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

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October 21, 2022

Woodridge of the Ozarks
Attn: Michael Hinton, Chief Executive Officer
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2466 South 48th Street, STE B
Springdale, AR 72762

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 the Ozarks
Provider ID #: [redacted]
Onsite Inspection Date: October 6, 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 main entrance by a Woodridge of the Ozarks staff member and a COVID-19 screening was conducted and temperatures noted. AFMC was immediately taken to a semi-private office space in the Medical Records/Case Management Office where they were 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 Chief Executive Officer and the Director of Nursing for the residential unit. Educational classes were in session. All staff members were observed interacting calmly and therapeutically with clients throughout the facility. Staff were able to answer questions regarding the facility.

The following is a list of observations made during the facility tour and survey:

- Broken floor tile in the corner of room 200.
- Trash and clutter in the floor of all units and classrooms.
- Classrooms were noted to have boxes and stacks of books cluttering the area. This was discussed with the CEO as a potential safety hazard for emergency exit of the classroom.
- AFMC staff noted during the facility tour observation of one client had bruising to face around both eyes. AFMC staff spoke with the Chief Executive Officer and the Director of Nursing regarding this client and found the bruising was due to a recent altercation within the facility between two of the clients. Appropriate steps and documentation have been done regarding this incident. It was discovered during conversation with the Director of Nursing that the month prior to the IOC the incident reports have not been reported within 24 hours to the appropriate state and federal agencies over last month due to transition of new Director of Nursing staff. The new Director of Nursing has corrected this issue and was able to show proof where all incidents are being reported within 24 hours to the appropriate agencies.

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: 241.200	Written Quality Assurance committee minutes were not available for review.	Provider lacked evidence of recent quality assurance meeting minutes. The submitted quality assurance meeting minutes were last dated December 1, 2021.
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).	Out of the staff selected five were lacking evidence of current certification in cardiopulmonary resuscitation (CPR).
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.	Out of the staff selected five lacked evidence of documentation in HR records of the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency

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.	Out of the staff selected five lacked evidence of documentation in HR records that all direct care personnel have ongoing education, training, and demonstrated knowledge of techniques to identify staff and resident behaviors, events and environmental fact
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.	Out of the staff selected five were lacking evidence of current training, as well as competency, in facility's Restraint and Seclusion policy and appropriate procedures to be used in Restraint and Seclusion interventions.

Personnel Records- Licenses, Certifications, Training:

There was a total of thirteen personnel records reviewed, two (29%) professional staff and eleven (26%) paraprofessional staff. During the review of the personnel records, the following deficiencies were noted:

Personnel Record Number	Rule	Credential Validated	Outcome	Reviewer Notes
SR011408 SR011412 SR011413 SR011417 SR011418	221.804.C.1	CPR Training- IP Acute	Failed	No file received No file received Expired August 2022 Expired September 2022 Expired July 2022
SR011408 SR011411 SR011414 SR011415 SR011416	Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376	Restraint and Seclusion Training (CPI) - IP Acute	Failed	No file received Expired 10/01/2022 Expired 07/26/2022 Expired 10/01/2022 Expired 08/26/2022

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

Program Activity/Service Milieu Observation:

Staff and residents were observed waiting in the cafeteria for lunch, in the classroom setting, and on the units and outside in group activities. Staff were calmly interacting with clients and redirecting behaviors, as well as, providing a therapeutic environment that was conducive for learning and treatment therapies.

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 a Woodridge of the Ozarks 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 the medication nurse. The only discrepancy found during the tour of the medication room was an opened multi-dose vial of TB skin test in the medication room refrigerator that was not dated and initialed according to the facility's policy.

Clinical Record Review Deficiencies:

No active FFS Medicaid clients 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. 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

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

AccessPoint

CAP-0005413

Corrective Action Plan Details

CAP Number	CAP-0005413	**Provider Response Due**	11/20/2022
Inspection	DPSQA-0005413	**AFMC Response Due**	
Status	Requested	**Due Date Override**	
Date Requested	10/21/2022		

CAP Approval Process

Submitted Date		**Submitted By**	
CAP Returned Date/Time			
Approved Date		**Approved By**	

Request for Reconsideration

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

Notes

Provider Overdue	☑
AFMC Overdue	☐
CAP Response Notes	
Timeliness Notes	
Next Step:	Please read the Information and Steps on the left. If you wish to request a Reconsideration, follow steps 2 & 3. If you wish to skip straight to submitting a Corrective Action Plan (CAP), see Step 4.

Followup

Require Followup	☐
Followup Date	

System Information

Created By	[redacted] 0/21/2022 12:19 PM	**Last Modified By**	[redacted] 10/21/2022 12:23 PM

Deficiency Areas

Med Pass/Administration

Origin	**Survey**
Regulation	
Instances	**1**
Corrective Action	

Person Responsible	
Completion Date	

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 241.200**
Instances	**1**
Corrective Action	
Person Responsible	
Completion Date	

Restraint and Seclusion Training (CPI) - IP Acute

Origin	**Credential Validation**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Instances	**5**
Corrective Action	
Person Responsible	
Completion Date	

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	
Person Responsible	
Completion Date	

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	
Person Responsible	
Completion Date	

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	
Person Responsible	
Completion Date	

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	
Person Responsible	
Completion Date	

Deficiencies

DEF-0058510

Status	**Requested**

Related To	**SURVEY-0005069**
Regulation	
Deficiency Statement	**Multi-dose vial facility policy was not followed.**
Service Details	**TB skin test multi-dose vial was not labeled per facility policy.**

DEF-0058511

Status	**Requested**
Related To	**SURVEY-0005068**
Regulation	**Medicaid IP Sec. 2: 241.200**
Deficiency Statement	**Written Quality Assurance committee minutes were not available for review.**
Service Details	**Provider lacked evidence of recent quality assurance meeting minutes. The submitted quality assurance meeting minutes were last dated December 1, 2021.**

DEF-0058669

Status	**Requested**
Related To	**SR011416**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: Expired 08/26/2022**

DEF-0058672

Status	**Requested**
Related To	**SR011415**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: Expired 10/01/2022**

DEF-0058673

Status	**Requested**
Related To	**SR011414**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: Expired 07/26/2022**

DEF-0058677

Status	**Requested**
Related To	**SR011411**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: Expired 10/01/2022**

DEF-0058675

Status	**Requested**
Related To	**SR011408**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**No File Received: No file received.**

DEF-0058678

Status	**Requested**
Related To	**SURVEY-0005068**
Regulation	**Medicaid IP Sec. 2; CFR 42 482.130, 483.376**
Deficiency Statement	**HR records did not indicate that all direct care personnel are currently certified in cardiopulmonary resuscitation (CPR).**

Service Details	**Out of the staff selected five were lacking evidence of current certification in cardiopulmonary resuscitation (CPR).**

DEF-0058679

Status	**Requested**
Related To	**SURVEY-0005068**
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.**
Service Details	**Out of the staff selected five were lacking evidence of current training, as well as competency, in facility's Restraint and Seclusion policy and appropriate procedures to be used in Restraint and Seclusion interventions.**

DEF-0058680

Status	**Requested**
Related To	**SURVEY-0005068**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Deficiency Statement	**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.**
Service Details	**Out of the staff selected five lacked evidence of documentation in HR records that all direct care personnel have ongoing education, training, and demonstrated knowledge of techniques to identify staff and resident behaviors, events and environmental factors that may trigger emergency safety situations on a semi-annual basis.**

DEF-0058681

Status	**Requested**
Related To	**SURVEY-0005068**
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.**
Service Details	**Out of the staff selected five lacked evidence of documentation in HR records of the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations on an annual basis.**

CAP History

10/21/2022 12:23 PM

User	[redacted]
Action	**Changed Next Step:. Changed Record Type from New to Requested. Changed Date Requested to 10/21/2022. Changed Status from New to Requested.**

10/21/2022 12:19 PM

User	[redacted]
Action	**Created.**