



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

May 9, 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 requierment(s):

N142 Orders For Use Of Restraint Or Seclusion

A revisit was conducted on April 25, 2023, and your facility was still not in substantial compliance with the following participation requirement(s):

N142 Orders For Use Of Restraints 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,

b.L

DPSQA/Office of Long Term Care Survey & Certification Section

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cc: DRA

	-	ID HUMAN SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		04L115	B. WING			R-C / <b>25/2023</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	i	
WOODRIE	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	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{N 000}	Initial Comments		{N 00	00}		
{N 142}	is an official, legal door remain unchanged ex- correction, correction space. Any discrepar- citation(s) will be repor- Office (RO) for referra- Inspector General (O information is inadver provider/supplier, the should be notified immediate The facility was not in Subpart G - Condition Psychiatric Residentiat ORDERS FOR USE of SECLUSION CFR(s): 483.358(c) A physician or other life permitted by the state restraint or seclusion restrictive emergency most likely to be effect emergency safety situ- with staff. This ELEMENT is no Based on record revi- facility failed to ensur- restraint and a chemi-	IG) for possible fraud. If tently changed by the State Survey Agency (SA) mediately. a compliance with §483, as of Participation for al Treatment Center. OF RESTRAINT OR icensed practitioner a and the facility to order must order the least safety intervention that is ctive in resolving the uation based on consultation of met as evidenced by: iew, and interview, the e an order for a physical	{N 14	12}		
	#2) sampled clients.	The findings are: noses of Attention Deficit				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/09/2023 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	ING .			-C
		04L115	B. WING				-C 25/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODRIDGE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
TAG {N 142}	Continued From page Traumatic Stress Disc a. An Incident Notifica documented, "Phys 1318 [1:18 PM] Stop Medication Administra Administered Thorazi 1321 [1:21 PM]" b. A Physician Order documented, "Order I of Order 4/15/23 Order up to: 1 hour due to a Practical Nurse (LPN) c. A Physician Order I documented, "Today's [1:25 PM] Order for et aggression Medicatio Dose: 50 mg [milligration by [LPN #1]. 2. Client #2 had a dia Dysregulation Disorder a. An Incident Notificat documented, "Phys 1305 [1:05 PM] Stop: Medication Administra Administered: Benadu Time given 1305 [1:05 b. A Physician Order I 1305 Order for physic	e 1 prder (PTSD). ation Report dated 04/15/23 ical Restraint (Hold) start 1332 [1:32 PM] Emergency ation Medication (s) ne/Benadryl Time Given: Physical Restraint Date: 1323 [1:23 PM] Time er for physical restraint for ggression by [Licensed ) #1's]" Emergency Medication s Date 4/15/23 Time 1325 mergency Medication due to n to be given: Thorazine m] Route [Intramuscular] gnosis of Disruptive Mood er (DMDD). ation Report dated 04/16/23 ical Restraint (Hold) start 1313 [1:13 PM] Emergency ation Medication (s) ryl 50 mg/Thorazine 50 mg. 5 PM]" Physical Restraint Order Date 4-16-23 Time of Order cal restraint for up to 1 hour	{N 1		DEFICIENCY)	ATE	
	[Registered Nurse (R	ssion towards staff by N) #1]" Emergency Medication					

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED 0.0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L115	B. WING				-	
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	COMPLETED R-C 04/25/2023 CITY, STATE, ZIP CODE AR 72335 DVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE		
WOODRIE	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION	
{N 142}	Order for emergency [physical] aggression be given Benadryl I by [RN #1]" 3. On 04/25/23 at 12: the Chief Executive C nursing staff should w restraint order and a c She stated, "Ten minu 4. On 04/25/23 at 1:2: the Director of Nursin nurses inservice. She asked if part of the ins ESI (Emergency Safe emergency medicine obtained at the same had to put that part or last survey." 5. The Nurse Meeting documented, "Obta is notified of initiation [Physician] to obtain of If the restraint continu The Nurse contacts [F orders. 3. If order recomedications, The Nur- Writing a separate or medications to include Administer medication danger to self or othe and Emergency medi obtained at the same	as Date 4-16-23 Time 1305 Medication due to phys toward staff Medication to Dose:50 mg Route: IM 00 PM, the Surveyor asked officer (CEO) how long vait between a physical chemical restraint order. utes." 4 PM, the Surveyor asked g (DON) if she did the stated, "Yes." The Surveyor service was that physical ty Intervention) order and orders should not be time. She stated, "Yes. I in there, it was new, since the Agenda for 04/13/23 ining ESI Orders - 1. Nurse of ESI. The Nurse calls order for the physical ESI. 2. ues for 10 minutes or longer, Physician] for additional eived include emergency se is to carry out orders by:	{N -	142}				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 3012

If continuation sheet Page 3 of 4

CENTERS FOR MEDICARE & MEDICAID SERVICES       OMB NO. 0         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SUI COMPLET         NAME OF PROVIDER OR SUPPLIER       04L115       B. WING       04/25/ 1521 ALBERT ST	URVEY ETED 5/2023
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLET R-C 04L115 B. WING 04L115 B. WING 04/25/	ETED C 5/2023
04L115         B. WING         04/25/           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         04/25/	5/2023 (X5)
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE	(X5)
	(X5)
	(X5)
WOODRIDGE OF FORREST CITY, LLC FORREST CITY, AR 72335	(X5)
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE     O       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     O	COMPLETION DATE
{N 142}       Continued From page 3       {N 142}         6. A Sign In Sheet for the Nurse Training, dated 4/13/2023, contained both LPN #1's and RN #1's names and signatures.       N 142}	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DK9Q13

Facility ID: 3012

If continuation sheet Page 4 of 4





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

May 16, 2023

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

Dear Ms. Lockhart:

On April 25, 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 May 15, 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,

Davil E. Miller For

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

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	ARTMENT OF HEALTH A	MEDICAID SERVICES		05/16/2023 DM	PRINTED: 05/09 FORM APPR
I STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		<u>OMB NO. 0938</u>
		IDENTIFICATION NUMBER:	A. BUILON		(X3) DATE SURVEY COMPLETED
Nation -		04L115	B. WING		R-C
NAME O	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/25/2023
WOOD	RIDGE OF FORREST CITY,	LLC		1521 ALBERT ST	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		[	FORREST CITY, AR 72335		
PREFID	(EACH DEFICIENC)	MUST BE PRECEDED AV ANN	ID	PROVIDER'S PLAN OF CORRECTION	N
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(AJ)
(N 000	0) Initial Comments		{N 00	D}	5/15/20
	Note: The CMS-2567	(Statement of Deficiencies)			
	is an Unicial, legal doci	Iment All information must			
	i oniani unchanged exc	ept for entering the plan of			1
	Correction, correction d	ates, and the signature y in the original deficiency			
	Circulor(S) Will be report	ed to the Dallas Postanal			
	once (RO) for referral	to the Office of the			
	Inspector General (O)G	i) for possible fraudult			
	information is inadverte	ntly changed by the tate Survey Agency (SA)			
	should be notified imme	diately.			
	The facility was not in c	ompliance with \$483.			
	Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.			Perimeter Behavioral of Forrest C	ity
{N 142}	ORDERS FOR USE OF	Freatment Center.		will conduct a mandatory re-educe	ation
,,	SECLUSION	RESTRAINTOR	{N 142}	I INFOUNCE TOP All I PN' and DN's T	Thin
	CFR(s): 483.358(c)			in-service will be led by the facilitie Director of Nursing.	es
	A physician or other licer	nsed practitioner			
	permitted by the state an restraint or seclusion mu	d the facility to order			
	restrictive emergency sat	etv intervention that is		a. The re-education in-service will	be
	most likely to be effective	in resolving the		conducted on 5/15/2023 at 9:00am	ı.
	emergency safety situation with staff.	on based on consultation			
				The in-service will cover the followi	ng
	This ELEMENT is not me	et as evidenced by:		competencies:	-
1	based on record review.	and interview the		a. Reviewing daily nursing process	
	facility failed to ensure an restraint and a chemical restraint	Astraint was not			es
I (	received at the same time	for 2 (Clients #1 and		b. Emergency Safety Intervention	
	rz) sampled clients. The f	indings are:		Documentation.	
1	. Client #1 had diagnoses	s of Attention Deficit		c. Obtaining and documenting	
	syperactivity Disorder (AD	HD) and Post		physician orders.	
ATORY DIF	RECTOR'S OR PROVIDER/SUPPO	ER REPRESENTATIVE'S SIGNATURE			
[1	IN ALL VALA	1911 LA DUL		ATTILE C	(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES		CONSTRUCTION	_	<u> 0938-039</u>
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:				E SURVEY PLETED
		04L115	B. WING			8-C
NAME OF F	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	04	/25/2023
WOODRI	DGE OF FORREST CITY,	LLC	1	521 ALBERT ST ORREST CITY, AR 72335		
(X4) ID	SUMMARY ST	TEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETIO DATE
{N 142}	Continued From page Traumatic Stress Diso		{N 142}	Continued from page #1		5/15/202
	documented, "Physia 1318 [1:18 PM] Stop 1 Medication Administra Administered Thorazin 1321 [1:21 PM]" b. A Physician Order P documented, "Order D of Order 4/15/23 Order up to: 1 hour due to ag Practical Nurse (LPN) a c. A Physician Order En documented, "Today's [1:25 PM] Order for em aggression Medication Dose: 50 mg [milligram by [LPN #1]. 2. Client #2 had a diagr Dysregulation Disorder a. An Incident Notification documented, "Physica 1305 [1:05 PM] Stop:13 Medication Administration Administered: Benadryl Time given 1305 [1:05 PM] b. A Physician Order Ph focumented, "Order Da	Physical Restraint ate: 1323 [1:23 PM] Time for physical restraint for gression by [Licensed #1's]" mergency Medication Date 4/15/23 Time 1325 ergency Medication due to to be given: Thorazine ] Route [Intramuscular] nosis of Disruptive Mood (DMDD). on Report dated 04/16/23 al Restraint (Hold) start 13 [1:13 PM] Emergency on Medication(s) 50 mg/Thorazine 50 mg. PM]" ysical Restraint Order te 4-16-23 Time of Order restraint for up to 1 hour ion towards staff by		<ul> <li>d. Review the facilities policy N 7.55 Emergency Safety Interve</li> <li>e. The facilities Director of Nurs and Quality Risk Director will co daily chart audits including Cliet and Client #2 to ensure ongoing compliance in Emergency Safet Intervention documentation use</li> <li>f. The Director of Nursing will di the compliance rate daily during facilities quality/safety meetings</li> <li>g. A compliance metric will be a to the facilities KPI metrics to en ongoing compliance. This inform will be reviewed and documenter monthly during the facilities mon board meetings.</li> </ul>	ntion sing onduct nt #1 g ty scuss the dded usure nation	

FORM CMS-2587(02-99) Previous Versions Obsolete

Facility ID: 3012

If continuation sheet Page 2 of 4

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/09/2023 FORM APPROVED

		KS FOR MEDICARE &	MEDICAID SERVICES					NO. 0938-03	
	STATEMENT AND PLAN O	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) D,	ATE SURVEY	91
			04L115	B. WING				R-C	
	NAME OF F	PROVIDER OR SUPPLIER			_			04/25/2023	
	WOODDI					REET ADDRESS, CITY, STATE, ZIP CODE			
ľ	HOODKI	DGE OF FORREST CITY,	LLC						
ľ	(X4) ID	SUMMARY STA				RREST CITY, AR 72335			
	PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	e Nte	(X5) COMPLETION DATE	
		documented, "Today's Order for emergency M [physical] aggression t be given Benadry! Do by [RN #1]" 3. On 04/25/23 at 12:0 the Chief Executive Off nursing staff should wa restraint order and a ch She stated, "Ten minut 4. On 04/25/23 at 1:24 the Director of Nursing nurses inservice. She s asked if part of the inse ESI (Emergency Safety emergency medicine or obtained at the same tim had to put that part on t last survey." 5. The Nurse Meeting A documented, "Obtaini is notified of initiation of [Physician] to obtain ord if the restraint continues The Nurse contacts [Phy orders. 3. If order receiv medications, The Nurse Writing a separate order medications to include d Administer medication if langer to self or others and Emergency medicino	Date 4-16-23 Time 1305 Medication due to phys oward staff Medication to ose:50 mg Route: IM 0 PM, the Surveyor asked ficer (CEO) how long it between a physical hemical restraint order. es." PM, the Surveyor asked (DON) if she did the stated, "Yes." The Surveyor rvice was that physical (DON) if she did the stated, "Yes." The Surveyor rvice was that physical (Intervention) order and ders should not be me. She stated, "Yes. I here, it was new, since the genda for 04/13/23 ng ESI Orders - 1. Nurse ESI. The Nurse calls ler for the physical ESI. 2. for 10 minutes or longer, ysician] for additional ed include emergency is to carry out orders by: for emergency ate, time, & rationale client continues to be a "Physical ESI orders e orders should not be	{N 1.	42}	DEFICIENCY)		5/15/202	3
		time received"."							
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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 3012

If continuation sheet Page 3 of 4

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT	OF DEFICIENCIES				OMB	RM APPRO\ NO. 0938-0;
AND PLAN (	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) D/	ATE SURVEY
		04L115	B. WING		l l	R-C
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		4/25/2023
WOODRI	DGE 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	ON SHOULD BE	(XS) COMPLETIC DATE
{N 142}	6. A Sign In Sheet for	the Nurse Training, dated both LPN #1's	{N 142}	DEFICIENCY	)	5/15/202

If continuation sheet Page 4 of 4