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

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June 8, 2022

Woodridge Northeast, LLC
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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 #: [redacted]
Onsite Inspection Date: May 24, 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 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 of West Memphis 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 Director of Quality, Director of Human Resources, and Director of Clinical Services. 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 Director of Nursing. 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: 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.	The provider lacked evidence of all staff having current training in restraint and seclusion interventions.
Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376	HR records did not indicate that all direct care personnel have ongoing education, training, and demonstrated knowledge of techniques to identify staff and resident behaviors that may trigger an emergency safety situation semi-annually.	The provider lacked evidence of all staff having current training in restraint and seclusion interventions.
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.	The provider lacked evidence of all staff having current training in restraint and seclusion interventions.

Personnel Records- Licenses, Certifications, Training:

There was a total of ten personnel records reviewed; three (33%) professional staff and seven (28%) paraprofessional staff. During the review of the personnel records, the following deficiencies were noted:

Personnel Record Number	Rule	Credential Validated	Outcome	Reviewer Notes
SR010775 SR010778 SR010779	Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376	Restraint and Seclusion Training (CPI) - IP Acute	Failed	Expired March 2022 Expired March 2022 Expired April 2022
SR010775 SR010777 SR010779 SR010780 SR010781 SR010782 SR010784	241.110B	State Background Check- IP Acute	Failed	Background check submitted did not indicate that the records for the background were pulled from the Arkansas State Police Database.

Quality of Care 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:

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

Program Activity/Service Milieu Observation:

Clients were observed in the classroom setting and in a group setting outside. Staff were engaged with the clients and were providing a therapeutic environment that was conducive to learning.

Medication Pass:

No FFS 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 medication 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 was no active FFS 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.

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

Respectfully,

AFMC Inspection Team
InspectionTeam@afmc.org

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