott The Director of Quali documentation of a re July 8, 2021. 2. Client #4 was adm diagnoses of Disrupti Disorder, and Attention Disorder, and Attention Disorder. a. The Emergency Sa Justification Packet d documented, "Date Restraint:7/5/21 Tim Time removed from R 1420 [2:20 PM]" b. The Emergency Sa Justification Packet R Assessment form date indicated, signed by S Licensed Practical Nu "Description of injuri Description of Treatmo of] [decreased] ROM [Right] wrist - sent to B 	ft side. 11:00 am, the Director of ked if there was any reassessment concerning to f pain to the left side after fen. The Director of Quality would check with the Director her available documentation. Ity Risk did not provide any eassessment prior to exit on itted on 04/26/2021 and had ive Mood Dysregulation on Deficit Hyperactivity afety Intervention ated 07/05/2021 & Time actually placed into ne- 1352 [1:52 PM]Date & Restraint:7/5/21 Time- afety Intervention testraint/Seclusion Body ed 7/5/21, with no time Staff # 9, Staff # 8, and trse (LPN) #1 documented, iesNo visible injuries. ent: [Resident] [Complains [Range of Motion] to Rt ER [Emergency Room] for reatment]"	N 128					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04L115			,		ATE SURVEY
		B. WING		C 07/08/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	V1100/2021
			1	1521 ALBERT ST	
WOODRIE	GE OF FORREST CITY,	LLC		FORREST CITY, AR 72335	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		N 128	3	n Ny Ig
	Based on record revi failed to ensure a phy restraint was docume	t met as evidenced by: ew and interview, the facility rsician's order for a chemical inted in the client's record for		Meeting.	
	the use of a chemical 1. Client #2 was adm diagnoses Major Dep	pled clients who required restraint. The findings are: hitted on 6/16/21 and had ressive Disorder Recurrent chosis, and Disruptive Mood			

		& MEDICAID SERVICES	- r		OMB NO. 0938	ROVE <u>8-039</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	COMPLETED		
		04L115	B. WING		С		
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	07/08/202	<u>.1</u>	
WOODRII	DGE OF FORREST CIT	Y, LLC		1521 ALBERT ST FORREST CITY, AR 72335			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPL THE APPROPRIATE DA	LETION	
N 143	Continued From pa		N 14	13			
	Packet dated 6/21// "Justification Prog Justification Criteria Self Staff Membe Give Detailed Justif [Patient] attacked s Benadryl- Dosage: [intramuscular] Me Thorazine- Dosage Administering Med Med Administered: was no Physician's Thorazine documer b. On 6/29/21 at 3: Nursing (DON) was Physician's order fo	Safety Intervention Justification 21 documented, gress Note: Restraint a: Prevent Assault/Injury to: rPatient Behavior: Please fication For Restraint: Pt taffMedication Administered: 25 mg (milligrams); Route: IM dication Adminstered: : 25 mg; Route: IM; Nurse [Medication]: [RN #2]; Time In: 2335 [11:35 p.m.]" There order for the Benadryl and ted in the client's chart. 46 p.m., the Director of asked, "Did you see the r the Thorazine and Benadryl stated, "No, it's not there."					
N 154	received from the D 6/30/21 at 10:04 a.m Physical Restraint: physician is required restraint or chemica Restraint Evaluation Activities: 1. The Dir each episode of rest completeness. The resolve any incompl	Safety Intervention policy irector of Quality Risk on h., documented, "B. 1. A written order from the d for the use of a physical I restraintH. Physical /Performance Improvement ector of Nursing shall assess traint documentation for Director of Nursing must ete documentation" COF RESTRAINT OR	N 154				
		st include] the name of staff					

STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		04L115	B. WING	WING		C 7/08/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		100/2021	
WOODRI	DGE OF FORREST CITY	, LLC		1521 ALBERT ST FORREST CITY, AR 72335			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION		
PREFIX	(EACH DEFICIEN(CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	Should be	(X5) COMPLETIC DATE	
N 154	Continued From pag	e 5	N 154				
		gency safety intervention.	IN 454				
	 This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the names of all staff physically participating in or providing assessments during an Emergency Safety Intervention (ESI) were documented in the client's record for 3 (Clients #2, #3, and #4) of 4 (Clients #1- #4) sampled clients reviewed for ESI. The findings are: 1. Client #3 was admitted on 03/19/2021 and had diagnoses of Major Depressive Disorder Recurrent, Severe without Psychosis, and Rule out Attention Deficit Hyperactivity Disorder. a. The Emergency Safety Intervention 			Due to the nature of these incid potential to impact all current ar residents, all direct care staff wi education by 8/7/21 from compa Executive on staff debriefing pro- required documentation in the E justification packet. Director of C or designated Leadership memi- review camera footage if availab of ESI for necessity and use of C technique. Member will then auc justification packets to ensure a involved in ESI were involved in and listed on packet.	nd future III receive any Nurse Decedures and ESI Quality Risk ber will ble on 100% correct dit 100% of II employees	8/7/202	
	Justification Packet d document the Directo providing an assessm physically participatin	ient, or Staff #7 as					
	Quality Risk was aske night [Staff #11] restra stated, "Yes ma'am. I and saw [Staff #11] ha in an ESI. I stopped b	9:04 AM, the Director of ed, "Were you there the ained [Client #3]?" She happened to be passing by ad [Client #3] in containment y to see if he was positioned in there, and the client was					
	initiated on 06/30/21 a reviewed with the Dire showed Staff #11 initia						

PRINTED: 07/22/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 04L115 B. WING 07/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST WOODRIDGE OF FORREST CITY, LLC FORREST CITY, AR 72335 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION 1D (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 154 Continued From page 6 N 154 chair. Client #3 went from the chair to sitting on the floor on his bottom with his feet in front of him, and Staff #11 standing behind him. Staff #11 then proceeded to pick Client #3 up to his chest level, holding Client #3 horizontally to the floor, and then appeared to throw Client #3 to the floor, with the client landing on his left side. Staff #7, identified by the Director of Quality Risk, is seen initially starting to help with the restraint, but then she proceeded to remove all clients from the area. 2. Client #2 was admitted on 06/16/21 and had diagnoses Major Depressive Disorder Recurrent, Severe without Psychosis, and Disruptive Mood Dysregulation Disorder. a. The Emergency Safety Intervention Justification Packet dated 07/05/2021 did not document Staff #5 and Staff #10 assisted in the restraint, or Therapist #1 was monitoring/counseling during the ESI. b. On 07/07/2021 at 3:31 PM, the video of the ESI on 07/05/2021 was reviewed with the Director of Quality Risk. She was asked during the viewing, to provide the names of the staff members involved in the ESI. She named: Staff #2, Staff #3, Staff #4, Staff #5, Staff #10, Therapist #1 (monitoring/counseling) and Licensed Practical Nurse (LPN) #1 (monitoring). c. On 07/07/2021 at 4:16 PM, the Director of Quality Risk was asked, "Are all the staff involved in the ESI on [Client #2] named on the ESI Justification Packet as being part of the ESI?" She answered "No." 3. Client #4 was admitted on 04/26/2021 and had

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 7 of 27

PRINTED: 07/22/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED С 04L115 B. WING 07/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST WOODRIDGE OF FORREST CITY, LLC FORREST CITY, AR 72335 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 7 N 154 N 154 diagnoses of Disruptive Mood Dysregulation Disorder, and Attention Deficit Hyperactivity Disorder. a. The Staff Emergency Safety Intervention Debriefing Form dated 07/05/2021 at 1430 [2:30 PM], documented the signatures of LPN #1, Staff #8, and Staff #9, as involved in the staff debriefing. b. On 07/08/2021 at 10:01 AM, Staff #2 was asked, "Did you assist in the restraint on [Client #4] on 7/5?" She stated, "Yes." Staff #2 was not included or documented as participating in the restraint of Client #4. 4. On 07/07/2021 at 4:16 PM, the Director of Quality Risk was asked, "Were all the staff who assisted in the restraint for [Clients #2, #3, and #4] included in the ESI documentation including those who did assessments?" She stated, "I'm thinking no, looking at it." She was then asked, "Since you observed [Client #3's] restraint should you have been included since you assessed the situation?" She stated, "Should I have been? I'm not usually." 5. The facility Emergency Safety Intervention policy, received from the Director of Quality Risk on 06/30/2021 at 10:04 AM, documented, "...F. Documentation for Emergency Safety Interventions:... 5. The name of staff involved in the emergency safety situation ... H. Physical Restraint Evaluation/Performance Improvement Activities: 1. The Director of Nursing shall assess each episode of restraint documentation for completeness. The Director of Nursing must resolve any incomplete documentation ... "

FORM CMS-2567(02-99) Previous Versions Obsciele

Facility ID: 3012

If continuation sheet Page 8 of 27

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIDI	E CONSTRUCTION		<u>D. 0938-03</u>
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	E SURVEY PLETED
		04L115	B. WNG			C (08/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	P CODE 07/08/2021	
WOODRI	OGE OF FORREST CITY	, LLC		1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES 2Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
N 155	Continued From pag	e 8	N 155			
N 155			N 155			
				Perimeter Behavioral of Forrest City of electronic Incident Reporting system to track the incident log. Director of Q Risk and alternate member will be ref VR of Quality and Risk on entry into	(Verge) uality rained by	8/13/202
	Based on interview a failed to ensure a cur for each Emergency 3	ot met as evidenced by: and record review, the facility nulative log was maintained Safety Interventions (ESIs) #3, and #4) of 4 sampled are:		VP of Quality and Risk on entry into N reporting features on 8/6/21. All incide be caught up with entry within 1 week training (by 8/13/21). For ongoing cor Director of Quality Risk or designee w reconcile the electronic log weekly. M will print monthly log and file in Incide binder.	ents will from npliance, vill ember	
	a. An Emergency Sa Packet was dated 6/1	fety Intervention Justification 7/21.				
	 b. An Emergency Sat Packet was dated 6/2 	fety Intervention Justification 1/21.				
	 c. An Emergency Safety Intervention Justification Packet was dated 6/24/21. d. An Emergency Safety Intervention Justification Packet was dated 6/25/21. 					
	2. Client #2 was admit diagnoses of Major De Recurrent, Severe wit Disruptive Mood Dysre	hout Psychosis, and				
	a. An Emergency Saf Packet was dated 6/19	ety Intervention Justification				

Event ID: CKCN11

Facility ID: 3012

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		MB NO, 0938-0 3) DATE SURVEY	
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER:		3	1	COMPLETED	
		04L115	B. WNG			C 07/08/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	CTIGGINGET	
WOODRIE	GE OF FORREST CIT	Y, LLC		1521 ALBERT ST FORREST CITY, AR 72335			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIE) REGULATORY O	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET	
N 155	Continued From pa	ge 9	N 15	5			
	b. An Emergency S Packet was dated 6	Safety Intervention Justification					
	c. An Emergency S Packet was dated 6	Safety Intervention Justification					
į	 d. An Emergency Safety Intervention Justification Packet was dated 7/05/21. 3. Client #3 was admitted on 03/19/2021 and had diagnoses of Major Depressive Disorder Recurrent, Severe without Psychosis, and Rule out Attention Deficit Hyperactivity Disorder. 						
:							
	a. An Emergency Sa Packet was dated 6	afety Intervention Justification /30/21.					
	diagnoses of Disrup	nitted on 04/26/2021 and had tive Mood Dysregulation ion Deficit Hyperactivity					
	a. An Emergency Sa Packet was dated 7/	afety Intervention Justification /05/21.					
	5. On 07/06/2021 at Quality Risk was asl for June and July.	9:04 a.m., the Director of ked for the facility's ESI log					
	Director was asked, does the facility keep stated, "Yes, we do h then asked, "Does it outcomes?" He answ indicate that in the cl	11:15 a.m., the Clinical "Do you keep a log of ESIs, o a cumulative log?" He keep track of them." He was include injuries? Other vered, "I don't know, we hart." The Clinical Director y of the June and July log at					

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
		04L115	B. WING			07	C 7/08/2021
NAME OF F	ROVIDER OR SUPPLIER		_	:	STREET ADDRESS, CITY, STATE, ZIP CODE		100/2021
WOODRI	DGE OF FORREST CITY,			1	1521 ALBERT ST		
	DOE OF FORREST CITT,				FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	LAN OF CORRECTION (COMP IVE ACTION SHOULD BE COMP ED TO THE APPROPRIATE D	
N 155			N	155			
	a copy of the cumulati While the surveyor was the Director of Nursing 8. The log form "Restrict the CEO on 07/08/202 include the outcome of any of the clients inclu- include information co- that were used. 9. On 07/08/2021, at the June and/or July had the POST INTERVENTION CFR(s): 483.370(a) Within 24 hours after the seclusion, staff involves intervention and the re- face-to-face discussion include all staff involves when the presence of may jeopardize the we Other staff and the res guardian(s) may partic when it is deemed app facility must conduct su language that is under by the resident's parent The discussion must pl and staff the opportunit circumstances resulting	asked to show the surveyor ive log for June and July. as in her office, she called g for the log. Taint for May" received from 21 at 2:30 PM, did not of any of the restraints for ided on the log and did not incerning the interventions the time of exit, no log for been provided. N DEBRIEFINGS the use of the restraint or red in an emergency safety sident must have a h. This discussion must id in the intervention except a particular staff person Ilbeing of the resident. ident's parent(s) or legal ipate in the discussion ropriate by the facility. The uch discussion in a stood by the resident and t(s) or legal guardian(s). rovide both the resident ty to discuss the g in the use of restraint or is to be used by the staff, that could prevent the	N	188	Due to the nature of these incidents and potential to impact all current and future residents, all direct care staff will receive education by company Nurse Executive 8/7/21 on staff debriefing procedures ar required documentation in the ESI justification packet. For ongoing complia Director of Quality Risk or designated Leadership member will review camera footage if available on 100% of ESI for necessity and use of correct technique. Member will then audit 100% of justifica packets to ensure all employees involve ESI were involved in debriefing and liste packet.	e e by nd ance, ance,	8/7/2021

FORM CMS-2567(02-99) Previous Versions Obsclete

Event ID: CKCN11

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		MEDICAID SERVICES			OMB NO. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		04L115	B. WING		C		
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, Z	07/08/2021		
WOODRIE	GE OF FORREST CITY,	LLC		1521 ALBERT ST FORREST CITY, AR 72335			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE		
N 188	Continued From page	e 11	N 18	38			
	Based on record revi failed to ensure all sta Safety Intervention (E	not met as evidenced by: iew and interview, the facility aff involved in an Emergency SI) were present during the (Clients #1 #2, #3 and #4) eviewed for ESI. The					
	1. Client #1 was admitted on 2/3/21 and had diagnoses Disruptive Mood Dysregulation Disorder and Major Depressive Disorder Recurrent, Severe without Psychosis.						
	Packet dated 6/17/21, Progress Note: Restra Prevent Assault/Injury Please Give Detailed Staff reported that R [r chairs and behind othe the chairs and could n observed on left side r during holdDate & [a restraint: Date 6/17/21 A Patient Emergency I	upon entry of this writer and] time actually placed in Time 1750 [5:50 p.m.]" Intervention Debriefing t 1816 (6:16 p.m.), had no					
	b. On 6/29/21 at 3:52 Nursing (DON) was as ESI on 6/17/21 started the client debriefing I d named, are there any s	ked, "[Client #1] had an at 1758 (5:58 p.m.). On lid not see where staff were staff names or signatures ted, "No, he filled out the					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING			MPLETED		
		04L115	B. WING		C 07/08/2021			
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP C	ODE	1100/2021		
NOODBIE	GE OF FORREST CITY		ſ	521 ALBERT ST				
			F	ORREST CITY, AR 72335				
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETIC		
N 188	Continued From pag	e 12	N 188		19			
[afety Intervention Justification	11100					
	Packet dated 6/21/2	1 at 6:40 p.m., documented,						
	"Justification Progres	ss Note: Restraint:						
	Justification Criteria:	Prevent Assault/Injury to:						
ľ	selfPatient Behavio	or: Please Give Detailed				1		
	Justification For Resi	traint: Pt [Patient] attempted						
	to attack staff/began	self harmingDate & [and]		5				
	Time Actually Placed Into Restraint: 6/21/21 Time: 1840 [6:40 p.m.]" The Patient Emergency Intervention Debriefing Form, dated 6/21/21 at 1945 (7:45 p.m.), documented, "Names of Staff Present for the Debriefing (Also							
	Note Any Who Were	Excused): [Registered						
		here were no other staff						
	signatures document	ed.						
	d. On 6/29/21 at 4:08	8 p.m., the DON was asked,						
	"On the ESI report or	n 6/21 at 1840 (6:40 p.m.),						
	do you see where the	e staff involved in the ESI						
	signed the client debr	riefing?" She stated, "The						
	RN signed it." The D	ON was asked, "Was that all						
	of the staff involved in	the ESI?" She stated,						
	"No."							
		fety Intervention Justification						
	Packet dated 6/24/21	at 1/05 (5:05 p.m.)						
	documented, "Justific Restraint: Justification		5					
	Restraint; Justification							
/ i	Assault/Injury to: Staf	MemberPatient Detailed Justification For						
		airs, hitting [at] staff-unable						
'	o self requiate " ∆ ⊑	Patient Emergency Safety						
i	ntervention Dehriefing	g Form, dated 6/24/21 at						
	1735 (5:35 p.m.). doc	umented, "Names of Staff						
F	Present for the Debrie	fing (Also Note Any Who						
V	Nere Excused) " Th	ere were no signatures of						
s	taff present or excuse	ed for the client debriefing.						
	An Emergency Safe							

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	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTIO			'E SURVEY IPLETED
		04L115	B. WNG				С
NAME OF PI	ROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CODE		7/08/2021
				1521 ALBERT S			
WOODRID	GE OF FORREST CITY,	LLC	j	FORREST CIT			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			ROVIDER'S PLAN OF COR	BEOTION	
PREFIX TAG	K (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		CORRECTIVE ACTION S S-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 188	Continued From page		N 1	38			
	Packet dated 6/25/21	at 1958 (7:58 p.m.),					
	documented, "Justific Restraint; Justificatio	ation Progress Note:					
	Assault/Injury to: Staf						
		Detailed Justification For					
		to hit staff" The Patient					
		ervention Debriefing Form,					
	dated 6/25/21 at 2020	(8:20 p.m.) documented,					
		ent for the Debriefing (Also					
		Excused)" The RN's					
	signature was preser	sent or excused for the					
	client debriefing.	sent of excused for the					
		itted on 6/16/21 and had					
	diagnoses Major Depr	essive Disorder Recurrent					
	Dysregulation Disorde	osis, and Disruptive Mood r.					
	a. An Emergency Saf	ety Intervention Justification					
	"Justification Progress	at 7:10 p.m. documented,					
	Justification Criteria F	Prevent Assault/Injury to:					
	Self, Staff Member F	atient Behavior: Please					
	Give Detailed Justifica	tion For Restraint: R					
	[Resident] was upset a	about being at facility. Staff					
-	attempted to process [with] R. R became more					
		kicking lid from cooler at					
	then started kicking do	attempted to redirect. R					3
	safety" A Patient En						
	Intervention Debriefing	Form, dated 6/19/21 at		· ·			
· ·	1650 (8:50 p.m.), docu	mented, "Names of Staff					
		ing (Also Note Any Who					
		ere were no signatures of					
	sian present of excuse	d for the client debriefing.					
		ety Intervention Justification at 9:35 p.m., documented,					
1 CMS-2567(02-99) Previous Versions Obsol	ete Event ID: CKCM	J11 E	acility ID: 3012			Baga 14 of 27

Facility ID: 3012

PRINTED: 07/22/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED С 04L115 B. WING 07/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1521 ALBERT ST** WOODRIDGE OF FORREST CITY, LLC FORREST CITY, AR 72335 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 188 Continued From page 14 N 188 "Justification Progress Note: Restraint; Justification Criteria: Prevent Assault/Injury to: Self...Patient Behavior: Please Give Detailed Justification For Restraint: R threatening to kill himself (with) piece of floor tile ... "A Patient Emergency Safety Intervention Debriefing Form, dated 6/19/21 at 2205 (10:05 p.m.), documented, "...Names of Staff Present for the Debriefing (Also Note Any Who Were Excused) ... " There were no signatures of staff present or excused for the client debriefing. c. An Emergency Safety Intervention Justification Packet dated 6/21/21 at 10:50 p.m., documented, "Justification Progress Note: Restraint; Justification Criteria: Prevent Assault/Injury to Self, Staff Member...Patient Behavior: Please Give Detailed Justification For Restraint: Pt [Patient] attacked staff ... " A Patient Emergency Safety Intervention Debriefing Form, dated 6/21/21 at 2354 (11:54 p.m.) documented, "...Names of Staff Present for the Debriefing (Also Note Any Who Were Excused) [RN #2] ... " There were no other signatures of staff present or excused for the client debriefing. d. An Emergency Safety Intervention Justification Packet dated 07/05/2021 at 1330 (1:30 p.m.) documented the signature of one nurse, Licensed Practical Nurse (LPN) #1, as the only staff member present for the client debriefing, with no staff documented as excused. e. On 07/07/2021 at 3:31 p.m., the video from the 07/05/2021 ESI was reviewed with the Director of Quality Risk. She was asked during the viewing, to tell the surveyor the names of the staff members involved in the ESI. She named: Staff #2, Staff #3, Staff #4, Staff #5, Staff #12,

Facility ID: 3012

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED С 04L115 B. WING 07/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST WOODRIDGE OF FORREST CITY, LLC FORREST CITY, AR 72335 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 15 N 188 N 188 Therapist #1 (monitoring/counseling) and Licensed Practical Nurse (LPN) #1 (monitoring). f. On 07/07/2021 at 4:16 p.m., the Director of Quality Risk was asked, "Are all the staff involved in the ESI on [Client #2] named on the ESI Justification Packet as being in the client debriefing?" She answered "No." 3. On 6/29/21 at 4:16 p.m., the DON was asked. "On the client debriefing, should all staff that were present at the ESI sign they were at the debriefing?" She stated, "Yes." 4. Client #3 was admitted on 03/19/2021 and had diagnoses of Major Depressive Disorder Recurrent, Severe without Psychosis, and Rule out Attention Deficit Hyperactivity Disorder. a. An Emergency Safety Intervention Justification Packet dated 6/30/2021 at 1:55 p.m., documented the signature of RN #3 and one staff member, Staff #11, as present in the client debriefing. b. On 07/07/2021 at 10:30 am, a video of the ESI was reviewed with the Director of Quality Risk. It showed Staff #11 initiating an ESI on Client #3. Staff #7, identified by the Director of Quality Risk, is seen initially starting to help with the restraint, but then she proceeded to remove clients from the area. c. On 07/07/2021, the Director of Quality Risk was asked, "Looking at the documentation, does it look like all the staff who were in the ESI on [Client #3] were included in the client and staff debriefing?" She stated, "[Staff #11] initiated the restraint, [RN #3] was the nurse who monitored." FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: CKCN11 Facility ID: 3012

PRINTED: 07/22/2021

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MERTION	E CONSTRUCTION		B NO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING) DATE SURVEY COMPLETED
		04L115	04L115 B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	IDE	07/08/2021
WOODRIE	GE OF FORREST CI	TY, LLC		1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIE REGULATORY	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE	COMPLETIC DATE
N 188	Continued From pa	age 16	N 188			
	She was also aske	ed, "Should [Staff #7] have				
	been included in th	ne debriefing, either the client or				
	staff debriefing?" S [Staff #7] only hein	She answered, "I don't know ed for a second or two."				
		dmitted on 04/26/2021 and had				
		ptive Mood Dysregulation ntion Deficit Hyperactivity				
	Disorder.					
i	a. An Emergency Safety Intervention Justification Packet dated 07/05/2021 at 1435 [2:35 p.m.],					
		gnature of one nurse, LPN #1, ember present for the client				
		iff members, Staff #8 and Staff				
	#9, were document debriefing.	ted as excused from the client				
	b. On 7/08/21 at 1	0:01 a.m., Staff #2 was asked,				
	"Did you assist in tl 7/5?" She stated, "	he restraint on [Client #4] on Yes."				
	6. The facility polic	y for Emergency Safety				
		ved from the Director of				
	Quality Risk on 6/3	0/21 at 10:04 a.m., Physical Restraint Debriefing:				
	Within 24 hours from	m the initiation of the restraint,				
		the ESI (Emergency Safety				
	Intervention) will me	eet in a post-intervention				
		iss the event and offer				
		other concerning events that ssible alternate methods				
		d to change behaviors"				
		rgency Safety Intervention				
		n the Director of Quality and				
		10:04 a.m., documented, "H. Evaluation/Performance				
	i nyaicai nestiaifit E	VANJANDUZEBUNUISIOS	1			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		04145			C
NAME OF P	ROVIDER OR SUPPLIER	04L115	8. WNG		07/08/2021
				STREET ADDRESS, CITY, STATE, ZIP CODE	
WOODRII	DGE OF FORREST CITY	, LLC		1521 ALBERT ST FORREST CITY, AR 72335	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET
N 188	Continued From pag	e 17	N 18		
	shall assess each ep				
	documentation for co Nursing must resolve	mpleteness. The Director of			
N 189	documentation" POST INTERVENTION CFR(s): 483.370(b)	ON DEBRIEFINGS	N 189	Due to the nature of these incidents potential to impact all current and fur residents, all direct care staff will re	uture 8/7/20
	seclusion, all staff inv safety intervention, a and administrative st debriefing session that review and discussion	at includes, at a minimum, a n of - nergency safety situation		education by company Nurse Exec 8/7/21 on staff debriefing procedure required documentation in the ESI justification packet. For ongoing co Director of Quality Risk or designat Leadership member will review can footage if available on 100% of ESI necessity and use of correct technic Member will then audit 100% of jus packets to ensure all employees in	utive by es and mpliance, ed nera for for que. tification
	discussion of the pred to the intervention;	cipitating factors that led up		ESI were involved in debriefing and packet.	listed on
	Based on observation interview, the facility f involved in an Emerger (ESI) were present du	ailed to ensure all staff ency Safety Intervention uring the staff debriefing for #4) of 4 (Clients #1 - #4) nad been physically			
	1. Client #2 was admitted on 06/16/21 and had diagnoses of Major Depressive Disorder Recurrent, Severe without Psychosis, and Disruptive Mood Dysregulation Disorder.				
	a. A Staff Emergency Debriefing Form dated p.m.], documented the	Safety Intervention 1 07/05/2021 at 1330 [1:30 9 signatures of Licensed			

OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER: 04L115 OF DEFICIENCIES E PRECEDED BY FULL TIFYING INFORMATION) aff #2, Staff #4, and off debriefing. the video from the d with the Director of during the viewing, s of the staff She named: Staff	1521		
OF DEFICIENCIES E PRECEDED BY FULL TIFYING INFORMATION) aff #2, Staff #4, and aff debriefing. the video from the d with the Director of during the viewing, s of the staff	ID PREFIX TAG	ALBERT ST REST CITY, AR 72335 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIM	07/08/2021
E PRECEDED BY FULL (IFYING INFORMATION) aff #2, Staff #4, and iff debriefing. the video from the d with the Director of during the viewing, s of the staff	ID PREFIX TAG	ALBERT ST REST CITY, AR 72335 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIM	(X5) E COMPLETIC
E PRECEDED BY FULL (IFYING INFORMATION) aff #2, Staff #4, and iff debriefing. the video from the d with the Director of during the viewing, s of the staff	ID PREFIX TAG	REST CITY, AR 72335 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI)	E COMPLETIC
E PRECEDED BY FULL (IFYING INFORMATION) aff #2, Staff #4, and iff debriefing. the video from the d with the Director of during the viewing, s of the staff	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	E COMPLETIC
If debriefing. the video from the d with the Director of during the viewing, s of the staff	N 189		
 b, Staff #12, inseling) and N) #1 (monitoring). the Director of all the staff involved ed on the ESI in the staff lo." 03/19/2021 and had e Disorder ychosis, and Rule vity Disorder. Intervention 1 at 1:55 p.m., Registered Nurse in staff member, aff debriefing. the Director of e you there the ent #3]? She ed to be passing by t #3], in ed by to see if he se was in there, 			
	all the staff involved ad on the ESI in the staff lo." 03/19/2021 and had e Disorder /chosis, and Rule vity Disorder. I at 1:55 p.m., Registered Nurse ine staff member, aff debriefing. the Director of e you there the ent #3]? She id to be passing by t #3], in ed by to see if he	all the staff involved ad on the ESI in the staff lo." 03/19/2021 and had e Disorder rchosis, and Rule vity Disorder. Intervention I at 1:55 p.m., Registered Nurse one staff member, aff debriefing. the Director of e you there the ent #3]? She id to be passing by t#3], in ed by to see if he se was in there,	all the staff involved ad on the ESI in the staff io." 03/19/2021 and had e Disorder vchosis, and Rule vity Disorder. Intervention L at 1:55 p.m., Registered Nurse ine staff member, aff debriefing. the Director of e you there the ent #3]? She id to be passing by t#3], in ed by to see if he se was in there, he video of the ESI

If continuation sheet Page 19 of 27

PRINTED: 07/22/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED С 04L115 B. WING 07/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST WOODRIDGE OF FORREST CITY, LLC FORREST CITY, AR 72335 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 189 Continued From page 19 N 189 initiated on 06/30 at 1740 [5:40 p.m.], was reviewed with the Director of Quality Risk. It showed Staff #11 initiating an ESI on Client #3 after Client #3 threw his food tray into the Staff Member's face. The Video shows Staff #11 struggled with the Client, who was sitting in a chair. Client #3 went from the chair to sitting on the floor on his bottom with his feet in front of him, and Staff #11 standing behind him. Staff #11 then proceeded to pick Client #3 up to his chest level, holding Client #3 horizontally to the floor, and then appeared to throw Client #3 to the floor. with the client landing on his left side. Staff #7, identified by the Director of Quality Risk, is seen initially starting to help with the restraint, but then she proceeded to remove all clients from the area. d. On 07/07/21, the Director of Quality Risk was asked, "Looking at the documentation, does it look like all the staff who were in the ESI on [Client #3] were included in the debriefing?" She stated, "[Staff #11] initiated the restraint, [RN #3] was the nurse who monitored." She was also asked, "Should [Staff #4] have been included in the debriefing, either the client or staff debriefing?" She answered, "I don't know ... [Staff #7] only helped for a second or two." 3. Client #4 was admitted on 04/26/2021 and had diagnoses of Disruptive Mood Dysregulation Disorder, and Attention Deficit Hyperactivity Disorder. a. A Staff Emergency Safety Intervention Debriefing Form dated 07/05/2021 at 1430 [2:30 p.m.], documented the signature of one nurse, LPN #1, and signatures of two staff members. Staff #8, Staff #9, as involved in the staff

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Facility ID: 3012

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ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		CONSTRUCTION ()	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		04L115	B. WNG		C 07/08/2021	
	(EACH DEFICIENC)	LLC ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	1	TREET ADDRESS, CITY, STATE, ZIP CODE 521 ALBERT ST ORREST CITY, AR 72335 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO	
	"Did you assist in the i 7/5?" She stated, "Yes 4. The facility policy fi Interventions, received Quality Risk on 6/30/2 documented, "G. Ph Within 24 hours from t all staff involved in the Intervention) will meet conference to discuss feedback to one anoth took placed and possil which could be used to Physical Restraint Eva Improvement Activities shall assess each epis documentation for com Nursing must resolve a documentation" MEDICAL TREATMEN CFR(s): 483.372(c) Staff involved in an em that results in an injury meet with supervisory circumstances that cau a plan to prevent future This ELEMENT is not	01 a.m., Staff #2 was asked restraint on [Client #4] on s." or Emergency Safety d from the Director of 1 at 10:04 a.m., ysical Restraint Debriefing: he initiation of the restraint, ESI (Emergency Safety in a post-intervention the event and offer er concerning events that ble alternate methods o change behaviorsH. duation/Performance S: 1. The Director of Nursing ode of restraint npleteness. The Director of any incomplete IT FOR INJURIES rergency safety intervention to a resident or staff must staff and evaluate the used the injury and develop a injuries.	N 189	Due to the nature of these incidents and potential to impact all current and future residents, all nurses will receive education by company Nurse Executive by 8/7/21 of documentation elements of the ESI packs including post intervention body assessment and assessment for injury. New process will be implemented beginn 8/6/21: If indicated, all staff involved in ar ESI resulting in resident injury will meet v direct supervisor or member of leadership team within 1 business day to complete post ESI with injury debriefing. This will include viewing camera footage if availab SAMA return demonstration, and discuss of alternative methods to prevent future	et 8/7/2021 ing vith b	

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Facility ID: 3012

If continuation sheet Page 21 of 27

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTI	RUCTION	I *	VIB NO. 0938-
		Sector ISTRICT TOMOEN.	A. BUILDING			COMPLETED	
		04L115				C 07/08/2021	
NAME OF P	AME OF PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
WOODRI	OGE OF FORREST CITY,	LLC		1521 ALB	ERT ST ST CITY, AR 72335		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRE	CTION	
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X6) COMPLE DATI
N 202	Continued From page 21		N 20	02			
	circumstances causin	g the injury and to develop					
	a plan to prevent injur	ry in the future for 2 (Clients					
		its #1-#4) sampled clients					
	who were reviewed for	or ESI. The findings are:					
	1. Client #3 was adm	itted on 03/19/2021 and had					
	diagnoses of Major D	epressive Disorder					
Recurrent, Severe wi	Recurrent, Severe wit	hout Psychosis, and Rule					
out Attention Deficit H		yperactivity Disorder.					
	a. The Emergency Sa	afety Intervention					
	Justification Packet da	ated 6/30/21 documented,					
	"Date & Time actually placed into						1
		me- 1745 [5:45 PM]Date					
	1750 [5:50 PM]"	Restraint:6/30/21 Time-					
	b. The Emergency Sa	afety Intervention					
		estraint/Seclusion Body					
	Assessment form date	ed 6/30/21 documented,					
	"Description of Injuri	es (4-Pain) No of Treatment: R [Resident]		8			
	reported left side of bo	ody hurt d/t [due to] ESI.					
		abnormalities found. R					
	rated pain a 7 out of 1	0. Ibuprofen given po (by					
	mouth) for pain" The						
	Registered Nurse (RN) #3.					
	c. On 07/07/2021 at 1	0:30 am, the video of the					
	ESI restraint was revie	wed and showed, during					1
		thrown to the floor, landing					
	on the floor on his left	side.					
		tted on 04/26/2021 and had		Š.			
	diagnoses of Disruptiv						
	Disorder, and Attentior	n Deficit Hyperactivity					
	Disorder.						
	a. The Emergency Sa						1

CENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-0391			
		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	TE SURVEY	-	
			04L115	B. WNG			С			
l	NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	0	7/08/2021		
I	WOODBI					21 ALBERT ST				
l					FC	RREST CITY, AR 72335				
	(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	TION SHOULD BE COMPLE THE APPROPRIATE DATE			
		Restraint:7/5/21 Tim Time removed from Re 1420 [2:20 PM]" b. The Emergency Sa Justification Packet Re Assessment form date indicated, signed by St Licensed Practical Nur "Description of injurie Description of Treatme of] [decreased] ROM [I [Right] wrist - sent to E eval [Evaluation]/tx [Tru c. The ER record date documented, "Sprain and hand." d. On 07/08/2021 at 8: splint to the right wrist. occurred during the res squirming around on th is pushing my arm agai wrist down, pushing my to dislocate my elbow of 3. On 07/08/2021 at 2: Director was shown the Client #3 and Client #4, section on the body ass follow up with staff follow He was asked, "Is staff meeting with supervisor caused the injury and to preventing future injury"	ated 07/05/2021 & Time actually placed into e- 1352 [1:52 PM]Date & estraint:7/5/21 Time- fety Intervention estraint/Seclusion Body d 7/5/21, with no time taff # 9, Staff # 8, and se (LPN) #1 documented, esNo visible injuries. ent: [Resident] [Complains Range of Motion] to Rt R [Emergency Room] for eatment]" d July 5, 2021 of other part of right wrist 59 am, Client #4 had a He indicated the injury straint, and stated, "I was e ground. Then [Staff #8] inst the ground, pushing r something" 30 pm, the Clinical e ESI documentation for specifically the blank sessment page regarding wing a restraint with injury. involved in an ESI ry staff to talk about what o talk about a plan for ?" The Clinical Director	N	202					
_		stated, "We do that here in administrative		23-52-52-	_					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 3012

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES	<u>.</u>			NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		04L115	B. WING _			C 17/08/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (1100/2021
	DGE OF FORREST CITY,			1521 ALBERT ST		
				FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETION DATE
	meetings when we rev we do it." He was ther in the ESI included?" supposed to? Are we up here when a kid co later or pull them out of short staffing? We do meetings, that is how asked, "Is there any du that changed, or staff the two injuries?" He is show you what we hav received prior to exit. EDUCATION AND TR. CFR(s): 483.376(a) The facility must require education, training, an of - This STANDARD is no Based on interview an failed to ensure staff E Intervention (ESI) re-tr. resulted in injury for 2 ((Clients #1-#4) sample reviewed for ESI. The 1. Client #3 was admitt diagnoses of Major De, Recurrent, Severe with out Attention Deficit Hy a. The Emergency Sat Justification Packet dat "Date & Time actually Restraint:6/30/21 Tim	view restraints, that's how in asked, "Are staff involved He stated, "Are we supposed to call them back implains of an injury a day of staff that would lead to it in administrative we do it here." He was then ocumentation of procedures training required following stated, "We have it, I can ve." No documentation was AINING re staff to have ongoing d demonstrated knowledge of met as evidenced by: id record review, the facility mergency Safety aining was done after ESI (Clients #3 and #4) of 4 d clients who were findings are: ted on 03/19/2021 and had pressive Disorder out Psychosis, and Rule peractivity Disorder. fety Intervention red 6/30/21 documented.	N 2		nt and future off received a d receive check by a sister facility /21. Facility HR se Executive will y 8/7/21 to ensure te 3 staff and will receive of direct care). ented 8/6/21: All ulting in resident upervisor or within 1 ost ESI with clude viewing SAMA return ion of alternative niury. Staff will	8/7/2021
	"Date & Time actually Restraint:6/30/21 Tim	/ placed into ne- 1745 [5:45 PM]Date		coaching post debriefing.	υασαιιση απο	

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Facility ID: 3012

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	S FOR MEDICARE 8	(X1) PROVIDER/SUPPLIER/CLIA	(72) 14 1000			RM APPRO\ <u>\O. 0938-0:</u>
	F CORRECTION	IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		04L115	B. WING		C 07/08/202	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CO		
WOODRII	DGE OF FORREST CITY	7, LLC		521 ALBERT ST ORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETI DATE
N 214	Continued From pag 1750 [5:50 PM]"	le 24	N 214			
	Assessment form da "Description of Inju injuries Description reported left side of b Upon assessment no rated pain a 7 out of mouth) for pain" Th Registered Nurse (RI c. On 07/06/2021 at "Did you follow up aff his left side to make s and he wasn't still in injuries?" RN #3 state other nurse about the clock out time." d. On 07/07/2021 at ESI restraint was revi	Restraint/Seclusion Body ted 6/30/21 documented, iries (4-Pain) No of Treatment: R [Resident] body hurt d/t [due to] ESI. b abnormalities found. R 10. Ibuprofen given po (by the form was signed by				
	on the floor on his left e. On 07/07/2021 at Quality Risk was aske documentation of a re Client #3's complaint he was given ibuprofe and Risk stated she w of Nursing for any oth The Director of Quality	t side. 11:00 am, the Director of				
	2. Client #4 was adm diagnoses of Disruptiv	itted on 04/26/2021 and had /e Mood Dysregulation				

PRINTED: 07/22/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 04L115 8. WNG 07/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST WOODRIDGE OF FORREST CITY, LLC FORREST CITY, AR 72335 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID. (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 214 Continued From page 25 N 214 Disorder, and Attention Deficit Hyperactivity Disorder. a. The Emergency Safety Intervention Justification Packet dated 07/05/2021 documented, "...Date & Time actually placed into Restraint:...7/5/21 Time- 1352 [1:52 PM]...Date & Time removed from Restraint:...7/5/21 Time-1420 [2:20 PM]..." b. The Emergency Safety Intervention Justification Packet Restraint/Seclusion Body Assessment form dated 7/5/21, with no time indicated, signed by Staff # 9, Staff # 8, and Licensed Practical Nurse (LPN) #1 documented. "...Description of injuries...No visible injuries. Description of Treatment: [Resident] [Complains ofl [decreased] ROM [Range of Motion] to Rt [Right] wrist - sent to ER [Emergency Room] for eval [Evaluation]/tx [Treatment] ... " c. The ER record dated July 5, 2021 documented, "...Sprain of other part of right wrist and hand." d. On 07/08/2021 at 8:59 am, Client #4 had a splint to the right wrist. He indicated the injury occurred during the restraint, and stated, "I was squirming around on the ground. Then [Staff #8] is pushing my arm against the ground, pushing wrist down, pushing my elbow up. He was trying to dislocate my elbow or something ... " e. On 07/06/2021 at 1:07 pm, the Clinical Director was asked, "Has the facility done any training since the incident [the restraint on Client #3]?" He answered, "Since this was an isolated incident with this staff [Staff # 11], we didn't do a correction with this incident. We have been doing

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Facility ID: 3012

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		& MEDICAID SERVICES				FORM APPRO OMB NO. 0938-	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURV COMPLETED		
		04L115	B. WING		C 07/08/202		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ÓDE	01100/2021	
	GE OF FORREST CI	TY, LLC		1521 ALBERT ST FORREST CITY, AR 72335			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE	E COMPLE TE DATI	
N 214	some summer trai training or any mo restraints or report the complaint surv stated, "No." f. On 07/08/2021 a was asked, "Is the procedures that ch required following "We have it, J can	age 26 ning." He was then asked, "Any nitoring done with staff on ting since this incident or since ey started last week?" He at 2:30 pm, the Clinical Director re any documentation of langed, or staff training the two injuries?" He stated, show you what we have." No s received prior to exit.	N 21				
M CMS-2567(02-99) Previous Versions O	bsolete Event ID: CKCN	11 Fa	cility ID: 3012	If postioust	ion sheet Page 27 d	





Division of Provider Services & Quality Assurance P.O. Box 8059, Slot S404 Little Rock, AR 72203-8059 P: 501.320.6182 F: 501.682.6159

August 20, 2021

Charlotte Lockhart, Administrator Woodridge Of Forrest City, Llc 1521 Albert St Forrest City, AR 72335

Dear Ms. Lockhart:

During the Revisit survey conducted on August 19, 2021, your facility was found to be in compliance with program requirements. Please email the signed CMS 2567 Sandra.Broughton@dhs.arkansas.gov.

If you have any questions, please contact your reviewer: Sandra Broughton at 501-320-6182 or email to Sandra.Broughton@dhs.arkansas.gov.

Sincerely,

Saudie Braufton Administrative Services Manager

DPSQA/Office of Long Term Care Survey and Certification Section

sgb

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		04L115	B. WING _			R-C 8/ 19/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
WOODRID	GE OF FORREST CITY,	LLC		1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
{N 000}	Initial Comments		{N 0(00}		
	is an official, legal do remain unchanged ex correction, correction space. Any discrepan citation(s) will be repo Office (RO) for referra Inspector General (O information is inadver	IG) for possible fraud. If tently changed by the State Survey Agency (SA)				
	deficiencies cited on , have been corrected,	ed on August 19, 2021 for all July 8, 2021. All deficiencies and no new noncompliance ty is in compliance with all				
		SUPPLIER REPRESENTATIVE'S SIGNATUF		TITLE		(X6) DATE

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.

PRINTED: 08/20/2021

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	**	Provider/Supplier Name WOODRIDGE OF FORREST CITY, LLC						
04L115	WOODRIDGE C							
Type of Survey (select all that apply)	A Complaint Investigation	Е	Initial Certification	Ι	Recertification			
	B Dumping Investigation	F	Inspection of Care	J	Sanctions/Hearing			
A	C Federal Monitoring	G	Validation	Κ	State License			
<u> </u>	D Follow-up Visit	Н	Life Safety Code	L	CHOW			
	M Other							
Extent of Survey (select all that apply)	A Routine/Standard Survey (all prov B Extended Survey (HHA or Long T	**	· · · · · · · · · · · · · · · · · · ·					
D	C Partial Extended Survey (HHA) D Other Survey	C Partial Extended Survey (HHA)						

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 2.)(6), (b) (7	06/29/2021 07/06/2021	06/30/2021 07/08/2021	1.00 1.00	0.00 0.00	9.50 19.50	0.00 0.00	8.25 5.25	7.50 13.50
3.	07/00/2021	07700/2021	1.00	0.00	19.50	0.00	5.25	15.50
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
Fotal SA Supervisory Re	view Hours	3	.00		Total RO Super	visory Review Ho	urs	0.00

Total SA Clerical/Data Entry Hours....

0.50

Total RO Clerical/Data Entry Hours

0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

FORM CMS-670 (12-91)

102000

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier N	Provider/Supplier Name WOODRIDGE OF FORREST CITY, LLC						
04L115	WOODRIDGE C							
Type of Survey (select all that apply)	A Complaint Investigation	E Initial Certification	Ι	Recertification				
	B Dumping Investigation	F Inspection of Care	J	Sanctions/Hearing				
AD	C Federal Monitoring	G Validation	Κ	State License				
	D Follow-up Visit	H Life Safety Code	L	CHOW				
	M Other							
Extent of Survey (select all that apply)	A Routine/Standard Survey (all prov B Extended Survey (HHA or Long C Partial Extended Survey (HHA) D Other Survey	11 /						

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1.	08/19/2021	08/19/2021	0.50	0.00	4.50	0.00	6.00	1.00
2. ⁽⁾ (6), (b) (7	08/19/2021	08/19/2021	0.50	0.00	4.50	0.00	5.50	0.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
Total SA Supervisory Re	view Hours	0	.25		Total RO Super	visory Review Ho	urs	0.00
Total SA Clerical/Data I	Entry Hours	0.	.25		Total RO Cleric	cal/Data Entry Hou	rs	0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

1