STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE, ZIP CODE
WOODRIDGE BEHAVIORAL CARE OF FORREST CITY	1521 ALBERT ST FORREST CITY, AR 72335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center. Complaint #AR00024974 was substantiated, all or in part, with deficiencies cited at N132 and N216.	N 000		
N 132	PROTECTION OF RESIDENTS CFR(s): 483.356(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a physical restraint was performed in a safe manner for 1	N 132		

LABORATORY D RECTOR'S OR PROV DER/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.

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N 132	Continued From page 1 (Client #1) of 1 (Client #1) sampled clients who was placed in a physical restraint. This failed practice had the potential to affect 55 facility clients as documented on a list provided by the Administrative Assistant on 6/24/20 at 10:52 a.m. The findings are: Client #1 was admitted on 6/2/20 and had diagnoses Disruptive Mood Dysregulation Disorder, Conduct Disorder, Attention-Deficit/Hyperactivity Disorder, and Anxiety. a. Nurse's Note, dated 6/16/20 at 9:40 p.m., documented, "R (Resident) moved to day room due to renovations. R asked staff about watching TV (television) staff informed R that it was time to go to bed and R began getting louder saying, "That some [expletive] we have been watching TV every night". When staff attempted to redirect the R he became physically aggressive towards staff he advanced towards staff showing physical aggression resulting in a containment..." b. On 6/24/20 at 3:00 p.m. the video of the restraint for Client #1 was reviewed with the CEO, Administrative Assistant and the SAMA (Satori Alternative for Managing Aggression) Instructor. The video dated 06/16/2020 was viewed as follows: At 214023 (9:40 p.m. and 23 seconds) the client was observed in the hallway outside of the dayroom talking with two female staff members. LYCW (Lead Youth Care Worker) #1 was observed walking through the dayroom door into the hallway carrying a broom and long handled dust pan, passing Client #1. Client #1 was observed to say something to LYCW #1, there was no audio on the video, who then	N 132		

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N 132	Continued From page 2	N 132		

dropped the broom and dust pan, walks up to Client #1 and with his right hand on the client's shoulder and his left hand on the client's right arm, pushes Client #1 backwards through the door into the dayroom.

At 214027 (9:40 and 27 seconds) LYCW #1 and Client #1 were observed coming through the dayroom door with an altercation taking place. Two other staff members were observed following the client and staff member into the dayroom. LYCW #1 was behind the client with his arms positioned across the client's chest area.

At 214034 (9:40 and 34 seconds) both the client and staff member were observed out of view of the camera.

At 214109 (9:41 and 9 seconds) LYCW #1 and Client #1 came back into the camera view with the staff members arms around the client's chest area. There were three other staff members in the dayroom.

At 214201 (9:42 and 1 second) Client was taken to the floor and restrained on his right side. LCW #1 was positioned behind the client at the shoulder area and another staff member was positioned at the client's legs.

At 214308 (9:43 and 8 seconds) LYCW #1 was observed to bring the client's left arm behind the client's back. The client's arm was bent at the elbow with his hand bent at the wrist, palm facing outward and toward the client's right shoulder. The client's upper arm was observed to be pushed upward, toward the middle of the client's upper back, by LYCW #1. The client was released from the physical restraint at 2150 (9:50

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N 132	Continued From page 3 p.m.). c. On 6/24/20 at 3:00 p.m. the SAMA Instructor was asked, "Should LYCW #1 bend Client #1's arm back behind his back like that?" The SAMA Instructor stated, "No, he shouldn't have."	N 132		
N 216	EDUCATION AND TRAINING CFR(s): 483.376(a)(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and This ELEMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure de-escalation attempts were tried before a client was placed in a physical restraint for 1 (Client #1) of 1 (Client #1) sampled clients. This failed practice had the potential to affect 55 facility clients as documented on a list provided by the Administrative Assistant on 6/24/20 at 10:52 a.m. The findings are: Client #1 was admitted on 6/2/20 and had diagnoses Disruptive Mood Dysregulation Disorder, Conduct Disorder, Attention-Deficit/Hyperactivity Disorder, and Anxiety. a. Nurse's Note, dated 6/16/20 at 9:40 p.m., documented, "R (Resident) moved to day room due to renovations. R asked staff about watching TV (television) staff informed R that it was time to go to bed and R began getting louder saying, "That some [expletive] we have been watching	N 216		

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N 216	Continued From page 4	N 216		

TV every night". When staff attempted to redirect the R he became physically aggressive towards staff he advanced towards staff showing physical aggression resulting in a containment..."

b. On 6/24/20 at 3:00 p.m. the video of the restraint for Client #1 was reviewed with the CEO, Administrative Assistant and the SAMA (Satori Alternative for Managing Aggression) Instructor.

The video dated 06/16/2020 was viewed as follows: At 214023 (9:40 p.m. and 23 seconds) the client was observed in the hallway outside of the dayroom talking with two female staff members. LYCW (Lead Youth Care Worker) #1 was observed walking through the dayroom door into the hallway carrying a broom and long handled dust pan, passing Client #1. Client #1 was observed to say something to LYCW #1, there was no audio on the video, who then dropped the broom and dust pan, walks up to Client #1 and with his right hand on the client's shoulder and his left hand on the client's right arm, pushes Client #1 backwards through the door into the dayroom.

At 214027 (9:40 and 27 seconds) LYCW #1 and Client #1 were observed coming through the dayroom door with an altercation taking place. Two other staff members were observed following the client and staff member into the dayroom. LYCW #1 was behind the client with his arms positioned across the client's chest area.

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N 216	Continued From page 5	N 216		

Client #1 came back into the camera view with the staff members arms around the client's chest area. There were three other staff members in the dayroom.

At 214201 (9:42 and 1 second) Client was taken to the floor and restrained on his right side. LCW #1 was positioned behind the client at the shoulder area and another staff member was positioned at the client's legs.

At 214308 (9:43 and 8 seconds) LYCW #1 was observed to bring the client's left arm behind the client's back. The client's arm was bent at the elbow with his hand bent at the wrist, palm facing outward and toward the client's right shoulder. The client's upper arm was observed to be pushed upward, toward the middle of the client's upper back, by LYCW #1. The client was released from the physical restraint at 2150 (9:50 p.m.).

c. There was no attempt by LYCW (Lead Youth Care Worker) #1 to use de-escalating techniques before he was viewed grabbing Client #1 and placing him in a physical restraint.

d. On 6/24/20 at 3:00 p.m. the SAMA (Satori Alternative for Managing Aggression) Instructor was asked, "Should de-escalation techniques been used before LYCW (Lead Youth Care Worker) #1 grabbed client #1?" He stated, "Yes, definitely."