



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

April 13, 2022

Derek Thompson, Administrator Woodridge Of The Ozarks 2466 S 48th Street Springdale, AR 72762

Dear Mr. Thompson:

On April 7, 2022 a Recertification 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 Broughton, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
(501) 320-6182
email to Sandra.Broughton@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 or the requirement for timely submission of an acceptable plan of correction. 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

Fax: 501-661-2165 ADH.HFS@Arkansas.gov

If you have any questions, please contact your Reviewer.

Sincerely,

sgb

DPSQA/Office of Long Term Care Survey & Certification Section

Saudie Biseretten
Administrative Services Manager

cc: DRA

PRINTED: 04/13/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED					
		04L120	B. WING _			04	1/07/2022	
	ROVIDER OR SUPPLIER DGE OF THE OZARKS			STREET ADDRESS, CITY, STATE, ZIP CODE 2466 S 48TH STREET SPRINGDALE, AR 72762				
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E 000	Initial Comments Note: The CMS-256	67 (Statement of Deficiencies)	E	000				
	is an official, legal d remain unchanged of correction, correction space. Any discrep citation(s) will be rep Office (RO) for refer Inspector General (dinformation is inadve	ocument. All information must except for entering the plan of n dates, and the signature ancy in the original deficiency ported to the Dallas Regional ral to the Office of the DIG) for possible fraud. If ertently changed by the e State Survey Agency (SA)						
N 000	demonstrate compli Emergency Prepare Psychiatric Residen Initial Comments	statement of deficiencies ance with §483.73 - dness Requirements for tial Treatment Facilities.	N (000				
N 131	Subpart G - Conditi Psychiatric Residen PROTECTION OF F CFR(s): 483.356(a)		N 1	31				
ADODATOSY	This ELEMENT is r Based on record re	not met as evidenced by: view and interview, the facility			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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L120	B. WING _			04/	07/2022
	ROVIDER OR SUPPLIER			24	TREET ADDRESS, CITY, STATE, ZIP CODE 166 S 48TH STREET PRINGDALE, AR 72762		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 131	were not used simulta #2) sampled resident placed in seclusion. T	ical restraint and seclusion aneously for 1 of 1 (Resident who was restrained and	N ·	131			
	placed in seclusion. M received at 1830 [6:3 [Physician] ordered R [milligrams] of Geodo and 50 mg of Benadr At 1843 [6:43 p.m.] IM	[7:28 p.m.] R [Resident] MD [Medical Doctor] orders 0 p.m.]. At 1833 [6:33 p.m.] It to be given 10 mg In by IM [intramuscularly] IM for psychotic agitation. M given R had to be At 1855 [6:55 p.m.] R					
	Packet dated 2/26/22 time actually placed in Time 1840 [6:40 p.m. placed in seclusion D p.m.] Date and time administered Date 2/2 Date and time remisered 2-26-22 Time 1844 [6:40]	fety Intervention Justification documented, "Date & [and] not or restraint Date 2-26-22] Date and time actually ate 2-26-22 Time 1828 [6:28 the emergency medication 26/22 Time 1843 [6:43 p.m.]. Loved from restraint Date 1:44 [p.m.] and Time on Date 2-26-22 Time 1855					
N 140	(DON) was asked, "V give a chemical restra		N ·	140			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED			
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N 140	physician, or other I by the State and the seclusion and trained safety interventions CFR 441.151 requires safety interventions CFR 441.151 requires revices for benefic provided under the This STANDARD is Based on record refailed to provide a peculusion and chern for 1 of 1 (Resident placed in seclusion. Resident #2 had a Stress Disorder a. A Nursing Shift Noumented, "192 placed in seclusion. received at 1830 [6: [Physician] ordered [milligrams] of Geodand 50 mg of Benard At 1843 [6:43 p.m.] restrained for the IN released from seclusion. An Emergency Security Packet dated 2/26/2 time actually placed Time 1840 [6:40 p.m.] placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.] Date and times a patential placed in seclusion p.m.]	or seclusion must be by a icensed practitioner permitted a facility to order restraint or an interest in the use of emergency. Federal regulations at 42 are that inpatient psychiatric fairies under age 21 are direction of a physician. Is not met as evidenced by: eview and interview the facility hysician's order for a restraint, nical restraint that were used #2) who was restrained and The findings are: Idiagnosis of Post Traumatic In MD [Medical Doctor] orders 30 p.m.]. At 1833 [6:33 p.m.] R to be given 10 mg and by IM [intramuscularly] dryl IM for psychotic agitation. IM given R had to be 1. At 1855 [6:55 p.m.] R	N 14	10			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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N 143	2-26-22 Time 1844 [6] removed from seclusin [6:55 p.m.]" c. On 4/7/22 at 11:42 (DON was asked for seclusion, and chemion 2/26/22. The DON find the physician's or every where and was d. The policy titled Empolicy provided by the 4/7/22 at 11:27 a.m. of from the physician is physical restraint, che The physician's verwith the physician's sorder. ORDERS FOR USE of SECLUSION CFR(s): 483.358(d) If the order for restrain verbal order must be nurse or other license practical nurse, while intervention is being intervention in seclusion in a signed written for The physician or other permitted by the state restraint or seclusion in a signed written for The physician or other permitted by the state restraint or seclusion in a seclusion in a seclusion in a secusion	a.m., the Director of Nursing the order for a restraint, cal restraint that was used stated, "We were unable to refer for 2/26/22. We looked unable to find it." mergency Safety Intervention to Director of Nursing on documented, "A written order required for the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint, or seclusion. The properties of the use of a temical restraint of the use of a te		140			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
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N 143	Continued From page period of the emerger	e 4 ncy safety intervention.	N 14	13			
	Based on record rev failed to ensure a phy restraint was signed l	of met as evidenced by: The wand interview the facility The sicians order for a physical The physician for 1 of 1 The sign of the physical restrained. The					
	Resident #3 had diag Severe Stress and Di Dysregulation.	noses of Other Reactions to sruptive Mood					
		or physical restraint for up saulting staff [with] intent to red 1710 [5:10 order did not have a					
	about the unsigned o	ctor of Nursing was asked rder. The Director of Nursing olem. It should be signed."					
N 207	policy provided by the 4/7/22 at 11:27 a.m. of from the physician is physical restraint, che The physician's ve	nergency Safety Intervention E Director of Nursing on documented, "A written order required for the use of a emical restraint, or seclusion. rbal order must be followed ignature verifying the verbal	N 20	07			
	CFR(s): 483.374(b) Reporting of serious						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER DGE OF THE OZARKS			STREET ADDRESS, CITY, STATE, ZIP CODE 2466 S 48TH STREET SPRINGDALE, AR 72762	, , , , , , , , , , , , , , , , , , , ,	
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N 207	prohibited by State la Protection and Advoc Serious occurrences include; - a resident's deat - a serious injury t section §483.352 of t - a resident's suici (1) Staff must report involving a resident to agency and the State Advocacy system by business the next bus occurrence. The report - the name of the serious occurrence, - a description of t	dicaid agency and, unless w, the State designated cacy system. that must be reported h; o a resident as defined in his part; and de attempt. any serious occurrence o both the State Medicaid e designated Protection and no later than close of siness day after a serious ort must include resident involved in the he occurrence and, address, and telephone	N 2	07		
	Based on record rev failed to ensure serio reported to the Office and Disability Rights notified after suicidal (Resident #1 and #2) findings are: 1. Resident #1 had d Dysregulation Disord Disorders. a. On 4/5/22 at 9:30 a	ot met as evidenced by: iew and interview, the facility us occurrences were of Long Term Care (OLTC) Arkansas (DRA) were attempts taken by 2 of 2 sampled residents. The iagnoses of Disruptive Mood er and Other Conduct a.m. Resident #1 was asked acility. She stated, "For trying				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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N 207	p.m. documented, "S mirror on both foreard around her neck." c. An Incident Notificat documented, "Self ingesture." The Authoriform was blank. Ther OLTC or DRA were not a Nursing Progress documented, "RS [Reagain after trying to use. An Incident Notificat documented, "Suicide Notified section of the not documented of the Notified Severe Stress and Dysregulation. a. A Nursing Shift Not documented, "1906 [a pillow case to tie art b. An Incident Notificat documented, "Suicide Notified Section of the notifi	elf harmed with a broken ms and tied a ligature tightly ation Report dated 4/2/22 flicted injury Suicide ities Notified section of the e was no documentation notified. Is Note dated 3/12/22 esident] had to be restrained use a garment as a ligature." ation Report dated 3/12/22 esident] had to be restrained use a garment as a ligature." ation Report dated 3/12/22 esident as a ligature. The Authorities es form was blank. There was a ligature in the form was blank. There was a ligature in the form was blank. There was a ligature in the dated 11/13/21 for p.m.] R [Resident] used found her neck." ation Report dated 11/13/21 es gesture. The Authorities es form was blank. There was a ligature. The Authorities es form was blank. There was a ligature. The Authorities es form was blank. There was a ligature. The Authorities es form was blank. There was a ligature in the light was blank. There was a ligature in the light was blank. There was a ligature in the light was blank. There was a ligature in the light was a light was blank. There was a light was a ligh	N 20	7		

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N 207	documented, "Suicide Notified section of the no documentation OL e. A Nursing Shift No documented, "R's ner numerous articles of around her neck." f. An Incident Notifica documented, "Self int gesture." The Authori form was blank. Ther OLTC or DRA were n 3. On 4/7/22 at 11:45 was asked why the O Disability Rights had incidents for Residen	ation Report dated 10/9/21 be gesture." The Authorities be form was blank. There was at C or DRA were notified. It dated 10/3/21 be is red r/t [related to] tying clothing, including a hair tye Ition Report dated 10/3/21 flicted injury Suicide ties Notified section of the be was no documentation otified. a.m. the Director of Nursing office of Long Term Care or not been notified of the t #1 and 2. He stated, "They idal gestures, not attempts,	N 2	207				





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

April 25, 2022

Derek Thompson, Administrator Woodridge Of The Ozarks 2466 S 48th Street Springdale, AR 72762

Dear Mr. Thompson:

On April 7, 2022, we conducted a Validation 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 May 2, 2022.

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: Sandra Broughton at 501-320-6182 or email to Sandra. Broughton@dhs.arkansas.gov.

Sincerely,

DPSQA/Office of Long Term Care

Saudie Biseighten Administrative Services Manager

Survey & Certification Section

sgb

Approved POC 04/25/2022 SGB

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 04/13/2022 FORM APPROVED OMB NO. 0938-0301

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		04L120	B. WNG		04	<i>(</i> 07/2022
NAMEOFP	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBIL	DGE OF THE OZARKS		l	2466 S 48TH STREET		
	DOE OF THE OZAKAS			SPRINGDALE, AR 72762		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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E 000	I Initial Comments					
E 000	Hilliai Comments		E 000	Please see Perimeter of the Ozarks: Plan	n of	
				Correction Addendum attached to the do	cument	
		(Statement of Deficiencies)		for additional information regarding cor	rective	1
		cument. All information must		actions and assurance monitoring proces	sses.	
		cept for entering the plan of dates, and the signature				İ
		ncy in the original deficiency				
	citation(s) will be repo	orted to the Dallas Regional				
	Office (RO) for referra					
		G) for possible fraud. If	Ì			Ì
	information is inadver					
		State Survey Agency (SA)				
	should be notified imn	nediately.				
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		atement of deficiencies				
	demonstrate compliar					
	Emergency Prepared	ness Requirements for				
N 000	Psychiatric Residentia Initial Comments	al Treatment Facilities.	NI 000			
110001	intial Continents		N 000			
	A validation currovy	as conducted AIAIOO to				
	4/7/22.	as conducted 4/4/22 to				
	12 F 1 day day.				1	
		compliance with §483,		631		
	Subpart G - Condition			Director of Nursing provided remedial tra	ining	4/7/22
A1 404	Psychiatric Residentia			to nursing staff regarding restraints, inclu		4/8/2022
N 131	PROTECTION OF RE		N 131	drugs/medications used as restraint, must		
	CFR(s): 483.356(a)(4)			utilized at the same time as utilizing sech A meeting was held with present nursing		
	Restraint and seclusio	n must not be used		on the evening of 4/7/22 addressing the d	eficient	
	simultaneously.	,, made not be deed		practice. An internal memo addressing the		
				deficient practice was posted in the nurse		
	This ELEMENT is not	met as evidenced by:		office on 4/8/22. Director of Nursing to p		
		w and interview, the facility		in-service training on Emergency Safety		
		•		Interventions in monthly nursing meeting	on	
ARODATORY	PECTOPIS OF PROMINERS	IDDI IET PEDDEOCUTATION OF STATE		4/28/22.		
ADURAIURT DI	INECTOR S LIKE PROVIDENSU	PPLIED REPRESENTATIVE'S SIGNATURE		TITLE	()	X6) DATE
	1 / 1			/ []		. / _ /

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.

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2466 S 48TH STREET SPRINGDALE, AR 72762			
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	were not used simulta #2) sampled resident placed in seclusion. T Resident #2 had a dia Stress Disorder a. A Nursing Shift Not documented, " 1928 placed in seclusion. N received at 1830 [6:30 [Physician] ordered R [milligrams] of Geodor and 50 mg of Benadry At 1843 [6:43 p.m.] IN restrained for the IM. A released from seclusion b. An Emergency Saft Packet dated 2/26/22 time actually placed in Time 1840 [6:40 p.m.] placed in seclusion Da p.m.] Date and time administered Date 2/2 Date and time administered Date	ical restraint and seclusion ineously for 1 of 1 (Resident who was restrained and the findings are: gnosis of Post Traumatic te dated 2/26/22 [7:28 p.m.] R [Resident] ID [Medical Doctor] orders 0 p.m.]. At 1833 [6:33 p.m.] to be given 10 mg in by IM [intramuscularly] If IM for psychotic agitation. I given R had to be At 1855 [6:55 p.m.] R on" ety Intervention Justification documented, "Date & [and] into restraint Date 2-26-22 Date and time actually into restraint Date 2-26-22 Date and time actually into restraint Date 2-26-22 Time 1828 [6:28 is emergency medication 6/22 Time 1843 [6:43 p.m.]. Inved from restraint Date 44 [p.m.] and Time on Date 2-26-22 Time 1855 a.m., the Director of Nursing ere you aware they couldn't int in seclusion?" The DON they should not be placed in nical."		Director of Nursing shall continumandated review process for each chemical restraint, physical restraseclusion, and shall investigate fit procedures and rule violations. It changes and other corrective actifications are timely manner. Will be reported to quality assurated during the next regular committee. Director of Nursing shall review Safety Intervention policy and micharifications regarding the use of restraints by 4/27/2022. Director of Nursing shall provide regarding Emergency Safety Interpolicies and procedures to nursing monthly nursing meeting on 4/28 meeting agenda and attendance retained by DON in training door binder. The Quality Coordinator/Designand publish an operational rule review of all Emergency Safety I or prior to the close of the next be hours of incident occurrence. Safety included in the Emergency Safety Intervention on the justification procedurator/Designee shall recommonth's ratio of Emergency Safety Intervention on Emergency Safety Intervention on Emergency Safety Intervention on the pustification of Emergency Safety Intervention on the previous month. A specific are conducted regarding any occurrer simultaneous utilization of restrains seclusion as required by agency is the previous monthly. N131Target is the previous monthly in the previous monthly.	th use of aint, and/or indings of Procedural ions will be fied Said findings nce committee e meeting. The Emergency ake findings in the continuity and the previous ty Interventions or usiness day interventions for the total erventions from allysis shall be ince of int and KPI and shall		
N 140	ORDERS FOR USE O SECLUSION	F RESTRAINT OR	N 1	5/2/22			

	OF DEFICIENCIES F CORRECTION	[[[[[[[[[[[[[[[[[[[(X3) DATE SURVEY COMPLETED	
		04L120	B. WING_		04	<i>(</i> 07/2022
NAME OF PI	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRIE	DGE OF THE OZARKS			2466 S 48TH STREET		
				SPRINGDALE, AR 72762		
(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 SHOLIC CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
N 140	Continued From page	2	N 1	40 -Physician was notified by Director	of Nursing	
}	CFR(s): 483.358(a)			regarding missing physician's order		
	01 1.(4). 100.000(2)			clarification order for the Emergenc	y Safety	
	Orders for restraint or	r seclusion must be by a		Intervention was provided by Physic		
		ensed practitioner permitted		then reviewed and placed in residen	t's record by	
		facility to order restraint or		Director of Nursing on 4/18/22.		
ļ		in the use of emergency		-Director of Nursing will continue n		
		Federal regulations at 42		process for each use of chemical res		
		that inpatient psychiatric		physical restraint, and/or seclusion t		
	services for beneficial			documentation completeness. Direct Nursing will resolve any incomplete		
	provided under the dir	rection of a physician.		documentation.		
	This STANDARD is r	not met as evidenced by:		-Director of Nursing shall continue	eview	
		ew and interview the facility		process for each use of chemical res		
		/sician's order for a restraint,		physical restraint, and/or seclusion for all		
		cal restraint that were used	residents to assess for documentation			
	[2) who was restrained and		completeness. Said review shall be completed		
	placed in seclusion. T			by the close of the next business day		
		-		the event. The Director of Nursing	shall resolve	
		ignosis of Post Traumatic		any incomplete documentation.		
ļ	Stress Disorder			-Director of Nursing shall provide in		
				regarding Emergency Safety Interve		
	a. A Nursing Shift No			policies and procedures to nursing s		
		[7:28 p.m.] R [Resident]		-Quality Coordinator/Designee shall		
		MD [Medical Doctor] orders		review process for each Emergency		
	ama	0 p.m.]. At 1833 [6:33 p.m.]		Intervention and document when the orders are signed and completed on		
i	[Physician] ordered R [milligrams] of Geodor	п by IM [intramuscularly]		report documentation for each Emer		
		/I IM for psychotic agitation.		Safety Intervention once completed.		
		I given R had to be		Coordinator/Designee will resolve a		
	restrained for the IM.			incomplete documentation.	رد.	
-	released from seclusion			-As a member of the QAC, Director	of Nursing	
	ı			shall review the use of physical restr		
		fety Intervention Justification		chemical restraint, and/or seclusion		
i		documented, "Date & [and]		to monitor performance for complian		
		nto restraint Date 2-26-22		providing a physician's orders for ea		
		Date and time actually		Emergency Safety Intervention and		
	· · · ·	ate 2-26-22 Time 1828 [6:28		deficiencies if observed with a goal		
		e emergency medication 26/22 Time 1843 [6:43 p.m.].		compliance monthly for four months	i.	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L120	B. WING		04/	07/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2466 S 48TH STREET SPRINGDALE, AR 72762		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) COMPLETION DATE
N 140	2-26-22 Time 1844 [6 removed from seclusion [6:55 p.m.]" c. On 4/7/22 at 11:42 at (DON was asked for the seclusion, and chemical on 2/26/22. The DON find the physician's or every where and was down the physician is replaced by the 4/7/22 at 11:27 a.m. down the physician is replaced by the physical restraint, chemical restraint, chemical restraint, chemical restraints are represented by the physician is replaced by	eved from restraint Date :44 [p.m.] and Time on Date 2-26-22 Time 1855 a.m., the Director of Nursing he order for a restraint, cal restraint that was used stated, "We were unable to der for 2/26/22. We looked unable to find it." ergency Safety Intervention Director of Nursing on ocumented, "A written order equired for the use of a mical restraint, or seclusion. that order must be followed gnature verifying the verbal		Director of Nursing shall be responsible assuring improvement does occur, and to implement other corrective actions if new prolong monitoring to ensure solution is sustained. Quality Coordinator/Designee shall review Emergency Safety Interventions no later close of business the next business day following the incident occurrence and deeach Emergency Safety Intervention Review form within the same time frame. Quality Coordinator/Designee shall record the promonth's ratio of Emergency Safety Interventions in the promonth regarding ensuring a physician's of was provided for each Emergency Safety Intervention on the KPI monthly. N140 Tecompletion 5/2/22 -Physician was notified by Director of N	ew all than ocument the Log y revious ventions aber of revious order	
IN 143	SECLUSION CFR(s): 483.358(d) If the order for restrain verbal order must be r nurse or other licenser practical nurse, while to intervention is being in immediately after the ends. The physician or permitted by the state restraint or seclusion r in a signed written form. The physician or other permitted by the state restraint or seclusion r	at or seclusion is verbal, the eceived by a registered distaff such as a licensed the emergency safety situation of the licensed practitioner and the facility to order must verify the verbal order in the resident's record.	100	regarding unsigned physician's order and clarification order for the Emergency Sai Intervention was provided by Physician a then reviewed and placed in resident's re Director of Nursing on 4/18/22. As a member of the QAC, Director of N shall review the use of physical restraint, chemical restraint, and/or seclusion monitor performance compliance in prov physician's orders for each Emergency S. Intervention and address deficiencies if observed. Director of Nursing shall be responsible for assuring improvement oc and implements other corrective actions in needed or extend enhanced monitoring to solution is sustained.	l a fety and cord by fursing thly, to iding a afety curs	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLECONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		04L120	B. WING_		04/1	07/2022		
NAMEOFP	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
WOODRIE	WOODRIDGE OF THE OZARKS			2486 S 48TH STREET				
				SPRINGDALE, AR 72762				
(X4) ID		ATEMENT OF DEFICIENCIES	CII	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
N 143	Continued From page	-As a member of the QAC, Director of Nurs. ontinued From page 4 N 143 shall continue review the use of physical						
				restraint, chemical restraint, and/or secl				
	period of the emergency safety intervention.			each month, to monitor performance co	mpliance			
				in providing a physician's orders for each	h			
	This ELEMENT is no	t met as evidenced by:		Emergency Safety Intervention and add	ress			
		ew and interview the facility		deficiencies if observed. Director of Nu	rsing			
		sicians order for a physical		shall be responsible for assuring improv	ement			
	restraint was signed b	by the physician for 1 of 1		occurs and implements other corrective				
	(Resident #3) who wa	s physically restrained. The	1	if needed or extend enhanced monitorin	g to			
	findings are:		ensure solution is sustained.					
				-Director of Nursing shall establish clear paths				
		noses of Other Reactions to		of communication with Physicians and				
	Severe Stress and Dis	sruptive Mood		staff to ensure verbal orders are signed a	ind	i		
	Dysregulation.		1	completed for each Emergency Safety				
				Intervention by 4/27/22.				
	a. A Physician's Order			Director of Nursing to provide in-servi		-		
		or physical restraint for up		regarding Emergency Safety Intervention policies and procedures to nursing staff				
	injure Order receive	saulting staff [with] intent to		monthly nursing meeting on 4/28/22.	111			
	p.m.]Telephone." The			-Quality Coordinator/Designee shall con	uima			
	Physician's signature			review process for each Emergency Safe				
	. Hy oronali o orginataro			Intervention and document when the ph				
i	b. On 4/7/22 the Direct	tor of Nursing was asked		orders are signed and completed on the		i		
		der. The Director of Nursing		report documentation for each Emergen				
		lem. It should be signed."		Safety Intervention once completed. Qua				
		_		Coordinator/Designee will resolve any	·	1		
1		ergency Safety Intervention		incomplete documentation. Quality		₩		
		Director of Nursing on		Coordinator/Designee shall review all				
		ocumented, "A written order		Emergency Safety Interventions by the				
		equired for the use of a		business the next business day following	; the	1		
		mical restraint, or seclusion.		incident occurrence and document each		i		
j		bal order must be followed	1	Emergency Safety Intervention on the	_			
-	· -	gnature verifying the verbal		Emergency Safety Intervention Review	Log	ĺ		
	order.			form. Quality Coordinator/Designee wil	record	Ì		
				the previous month's ratio of Emergency	Safety			
				Interventions in compliance compared to				
				total number of Emergency Safety Interviews month. Fearer shall also ince				
	the previous month. Focus shall also include verification each physician's order has been							
	Target Completion			signed by the physician on the KPI mon				
	N1-	43 5/2/22		Signed by the physician on the KPI mon	лпу.			

	OF DEFICIENCIES F CORRECTION	(AS) DAT		SURVEY PLETED		
		04L120	B. WING_		04	<i>(</i> 07/2022
	ROVIDER OR SUPPLIER DGE OF THE OZARKS			STREET ADDRESS, CITY, STATE, ZIP CODE 2466 S 48TH STREET SPRINGDALE, AR 72762		
(X4) ID PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
N 207	to both the State Med prohibited by State lar Protection and Advoc Serious occurrences include; - a resident's death - a serious injury to section §483.352 of th - a resident's suicid (1) Staff must report a involving a resident to agency and the State Advocacy system by a business the next bus occurrence. The report and the name of the serious occurrence, - a description of the the name, street a number of the facility. This ELEMENT is not Based on record reviet failed to ensure serious reported to the Office and Disability Rights anotified after suicidal a (Resident #1 and #2) findings are: 1. Resident #1 had dia Dysregulation Disorders. a. On 4/5/22 at 9:30 a	occurrences. In each serious occurrence icaid agency and, unless w, the State designated acy system. Ithat must be reported In; In a resident as defined in his part; and de attempt. Ithat must be serious occurrence to both the State Medicaid designated Protection and ho later than close of siness day after a serious int must include resident involved in the me occurrence and, address, and telephone It met as evidenced by: It was not interview, the facility is occurrences were of Long Term Care (OLTC) Arkansas (DRA) were attempts taken by 2 of 2 sampled residents. The In agnoses of Disruptive Mood er and Other Conduct I.M. Resident #1 was the facility. She stated,	N 26	Director of Nursing adjusted serior reporting guidelines to include suice on 4/7/22 upon receiving notice of deficiency by Surveyor. Director of Nursing updated the Orlong-Term Care and the Disability Center personnel contact informatio occurrence notifications with the in provided by Surveyor on 4/7/22 to enotifications are successfully compledirector of Nursing shall review as serious occurrence reporting policie procedures to include suicidal gesture reporting parameters for serious occurrence for making sure all incidences in place for making sure all incidences in place for the residents. Director of Nursing shall provide it training to nursing staff regarding perocedures for incident reporting an occurrence reporting parameters and in monthly nursing meeting on 4/28. Quality Coordinator/Designee shall review process for each incident reporting an occurrence nade and shall document severity level on incident notification form. Quality Coordinator/Designee shall copy of any serious occurrence reporting the resident's record, attached to notification report, and placed in critical incident log binder. Said binder is to in the DON office in accordance with HIPAA records security rules and p	dal gestures he fice of Rights in for serious formation insure eted di update is and ites in the jurrences by the best of the procedures appropriate etion plans in procedures procedures appropriate of the procedures appropriate in report it of ensure a it is placed incident it is placed in agency	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L120	B. WING		04/07/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2466 S 48TH STREET SPRINGDALE, AR 72762		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
N 207	b. A Nursing Progress p.m. documented, "Somirror on both forearm around her neck." c. An Incident Notificat documented, "Self infigesture." The Authorit form was blank. There OLTC or DRA were noted. A Nursing Progress documented, "RS [Reagain after trying to use. An Incident Notificat documented, "Suicide Notified section of the noted documented, "Suicide Notified section of the noted documented, "1906 [7 a pillow case to tie arc b. An Incident Notificat documented, "Suicide Notified section of the noted documented, "Suicide Notified section of the noted documented, "Resident Notificat documented, "Suicide Notified section of the noted documented, "Resident Notificat section of the noted a pillow case as	s Note dated 4/2/22 at 6:30 all harmed with a broken in and tied a ligature tightly stion Report dated 4/2/22 licted injury Suicide ies Notified section of the exwas no documentation of tified. S Note dated 3/12/22 sident] had to be restrained as a garment as a ligature." Ition Report dated 3/12/22 agesture." The Authorities form was blank. There was TC or DRA were notified. Ition Report dated 11/13/21 agesture." The Authorities form was blank. There was Disruptive Mood To the dated 11/13/21 agesture." The Authorities form was blank. There was TC or DRA were notified.	N 201	As part of the QAC meetings, Director Nursing shall review serious occurrence incidents to monitor performance for compliance in completing notification to Office of Long-Term Care and the Disal Rights Center for each occurrence with a 100% compliance monthly for four mon Director of Nursing shall be responsible assuring improvement does occur, and to implement other corrective actions if neurolong monitoring to ensure solution is sustained. - Quality Coordinator/Designee shall revincident notification reports before the cousiness the next business day following incident occurrence and place a copy of serious occurrence report in the critical is log binder. Quality Coordinator/Designer record monthly on the KPI the previous ratio of serious occurrence incidents from the previous ratio of serious occurrence incidents from the previous remonitor for compliance. N207 Target Completion Date: 5/2/2022	o the collity a goal of ths. for collity and collity and colling the colling t	

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		04L120	B, WING			04/07/2022		
	ROVIDER OR SUPPLIER DGE OF THE OZARKS		STREET ADDRESS, CITY, STATE, ZIP CODE 2466 S 48TH STREET SPRINGDALE, AR 72762		E	V-110112022		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
N 207	d. An Incident Notific documented, "Suici Notified section of the non-documentation of the non-documented, "R's in numerous articles of around her neck." f. An Incident Notific documented, "Self in gesture." The Author form was blank. The OLTC or DRA were as a sked why the Disability Rights has incidents for Reside	ication Report dated 10/9/21 ide gesture." The Authorities the form was blank. There was DLTC or DRA were notified. Ideted dated 10/3/21 teck is red r/t [related to] tying of clothing, including a hair tye cation Report dated 10/3/21 inflicted injury Suicide brities Notified section of the tere was no documentation the notified. Is a.m. the Director of Nursing Office of Long Term Care or d not been notified of the tent #1 and 2. He stated, "They dicidal gestures, not attempts,	N 20'	7				





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

May 10, 2022

Derek Thompson, Administrator Woodridge Of The Ozarks 2466 S 48th Street Springdale, AR 72762

Dear Mr. Thompson:

During the Revisit survey conducted on May 9, 2022, 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,

DPSQA/Office of Long Term Care

Saudie Bisuston Administrative Services Manager

Survey and Certification Section

sgb

PRINTED: 05/10/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		04L120	B. WING _				R 09/2022
NAME OF PROVIDER OR SUPPLIER WOODRIDGE OF THE OZARKS				STREET ADDRESS, CITY 2466 S 48TH STREET		1 00.	00,202
WOODKIL	IGE OF THE OZAKKS			SPRINGDALE, AR 7	72762		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI: TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{N 000}	Initial Comments		{N 0	00}			
	is an official, legal do remain unchanged excorrection, correction space. Any discrepar citation(s) will be reproffice (RO) for referr Inspector General (Conformation is inadve provider/supplier, the should be notified im A revisit was conduct deficiencies cited on deficiencies have been	elG) for possible fraud. If rently changed by the state Survey Agency (SA) mediately. eled on May 9, 2022 for all April 7, 2022. All een corrected, and no new found. The facility is in					
L ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	 F	 	rle		(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.