ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services and Quality Assurance
Office of Long Term Care
http://humanservices.arkansas.gov/dms/Pages/oltcHome.aspx
PO Box 8059, Slot S404, Little Rock, AR 72203-8059
Fax: 501-682-6159

CERTIFIED MAIL # 7017 0190 0000 3768 2010

January 16, 2019

Marcel Lue, Administrator
Woodridge Behavioral Care Of Forrest City
1521 Albert St
Forrest City, AR 72335

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Dear Mr. Lue:

On January 8, 2019 the Office of Long Term Care conducted a Complaint survey to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid program. This survey found that your facility was not in compliance with conditions of participation that resulted in Immediate Jeopardy conditions as specified in the attached CMS 2567. The Immediate Jeopardy was removed on December 20, 2018. The facility failed to meet the Condition of Participation for Use of Restraint and Seclusion. Specifically, the facility was not in compliance with the following requirements:

483.354 Use of Restraint and Seclusion
483.356(a)(3) Protection of Residents
483.356(a)(3)(i) Protection of Residents

The CMS 2567 "Statement of Deficiencies and Plan of Correction" with all deficiencies identified during the complaint survey on January 8, 2019 is enclosed.

Remedies
Based on the deficiencies cited, we are recommending to the State Medicaid Agency (SMA) the immediate imposition of the following remedies:

Termination of the provider agreement effective April 8, 2019 if substantial compliance is not achieved by that date.

Plan of Correction
A Plan of Correction (PoC) must be submitted witin ten (10) calendar days of receipt of the fax trasnmission of the Statement of Deficienicies. It is imperative that an acceptable plan of correction be received by this office by date to ensure a revisit can be conducted within 45 calendar days of the

survey. Termination will take place on April 8, 2019 if compliance is not achieved.

A revisit will be authorized after an acceptable PoC is received. The PoC must be faxed to:

Sandra Broughton, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
Telephone (501) **320-6182;** Fax (501) 682-6159

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 deficiency 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. 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 via fax to:

Becky Bennett, Section Chief
Health Facility Services
Arkansas Department of Health

5800 West 10th Street, Suite 400
Little Rock, AR 72204
Fax (501) 661-2165

Appeal Rights
To appeal a sanction regarding licensure and certification, you or your legal counsel must make a written request to:

Director
Arkansas Department of Human Services
P.O. Box 1437, Slot 210
Little Rock, AR 72203-1437

Pursuant to Appendix A of the Long Term Care Provider Manual, the Chairman must receive the request within sixty (60) days of receipt of this letter. The request must state the basis for the appeal with supporting documentation attached.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

If you have any questions, please contact Sandra Broughton, Reviewer at 501 **320-6182.**

Sincerely,

Lori Hobbs, Nursing Manager
Office of Long Term Care
Survey & Certification Section

sgb

cc: Ombudsman
DRC
file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID 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. Complaint #AR00022366 was substantiated, all or in part, with deficiencies cited at N100, N128 and N129. Complaint #AR00022450 was substantiated, all or in part, with no deficiencies cited.	N 000		
N 100	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Centers. USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by:	N 100		

LABORATORY DIRECTOR'S OR PROVIDER/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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 100	Continued From page 1 Complaint AR00022366 was substantiated (all or in part) with these findings: Based on observation, record review and interview, the facility failed to meet the requirements of the Condition of Participation for Protection of Residents, as evidenced by the facility's failure to meet the regulatory requirements at N128 and N129. The facility failed to ensure policy and procedures were followed and a resident was protected from harm during the use of a restraint for 1 (Resident #1) and a restraint was correctly applied in response to an emergency safety situation for 1 (Resident #1) of 5 (Residents #1, #2, #3, #4, and #5) sampled residents who were involved in physical restraints. This failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury, or death to Resident #1, who sustained a contusion above the right ear. The Administrator was notified of the immediate jeopardy on 12/20/10 at 12:40 p.m. The findings are: 1. The facility failed to meet the regulatory requirements for Protection of Residents at N128, as evidenced by the facility's failure to ensure Resident #1 was free from injury during a restraint. This failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury, or death to Resident #1, who sustained a contusion above the right ear. 2. The facility failed to ensure a restraint was correctly applied in response to an emergency safety situation for Resident #1. This failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm,	N 100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 100	Continued From page 2 injury, or death to Resident #1, who sustained a contusion above the right ear. 3. The immediate jeopardy was removed on 12/20/18 at 12:40 p.m. when the facility implemented the following Plan of Removal: "a. Current Census at [facility] as of December 20, 2018 is 56 b. Assessments: Immediate Jeopardy Regarding Safety Plan c. Restraints: All staff will receive immediate training following a restraint where the resident being restrained makes an allegation of the use of an inappropriate restraint. d. The retraining will begin immediately on that shift and carryon throughout the remainder shifts until all staff have signed off on the training signature page. e. Proper SAMA (Satori Alternatives to Managing Aggression) techniques will begin in the Elbow to Hip standing position, if the resident begins to go limp in the knees or drop to the ground the floor to ground technique will be utilized to prevent any injury to the resident. f. At the time of the restraint a supervisor/lead staff member will be summoned via radio to report immediately to the area to assist with the restraint. g. All staff will be informed that a resident can be let go from a restraint if it appears that the resident is calm and can follow simple instruction. The certified restraint trainer or a lead/supervisor	N 100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 100	Continued From page 3 along with the nurse can make the decision to let a resident out of a restraint as soon as they are able to show compliance, or if an improper technique is being utilized which could cause more injury to the resident h. In order to prevent injury to a resident and keep all residents safe, if there is a potentially threatening situation a lead or supervisor must explore all avenues of safety to de-escalate all potential situations from occurring. If that means taking another group of residents a different direction or holding a resident back so a physical altercation does not occur that will be the responsibility of the shift lead or the supervisor. i. All staff will receive refresher SAMA specifically program at protection of self and others. Being aware of environment and surrounding. j. Plan will be effective immediately beginning December 20, 2018 k. Nursing Staff will: l. All videos will be reviewed within 60 minutes of a restraint by the Director of Nursing (DON) or and Registered Nurse (RN), if there is not a clear view of the restraint from the nurses' station, the camera in the video room must be viewed as well for more clarity if need be. m. Director of Nursing will provide additional training to all RNs involved in the restraint on what to do if proper technique was not utilized or an injury resulted from the restraint. The RN Nurse will notify the AOC (Administrator on Call) and the determination will be made to remove the staff from the unit or the shift pending	N 100		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 100	Continued From page 4 the results of the video. The CEO (Chief Executive Officer) along with HR (Human Resource) will view the video to see if termination of the employee needs to occur immediately or pending the investigation. n. DON will receive additional training from the Certified SAMA Trainer to look at footage of restraints and be able to ascertain correct techniques. Training will begin the week of 12/26/18 or shortly thereafter depending on Trainers holiday schedule. o. All resident complaints will be investigated by one if not all appropriate administrative staff to include CEO, DON, Clinical Director and Residential Director. p. All Corrective Actions will be documented in the staff and youth file. q. All information pertaining to a resident restraint to include the restraint logs, medical notes and therapy information and any other communication surrounding the restraint will be documented together for easy reference data. r. The Certified Trainer will review the restraint with the DON and document that it was reviewed. s. Plan to begin immediately 12/20/18 t. Chart audits will occur monthly and be discussed in the Committee of a Whole (COW) and it will show if there are any trends".	N 100		
N 128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3)	N 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 128	Continued From page 5 Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Complaint AR00022366 was substantiated (all or in part) with these findings: Based on observation, record review and interview, the facility failed to ensure the use of a physical restraint did not result in injuries for 1 (Resident #1) of 5 (Residents #1, #2, #3, #4, and #5) sampled residents who were involved in physical restraints. This failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury, or death to Resident # 1 who sustained a contusion above the right ear. The Administrator was notified of the immediate jeopardy on 12/20/10 at 12:40 p.m. The findings are: 1. Resident #1 had diagnoses of Disruptive Mood Dysregulation Disorder and Major Depressive Disorder. 2. An "Emergency Restraint Intervention Justification Packet" form dated 12/13/18 at 4:04 p.m. documented, "resident was placed in a physical hold on 12/13/18 at 3:04 p.m. due to R [resident] trying to hit another R." The report documented that during the face-to-face assessment after the physical hold, a Registered Nurse (RN) documented, "hematoma under [right] ear - unsure if happened during restraint." The form also documented in the "Staff Emergency Safety Intervention Debriefing Form" that the client was removed, "from the provoking stimuli and separating patient from peer..." The Patient Emergency Safety Intervention Debriefing Form conducted on 12/13/18 at 8:46 p.m. by the	N 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 128	Continued From page 6 client documented, "[Staff #1] decided it would be smart to let [Client #1] walk pass [sic] knowing I would swing so he dropped me and my head is swell [sic]." 3. On 12/19/18 at 9:10 a.m., the video footage of the restraint was provided by the Administrator. The video showed at 3:00 p.m., Client #1 and Staff #1 were standing in the doorway of the hallway. At 3:04:56 p.m., another client and a staff member were going through the doorway when Client #1 attempted to hit the other client. Standing between Client #1 and the other client was Staff #1 and another staff member. At 3:05:02 p.m., Staff #1 placed his left hand under the arm of Client #1 and turned him around and both Client #1 and Staff #1 fell to the floor with Staff #1 lying on top of Client #1. At 3:05:03 p.m., Client #1 was struggling and Staff #1 was observed lying across Client #1's chest. At 3:05:04 p.m., Staff #1 was observed in the video clip bouncing in an up and down motion on top of Client #1. At 3:05:15 p.m., Staff #1 was lying over the client who had been turned onto his back. 4. On 12/19/18 at 2:10 p.m., Staff #1 was asked, "Knowing that there had been an incident in the cafeteria and that the clients were angry and irritable, why did you bring the other client past [Client #1] in the doorway instead of taking him in an alternate route?" Staff #1 stated, "Because the others were the other way. It was better to handle one [client] than all the others [clients]." Staff #1 was asked, "Do you see any problems with this hold?" Staff #1 stated "Yes sir, I do." Staff #1 was asked, "What could you have done differently?" He stated, "I probably could have kept the kid in the choir room. I was trying to keep	N 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 128	Continued From page 7 him safe, so one kid versus all the kids, I decided one would be easier to deal with." He was asked, "This restraint occurred on 12/13/18?" He stated, "yes". Staff #1 was asked, "Did you have retraining on the SAMA (Satori Alternatives to Managing Aggression) consisting of Emergency Safety Intervention, Performance Assessment, Protection of self and others, containment and object retrieval?" He stated, "Yes." 5. On 12/19/18 at 2:25 p.m., Client #1 was asked, "Were you involved in a restraint on 12/13/18?" The client stated, "Yes." Client #1 was asked, "Can you tell me what happened?" Client #1 stated, "Earlier in the day another client hit a staff member and everybody started getting up trying to get him [the non-case mix client] back, but staff wouldn't let us. I was mad and [Staff #1] took me down the hall, and then another staff member brought the other client [the one who hit the staff] down the hallway toward me, and I tried to hit him." Client #1 was asked, "What happened next?" Client #1 stated, "Then [Staff #1] slammed me to the ground, basically restrained me. [Staff #3] grabbed one of my arms; someone else was on my legs... [Staff #1] was on top of me, I was fighting the restraint, [Staff #1] bent my wrist". Client #1 was asked, "Were you injured during the restraint?" The client stated, "Yeah, there was a knot behind my ear... Yeah I feel like [Staff #1] wanted to restrain me because he said he hoped I swung on the other client. I couldn't breathe; he [Staff #1] was across my throat." 6. On 12/19/18 at 4:00 p.m., Staff #2 was asked, "What was your role in the restraint of [Client #1] on 12/13/18 at 3:04 p.m.?" He stated, "I grabbed his feet because he was kicking [Staff #1]." Staff #2 was asked, "When you grabbed [Client #1's]	N 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 128	Continued From page 8 legs, where was [Staff #1]?" He stated, "[Staff #1's] body lay across him [Client #1]." 7. On 12/20/18 at 9:26 a.m., the Administrator was asked, "According to the SAMA, should there ever be weight applied to the client's chest while the client is on the floor?" The Administrator stated, "No." The Administrator was asked, "Has any training occurred as a result of this restraint with a resultant injury?" The Administrator stated, "yes on December 14 and 15th to refresh staff on containments and assisting process." 8. A form titled "Training Document" dated 12/14/18 documented 46 of 89 (52%) of the staff were retrained on SAMA technique. 9. The immediate jeopardy was removed on 12/20/18 at 12:40 p.m. when the facility implemented the following Plan of Removal. "a. Current Census at [facility] as of December 20, 2018 is 56 b. Assessments: Immediate Jeopardy Regarding Safety Plan c. Restraints: All staff will receive immediate training following a restraint where the resident being restrained makes an allegation of the use of an inappropriate restraint. d. The retraining will begin immediately on that shift and carryon throughout the remainder shifts until all staff have signed off on the training signature page. e. Proper SAMA (Satori Alternatives to Managing Aggression) techniques will begin in the Elbow to	N 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 128	Continued From page 9 Hip standing position, if the resident begins to go limp in the knees or drop to the ground the floor to ground technique will be utilized to prevent any injury to the resident. f. At the time of the restraint a supervisor/lead staff member will be summoned via radio to report immediately to the area to assist with the restraint. g. All staff will be informed that a resident can be let go from a restraint if it appears that the resident is calm and can follow simple instruction. The certified restraint trainer or a lead/supervisor along with the nurse can make the decision to let a resident out of a restraint as soon as they are able to show compliance, or if an improper technique is being utilized which could cause more injury to the resident h. In order to prevent injury to a resident and keep all residents safe, if there is a potentially threatening situation a lead or supervisor must explore all avenues of safety to de-escalate all potential situations from occurring. If that means taking another group of residents a different direction or holding a resident back so a physical altercation does not occur that will be the responsibility of the shift lead or the supervisor. i. All staff will receive refresher SAMA specifically program at protection of self and others. Being aware of environment and surrounding. j. Plan will be effective immediately beginning December 20, 2018 k. Nursing Staff will:	N 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 128	Continued From page 10 l. All videos will be reviewed within 60 minutes of a restraint by the Director of Nursing (DON) or and Registered Nurse (RN), if there is not a clear view of the restraint from the nurses' station, the camera in the video room must be viewed as well for more clarity if need be. m. Director of Nursing will provide additional training to all RNs involved in the restraint on what to do if proper technique was not utilized or an injury resulted from the restraint. The RN Nurse will notify the AOC (Administrator on Call) and the determination will be made to remove the staff from the unit or the shift pending the results of the video. The CEO (Chief Executive Officer) along with HR (Human Resource) will view the video to see if termination of the employee needs to occur immediately or pending the investigation. n. DON will receive additional training from the Certified SAMA Trainer to look at footage of restraints and be able to ascertain correct techniques. Training will begin the week of 12/26/18 or shortly thereafter depending on Trainers holiday schedule. o. All resident complaints will be investigated by one if not all appropriate administrative staff to include CEO, DON, Clinical Director and Residential Director. p. All Corrective Actions will be documented in the staff and youth file. q. All information pertaining to a resident restraint to include the restraint logs, medical notes and therapy information and any other communication surrounding the restraint will be documented	N 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 128	Continued From page 11 together for easy reference data. r. The Certified Trainer will review the restraint with the DON and document that it was reviewed. s. Plan to begin immediately 12/20/18 t. Chart audits will occur monthly and be discussed in the Committee of a Whole (COW) and it will show if there are any trends".	N 128		
N 129	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3)(i) To ensure the safety of the resident or others during an emergency safety situation; and This ELEMENT is not met as evidenced by: Complaint AR00022366 was substantiated (all or in part) with these findings: Based on observation, interview and record review, the facility failed to ensure a restraint was appropriately applied in response to an emergency safety situation to prevent injury for 1 (Resident 1) of 5 (Residents #1, #2, #3, #4, and #5) sampled residents who were involved in physical restraints. This failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury, or death to Resident #1, who sustained a contusion above the right ear. The Administrator was notified of the immediate jeopardy on 12/20/10 at 12:40 p.m. The findings are: 1. Resident #1 had diagnoses of Disruptive Mood Dysregulation Disorder and Major Depressive Disorder.	N 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 129	Continued From page 12 2. An "Emergency Restraint Intervention Justification Packet" form dated 12/13/18 at 4:04 p.m. documented, "resident was placed in a physical hold on 12/13/18 at 3:04 p.m. due to R [resident] trying to hit another R." The report documented that during the face-to-face assessment after the physical hold, a Registered Nurse (RN) documented, "hematoma under [right] ear - unsure if happened during restraint." The form also documented in the "Staff Emergency Safety Intervention Debriefing Form" that the client was removed, "from the provoking stimuli and separating patient from peer..." The Patient Emergency Safety Intervention Debriefing Form conducted on 12/13/18 at 8:46 p.m. by the client documented, "[Staff #1] decided it would be smart to let [Client #1] walk pass [sic] knowing I would swing so he dropped me and my head is swell [sic]." 3. On 12/19/18 at 9:10 a.m., the video footage of the restraint was provided by the Administrator. The video showed at 3:00 p.m., Client #1 and Staff #1 were standing in the doorway of the hallway. At 3:04:56 p.m., another client and a staff member were going through the doorway when Client #1 attempted to hit the other client. Standing between Client #1 and the other client was Staff #1 and another staff member. At 3:05:02 p.m., Staff #1 placed his left hand under the arm of Client #1 and turned him around and both Client #1 and Staff #1 fell to the floor with Staff #1 lying on top of Client #1. At 3:05:03 p.m., Client #1 was struggling and Staff #1 was observed lying across Client #1's chest. At 3:05:04 p.m., Staff #1 was observed in the video clip bouncing in an up and down motion on top of Client #1. At 3:05:15 p.m., Staff #1 was lying	N 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 129	Continued From page 13 over the client who had been turned onto his back. 4. On 12/19/18 at 2:10 p.m., Staff #1 was asked, "Knowing that there had been an incident in the cafeteria and that the clients were angry and irritable, why did you bring the other client past [Client #1] in the doorway instead of taking him in an alternate route?" Staff #1 stated, "Because the others were the other way. It was better to handle one [client] than all the others [clients]." Staff #1 was asked, "Do you see any problems with this hold?" Staff #1 stated "Yes sir, I do." Staff #1 was asked, "What could you have done differently?" He stated, "I probably could have kept the kid in the choir room. I was trying to keep him safe, so one kid versus all the kids, I decided one would be easier to deal with." He was asked, "This restraint occurred on 12/13/18?" He stated, "yes". Staff #1 was asked, "Did you have retraining on the SAMA (Satori Alternatives to Managing Aggression) consisting of Emergency Safety Intervention, Performance Assessment, Protection of self and others, containment and object retrieval?" He stated, "Yes." 5. On 12/19/18 at 2:25 p.m., Client #1 was asked, "Were you involved in a restraint on 12/13/18?" The client stated, "Yes." Client #1 was asked, "Can you tell me what happened?" Client #1 stated, "Earlier in the day another client hit a staff member and everybody started getting up trying to get him [the non-case mix client] back, but staff wouldn't let us. I was mad and [Staff #1] took me down the hall, and then another staff member brought the other client [the one who hit the staff] down the hallway toward me, and I tried to hit him." Client #1 was asked, "What happened next?" Client #1 stated, "Then [Staff #1]	N 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 129	Continued From page 14 slammed me to the ground, basically restrained me. [Staff #3] grabbed one of my arms; someone else was on my legs... [Staff #1] was on top of me, I was fighting the restraint, [Staff #1] bent my wrist". Client #1 was asked, "Were you injured during the restraint?" The client stated, "Yeah, there was a knot behind my ear... Yeah I feel like [Staff #1] wanted to restrain me because he said he hoped I swung on the other client. I couldn't breathe; he [Staff #1] was across my throat." 6. On 12/19/18 at 4:00 p.m., Staff #2 was asked, "What was your role in the restraint of [Client #1] on 12/13/18 at 3:04 p.m.?" He stated, "I grabbed his feet because he was kicking [Staff #1]." Staff #2 was asked, "When you grabbed [Client #1's] legs, where was [Staff #1]?" He stated, "[Staff #1's] body lay across him [Client #1]." 7. On 12/20/18 at 9:26 a.m., the Administrator was asked, "According to the SAMA, should there ever be weight applied to the client's chest while the client is on the floor?" The Administrator stated, "No." The Administrator was asked, "Has any training occurred as a result of this restraint with a resultant injury?" The Administrator stated, "yes on December 14 and 15th to refresh staff on containments and assisting process." 8. A form titled "Training Document" dated 12/14/18 documented 46 of 89 (52%) of the staff were retrained on SAMA technique. 9. The immediate jeopardy was removed on 12/20/18 at 12:40 p.m. when the facility implemented the following Plan of Removal. "a. Current Census at [facility] as of December 20, 2018 is 56	N 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 129	Continued From page 15 b. Assessments: Immediate Jeopardy Regarding Safety Plan c. Restraints: All staff will receive immediate training following a restraint where the resident being restrained makes an allegation of the use of an inappropriate restraint. d. The retraining will begin immediately on that shift and carryon throughout the remainder shifts until all staff have signed off on the training signature page. e. Proper SAMA (Satori Alternatives to Managing Aggression) techniques will begin in the Elbow to Hip standing position, if the resident begins to go limp in the knees or drop to the ground the floor to ground technique will be utilized to prevent any injury to the resident. f. At the time of the restraint a supervisor/lead staff member will be summoned via radio to report immediately to the area to assist with the restraint. g. All staff will be informed that a resident can be let go from a restraint if it appears that the resident is calm and can follow simple instruction. The certified restraint trainer or a lead/supervisor along with the nurse can make the decision to let a resident out of a restraint as soon as they are able to show compliance, or if an improper technique is being utilized which could cause more injury to the resident h. In order to prevent injury to a resident and keep all residents safe, if there is a potentially threatening situation a lead or supervisor must	N 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 129	Continued From page 16 explore all avenues of safety to de-escalate all potential situations from occurring. If that means taking another group of residents a different direction or holding a resident back so a physical altercation does not occur that will be the responsibility of the shift lead or the supervisor. i. All staff will receive refresher SAMA specifically program at protection of self and others. Being aware of environment and surrounding. j. Plan will be effective immediately beginning December 20, 2018 k. Nursing Staff will: l. All videos will be reviewed within 60 minutes of a restraint by the Director of Nursing (DON) or and Registered Nurse (RN), if there is not a clear view of the restraint from the nurses' station, the camera in the video room must be viewed as well for more clarity if need be. m. Director of Nursing will provide additional training to all RNs involved in the restraint on what to do if proper technique was not utilized or an injury resulted from the restraint. The RN Nurse will notify the AOC (Administrator on Call) and the determination will be made to remove the staff from the unit or the shift pending the results of the video. The CEO (Chief Executive Officer) along with HR (Human Resource) will view the video to see if termination of the employee needs to occur immediately or pending the investigation. n. DON will receive additional training from the Certified SAMA Trainer to look at footage of restraints and be able to ascertain correct	N 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L115	A. BUILDING _____ B. WING _____	C 01/08/2019

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 129	Continued From page 17 techniques. Training will begin the week of 12/26/18 or shortly thereafter depending on Trainers holiday schedule. o. All resident complaints will be investigated by one if not all appropriate administrative staff to include CEO, DON, Clinical Director and Residential Director. p. All Corrective Actions will be documented in the staff and youth file. q. All information pertaining to a resident restraint to include the restraint logs, medical notes and therapy information and any other communication surrounding the restraint will be documented together for easy reference data. r. The Certified Trainer will review the restraint with the DON and document that it was reviewed. s. Plan to begin immediately 12/20/18 t. Chart audits will occur monthly and be discussed in the Committee of a Whole (COW) and it will show if there are any trends".	N 129		