ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

November 14, 2022

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

Dear Mr. Thompson:

On November 4, 2022, a Complaint Investigation 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.

Theresa Forrest, LPN, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
(501) **320-6235**
email to Theresa.Forrest@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.

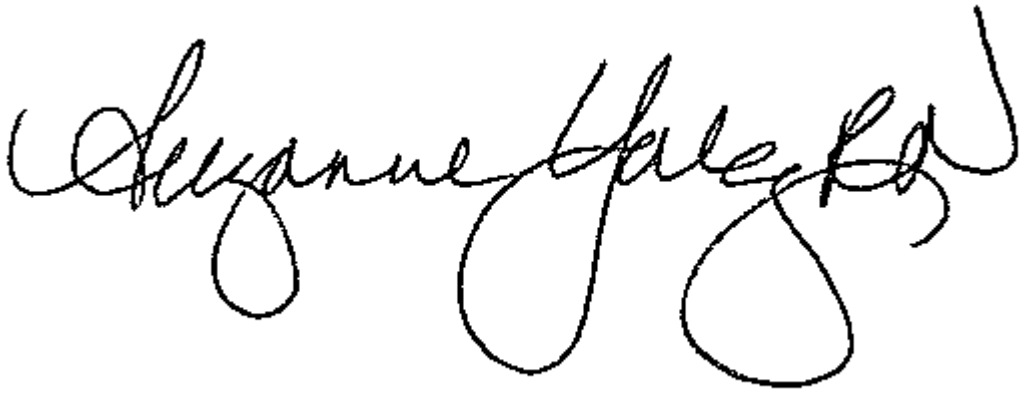
An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action or the requirement for timely submission of an acceptable plan of correction. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative 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

tf

cc: DRA

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 _____	C 11/04/2022

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
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. Complaint #AR00028965 was not in compliance, all or in part, with deficiencies cited at N132, N215 and N216. Complaint #AR00029061 was in compliance. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.	N 000		
N 132	PROTECTION OF RESIDENTS CFR(s): 483.356(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on observation, record review, and	N 132		

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 132	Continued From page 1	N 132		

interview, the facility failed to ensure a physical hold of Client #1 was performed in a safe manner. The findings are:

1. Client #1 had diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, and Intermittent Explosive Disorder.

a. On 10/19/22 at 9:05 a.m., a video dated 9/25/22 at 4:47 p.m. was observed with Unit Director (UD) #1. UD #1 was one of the Satori Alternatives to Manage Aggression (SAMA) instructors at the facility. The video showed Client #1 punched Certified Nursing Assistant (CNA) #1. Client #1 and CNA #1 then wrestled and fell to the floor. CNA #1 then got on top of Client #1. Client #1 was on her back. The UD stated, "The take down was not correct. The staff being on top of her was not appropriate. It could constrict the chest."

b. On 10/19/22 at 1:25 p.m., the Surveyor watched the video with UD #1. The video showed CNA #1 got on top of Client #1 at 4:48:53 p.m. At 4:49:01 Youth Care Worker (YCW) #1 came and positioned by the client to assist with the restraint. Another staff member and Registered Nurse (RN) #1 then came to assist. CNA #1 stayed on top of Client #1 until 4:53:52.

c. On 10/18/22 at 2:21 p.m., Registered Nurse (RN) #1 stated, "When I got there the CNA was on Client #1, holding her down. When we got other staff there, we were able to do a proper restraint."

d. On 10/18/22 at 2:45 p.m., the Surveyor asked YCW #1 about the restraint on 9/25/22. YCW #1 stated, "One of the children attacked the CNA

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N 132	Continued From page 2 and she took her down. Me and the nurse and another staff moved into a restraint. The CNA did not have the child in a proper restraint. She was just sitting on her. Me and the other staff held her arms and asked the CNA to leave. She refused." e. The Emergency Safety Interventions policy provided by the Director of Nursing on 10/19/22 documented, "...Physical restraint and seclusion shall be in a way that is humanitarian and caring and used in a way in which the resident's rights, dignity, well-being, and safety are assured..."	N 132		
N 215	EDUCATION AND TRAINING CFR(s): 483.376(a)(1) Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations; This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a Certified Nursing Assistant, hired through an agency, had received Satori Alternatives to Manage Aggression (SAMA) training for the safe use of restraints prior to placing Client #1 in a restraint. The findings are: 1. Client #1 had diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, and Intermittent Explosive Disorder. a. On 10/19/22 at 9:05 a.m., a video dated 9/25/22 at 4:47 p.m. was observed with Unit Director (UD) #1. UD #1 was one of the SAMA instructors at the facility. The video showed Client #1 punching Certified Nursing Assistant (CNA) #1. Client #1 and CNA #1 then wrestled and fell to	N 215		

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N 215	Continued From page 3	N 215		

the floor. CNA #1 then got on top of Client #1. Client #1 was lying on her back. UD #1 stated, "The take down was not correct. The staff being on top of her was not appropriate. It could constrict the chest. She was unable to get her certificate. She was not supposed to be on the unit alone."

b. On 10/19/22 at 1:25 p.m., the video was watched with UD #1. The video showed that CNA #1 got on top of Client #1 at 4:48:53 p.m. At 4:49:01 Youth Care Worker (YCW) #1 came and positioned by the client to assist with the restraint. Another staff member and Registered Nurse (RN) #1 then came to assist. The CNA stayed on top of Client #1 until 4:53:52.

c. On 10/18/22 at 2:21 p.m., Registered Nurse (RN) #1 stated, "When I got there the CNA was on Client #1, holding her down. When we got other staff there, we were able to do a proper restraint."

d. On 10/18/22 at 2:45 p.m., the Surveyor asked YCW #1 about the restraint on 9/25/22. YCW #1 stated, "One of the children attacked the CNA and she took her down. Me and the nurse and another staff moved into a restraint. The CNA did not have the child in a proper restraint. She was just sitting on her. Me and the other staff held her arms and asked the CNA to leave. She refused."

e. On 10/19/22 at 9:19 a.m., Program Director #1 stated," CNA #1 had not done SAMA training. Something with her schedule. She didn't get it on orientation week." Program Director #1 was also a SAMA instructor for the facility.

f. On 10/19/22 at 10:40 a.m., the Administrator

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N 215	Continued From page 4 stated, "She was hired through an agency. She no longer works here, and we won't be using an agency again." g. The Emergency Safety Interventions policy provided by the Director of Nursing on 10/19/22 documented, " ...All direct care staff are trained in SAMA and will follow the procedures outlined in their manual and training. Staff who is not currently certified shall not be allowed to participate in the restraint procedures..."	N 215		
N 216	EDUCATION AND TRAINING CFR(s): 483.376(a)(2) 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; and This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure a Certified Nursing Assistant, hired through an agency, had received training on de-escalation techniques prior to placing Client #1 in a restraint. The findings are: 1. Client #1 had diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, and Intermittent Explosive Disorder. a. On 10/19/22 at 9:05 a.m., a video dated 9/25/22 at 4:47 p.m. was observed with Unit Director (UD) #1. The video showed Client #1 and Certified Nursing Assistant (CNA) #1 talking. The video then showed Client #1 throwing a package of crackers at CNA #1 and punching	N 216		

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N 216	Continued From page 5 CNA #1. Client #1 and CNA #1 then wrestled and fell to the floor, CNA #1 got on top of Client #1." UD #1 stated that CNA #1 should not have been on the unit alone. b. On 10/18/22 at 2:45 p.m., Client #1 stated, "CNA #1 was a trial CNA. She was rude. She kept interrupting me. I asked her to stop, I grabbed a package of crackers and threw it at her. She got on top of me." c. On 10/19/22 at 10:40 a.m., the Administrator stated, "She was hired through an agency. She no longer works here, and we won't be using an agency again." d. On 10/19/22 at 1:25 p.m., the Administrator stated, "[CNA #1] did not receive training for de-escalation. It was to be done on the same day as Satori Alternatives to Manage Aggression (SAMA) training."	N 216		

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

December 7, 2022

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

Dear Mr. Thompson:

On November 4, 2022, we conducted a complaint investigation 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 December 04, 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:**Theresa Forrest at 501-320-6235 or email to theresa.forrest@dhs.arkansas.gov.**

Sincerely,

Rodney Ryser for
Theresa Forrest, Reviewer
DPSQA/Office of Long Term Care
Survey & Certification Section

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APOC
12/07/2022
RR RR

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

PRINTED: 11/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 132	PROTECTION OF RESIDENTS CFR(s): 483.356(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on observation, record review, and	N 132	W132 Step #1: 12/4/22 DON identified all direct care staff will attend a refresher course for SAMA de-escalation and holding technique. This is scheduled to be completed by 12/04/22. No agency staff will be placed on the schedule until they have completed a full SAMA class, to include de-escalation. Step #2: 12/4/22 All staff have completed initial SAMA training. Due to the importance of appropriate de-escalation and holding technique, all direct care staff will be completing a refresher course by 12/04/22. All identified employees who do not complete the refresher course will not be allowed to work until this has been completed. Step #3: By 12/04, all direct care employees will complete a refresher course by a certified instructor. Step #4: DON will camera review all episodes of safety interventions to ensure physical holds are performed in a safe manner for 8 weeks or until compliance is verified by QLTC. Completion Date: 12/04/2022	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Group CEO (X6) DATE: 12-6-22

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 132	Continued From page 1	N 132		

interview, the facility failed to ensure a physical hold of Client #1 was performed in a safe manner. The findings are:

1. Client #1 had diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, and Intermittent Explosive Disorder.

a. On 10/19/22 at 9:05 a.m., a video dated 9/25/22 at 1:17 p.m. was observed with Unit Director (UD) #1. UD #1 was one of the Satori Alternatives to Manage Aggression (SAMA) instructors at the facility. The video showed Client #1 punched Certified Nursing Assistant (CNA) #1. Client #1 and CNA #1 then wrestled and fell to the floor. CNA #1 then got on top of Client #1. Client #1 was on her back. The UD stated, "The take down was not correct. The staff being on top of her was not appropriate. It could constrict the chest."

b. On 10/19/22 at 1:25 p.m., the Surveyor watched the video with UD #1. The video showed CNA #1 got on top of Client #1 at 4:48:53 p.m. At 4:49:01 Youth Care Worker (YCW) #1 came and positioned by the client to assist with the restraint. Another staff member and Registered Nurse (RN) #1 then came to assist. CNA #1 stayed on top of Client #1 until 4:53:52.

c. On 10/18/22 at 2:21 p.m., Registered Nurse (RN) #1 stated, "When I got there the CNA was on Client #1, holding her down. When we got other staff there, we were able to do a proper restraint."

d. On 10/18/22 at 2:45 p.m., the Surveyor asked YCW #1 about the restraint on 9/25/22. YCW #1 stated, "One of the children attacked the CNA

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N 132 Continued From page 2

and she took her down. Me and the nurse and another staff moved into a restraint. The CNA did not have the child in a proper restraint. She was just sitting on her. Me and the other staff held her arms and asked the CNA to leave. She refused."

e. The Emergency Safety Interventions policy provided by the Director of Nursing on 10/19/22 documented, "...Physical restraint and seclusion shall be in a way that is humanitarian and caring and used in a way in which the resident's rights, dignity, well-being, and safety are assured..."

N 215 EDUCATION AND TRAINING
CFR(s): 483.376(a)(1)

Techniques to identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations;

This ELEMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure a Certified Nursing Assistant, hired through an agency, had received Satori Alternatives to Manage Aggression (SAMA) training for the safe use of restraints prior to placing Client #1 in a restraint. The findings are:

1. Client #1 had diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, and Intermittent Explosive Disorder.

a. On 10/19/22 at 9:05 a.m., a video dated 9/25/22 at 4:47 p.m. was observed with Unit Director (UD) #1. UD #1 was one of the SAMA instructors at the facility. The video showed Client #1 punching Certified Nursing Assistant (CNA) #1. Client #1 and CNA #1 then wrestled and fell to

N 132

W215
Step #1:
12/4/22 HR will schedule any staff, including Certified Nursing Assistant(s), hired through an agency to attend new hire orientation prior to being placed in the milieu. New hire orientation will include the approved agency emergency safety intervention technique prior to placing agency staff on the schedule.

Step #2:
12/4/22 DON identified all clients currently residing at the facility would be affected if current practice continued. For this reason, no agency staff have been scheduled since the incident.

N 215

Step #3:
12/4/22 HR has audited all personnel records to ensure training compliance with emergency safety intervention technique.

Step #4:
HR will report FSI training compliance of all employees weekly to CEO, DON and Corporate Risk Manager for 8 weeks or until compliance is verified by OLTC.

Completion Date: 12/04/2022

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N 215	Continued From page 3	N 215		

the floor. CNA #1 then got on top of Client #1. Client #1 was lying on her back. UD #1 stated, "The take down was not correct. The staff being on top of her was not appropriate. It could constrict the chest. She was unable to get her certificate. She was not supposed to be on the unit alone."

b. On 10/19/22 at 1:25 p.m., the video was watched with UD #1. The video showed that CNA #1 got on top of Client #1 at 4:48:53 p.m. At 4:49:01 Youth Care Worker (YCW) #1 came and positioned by the client to assist with the restraint. Another staff member and Registered Nurse (RN) #1 then came to assist. The CNA stayed on top of Client #1 until 4:53:52.

c. On 10/18/22 at 2:21 p.m., Registered Nurse (RN) #1 stated, "When I got there the CNA was on Client #1, holding her down. When we got other staff there, we were able to do a proper restraint."

d. On 10/18/22 at 2:45 p.m., the Surveyor asked YCW #1 about the restraint on 9/25/22. YCW #1 stated, "One of the children attacked the CNA and she took her down. Me and the nurse and another staff moved into a restraint. The CNA did not have the child in a proper restraint. She was just sitting on her. Me and the other staff hold her arms and asked the CNA to leave. She refused."

e. On 10/19/22 at 9:19 a.m., Program Director #1 stated," CNA #1 had not done SAMA training. Something with her schedule. She didn't get it on orientation week." Program Director #1 was also a SAMA instructor for the facility.

f. On 10/19/22 at 10:40 a.m., the Administrator

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

PRINTED: 11/14/2022
FORM APPROVED
OMB NO. 0938-0391

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 _____	C 11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2465 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

N 215 Continued From page 4

stated, "She was hired through an agency. She no longer works here, and we won't be using an agency again."

g. The Emergency Safety Interventions policy provided by the Director of Nursing on 10/19/22 documented, " ...All direct care staff are trained in SAMA and will follow the procedures outlined in their manual and training. Staff who is not currently certified shall not be allowed to participate in the restraint procedures..."

N 216 EDUCATION AND TRAINING
CFR(s): 483.376(a)(2)

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; and

This ELEMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure a Certified Nursing Assistant, hired through an agency, had received training on de-escalation techniques prior to placing Client #1 in a restraint. The findings are:

1. Client #1 had diagnoses of Major Depressive Disorder, Generalized Anxiety Disorder, and Intermittent Explosive Disorder.

a. On 10/19/22 at 9:05 a.m., a video dated 9/25/22 at 4:47 p.m. was observed with Unit Director (UD) #1. The video showed Client #1 and Certified Nursing Assistant (CNA) #1 talking. The video then showed Client #1 throwing a package of crackers at CNA #1 and punching

N 215

W216
12/4/22 DON identified all direct care staff will attend a refresher course for SAMA de-escalation and holding technique. This is scheduled to be completed by 12/04/22. No agency staff will be placed on the schedule until they have completed a full SAMA class, to include de-escalation.

Step #2:
12/4/22 All staff have completed initial SAMA training. Due to the importance of appropriate

N 216 de-escalation and holding technique, all direct care staff will be completing a refresher course by 12/04/22. All identified employees who do not complete the refresher course will not be allowed to work until this has been completed.

Step #3:
By 12/04, all direct care employees will complete a refresher course by a certified instructor.

Step #4:
DON will camera review all episodes of safety interventions to ensure physical holds are performed in a safe manner for 8 weeks or until compliance is verified by OLTC.

Completion Date: 12/04/2022

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

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FORM APPROVED
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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 _____	C 11/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODRIDGE OF THE OZARKS	2460 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
N 216	Continued From page 5 CNA #1. Client #1 and CNA #1 then wrestled and fell to the floor, CNA #1 got on top of Client #1." UD #1 stated that CNA #1 should not have been on the unit alone. b. On 10/18/22 at 2:45 p.m., Client #1 stated, "CNA #1 was a trial CNA. She was rude. She kept interrupting me. I asked her to stop, I grabbed a package of crackers and threw it at her. She got on top of me." c. On 10/19/22 at 10:40 a.m., the Administrator stated, "She was hired through an agency. She no longer works here, and we won't be using an agency again." d. On 10/19/22 at 1:25 p.m., the Administrator stated, "[CNA #1] did not receive training for de-escalation. It was to be done on the same day as Satori Alternatives to Manage Aggression (SAMA) training."	N 216		

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

December 27, 2022

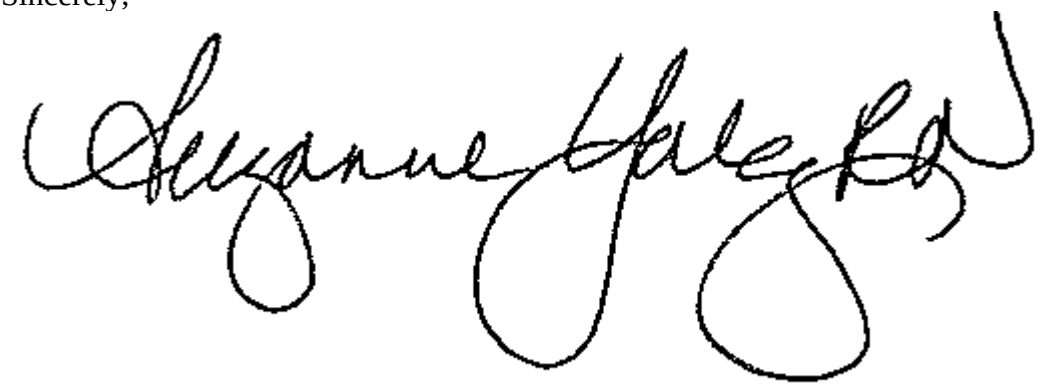
Derek Thompson, Administrator
Woodridge Of The Ozarks
2466 S 48th Street
Springdale, AR 72762

Dear Mr. Thompson:

During the Revisit survey conducted on December 21, 2022, your facility was found to be in compliance with program requirements. **Please email the signed CMS 2567 Theresa.Forrest@dhs.arkansas.gov.**

If you have any questions, please contact your reviewer: **Theresa Forrest, LPN at 501-320-6235 or email to Theresa.Forrest@dhs.arkansas.gov.**

Sincerely,



DPSQA/Office of Long Term Care
Survey and Certification Section

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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-C 12/21/2022

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
{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 December 21, 2022 for all deficiencies cited on November 4, 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.