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

April 13, 2022

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

Dear Mr. Thompson:

On April 7, 2022 a Recertification survey was conducted at your facility by the Office of Long Term Care to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid (Title XIX) Program. This survey found that your facility had deficiencies requiring correction/substantial correction prior to a revisit as specified in the attached CMS-2567.

Plan of Correction

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

Sandra Broughton, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
(501) **320-6182**
email to Sandra.Broughton@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 or the requirement for timely submission of an acceptable plan of correction. 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 contact your Reviewer.

Sincerely,

DPSQA/Office of Long Term Care
Survey & Certification Section

sgb

cc: DRA

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 ____	04/07/2022

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
E 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. The findings on this statement of deficiencies demonstrate compliance with §483.73 - Emergency Preparedness Requirements for Psychiatric Residential Treatment Facilities.	E 000		
N 000	Initial Comments A validation survey was conducted 4/4/22 to 4/7/22. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000		
N 131	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(4) Restraint and seclusion must not be used simultaneously. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility	N 131		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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N 131	Continued From page 1	N 131		

failed to ensure chemical restraint and seclusion were not used simultaneously for 1 of 1 (Resident #2) sampled resident who was restrained and placed in seclusion. The findings are:

Resident #2 had a diagnosis of Post Traumatic Stress Disorder

a. A Nursing Shift Note dated 2/26/22 documented, "...1928 [7:28 p.m.] R [Resident] placed in seclusion. MD [Medical Doctor] orders received at 1830 [6:30 p.m.]. At 1833 [6:33 p.m.] [Physician] ordered R to be given 10 mg [milligrams] of Geodon by IM [intramuscularly] and 50 mg of Benadryl IM for psychotic agitation. At 1843 [6:43 p.m.] IM given . . . R had to be restrained for the IM. At 1855 [6:55 p.m.] R released from seclusion..."

b. An Emergency Safety Intervention Justification Packet dated 2/26/22 documented, "Date & [and] time actually placed into restraint Date 2-26-22 Time 1840 [6:40 p.m.] Date and time actually placed in seclusion Date 2-26-22 Time 1828 [6:28 p.m.]. . . Date and time emergency medication administered Date 2/26/22 Time 1843 [6:43 p.m.]. . . Date and time removed from restraint Date 2-26-22 Time 1844 [6:44 [p.m.] and Time removed from seclusion Date 2-26-22 Time 1855 [6:55 p.m.]..."

c. On 4/7/22 at 11:42 a.m., the Director of Nursing (DON) was asked, "Were you aware they couldn't give a chemical restraint in seclusion?" The DON stated, "I didn't know they should not be placed in seclusion after a chemical."

N 140	ORDERS FOR USE OF RESTRAINT OR SECLUSION	N 140		

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N 140	Continued From page 2	N 140		

CFR(s): 483.358(a)

Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician.

This STANDARD is not met as evidenced by:
Based on record review and interview the facility failed to provide a physician's order for a restraint, seclusion and chemical restraint that were used for 1 of 1 (Resident #2) who was restrained and placed in seclusion. The findings are:

Resident #2 had a diagnosis of Post Traumatic Stress Disorder

a. A Nursing Shift Note dated 2/26/22 documented, "...1928 [7:28 p.m.] R [Resident] placed in seclusion. MD [Medical Doctor] orders received at 1830 [6:30 p.m.]. At 1833 [6:33 p.m.] [Physician] ordered R to be given 10 mg [milligrams] of Geodon by IM [intramuscularly] and 50 mg of Benadryl IM for psychotic agitation. At 1843 [6:43 p.m.] IM given . . . R had to be restrained for the IM. At 1855 [6:55 p.m.] R released from seclusion..."

b. An Emergency Safety Intervention Justification Packet dated 2/26/22 documented, "Date & [and] time actually placed into restraint Date 2-26-22 Time 1840 [6:40 p.m.] Date and time actually placed in seclusion Date 2-26-22 Time 1828 [6:28 p.m.]. . . Date and time emergency medication administered Date 2/26/22 Time 1843 [6:43 p.m.].

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N 140	Continued From page 3 . . Date and time removed from restraint Date 2-26-22 Time 1844 [6:44 [p.m.] and Time removed from seclusion Date 2-26-22 Time 1855 [6:55 p.m.]..." c. On 4/7/22 at 11:42 a.m., the Director of Nursing (DON was asked for the order for a restraint, seclusion, and chemical restraint that was used on 2/26/22. The DON stated, "We were unable to find the physician's order for 2/26/22. We looked every where and was unable to find it." d. The policy titled Emergency Safety Intervention policy provided by the Director of Nursing on 4/7/22 at 11:27 a.m. documented, "A written order from the physician is required for the use of a physical restraint, chemical restraint, or seclusion. . . The physician's verbal order must be followed with the physician's signature verifying the verbal order.	N 140		
N 143	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the	N 143		

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N 143	Continued From page 4	N 143		

period of the emergency safety intervention.

This ELEMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure a physicians order for a physical restraint was signed by the physician for 1 of 1 (Resident #3) who was physically restrained. The findings are:

Resident #3 had diagnoses of Other Reactions to Severe Stress and Disruptive Mood Dysregulation.

a. A Physician's Order dated 10/7/21 documented, "Order for physical restraint for up to one hour due to assaulting staff [with] intent to injure. . . Order received 1710 [5:10 p.m.]Telephone." The order did not have a Physician's signature on it.

b. On 4/7/22 the Director of Nursing was asked about the unsigned order. The Director of Nursing stated, "That is a problem. It should be signed."

c. The policy titled Emergency Safety Intervention policy provided by the Director of Nursing on 4/7/22 at 11:27 a.m. documented, "A written order from the physician is required for the use of a physical restraint, chemical restraint, or seclusion. . . The physician's verbal order must be followed with the physician's signature verifying the verbal order.

N 207 FACILITY REPORTING — N 207
CFR(s): 483.374(b)

Reporting of serious occurrences.
The facility must report each serious occurrence

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N 207	Continued From page 5	N 207		

to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system.
Serious occurrences that must be reported include;
- a resident's death;
- a serious injury to a resident as defined in section §483.352 of this part; and
- a resident's suicide attempt.

(1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include
- the name of the resident involved in the serious occurrence,
- a description of the occurrence and,
- the name, street address, and telephone number of the facility.

This ELEMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure serious occurrences were reported to the Office of Long Term Care (OLTC) and Disability Rights Arkansas (DRA) were notified after suicidal attempts taken by 2 of 2 (Resident #1 and #2) sampled residents. The findings are:

1. Resident #1 had diagnoses of Disruptive Mood Dysregulation Disorder and Other Conduct Disorders.

a. On 4/5/22 at 9:30 a.m. Resident #1 was asked why she was in the facility. She stated, "For trying to kill myself."

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N 207	Continued From page 6	N 207		

b. A Nursing Progress Note dated 4/2/22 at 6:30 p.m. documented, "Self harmed with a broken mirror on both forearms and tied a ligature tightly around her neck."

c. An Incident Notification Report dated 4/2/22 documented, "Self inflicted injury Suicide gesture." The Authorities Notified section of the form was blank. There was no documentation OLTC or DRA were notified.

d. A Nursing Progress Note dated 3/12/22 documented, "RS [Resident] had to be restrained again after trying to use a garment as a ligature."

e. An Incident Notification Report dated 3/12/22 documented, "Suicide gesture." The Authorities Notified section of the form was blank. There was no documentation OLTC or DRA were notified.

2. Resident #3 had diagnoses of Other Reactions to Severe Stress and Disruptive Mood Dysregulation.

a. A Nursing Shift Note dated 11/13/21 documented, "1906 [7:06 p.m.] R [Resident] used a pillow case to tie around her neck."

b. An Incident Notification Report dated 11/13/21 documented, "Suicide gesture." The Authorities Notified section of the form was blank. There was no documentation OLTC or DRA were notified.

c. A Nursing Shift Note dated 10/9/21 documented, "R went to the end of the hall and used a pillow case as a ligature to tie around her neck. R stated, "I want to die. I'm going to kill myself."

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N 207	Continued From page 7 d. An Incident Notification Report dated 10/9/21 documented, "Suicide gesture." The Authorities Notified section of the form was blank. There was no documentation OLTC or DRA were notified. e. A Nursing Shift Note dated 10/3/21 documented, "R's neck is red r/t [related to] tying numerous articles of clothing, including a hair tye around her neck." f. An Incident Notification Report dated 10/3/21 documented, "Self inflicted injury Suicide gesture." The Authorities Notified section of the form was blank. There was no documentation OLTC or DRA were notified. 3. On 4/7/22 at 11:45 a.m. the Director of Nursing was asked why the Office of Long Term Care or Disability Rights had not been notified of the incidents for Resident #1 and 2. He stated, "They were considered suicidal gestures, not attempts, because they were in front of staff."	N 207		

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& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059

April 25, 2022

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

Dear Mr. Thompson:

On April 7, 2022, we conducted a Validation 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 May 2, 2022.

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
Survey & Certification Section

sgb

Approved POC 04/25/2022 SGB

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

PRINTED: 04/13/2022
FORM APPROVED
OMB NO. 0938-0391

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E 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. The findings on this statement of deficiencies demonstrate compliance with §483.73 - Emergency Preparedness Requirements for Psychiatric Residential Treatment Facilities.	E 000	*Please see Perimeter of the Ozarks: Plan of Correction Addendum attached to the document for additional information regarding corrective actions and assurance monitoring processes.*	
N 000	Initial Comments A validation survey was conducted 4/4/22 to 4/7/22. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000		
N 131	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(4) Restraint and seclusion must not be used simultaneously. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility	N 131	Director of Nursing provided remedial training to nursing staff regarding restraints, including drugs/medications used as restraint, must not be utilized at the same time as utilizing seclusion. A meeting was held with present nursing staff on the evening of 4/7/22 addressing the deficient practice. An internal memo addressing the deficient practice was posted in the nurse's office on 4/8/22. Director of Nursing to provide in-service training on Emergency Safety Interventions in monthly nursing meeting on 4/28/22.	4/7/22 4/8/2022

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

TITLE: CEO

(X6) DATE: 4/25/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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N 131	Continued From page 1 failed to ensure chemical restraint and seclusion were not used simultaneously for 1 of 1 (Resident #2) sampled resident who was restrained and placed in seclusion. The findings are: Resident #2 had a diagnosis of Post Traumatic Stress Disorder a. A Nursing Shift Note dated 2/26/22 documented, "...1928 [7:28 p.m.] R [Resident] placed in seclusion. MD [Medical Doctor] orders received at 1830 [6:30 p.m.]. At 1833 [6:33 p.m.] [Physician] ordered R to be given 10 mg [milligrams] of Geodon by IM [intramuscularly] and 50 mg of Benadryl IM for psychotic agitation. At 1843 [6:43 p.m.] IM given . . . R had to be restrained for the IM. At 1855 [6:55 p.m.] R released from seclusion..." b. An Emergency Safety Intervention Justification Packet dated 2/26/22 documented, "Date & [and] time actually placed into restraint Date 2-26-22 Time 1840 [6:40 p.m.] Date and time actually placed in seclusion Date 2-26-22 Time 1828 [6:28 p.m.]. . . Date and time emergency medication administered Date 2/26/22 Time 1843 [6:43 p.m.]. . . Date and time removed from restraint Date 2-26-22 Time 1844 [6:44 [p.m.] and Time removed from seclusion Date 2-26-22 Time 1855 [6:55 p.m.]..." c. On 4/7/22 at 11:42 a.m., the Director of Nursing (DON) was asked, "Were you aware they couldn't give a chemical restraint in seclusion?" The DON stated, "I didn't know they should not be placed in seclusion after a chemical."	N 131	Director of Nursing shall continue agency rule mandated review process for each use of chemical restraint, physical restraint, and/or seclusion, and shall investigate findings of procedures and rule violations. Procedural changes and other corrective actions will be implemented according to identified deficiencies in a timely manner. Said findings will be reported to quality assurance committee during the next regular committee meeting. -Director of Nursing shall review Emergency Safety Intervention policy and make clarifications regarding the use of multiple restraints by 4/27/2022 -Director of Nursing shall provide in-service regarding Emergency Safety Interventions policies and procedures to nursing staff in monthly nursing meeting on 4/28/22. Said meeting agenda and attendance roster shall be retained by DON in training documentation binder. -The Quality Coordinator/Designee shall create and publish an operational rule requiring a review of all Emergency Safety Interventions on or prior to the close of the next business day hours of incident occurrence. Said review shall be included in the Emergency Safety Intervention on the justification packet. Quality Coordinator/Designee shall record the previous month's ratio of Emergency Safety Interventions found in compliance in addition to the total number of Emergency Safety Interventions from the previous month. A specific analysis shall be conducted regarding any occurrence of simultaneous utilization of restraint and seclusion as required by agency KPI and shall be reported monthly. *N131Target completion 5/2/22*	
N 140	ORDERS FOR USE OF RESTRAINT OR SECLUSION	N 140		

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N 140	Continued From page 2 CFR(s): 483.358(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to provide a physician's order for a restraint, seclusion and chemical restraint that were used for 1 of 1 (Resident #2) who was restrained and placed in seclusion. The findings are: Resident #2 had a diagnosis of Post Traumatic Stress Disorder a. A Nursing Shift Note dated 2/26/22 documented, "...1928 [7:28 p.m.] R [Resident] placed in seclusion. MD [Medical Doctor] orders received at 1830 [6:30 p.m.]. At 1833 [6:33 p.m.] [Physician] ordered R to be given 10 mg [milligrams] of Geodon by IM [intramuscularly] and 50 mg of Benadryl IM for psychotic agitation. At 1843 [6:43 p.m.] IM given . . . R had to be restrained for the IM. At 1855 [6:55 p.m.] R released from seclusion..." b. An Emergency Safety Intervention Justification Packet dated 2/26/22 documented, "Date & [and] time actually placed into restraint Date 2-26-22 Time 1840 [6:40 p.m.] Date and time actually placed in seclusion Date 2-26-22 Time 1828 [6:28 p.m.]. . . Date and time emergency medication administered Date 2/26/22 Time 1843 [6:43 p.m.].	N 140	-Physician was notified by Director of Nursing regarding missing physician's order and a clarification order for the Emergency Safety Intervention was provided by Physician and then reviewed and placed in resident's record by Director of Nursing on 4/18/22. -Director of Nursing will continue review process for each use of chemical restraint, physical restraint, and/or seclusion to assess for documentation completeness. Director of Nursing will resolve any incomplete documentation. -Director of Nursing shall continue review process for each use of chemical restraint, physical restraint, and/or seclusion for all residents to assess for documentation completeness. Said review shall be completed by the close of the next business day following the event. The Director of Nursing shall resolve any incomplete documentation. -Director of Nursing shall provide in-service regarding Emergency Safety Interventions policies and procedures to nursing staff. -Quality Coordinator/Designee shall continue review process for each Emergency Safety Intervention and document when the physician's orders are signed and completed on the incident report documentation for each Emergency Safety Intervention once completed. Quality Coordinator/Designee will resolve any incomplete documentation. -As a member of the QAC, Director of Nursing shall review the use of physical restraint, chemical restraint, and/or seclusion each month, to monitor performance for compliance in providing a physician's orders for each Emergency Safety Intervention and address deficiencies if observed with a goal of 100% compliance monthly for four months.	

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 ______	04/07/2022

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

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N 140	Continued From page 3 . . Date and time removed from restraint Date 2-26-22 Time 1844 [6:44 [p.m.] and Time removed from seclusion Date 2-26-22 Time 1855 [6:55 p.m.]..." c. On 4/7/22 at 11:42 a.m., the Director of Nursing (DON was asked for the order for a restraint, seclusion, and chemical restraint that was used on 2/26/22. The DON stated, "We were unable to find the physician's order for 2/26/22. We looked every where and was unable to find it." d. The policy titled Emergency Safety Intervention policy provided by the Director of Nursing on 4/7/22 at 11:27 a.m. documented, "A written order from the physician is required for the use of a physical restraint, chemical restraint, or seclusion. . . The physician's verbal order must be followed with the physician's signature verifying the verbal order.	N 140	Director of Nursing shall be responsible for assuring improvement does occur, and to implement other corrective actions if needed or prolong monitoring to ensure solution is sustained. Quality Coordinator/Designee shall review all Emergency Safety Interventions no later than close of business the next business day following the incident occurrence and document each Emergency Safety Intervention on the Emergency Safety Intervention Review Log form within the same time frame. Quality Coordinator/Designee shall record the previous month's ratio of Emergency Safety Interventions in compliance compared to the total number of Emergency Safety Interventions in the previous month regarding ensuring a physician's order was provided for each Emergency Safety Intervention on the KPI monthly. *N140 Target completion 5/2/22*	
N 143	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(d) If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the	N 143	-Physician was notified by Director of Nursing regarding unsigned physician's order and a clarification order for the Emergency Safety Intervention was provided by Physician and then reviewed and placed in resident's record by Director of Nursing on 4/18/22. -As a member of the QAC, Director of Nursing shall review the use of physical restraint, chemical restraint, and/or seclusion monthly, to monitor performance compliance in providing a physician's orders for each Emergency Safety Intervention and address deficiencies if observed. Director of Nursing shall be responsible for assuring improvement occurs and implements other corrective actions if needed or extend enhanced monitoring to ensure solution is sustained.	

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	04L120	A. BUILDING ______ B. WING ______	04/07/2022

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N 143	Continued From page 4 period of the emergency safety intervention. This ELEMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a physicians order for a physical restraint was signed by the physician for 1 of 1 (Resident #3) who was physically restrained. The findings are: Resident #3 had diagnoses of Other Reactions to Severe Stress and Disruptive Mood Dysregulation. a. A Physician's Order dated 10/7/21 documented, "Order for physical restraint for up to one hour due to assaulting staff [with] intent to injure. . . Order received 1710 [5:10 p.m.]Telephone." The order did not have a Physician's signature on it. b. On 4/7/22 the Director of Nursing was asked about the unsigned order. The Director of Nursing stated, "That is a problem. It should be signed." c. The policy titled Emergency Safety Intervention policy provided by the Director of Nursing on 4/7/22 at 11:27 a.m. documented, "A written order from the physician is required for the use of a physical restraint, chemical restraint, or seclusion. . . The physician's verbal order must be followed with the physician's signature verifying the verbal order. *Target Completion Date for N143 5/2/22* →	N 143	-As a member of the QAC, Director of Nursing shall continue review the use of physical restraint, chemical restraint, and/or seclusion each month, to monitor performance compliance in providing a physician's orders for each Emergency Safety Intervention and address deficiencies if observed. Director of Nursing shall be responsible for assuring improvement occurs and implements other corrective actions if needed or extend enhanced monitoring to ensure solution is sustained. -Director of Nursing shall establish clear paths of communication with Physicians and nursing staff to ensure verbal orders are signed and completed for each Emergency Safety Intervention by 4/27/22. -Director of Nursing to provide in-service regarding Emergency Safety Interventions policies and procedures to nursing staff in monthly nursing meeting on 4/28/22. -Quality Coordinator/Designee shall continue review process for each Emergency Safety Intervention and document when the physician's orders are signed and completed on the incident report documentation for each Emergency Safety Intervention once completed. Quality Coordinator/Designee will resolve any incomplete documentation. Quality Coordinator/Designee shall review all Emergency Safety Interventions by the close of business the next business day following the incident occurrence and document each Emergency Safety Intervention on the Emergency Safety Intervention Review Log form. Quality Coordinator/Designee will record the previous month's ratio of Emergency Safety Interventions in compliance compared to the total number of Emergency Safety Interventions the previous month. Focus shall also include verification each physician's order has been signed by the physician on the KPI monthly.	

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	04L120	A. BUILDING ____ B. WING ____	04/07/2022

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N 207	Continued From page 5 FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include - the name of the resident involved in the serious occurrence, - a description of the occurrence and, - the name, street address, and telephone number of the facility. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure serious occurrences were reported to the Office of Long Term Care (OLTC) and Disability Rights Arkansas (DRA) were notified after suicidal attempts taken by 2 of 2 (Resident #1 and #2) sampled residents. The findings are: 1. Resident #1 had diagnoses of Disruptive Mood Dysregulation Disorder and Other Conduct Disorders. a. On 4/5/22 at 9:30 a.m. Resident #1 was asked why she was in the facility. She stated, "For trying to kill myself."	N 207	-Director of Nursing adjusted serious occurrence reporting guidelines to include suicidal gestures on 4/7/22 upon receiving notice of the deficiency by Surveyor. -Director of Nursing updated the Office of Long-Term Care and the Disability Rights Center personnel contact information for serious occurrence notifications with the information provided by Surveyor on 4/7/22 to ensure notifications are successfully completed. -Director of Nursing shall review and update serious occurrence reporting policies and procedures to include suicidal gestures in the reporting parameters for serious occurrences by 4/27/22. -Director of Nursing shall continue to be responsible for making sure all incidents are investigated, interventions provided, appropriate notifications made, and necessary action plans are in place for the residents. -Director of Nursing shall provide in-service training to nursing staff regarding policies and procedures for incident reporting and serious occurrence reporting parameters and procedures in monthly nursing meeting on 4/28/22. -Quality Coordinator/Designee shall continue review process for each incident report to ensure documentation and all appropriate notifications have been made and shall document appropriate severity level on incident notification report form. -Quality Coordinator/Designee shall ensure a copy of any serious occurrence report is placed in the resident's record, attached to incident notification report, and placed in critical incident log binder. Said binder is to be secured in the DON office in accordance with agency HIPAA records security rules and policies.	

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N 207	Continued From page 6 b. A Nursing Progress Note dated 4/2/22 at 6:30 p.m. documented, "Self harmed with a broken mirror on both forearms and tied a ligature tightly around her neck." c. An Incident Notification Report dated 4/2/22 documented, "Self inflicted injury Suicide gesture." The Authorities Notified section of the form was blank. There was no documentation OLTC or DRA were notified. d. A Nursing Progress Note dated 3/12/22 documented, "RS [Resident] had to be restrained again after trying to use a garment as a ligature." e. An Incident Notification Report dated 3/12/22 documented, "Suicide gesture." The Authorities Notified section of the form was blank. There was no documentation OLTC or DRA were notified. 2. Resident #3 had diagnoses of Other Reactions to Severe Stress and Disruptive Mood Dysregulation. a. A Nursing Shift Note dated 11/13/21 documented, "1906 [7:06 p.m.] R [Resident] used a pillow case to tie around her neck." b. An Incident Notification Report dated 11/13/21 documented, "Suicide gesture." The Authorities Notified section of the form was blank. There was no documentation OLTC or DRA were notified. c. A Nursing Shift Note dated 10/9/21 documented, "R went to the end of the hall and used a pillow case as a ligature to tie around her neck. R stated, "I want to die. I'm going to kill myself."	N 207	-As part of the QAC meetings, Director of Nursing shall review serious occurrence incidents to monitor performance for compliance in completing notification to the Office of Long-Term Care and the Disability Rights Center for each occurrence with a goal of 100% compliance monthly for four months. Director of Nursing shall be responsible for assuring improvement does occur, and to implement other corrective actions if needed or prolong monitoring to ensure solution is sustained. - Quality Coordinator/Designee shall review all incident notification reports before the close of business the next business day following the incident occurrence and place a copy of each serious occurrence report in the critical incident log binder. Quality Coordinator/Designee shall record monthly on the KPI the previous month's ratio of serious occurrence incidents reported compared to the total number of serious occurrence incidents from the previous month to monitor for compliance. *N207 Target Completion Date: 5/2/2022*	

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N 207	Continued From page 7	N 207		

d. An Incident Notification Report dated 10/9/21 documented, "Suicide gesture." The Authorities Notified section of the form was blank. There was no documentation OLTC or DRA were notified.

e. A Nursing Shift Note dated 10/3/21 documented, "R's neck is red r/t [related to] tying numerous articles of clothing, including a hair tye around her neck."

f. An Incident Notification Report dated 10/3/21 documented, "Self inflicted injury Suicide gesture." The Authorities Notified section of the form was blank. There was no documentation OLTC or DRA were notified.

3. On 4/7/22 at 11:45 a.m. the Director of Nursing was asked why the Office of Long Term Care or Disability Rights had not been notified of the incidents for Resident #1 and 2. He stated, "They were considered suicidal gestures, not attempts, because they were in front of staff."

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

May 10, 2022

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

Dear Mr. Thompson:

During the Revisit survey conducted on May 9, 2022, 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
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 05/09/2022

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WOODRIDGE OF THE OZARKS	**2466 S 48TH STREET** **SPRINGDALE, AR 72762**

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{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 May 9, 2022 for all deficiencies cited on April 7, 2022. 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.