ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

September 22, 2022

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

Dear Ms. Lockhart:

On September 14, 2022 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 deficieny cited.

Theresa Forrest, LPN, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
(501) **320-6235**
email to Theresa.Forrest@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.

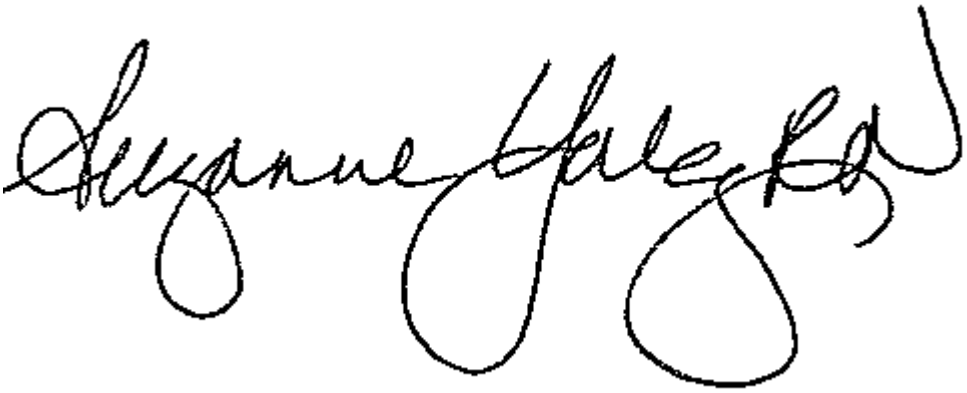
An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action or the requirement for timely submission of an acceptable plan of correction. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative 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
ADH.HFS@Arkansas.gov

If you have any questions, please contact your Reviewer.

Sincerely,



DPSQA/Office of
Long Term Care
Survey & Certification Section

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cc: DRA

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 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF FORREST CITY, LLC	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 #AR00028851 was substantiated, all or in part, with no deficiency cited. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.	N 000		
N 145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior;	N 145		

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

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N 145	Continued From page 1 (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Face to Face Assessments For Emergency Safety Interventions documented the time they took place to ensure they were done within an hour of initiating the emergency safety intervention for 1 (Client #1) of 1 sampled client who was placed in physical restraints. The findings are: 1. Client #1 had diagnoses of Disruptive Mood Dysregulation Disorder (DMDD), Attention Deficit Hyperactivity Disorder (ADHD) and Generalized Anxiety Disorder. a. The Emergency Safety Intervention Reporting Form dated 9/12/22 documented Client #1 was placed in a restraint from 1:07 p.m. to 1:13 p.m. The Face to Face Assessment for Emergency Safety Interventions did not document the time or date that it took place. b. The Emergency Safety Intervention Reporting Form dated 8/16/22 documented Client #1 was placed in a restraint from 11:32 a.m. to 11:25 a.m. The Face to Face Assessment for Emergency Safety Interventions did not document the time that it took place. c. The Emergency Safety Intervention Reporting Form dated 8/6/22 documented Client #1 was placed in a restraint from 8:30 p.m. to 9:07 p.m. The Face to Face Assessment for Emergency	N 145		

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N 145	Continued From page 2 Safety Interventions did not document the time or date that it took place. d. On 9/14/22 at 3:00 p.m., the Surveyor asked the Quality and Risk Director about the Face to Face Reporting Forms. She stated, "It is not documented any other place. It should have been dated and timed.	N 145		
N 189	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a staff debriefing was conducted and documented within 24 hours after Client #1 was placed in a physical restraint. The findings are: 1. Client #1 had diagnoses of Disruptive Mood Dysregulation Disorder (DMDD), Attention Deficit Hyperactivity Disorder (ADHD) and Generalized Anxiety Disorder. a. On 9/14/22 at 2:00 p.m., during the observation	N 189		

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N 189	Continued From page 3	N 189		

of a video of Client #1, the client was placed in a physical hold by staff on 9/12/22 at 1:11 p.m.

b. The Emergency Safety Intervention Reporting Form dated 9/12/22 documented Client #1 was placed in a hold from 1:07 p.m. to 1:07 p.m. Youth Care Worker #1, Youth Care Worker #2, and Licensed Practical Nurse #1 was involved with the restraint. The Staff Debriefing section of the Emergency Safety Intervention Reporting Form only had the date 9/12/22 documented on it. The rest of the form was blank.

c. On 9/14/22 at 3:00 p.m., the Surveyor asked the Quality and Risk Director about the Staff Debriefing. She stated, "They did not complete the staff debriefing."

d. On 9/15/22 at 10:12 a.m., during a telephone interview with Youth Care Worker #2 she stated that she was asked to get on [Client #1's] legs during the restraint on 9/12/22. The Surveyor asked if she participated in a staff debriefing. She stated, "No."

e. The Emergency Safety Interventions Policy provided by the Quality and Risk Director on 9/15/22 at 11:38 a.m. documented, " ...During the debriefing staff involved will determine what can be done to prevent such injuries during Emergency Safety Interventions (ESI) in the future..."

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

October 11, 2022

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

Dear Ms. Lockhart:

On September 14, 2022, 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 October 08, 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:**Theresa Forrest at 501-320-6235 or email to theresa.forrest@dhs.arkansas.gov.**

Sincerely,

Rodney Ryser for
Theresa Forrest, Reviewer
DPSQA/Office of Long Term Care
Survey & Certification Section

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APOC
10/11/2022
RR RR

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

PRINTED: 09/22/2022
FORM APPROVED
OMB NO. 0938-0391

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 145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior;	N 145	Perimeter Behavioral of Forrest City will conduct a mandatory re-education In-Service for all RN's and LPN's led by the facilities Director of Nursing. a. The re-education will be conducted on 10/08/2022 at 9am. Re-education will be over the following competencies: a. Re-educate the scope of practice regarding restraints/seclusions for RN vs LPN b. Emergency safety intervention forms and compliance test.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Merlotte Lockhart | TITLE: CEO | (X6) DATE: 10-5-22

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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ARKANSAS DEPARTMENT OF HUMAN SERVICES

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P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059

November 2, 2022

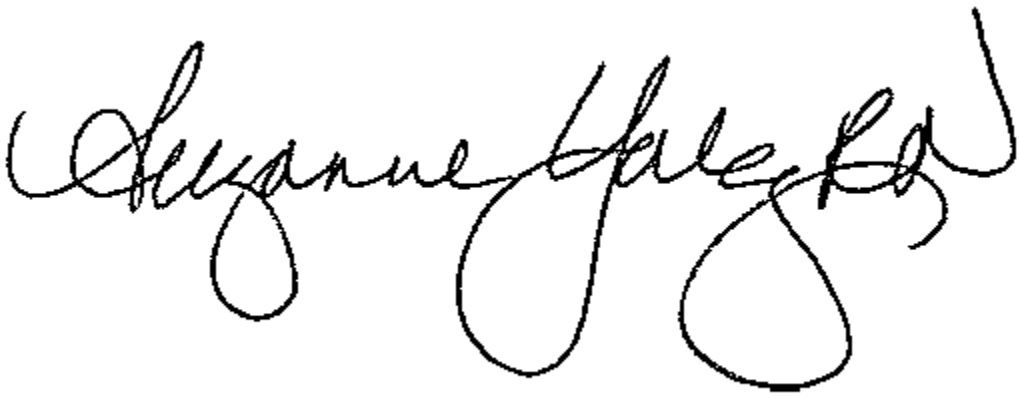
Charlotte Lockhart, Administrator
Woodridge Of Forrest City, Llc
1521 Albert St
Forrest City, AR 72335

Dear Ms. Lockhart:

During the Revisit survey conducted on October 31, 2022, your facility was found to be in compliance with program requirements. **Please email the signed CMS 2567 to Theresa.Forrest@dhs.arkansas.gov.**

If you have any questions, please contact your reviewer:**Theresa Forrest, LPN at 501-320-6235 or email to Theresa.Forrest@dhs.arkansas.gov.**

Sincerely,



DPSQA/Office of
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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