



Division of Provider Services & Quality Assurance P.O. Box 8059, Slot S404 Little Rock, AR 72203-8059 P: 501.320.6182 F: 501.682.6159

July 16, 2021

Derek Thompson, Administrator Woodridge Of The Ozarks 2466 S 48th Street Springdale, AR 72762

Dear Mr. Thompson:

On July 8, 2021 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.

Amanda Smith, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
(501) 320-3963
email to Amanda.Smith@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:

IDR/IIDR Program Coordinator Health Facilities Services 5800 West 10<sup>th</sup> Street, Suite 400 Little Rock, AR 72204 Phone: 501-661-2201 Fax: 501-661-2165

ADH.HFS@Arkansas.gov

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

Sincerely,

RN Manager

DPSQA/Office of Long Term Care Survey & Certification Section

Smanda mesmille

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cc: DRA

PRINTED: 07/27/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		04L120	B. WING _			C 07/08/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2466 S 48TH STREET SPRINGDALE, AR 72762		3770072021	
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N 126	part, with defeciencie  The facility was not in Subpart G - Condition Psychiatric Residentia	ESIDENTS	N 1.	26			
	means of coercion, di retaliation.  This ELEMENT is no Based on record revi	e right to be free from , of any form, used as a iscipline, convenience, or of met as evidenced by: iew and interview the facility				(VG) DATE	

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

TITLE

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.

Facility ID: 3017

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		04L120	B. WING _				08/2021	
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N 126	of retaliation and/or d #1) who forcefully pla finding are:  Resident #1 had a dia Stress Disorder and I  a. A facility Serious C documented, "On 7 /3 [p.m.], a resident tool unit. She was disregu off unit and began sw Care Coordinator [YC Care Worker (YCW) a from behind. [YCW # ground, swung her ar room. He released th force. The resident hi wall. [YCW #1] kicked room and closed the #1] away from the are At this time, the RN [I	sion was not used as a form iscipline for 1 of 1 (Resident ced in seclusion. The agnoses of Post-Traumatic Major Depressive Disorder.  Courrence report 3/21 at approximately 4:03 an exit off her assigned alated when she took the exit atting her fists at a Youth CC]. Another staff, [Youth 4/1], grabbed the resident 1] picked her up off the ound and into the Seclusion eresident with excessive the floor and slid into the did the resident's shoe into the door. The YCC took [YCW ea and into a separate office. Registered Nurse] was able	N ·	126	ver)			
	wound on her forehead wall. The RN stopped resident was given a neuro checks after the outcomes. The resident no pain at the time of suspended on 7/3/20 7/6/2021.  On 7/7/21 at 11:04 a. by the Surveyors during confirmed what was confirmed what was conceived by the Surveyors during	band aid. RN performed e incident with no negative ent was crying, but reported incident. [YCW #1] was						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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N 126	#1]? "He replied, "The asked for the client to room and I was alread asked them to wait at the staff was letting he with her to the comfound yelling at me. Then I and said "Hey, you do she tried to hit me and couldn't hit me. At the and put her in the second asked. "Was the second stated, "For her yes. happened."  c. On 7/8/2021 at 11:	pened on 7/3/21 to [Resident to e staff on another unit had to be taken to the comfort dy with another resident and minute. Yelling started and er off the unit and I walked in troom and she started was standing in front of her on't need to yell at me, so d I grabbed her wrist so she at time [YCW#1] grabbed her clusion room. "He was usion appropriate?" He	N 12	26		
N 216	The resident stated, 'said something that regrabbed me and three hit my head, and it wasked, "Did the nurse stated, "No they took care."  EDUCATION AND TRUETEDUCATION AND TRUETEDUCATION, and was de-escalation, meactive listening, and was methods, to prevent eand  This ELEMENT is not based on record rev	If went to hit YCC and he hade me mad. YCW #1]  w me in the comfort room. It as sore. The resident was a look at it?" The resident a picture but they don 't to a picture but they don 't to a picture but they don't to use they are they	N 21	16		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	, , ,	(X3) DATE SURVEY COMPLETED	
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N 216	incident with 1 of 1 forcefully placed in Resident #1 had a Stress Disorder and a. A facility Serious documented, "On 7 [p.m.], a resident to unit. She was disreoff unit and begans Care Coordinator [Care Worker (YCW from behind. [YCW ground, swung her room. He released force. The resident wall. [YCW #1] kick room and closed the #1] away from the At this time, the RN to assess the child wound on her forewall. The RN stopp resident was given neuro checks after outcomes. The resident was given neuro checks after outcomes.	Resident #1 who was seclusion. The findings are:  diagnoses of Post-Traumatic diagnose	N 2				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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N 216	or monitoring with you incident?" He stated, training and re-certific parties involved"  c. On 7/8/21 at 11:30 you tell me what happ #1]? " He replied, "The asked for the client to room and I was alread asked them to wait at the staff was letting he with her to the comfor yelling at me. Then I wand said "Hey, you do she tried to hit me and couldn't hit me. At the and put her in the second asked. "Was the second stated, "For her yes."	ur staff, concerning the "We have scheduled cations. We only retrain the a.m., YCC was asked, "Can bened on 7/3/21 to [Resident be staff on another unit had be taken to the comfort dy with another resident and minute. Yelling started and er off the unit and I walked out room and she started was standing in front of her on't need to yell at me, so d I grabbed her wrist so she at time [YCW#1] grabbed her clusion room." He was usion appropriate?" He But not the way it lasked, "Did you receive any	N 2	216			





Division of Provider Services & Quality Assurance P.O. Box 8059, Slot S404 Little Rock, AR 72203-8059 P: 501.320.6182 F: 501.682.6159

August 5, 2021

Derek Thompson, Administrator Woodridge Of The Ozarks 2466 S 48th Street Springdale, AR 72762

Dear Mr. Thompson:

On July 8, 2021, we conducted a Complaint survey at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and have approved your plan of correction and presume that you will achieve substantial correction by July 22, 2021.

We will be conducting a revisit of your facility to verify that substantial correction has been achieved and maintained.

If you have any questions, please contact your reviewer: Sandra Broughton at 501-320-6182 or email to Sandra. Broughton@dhs.arkansas.gov.

Sincerely,

DPSQA/Office of Long Term Care

Saudie Biseighten Administrative Services Manager

Survey & Certification Section

sgb

### Approved POC 8/5/2021 SGB PRINTED: 07/27/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO 0938-0391	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		F 'e	(X3) DATE SURVEY COMPLETED	
		04L120	B. WING			C 07/08/2021	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	0770012021	
				25	466 S 48TH STREET		
WOODRID	GE OF THE OZARKS			S	PRINGDALE, AR 72762		
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N 000	is an official, legal do remain unchanged e correction, correction space. Any discrepa citation(s) will be rep Office (RO) for referr Inspector General (Conformation is inadve	of (Statement of Deficiencies) ocument. All information must except for entering the plan of a dates, and the signature ency in the original deficiency orted to the Dallas Regional real to the Office of the DIG) for possible fraud. If extently changed by the estate Survey Agency (SA) imediately.	N	0000	Perimeter Behavioral of the Ozarks is committed to the safety, security and thereuptic treatment to all residents in our care. The below Plans of Correcti shall address each of the discrepancie listed herein.		
		6825 was substantiated, all in es cited at N126 and N216.					
N 126	Subpart G - Condition Psychiatric Resident PROTECTION OF R CFR(s): 483.356 (a)  Each resident has the restraint or seclusion means of coercion, or retaliation.  This ELEMENT is n	ESIDENTS	N	126	Perimeter Behavioral of the Ozarks is committed to the safety, security and thereuptic treatment to all residents in ocare. During the investigation, it was found that YCW #1 was not compliant withe restraint and seclusion policy, guidelines and/or expectations. Immediaction was taken upon YCW #1, placing him upon administrative leave within approximately 20 minutes of the inciden and his subsequent termination upon the complete and formal, in-house investigation.	ate	
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	_	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	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _	COMPLETED		
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N 126	of retaliation and/or #1) who forcefully plifinding are:  Resident #1 had a distress Disorder and  a. A facility Serious of documented, "On 7 [p.m.], a resident too unit. She was disreg off unit and began store Coordinator [Y Care Worker (YCW) from behind. [YCW aground, swung her aroom. He released to force. The resident I wall. [YCW #1] kicker oom and closed the #1] away from the and this time, the RN to assess the child, wound on her forehe wall. The RN stopperesident was given an euro checks after to outcomes. The resident pain at the time of suspended on 7/3/2 7/6/2021.  On 7/7/21 at 11:04 a by the Surveyors du confirmed what was Occurrence Report.	usion was not used as a form discipline for 1 of 1 (Resident aced in seclusion. The liagnoses of Post-Traumatic Major Depressive Disorder.  Occurrence report /3/21 at approximately 4:03 ok an exit off her assigned gulated when she took the exit watting her fists at a Youth CC]. Another staff, (Youth #1], grabbed the resident #1] picked her up off the around and into the Seclusion he resident with excessive with the floor and slid into the exit door. The YCC took [YCW area and into a separate office and when she hit the floor or exit the bleeding and the aband aid. RN performed the incident with no negative dent was crying, but reported of incident. [YCW #1] was 021 and terminated on	N 126	The incident that took place has identified as an isolated event wisclusion had been inappropriate without obtaining necessary app Director of Nursing reviews each where seclusion is utilized to enshas been completed according to a member of the administration on Call rounds which are completely a member of the administration will now include specific video reseclusions and any significant arirregular restraints. This update permanent implementation to the documentation. Additional training provided immediately upon any of seen by the Administrator on Call As of July 12, 2021, all staff has retrained on seclusion expectational including, but not limited to, series not meant as a form of coerce discipline, convenience and/or retaliation. This was completed through the internal messaging. This is also covered in all orient bi-annual and monthly training completed by the Director of N SAMA instructor and/or assign trainers.  Bi-annual SAMA recertification been successfully completed by the Nursing/SAMA instructor.  Any future incidents and subsettraining will be handled in the seasion from this point forward but not limited to, utilizing our imessaging system, in-person orientation, bi-annual, annual amonthly training	here ely utilized roval. The incident sure that it o policy.  eted weekly we team eview of all ind/or is a e AOC ng will be deficiency il.  eve been tions, clusion cion, d g system.  etetion, (s), ursing, ed in has as of ne Dir. of equent same including internal training,	

PRINTED: 07/27/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING  $\cap$ 04L120 B. WING 07/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2466 S 48TH STREET WOODRIDGE OF THE OZARKS** SPRINGDALE, AR 72762 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) N 126 | Continued From page 2 N 126 you tell me what happened on 7/3/21 to [Resident #1]? " He replied, "The staff on another unit had asked for the client to be taken to the comfort room and I was already with another resident and asked them to wait a minute. Yelling started and the staff was letting her off the unit and I walked with her to the comfort room and she started yelling at me. Then I was standing in front of her and said "Hey, you don't need to yell at me, so she tried to hit me and I grabbed her wrist so she couldn't hit me. At that time [YCW#1] grabbed her and put her in the seclusion room. " He was asked. "Was the seclusion appropriate?" He stated, "For her yes. But not the way it happened." c. On 7/8/2021 at 11:45 a.m., Resident #1 was asked, "What happened on the 3rd (7/3/21)?" The resident stated, "I went to hit YCC and he said something that made me mad. YCW #1] grabbed me and threw me in the comfort room. I hit my head, and it was sore. The resident was asked, "Did the nurse look at it?" The resident Perimeter Behavioral of the Ozarks is stated, "No they took a picture but they don't committed to the safety, security and care." thereuptic treatment to all residents in our N 216 EDUCATION AND TRAINING N 216 care. CFR(s): 483.376(a)(2) Perimeter Behavioral of the Ozarks currently, and historically, conducts The use of nonphysical intervention skills, such bi-annual Restraint, Seclusion and Verbal as de-escalation, mediation conflict resolution, De-Escalation training (Mandatory) for all active listening, and verbal and observational employees. This includes recognizing methods, to prevent emergency safety situations; distress in patients, therapeutic conflict and resolution with patients, ESI (Emergency

This ELEMENT is not met as evidenced by:

failed to ensure all staff were trained not to use

restraint and/or seclusion for disciplines.

Based on record review and interview, the facility

Safety Intervention). All training, including

but not limited to, orientation, bi-annual training, annual training and as-needed, is

maintained with the Human Resources

Department and contained in each

Employees' Training file.

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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N 216	retaliation, coercion of incident with 1 of 1 R forcefully placed in set. Resident #1 had a di Stress Disorder and a. A facility Serious C documented, "On 7 / [p.m.], a resident too unit. She was disregt off unit and began sw Care Coordinator [YC Care Worker (YCW) from behind. [YCW # ground, swung her ar room. He released th force. The resident h wall. [YCW #1] kicker room and closed the #1] away from the an At this time, the RN [to assess the child, wound on her forehe wall. The RN stopper resident was given a neuro checks after th outcomes. The resident pain at the time of suspended on 7/3/20 7/6/2021  On 7/7/21 at 11:04 a. by the Surveyors dur confirmed what was a Occurrence Report.	or convenience after an resident #1 who was reclusion. The findings are: agnoses of Post-Traumatic Major Depressive Disorder.  Occurrence report 3/21 at approximately 4:03 k an exit off her assigned ulated when she took the exit watting her fists at a Youth CC]. Another staff, [Youth #1], grabbed the resident round and into the Seclusion re resident with excessive it the floor and slid into the door. The YCC took [YCW rea and into a separate office. Registered Nurse] was able who had reopened a prior ad when she hit the floor or d the bleeding and the band aid. RN performed reincident with no negative rent was crying, but reported incident. [YCW #1] was 21 and terminated on m., the video was reviewed ing the investigation and documented in the Serious	N 216	Perimeter Behavioral of the Ozarks currently, and historically, retrains a directly involved in Serious Inciden Occurrences. This includes recogn distress in patients, therapeutic corresolution with patients, ESI (Emer Safety Intervention). All training, in but not limited to, orientation, bi-an training, annual training and as-net training, is maintained with the Hur Resources Department and containe each Employees' Training file.  As of July 8, 2021 Perimeter Behave the Ozarks will commit to utilizing of internal messaging system to reiter retrain restraint, seclusion and de-escalation policy, guidelines and expectations to all staff after any in restraints and/or seclusions, mindfor confidentiality and HIPPA guidelines the 24–48-hour timeframe as verbaindicated by the Auditor.  All training materials will be maintathe Human Resources Department contained in the employees' training has of July 22, 2021 Administration Leadership will be meeting every Boay to review any incident(s) within the previous 24 hours.	any staff t t nizing nflict gency icluding nual eded nan ned in vioral of our rate and d regular ul of all es within ally ined in g file(s).	7/00/04
		a.m., Corporate Executive lave you done any retraining		Within the previous 24 flours.	11	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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Division of Provider Services & Quality Assurance P.O. Box 8059, Slot S404 Little Rock, AR 72203-8059 P: 501.320.6182 F: 501.682.6159

August 18, 2021

Derek Thompson, Administrator Woodridge Of The Ozarks 2466 S 48th Street Springdale, AR 72762

Dear Mr. Thompson:

During the Revisit survey conducted on August 16, 2021, your facility was found to be in compliance with program requirements. Please email the signed CMS 2567 Sandra.Broughton@dhs.arkansas.gov.

If you have any questions, please contact your reviewer: Sandra Broughton at 501-320-6182 or email to Sandra. Broughton@dhs.arkansas.gov.

Sincerely,

DPSQA/Office of Long Term Care

Saudie Bisuston Administrative Services Manager

Survey and Certification Section

sgb

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L120	B. WING	B. WING			R-C <b>08/16/2021</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	1 00/	16/2021	
WOODRID	GE OF THE OZARKS			2466 S 48TH STREET SPRINGDALE, AR 72762	2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION S			(X5) COMPLETION DATE	
{N 000}	Initial Comments	7 (Statement of Deficiencies)	{N 0	00}				
	is an official, legal do remain unchanged excorrection, correction space. Any discrepar citation(s) will be reprofice (RO) for referr. Inspector General (Oinformation is inadve provider/supplier, the should be notified im	erd on August 16, 2021 for all July 8, 2021. All deficiencies and no new noncompliance lity is in compliance with all						
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.

#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Nam	Provider/Supplier Name						
04L120	WOODRIDGE OF T	WOODRIDGE OF THE OZARKS						
Type of Survey (select all that apply)	A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit M Other	<ul><li>E Initial Certification</li><li>F Inspection of Care</li><li>G Validation</li><li>H Life Safety Code</li></ul>	I J K L	Recertification Sanctions/Hearing State License CHOW				
Extent of Survey (select all that apply)	A Routine/Standard Survey (all provide B Extended Survey (HHA or Long Tern C Partial Extended Survey (HHA) D Other Survey	** /						

#### SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1.	07/07/2021	07/08/2021	0.50	0.00	11.00	0.00	6.50	0.50
2. (6), (b) (7	07/08/2021	07/08/2021	0.50	0.00	0.50	0.00	6.00	0.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

-						
Total SA Supervisory Review Hours	1	.00	Total RO Super	visory Review Ho	urs	0.00
Total SA Clerical/Data Entry Hours	0.	50	Total RO Cleric	al/Data Entry Hou	rs	0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

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#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier	Provider/Supplier Name						
04L120	WOODRIDGE OF THE OZARKS							
Type of Survey (select all that apply)	A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit M Other	<ul><li>E Initial Certification</li><li>F Inspection of Care</li><li>G Validation</li><li>H Life Safety Code</li></ul>	I J K L	Recertification Sanctions/Hearing State License CHOW				
Extent of Survey (select all that apply)	• ` •							

#### SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1.	08/16/2021	08/16/2021	0.50	0.00	3.50	0.00	4.00	0.50
)(6), (b) (7	08/16/2021	08/16/2021	0.50	0.00	3.50	0.00	4.50	0.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

-						
Total SA Supervisory Review Hours	0.25	5	Total RO Super	visory Review Ho	urs	0.00
Total SA Clerical/Data Entry Hours	0.25	5	Total RO Clerio	cal/Data Entry Hou	rs	0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No

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