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

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December 19, 2022

Woodridge of the Ozarks
Attn: Shauna Bertoni, Director of Human Resources
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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: December 5, 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. AFMC was immediately taken to a private conference room 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.

This IOC visit was upon request of DPSQA to follow up on a recent IOC inspection conducted on October 6, 2022. A tour of the facility was completed with the Chief Executive Officer and the Director of Plant Operations 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:

- Rubber mat outside of seclusion room was overlapping causing a trip hazard.
- Toilets in each room has a wooden covering with openings around the bottom of the toilet and the flush handle to provide anti-ligature safety for the clients. Clients have stuck trash, personal items such as socks and underwear, used feminine products in these openings in every client bathroom. These openings are difficult to clean which provides an area to harbor germs, biohazard waste, as well as contraband.
- Multiple doorways, walls, and bedframes in rooms that had profanity that included names and vulgar statements that were sexual in nature. Graffiti was dated as far back as February 2022 with no obvious attempts to remove by facility. Interim CEO did state that they have a plan to start painting over facility in the near future.
- Missing floor tiles were noted throughout the entire facility in the hallways, various client rooms and the day room.
- Last Inspection of Care survey conducted October 6, 2022, AFMC staff noted that classrooms had boxes and stacks of books cluttering the area. This was discussed with the former CEO as a potential safety hazard for emergency exit of the classroom. This current inspection classrooms were noted to be de-cluttered providing a much safer environment for potential emergency exits of the classrooms.
- During tour of the medication room AFMC staff opened a refrigerator that was for staff only. There were several bottles of cola that had spilled and a jar of mayonnaise that was leaking. This was reported to the Director of Nursing who immediately had the maintenance department remove the refrigerator.

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 lacked 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, two 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.
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, three 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.
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 eight 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 eighteen personnel records reviewed, two (29%) professional staff and sixteen (39%) paraprofessional staff. During the review of the personnel records, the following deficiencies were noted:

Personnel Record Number	Rule	Credential Validated	Outcome	Reviewer Notes
SR012113 SR012116 SR012120 SR012123 SR012124 SR012126 SR012127 SR012129	221.804.C.1	CPR Training- IP Acute	Failed	No file received No file received No file received No file received Expired October 2022 Expired September 2022 Expired October 2022 No file received
SR012114 SR012115 SR012119	Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376	Restraint and Seclusion Training (CPI) - IP Acute	Failed	Expired 04/21/2022 Expired 11/27/2022 Expired 04/01/2022

General Observations:

When reviewing the staff Satori Alternative to Managing Aggression certifications, it was noted that some had expiration dates of six months from the date of training and others were a year from the date of training.

- SR012115 last had restraint and seclusion training on 05/27/2022 (this does not meet the requirement of semi-annual training Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376)

- SR012114 last had restraint and seclusion training on 10/21/2021
- SR012114 last had restraint and seclusion training on 10/01/2021

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.

Clinical Record Review Deficiencies:

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

Program Activity/Service Milieu Observation:

Staff and residents were in the classroom setting. Staff were calmly interacting with clients and 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 and no discrepancies with medication storage, cleanliness of medication room, and knowledge of medication dispensing found. See above facility tour regarding employee refrigerator in the medication room.

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-0006416

Corrective Action Plan Details

CAP Number	CAP-0006416	**Provider Response Due**	
Inspection	DPSQA-0006416	**AFMC Response Due**	
Status	Approved	**Due Date Override**	
Cancellation Reason			
Date Requested	12/19/2022		

CAP Approval Process

Submitted Date	1/17/2023	**Submitted By**	[redacted]
CAP Returned Date/Time			
Approved Date	1/23/2023	**Approved By**	[redacted]

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

For this CAP:
Of the 8 deficiency areas submitted:
8 plan(s) have been approved as submitted
0 were rejected and will need changes

Outcome: This CAP was Approved.

Overall Feedback:
Thank you for your response.

Timeliness Notes

Next Step: Your CAP has been accepted by AFMC. AFMC recommends you download a copy of your accepted CAP for your records by selecting the Printable View button in the top right-hand corner.

Followup

Require Followup ☐

Followup Date

System Information

Created By [redacted] 12/19/2022 4:00 PM

Last Modified By [redacted] 1/23/2023 9:54 AM

Deficiency Areas

Med Pass/Administration

Origin	**Survey**
Regulation	
Instances	**1**
Corrective Action	**All nurses have been re-educated on narcotic count policy and have been given the policy handout for future reference.**
Person Responsible	**Director of Nursing**
Completion Date	**1/17/2023**

Med Pass/Administration

Origin	**Survey**
Regulation	
Instances	**1**
Corrective Action	**All nurses have been re-educated on the medication error policy along with appropriate steps to take when they become aware of a medication error. They have been given the handout for future reference.**
Person Responsible	**Director of Nursing**
Completion Date	**1/17/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 241.200**
Instances	**1**
Corrective Action	**Quality Assurance meeting was held on 1/17/23 to review December quality information. Meeting minutes from the previous meeting will be presented at each Quality meeting for approval and then filed appropriately with the CEO and Quality Director. All meetings for 2023 have been scheduled for the 3rd Tuesday of each month to ensure sustained compliance.**
Person Responsible	**CEO**
Completion Date	**1/17/2023**

Restraint and Seclusion Training (CPI) - IP Acute

Origin	**Credential Validation**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Instances	**3**
Corrective Action	**All direct care staff have completed a refresher course of the selected Emergency Safety Intervention technique (SAMA). Ongoing, HR has created a tracking spreadsheet to ensure all appropriate personnel complete a refresher on an annual basis and de-escalation training biannually.**
Person Responsible	**Director of Human Resources**
Completion Date	**1/13/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	**All direct care staff have completed a refresher course of the selected Emergency Safety Intervention technique (SAMA). During this course, all personnel were re-educated on the facility policy for restraint and seclusion. Ongoing, the policy attestation will be included in annual training education.**
Person Responsible	**Director of Human Resources**
Completion Date	**1/17/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	**All direct care staff have completed a refresher course of the selected Emergency Safety Intervention technique (SAMA). Ongoing, HR has created a tracking spreadsheet to ensure all appropriate personnel**

	complete a refresher on an annual basis and de-escalation training biannually.
Person Responsible	**Director of Human Resources**
Completion Date	**1/17/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	**All direct care staff have completed a refresher course of the selected Emergency Safety Intervention technique (SAMA). Included in the refresher course is the use of nonphysical intervention, i.e. verbal de-escalation. Ongoing, HR has created a tracking spreadsheet to ensure all appropriate personnel complete a refresher on an annual basis and de-escalation training biannually.**
Person Responsible	**Director of Human Resources**
Completion Date	**1/13/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	**All direct care staff have completed a retraining course on CPR. Evidence of training has been filed in the personnel files. Ongoing, HR has created a tracking spreadsheet to ensure all appropriate personnel complete a refresher prior to expiration of certification.**
Person Responsible	**Director of Human Resources**
Completion Date	**1/13/2023**

Deficiencies

DEF-0063842

Status	**Accepted**
Related To	**SURVEY-0005500**
Regulation	
Deficiency Statement	**The facility/staff was unable to describe the facilities narcotic count policy.**
Service Details	**Facility staff nurse could not describe the narcotic count policy regarding what the process is if a discrepancy in the narcotic count occurs.**

DEF-0063849

Status	**Accepted**
Related To	**SURVEY-0005500**
Regulation	
Deficiency Statement	**The staff/facility was unable to describe the medication error policy.**
Service Details	**Facility staff nurse could not describe the medication error policy.**

DEF-0063851

Status	**Accepted**
Related To	**SURVEY-0005499**
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-0064047

Status	**Accepted**
Related To	**SR012114**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: Expired 04/21/22**

DEF-0064049

Status	**Accepted**
Related To	**SR012115**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: Expired 11/27/22**

DEF-0064053

Status	**Accepted**
Related To	**SR012119**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: Expired 04/01/2022**

DEF-0064059

Status	**Accepted**
Related To	**SURVEY-0005499**
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	**Not all of the staff selected for review had 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-0064060

Status	**Accepted**
Related To	**SURVEY-0005499**
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	**Not all of the staff selected for review had 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-0064062

Status	**Accepted**
Related To	**SURVEY-0005499**
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	

DEF-0064063

Status	**Accepted**
Related To	**SURVEY-0005499**
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

CAP History

1/23/2023 9:54 AM

User [redacted]

Action **Changed Next Step:. Changed Record Type from Submitted to Completed. Changed CAP Response Notes. Changed Approved Date to 1/23/2023. Changed Approved By t[redacted]Changed Status from Submitted to Approved.**

1/17/2023 4:31 PM

User [redacted]

Action **Changed Submitted Date to 1/17/2023. Changed Submitted By to[redacted]Changed Next Step:. Changed Record Type from Requested to Submitted. Changed Status from Requested to Submitted.**

12/19/2022 4:01 PM

User [redacted]

Action **Changed Next Step:. Changed Record Type from New to Requested. Changed Date Requested to 12/19/2022. Changed Status from New to Requested.**

12/19/2022 4:00 PM

User [redacted]

Action **Created.**