ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services and Quality Assurance
Office of Long Term Care
PO Box 8059, Slot S404
Little Rock, AR 72203-8059
Fax: 501-682-6159

July 31, 2019

Tony Mobley, Administrator
Woodridge Behavioral Care Of Forrest City
1521 Albert St
Forrest City, AR 72335

Dear Mr. Mobley:

On July 19, 2019 a Complaint 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 deficieny cited.

Sandra Borughton, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
Telephone (501) **320-6182;** Fax (501) 682-6159
e-mail Rodney.Raper@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:

Becky Bennett, Section Chief
Health Facility Services
Arkansas Department of Health
5800 West 10th Street, Suite 400
Little Rock, AR 72204
Fax (501) 661-2165

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

Sincerely,

Sandra Broughton

Sandra Broughton, DHS Program Administrator
Office of Long Term Care
Survey & Certification Section

sgb

cc: Ombudsman
DRC
file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 07/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE BEHAVIORAL CARE OF FORREST CITY	1521 ALBERT ST 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. Complaint #AR00023197 was unsubstantiated. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000		
N 156	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a physician's order for a physical restraint was signed in a timely manner for 1 (Client #2) of 2 (Client #1 and #2) sampled clients who had Physician's order for a physical restraint. The findings are:	N 156		

LABORATORY DIRECTOR'S OR PROVIDER/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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 156	Continued From page 1 Client #2 had diagnoses Bipolar MRE (Most Recent Event) Depressed with Psychosis, GAD (Generalized Anxiety Disorder), ODD (Oppositional Defiant Disorder), Conduct Disorder Childhood Onset), ADHD (Attention Deficit Hyperactivity Disorder), History of Trauma and Rule Out PTSD (Post Traumatic Stress Disorder). a. A Shift Note dated 6/16/19 at 11:00 a.m., documented, "R [Resident] on assault precaution R had ESI [Emergency Safety Intervention] yesterday in gym r/t [related to] fighting [with] peer & [and] also fighting some peer today... [Doctor] aware of ESI... R had significant abrasion to [left] elbow from struggling on the concrete during ESI-No TX [treatment] indicated..." b. A Physician's Order for a Physical Restraint dated 6/15/19 at 5:40 p.m., documented, "Order for physical restraint for up to: 1 hour; due to fighting [with] peer/hitting peer..." As of the 7/19/19 the Physician's Order for the use of the restraint had not been signed by the Physician, 44 days after the order had been written. c. On 7/19/19 at 10:59 a.m., Registered Nurse (RN) #1 was asked, "Is that an appropriate length of time for an order to be signed?" She stated, "We had a little problem with nurses, but no that's too long."	N 156		

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Office of Long Term Care
PO Box 8059, Slot S404
Little Rock, AR 72203-8059
Fax: 501-682-6159

Matthew Doyle, Administrator
Woodridge Behavioral Care Of Forrest City
1521 Albert St
Forrest City, AR 72335

Dear Mr. Doyle:

On July 19, 2019, we conducted a complaint investigation 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 05, 2019.

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 at (501)**320-6182**.

Sincerely,

Rodney Roper for
Sandra Broughton, Reviewer
Survey & Certification Section
Office of Long Term Care

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August 29, 2019

Mathew Doyle, Administrator
Woodridge Behavioral Care Of Forrest City
1521 Albert St
Forrest City, AR 72335

Dear Mr. Doyle:

During the revisit conducted on August 28, 2019, your facility was found to be in compliance with program requirements. Your certification remains in effect unless terminated due to non-compliance with program requirements or voluntary withdrawal from the program. **A CMS 2567 is enclosed, indicating your facility's compliance status. Please sign and date the 2567 and fax to** Sandra Broughton **at (501) 682-6159 or email to** Sandra.Broughton@dhs.arkansas.gov **as soon as possible.**

If you have any questions please contact your reviewer at 501-**320-6182**.

Sincerely,

Sandra Broughton

Sandra Broughton, DHS Program Administrator
Office of Long Term Care
Survey and Certification Section

sgb

cc: file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	R-C 08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE BEHAVIORAL CARE OF FORREST CITY	1521 ALBERT ST FORREST CITY, AR 72335

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