



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 10<sup>th</sup> 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

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

|                          | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  NG  |                                | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|--|--|-------------------------|--|--------------------------------|-------------------------------|--|--|
|                          |  | 04L120   | B. WING _               |  |                                | C<br><b>11/04/2022</b>        |  |  |
|                          | ROVIDER OR SUPPLIER  |  |                         | STREET ADDRESS, CITY, STATE, ZIP C<br>2466 S 48TH STREET<br>SPRINGDALE, AR 72762 | CODE                           | 11/04/2022                    |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG     | PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE       | TON SHOULD BE<br>THE APPROPRIA |                               |  |  |
| N 000                    | Initial Comments   |  | N 0                     | 000  |                                |                               |  |  |
| N 132                    | is an official, legal do remain unchanged e correction, correction space. Any discrepa citation(s) will be rep Office (RO) for referr Inspector General (Conformation is inadve provider/supplier, the should be notified im Complaint #AR0002 all or in part, with de N215 and N216.  Complaint #AR0002  The facility was not i Subpart G - Condition PROTECTION OF ROTECTION of | 8965 was not in compliance, ficiencies cited at N132,  9061 was in compliance.  In compliance with §483, cons of Participation for cial Treatment Center.  RESIDENTS  Itervention. An emergency nust be performed in a proportionate, and everity of the behavior, and cological and developmental | N 1                     | 32   |                                |                               |  |  |
| I ABORATORY              | DIRECTOR'S OR PROVIDER   | /SUPPLIER REPRESENTATIVE'S SIGNATUR  | <br>PE                  | 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.

Facility ID: 3017

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` '   | E CONSTRUCTION      | (X3) DATE SURVEY COMPLETED   |                 |
|---|--|---|---------------------|--|-----------------|
|   |  | 04L120  | B. WING             |  | C<br>11/04/2022 |
|   | ROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  2466 S 48TH STREET  SPRINGDALE, AR 72762                              | 1110-112022     |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETION |
| N 132   | interview, the facility hold of Client #1 wa manner. The finding 1. Client #1 had dia Disorder, Generaliz Intermittent Explosiv a. On 10/19/22 at 9/25/22 at 4:47 p.m. Director (UD) #1. Ul Alternatives to Maninstructors at the fac #1 punched Certific Client #1 and CNA floor. CNA #1 then g #1 was on her back down was not correher was not approprichest."  b. On 10/19/22 at 1: watched the video w CNA #1 got on top of 4:49:01 Youth Care positioned by the client #1 until 4:53:: c. On 10/18/22 at 2: (RN) #1 stated, "Whon Client #1, holding the client # | y failed to ensure a physical is performed in a safe gs are:  gnoses of Major Depressive ed Anxiety Disorder, and ve Disorder.  205 a.m., a video dated . was observed with Unit D #1 was one of the Satori age Aggression (SAMA) cility. The video showed Client d Nursing Assistant (CNA) #1. #1 then wrestled and fell to the got on top of Client #1. Client . The UD stated, "The take ct. The staff being on top of riate. It could constrict the  225 p.m., the Surveyor with UD #1. The video showed of Client #1 at 4:48:53 p.m. At Worker (YCW) #1 came and ient to assist with the restraint. er and Registered Nurse (RN) sist. CNA #1 stayed on top of | N 13                |  |                 |
|   | YCW #1 about the r   | :45 p.m., the Surveyor asked<br>restraint on 9/25/22. YCW #1<br>children attacked the CNA   |                     |  |                 |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   |      | SURVEY                     |
|---|--|---|--------------------|---|---|------|----------------------------|
|   |  | 04L120  | B. WING            |   |   |      | 04/2022                    |
| NAME OF PROVIDER OR S   |  | 0.2.2   |                    | s<br>2                                  | TREET ADDRESS, CITY, STATE, ZIP CODE 466 S 48TH STREET SPRINGDALE, AR 72762                                   | 1170 | 04/2022                    |
|   | CH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |      | (X5)<br>COMPLETION<br>DATE |
| and she to another st not have t just sitting arms and  e. The Emprovided be document shall be in and used dignity, we EDUCATI CFR(s): 4  Technique behaviors may trigge This ELEM Based on interview, Nursing A received S Aggressio restraints The findin  1. Client # Disorder, Intermitter  a. On 10/7 9/25/22 at Director (Unstructors #1 punchi | taff moved in the child in a pon her. Me asked the Control of the Direct of the Control of the C | In. Me and the nurse and into a restraint. The CNA did a proper restraint. She was and the other staff held her CNA to leave. She refused."  Infety Interventions policy tor of Nursing on 10/19/22 ical restraint and seclusion is humanitarian and caring which the resident's rights, and safety are assured"  In AlNING  In the staff and resident denvironmental factors that bey safety situations;  In the tas evidenced by:  In, record review, and failed to ensure a Certified ed through an agency, had actives to Manage raining for the safe use of sing Client #1 in a restraint. |                    | 215                                     |   |      |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | · '  | CONSTRUCTION        | (X3) DATE SURVEY COMPLETED  |                 |  |
|---|---|--|---------------------|---|-----------------|--|
|   |   | 04L120   | B. WING             |   | C<br>11/04/2022 |  |
|   | ROVIDER OR SUPPLIER   |  | 24                  | REET ADDRESS, CITY, STATE, ZIP CODE<br>166 S 48TH STREET<br>PRINGDALE, AR 72762                                   | 1110-112022     |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETION   |  |
| N 215   | the floor. CNA #1 the Client #1 was lying "The take down was on top of her was not constrict the chest. certificate. She was unit alone."  b. On 10/19/22 at 1 watched with UD #1 #1 got on top of Clied 4:49:01 Youth Care positioned by the client #1 until 4:53:  c. On 10/18/22 at 2: (RN) #1 stated, "Whon Client #1, holding other staff there, we restraint."  d. On 10/18/22 at 2: YCW #1 about the restraint."  d. On 10/18/22 at 2: YCW #1 about the restraint."  d. On 10/18/22 at 2: YCW #1 about the restraint."  d. On 10/18/22 at 2: YCW #1 about the restraint."  d. On 10/18/22 at 2: YCW #1 about the restraint."  d. On 10/18/22 at 2: YCW #1 about the restraint."  d. On 10/18/22 at 2: YCW #1 about the restraint." | en got on top of Client #1. on her back. UD #1 stated, s not correct. The staff being of appropriate. It could She was unable to get her not supposed to be on the  25 p.m., the video was 1. The video showed that CNA ent #1 at 4:48:53 p.m. At Worker (YCW) #1 came and ent to assist with the restraint. er and Registered Nurse (RN) sist. The CNA stayed on top of 52.  21 p.m., Registered Nurse nen I got there the CNA was g her down. When we got e were able to do a proper  245 p.m., the Surveyor asked restraint on 9/25/22. YCW #1 children attacked the CNA own. Me and the nurse and I into a restraint. The CNA did a proper restraint. She was Me and the other staff held her e CNA to leave. She refused."  219 a.m., Program Director #1 d not done SAMA training. schedule. She didn't get it on Program Director #1 was also | N 215               |   |                 |  |
|   | f. On 10/19/22 at 10  | :40 a.m., the Administrator  |                     |   |                 |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | IDENTIFICATION NUMBER  |                    |         | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|---|---|--|--------------------|---------|---|-------------------------------|----------------------------|
|   |   |  |                    | P. WING |   | (                             |                            |
|   |   | 04L120   | B. WING _          |         |   | 11/                           | 04/2022                    |
|   | ROVIDER OR SUPPLIER   |  |                    | 2       | TREET ADDRESS, CITY, STATE, ZIP CODE<br>466 S 48TH STREET<br>PRINGDALE, AR 72762                              |                               |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG | X       | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| N 215   | no longer works here, agency again." g. The Emergency Sa                | e 4 d through an agency. She , and we won't be using an afety Interventions policy tor of Nursing on 10/19/22                                  | N:                 | 215     |   |                               |                            |
| N 216   | documented, "All d  | irect care staff are trained in the procedures outlined in hing. Staff who is not Il not be allowed to raint procedures"                       | N:                 | 216     |   |                               |                            |
|   | as de-escalation, med active listening, and v                           | al intervention skills, such<br>diation conflict resolution,<br>rerbal and observational<br>emergency safety situations;                       |                    |         |   |                               |                            |
|   | Based on observation interview, the facility for Nursing Assistant, him | ailed to ensure a Certified<br>ed through an agency, had<br>le-escalation techniques   |                    |         |   |                               |                            |
|   |   | noses of Major Depressive<br>d Anxiety Disorder, and<br>e Disorder.  |                    |         |   |                               |                            |
|   | Director (UD) #1. The and Certified Nursing The video then shows        | 5 a.m., a video dated was observed with Unit video showed Client #1 Assistant (CNA) #1 talking. ed Client #1 throwing a at CNA #1 and punching |                    |         |   |                               |                            |

|                          | ID DI AN OF CORRECTION INTERPRETATION NUMBERS  |  | ` ′                 | IPLE CONSTRUCTION IG   | (XX       | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|--|--|---------------------|--|-----------|-------------------------------|--|--|
|                          |  | 04L120   | B. WING _           |  |           | C                             |  |  |
|                          | ROVIDER OR SUPPLIER  | 042120   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE 2466 S 48TH STREET SPRINGDALE, AR 72762            |           | 11/04/2022                    |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |  |
| N 216                    | CNA #1. Client #1 an fell to the floor, CNA UD #1 stated that CN on the unit alone.  b. On 10/18/22 at 2:4 "CNA #1 was a trial Ckept interrupting me. grabbed a package cher. She got on top of c. On 10/19/22 at 10: stated, "She was hire no longer works here agency again."  d. On 10/19/22 at 1:2 stated, "[CNA #1] did de-escalation. It was | d CNA #1 then wrestled and #1 got on top of Client #1."  NA #1 should not have been  5 p.m., Client #1 stated,  CNA. She was rude. She I asked her to stop, I  of crackers and threw it at | N 2                 | 216  |           |                               |  |  |





Division of Provider Services & Quality Assurance 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,

Redney Reper for

Theresa Forrest, Reviewer

DPSQA/Office of Long Term Care

Survey & Certification Section

tf

APOC

12/07/2022

PRINTED: 11/14/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING\_ 04L120 B. WING 11/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2466 S ABTH STREET WOODRIDGE OF THE OZARKS SPRINGDALE, AR 72762 SUMMARY STATEMENT OF DEFICIENCES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) (X5) (X6) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR 1.80 IDENTIFYING INFORMATION) TAG CROSS-HFFERENCED TO THE APPROPRIATE DEFICIENCY) TAG N 000 Initial Comments N 000 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 Dallos Regional W132 Office (RO) for referral to the Office of the Step #1: inspector General (OIG) for possible fraud. If 12/4/22 DON identified all direct care staff will information is inadvertently changed by the allond a refresher course for SAMA deprovider/supplier, the State Survey Agency (SA) oscalation and holding technique. This is should be notified immediately. scheduled to be completed by 12/04/22. No agency staff will be placed on the schedule Complaint #AR00028965 was not in compliance. until they have completed a full SAMA class, all or in part, with deficiencies cited at N132, to include de-escalation. N215 and N216. Step #2: Complaint #AR00029061 was in compliance. 12/4/22 All staff have completed initial SAMA training. Due to the importance of appropriate de-escalation and holding technique, all direct The facility was not in compliance with §483, Subpart G - Conditions of Participation for care staff will be completing a refresher course by 12/04/22. All identified employees Psychiatric Residential Treatment Center. who do not complete the refresher course will PROTECTION OF RESIDENTS N 132 not be allowed to work until this has been GFR(s): 483,356(b) completed. Emergency safety Intervention. An emergency Step #3: safely intervention must be performed in a By 12/04, all direct care employees will manner that is safe, proportionate, and complete a refresher course by a certified appropriate to the severity of the behavior, and instructor. the resident's chronological and developmental age; size; gender; physical, medical, and Slep #4: psychiatric condition; and parsonal history DON will camera review all apisodes of safety (including any history of physical or sexual interventions to ensure physical holds are performed in a safe manner for 8 weeks or abusei. until compliance is verified by OLTC.

Based on observation, record review, and

LABORATORY OR SECTION'S OR SECURITY OF SECURITY SECURITY OF SECURITY OF

This ELEMENT is not met as evidenced by:

TITLE

Completion Date: 12/04/2022

(X0) DATE 12-6-22

Any obtidiancy statement orders with an naturisk (\*) denotes a distriction which the fratitution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the pullents. (See instructions.) Except for nursing france, the findings stated above are disclosoble \$1 dolored in the date of survey whether or not a plan of correction is provided. For nursing france, the above likelings and plans of correction are disclosoble \$1 down the date these documents are made available to the facility. If definancies are cited, an approved plan of correction is requisive to continued program participation.

FORM CMS-2587(02-99) Provious Varsions Obsolote

Event ID:W55511

Facility ID: 1017

Il continuation shoot Page 1 of 6 .

|                            |   | D HUMAN SERVICES  |                         |  |  | FORM APPR                     |       |
|----------------------------|---|---|-------------------------|--|--|-------------------------------|-------|
|                            |   | MEDICAID SERVICES   |                         | <del></del>                              | (  | OMB NO. 0938                  |       |
|                            | DEPOSITION :  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULI<br>A. RUII DI | NPLF CONSTRUCTION<br>NG                  |  | (X3) DAJE SURVEY<br>COMPLETED | -     |
|                            |   | 04L120  | B. WING                 |  |  | C                             | _     |
| NAME OF P                  | ROVIDER OR SUPPLIER   |   |                         | STREET ADDRESS, CITY,                    | STATE ZIP CODE   | 11/04/202                     | 2     |
| WOODRID                    | GE OF THE OZARKS  |   |                         | 2466 \$ 487H STREET<br>SPRINGDALE, AR 72 |  |                               |       |
| (X4) ID<br>PREFIX :<br>TAG | (FACH DEFICIENC   | NTEMENT OF DEPICIENCIES<br>/ MUST DE PRECEDED BY FULL<br>SC IDEN II-YING INFORMATION)   | ID<br>PRFFI<br>TAG      | PROVIDE<br>X (EACH CORI                  | R'S PLAN OF CORRECTION<br>RECTIVE ACTION SHOULD BE<br>RENCED TO THE APPROPRIA<br>DEHICIENCY) |                               | ETION |
| N 132                      | Continued From page   | 1   |                         | 120                                      |  | :                             |       |
|                            |   | ailed to ensure a physical<br>performed in a safo   | · 91                    | 132                                      |  |                               | •     |
| :                          | Client I/1 had diagn<br>Disordor, Generalized<br>Intermittent Explosive               | oses of Major Depressive<br>Anxiety Disorder, and<br>Disorder,  |                         |  |  |                               |       |
| :                          | Alternatives to Manag<br>instructors at the facili<br>#1 punched Cortified I          | vas observed with Unit<br>#1 was one of the Satori<br>o Aggression (SAMA)<br>ty. The video showed Client<br>Nursing Assistant (CNA) #1.                             |                         |  |  | . :                           |       |
|                            | Client #1 and CNA #1 floor. CNA #1 then go #1 was on her back. (down was not correct. | then wrestled and fell to the on top of Client #1. Client he UD stated, "The take The staff being on top of to. It could constrict the                              |                         |  |  | ·<br>·                        |       |
|                            | CNA#1 got on top of 4:49:01 Youth Care W positioned by the clier Another staff mambar | TUD #1. The video showed Client #1 at 4:48:53 p.m. At orker (YCW) #1 came and it to assist with the restraint, and Registered Nurse (RN) t. CNA #1 stayed on top of |                         | · .                                      |  |                               |       |
|                            | (RN) #1 stated, "When<br>on Client #1, holding it                                     | p.m., Rogistored Nurse<br>of got there the CNA was<br>nor down. When we got<br>sere able to do a proper   |                         | ·  | ·  |                               | •     |
|                            | YCW #1 about the res<br>stated, "One of the chi                                       | p.m., the Surveyor asked<br>traint on 9/25/22, YCW #1<br>Idren attacked the CNA   |                         |  |  |                               |       |
| U(M) CMS-2557              | (02-99) Provious Versions Obsi  | inte Pvent ID:W55   | ទទ                      | Facility ID: 3017                        | [[ cauli   | unlien sleet Proc             | 2018  |

PRINTED: 11/14/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/GLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A, BUII DING . B. WING 04L120 11/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COOS 2480 S 48TH STREET WOODRIDGE OF THE OZARKS SPRINGDALE, AR 72762 SUMMARY STATEMENT OF DEFICIPACIES
[EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION 'IAG N 132 Continued From page 2 N 132 and she look her down. Me and the nurse and W215 another staff moved into a restraint. The CNA did Slep #1: not have the child in a proper restraint. She was 12/4/22 HR will schedule any slaff, including just silling on her. Me and the other staff held her Certified Nursing Assistant(s), hired through arms and esked the CNA to leave. She refused," an agency to attend now hire orientation prior to being placed in the milieu. New hire e. The Emergency Safety Interventions policy orientation will include the approved agency provided by the Director of Nursing on 10/19/22 entergency safety intervention technique prior documented, "...Physical restraint and seclusion to placing agency staff on the schedule. shall be in a way that is humanitarian and caring and used in a way in which the resident's rights, 12/4/22 DON identified all clients currently dignity, well-being, and safety are assured..." residing at the facility would be affected if N 215 EDUCATION AND TRAINING current practice continued. For this reason, CFR(s): 483.376(a)(1) no agency staff have been scheduled since the incident. Techniques to Identify staff and resident behaviors, events, and environmental factors that may trigger emergency safety situations; 12/4/22 HR has sudited all personnel records to ensure training compliance with This ELEMENT is not met as evidenced by: emergency safely intervention technique. Based on observation, record review, and interview, the facility falled to ensure a Certified Slep #4: Nursing Assistant, hired through an agency, had HR will report FSI training compliance of all received Satori Alternatives to Manage employees weekly to CEO, DON and Aggression (SAMA) training for the safe use of Corporate Risk Manager for 8 weeks or until compliance is verified by OLTC. restraints prior to placing Client #1 in a restraint. The findings are: Completion Date: 12/()4/2022 1. Olient #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 westled and fell to

|                           |  | ID HUMAN SERVICES<br>MEDICAID SERVICES   |                         |           |   | F                        | NTED: 11/14/2022<br>FORM APPROVED<br>B NO. 0938-0391 |
|---------------------------|--|--|-------------------------|-----------|---|--------------------------|--|
| SIATEMENT                 | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDERSUPPLIERCLIA<br>IDENTIFICATION NUMBER:  | V. DOIITO<br>(XX) VICII | TIPLE COI | (X3)  | DATE SURVEY<br>COMPLITED |  |
|                           |  | 04L120   | H WING                  |           |   |                          | C<br>11/04/2022                                      |
| ИАМЕ ОЕРІ                 | ROVIDER OR SUPPLIER  | The state of the s |                         | STRE      | CT ADDRESS, CITY, STATE, AIF CODE   |                          | 1804/2022  |
| WOODRIE                   | GE OF THE OZARKS   |  |                         |           | s 48th Street<br>Ingdale, ar 72762  |                          | •  |
| (X4) ID<br>I'REFIX<br>IAG | (EACH DEFICIENC  | ALEMENT OF DEFICIENCIES<br>Y MUST RE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>I'REH<br>JAC      |           | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                       | (X5)<br>COMIN FILM<br>DAIL                           |
| N 215                     | Continued From page  |  | M                       | 215       |   |                          |  |
|                           | the floor. CNA #1 the<br>Client #1 was lying or<br>"The take down was on<br>top of her was not<br>constrict the chest. Si                            | n got on top of Client #1.<br>n hor back. UD #1 stated,<br>not correct. The staff being  | . 14                    |           |   |                          |  |
|                           | II-1 got on top of Clion<br>4:49:01 Youth Care V<br>positioned by the clie<br>Another staff member   | The video showed that CNA it #1 at 4:48:53 p.m. At Vorker (YCW) #1 came and it to assist with the restraint, it and Registered Nurso (RN) st. The CNA stayed on top of   |                         |           |   |                          |  |
|                           | (RN) #1 stated, "Whe<br>on Client #1, holding  | 1 p.m., Registered Nurse<br>on I got there the CNA was<br>her down. When we got<br>were able to do a proper  |                         |           |   |                          | ;<br>;   |
|                           | YCW #1 about the ro<br>stated, "One of the cl<br>and she took her dow<br>another staff moved i<br>not have the child in a<br>just sitting on her. Me | 5 p.m., the Surveyor asked straint on 9/25/22. YCW #1 nildren attacked the CNA /n. Me and the nurse and nto a restraint. The CNA did a proper restraint. She was and the olher staff hold her CNA to leave. She refused."  | •                       |           |   |                          |  |
|                           | stated," CNA //1 had<br>Something with her s   | 9 a.m., Program Director #1<br>not done SAMA training,<br>chedule. She didn't get it on<br>ogram Director #1 was also<br>r the facility.   |                         |           |   |                          |  |
|                           | f. On 10/19/22 at 10:  | 40 a.m., the Administrator   |                         |           |   |                          |  |

#### PRINTED: 11/14/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDENTIULT LERKILIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING. 041120 11/04/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COOR 2466 S 48TH STREET WOODRIDGE OF THE OZARKS SPRINGDALE, AR 72762 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CURRECTIVE ACTION SHOULD BE CHOSS-REFERENCED TO THE APPROPRIATE (XA) (D ID PREFIX CONLITTION (X2) (EACH DEFICIENCY MUST BE PHECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) TAG DEFICIENCY N 215 Continued From page 4 N 215 stated, "She was hired through an agency, She W216 no longer works here, and we won't be using an 12/4/22 DON identified all direct care staff will agency again." atlend a refresher course for SAMA deescalation and holding technique. This is g. The Emergency Safety Interventions policy solveduled to be completed by 12/04/22. No agency staff will be placed on the schedule provided by the Director of Nursing on 10/19/22 documented, " ... All direct care staff are trained in until they have completed a full SAMA class. to include de-escalation. SAMA and will follow the procedures outlined in their manual and training. Staff who is not Step #2: currently cartified shall not be allowed to 12/4/22 All staff have completed initial SAMA participate in the restraint procedures..." training. Due to the importance of appropriate N 216 EDUCATION AND TRAINING de-escalation and holding technique, all direct CFR(s): 483.376(a)(2) care staff will be completing a refresher course by 12/04/22. All identified employees The use of nonphysical intervention skills, such who do not complete the refresher course will as de-escalation, mediation conflict resolution, not be allowed to work until this has been active listening, and verbal and observational completed. methods, to prevent amergency safety situations: Step #3: By 12/04, all direct care employees will complete a refresher course by a certifled This ELEMENT is not met as evidenced by: instructor. Based on observation, record review, and interview, the facility failed to ensure a Certified Step #4: Nursing Assistant, hired through an agency, had DON will camera review all episodes of safety received training on de-escalation techniques interventions to ensure physical holds are prior to placing Client #1 in a restraint. The performed in a safe manner for 8 weeks or findings are: until compliance is verified by OLTC. 1. Client #1 had diagnoses of Major Depressive Completion Date: 12/04/2022 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

PRINTED: 11/14/2022

| DEPART                   | MENT OF HEALTH AN                                | ID HUMAN SERVICES   |                       |        |   |                                |                                 | APPROVED                   |  |
|--------------------------|--|---|-----------------------|--------|---|--------------------------------|---------------------------------|----------------------------|--|
| CENTER                   | S FOR MEDICARE &                                 | MEDICAID SERVICES   | ····                  |        |   |                                |                                 | 0. 0938-0391               |  |
|                          | F DEFICIENCIES<br>FEORRECTION                    | AI EMH-II IYYUZIMIVORY<br>RITRAMIN MCATADITRIADI  | A, BUILDII            |        | STRUCTION   |                                | (X3) DATE SURI<br>COMPLETE<br>C |                            |  |
|                          |  | 04L120  | R. WING_              |        |   |                                |                                 | 04/2022                    |  |
| NAME OF P                | ROVIDER OX SUPPLIFE                              | <del> </del>  |                       | STREET | ADDRESS, CITY, STATE, ZIP   | CONE                           |                                 |                            |  |
| WOODRIE                  | IGE OF THE OZARKS                                |   |                       |        | 40TH STREET<br>IGDALE, AR 72762   |                                |                                 | -                          |  |
| (X4) ID<br>PREFIX<br>TAC | (EACH DEFICIENC                                  | ATTMENT OF DEHCIFNOITS<br>Y MUST BE PRECEDED DY FULL<br>LSC (DENTIFYING INFORMATION)                | , ID<br>PREFII<br>TAG | ς -    | PROVIDER'S PLAN OF<br>(FACII CORRECTIVE AC<br>CROSS-REFERENCED FO<br>DEFICIEN | HON SHOULD BU<br>THE APPROPRIA | t E                             | (X5)<br>COMPLETION<br>DATE |  |
| N 216                    | :<br>. Continued From page                       | 5 5   | · Nt                  | 216    |   |                                |                                 |                            |  |
|                          | GNA #1. Client #1 an fell to the floor, CNA      | d CNA #1 then wrestled and<br>#1 got on top of Client #1."<br>IA #1 should not have been            | ,                     |        |   |                                |                                 |                            |  |
|                          | . "CNA #1 was a trial C<br>kept interrupting me. | f crackers and throw it at  | ·                     |        |   |                                |                                 | :<br>!                     |  |
|                          | stated, "She was hire                            | 40 a.m., the ∧dministrator ad through an agency. She , and we won't be using an                     | ·<br>·<br>·<br>:      |        |   |                                |                                 | :<br>:                     |  |
| i                        | ' stated, "[CNA#1] did<br>de-escalation. It was  | 5 p.m., the Administrator not receive training for to be donn on the same (lay to Manage Aggression |                       | ٠      |   |                                |                                 | :                          |  |
|                          |  |   |                       |        |   |                                |                                 |                            |  |
|                          | :  |   |                       |        |   |                                |                                 | <i>!</i>                   |  |
|                          | ;  |   |                       |        |   |                                | •                               |                            |  |
| •                        |  |   |                       |        | •   |                                |                                 | :                          |  |
| ·                        |  |   |                       |        |   |                                |                                 | •                          |  |





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

tf

PRINTED: 12/27/2022 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |               |  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|---|---|--|---------------|--|-------------------------------|----------------------------|
|  |   | 04L120  | B. WING                                |               |  | R-C                           |                            |
|  |   | 04L120  | D. WING_                               |               |  | 12/                           | 21/2022                    |
| NAME OF PI   | ROVIDER OR SUPPLIER   |   |  | STREET ADDRE  | ESS, CITY, STATE, ZIP CODE   |                               |                            |
| WOODBIE  | GE OF THE OZARKS  |   |  | 2466 S 48TH S | TREET  |                               |                            |
| WOODKIL  | GE OF THE OZAKKS  |   |  | SPRINGDALI    | E, AR 72762  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     |               | PROVIDER'S PLAN OF CORRECTION<br>ACH CORRECTIVE ACTION SHOULD E<br>DSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) |                               | (X5)<br>COMPLETION<br>DATE |
| {N 000}  | Initial Comments  |   | {N 0                                   | 00}           |  |                               |                            |
|  | is an official, legal do remain unchanged excorrection, correction space. Any discrepar citation(s) will be reproffice (RO) for referral Inspector General (O information is inadve provider/supplier, the should be notified im  A revisit was conduct for all deficiencies cit deficiencies have been | erich (PG) for possible fraud. If rently changed by the estate Survey Agency (SA) mediately.  Ited on December 21, 2022 and on November 4, 2022. All the en corrected, and no new found. The facility is in |  |               |  |                               |                            |
| LABORATORY   | <br>DIRECTOR'S OR PROVIDER/   | SUPPLIER REPRESENTATIVE'S SIGNATUR  |  |               | 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.