ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of Provider Services and Quality Assurance

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June 7, 2022

Woodridge of Forrest City, LLC
Attn: Charlotte Lockhart, Chief Executive Officer
clockhart@perimeterhealthcare.com
603 Kittel Road
Forrest City, Arkansas 72335

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 of Forrest City, LLC
Provider ID #: [redacted]
Onsite Inspection Date: May 23, 2022

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 this 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 entrance by a Woodridge of Forrest City, LLC staff member where a COVID-19 screening was conducted. Sign posted in front stating temperature checks were mandatory, but no temperature checks conducted by facility staff upon entry to facility. AFMC was taken to a conference room by the Clinical Director and met by the Chief Executive Officer. 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 Clinical Director. Staff were able to answer questions regarding the facility. The following is a list of environmental observations that was noted by AFMC staff during the facility tour:

- During tour of bathrooms on the SRU unit, one client escalated with behavior. The Clinical Director left AFMC staff in bathroom alone to help with client behavior.
- Classrooms were noted to have an excessive amount of crumpled paper, candy wrappers, and empty water bottles on floor.
- One classroom had a large glass jar of jalapenos sitting on a desk by the doorway. This same classroom had an excessive amount of clutter blocking the doorway from being opened fully.
- One client was noted in "quiet room" pacing with a staff member observing client at arm's length for safety. Staff member was attempting to verbally calm client with quiet, calming voice.
- Ceiling tiles were pushed away from ceiling grid with wiring exposed in ceiling.
- All units were noted to have a sticky substance, trash, and dirt on floors. Around the baseboards in all areas had dirt.
- Broken, hard, plastic laundry baskets were noted in multiple rooms. When AFMC staff noted safety concern with first broken basket, Clinical Director immediately removed basket. Once more baskets were discovered throughout the tour, the Clinical Director left AFMC staff alone on unit to take care of removal of other broken baskets.
- Bedsheets were noted to have holes and were excessively stained.
- Gymnasium was noted to have recently had the floor resurfaced and was noted to be very clean and inviting.

Additionally Ordered Inspection of Care Summary:

This additionally ordered inspection was triggered by a report made to DPSQA pertaining to Woodridge of Forrest City LLC regarding elopements, broken windows, children complaining about pain, medication administration, peer on peer fights, and five pending maltreatment investigations.

Health and Safety-Policy Review

Based on the nature of the incidents, the following additional policies were requested for review:

- Policy regarding Client to staff ratios
- Incident logs

Summary of Findings:

AFMC reviewed all relevant policies related to the incidents and noted the below areas of concern:

- Several doors throughout the facility were noted to not latch when closing unless physically pulled or pushed shut. During the tour the Clinical Director walked ahead of AFMC staff and did not ensure that said doors were latched appropriately after entering doorways. AFMC staff checked doorways to ensure they were latched appropriately to ensure clients did not enter areas they were not allowed.
- The entry door to gymnasium from outside courtyard did not have a lock to ensure that clients were not going into gymnasium from courtyard unsupervised.

- Currently, the facility doors are opened using a staff member's badge that is scanned at each door. The staff currently wear the badge on a breakaway lanyard around staff members necks. This process presents an easy "grab and go" scenario for clients to obtain badge swipes and run out of doorways. The Clinical Director stated that the facility is looking into different systems that would be more secure than current badge only swipe system that is utilized for entering and exiting doorways.
- Noon medication pass was in process during the facility tour. AFMC staff noted the medication nurse asking client if they needed a PRN (as needed) medication for reasons such as pain, anxiety, etc. Nurse was also observed following up with client regarding early medication that was given for anxiety to make sure medication was effective.
- AFMC did not observe any broken windows during facility tour.
- Medication administration and medication error policies and procedures were reviewed and meet required guidelines.
- Restraint and seclusion policies and procedures were reviewed. These policies and procedures comply with Medicaid, state, and federal regulations and provides for beneficiaries' safety.
- Incident log from April 1, 2022, through May 23, 2022, was reviewed. The following observations were noted:
    - On April 17, 2022, four clients eloped with one resulting in a visit to the Emergency Department. AFMC was unable to obtain from log if the Emergency Department visit was due to an injury sustained during elopement or for another reason. This elopement was in addition to the above mentioned elopements provided by DPSQA. Minimal details of elopement were provided on incident log.
    - On May 1, 2022, two clients eloped from facility. This elopement was in addition to the above mentioned elopements provided by DPSQA. Minimal details of elopement were provided on incident log.
    - AFMC staff noted multiple incidents are recorded almost daily on incident log provided. Incidents include self-inflicted injuries, clients attacked by other clients, contraband found including pills, medication errors, property damage, physical altercations, client's aggressive behavior toward staff members, clients found in unauthorized areas of facility. It was noted that many of these incidents occurred the same date and time and involved multiple clients. The incident log provided minimal details regarding each incident. Staff members involved in the incidents were not included in the incident log.

- The provider submitted a policy titled "Ensuring Adequate Staff Levels" to identify their requirements for staff to client ratios within the facility. The policy noted the following: *'There will be one Youth Care Worker (YCW)/staff member staffed to 6 (six) residents to maintain a 1:6 ratio for the 7a-3p shift and from the 3p-11p shift. There will be one YCW/staff member staffed to 8 (eight) residents at 9p at bedtime and the staffing will remain 1:8ration until 7:15a.'* The clinical director noted that the client to staff ratio is adequate to the overall census of the facility and not direct to the individual units.
- Per the above policy provided, it was noted that the facility was not adequately staffed to ensure risk and safety management. At the time of the elopement occurring on May 9, 2022, the facility's staff to client ratio was 5:55.

Facility Review-Policies and Procedures:

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

Rule	Deficiency Statement	Reviewer Notes
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.	Provider lacked evidence of documentation to ensure all staff have current training in nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations.
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.	Provider did not have evidence of documentation to ensure that all personnel were adequately trained in the facility's Restraint and Seclusion policy and appropriate procedures to be used in Restraint and Seclusion interventions.

Observations:
It was noted that the provider's Letter of Attestation to Arkansas Medicaid was submitted the same day as the last inspection of care, completed on September 16, 2021.

Personnel Records- Licenses, Certifications, Training:
There were twenty-one of personnel records reviewed, six (25%) professional staff and fifteen (26%) paraprofessional staff. During the review of the personnel records, the following deficiencies were noted:

Personnel Record Number	Rule	Credential Validated	Outcome	Reviewer Notes
SR010739 SR010743	Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376	Restraint and Seclusion Training (CPI) - IP Acute	Failed	Certification expired March 2022 Certification expired March 2022
SR010745	241.100B	Child Maltreatment Check - IP Acute	Failed	Child maltreatment check dated for July 27, 2021, however the check did not include the outcomes.

Clinical Summary
As a part of the Quality of Care survey of the IOC, an active Fee for Service (FFS) 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:
No active FFS Medicaid clients were currently admitted at the time of IOC. Therefore, there were no client interviews were conducted.

Program Activity/Service Milieu Observation:
Classes and outside group activities were in session. One class had a fight break out just before AFMC staff entered the classroom hallway. The students in this classroom were immediately taken back to their unit for a cool down period. AFMC staff noted a large group of clients outside engaging in some activities. AFMC staff observed aggressive behaviors between some of the clients such as several clients throwing dirt on a client. Clients were observed loudly yelling at each other and cursing while playing a game on the basketball court area.

Medication Pass:

No FFS Medicaid clients received medications during a medication pass while AFMC staff was onsite. AFMC RN visited with the medication nurse at the first nurses' station who was able to show AFMC RN the facility policies and procedures regarding medication administration, narcotic count/reconciliation/handling, and medication discrepancies. The tour of the first nurses' station was interrupted by the noon medication pass. AFMC staff did observe one client receiving medications. AFMC staff noted the medication nurse asking client if they needed a PRN (as needed) medication for reasons such as pain, anxiety, etc. Nurse was also observed following up with client regarding early medication that was given for anxiety to make sure medication was effective. AFMC RN visited with the medication nurse at the second nurses' station who was able to answer more questions regarding the process of medication delivery. No discrepancies were noted with medication storage, cleanliness of medication room, and knowledge of medication dispensing found.

Clinical Record Review Deficiencies:

No active FFS Medicaid clients were currently admitted at the time of IOC. Therefore, there were no clinical records reviewed.

Corrective Action Plan:

The CAP must be completed within 30 calendar days of the date of the email notice of the IOC reports.

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

Respectfully,

AFMC Inspection Team
InspectionTeam@afmc.org

Improving health care. Improving lives.
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LITTLE ROCK, AR 72201 • afmc.org

AccessPoint

CAP 0005195

Corrective Action Plan Details

CAP Number	CAP-0005195
Inspection	DPSQA-0005195
Status	Approved

CAP Approval Process

Date Requested	6/7/2022
Submitted Date	7/14/2022
Approved Date	7/14/2022

Notes

Timeliness Notes	

Request for Reconsideration

Recon Submitted Date	
Recon Reviewed Date/Time	
Revised Report Sent	
Recon Review Results	

Deficiency Areas

Inspection Elements

Regulation	**Medicaid IP Sec. 2; CFR 42 482.130, 483.376**
Deficiency Statement	**There is no documentation in the HR records that all direct care personnel are trained in facility's Restraint and Seclusion policy.**
Instances	**1**
Corrective Action	**Personnel files and training files are filed separately. When asked to review personnel files, training files were not included for review. To ensure employee files are reviewed in their entirety, BMO/ HR Manager will be sure to provide both files during all surveys moving forward.**
Person Responsible	**Carla Lewis**
Completion Date	**7/14/2022**

Inspection Elements

Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Deficiency Statement	**HR records did not indicate training in the use of nonphysical intervention skills, such as de-escalation on an annual basis.**
Instances	**1**
Corrective Action	**One classroom had a large glass jar of jalapenos sitting on a desk by the doorway. This same classroom had an excessive amount of clutter blocking the doorway from being opened fully: Glass items that residents can mishandle should not be accessible at any time. Teachers will be sure to do a thorough cleaning of their classrooms and remove any items that residents could use to cause bodily injury to themselves or others. Teachers will also ensure that all classrooms meet the minimal licensing requirements as it relates to square footage per resident.**
Person Responsible	**Director of Education**
Completion Date	**7/14/2022**

Restraint and Seclusion Training (CPI) - IP Acute

Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Instances	**2**
Corrective Action	**Upon review of the training files, it was noted that the certificates were not expired and had a expiration date of September 2022.**
Person Responsible	**Carla Lewis**
Completion Date	**7/14/2022**

Child Maltreatment Check - IP Acute

Regulation	**241.100B**
Deficiency Statement	**Failed Validation**
Instances	**1**
Corrective Action	**Upon review of the Child Maltreatment check, it does state that Arkansas State Maltreatment Central Registry contains no record under personnel record number SR010745 in a true report of child maltreatment**
Person Responsible	**Carla Lewis**
Completion Date	**7/14/2022**

Deficiencies

DEF-0048874

Related To	**SR010739**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Reconsideration	

DEF-0048875

Related To	**SR010743**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Reconsideration	

DEF-0048876

Related To	**SR010745**
Regulation	**241.100B**
Deficiency Statement	**Failed Validation**
Reconsideration	

DEF-0048968

Related To	**SURVEY-0004331**
Regulation	**Medicaid IP Sec. 2; CFR 42 482.130, 483.376**
Deficiency Statement	**There is no documentation in the HR records that all direct care personnel are trained in facility's Restraint and Seclusion policy.**
Reconsideration	

DEF-0048969

Related To	**SURVEY-0004331**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Deficiency Statement	**HR records did not indicate training in the use of nonphysical intervention skills, such as de-escalation on an annual basis.**
Reconsideration	

Files

Perimeter Healthcare - Door Correspondence

Last Modified **7/8/2022 2:24 PM**
Created By **Carla Lewi**

2022 AFMC Corrective Action Plan

Last Modified **7/8/2022 2:22 PM**
Created By **Carla Lewi**

HR document

La t Modified **7/8/2022 2 15 PM**
Created By **Carla Lewis**