

Division of Provider Services and Quality AssuranceOffice 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 Deficiencies. 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

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MUL [*] A. BUILDI | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 04L115 | B. WING | • | ı | 0 | |
| NAME OF F | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | 08/2019 | |
| WOODRI | DGE BEHAVIORAL (| CARE OF FORREST CITY | | 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 CORRECTIVE ACTION SHO | OULD BE | (X5) COMPLETION DATE | |
| N 000 | Initial Comments | | N 0 | 000 | | | |
| | is an official, legal remain unchanged correction, correct space. Any discreptication(s) will be recommended of the confice (RO) for refunspector General information is inad provider/supplier, the should be notified. Complaint #AR000 or in part, with definant N129. | 022366 was substantiated, all ciencies cited at N100, N128 022450 was substantiated, all | - | | | | |
| N 100 | The facility was no Subpart G - Condi Psychiatric Reside USE OF RESTRA CFR(s): 483.354 | ot in compliance with §483, tions of Participation for ential Treatment Centers. INT AND SECLUSION ion of Participation for the Use | N 1 | 100 | | | |
| | of Restraint and S Residential Treatn Inpatient Psychiati Under Age Twenty This CONDITION | eclusion in Psychiatric nent Facilities Providing ric Services for Individuals | NATIDE | 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: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | (X3) DATE SURVEY COMPLETED C | | | |
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| N 100 | in part) with these | 22366 was substantiated (all or findings: | N 1 | 100 | | | | |
| | interview, the facilir requirements of the Protection of Residual facility's failure to requirements at N failed to ensure possible followed and a residuring the use of a and a restraint was to an emergency s#1) of 5 (Residents sampled residents restraints. This fail Immediate Jeopan caused serious haw #1, who sustained ear. The Administr | tion, record review and ty failed to meet the e Condition of Participation for dents, as evidenced by the neet the regulatory 128 and N129. The facility licy and procedures were ident was protected from harm restraint for 1 (Resident #1) is correctly applied in response afety situation for 1 (Resident s #1, #2, #3, #4, and #5) who were involved in physical ed practice resulted in dy, which caused or could have rm, injury, or death to Resident a contusion above the right ator was notified of the ly on 12/20/10 at 12:40 p.m. | | | | | | |
| | requirements for F as evidenced by the Resident #1 was for restraint. This fail Immediate Jeopar caused serious ha | ed to meet the regulatory Protection of Residents at N128, ne facility's failure to ensure reé from injury during a ed practice resulted in dy, which caused or could have rm, injury, or death to Resident a contusion above the right | | | | | | |
| | correctly applied in safety situation for practice resulted in | d to ensure a restraint was n response to an emergency Resident #1. This failed n Immediate Jeopardy, which ave caused serious harm, | | | | | | |

| | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILE | | E GONSTRUCTION | СОМІ | PLETED |
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| N 100 | • | Resident #1, who sustained a | N | 100 | | | . • |
| | 12/20/18 at 12:40 | eopardy was removed on p.m. when the facility ollowing Plan of Removal: | | | | | |
| | "a. Current Censu 20, 2018 is 56 | s at [facility] as of December | | | | • | |
| | b. Assessments: I Safety Plan | mmediate Jeopardy Regarding | | | | • | |
| | training following a | taff will receive immediate a restraint where the resident nakes an allegation of the use e restraint. | | | | | , |
| | shift and carryon t | vill begin immediately on that hroughout the remainder shifts signed off on the training | | | | | |
| | Aggression) techn Hip standing posit limp in the knees | Satori Alternatives to Managing iques will begin in the Elbow to ion, if the resident begins to go or drop to the ground the floor ue will be utilized to prevent anyent. | | | | • | |
| | staff member will | e restraint a supervisor/lead be summoned via radio to y to the area to assist with the | | × | • | | |
| | let go from a restr resident is calm a | nformed that a resident can be aint if it appears that the nd can follow simple instruction aint trainer or a lead/supervisor | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | IDENTIFICATION NUMBER: | A. BUILDI | ING | СОМ | COMPLETED | | |
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| N 100 | a resident out of a able to show com technique is being more injury to the h. In order to prevkeep all residents threatening situatiexplore all avenue potential situation | se can make the decision to let restraint as soon as they are pliance, or if an improper utilized which could cause | N 1 | 00 | | | | |
| | direction or holdin altercation does n responsibility of th i. All staff will rece program at protect aware of environn j. Plan will be effe | g a resident back so a physical of occur that will be the se shift lead or the supervisor. Sive refresher SAMA specifically stion of self and others. Being nent and surrounding. | | | | | | |
| | a restraint by the and Registered N view of the restrai | rill: e reviewed within 60 minutes of Director of Nursing (DON) or urse (RN), if there is not a clear nt from the nurses' station, the eo room must be viewed as well | | | | | | |
| | training to all RNs what to do if prop an injury resulted The RN Nurse wi on Call) and the o | rsing will provide additional involved in the restraint on er technique was not utilized or from the restraint. If notify the AOC (Administrator letermination will be made to from the unit or the shift pending | | | | | | |

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SÜRVEY

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI A. BUILE | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| N 100 | Executive Officer) Resource) will view | ideo. The CEO (Chief along with HR (Human v the video to see if termination seeds to occur immediately or | N | 100 | | | |
| - | Certified SAMA Tra restraints and be a techniques. Traini | e additional training from the ainer to look at footage of able to ascertain correct ng will begin the week of thereafter depending on chedule. | • | | | | |
| | one if not all appro | plaints will be investigated by priate administrative staff to N, Clinical Director and Dr. | | | | | |
| | p. All Corrective Adstaff and youth file | ctions will be documented in the | | ٠. | | | |
| | to include the resti therapy informatio | pertaining to a resident restraint raint logs, medical notes and n and any other communication estraint will be documented reference data. | | | | | - |
| | | ainer will review the restraint document that it was reviewed. | | | | | |
| ٠. | s. Plan to begin im | nmediately 12/20/18 | | | | | |
| N 128 | discussed in the Cand it will show if t | | N | 128 | | | |
| | | | | | | | |

| | ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| N 128 | injury to the resider This ELEMENT is Complaint AR0002 in part) with these t | ion must not result in harm or nt and must be used only- not met as evidenced by: 22366 was substantiated (all or findings: | N | 128 | | | | |
| | interview, the facilit physical restraint d (Resident #1) of 5 #5) sampled reside physical restraints. Immediate Jeopard caused serious hai # 1 who sustained ear. The Administr | ion, record review and by failed to ensure the use of a id not result in injuries for 1 (Residents #1, #2, #3, #4, and ents who were involved in This failed practice resulted in dy, which caused or could have rm, injury, or death to Resident a contusion above the right rator was notified of the y on 12/20/10 at 12:40 p.m. | | | | | | |
| | Mood Dysregulation Depressive Disord 2. An "Emergency Justification Packet p.m. documented, physical hold on 12 [resident] trying to documented that document | Restraint Intervention t" form dated 12/13/18 at 4:04 "resident was placed in a 2/13/18 at 3:04 p.m. due to R hit another R." The report luring the face-to-face the physical hold, a Registered mented, "hematoma under if happened during restraint." umented in the "Staff | | | | | | |
| | that the client was stimuli and separa Patient Emergency | Intervention Debriefing Form" removed, "from the provoking ting patient from peer" The y Safety Intervention Debriefing n 12/13/18 at 8:46 p.m. by the | | | | | | |

| | AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILE | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| N 128 | smart to let [Clien would swing so he swell [sic]." 3. On 12/19/18 at the restraint was properties the restraint was staff member were when Client #1 and 3:05:02 p.m., Staff #1 lying on the client #1 was structured lying and 3:05:04 p.m., Staff bouncing in a Client #1. At 3:05:05 of the swing was client #1. At 3:05:05 of the swing was staff was structured by the swing was structured by | page 6 d, "[Staff #1] decided it would be t #1] walk pass [sic] knowing I be dropped me and my head is 9:10 a.m., the video footage of provided by the Administrator. It at 3:00 p.m., Client #1 and anding in the doorway of the 56 p.m., another client and a regoing through the doorway tempted to hit the other client another staff member. At fif #1 placed his left hand under #1 and turned him around and the Staff #1 fell to the floor with op of Client #1. At 3:05:03 p.m., reggling and Staff #1 was ross Client #1's chest. At fif #1 was observed in the video in up and down motion on top of 5:15 p.m., Staff #1 was lying o had been turned onto his | N | 128 | | | |
| | "Knowing that the cafeteria and that irritable, why did y [Client #1] in the can alternate route the others were thandle one [client Staff #1 was asked with this hold?" Staff #1 was asked differently?" He staff #1 was asked differently?" | 2:10 p.m., Staff #1 was asked, are had been an incident in the the clients were angry and you bring the other client past doorway instead of taking him in e?" Staff #1 stated, "Because ne other way. It was better to than all the others [clients]." ed, "Do you see any problems taff #1 stated "Yes sir, I do." ed, "What could you have done tated, "I probably could have e choir room. I was trying to keep | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| N 128 | Continued From pa | age 7 | N 128 | | |
| | him safe, so one ki one would be easie "This restraint occu "yes". Staff #1 was retraining on the S. Managing Aggress Safety Intervention | d versus all the kids, I decided er to deal with." He was asked, urred on 12/13/18?" He stated, asked, "Did you have AMA (Satori Alternatives to ion) consisting of Emergency, Performance Assessment, and others, containment and | | | |
| | "Were you involved The client stated, " "Can you tell me w stated, "Earlier in t | 2:25 p.m., Client #1 was asked, d in a restraint on 12/13/18?" Yes." Client #1 was asked, hat happened?" Client #1 the day another client hit a staff | | | |
| | to get him [the non wouldn't let us. I w down the hall, and brought the other odown the hallway thim." Client #1 wanext?" Client #1 sislammed me to the me. [Staff #3] gratelse was on my legme, I was fighting wrist". Client #1 waduring the restraint there was a knot b | body started getting up trying -case mix client] back, but staff ras mad and [Staff #1] took me then another staff member client [the one who hit the staff] oward me, and I tried to hit s asked, "What happened cated, "Then [Staff #1] e ground, basically restrained obed one of my arms; someone gs [Staff #1] was on top of the restraint, [Staff #1] bent my as asked, "Were you injured the company of the client stated, "Yeah, ehind my ear Yeah I feel like to restrain me because he said | | | |
| | he hoped I swung | on the other client. I couldn't #1] was across my throat." | | | |
| | "What was your ro on 12/13/18 at 3:0 his feet because h | 4:00 p.m., Staff #2 was asked, le in the restraint of [Client #1] 4 p.m.?" He stated, "I grabbed e was kicking [Staff #1]." Staff hen you grabbed [Client #1's] | - | | |

| STALEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILE | | (X3) DATE SURVEY COMPLETED C | | | |
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| N 128 | | page 8 Staff #1]?" He stated, "[Staff pass him [Client #1]." | N | 128 | 3 | | |
| | was asked, "Acco ever be weight ap the client is on the stated, "No." The any training occur with a resultant in "yes on Decembe | 9:26 a.m., the Administrator rding to the SAMA, should there plied to the client's chest while a floor?" The Administrator Administrator was asked, "Has red as a result of this restraint jury?" The Administrator stated, r 14 and 15th to refresh staff on assisting process." | | | | | |
| | 12/14/18 docume | raining Document" dated nted 46 of 89 (52%) of the staff SAMA technique. | | - | | | |
| | 12/20/18 at 12:40 | jeopardy was removed on p.m. when the facility following Plan of Removal. | | | | | |
| | "a. Current Censu 20, 2018 is 56 | us at [facility] as of December | | | | | |
| | b. Assessments: Safety Plan | Immediate Jeopardy Regarding | | | | | |
| ż | training following | staff will receive immediate a restraint where the resident makes an allegation of the use re restraint. | | | | • | |
| | shift and carryon | will begin immediately on that throughout the remainder shifts signed off on the training | | | | | |
| | | Satori Alternatives to Managing niques will begin in the Elbow to | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | A. BUILDI | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| N 128 | limp in the knees of | on, if the resident begins to go or drop to the ground the floor ue will be utilized to prevent any | N 1 | 28 | | | | |
| | f. At the time of the staff member will t | e restraint a supervisor/lead be summoned via radio to to the area to assist with the | | | | | | |
| | let go from a restra resident is calm ar The certified restra along with the nurs a resident out of a able to show comp | nformed that a resident can be aint if it appears that the nd can follow simple instruction. aint trainer or a lead/supervisor se can make the decision to let restraint as soon as they are pliance, or if an improper utilized which could cause resident | | · · | | | | |
| | keep all residents threatening situation explore all avenue potential situations taking another gro direction or holding altercation does no | ent injury to a resident and safe, if there is a potentially on a lead or supervisor must es of safety to de-escalate all from occurring. If that means oup of residents a different g a resident back so a physical ot occur that will be the e shift lead or the supervisor. | | | | | | |
| | program at protec | ive refresher SAMA specifically tion of self and others. Being nent and surrounding. | | | | | | |
| | j. Plan will be effect December 20, 20 | ctive immediately beginning 18 | | | | | | |
| · | k. Nursing Staff w | ill: | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILD | | (X3) DATE SURVEY COMPLETED C | | | |
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| | F PROVIDER OR SUPPLIE | R . CARE OF FORREST CITY | STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST FORREST CITY, AR 72335 | | | | 0.2010 |
| (X4) IE PREFI TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| N 12 | I. All videos will be a restraint by the and Registered Notework the restraint by the restraint are straint by the restraint | e reviewed within 60 minutes of Director of Nursing (DON) or Iurse (RN), if there is not a clear int from the nurses' station, the leo room must be viewed as well | | 128 | | | |
| | training to all RN what to do if propan injury resulted The RN Nurse won Call) and the remove the staff the results of the Executive Office Resource) will view of the training the training the results of the Executive Office Resource) will view of the training to all RN Nurse when the training to all RN Nurse when the training to all RN Nurse when the training to all RN what to do if propagation to all the training to all RN what to do if propagation to all the training to all RN what to do if propagation to all the training to all RN what the training the trainin | rsing will provide additional is involved in the restraint on per technique was not utilized or from the restraint. If notify the AOC (Administrator determination will be made to from the unit or the shift pending video. The CEO (Chief along with HR (Human ew the video to see if termination needs to occur immediately or stigation. | , | | | | |
| | Certified SAMA restraints and be techniques. Train | ve additional training from the rainer to look at footage of able to ascertain correct ning will begin the week of the thereafter depending on schedule. | | | | | |
| | one if not all app | mplaints will be investigated by ropriate administrative staff to DN, Clinical Director and ctor. | | | | | |
| , | p. All Corrective staff and youth f | Actions will be documented in the | е | | | | |
| | to include the retherapy informat | n pertaining to a resident restraint straint logs, medical notes and ion and any other communication restraint will be documented | | | | | |

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | A. BUILDING | 3 | COMPLETED | | |
|---|--|---|---------------------|---|-----------|----------------------------|--|
| | | 04L115 | B. WING | | 01/0 | ; 8/2019 | |
| | PROVIDER OR SUPPLIER | ARE OF FORREST CITY | | STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST FORREST CITY, AR 72335 | 1 0110 | 0/2010 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE | |
| N 128 | together for easy re | eference data. | N 128 | 8 | ı | | |
| | s. Plan to begin imit t. Chart audits will o discussed in the Co | mediately 12/20/18 cocur monthly and be ommittee of a Whole (COW) here are any trends". | | | | | |
| N 129 | | | N 12 | 9 | | | |
| | Compláint AR0002 in part) with these t | | | | | | |
| | review, the facility of appropriately applied emergency safety of (Resident 1) of 5 (Feb. #5) sampled resident physical restraints. In Immediate Jeophave caused serior Resident #1, who so the right ear. The | ion, interview and record failed to ensure a restraint was ed in response to an esituation to prevent injury for 1 Residents #1, #2, #3, #4, and ents who were involved in This failed practice resulted ardy, which caused or could us harm, injury, or death to sustained a contusion above Administrator was notified of pardy on 12/20/10 at 12:40 p.m. | | | | | |
| | | d diagnoses of Disruptive n Disorder and Major er. | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|----------------------|----------|---|-------------------------------|----------------------------|
| | | 04L115 | B. WING | | · · · · · · · · · · · · · · · · · · · | 1 | C 08/2019 |
| | PROVIDER OR SUPPLIER DGE BEHAVIORAL | CARE OF FORREST CITY | | S1 15 | | 01/00/2019 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| N 129 | Continued From p | age 12 | N 1 | 129 | | | |
| | Justification Packet p.m. documented, physical hold on 1 [resident] trying to documented that cassessment after Nurse (RN) documented that the form also documented that the client was stimuli and separate Patient Emergency Form conducted of client documented smart to let [Client was smart to let [Client]] | Restraint Intervention at" form dated 12/13/18 at 4:04 "resident was placed in a 2/13/18 at 3:04 p.m. due to R hit another R." The report during the face-to-face the physical hold, a Registered nented, "hematoma under a if happened during restraint." cumented in the "Staff of Intervention Debriefing Form" removed, "from the provoking ating patient from peer" The by Safety Intervention Debriefing on 12/13/18 at 8:46 p.m. by the d, "[Staff #1] decided it would be the the dropped me and my head is | | | | | |
| | the restraint was property The video showed Staff #1 were start hallway. At 3:04:8 staff member were when Client #1 and 3:05:02 p.m., Staff the arm of Client #1 and Staff #1 lying on the Client #1 was structure observed lying ac 3:05:04 p.m., Staff clip bouncing in a | 9:10 a.m., the video footage of provided by the Administrator. If at 3:00 p.m., Client #1 and ading in the doorway of the 56 p.m., another client and a see going through the doorway tempted to hit the other client. If Client #1 and the other client another staff member. At if #1 placed his left hand under #1 and turned him around and I Staff #1 fell to the floor with the pof Client #1. At 3:05:03 p.m., aggling and Staff #1 was ross Client #1's chest. At if #1 was observed in the video in up and down motion on top of 5:15 p.m., Staff #1 was lying | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | | (X3) DATE SURVEY COMPLETED | | | |
|--|--|---|-------------------------|----------|---|-------------------------------|------------|----------------------------|--|
| | | 04L115 | B. WING | | | | 01/0 | i | |
| NAME OF PROVIDER OR SUPPLIER WOODRIDGE BEHAVIORAL CARE OF FORREST CITY | | | | 1521 | EET ADDRESS, CITY, STATE, ZIP COL 1 ALBERT ST RREST CITY, AR 72335 |)E | 01/08/2019 | | |
| (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 S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD | BE | (X5) COMPLETION DATE | |
| N 129 | Continued From pa over the client who back. | age 13 had been turned onto his | N 1 | 29 | | | | | |
| | "Knowing that ther cafeteria and that irritable, why did yo [Client #1] in the dan alternate route? the others were the handle one [client] Staff #1 was asked with this hold?" Staff #1 was asked differently?" He stakept the kid in the him safe, so one k one would be easi "This restraint occ "yes". Staff #1 waretraining on the S Managing Aggress Safety Intervention | 2:10 p.m., Staff #1 was asked, e had been an incident in the che clients were angry and ou bring the other client past corway instead of taking him in P" Staff #1 stated, "Because e other way. It was better to than all the others [clients]." d, "Do you see any problems aff #1 stated "Yes sir, I do." d, "What could you have done ated, "I probably could have choir room. I was trying to keep id versus all the kids, I decided er to deal with." He was asked, urred on 12/13/18?" He stated, s asked, "Did you have AMA (Satori Alternatives to sion) consisting of Emergency of Performance Assessment, and others, containment and the stated, "Yes." | | | | | | | |
| | "Were you involve The client stated," "Can you tell me w stated, "Earlier in member and ever to get him [the nor wouldn't let us. I w down the hall, and brought the other down the hallway him." Client #1 was | 2:25 p.m., Client #1 was asked, d in a restraint on 12/13/18?" 'Yes." Client #1 was asked, what happened?" Client #1 the day another client hit a staff ybody started getting up trying n-case mix client] back, but staff was mad and [Staff #1] took me then another staff member client [the one who hit the staff] toward me, and I tried to hit as asked, "What happened tated, "Then [Staff #1] | | | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | A. BUILDI | NG | | COMPLETED | | |
|--|--|---|---------------------|---|---|----------------------------|--|--|
| | | 04L115 | B. WING | | _ _ | C 1/08/2019 | | |
| NAME OF PROVIDER OR SUPPLIER WOODRIDGE BEHAVIORAL CARE OF FORREST CITY | | | | STREET ADDRESS, CITY, STA 1521 ALBERT ST FORREST CITY, AR 723 | TE, ZIP CODE | 1 01/00/2019 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION EACTION SHOULD BE D TO THE APPROPRIATE CIENCY) | (X5) COMPLETION DATE | | |
| N 129 | me. [Staff #3] grabelse was on my legme, I was fighting twrist". Client #1 waduring the restraint there was a knot be [Staff #1] wanted to he hoped I swung of | age 14 a ground, basically restrained abed one of my arms; someone s [Staff #1] was on top of the restraint, [Staff #1] bent my s asked, "Were you injured?" The client stated, "Yeah, whind my ear Yeah I feel like to restrain me because he said on the other client. I couldn't tet] was across my throat." | N 1 | 29 | | | | |
| | "What was your rol on 12/13/18 at 3:04 his feet because he #2 was asked, "Wh | e in the restraint of [Client #1] p.m.?" He stated, "I grabbed was kicking [Staff #1]." Staff nen you grabbed [Client #1's] taff #1]?" He stated, "[Staff ss him [Client #1]." | | | | | | |
| | was asked, "Accor ever be weight app the client is on the stated, "No." The any training occurr with a resultant inju | 2:26 a.m., the Administrator ding to the SAMA, should there blied to the client's chest while floor?" The Administrator Administrator was asked, "Hased as a result of this restraint ury?" The Administrator stated, 14 and 15th to refresh staff on assisting process." | | | | | | |
| | 12/14/18 document were retrained on | | | | | | | |
| | 12/20/18 at 12:40 implemented the fo | eopardy was removed on common when the facility collowing Plan of Removal. S at [facility] as of December | , | | | | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILD | | | COMPLETED | | |
|--|--|--|-------------------|--------|---|------|----------------------------|
| | | 04L115 | B. WING | | | 01/0 |) 08/2019 |
| NAME OF PROVIDER OR SUPPLIER WOODRIDGE BEHAVIORAL CARE OF FORREST CITY | | | | , ,,,, | 01/00/2013 | | |
| (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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| N 129 | Continued From pa | age 15 | N · | 129 | | , | |
| | b. Assessments: In Safety Plan | nmediate Jeopardy Regarding | | | | | : |
| | training following a | aff will receive immediate restraint where the resident akes an allegation of the use restraint. | | | | | |
| | shift and carryon th | ill begin immediately on that proughout the remainder shifts signed off on the training | | | | - | - |
| | Aggression) techni Hip standing positi limp in the knees of | Satori Alternatives to Managing ques will begin in the Elbow to on, if the resident begins to go or drop to the ground the floor e will be utilized to prevent any nt. | | | | | |
| · | staff member will b | e restraint a supervisor/lead be summoned via radio to to the area to assist with the | | | | | |
| | let go from a restra resident is calm an The certified restra along with the nurs a resident out of a able to show comp | nformed that a resident can be aint if it appears that the aid can follow simple instruction. Aint trainer or a lead/supervisor se can make the decision to let restraint as soon as they are pliance, or if an improper utilized which could cause resident | | | | | |
| | keep all residents | ent injury to a resident and safe, if there is a potentially on a lead or supervisor must | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURV | | |
|---|--|---|-------------------|-----|---|----------------|----------------------------|--|
| | | 04L115 | B. WING | | | 01/08/2019 | | |
| NAME OF PROVIDER OR SUPPLIER WOODRIDGE BEHAVIORAL CARE OF FORREST CITY | | | | . 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST FORREST CITY, AR 72335 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF | D BE | (X5) COMPLETION DATE | |
| N 129 | potential situations taking another gro direction or holdin altercation does n responsibility of th i. All staff will rece | age 16 es of safety to de-escalate all se from occurring. If that means oup of residents a different g a resident back so a physical ot occur that will be the e shift lead or the supervisor. ive refresher SAMA specifically tion of self and others. Being | N. | 129 | , | | | |
| | j. Plan will be effe December 20, 20 k. Nursing Staff w I. All videos will be a restraint by the and Registered N | nent and surrounding. ctive immediately beginning 18 ill: e reviewed within 60 minutes of Director of Nursing (DON) or urse (RN), if there is not a clear | | | | | | |
| | camera in the vide for more clarity if m. Director of Nurtraining to all RNs what to do if propan injury resulted The RN Nurse will on Call) and the cremove the staff of the results of the Executive Officer Resource) will view | rsing will provide additional involved in the restraint on er technique was not utilized or from the restraint. Il notify the AOC (Administrator letermination will be made to from the unit or the shift pending video. The CEO (Chief along with HR (Human we will the video to see if termination needs to occur immediately or | | | | | | |
| | Certified SAMA T | re additional training from the rainer to look at footage of able to ascertain correct | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | | |
|--|---|--|---|----------------|---|------|----------------------------|--|--|
| | | 04L115 | B. WING |) | | 01/0 |) 8/2019 | | |
| NAME OF PROVIDER OR SUPPLIER WOODRIDGE BEHAVIORAL CARE OF FORREST CITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1521 ALBERT ST FORREST CITY, AR 72335 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETION DATE | | |
| N 129 | | ng will begin the week of thereafter depending on | N | 129 | | | | | |
| | one if not all appro | plaints will be investigated by priate administrative staff to l, Clinical Director and or. | | - | | | | | |
| | p. All Corrective Ac staff and youth file. | ctions will be documented in the | | | | | | | |
| | to include the restr therapy information | ertaining to a resident restraint aint logs, medical notes and n and any other communication straint will be documented eference data. | | | | • | | | |
| | | niner will review the restraint document that it was reviewed. | | | | | | | |
| | s. Plan to begin im | mediately 12/20/18 | , | | | | - | | |
| | discussed in the C | occur monthly and be ommittee of a Whole (COW) here are any trends". | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| - | | | | | | | | | |