ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services and Quality Assurance
Office of Long Term Care
PO Box 8059, Slot S404
Little Rock, AR 72203-8059
Fax: 501-682-6159

December 3, 2019

Barbara Radebaugh, Administrator
Woodridge Behavioral Care Northeast
600 North 7th Street
West Memphis, AR 72301

Dear Ms. Radebaugh:

On November 25, 2019 a Complaint survey was conducted at your facility by the Office of Long Term Care to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid (Title XIX) Program. This survey found that your facility had deficiencies requiring correction/substantial correction prior to a revisit as specified in the attached CMS-2567.

Plan of Correction
A POC must be submitted within 10 calendar days of you receipt of the Statement of Deficiencies. Failure to submit a POC may result in termination. Include a completion date for each deficieny cited.

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
or email to Rodney.Raper@dhs.arkansas.gov

Your Plan of Correction must also include the following:

a. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice;

b. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

c. Address what measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur;

d. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.

e. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. Your facility is ultimately accountable for its own compliance. The plan of correction will serve as the facility's allegation of compliance. Unless otherwise stated on the PoC, the last completion date will be the date of alleged compliance.

Informal Dispute Resolution

In accordance with 42 CFR § 488.331, you have one opportunity to question deficiencies through an informal dispute resolution (IDR) process. To obtain an IDR, you must send your written request to Health Facility Services, Arkansas Department of Health within ten (10) calendar days from receipt of the Statement of Deficiencies. The request must state the specific deficiencies the facility wishes to challenge. The request should also state whether the facility wants the IDR to be performed by a telephone conference call, record review, or a face-to-face meeting.

An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

Please submit your request to:

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

If you have any questions, please call Sandra Broughton, Program Administrator at 501-320-6182.

Sincerely,

Sandra Broughton

Sandra Broughton, DHS Program Administrator
Office of Long Term Care
Survey & Certification Section

sgb

cc: DRA
file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L114	A. BUILDING _____ B. WING _____	C 11/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE BEHAVIORAL CARE NORTHEAST	600 NORTH 7TH STREET WEST MEMPHIS, AR 72301

(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. A Complaint survey was conducted on 11/20/10 through 11/25/19. Complaint #AR00023839 was substantiated, all or in part, with a deficiency cited at N0126.	N 000		
N 126	PROTECTION OF RESIDENTS CFR(s): 483.356 (a)(1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation. This ELEMENT is not met as evidenced by: Complaint #AR00023839 was substantiated, all or in part, in these findings. Based on record review and interviews, the facility failed to ensure the clients were free from restraint as a means of discipline for 1 of 1	N 126		

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.

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N 126	Continued From page 1 (Resident #1) case mix Resident who was physically restrained. The findings are: Resident #1 had diagnoses of Disruptive Mood Dysregulation Disorder, Posttraumatic Stress Disorder, Reactive Attachment Disorder, Attention-deficient Hyperactivity Disorder, Combined Presentation and Personal History of Self-harm. a. A report titled "Subject: Incident" documented... "On Tuesday, November 12, 2019 at approximately 5:45 p.m., a RTC [residential treatment care] patient [Resident #1] was placed in a physical hold, the patient found a pen and was writing all over her shoes. Since the pen is a potential weapon, the female tech [technician] requested that the child put the pen down on the table. The resident refused and became angry and combative. The female tech attempted to take the away from the resident and the resident bit the staff member's arm and refused to unclench her teeth. The staff member placed the child in a semi-restraint and called for help. Assistance arrived immediately and the child was properly restrained. Once the patient stopped biting the staff member's arm, that staff member left the restraint and room immediately. After shift change, the patient reported to the night nurse that the staff member pulled her out of the chair causing her to strike her head on the floor. The night RN [Registered Nurse] informed me at 1823 [6:23 p.m.]. Since there was an allegation of harm, I immediately suspended the tech pending an investigation. The staff member left the facility at 1830 [6:30 p.m.] I have obtained statements from those staff members who were involved in the incident. They all report that the patient was violent, hitting, kicking, and biting. The resident	N 126		

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N 126	Continued From page 2	N 126		

refuses to provided a verbal or written statement. I have reviewed video footages of the incident; however, the incident is out camera range. The employee is suspended pending outcome of the investigation..." The report was completed by the Chief Nursing Officer.

b. On 11/20/19 at 3:40 p.m., Resident #1, was asked to tell about what had occurred on 11/12/19. She stated, "I was coloring on a flip flop. She [Psychiatric Technician (PT) #1] tried to take the flip flop away from me. She pushed me off the chair, she hit my head on the ground. I put the flip flop up under me. I kicked and bit her on the arm. My therapist was in the hall and called for help. [PT #1] came and put me in a restraint." She was asked, "Did you get injured during the restraint?" She stated, "No." She was asked, "Who was present when this incident occurred?" She stated, "I don't think anyone saw the whole thing, cause she [PT #]) told them to get out of the room."

c. On 11/20/19 at 3:50 p.m., RN #1 stated, "I was called to the butterfly room, where the restraint was in progress. It was a proper restraint, with [PT #1] at the upper side and [Therapist #1] at the legs. Then [PT #1] and [PT #3] came in. [Resident #1] was screaming, "I didn't do anything" and [PT #1] stated, "Yes you did, you kicked me. I didn't put you in a restraint until you physically kicked me." [Resident #1] had already bit [PT #1] and was trying to head butt her..."

d. On 11/20/19 at 4:22 p.m., PT #1 was asked about the incident on 11/12/19 with Resident #1. She stated, "I went to relieve [another staff member] who was helping in residential in the butterfly room. [Resident #1] was drawing on a

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N 126	Continued From page 3 flip flop, I told her to stop, because it was damaging property. So she wouldn't stop so I took the flip flop. I put the flip flop in my chair. While I was checking on another client, [Resident #1] took the flip flop and my pen from my clip board. So I went to get the pen and she kicked me and I went to put her in a restraint with my arm around her crossed arms, and took her to the ground. [Therapist #1] came by and saw what was happening and got on her [Resident #1's] legs. [Resident #1] moved my right arm to her mouth and bit me. [PT #2] came to relieve me and took over the restraint and she tried to bite him. She tried to tell the nurse that I slammed her head in the ground but I didn't. They checked her head out and she didn't have anything wrong. Then they sent me home." On 11/25/19 at 3:06 p.m., PT #1 was asked, "Why didn't you call for assistance when [Resident #1] wouldn't give you the pen and the flip flop?" She stated, "Because my walkie was dead and I didn't have time to get another one at that time. I had already taken one flip flop from her and she sat on the other one. I put the flip flop on my chair where my book [of behaviors] was. Then I went to check on a client who was upset. I saw her [Resident #1] get the flip flop. I didn't know at that time that she had taken the pen. I was going to let her keep the flip flop to avoid a disruption, but then she kicked me. She was standing up, kicked me, then I got behind her and crossed her arms and went to the ground with her and that's when she was fighting me and bit my right forearm. I realized that I should have just let her have the flip flops and just written her up. I feel like it was necessary because she kicked me., but if I never took the flip flops, she would not have kicked me	N 126		

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N 126	Continued From page 4 e. On 11/20/19 at 4:40 p.m., PT #2 stated, "I got a call to come to the butterfly room. [PT #1] and [Therapist #1] was in a restraint with [Resident #1]..." f. On 11/25/19 at 1:30 p.m., the surveillance cameras were reviewed, however the event was not in camera range. The view from the hallway showed that on 11/12/19 at 5:38 p.m. PT #1 was seen talking to another client in the hallway. At 5:39 p.m., Resident #1 was viewed coming out the butterfly room, picked up an ink pen and flip flop, waved a flip flop at the staff member then went back into the butterfly room. PT #1 went into the butterfly room. At 5:59:52 p.m., Therapist #1, was seen coming out of a side door into the hallway and looked into the butterfly room where PT #1 and Resident #1 had gone into. Therapist #1 looked into the butterfly room, then went down the hall, opened the door then at 5:40 p.m., RN #1, PT #2 and RN #2 went into the butterfly room. g. On 12/3/19 at approximately 3:00 p.m., in a telephone interview, the Chief Executive Officer and Chief Nursing Officer stated that PT #1 was inserviced on appropriateness of when to use a restraint, but no other staff were inserviced.	N 126		