



December 28, 2022

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

Dear Ms. Lockhart:

On December 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

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cc: DRA

PRINTED: 12/27/2022 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(>	(3) DATE SURVEY COMPLETED	
		04L115	B. WING			C <b>12/14/2022</b>	
NAME OF PR	ROVIDER OR SUPPLIER	0.20	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		12/14/2022	
	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 PREFIX TAG			(X5) COMPLETION DATE	
N 000	Initial Comments		N O	00			
N 134	is an official, legal dorremain unchanged excorrection, correction space. Any discrepancitation(s) will be reported office (RO) for referral Inspector General (Olinformation is inadver provider/supplier, the should be notified immoduled by the should be notified	IG) for possible fraud. If tently changed by the State Survey Agency (SA) mediately.  9294 was in compliance.  compliance with §483, as of Participation for al Treatment Center ESIDENTS )  idity must] communicate its in policy in a language that her parent(s) or legal inds (including American Signiate) and when necessary, de interpreters or  It met as evidenced by: ew and interview the facility in physician's order for a cobtained and documented indings are:	N 1	34			
ABORATORY I	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.

PRINTED: 12/27/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L115	B. WING		C 12/14/2022	
	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  1521 ALBERT ST  FORREST CITY, AR 72335	12/1-7/2022	
(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 SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
N 134	documented Client #restraint on 11/3/22 at 3:5 the restraint of Client reviewed. There was the restraint.  c . A Nurse's Note dadocumented, "Resided 38834 threatening to Altercation took placed dayroom to verbally pinitiated with 2 - persod. On 12/13/22 at 4:0 Director was asked if for the restraint for Client.	afety Intervention (ESI) log 1 was placed in a physical t 8:00 p.m.  0 p.m. the ESI packet for #1 on 11/3/22 was no physician order found for  ted 11/3/22 8:30 pm nt (R) walked up on per physically hit him. e. Staff removed R from process and calm R. ESI was on hold until R became calm.  0 p.m. the Quality & Risk there was a physician order ient #1 on 11/3/22 at 8:00 isk Director reviewed the	N 13	4		





January 9, 2023

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

Dear Ms. Lockhart:

On December 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 January 10, 2023.

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,

David E. Miller for

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

tf

### **APOC** 01/09/2023

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

PRINTED: 12/27/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. DOILDII	_			С
		04L115	B. WING_			12/	14/2022
NAME OF PR	ROVIDER OR SUPPLIER			-	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 PREFI) TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD I  CROSS-REFERENCED TO THE APPROPR  DEFICIENCY)			(X5) COMPLETION DATE
N 000	Initial Comments	80	N (	000			01/10/2023
N 134	is an official, legal doremain unchanged excorrection, correction space. Any discrepancitation(s) will be reported from the resident from the resident from the resident, or his or guardian(s) understart Language, if appropriation appropriation from the record revision for the resident from the resid	IG) for possible fraud. If tently changed by the State Survey Agency (SA) mediately.  9294 was in compliance.  1 compliance with §483, as of Participation for all Treatment Center ESIDENTS  1 ility must] communicate its in policy in a language that her parent(s) or legal ands (including American Signate) and when necessary, de interpreters or  1 t met as evidenced by:  1 ew and interview the facility of physician's order for a cobtained and documented andings are:	<b>N</b> 1	134	Due to the nature of this incident and the potential for future impact on all current and future resident. All nursing employee's will be re-educated by the company Director of Nursing on the followi information:  1. Re-education will be conducte on 01/10/2023 at 10:00am on the required documentation standard for an Emergency Safety Intervention on how to obtain and document orders from the physician.  2.D.O.N and Quality Risk Director will review and audit ESI packets daily to ensure ongoing	et s. ng d e ds	
Ancheron	Unspecified bereaven	noses of Psychiatric and nent.			compliance and follow-up with ar delinquent documentation.	•	(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: 12/27/2022 FORM APPROVED

OCIVICI	O T OIT MEDIOAITE &	WEDICAID SERVICES				OMB NO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		04L115	B. WING			12	C 2 <b>/14/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			T s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12	1412022
MOODDIE	10F 0F F00DF0T 077/				521 ALBERT ST		
WOODKIL	OGE OF FORREST CITY,	LLC			ORREST CITY, AR 72335		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID.	_	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
N 134	Continued From page	1	N	134		_	01/10/202
	<b>_</b>				3. D.O.N or Quality Risk Director		
	a. The Emergency Sa			report ongoing compliance rates	ı		
	restraint on 11/3/22 at	was placed in a physical 8:00 p.m.			during daily leadership meeting.		
	b. On 12/13/22 at 3:50			4. The facility D.O.N obtained an	ıd		
	the restraint of Client #1 on 11/3/22 was				documented a physician's order	for	
	reviewed. There was r the restraint.	no physician order found for			Client #1 on 12/19/2022.		
	c . A Nurse's Note date		İ				
	documented,"Residen		ĺ				
	38834 threatening to p						
	Altercation took place.	Staff removed R from					
	initiated with 2 - person	rocess and calm R. ESI was n hold until R became calm.					
	d. On 12/13/22 at 4:00	p.m. the Quality & Risk		İ			
	Director was asked if t	here was a physician order					
		ent #1 on 11/3/22 at 8:00				:	
•	p.m. The Quality & Ris ESI packet and respor	k Director reviewed the					
	Cor packet and respor	ided 110.					





April 5, 2023

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

#### IMPORTANT NOTICE - PLEASE READ CAREFULLY

Dear Ms. Lockhart:

On December 14, 2022, a Complaint survey was conducted at your facility by the Office of Long Term Care to determine compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid program(s). This survey found your facility was not in substantial compliance with participation requirements. Please refer to our letter, dated December 28, 2022.

A revisit was conducted on March 30, 2023, and your facility was still not in substantial compliance with the following participation requirement(s):

#### N142- Orders For Use Restraint Or Seclusion

#### Plan of Correction (PoC)

A Plan of Correction (PoC) for the cited deficiencies must be submitted within 10 calendar days of receipt of this letter to:

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.

A revisit will be authorized after an acceptable PoC is received. A completion date for each deficiency cited must be included. Your Plan of Correction must also include the following:

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. At the revisit, the quality assurance plan is reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- 5. 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 and Human Services 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 concerning this letter, please contact your reviewer. Sincerely,



DPSQA/Office of Long Term Care Survey & Certification Section

tf

cc: DRA

PRINTED: 04/05/2023 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  WOODRIDGE OF FORREST CITY, LLC   STREET ADDRESS, CITY, STATE, ZIP CODE  1521 ALBERT ST FORREST CITY, AR 72335   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
MOODRIDGE OF FORREST CITY, LLC  (P41) In SUMMARY STATEMENT OF DEFICIENCES FORREST CITY, AR 72335  (PATE IN INC. ARCHITECTURY MINISTER PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (N 000) Initial Comments  (N 00			04L115					
(N 000) Initial Comments  (N 000) Initial Co					1521 ALBERT ST		03/	30/2023
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.  The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.  N 142 ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(c)  A physician or other licensed practitioner permitted by the state and the facility to order restraint or seculsion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.  This ELEMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure an order for a physical and chemical restraint was not received at the same time for 3 (Clients #1, #2 and #3) sampled clients and a physical restraint was utilized long enough	PREFIX	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP		OULD BE		(X5) COMPLETION DATE
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.  The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.  N 142  ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(c)  A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.  This ELEMENT is not met as evidenced by: Based on record review, and interview, the facility failed to ensure an order for a physical and chemical restraint was not received at the same time for 3 (Clients #1, #2 and #3) sampled clients and a physical restraint was utilized long enough	{N 000}	Initial Comments		{N 0	00}			
administration of a chemical restraint for 1 (Client #3) of 4 (Clients #1, #2, #3 and #4) sampled		is an official, legal do remain unchanged excorrection, correction space. Any discreparcitation(s) will be reported for the control of the co	cument. All information must accept for entering the plan of dates, and the signature acy in the original deficiency orted to the Dallas Regional all to the Office of the IG) for possible fraud. If tently changed by the State Survey Agency (SA) mediately.  In compliance with §483, and of Participation for all Treatment Center.  OF RESTRAINT OR  Indicate the least of the safety intervention that is exive in resolving the unation based on consultation of the anorder for a physical and so not received at the same of the	N 1				(X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L115	B. WING			R-C )3/30/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST FORREST CITY, AR 72335	1	33/30/2023	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 142	Hyperactivity Disord Disorder.  a. An "Emergency S Form" [ESI Report] of PM] documented Cliphysical restraint at a taken out of the physical restraint at a take	are:  gnosis of Attention Deficit er and Post Traumatic Stress  afety Intervention Reporting dated 02/04/23 at 2012 [8:12 ent #1 was placed in the 2012 [8:12 PM] and was sical restraint at 2025 [8:25 Benadryl 50 mg [milligram] The Physician's Order eport documented, "2/4/23 er for physical restraint for up 2020 Order for emergency ssion toward staff and peers en: Benadryl x's [times] 1	N 14	· ·			
	documented, "Phy 0912 [9:12 AM] Stop AM] to 0925 [9:25 Al Administration. Time b. A Physician's Ord- documented, "Ord- Order 0912 [9:12 AM	cation Report dated 01/13/23 sical Restraint (Hold) Start 0913 [9:13 AM] / 0918 [9:18 M] Emergency Medication given 0930 [9:30 AM]"  er Physical Restraint er Date: 1-13-23 Time of M] Order for physical restraint to aggression towards					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L115	B. WING			l	-C <b>30/2023</b>
	ROVIDER OR SUPPLIER	LLC		1	STREET ADDRESS, CITY, STATE, ZIP CODE  521 ALBERT ST  FORREST CITY, AR 72335	1 00.	00/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
N 142	documented, "Orde Order 0912 Order for to aggression towards given: Benadryl Dos Medication to be give Route IM"  d. The January 2023 Record documented of Thorazine 50 milligram mg intramuscularly (II  3. Client #3 had diagr Dysregulation Disorde a. An Incident Notificat documented, "Phys 6:46 p [pm] Stop 6:51 Administration Medicat mg/Thorazine 25 mg b. A Physician's Ordet documented, "Today's [6:48 PM] Order for p hour due to physical t kicking doors."  c. A Physician's Ordet documented, "Today's Order for emergency aggression toward sta staff Medication to be Dose X1 Route IM"	r Emergency Medication r Date 1-13-23. Time of emergency Medication due s staff. Medication to be se: 50 mg Route IM n: Thorazine Dose: 50 mg  Medication Administration Client #2 was given ms (mg) and Benadryl 50 M) on 1/13/23 at 9:30 a.m. hoses of Disruptive Mood er (DMDD) and MDD.  ation Report dated 03/23/23 ical Restraint (Hold) Start pm. Emergency Medication ation(s) Benadryl 50 Time given 6:48 p.m"	N	142			
	the QA [Quality Assur	rance] staff if the orders for a chemical restraint were					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R-C
		04L115	B. WING _			03/30/2023
	ROVIDER OR SUPPLIER  DGE OF FORREST CITY,	LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1521 ALBERT ST FORREST CITY, AR 72335	E	
(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 CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 142	taken from the Physic stated, "No they sho physical restraint first chemical restraint"  5. On 03/30/23 at 2:5 the Medical Director irestraint and chemical same time. She state but they always try a she likes for them to the before going to a cheal severe emergent sit automatically give ord.  6. On 03/30/23 at 4:0 the CEO [Chief Executions of the CEO [Chie	sian at the same time. She buldn't, They should try the a before they call for a self-graph of the orders for a physical all restraint were given at the d, "Sometimes they were, physical restraint first, and try at least 30 minutes mical restraint, unless it was tuation. She didn't ders for an injection"  10 PM, the Surveyor asked utive Officer, RN, APN] how all wait between a physical chemical restraint order. It is to minutes" The the orders for a physical all restraint received at the	N 1	,		





April 14, 2023

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

Dear Ms. Lockhart:

On March 30, 2023, we conducted a Complaint Investigation, Follow-Up/Revisit 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 April 14, 2023.

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,

Theresa Forrest, Reviewer

David E. Miller for

DPSQA/Office of Long Term Care

Survey & Certification Section

tf

APOC 04/14/2023

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		04L115	B. WING_		R-C 03/30/2023
	ROVIDER OR SUPPLIER	ııc		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
{N 000}	is an official, legal do remain unchanged ex	7 (Statement of Deficiencies) cument. All information must scept for entering the plan of dates, and the signature	{N 00	00)	4/14/2023
	space. Any discrepant citation(s) will be reported office (RO) for referrationspector General (Oinformation is inadversignment.	cy in the original deficiency orted to the Dallas Regional al to the Office of the IG) for possible fraud. If tently changed by the State Survey Agency (SA)			
	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.  ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(c)  A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff.		N 14	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 in-service with the facilities of the service with the facilities of the	on s led by
				Re-education will cover the follow competencies:  a. The re-education misservice will conducted on 4/14/2023 at 9:00a  Re-education will cover the follow competencies:  a. Emergency Safety Intervention Documentation	wing
	Based on record revifacility falled to ensure chemical restraint watime for 3 (Clients #1, and a physical restrait o determine its effect administration of a ch	t met as evidenced by: ew, and interview, the e an order for a physical and s not received at the same #2 and #3) sampled clients nt was utilized long enough iveness before the emical restraint for 1 (Client 12, #3 and #4) sampled		<ul> <li>b. Obtaining and documenting physician orders.</li> <li>c. Review the facilities policy NS Physician Transcribing and Authentication.</li> <li>d. Review the facilities policy NS Emergency Safety Intervention</li> </ul>	
ABORATORY	DIRECTOR'S OR PROVIDERS	SUPPLIER REPRESENTATIVE'S SIGNATURE	li-	am e	(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

program participation.

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

PRINTED: 04/05/2023

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	04L115	B. WING		R-C 03/30/2023	
NAME OF PROVIDER OR SUPPLIER  WOODRIDGE OF FORREST CITY, L	rc	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST FORREST CITY, AR 72335	1 0000,2020	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 APPROPRI DEFICIENCY)		
Hyperactivity Disorder Disorder.  a. An "Emergency Safe Form" [ESI Report] dat PM] documented Clien physical restraint at 20 taken out of the physic PM] and was given Be IM [intramuscularly]. Tincluded in the ESI rep 2020 [8:20 PM] Order to: 1 hour; 2/4/23 202 medication to Aggressi Medication to be given (one) dose; Dose 50 m b. The Medication Adm documented, "Benad 2025"  2. Client #2 had diagnot Disorder (MDD) and Tr Substantiated.  a. An Incident Notificat documented, "Physic 0912 [9:12 AM] Stop 09 AM] to 0925 [9:25 AM] Administration. Time gib. A Physician's Order documented, "Order	re:  cosis of Attention Deficit and Post Traumatic Stress  ety Intervention Reporting ted 02/04/23 at 2012 [8:12 at #1 was placed in the 112 [8:12 PM] and was cal restraint at 2025 [8:25 enadryl 50 mg [milligram] The Physician's Order cort documented, "2/4/23 for physical restraint for up 20 Order for emergency con toward staff and peers a: Benadryl x's [times] 1 ang route IM"  Ininistration Record (MAR) dryl 50 mg IM @ [at]  coses of Major Depressive rauma Subsequent  tion Report dated 01/13/23 cal Restraint (Hold) Start 1913 [9:13 AM] / 0918 [9:18 1 Emergency Medication 1 iven 0930 [9:30 AM]"  Physical Restraint Date: 1-13-23 Time of Order for physical restraint	N 142	e. The facilities Director of Nursir and Quality Risk Director will condaily chart audits including client client #2, and client #3 to ensure 100% compliance on documenta use for Emergency Safety Interventions.  f. The D.O.N will discuss the daily compliance rate in Quality/Safety Meeting for continued ongoing compliance.  g. Compliance rates will be documented and submitted in the organizations monthly Quality Padashboard.	duct #1, tion	023

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		04L115	B. WING				-C
	ROVIDER OR SUPPLIER			15	REET ADDRESS, CITY, STATE, ZIP CODE 21 ALBERT ST DRREST CITY, AR 72335	<u> </u>	30/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 142	documented, "Orde Order 0912 Order for to aggression towards given: Benadryl Dos Medication to be given Route IM"  d. The January 2023 Record documented of Thorazine 50 milligram gintramuscularly (III 3. Client #3 had diagr Dysregulation Disorde a. An Incident Notificat documented, "Physi 6:46 p [pm] Stop 6:51 Administration Medicat mg/Thorazine 25 mg b. A Physician's Order documented, "Today's [6:48 PM] Order for pl hour due to physical te kicking doors."  c. A Physician's Order documented, "Today's Order for emergency aggression toward sta staff Medication to be Dose X1 Route IM"  4. On 03/30/23 at 2:57 the QA [Quality Assur-	r Emergency Medication r Date 1-13-23. Time of emergency Medication due s staff. Medication to be se: 50 mg Route IM n: Thorazine Dose: 50 mg  Medication Administration Client #2 was given ms (mg) and Benadryl 50 M) on 1/13/23 at 9:30 a.m.  noses of Disruptive Mood er (DMDD) and MDD.  ation Report dated 03/23/23 ical Restraint (Hold) Start pm. Emergency Medication ation(s) Benadryl 50 Time given 6:48 p.m"	N	142			4/14/2023

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION ING			SURVEY
		04L115	B. WING_				-C /30/2023
	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1521 ALBERT ST FORREST CITY, AR 72335	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIA		(X5) COMPLETION DATE
N 142	taken from the Physic stated, "No they sho physical restraint first chemical restraint"  5. On 03/30/23 at 2:5 the Medical Director is restraint and chemical same time. She state but they always try a she likes for them to the before going to a chear a severe emergent situatomatically give or 6. On 03/30/23 at 4:0 the CEO [Chief Exections of the CEO [Chief E	sian at the same time. She buildn't, They should try the buildn't, They should try the before they call for a second of the orders for a physical of restraint were given at the d, "Sometimes they were, physical restraint first, and ry at least 30 minutes mical restraint, unless it was tuation. She didn't ders for an injection"  10 PM, the Surveyor asked ative Officer, RN, APN] how all wait between a physical chemical restraint order. It is 10 minutes" The the orders for a physical of restraint received at the	N	142			4/14/2023