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

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February 15, 2023

Woodridge of the Ozarks
Attn: Cassie Sowder, Chief Executive Officer
casowder@perimeterhealthcare.com
2466 South 48th Street, STE B
Springdale, AR 72762

The Division of Provider Services and Quality Assurance of the Arkansas Department of Human Services has contracted with Arkansas Foundation for Medical Care (AFMC) to perform Inspections of Care (IOC) for Inpatient Psychiatric for Under 21. The Medicaid Manual for Inpatient Psychiatric Services for Under Age 21 was used in the completion of this report.

Deficiencies were noted during the Inpatient Psychiatric Inspection of Care (IOC) conducted at the following service site on the specified dates:

Woodridge of the Ozarks
Provider ID #: [redacted]
Onsite Inspection Date: February 6, 2023

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 at the link provided.

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 noted two men sitting on sidewalk of facility smoking cigarettes within 25 feet of the main entrance. AFMC staff also noted a large pile of mail sitting unattended on sidewalk at the front door. Mail labels included client's names. AFMC staff was promptly greeted at the main entrance by a Woodridge of the Ozarks staff member. AFMC was immediately taken to an office on the administrative hallway where they were met by the Director of Clinical Services. 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, and December 5, 2022. A tour of the facility was completed with the Director of Clinical Services. Group activities and 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 areas that were toured included three client units, the seclusion room area, the school unit, gymnasium, outside grounds, and cafeteria. The following is a list of environmental observations noted during the facility tour.

- The three client units toured included Blue Unit, Orange Unit, and Green Unit.
    - Units appeared to be much cleaner than the past IOC visits. All client's beds were made, and the rooms did not have excessive trash and clutter which has been a problem noted on previous inspections.
    - Multiple walls and doors that previous had an excessive amount of profanity carved into the paint have been repainted recently.
    - The unit floors have been recently waxed and stripped and looked very clean.
    - As noted on previous inspections, each unit had missing floor tiles in the main hallways.
    - As noted on previous inspections, the client toilets in each room have 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.
    - The client's shower floors had recently been concreted or had plastic shower floor inserts placed to prevent injury or self-harm from sharp edges from the broken shower tiles or peeling epoxy. This was implemented due to a recent DHS Division of Child Care and Early Childhood Education visit on January 24, 2023.
- As noted on previous inspections, the rubber flooring outside of the seclusion room was overlapping causing a trip hazard.
- The client restroom outside of the seclusion room had excessive spills dried on the floor, the trash was overflowing, and there was a foul odor noted.
- Two classrooms were toured. There were twelve clients with three staff members and one teacher noted per class. Staff were calmly interacting with clients and providing a therapeutic environment that was conducive for learning and treatment therapies.
- Per the clinical director the outdoor area is not being utilized at the time due to the metal roof being replaced, which is causing the presence of sharp pieces of metal, screws, and other hazardous objects on the ground. Due to clients picking up scattered pieces of debris from the roof replacement and using it as contraband, staff decided to close the outside area until project is completed. Maintenance staff are going out frequently with a magnet to help keep area as clean as possible for safety of clients and staff.

- There were no issues noted in the gymnasium. It was noted that this area is shared with an adolescent outpatient day treatment provider that is housed next door and this facility was currently utilizing gymnasium as AFMC staff toured. There are two side doors in the gymnasium that open to the above mentioned outside area that is closed due to the metal roof being replaced. These gymnasium outside access doors must remain unlocked due to fire safety code, so currently the residential patients of Woodridge of the Ozarks have not accessed the gymnasium area in several weeks. The CEO did state later during the inspection that she has implemented an exercise plan that is being done on each unit at this time.
- There were no concerns noted in the cafeteria.

AFMC staff noted that while working in the office space provided on the administration hallway throughout the day, that the offices and hallways had a lot of staff traffic, and that privacy was lacking. Staff had multiple personal and inappropriate conversations that could be heard. The CEO conducted an interview with a Director of Nursing candidate that was also not private to the surrounding offices in that area.

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: 221.801; 42 CFR 482.130, 483.376	The facility has not complied with Medicaid, state, and federal reporting requirements of death, serious injury, or attempted suicide.	The provider had a reportable incident that occurred after-hours on January 31, 2023, however it was not reported until February 3, 2023. The provider also had a documented 521 visit from the Division of Child Care and Early Childhood Education.

Personnel Records- Licenses, Certifications, Training:

There were fourteen personnel records requested, two (25%) professional staff and twelve (27%) paraprofessional staff. During the review of the personnel records, no deficiencies were noted.

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. There was no active FFS Medicaid clients at the time of the inspection.

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 and on the units. 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.

AFMC staff did note that the hinge on narcotic box was found to be bent causing the narcotic box to not close properly. Narcotic box was still able to be locked but there was a small gap between the lid and side. This was reported to the Assistant Director of Nursing who stated they were already aware of the issue with the narcotic box and had she had been informed by someone that if the box could be locked, and the medication room door was locked the box was fine as this would be considered double locked.

Corrective Action Plan:

The CAP must be completed within 30 calendar days of the date of the email notice of the IOC report available for review. The IOC Report and Request for Corrective Action can be accessed through the link to AccessPoint, provided via email.

**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.
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CAP-0006722

Corrective Action Plan Details

CAP Number	CAP-0006722	**Provider Response Due**	
Inspection	DPSQA-0006722	**AFMC Response Due**	
Status	Approved	**Due Date Override**	
Cancellation Reason			
Date Requested	2/17/2023		

CAP Approval Process

Submitted Date	3/13/2023	**Submitted By**	Rebecca Thomas
CAP Returned Date/Time			
Approved Date	3/13/2023	**Approved By**	Ladeana Bell

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 1 deficiency areas submitted:
1 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 Shelley Ruth, 2/17/2023 4:47 PM **Last Modified By** Ladeana Bell, 3/13/2023 12:56 PM

Deficiency Areas

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 221.801; 42 CFR 482.130, 483.376**
Instances	**1**
Corrective Action	**All staff were re-educated on the incident reporting process, how to complete facility forms. A new drop box has been installed for a central location to submit incident notifications. In addition, the Administrator on Call calls into the facility every evening for a briefing on all incidents that have occurred after hours. The Director of Nursing obtains and reviews all incidents from the prior day and immediately reports any significant incidents to the appropriate agencies. The CEO is overseeing the process to ensure no delays occur.**
Person Responsible	**Chief Executive Officer**
Completion Date	**2/8/2023**

Deficiencies

DEF-0069682

Status	**Accepted**
Related To	**SURVEY-0005865**
Regulation	**Medicaid IP Sec. 2: 221.801; 42 CFR 482.130, 483.376**
Deficiency Statement	**The facility has not complied with Medicaid, state, and federal reporting requirements of death, serious injury, or attempted suicide.**
Service Details	**The provider had a reportable incident that occured after-hours on January 31, 2023, however it was not reported until February 3, 2023. The provider also had a documented 521 visit from the Division of Child Care and Early Childhood Education.**

CAP History

3/13/2023 12:56 PM

User	**Ladeana Bell**
Action	**Changed Next Step:. Changed Record Type from Submitted to Completed. Changed CAP Response Notes. Changed Approved Date to 3/13/2023. Changed Approved By to Ladeana Bell. Changed Status from Submitted to Approved.**

3/13/2023 11:47 AM

User	**Rebecca Thomas**
Action	**Changed Submitted Date to 3/13/2023. Changed Submitted By to Rebecca Thomas. Changed Next Step:. Changed Record Type from Requested to Submitted. Changed Status from Requested to Submitted.**

2/17/2023 4:54 PM

User	**Shelley Ruth**
Action	**Changed Next Step:. Changed Record Type from New to Requested. Changed Date Requested to 2/17/2023. Changed Status from New to Requested.**

2/17/2023 4:47 PM

User	**Shelley Ruth**
Action	**Created.**