



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 10<sup>th</sup> 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 tf

cc: DRA

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

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N 145	is an official, legal diremain unchanged of correction, correction space. Any discrepation of the control of the correction of the correct	28851 was substantiated, all eficiency cited.  in compliance with §483, ons of Participation for tial Treatment Center.  E OF RESTRAINT OR  initiation of the emergency a physician, or other licensed in the use of emergency and permitted by the state issess the physical and eing of residents, must lice assessment of the ological wellbeing of the out not limited to- si physical and psychological	N.	145			
APODATORY	NIBECTOR'S OR DROVINE	R/SLIPPLIER REPRESENTATIVE'S SIGNATUR	DE .		TITI F		(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) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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N 145	measures; and  (4) Any complication intervention.  This ELEMENT is not a Based on record reversed failed to ensure the life of Emergency Safethe time they took plowithin an hour of inition intervention for 1 (Clowho was placed in possible findings are:  1. Client #1 had diagonysregulation Disorder.	teness of the intervention  tons resulting from the  ot met as evidenced by: view and interview, the facility Face to Face Assessments ety Interventions documented ace to ensure they were done teating the emergency safety tient #1) of 1 sampled client hysical restraints. The  gnoses of Disruptive Mood der (DMDD), Attention Deficit er (ADHD) and Generalized	N 1	DEFICIENCY) 45			
	Form dated 9/12/22 placed in a restraint The Face to Face As Safety Interventions date that it took place b. The Emergency S Form dated 8/16/22 placed in a restraint The Face to Face As Safety Interventions that it took place.  c. The Emergency S Form dated 8/6/22 d placed in a restraint	dafety Intervention Reporting documented Client #1 was from 1:07 p.m. to 1:13 p.m. ssessment for Emergency did not document the time or e.  afety Intervention Reporting documented Client #1 was from 11:32 a.m. to 11:25 a.m. ssessment for Emergency did not document the time  afety Intervention Reporting ocumented Client #1 was from 8:30 p.m. to 9:07 p.m. ssessment for Emergency					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  WOODRIDGE OF FORREST CITY, LLC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				1	TREET ADDRESS, CITY, STATE, ZIP CODE 521 ALBERT ST ORREST CITY, AR 72335			
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N 145	date that it took place d. On 9/14/22 at 3:00 the Quality and Risk II Face Reporting Form documented any othe dated and timed. POST INTERVENTIC CFR(s): 483.370(b)  Within 24 hours after seclusion, all staff inv safety intervention, ar and administrative sta debriefing session tha review and discussion  483.370(b)(1) The em that required the inter	p.m., the Surveyor asked Director about the Face to s. She stated, "It is not er place. It should have been EN DEBRIEFINGS  the use of restraint or colved in the emergency and appropriate supervisory eff, must conduct a at includes, at a minimum, a an of -		145				
	Based on observation interview, the facility f debriefing was conducted to the conduction of the condu	ailed to ensure a staff cted and documented within #1 was placed in a physical						
	Dysregulation Disorde Hyperactivity Disorde Anxiety Disorder.	noses of Disruptive Mood er (DMDD), Attention Deficit r (ADHD) and Generalized p.m., during the observation						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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WOODRIDGE OF FORREST CITY, LLC				1	IS21 ALBERT ST FORREST CITY, AR 72335		
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N 189	b. The Emergency Sa Form dated 9/12/22 d placed in a hold from Youth Care Worker # and Licensed Practica with the restraint. The the Emergency Safety Form only had the da it. The rest of the form c. On 9/14/22 at 3:00 the Quality and Risk ID Debriefing. She stated the staff debriefing."  d. On 9/15/22 at 10:12 interview with Youth Country that she was asked to during the restraint or asked if she participar stated, "No."  e. The Emergency Sa provided by the Quality 9/15/22 at 11:38 a.m. debriefing staff involved to the prevent such as the provided one to prevent such as the provided in the provided to the prevent such as the provided by the Quality 9/15/22 at 11:38 a.m. debriefing staff involved to the prevent such as the provided by the Quality 9/15/22 at 11:38 a.m. debriefing staff involved the prevent such as the provided by the Quality 9/15/22 at 11:38 a.m. debriefing staff involved the prevent such as the provided by the Quality 9/15/22 at 11:38 a.m. debriefing staff involved the prevent such as the provided by the Quality 9/15/22 at 11:38 a.m. debriefing staff involved the prevent such as the provided by the Quality 9/15/22 at 11:38 a.m. debriefing staff involved the prevent such as the prevent such a	, the client was placed in a on 9/12/22 at 1:11 p.m.  If the provided in the complete of the c	N	189			





Division of Provider Services & Quality Assurance 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,

Redney Reper for

Theresa Forrest, Reviewer DPSQA/Office of Long Term Care

Survey & Certification Section

tf

APOC

DEPARTMENT OF HEALTH AND HUMAN SERVICES

10/11/2022

PRINTED: 09/22/2022 FORM APPROVED

RR P 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 C 04L115 B. WING 09/14/2022 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 PRÉFIX (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) 10/08/22 N 000 **Initial Comments** N 000 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 145 ORDERS FOR USE OF RESTRAINT OR N 145 Perimeter Behavioral of Forrest City SECLUSION will conduct a mandatory CFR(s): 483.358(f) re-education In-Service for all RN's and LPN's led by the facilities Within 1 hour of the initiation of the emergency Director of Nursing. safety intervention a physician, or other licensed practitioner trained in the use of emergency a. The re-education will be safety interventions and permitted by the state conducted on 10/08/2022 at 9am. and the facility to assess the physical and psychological wellbeing of residents, must Re-education will be over the conduct a face-to-face assessment of the following competencies: physical and psychological wellbeing of the resident, including but not limited toa. Re-educate the scope of practice (1) The resident's physical and psychological regarding restraints/seclusions for RN vs LPN status: b. Emergency safety intervention (2) The resident's behavior; forms and compliance test.

LABORATORY PIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

-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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	(3) The appropriate measures; and  (4) Any complication intervention.  This ELEMENT is not Based on record reviet failed to ensure the Fa For Emergency Safety the time they took place within an hour of initiat intervention for 1 (Client who was placed in phy findings are:  1. Client #1 had diagnot Dysregulation Disorder Hyperactivity Disorder Anxiety Disorder.  a. The Emergency Safety Form dated 9/12/22 do placed in a restraint from The Face to Face Asses Safety Interventions did date that it took place.  b. The Emergency Safety Form dated 8/16/22 do placed in a restraint from The Face to Face Asses Safety Interventions did that it took place.  c. The Emergency Safety Interventions did that it took place.	mess of the intervention  ms resulting from the  met as evidenced by: ew and interview, the facility ice to Face Assessments interventions documented ex to ensure they were done ing the emergency safety int #1) of 1 sampled client exical restraints. The  passes of Disruptive Mood (DMDD), Attention Deficit (ADHD) and Generalized  exty Intervention Reporting cumented Client #1 was in 1:07 p.m. to 1:13 p.m. existent for Emergency if not document the time or  exty Intervention Reporting cumented Client #1 was in 11:32 a.m. to 11:25 a.m. existent for Emergency in the comment of the time  ty Intervention Reporting imented Client #1 was in 8:30 p.m. to 9:07 p.m.  in 8:30 p.m. to 9:07 p.m.	N	145	Continued from page 1  c. Review state policy and regulations on how and when to perform Face to Face assessment on all residents including client.  d. Director of Nursing and Director of Quality & Risk Management of Quality & Risk Management on 3 medical records including client #1 to ensure 100% compliance of all in ESI forms of compliance is verified by OLTC.  e. DON will discuss compliance daily in Quality/Safety meetings continued ongoing compliance.  f. Compliance rate will be documented and submitted in the organizations monthly Quality/Patient Dashboard.	ents #1 ctor will dits until rate for	10/08/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	V7L110	5, 11110		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	14/2022
WOODRIDGE OF FORREST CITY, LLC					521 ALBERT ST CORREST CITY, AR 72335		
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N 145	Safety Interventions of date that it took place.  d. On 9/14/22 at 3:00 the Quality and Risk Eface Reporting Forms documented any other dated and timed.  POST INTERVENTION CFR(s): 483.370(b)  Within 24 hours after the seclusion, all staff investated and discussion and administrative standebriefing session that review and discussion 483.370(b)(1) The emotion of the intervention;  This ELEMENT is not Based on observation interview, the facility facebriefing was conducted to the intervention of the precision of the precision of the precision of the precision of the intervention;  This ELEMENT is not Based on observation interview, the facility facebriefing was conducted to the intervention of the precision of the	p.m., the Surveyor asked Director about the Face to s. She stated, "It is not r place. It should have been N DEBRIEFINGS  the use of restraint or place in the emergency d appropriate supervisory ff, must conduct a t includes, at a minimum, a of - ergency safety situation rention, including pitating factors that led up  met as evidenced by: , record review, and filed to ensure a staff fed and documented within the stage of the surveyor of the stage of the surveyor of the sur		189	Perimeter Behavioral of Forrest Conduct a mandatory re-education In-Service for all RN's and LPN's the facilities Director of Nursing.  a. The re-education will be conducted 10/08/2022 at 9am.  Re-education will be over the follocompetencies:  a. staff and client debriefing process and required documentation in the justification packet.  b. Review the facilities Incident Reporting Policy.  c. DON and Quality Risk Director conduct daily audits on 3 client chincluding client #1 to ensure 100% compliance on staff and client detent of DON will discuss compliance rain Quality/Safety meetings for contongoing compliance.  e Compliance rate will be docume and submitted in the organizations.	n led by  cted on  owing  edure e ESI  will earts  oriefing te daily tinued	
	a. On 9/14/22 at 2:00 p	o.m., during the observation			monthly Quality/Patient Dashboar	d.	

PRINTED: 09/22/2022 FORM APPROVED

CENTERS FOR WEDICARE &	WEDICAID SERVICES				OMB N	O. 0938-0391
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b. The Emergency Saf Form dated 9/12/22 do placed in a hold from 1 Youth Care Worker #1, and Licensed Practical with the restraint. The the Emergency Safety Form only had the date it. The rest of the form c. On 9/14/22 at 3:00 p the Quality and Risk Di Debriefing. She stated, the staff debriefing."  d. On 9/15/22 at 10:12 interview with Youth Cathat she was asked to go during the restraint on 9 asked if she participate stated, "No."  e. The Emergency Safe provided by the Quality 9/15/22 at 11:38 a.m. do	the client was placed in a on 9/12/22 at 1:11 p.m.  fety Intervention Reporting ocumented Client #1 was 1:07 p.m. to 1:07 p.m.  Youth Care Worker #2, I Nurse #1 was involved Staff Debriefing section of Intervention Reporting e 9/12/22 documented on was blank.  D.m., the Surveyor asked irector about the Staff, "They did not complete  a.m., during a telephone are Worker #2 she stated get on [Client #1's] legs 9/12/22. The Surveyor and in a staff debriefing. She ety Interventions Policy and Risk Director on focumented, "During the did will determine what can hinjuries during	N	189			10/08/22





Division of Provider Services & Quality Assurance 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

Long Term Care Survey and Certification Section

PRINTED: 11/02/2022 FORM APPROVED OMB NO. 0938-0391

AND BLAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		04L115	D. WING			10/	31/2022
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WOODKIL	OGE OF FORREST CITT,	LLC		FOR	RREST CITY, AR 72335		
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	is an official, legal do remain unchanged excorrection, correction space. Any discrepar citation(s) will be reprofice (RO) for referral Inspector General (O information is inadver provider/supplier, the should be notified impact of the should be notified in all deficiencies cited deficiencies have been	erich (S) for possible fraud. If rently changed by the se State Survey Agency (SA) mediately.  The first on October 31, 2022 for on September 14, 2022. All the corrected, and no new found. The facility is in					
LABORATORY	 DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	 F		TITLE		(X6) DATE

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