



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

June 18, 2024

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

Dear Ms. Lockhart:

On June 7, 2024, a Recertification, and 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 deficiency cited.

Theresa Forrest, 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 a 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 ADH.HFS@Arkansas.gov

If you have any questions, please contact your Reviewer.

Jeff Rosenbaum

DPSQA/Office of Long Term Care
Survey & Certification Section

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cc: DRA

Sincerely,

PRINTED: 06/18/2024 FORM APPROVED OMB NO. 0938-0391

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N 142	is an official, legal do remain unchanged excorrection, correction space. Any discrepar citation(s) will be reported for the citation of the citation of the citation of the correction of the citation of the c	IG) for possible fraud. If reently changed by the state Survey Agency (SA) mediately. urvey was conducted from 06/07/2024. 8421, was not in compliance, iciencies cited at N0142 and in compliance with §483, as of Participation for al Treatment Center. OF RESTRAINT OR icensed practitioner eand the facility to order must order the least y safety intervention that is	N.	142			
45054T05V					TITLE		(Y6) DATE

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

TITLE (X6) DAT

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 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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N 156	dated 04/01/2024 for 2:23 PM, 3:52 PM, ar 7:25 AM; 05/02/2024 7:15 AM; 05/04/2024 3:25 AM; 05/08/2024 9:27 AM were review was absent and the orecord. c. The "Physician Ordorder forms dated 04/05/02/2024 for 7:15 A and 05/13/2024 for 9: physician's signature was not in the clients 2. Client #5 had diagr disorder severe with present the generalized anxiety of dated 05/11/2024 for physician's signature was not in the clients b. The "Physician Ordorder form dated 05/11/2024 for physician's signature was not in the clients b. The "Physician Ordorder form dated 05/11/2024 for physician's signature was not in the clients c. Client #8 had diagr disorder severe with present the physician ordorder form dated 05/11/2024 for physician ord	der Physical Restraint" forms the following times 1:40 PM, and 4:04 PM; 04/24/2024 for for 7:12 AM; 05/02/2024 for for 3:25 AM; 05/04/2024 for for 3:28 PM; 05/13/2024 for ed, the physician's signature reder was not in the clients der Emergency Medication" 101/2024 for 4:05 PM; M; 05/04/2024 for 3:25 AM; 35 AM were reviewed, the was absent, and the order record. Inoses of major depressive psychotic features, and isorder. der Physical Restraint" form 7:25 PM was reviewed, the was absent, and the order record. der Emergency Medication" 11/2024 for 7:30 PM was an's signature was absent, tin the client's record.	N	156			

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	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 521 ALBERT ST FORREST CITY, AR 72335	1 06/	07/2024
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N 156	04/09/2024 for 8:52 A 04/10/2024 for 12:49 04/14/2024 for 5:04 F and 2:16 PM; 04/16/2 04/18/2024 for 5:07 F PM; 04/23/2024 for 1:4:32 PM; 04/27/2024 05/16/2024 for 2:14 F PM were reviewed, thabsent, and the order record. b. The "Physician Ordorder forms dated 04/04/09/2024 for 1:06 F 04/16/2024 for 1:06 F 04/16/2024 for 1:06 F 04/16/2024 for 12:36 PM; 05/16/2024 for 2:3:21 PM were review was absent, and the orecord. 4. Client #10 had diag dysregulation disorder a. The "Physician Ordoted 04/21/2024 for 7:48 AM were review was absent, and the orecord. b. An "Emergency Sa was received on 06/0 reviewed and read in the physician is required to the physician physician is physician to the physician physicia	PM; 04/05/2024 at 9:05 AM; AM and 12:40 PM; PM, 1:22 PM, and 5:54 PM; PM; 4/15/2024 for 8:06 AM; PM; 04/19/2024 for 12:26 2:52 PM; 04/24/2024 for 3:21 ne physician's signature was a was not in the clients of the physician's signature was a was not in the clients of the physician's signature was another physician's signature was another physician's signature was another physician's signature was another physician's signature order was not in the clients of the physician's signature order was not in the clients of the physician's signature order was not in the clients of the physician's signature order was not in the clients of the physician's signature order was not in the client's of the physician's signature order was not in the client's of the physician's signature order was not in the client's of the physician's signature order was not in the client's order was	N	156			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(×	(X3) DATE SURVEY COMPLETED		
		04L115	B. WING _			C 06/07/2024		
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD 1521 ALBERT ST FORREST CITY, AR 72335		00/01/2024		
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
N 156	forty-eight (48) hours c. On 06/06/2024 at 2 Nursing (DON) was a orders should be sign record. She said, with asked what was hind the orders. She said to orders, they are then where she signs then said she doesn't know	2:24 PM, the Director of isked when the physician's ned and put in the client's nin 24 hours. The Surveyor ering the physician in signing that when the nurses get the scanned to the physician in every morning. The DON w what the reason is that the signed, stating she has a	N 1	156				





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

June 26, 2024

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

Dear Ms. Lockhart:

On June 7, 2024, we conducted a Recertification and 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 June 26, 2024.

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 DPSQA/Office of Long Term Care Survey & Certification Section

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tf

1410C 06/26/2024

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

PRINTED: 06/18/2024 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		Solito III College	(X3) DATE SURVEY COMPLETED	
		04L115	B. WING			06/0	7/2024
	OVIDER OR SUPPLIER	LLC		1	TREET ADDRESS, CITY, STATE, ZIP CODE 521 ALBERT ST ORREST CITY, AR 72335		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	-	(X5) COMPLETION DATE
N 000	is an official, legal do remain unchanged excorrection, correction space. Any discreparcitation(s) will be reported (RO) for referr Inspector General (Conformation is inadversible provider/supplier, the should be notified im A 5 year Validation so 06/03/2024 through the complaint #AR0003 all or in part, with definition in part, with definition of the facility was not in Subpart G - Condition Psychiatric Resident ORDERS FOR USE SECLUSION CFR(s): 483.358(c) A physician or other permitted by the stat restraint or seclusion restrictive emergency most likely to be effect emergency safety significant with staff.	olicitical processible fraud. If reently changed by the estate Survey Agency (SA) mediately. olicitical processible fraud. If reently changed by the estate Survey Agency (SA) mediately. olicitical processible from olicitical		142	Perimeter Behavioral of Forrest City we conduct a mandatory, in-service retrained with all Nurses led by the Director of Nursing 06/25/2024. The in service training will include the following competencies: reviewing dainursing procedures, Emergency Safet Intervention documentation, and obtain Physician signature within 48 hours. Training will also cover ordering interventions from least restrictive to emergency intervention. Director of Nursing and Director of Quality/Risk Management will review Incident Reports daily during Safety material to evidence least restrictive attempts a de-escalation before ordering emerge interventions. This practice will be begong/25/2024 and ongoing indefinitely.	rill ning elly by ining at ancy	06/26/2024
L	- ALCONO AD AD AN AD ALCONO AD ALCON	VOLIDOLIED DEDDESENTATIVE'S SIGNATURE	····	-	A JULE	2	(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 hornes, 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.

Facility ID: 3012

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L115	B. WING_			06#	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 06/1	07/2024
					21 ALBERT ST		
WOODRIE	GE OF FORREST CITY,	LLC			DRREST 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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 142	Continued From page	÷1	N 1	42			
		der for a physical and re not received at the same #4, #5, #8 and #9) case					
	dysregulation disorder hyperactivity disorder a. The "Physician Ordated 10/01/2023 was "Order date: 10/01/20 [7:50 PM], From: [Pb. The "Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 50 mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 50 mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 50 mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 50 mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 so mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 so mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 so mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 so mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 so mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 so mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 so mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 so mg, From: [Physician Order form dated 10/0 read in part, "Today's 1950, Benadryl 100 so mg]	der Physical Restraint" form serviewed and read in part, 123, Time of order: 1950 hysician's Name]". der Emergency Medication" 11/2023 was reviewed and date: 10/01/2023, Time: mg [milligram], Thorazine ician's Name]".			Milieu makeup including general ages diagnosis, and cognitive developmen will be reviewed during Staff training 06/26/2024. Training will be provided further itinerate the importance of interventions and de-escalation attempts starting from least restrictive to emergency interventions. This is to prevent any interventions that do not follow the de-escalation model.	to	
	dated 11/05/2023 was "Order date: 11/05/20 [2:45 PM], From: [P d. The "Physician Order form dated 11/0 read in part, "Today's 1445, Benadryl 50 r From: [Physician's Na 2. Client #4 had diagr disorder, attention de and post traumatic str a. The "Physician Order	der Emergency Medication* 15/2023 was reviewed and date: 11/05/2023, Time: mg, Zyprexa 10 mg, ame]". noses of generalized anxiety ficit hyperactivity disorder					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		04L115	B. WING			C 06/07/2024
	ROVIDER OR SUPPLIER DIGE OF FORREST CITY			STREET ADDRESS, CITY, STATE, ZIP O 1521 ALBERT ST FORREST CITY, AR 72335		
(X4) ID PRFFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
N 142	"Order date: 05/04/2/ [3:25 AM], From: [f b. The "Physician Or order form dated 05/ read in part "Today's 0325, Thorazine 28 From: [Physician's N 3. Client #5 had diag disorder, severe with generalized anxiety of a. The "Physician Or dated 12/09/2023 wa "Order date: 12/09/2 [7:49 PM], From: [f b. The "Physician Or order form dated 12/ read in part "Today's 1949, Benadryl 25 From: [Physician's N 4. Client #8 had diag disorder, severe with generalized anxiety a. The "Physician Or dated 04/01/2024 wa "Order date: 04/01/2 [10:22 PM], From: b. The "Physician O order form dated 04 read in part "Today's	o24, Time of order: 0325 Physician's Name]". der Emergency Medication" 04/2024 was reviewed and date: 05/04/2024, Time: 5 mg, Benadryl 25 mg, ame]". nosis of major depressive a psychotic features, and disorder. der Physical Restraint" form as reviewed and read in part 023, Time of order: 1949 Physician's Name]". der Emergency Medication" 09/2023 was reviewed and date: 12/09/2023, Time: mg, Thorazine 25 mg, lame]". gnosis of major depressive a psychotic features, and disorder. rder Physical Restraint" form as reviewed and read in part 024, Time of order: 2022 [Physician's Name]". rder Emergency Medication" ////////////////////////////////////	N	142		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		04L115	B. WING_			C	
NAME OF P	ROVIDER OR SUPPLIER		1 1	STREET ADDRESS, CITY, STATE, ZIP CODE		06/07/2024	
WOODRIE	GE 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	X (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
N 142	c. The "Physician Ord dated 04/12/2024 was "Order date: 04/12/20 [09:27 AM], From: [I d. The "Physician Ordorder form dated 04/1 read in part "Today's 0927, Benadryl 50 r From: [Physician Ordorder date: 04/26/2024 was "Order date: 04/26/2024 was "Order date: 04/26/20[3:45 PM], From: [Pf. The "Physician Ordorder form dated 04/2 read in part "Today's 1545, Thorazine 25 From: [Physician Ordorder date: 05/08/2024 was "Order date: 05/17/2024 was "Order date: 05/17/20	ler Physical Restraint" form is reviewed and read in part 124, Time of order: 0927 Physician's Name]". Ider Emergency Medication" 2/2024 was reviewed and date: 04/12/2024, Time: ng, Thorazine 25 mg, ame]". Ider Physical Restraint" form is reviewed and read in part 124, Time of order: 1545 hysician's Name]". Ider Emergency Medication" 16/2024 was reviewed and date: 04/26/2024, Time: mg, Benadryl 50 mg, ame]". Ider Physical Restraint" form is reviewed and read in part 124, Time of order: 1805 hysician's Name]". Ider Emergency Medication" 182024 was reviewed and date: 05/08/2024, Time: ng, Benadryl 50 mg Physician's Name]". Ider Emergency Medication" 182024 was reviewed and date: 05/08/2024, Time: ng, Benadryl 50 mg Physician's Name]". Ider Physical Restraint" form is reviewed and read in part 124, Time of order: 1521	N 1	142			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		E SURVEY PLETED
		04L115	B. WING _		06	/07/2024
NAME OF PROVIDER OR SUPPLIER WOODRIDGE OF FORREST CITY, LLC				STREET ADDRESS, CITY, STATE, ZIP C 1521 ALBERT ST FORREST CITY, AR 72335	ODE	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	(X5) COMPLETION DATE	
N 142	read in part "Today's 1521, Thorazine 50 From: [Physician's Ni 5. Client #9 had diagra. The "Physician Ordated 10/08/2023 wa "Order date: 10/08/20[3:00 PM], From: [Fb. The "Physician Order form dated 10/0 read in part "Today's 1500, Benadryl 50 From: [Physician's Ni c. An "Emergency Sawas received on 06/0 reviewed and read in restraint shall always the least restrictive m from injuring self or a safety situation, Maintorvention used to situation to contain s behavior, exacerbatilikely to cause harm residents, or staff, physician is required restraint, or emerger physician must order emergency safety in to be effective in resintervention based o	ar//2024 was reviewed and date: 05/17/2024, Time: mg, Benadryl 50 mg, ame]". Inosis of der Physical Restraint" form as reviewed and read in part 223, Time of order: 1500 Physician's Name]". Ider Emergency Medication" 08/2023 was reviewed and date: 10/08/2023, Time: mg, Thorazine 50 mg, ame]". Inosis of der Physical serviewed and date: 10/08/2023, Time: mg, Thorazine 50 mg, ame]". Inosis of der Physical serviewed and date: 10/08/2023, Time: mg, Thorazine 50 mg, ame]". Inosis of der Physical serviewed and date: 10/08/2023, Time: mg, Thorazine 50 mg, ame]". Inosis of der Physical serviewed and date: 10/08/2023, Time: mg, The use of physical serviewed and date: 10/08/2023, Time: mg, The use of physical serviewed and emergency safety evere, out of control on of psychosis which is to the resident other A written order from the or the use of a physical new medication, The releast restrictive tervention that is most likely olving the emergency safety in the consultation with staff, an must sign the verbal order	N	142		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

1 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		04 <u>1.11</u> 5	B. WING _			1	С	
NAME OF PROVI	IDER OR SUPPLIER	044110	2. 11.110_		REET ADDRESS, CITY, STATE, ZIP CODE	06/0	07/2024	
WOODRIDGE OF FORREST CITY, LLC				15	21 ALBERT ST DRREST CITY, AR 72335			
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
d. Nu wr ph sa e. as co wh ph ph orc OF Th pe res se as Th Brail an an Th 1. dis an a.	ursing (DON) stated ritten for that before by sical and chemical ame time. On 06/06/2024 at 2 sked when should a behavior contract and the same traction of	:00 PM, the Director of the facility had "been ' when asked about getting I restraint orders at the :24 PM, the DON was chemical restraint be avior incident. She stated inues to escalate in a e Surveyor asked should a chemical restraint be ime. She stated, "No." OF RESTRAINT OR r licensed practitioner and the facility to order must sign the restraint or resident's record as soon t met as evidenced by: nd record review the facility clan's orders were signed ford for 4 (Clients #4, #5, #8 ents.		1142	During mandatory in-service retraind Director of Nursing will ensure to coordering emergency interventions a delineating in proper escalation with Nurses and Physician 06/25/2024. Director of Nursing and Director of Quality/Risk Management will conduct twice weekly chart audits to ensure ongoing compliance with Emergence Safety Intervention documentation. Director of Quality/Risk Management rack Emergency Safety Intervention compliance rate as a compliance meand share compliance data during mand share compliance data during mandefinitely beginning 06/26/2024. Emergency Safety Interventions procedure and expectations will be revisited with the Physician to ensure compliance with signing orders within hours per facility policy.	ver nd all twill etric conthly c,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING	(X3) DATE SURVEY COMPLETED
	C
04L115 B. WING	06/07/2024
NAME OF PROVIDER OR SUPPLIER WOODRIDGE OF FORREST CITY, LLC STREET ADDRESS, CITY, STATE, 1521 ALBERT ST FORREST CITY, AR 72335	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCES	AN OF CORRECTION (XS) YE ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE CIENCY)
N 156 Continued From page 6 deficient practice was identified. b. The "Physician Order Physical Restraint" forms dated 04/01/2024 for the following times 1:40 PM, 2:23 PM, 3:52 PM, and 4:04 PM; 04/24/2024 for 7:25 AM; 05/02/2024 for 7:12 AM; 05/02/2024 for 7:15 AM; 05/04/2024 for 3:25 PM; 05/04/2024 for 3:25 AM; 05/08/2024 for 3:25 PM; 05/04/2024 for 9:27 AM were reviewed, the physician's signature was absent and the order was not in the clients record. c. The "Physician Order Emergency Medication" order forms dated 04/01/2024 for 4:05 PM; 05/02/2024 for 7:15 AM; 05/04/2024 for 3:25 AM; and 05/13/2024 for 9:35 AM were reviewed, the physician's signature was absent, and the order was not in the clients record. 2. Client #5 had diagnoses of major depressive disorder severe with psychotic features, and generalized anxiety disorder. a. The "Physician Order Physical Restraint" form dated 05/11/2024 for 7:25 PM was reviewed, the physician's signature was absent, and the order was not in the clients record. b. The "Physician Order Emergency Medication" order form dated 05/11/2024 for 7:30 PM was reviewed, the physician's signature was absent, and the order was not in the clients's record. 3. Client #8 had diagnoses of major depressive disorder severe with psychotic features and generalized anxiety disorder. a. The "Physician Order Physical Restraint" forms disted 04/01/2024 for 3:05 PM and 10:22 PM:	

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
ļ 		04L115	B. WING			1	C 07/2024
	ROVIDER OR SUPPLIER DGE OF FORREST CITY,	ЩС		STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST FORREST CITY, AR 72335	=	1 001	OIJAVAT
(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 COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
N 156	04/04/2024 at 12:30 in 04/09/2024 for 8:52 / 04/10/2024 for 12:49 04/14/2024 for 5:04 Fand 2:16 PM; 04/16/2024 for 5:07 FPM; 04/23/2024 for 14:32 PM; 04/27/2024 05/16/2024 for 2:14 FPM were reviewed, the absent, and the order record. b. The "Physician Order forms dated 04/29/2024 for 1:06 F04/16/2024 for 1:06 F04/16/2024 for 1:06 F04/16/2024 for 12:36 PM; 05/16/2024 for 2:3:21 PM were review was absent, and the record. 4. Client #10 had diagonal d	PM; 04/05/2024 at 9:05 AM; AM and 12:40 PM; PM, 1:22 PM, and 5:54 PM; PM, 1:415/2024 for 8:06 AM; PM; 04/19/2024 for 12:26 2:52 PM; 04/24/2024 for for 9:40 AM and 1:02 PM; PM; and 05/17/2024 for 3:21 ne physician's signature was a was not in the clients of the physician's signature was a was not in the clients of the physician's physician's physician's physician's physician's physician's signature was a was not in the clients of the physician's physician's physician's physician's physician's physician's signature proder was not in the clients of the physician's signature proder was not in the clients of the physician's signature proder was not in the clients of the physician's signature proders of the phy	N 1	56			
	was received on 06/0 reviewed and read in the physician is requi restraint, or emergen	afety Interventions" policy 4/2024 at 8:56 AM, it was part, "A written order from red or the use of a physical cy medicationThe ordering he verbal order within					of Victoria National Association and Association and Association (Association)

	APIG PIC	O I O I THE DIO WATER OF	TEDIOTO OLITARE	· I · · · · · · · · · · · · · · · · · ·					
NAME OF PROVIDER OR SUPPLIER WOODRIDGE OF FORREST CITY, LLC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 156 Continued From page 8 forty-eight (48) hours" c On 06/06/2024 at 2*24 PM, the Director of Nursing (DON) was asked when the physician's orders should be signed and put in the client's record. She said, within 24 hours. The Surveyor asked what was hindering the physician in signing the orders. She said that when the nurses get the orders, they are then scanned to the physician where she signs them every morning. The DON said she doesn't know what the reason is that the orders haven't been signed, stating she has a	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION								
NAME OF PROVIDER OR SUPPLIER WOODRIDGE OF FORREST CITY, LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 156 Continued From page 8 forty-eight (48) hours" C On 06/06/2024 at 2'24 PM, the Director of Nursing (DON) was asked when the physician's orders should be signed and put in the client's record. She said, within 24 hours. The Surveyor asked what was hindering the physician in signing the orders. She said that when the nurses get the orders, they are then scanned to the physician where she signs them every morning. The DON said she doesn't know what the reason is that the orders haven't been signed, stating she has a							C	;	
WOODRIDGE OF FORREST CITY, LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 156 Continued From page 8 forty-eight (48) hours" C On 06/06/2024 at 2*24 PM, the Director of Nursing (DON) was asked when the physician's orders should be signed and put in the client's record. She said, within 24 hours. The Surveyor asked what was hindering the physician in signing the orders. She said that when the nurses get the orders, they are then scanned to the physician where she signs them every morning. The DON said she doesn't know what the reason is that the orders haven't been signed, stating she has a			04L115	B. WING			06/	07/2024	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 156 Continued From page 8 forty-eight (48) hours" C On 06/06/2024 at 2·24 PM, the Director of Nursing (DON) was asked when the physician's orders should be signed and put in the client's record. She said, within 24 hours. The Surveyor asked what was hindering the physician in signing the orders. She said that when the nurses get the orders, they are then scanned to the physician where she signs them every morning. The DON said she doesn't know what the reason is that the orders haven't been signed, stating she has a			LLC		15	521 ALBERT ST			
forty-eight (48) hours" c. On 06/06/2024 at 2:24 PM, the Director of Nursing (DON) was asked when the physician's orders should be signed and put in the client's record. She said, within 24 hours. The Surveyor asked what was hindering the physician in signing the orders. She said that when the nurses get the orders, they are then scanned to the physician where she signs them every morning. The DON said she doesn't know what the reason is that the orders haven't been signed, stating she has a	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
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Division of Provider Services & Quality Assurance P.O. Box 8059, Slot S404 Little Rock, AR 72203-8059

July 10, 2024

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

Dear Ms. Lockhart:

During the Revisit Survey conducted on July 8, 2024, your facility was found to be in compliance with program requirements. Please email the signed CMS 2567 Theresa.Forrest@dhs.arkansas.gov.

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

Sincerely,

DPSQA/Office of Long Term Care Survey and Certification Section

Jeff Rosenbaum

tf

PRINTED: 07/10/2024 FORM APPROVED OMB NO. 0938-0391

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			I	R 08/2024
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 077	00/2024
				1521	ALBERT ST		
WOODRIE	GE OF FORREST CITY,	LLC		FOR	RREST CITY, AR 72335		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
{N 000}	Initial Comments		{N 0	(00)			
	is an official, legal do remain unchanged excorrection, correction space. Any discrepar citation(s) will be reproffice (RO) for referral Inspector General (O information is inadve provider/supplier, the should be notified im A revisit was conduct deficiencies cited on deficiencies have been	erich (PG) for possible fraud. If rently changed by the estate Survey Agency (SA) mediately. Ited on July 8, 2024, for all June 7, 2024. All een corrected, and no new found. The facility is in					
LABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>		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.