ARKANSAS DEPARTMENT OF HUMAN SERVICES

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 10th 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,

Amanda McSmith

RN Manager
DPSQA/Office of Long Term Care
Survey & Certification Section

as

cc: DRA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L120	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2466 S 48TH STREET SPRINGDALE, AR 72762

(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 #AR00026825 was substantiated, all in part, with defeciencies cited at N126 and N216.	N 000		
N 126	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center 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: Based on record review and interview the facility	N 126		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L120	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2466 S 48TH STREET SPRINGDALE, AR 72762

(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 126	Continued From page 1	N 126		

failed to ensure seclusion was not used as a form of retaliation and/or discipline for 1 of 1 (Resident #1) who forcefully placed in seclusion. The finding are:

Resident #1 had a diagnoses of Post-Traumatic Stress Disorder and Major Depressive Disorder.

a. A facility Serious Occurrence report documented, "On 7 /3/21 at approximately 4:03 [p.m.], a resident took an exit off her assigned unit. She was disregulated when she took the exit off unit and began swatting her fists at a Youth Care Coordinator [YCC]. Another staff, [Youth Care Worker (YCW) #1], grabbed the resident from behind. [YCW #1] picked her up off the ground, swung her around and into the Seclusion room. He released the resident with excessive force. The resident hit the floor and slid into the wall. [YCW #1] kicked the resident's shoe into the room and closed the door. The YCC took [YCW #1] away from the area and into a separate office. At this time, the RN [Registered Nurse] was able to assess the child, who had reopened a prior wound on her forehead when she hit the floor or wall. The RN stopped the bleeding and the resident was given a band aid. RN performed neuro checks after the incident with no negative outcomes. The resident was crying, but reported no pain at the time of incident. [YCW #1] was suspended on 7/3/2021 and terminated on 7/6/2021.

On 7/7/21 at 11:04 a.m., the video was reviewed by the Surveyors during the investigation and confirmed what was documented in the Serious Occurrence Report.

b. On 7/8/21 at 11:30 a.m. YCC was asked, "Can

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L120	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2466 S 48TH STREET SPRINGDALE, AR 72762

(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 126	Continued From page 2 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 stated, "No they took a picture but they don ' t care."	N 126		
N 216	EDUCATION AND TRAINING CFR(s): 483.376(a)(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff were trained not to use restraint and/or seclusion for disciplines,	N 216		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L120	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2466 S 48TH STREET SPRINGDALE, AR 72762

(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 216	Continued From page 3	N 216		

retaliation, coercion or convenience after an incident with 1 of 1 Resident #1 who was forcefully placed in seclusion. The findings are:

Resident #1 had a diagnoses of Post-Traumatic Stress Disorder and Major Depressive Disorder.

a. A facility Serious Occurrence report documented, "On 7 /3/21 at approximately 4:03 [p.m.], a resident took an exit off her assigned unit. She was disregulated when she took the exit off unit and began swatting her fists at a Youth Care Coordinator [YCC]. Another staff, [Youth Care Worker (YCW) #1], grabbed the resident from behind. [YCW #1] picked her up off the ground, swung her around and into the Seclusion room. He released the resident with excessive force. The resident hit the floor and slid into the wall. [YCW #1] kicked the resident's shoe into the room and closed the door. The YCC took [YCW #1] away from the area and into a separate office. At this time, the RN [Registered Nurse] was able to assess the child, who had reopened a prior wound on her forehead when she hit the floor or wall. The RN stopped the bleeding and the resident was given a band aid. RN performed neuro checks after the incident with no negative outcomes. The resident was crying, but reported no pain at the time of incident. [YCW #1] was suspended on 7/3/2021 and terminated on 7/6/2021

On 7/7/21 at 11:04 a.m., the video was reviewed by the Surveyors during the investigation and confirmed what was documented in the Serious Occurrence Report.

b. On 7/7/21 at 10:00 a.m., Corporate Executive Officer was asked, "Have you done any retraining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L120	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2466 S 48TH STREET SPRINGDALE, AR 72762

(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 216	Continued From page 4	N 216		

or monitoring with your staff, concerning the incident?" He stated, "We have scheduled training and re-certifications. We only retrain the parties involved..."

c. On 7/8/21 at 11:30 a.m., YCC was asked, "Can 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." He was asked, "Did you receive any retraining?" He stated, "No."

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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,

Sandra Broughton
Administrative Services Manager

DPSQA/Office of Long Term Care
Survey & Certification Section

sgb

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L120	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2466 S 48TH STREET SPRINGDALE, AR 72762

(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 #AR00026825 was substantiated, all in part, with defeciencies cited at N126 and N216.	N 000	Perimeter Behavioral of the Ozarks is committed to the safety, security and thereuptic treatment to all residents in our care. The below Plans of Corrections shall address each of the discrepancies listed herein.	N/A
N 126	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center 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: Based on record review and interview the facility	N 126	Perimeter Behavioral of the Ozarks is committed to the safety, security and thereuptic treatment to all residents in our care. During the investigation, it was found that YCW #1 was not compliant with the restraint and seclusion policy, guidelines and/or expectations. Immediate action was taken upon YCW #1, placing him upon administrative leave within approximately 20 minutes of the incident and his subsequent termination upon the complete and formal, in-house investigation.	7/22/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] CEO 7/29/21

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
	04L120	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2466 S 48TH STREET SPRINGDALE, AR 72762

(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 126	Continued From page 1 failed to ensure seclusion was not used as a form of retaliation and/or discipline for 1 of 1 (Resident #1) who forcefully placed in seclusion. The finding are: Resident #1 had a diagnoses of Post-Traumatic Stress Disorder and Major Depressive Disorder. a. A facility Serious Occurrence report documented, "On 7 /3/21 at approximately 4:03 [p.m.], a resident took an exit off her assigned unit. She was disregulated when she took the exit off unit and began swatting her fists at a Youth Care Coordinator [YCC]. Another staff, [Youth Care Worker (YCW) #1], grabbed the resident from behind. [YCW #1] picked her up off the ground, swung her around and into the Seclusion room. He released the resident with excessive force. The resident hit the floor and slid into the wall. [YCW #1] kicked the resident's shoe into the room and closed the door. The YCC took [YCW #1] away from the area and into a separate office. At this time, the RN [Registered Nurse] was able to assess the child, who had reopened a prior wound on her forehead when she hit the floor or wall. The RN stopped the bleeding and the resident was given a band aid. RN performed neuro checks after the incident with no negative outcomes. The resident was crying, but reported no pain at the time of incident. [YCW #1] was suspended on 7/3/2021 and terminated on 7/6/2021. On 7/7/21 at 11:04 a.m., the video was reviewed by the Surveyors during the investigation and confirmed what was documented in the Serious Occurrence Report. b. On 7/8/21 at 11:30 a.m. YCC was asked, "Can	N 126	The incident that took place has been identified as an isolated event where seclusion had been inappropriately utilized without obtaining necessary approval. The Director of Nursing reviews each incident where seclusion is utilized to ensure that it has been completed according to policy. As of July 8, 2021, Administrator on Call rounds which are completed weekly by a member of the administrative team will now include specific video review of all seclusions and any significant and/or irregular restraints. This update is a permanent implementation to the AOC documentation. Additional training will be provided immediately upon any deficiency seen by the Administrator on Call. As of July 12, 2021, all staff have been retrained on seclusion expectations, including, but not limited to, seclusion is not meant as a form of coercion, discipline, convenience and/or retaliation. This was completed through the internal messaging system. This is also covered in all orientation, bi-annual and monthly training(s), completed by the Director of Nursing, SAMA instructor and/or assigned trainers. Bi-annual SAMA recertification has been successfully completed as of July 14, 2021, conducted by the Dir. of Nursing/SAMA instructor. Any future incidents and subsequent training will be handled in the same fashion from this point forward, including but not limited to, utilizing our internal messaging system, in-person training, orientation, bi-annual, annual and monthly training	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L120	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2466 S 48TH STREET SPRINGDALE, AR 72762

(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 126	Continued From page 2 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 stated, "No they took a picture but they don ' t care."	N 126		
N 216	EDUCATION AND TRAINING CFR(s): 483.376(a)(2) The use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations; and This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all staff were trained not to use restraint and/or seclusion for disciplines,	N 216	Perimeter Behavioral of the Ozarks is committed to the safety, security and thereuptic treatment to all residents in our care. Perimeter Behavioral of the Ozarks currently, and historically, conducts bi-annual Restraint, Seclusion and Verbal De-Escalation training (Mandatory) for all employees. This includes recognizing distress in patients, therapeutic conflict resolution with patients, ESI (Emergency 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L120	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2466 S 48TH STREET SPRINGDALE, AR 72762

(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 216	Continued From page 3 retaliation, coercion or convenience after an incident with 1 of 1 Resident #1 who was forcefully placed in seclusion. The findings are: Resident #1 had a diagnoses of Post-Traumatic Stress Disorder and Major Depressive Disorder. a. A facility Serious Occurrence report documented, "On 7 /3/21 at approximately 4:03 [p.m.], a resident took an exit off her assigned unit. She was disregulated when she took the exit off unit and began swatting her fists at a Youth Care Coordinator [YCC]. Another staff, [Youth Care Worker (YCW) #1], grabbed the resident from behind. [YCW #1] picked her up off the ground, swung her around and into the Seclusion room. He released the resident with excessive force. The resident hit the floor and slid into the wall. [YCW #1] kicked the resident's shoe into the room and closed the door. The YCC took [YCW #1] away from the area and into a separate office. At this time, the RN [Registered Nurse] was able to assess the child, who had reopened a prior wound on her forehead when she hit the floor or wall. The RN stopped the bleeding and the resident was given a band aid. RN performed neuro checks after the incident with no negative outcomes. The resident was crying, but reported no pain at the time of incident. [YCW #1] was suspended on 7/3/2021 and terminated on 7/6/2021 On 7/7/21 at 11:04 a.m., the video was reviewed by the Surveyors during the investigation and confirmed what was documented in the Serious Occurrence Report. b. On 7/7/21 at 10:00 a.m., Corporate Executive Officer was asked, "Have you done any retraining	N 216	Perimeter Behavioral of the Ozarks currently, and historically, retrains any staff directly involved in Serious Incident Occurrences. This includes recognizing distress in patients, therapeutic conflict resolution with patients, ESI (Emergency Safety Intervention). All training, including but not limited to, orientation, bi-annual training, annual training and as-needed training, is maintained with the Human Resources Department and contained in each Employees' Training file. As of July 8, 2021 Perimeter Behavioral of the Ozarks will commit to utilizing our internal messaging system to reiterate and retrain restraint, seclusion and de-escalation policy, guidelines and expectations to all staff after any irregular restraints and/or seclusions, mindful of all confidentiality and HIPPA guidelines within the 24–48-hour timeframe as verbaly indicated by the Auditor. All training materials will be maintained in the Human Resources Department and contained in the employees' training file(s). As of July 22, 2021 Administration Leadership will be meeting every Business Day to review any incident(s) within the previous 24 hours.	7/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L120	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2466 S 48TH STREET SPRINGDALE, AR 72762

(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 216	Continued From page 4 or monitoring with your staff, concerning the incident?" He stated, "We have scheduled training and re-certifications. We only retrain the parties involved..." c. On 7/8/21 at 11:30 a.m., YCC was asked, "Can 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." He was asked, "Did you receive any retraining?" He stated, "No."	N 216		

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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,

Sandra Broughton
Administrative Services Manager

DPSQA/Office of Long Term Care
Survey and Certification Section

sgb

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L120	A. BUILDING _____ B. WING _____	R-C 08/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	**2466 S 48TH STREET SPRINGDALE, AR 72762**

(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 revisit was conducted on August 16, 2021 for all deficiencies cited on July 8, 2021. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{N 000}		

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
04L120	WOODRIDGE OF THE OZARKS

Type of Survey (select all that apply)

A				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
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. (6), (b) (7	07/07/2021	07/08/2021	0.50	0.00	11.00	0.00	6.50	0.50
2.	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 Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.50

Total RO Clerical/Data Entry Hours..... 0.00

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
04L120	WOODRIDGE OF THE OZARKS

Type of Survey (select all that apply)

A	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
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.)(6), (b) (7	08/16/2021	08/16/2021	0.50	0.00	3.50	0.00	4.00	0.50
2.	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

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.25

Total RO Clerical/Data Entry Hours..... 0.00

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