July 16, 2021

Woodridge Northeast, LLC
[redacted]
[redacted]
600 North 7th Street
West Memphis, Arkansas 72301

The Division of Provider Services and Quality Assurance of the Arkansas Department of Human Services has contracted with Arkansas Foundation for Medical Care (AFMC) to perform Inspections of Care (IOC) for Inpatient Psychiatric for Under 21. The Medicaid Manual for Inpatient Psychiatric Services for Under Age 21 was used in the completion of this report.

Deficiencies were noted during the Inpatient Psychiatric Inspection of Care (IOC) conducted at the following service site on the specified dates:

Woodridge Northeast, LLC
Provider ID: 166757125
Onsite Inspection Date: July 1, 2021

A summary of the inspection and deficiencies noted are outlined below. The provider must submit a Corrective Action Plan (CAP) designed to correct any deficiency notes in the written report of the IOC. Accordingly, you must complete and submit to AFMC a Corrective Action Plan for each deficiency noted. The Corrective Action Plan must state with the specificity the:

(a) Corrective action to be taken,
(b) Person(s) responsible for implementing and maintaining the corrective action; and
(c) Completion date or anticipated completion date for each corrective action.

The CAP must be completed within 30 calendar days of the date of the email notice of the IOC report. Please complete the attached Corrective Action Plan document and submit it via email to Inspectionteam@afmc.org.

The contractor (AFMC) will:

(a) Review the Corrective Action Plan,
(b) Determine whether the Corrective Action Plan is sufficient to credibly assure future compliance; and
(c) Provide the Corrective Action Plan to the Division of Provider Services and Quality Assurance (DPSQA).

Please see §160 of the Medicaid Manual for an explanation of your rights to administrative reconsideration and appeal. Additionally, the imposition of the Corrective Action Plan does not prevent the Department of Human Services from prescribing additional remedial actions as may be necessary.

Inspection of Care Summary

Facility Tour:

Upon arrival to facility, AFMC staff was promptly greeted at the locked entrance by a Woodridge Northeast Behavioral Health staff member and a COVID-19 screening was conducted and temperatures noted. AFMC was immediately taken to a conference room where they were met by the Chief Executive Officer and the Director of Quality. AFMC staff was given the completed and signed consent form listing approval for access to the AFMC portal.

A tour of the facility was completed with the Plant Operations Director and the Infection Control Nurse. All facility staff were observed wearing face mask. The facility environment was extremely clean, well-organized, and appeared to be in good repair. Therapeutic groups and educational classes were in session. There were no immediate issues noted during the facility tour. Staff were able to answer questions regarding the facility.

Facility Review-Policies and Procedures:

Upon review of the site's policies and procedures, the following deficiencies were noted:

Regulation	Deficiency Statement	Reviewer Notes
Medicaid IP Sec. 2; CFR 42 482.130, 483.376	There is no documentation in the HR records that all direct care personnel are trained in facility's Restraint and Seclusion policy.	Seven staff members had no file submitted for review or had expired Restraint and Seclusion training.
Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376	HR records did not indicate training in the use of nonphysical intervention skills, such as de-escalation on an annual basis.	Seven staff members had no file submitted for review or had expired nonphysical intervention skills training such as CPI training.
Medicaid IP Sec. 2; CFR 42 482.130, 483.376	HR records did not indicate that all direct care personnel are currently certified in cardiopulmonary resuscitation (CPR).	Thirteen staff members had no file submitted for review or had expired CPR training.

Personnel Records- Licenses, Certifications, Training:

Twenty-five percent of personnel records were requested. Of those requested, there were 4 professional staff and 12 paraprofessional staff. During the review of the personnel records, the following deficiencies were noted:

Personnel Record Number	Rule	Credential Validated	Outcome	Reviewer Notes
SR00[redacted] SR00[redacted] SR00[redacted] SR00[redacted]	241.100B	Adult Maltreatment Check	No File Received	SR00[redacted], SR00[redacted], SR00[redacted], and SR00[redacted] had no files submitted for review.
SR00[redacted] SR00[redacted]	241.100B	Child Maltreatment Check	No File Received	SR00[redacted] and SR00[redacted] had no files submitted for review.

SR00 SR00 SR00 SR00 SR00 SR00 SR00 SR00 SR00 SR00 SR00 SR00 SR00	221.804C	CPR training	No File Received/ Expired	SR00, SR00, SR00, SR00, SR00, SR00. SR00, SR00, SR00, and SR00 had no file submitted for review. SR00, SR00, and SR00 were expired.
SR00 SR00 SR00 SR00 SR00 SR00 SR00	221.804	Restraint and Seclusion Training (CPI)	No File Received/ Expired	SR00, SR00, and SR00 had no file submitted for review. SR00, SR00, SR00, and SR00 were expired.
SR00	241.100B	Federal Background Check	No File Received	SR00 had no file submitted for review.
SR00 SR00 SR00 SR00	241.100B	State Criminal Background Check	No File Received/ Other	SR00 had no file submitted for review. SR00, SR00 and SR00 did not indicate the information received for the background check was from the state police database.

General Observations:

According to the Corporate Office HR Director who was onsite during the survey, there has been a recent internal audit of the HR records at the Woodridge Facility. They have discovered multiple issues with incomplete HR records resulting in termination of the HR Manager. They have developed an internal action plan for correction and are working to update all HR files. Deficiencies are noted below:

- One staff member was observed to have driver's license or state I.D. that had no file submitted for review.
- Four staff members had no file submitted for review for adult maltreatment check.
- Two staff members had no file submitted for review for child maltreatment check.
- Thirteen staff members had no file submitted for review or had expired CPR training.
- Seven staff members had no file submitted for review or had expired Restraint and Seclusion training and nonphysical intervention skills such as CPI training.
- One staff member had no file submitted for review for a federal background check.
- Four staff members had a state background check that was not submitted for review or did not identify that the information is from the state police database.

Quality of Care Summary

As a part of the Quality of Care survey of the IOC, an active Medicaid client list was requested, client and/or guardian interviews were conducted, and a clinical record review was completed. The following is a summary of findings and noted deficiencies.

Client/Guardian Interviews:

There were no active Medicaid clients currently admitted at the time of IOC. Therefore, there were no client interviews were conducted.

Program Activity/Service Milieu Observation:

See facility tour details for observations during the onsite visit.

Medication Pass:

No Medicaid clients received medications during medication pass. Due to the observation of non-Medicaid clients not being complaint with the HIPAA minimal necessary rule, no medication pass was observed. AFMC RN visited with the Woodridge Behavioral Health nurse who was able to show AFMC RN the facility policies and procedures regarding medication administration, narcotic count/reconciliation/handling, and medication discrepancies. Tour of medication room completed with a Woodridge Behavioral Health nurse and no discrepancies with medication storage, cleanliness of medication room, and knowledge of medication dispensing found.

Clinical Record Review Deficiencies:

There were no active Medicaid clients currently admitted at the time of IOC. Therefore, there were no clinical records reviews conducted.

Corrective Action Plan:

The CAP must be completed within 30 calendar days of the date of the email notice of the IOC reports. Please complete the attached Corrective Action Plan document and submit it via email to Inspectionteam@afmc.org.

**For more details on the individual related deficiencies, please log into the portal.*

Respectfully,

AFMC Inspection Team
InspectionTeam@afmc.org

1020 W. 4TH ST., SUITE 300
LITTLE ROCK, AR 72201 • afmc.org

Notice of Action Required

_____Corrective Action Plan **_____Reconsideration Request**

Woodridge Northeast, LLC
600 North 7th Street
West Memphis, Arkansas 72301

Deficiencies were noted during the Inspection of Care visit conducted at the following service site on the following dates:

Woodridge Northeast, LLC
Provider ID: 166757125
Onsite Inspection Date: July 1, 2021

Correction Action Plan

Note: Please use this format (copy and paste as needed) to complete a corrective action for each deficiency noted on the Inspection of Care Report.

Deficiency: ____

Corrective Action: ____

Identify Person Responsible: ____

Completion Date: __________

Deficiency: ____

Corrective Action: ____

Identify Person Responsible: ____

Completion Date: __________

Upon completion of this CAP, please email:

InspectionTeam@afmc.org

Or fax: 501-375-0705
Attention: Inspection of Care Team

Reconsideration Request Notice

NOTE: If you have additional documentation to refute a deficiency identified in your Inspection of Care or Desk Review Report, please request a reconsideration. You have thirty (30) calendar days from the date of this notice to request reconsideration, in writing, or email to InspectionTeam@afmc.org. Please include all additional information that you believe supports the refuted deficiency.

I have attached a copy of the Inspection of Care report pertaining to ______________________________.
(Site for Inspection of Care)

The date of the Inspection of Care report was ___________________.

Using the table below list elements and chart numbers requested for each reconsideration item.

Regulation #	Record Review Number (RR#) for QOC or Staff Record (SR#) for H/S	Deficiency Comment (Specifically copied from report)	Reason for Reconsideration Request *Please attach supporting evidence.

____
Provider Name

____
Provider's Medicaid ID Number

____
Provider Site

____
Provider Site Address

____
Provider Representative

____
Telephone Number

For Provider reconsiderations please send your request to:

AFMC – InspectionTeam@AFMC.org

1020 West 4th, Suite 300
Little Rock, AR 72201

Rights and Responsibilities

Notice of Action

NOTE: If you have additional documentation to refute a deficiency identified in your Inspection of Care or Desk Review Report, please request a reconsideration. You have thirty (30) calendar days from the date of this notice to request reconsideration, in writing, or email to InspectionTeam@afmc.org. Please include all additional information that you believe supports the refuted deficiency. The timeframe for the requirement for a Corrective Action Plan is suspended until the determination of the reconsideration.

Beneficiary and Provider Right to Appeal This Decision

Pursuant to ACT 1758 of 2005, both the beneficiary and the provider have the right to appeal this decision. If either party is not satisfied with the decision on your case, the beneficiary may request a fair hearing from the Office of Appeals and Hearings or the provider may request a fair hearing from the Arkansas Department of Health. If both the provider and beneficiary are requesting a hearing, these will also go to the Arkansas Department of Health. Please enclose a copy of this Notice of Action with your appeal. Failure to provide a copy of this Notice of Action will result in your appeal being delayed.

How and When to Appeal

Beneficiary:
The Office of Appeals and Hearings must receive a written hearing request within thirty (30) calendar days of the date on this letter. Send your request to Office of Appeals and Hearings, PO Box 1437, Slot N401, Little Rock, AR 72203-1437.

Provider or Provider/Beneficiary:
The Arkansas Department of Health must receive a written hearing request within thirty (30) calendar days of the date on this letter. Send your request to Arkansas Department of Health, Attn: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.

Continuation of Services Pending Appeal (Beneficiary only)

If you are already receiving services and the Department's decision was to reduce or eliminate those services, you may postpone the reduction or elimination of services until the appeal is decided by sending your appeal request in time to be received by the Office of Appeals and Hearings or Arkansas Department of Health within ten (10) calendar days from the date of this letter. However, if you do that and you lose or abandon the appeal, you will be responsible for the cost of all services that are not approved in Section I (above). The Department will take action against you to recover those costs.

Your Right to Representation

If you request a Hearing, you have the right to appear in person and to be represented by a lawyer or other person you select. If you wish to have a lawyer, you may ask the local County Office to help you identify one. If free legal services are available where you live, you may ask your County Office for their address and phone number.

July 16, 2021

Woodridge Northeast, LLC
Attn: Barbara Radebaugh, CEO
bradebaugh@perimeterhealthcare.com
600 North 7th Street
West Memphis, Arkansas 72301

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Inspection of Care Summary

Facility Tour:

Upon arrival to facility, AFMC staff was promptly greeted at the locked entrance by a Woodridge Northeast Behavioral Health staff member and a COVID-19 screening was conducted and temperatures noted. AFMC was immediately taken to a conference room where they were met by the Chief Executive Officer and the Director of Quality. AFMC staff was given the completed and signed consent form listing approval for access to the AFMC portal.

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Upon review of the site's policies and procedures, the following deficiencies were noted:

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Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376	HR records did not indicate training in the use of nonphysical intervention skills, such as de-escalation on an annual basis.	Seven staff members had no file submitted for review or had expired nonphysical intervention skills training such as CPI training.
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Personnel Records- Licenses, Certifications, Training:

Twenty-five percent of personnel records were requested. Of those requested, there were 4 professional staff and 12 paraprofessional staff. During the review of the personnel records, the following deficiencies were noted:

Personnel Record Number	Rule	Credential Validated	Outcome	Reviewer Notes
SR007809 SR007812 SR007822 SR007829	241.100B	Adult Maltreatment Check	No File Received	SR007809, SR007812, SR007822, and SR007829 had no files submitted for review.
SR007809 SR007829	241.100B	Child Maltreatment Check	No File Received	SR007809 and SR007829 had no files submitted for review.

SR007809 SR007812 SR007821 SR007822 SR007823 SR007824 SR007825 SR007827 SR007828 SR007829 SR007831 SR007832 SR007833	221.804C	CPR training	No File Received/ Expired	SR007809, SR007812, SR007822, SR007823, SR007824, SR007825. SR007827, SR007828, SR007829, and SR007830 had no file submitted for review. SR007821, SR007832, and SR007833 were expired.
SR007809 SR007822 SR007826 SR007829 SR007830 SR007831 SR007832	221.804	Restraint and Seclusion Training (CPI)	No File Received/ Expired	SR007809, SR007829, and SR007831 had no file submitted for review. SR007822, SR007826, SR007830, and SR007832 were expired.
SR007829	241.100B	Federal Background Check	No File Received	SR007829 had no file submitted for review.
SR007809 SR007826 SR007827 SR007829	241.100B	State Criminal Background Check	No File Received/ Other	SR007829 had no file submitted for review. SR007826, SR007827, and SR007829 did not indicate the information received for the background check was from the state police database.

General Observations:

According to the Corporate Office HR Director who was onsite during the survey, there has been a recent internal audit of the HR records at the Woodridge Facility. They have discovered multiple issues with incomplete HR records resulting in termination of the HR Manager. They have developed an internal action plan for correction and are working to update all HR files. Deficiencies are noted below:

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Medication Pass:

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Corrective Action Plan:

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**For more details on the individual related deficiencies, please log into the portal.*

Respectfully,

AFMC Inspection Team
InspectionTeam@afmc.org

1020 W. 4TH ST., SUITE 300
LITTLE ROCK, AR 72201 • afmc.org

Notice of Action Required

____X_ Corrective Action Plan **_____Reconsideration Request**

Woodridge Northeast, LLC
600 North 7th Street
West Memphis, Arkansas 72301

Deficiencies were noted during the Inspection of Care visit conducted at the following service site on the following dates:

Woodridge Northeast, LLC
Provider ID: [redacted]
Onsite Inspection Date: July 1, 2021

Correction Action Plan

Note: Please use this format (copy and paste as needed) to complete a corrective action for each deficiency noted on the Inspection of Care Report.

Deficiency: IP Sec. 2;CFR 42 482.130, 483.376 There is no documentation in the HR records that all direct care personnel are trained in the facility's Restraint and Seclusion policy. Seven staff had no file submitted for review or had expired Restraint and Seclusion training.

Corrective Action:
100% of the files were updated by verifying the training sign in sheets and placing the completed Restraint and Seclusion tests in their employee file. Employees that had signed in but there was no test completed a self-study guide which included the Restraint & Seclusion Policy, presentation slides related to De-escalation and Restraints and the test. The test was then placed in their files.

All HR files are being audited and an Excel Spreadsheet has been developed. The HR manager will utilize this spreadsheet to maintain compliance. The spreadsheet has formulas imbedded in the cells to alert managers 30 days prior to Restraint & Seclusion Policy Refresher and SAMA (Physical Intervention) being due. The Regional HR Director will provide ongoing oversight of the spreadsheet and will review monthly through Quality Council with

Identify Person Responsible: Regional HR Director

Completion Date: For the files that were requested during the on site survey, 100% of those personnel records have been audited. By 9/1/2021, 100% of those files will have a completed Restraint and Seclusion Policy on file. All remaining employee files will be audited by 9/1/2021 and for any deficiencies found, compliance be obtained by 9/15/2021

<u>Deficiency</u>: IP Sec. 2;CFR 42 482.130, 483.376 There is no documentation in the HR records that all direct care personnel are trained in the facility's Restraint and Seclusion policy. Seven staff had no file submitted for review or had expired Restraint and Seclusion training and ***nonphysical Intervention shills such as CPI training***

Corrective Action: 100% of the files were updated by verifying the training sign in sheets and placing the completed Restraint and Seclusion tests in their employee file. Employees that had signed in but there was no test completed a self-study guide which included the Restraint & Seclusion Policy, presentation slides related to De-escalation and Restraints and the test. The test was then placed in their files**.**

All HR files are being audited and an Excel Spreadsheet has been developed. The HR manager will utilize this spreadsheet to maintain compliance. The spreadsheet has formulas imbedded in the cells to alert managers 30 days prior to Restraint & Seclusion Policy Refresher and SAMA (Physical Intervention) being due. The Regional HR Director will provide ongoing oversight of the spreadsheet and will review monthly through Quality Council

Identify Person Responsible: Regional HR Director

Completion Date: For the files that were requested during the on site survey, 100% of those personnel records have been audited. By 9/1/2021, 100% of those files will have a completed Restraint and Seclusion Policy on file. All remaining employee files will be audited by 9/1/2021 and for any deficiencies found, compliance be obtained by 9/15/2021

<u>Deficiency</u>: Medicaid IP Sec. 2, CFR 42 482.130 486.376 Fourteen HR records did not indicate that all direct care personnel were currently certified in cardiopulmonary resuscitation (CPR). Thirteen staff members had no file submitted for review or had expired CPR training.

Corrective Action: 100% of the files pulled during the on site visit have been audited. All but one staff member has a verified sign in sheet where they attended CPR class. CPR cards are being requested for the staff that do not have a card on file. For the singular staff that we were not able to verify had attended a class, they will be taken off the schedule until a class is completed (which is scheduled for the week of 8/16/2021.

All HR files are being audited and an Excel Spreadsheet has been developed. The HR manager will utilize this spreadsheet to maintain compliance. The spreadsheet has formulas imbedded in the cells to alert managers 30 days prior to CPR being due so they can enter a class. Regional HR Director will provide ongoing oversight of compliance and report to the CEO monthly via Quality Council.

Person Responsible: Regional HR Director

Completion Date: For the files that were requested during the on site survey, 100% of those personnel records have been audited. For those staff identified by the survey to be out of compliance with CPR, class will be completed by 8/20/21. For the remaining HR files, a complete audit will be done by 9/1/2021 and anyone out of compliance with CPR will take a class within 30 days or be removed from the schedule

<u>Deficiency</u>: Rule 241.100B Adult Maltreatment Check. No file received/registry outcome missing.

<u>Corrective Action</u>: For the files that were reviewed during the on-site survey, 100% of those files with a missing registry were sent in by August 12, 2021 and are pending reports.

The HR Manager developed an excel file to be used in the monitoring process. Forms will be completed during the first week of orientation and the HR Manager will audit 100% of new hires at the end of the new employee first week to make sure forms were completed and sent to appropriate agency to obtain results.

100% of all current employee files are being audited and placed on the excel spreadsheet. This excel spreadsheet will have formulas embedded to alert within 30 days of expiration. Completion date for this is 9/1/2021. During the full facility record audit, if a personnel does not have Adult Maltreatment on file, it will be submitted within 72 hours.

The Regional HR Director will monitor the audit spreadsheet on an ongoing basis and a monthly summary will be provided to CEO via Quality Council

Identify Person Responsible: Regional HR Director

Completion Date: For the files that were requested during the on site survey, 100% of those personnel records have been audited. For those staff identified by the survey to be out of compliance Adult Maltreatment Checks have been submitted as of 9/12/21 and are pending results. For the remaining HR files, a full audit will be completed by 9/1/2021 and if Adult Maltreatment is missing or expired, it will be submitted within 72 hours.

<u>Deficiency</u>: Rule 241.100B Child Maltreatment Check. Files reviewed had no file received/registry outcome mission/Expired:

Corrective Action: All files with a missing registry were sent in by August 12, 2021 and are pending reports.

The HR Manager developed an excel file to be used in the monitoring process. Forms will be completed during the first week of orientation and the HR Manager will audit 100% of new hires at the end of the new employee first week to make sure forms were completed and sent to appropriate agency to obtain results.

100% of all current employee files are being audited and placed on the excel spreadsheet. This excel spreadsheet will have formulas embedded to alert within 30 days of expiration. Completion date for this is 9/1/2021. During the full facility record audit, if a personnel does not have Child Maltreatment on file, it will be submitted within 72 hours.

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Identify Person Responsible: Regional HR Director

Completion Date: For the files that were requested during the on site survey, 100% of those personnel records have been audited. For those staff identified by the survey to be out of compliance Child Maltreatment Checks have been submitted as of 9/12/21 and are pending results. For the remaining HR

files, a full audit will be completed by 9/1/2021 and if Child Maltreatment is missing or expired, it will be submitted within 72 hours.

Deficiency: Rule 221.804C – CPR Training. No file received/Expired

Corrective Action: 100% of the files pulled during the on site visit have been audited. All but one staff member has a verified sign in sheet where they attended CPR class. CPR cards are being requested for the staff that do not have a card on file. For the singular staff that we were not able to verify had attended a class, they will be taken off the schedule until a class is completed (which is scheduled for the week of 8/16/2021).

All HR files are being audited and an Excel Spreadsheet has been developed. The HR manager will utilize this spreadsheet to maintain compliance. The spreadsheet has formulas imbedded in the cells to alert managers 30 days prior to CPR being due so they can enter a class. Regional HR Director will provide ongoing oversight of compliance and report to the CEO monthly via Quality Council.

Person Responsible: Regional HR Director

Completion Date: For the files that were requested during the on site survey, 100% of those personnel records have been audited. For those staff identified by the survey to be out of compliance with CPR, class will be completed by 8/20/21. For the remaining HR files, a complete audit will be done by 9/1/2021 and anyone out of compliance with CPR will take a class within 30 days or be removed from the schedule.

Deficiency: Rule 221.804 – Restraint and Seclusion Training (CPI) No file Received/ Expired

Corrective Action: 100% of the files were updated by verifying the training sign in sheets and placing the completed Restraint and Seclusion tests in their employee file. Employees that had signed in but were unable to locate a completed test were given a self-study guide which included the Restraint & Seclusion Policy, presentation slides related to De-escalation and Restraints, as well as the test. The test was then placed in their files.

All HR files are being audited and an Excel Spreadsheet has been developed. The HR manager will utilize this spreadsheet to maintain compliance. The spreadsheet has formulas imbedded in the cells to alert managers 30 days prior to Restraint & Seclusion Policy Refresher and SAMA (Physical Intervention) being due. The Regional HR Director will provide ongoing oversight of the spreadsheet and will review monthly through Quality Council

Identify Person Responsible: Regional HR Director

Completion Date: For the files that were requested during the on site survey, 100% of those personnel records have been audited. By 9/1/2021, 100% of those files will have a completed Restraint and Seclusion Test on file. All remaining employee files will be audited by 9/1/2021 and for any deficiencies found, compliance be obtained by 9/15/2021

Deficiency: Rule 241.100 B Federal Background Check. No File Received

Corrective Action: All files that were pulled during the on-site survey with a missing Federal Background Check were sent in by August 12, 2021 and are pending results. For the remaining files, they will be audited by 9/1/2021 and any files missing Federal Background Check will be submitted within 72 hours.

The HR Manager developed an excel file to be used in the monitoring process. Forms will be completed during the first week of orientation and the HR Manager will audit 100% of new hires at the end of the new employee first week to make sure forms were completed and sent to appropriate agency to obtain results.

The Regional HR Director will monitor the audit spreadsheet on an ongoing basis and a monthly summary will be provided to CEO via Quality Council

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Completion Date: For the files that were requested during the on site survey, 100% of those personnel records have been audited. For those staff identified by the survey to be out of compliance. Federal Background Checks have been submitted as of 9/12/21 and are pending results. For the remaining HR files, a full audit will be completed by 9/1/2021 and if Federal Background is missing or expired, it will be submitted within 72 hours.

Deficiency: Rule 241.100B State Criminal Background Check – No File received/Expired/Other

Corrective Action: All files that were pulled during the on-site survey with a missing registry were sent in by August 12, 2021 and are pending results. For the remaining files, they will be audited by 9/1/2021 and any files missing State Criminal Background Check will be submitted within 72 hours.

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The Regional HR Director will monitor the audit spreadsheet on an ongoing basis and a monthly summary will be provided to CEO via Quality Council

Identify Person Responsible: Regional HR Director

Completion Date: For the files that were requested during the on site survey, 100% of those personnel records have been audited. For those staff identified by the survey to be out of compliance State Criminal Background Checks have been submitted as of 9/12/21 and are pending results. For the remaining HR files, a full audit will be completed by 9/1/2021 and if State Criminal Background is missing or expired, it will be submitted within 72 hours.

Upon completion of this CAP, please email:

InspectionTeam@afmc.org

Or fax: 501-375-0705
Attention: Inspection of Care Team

Reconsideration Request Notice

NOTE: If you have additional documentation to refute a deficiency identified in your Inspection of Care or Desk Review Report, please request a reconsideration. You have thirty (30) calendar days from the date of this notice to request reconsideration, in writing, or email to InspectionTeam@afmc.org. Please include all additional information that you believe supports the refuted deficiency.

I have attached a copy of the Inspection of Care report pertaining to ______________________________.
(Site for Inspection of Care)

The date of the Inspection of Care report was ____________________.

Using the table below list elements and chart numbers requested for each reconsideration item.

Regulation #	Record Review Number (RR#) for QOC or Staff Record (SR#) for H/S	Deficiency Comment (Specifically copied from report)	Reason for Reconsideration Request *Please attach supporting evidence.

____
Provider Name

____
Provider's Medicaid ID Number

____
Provider Site

____
Provider Site Address

____
Provider Representative

____
Telephone Number

For Provider reconsiderations please send your request to:

AFMC –
InspectionTeam@AFMC.org

1020 West 4th, Suite 300
Little Rock, AR 72201

Rights and Responsibilities
Notice of Action

NOTE: If you have additional documentation to refute a deficiency identified in your Inspection of Care or Desk Review Report, please request a reconsideration. You have thirty (30) calendar days from the date of this notice to request reconsideration, in writing, or email to InspectionTeam@afmc.org. Please include all additional information that you believe supports the refuted deficiency. The timeframe for the requirement for a Corrective Action Plan is suspended until the determination of the reconsideration.

Beneficiary and Provider Right to Appeal This Decision

Pursuant to ACT 1758 of 2005, both the beneficiary and the provider have the right to appeal this decision. If either party is not satisfied with the decision on your case, the beneficiary may request a fair hearing from the Office of Appeals and Hearings or the provider may request a fair hearing from the Arkansas Department of Health. If both the provider and beneficiary are requesting a hearing, these will also go to the Arkansas Department of Health. Please enclose a copy of this Notice of Action with your appeal. Failure to provide a copy of this Notice of Action will result in your appeal being delayed.

How and When to Appeal

Beneficiary:
The Office of Appeals and Hearings must receive a written hearing request within thirty (30) calendar days of the date on this letter. Send your request to Office of Appeals and Hearings, PO Box 1437, Slot N401, Little Rock, AR 72203-1437.

Provider or Provider/Beneficiary:
The Arkansas Department of Health must receive a written hearing request within thirty (30) calendar days of the date on this letter. Send your request to Arkansas Department of Health, Attn: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.

Continuation of Services Pending Appeal (Beneficiary only)

If you are already receiving services and the Department's decision was to reduce or eliminate those services, you may postpone the reduction or elimination of services until the appeal is decided by sending your appeal request in time to be received by the Office of Appeals and Hearings or Arkansas Department of Health within ten (10) calendar days from the date of this letter. However, if you do that and you lose or abandon the appeal, you will be responsible for the cost of all services that are not approved in Section I (above). The Department will take action against you to recover those costs.

Your Right to Representation

If you request a Hearing, you have the right to appear in person and to be represented by a lawyer or other person you select. If you wish to have a lawyer, you may ask the local County Office to help you identify one. If free legal services are available where you live, you may ask your County Office for their address and phone number.

August 16, 2021

Woodridge Northeast, LLC
600 North 7th Street
West Memphis, Arkansas 72301

Thank you for your timely response to the request to submit a Corrective Action Plan (CAP) for the deficiencies noted during the Inspection of Care (IOC) conducted at the following service site on the following date:

Woodridge Northeast, LLC
Provider ID: [redacted]
Onsite Inspection Date: July 1, 2021

The Division of Provider Services and Quality Assurance of the Arkansas Department of Human Services has contracted with Arkansas Foundation for Medical Care (AFMC) to perform Inspections of Care (IOC), which will include a review of all CAPs. AFMC has completed the review and has determined the CAP is sufficient to credibly assure future compliance.

A copy of the CAP will be forwarded to the Division of Provider Services and Quality Assurance (DPSQA).

Respectfully,

Inspections of Care Team
InspectionTeam@afmc.org

1020 W. 4TH ST., SUITE 300
LITTLE ROCK, AR 72201 • afmc.org