April 12, 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: April 3, 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 pressed the entrance buzzer and waited several minutes before facility staff acknowledged the buzzer. AFMC staff was greeted at the main entrance by the Human Resource Director. AFMC waited in the waiting room for 30 minutes due to an internal meeting. The Human Resource Director updated AFMC staff regarding the wait time. AFMC staff was greeted by the Chief Executive Officer (CEO) and taken to their office to start the Inspection of Care. 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, December 5, 2022, and February 6, 2023. A tour of the facility was completed with the CEO. All clients were in the classroom setting except for one client who was in the comfort room with one-on-one staff observation. All staff members were observed interacting calmly and therapeutically with clients throughout the facility. The CEO was able to answer questions and show updates that the facility has made since last AFMC Inspections of Care.

The areas that were toured included the administration office hallways, three client units, the seclusion room area, the school unit, outside grounds, cafeteria, and medication room. The following is a list of environmental observations noted during the facility tour.

- The CEO stated since the last IOC visit this facility had started having their mail held instead of being left at the front door on the ground. The CEO stated this is a temporary fix until they decide what will be the best way to confidentially receive the facility mail.
- During the previous IOC, 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. AFMC staff noted during this visit that there was still a lot of staff traffic, but conversations were appropriate to the job duties of staff. AFMC staff also noted that there has been a sound machine placed outside of the CEO’s office for office privacy.
- The three client units toured included Blue Unit, Orange Unit, and Green Unit. No clients were on units during the tour.
    - Blue Unit:
        - Missing tiles in hallway floor that were noted on previous inspections were fixed.
        - Shower curtain in Room 103 had fallen. The CEO immediately notified maintenance. Shower curtain was being rehung using Velcro tabs before AFMC staff left unit.
        - There was clothing found hidden under the mattress in Room 103. The CEO stated they had recently implemented a policy that was limiting how much clothing each client is allowed to keep in their rooms and that the hiding of the clothing was due to this new policy change.
    - Orange Unit:
        - Vulgar slurs were noted written on a piece of paper hanging above the bed in Room 203. This was immediately removed by the CEO and taken to the Program Manager to be address with the client.
    - Green Unit:
        - Maintenance was noted to be fixing broken tile in hallway floor.
        - No issues noted on this unit.
    - All client units were clean, and all beds were made. No excessive trash noted. Chairs in the common areas had been rearranged to provide better line of sight for staff and cameras as well as to provide safety to staff and clients if a client had an outburst of behavior.

- Walls throughout the facility were noted to have been recently painted or touched up with paint where necessary.
- 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. Improvements have been made to the wooden coverings by adding extra pieces of wood and utilizing foam spray to fill in gaps so trash and personal items cannot be placed in the openings.

- Two classrooms were toured. Adequate staffing was noted in both classrooms. Staff were calmly interacting with clients and providing a therapeutic environment that was conducive for learning and treatment therapies.
- The outdoor area is opened back up for use by the clients. The previous visit the outdoor area was not being utilized due to the metal roof being replaced, which was causing the presence of sharp pieces of metal, screws, and other hazardous objects on the ground. Due to the wind still blowing metal debris off the roof, staff are going out prior to outdoor area being utilized by clients with a magnet to help keep area as clean as possible for safety of clients and staff. The outdoor area was clean and well maintained. There is a new four square painted on the basketball court.
- There were no concerns noted in the cafeteria. One wall had the handprints of recent facility graduates painted on it since the last IOC visit.

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: 221.804; 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.	On some of the certifications for staff uploaded it was unidentifiable if the staff had training in 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.	The provider lacked evidence that all personnel 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.	The provider lacked evidence in the personnel records that all direct care personnel are trained, as well as demonstrate competency, in facility's Restraint and policy and appropriate procedures to be used in Restraint and Seclusion interventions on a semiannual basis.
Medicaid IP Sec. 2: 215.220, 218.000 42 CFR: 441.156	There is no documentation that all direct care personnel hold current licenses, as required by their position	Out of the professionals chosen for file review, the provider lacked evidence of professional licenses for

	and profession and/or licensing authority.	one of them. That individual was identified as a therapist on the staff list.
	Multi-dose vial facility policy was not followed.	Multi-dose vial of TB skin test opened but not dated or initialed.

Personnel Records- Licenses, Certifications, Training:

There were a total of 12 personnel records requested, two (25%) professional staff and 10 (26%) paraprofessional staff. During the review of the personnel records, the following deficiencies were noted:

Personnel Record Number	Rule	Credential Validated	Outcome	Reviewer Notes
SR013515	Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376	Restraint and Seclusion Training (CPI)	Failed	The employee's certification uploaded indicates that the certification expires on 06/30/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 06/30/2021.
SR013517				The employee's certification uploaded indicates that the certification expires on 12/15/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 10/10/2020.
SR013519				The employee's certification uploaded indicates that the certification expires on 06/30/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 06/30/2021.
SR013521				The employee's certification uploaded indicates that the certification expires on 12/15/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment

				uploaded indicates the training occurred on 02/16/2022.
SR013522				The employee’s certification uploaded indicates that the certification expires on 04/01/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 09/28/2022.
SR013524				The employee’s certification uploaded indicates that the certification expires on 11/16/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 11/14/2022.
SR013527				The employee’s certification uploaded indicates that the certification expires on 06/30/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 07/09/2020.
SR013728				The employee’s certification uploaded indicates that the certification expires on 12/15/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 10/21/2021.
SR013514	215.220, 218.000	Professional Licenses	Failed	No file submitted for review.

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, no client interviews were conducted.

Clinical Record Review Deficiencies:

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

Program Activity/Service Milieu Observation:

Staff and clients 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. A tour of the medication room was completed with the medication nurse. An open vial of TB skin test was observed in medication refrigerator in nurse's station that was not labeled with date of opening and with nurse's initials.

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

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

- Close Window
- Print This Page
- Expand All | Collapse All

CAP-0007005

Corrective Action Plan Details

CAP Number	CAP-0007005	**Provider Response Due**	
Inspection	DPSQA-0007005	**AFMC Response Due**	
Status	Approved	**Due Date Override**	
Cancellation Reason			
Date Requested	4/18/2023		

CAP Approval Process

Submitted Date	6/21/2023	**Submitted By**	Rebecca Thomas
CAP Returned Date/Time			
Approved Date	6/22/2023	**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 7 deficiency areas submitted:
7 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, 4/18/2023 3:15 PM **Last Modified By** Ladeana Bell, 6/22/2023 10:08 AM

Deficiency Areas

Restraint and Seclusion Training (CPI) - IP Acute

Origin	**Credential Validation**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Instances	**8**
Corrective Action	**Facility has made the transition to a new ESI technique model, Handle With Care. All staff have been trained on Handle With Care to include verbal de-escalation and physical intervention techniques. Evidence of training is filed in the employee's training file. Ongoing, Director of Human Resources will maintain a tracking spreadsheet to ensure de-escalation training as well as imminent danger situations that require physical intervention is scheduled within 6 months of prior training.**
Person Responsible	**Director of Human Resources**
Completion Date	**5/26/2023**

Professional License or Certificate - IP Acute

Origin	**Credential Validation**
Regulation	**215.220, 218.000**
Instances	**1**
Corrective Action	**License verification has been completed for all professional staff that require a license. Ongoing, human resources department will verify license prior to date of hire to ensure active license is present. All active employees license expirations are being tracked on spreadsheet with HR to ensure licenses are verified prior to expiration.**
Person Responsible	**Director of Human Resources**
Completion Date	**5/15/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 215.220, 218.000 42 CFR: 441.156**
Instances	**1**
Corrective Action	**License verification has been completed for all professional staff that require a license. Ongoing, human resources department will verify license prior to date of hire to ensure active license is present. All active employees license expirations are being tracked on spreadsheet with HR to ensure licenses are verified prior to expiration.**
Person Responsible	**Director of Human Resources**
Completion Date	**5/15/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	**All staff have completed training of Handle With Care. During this training, all staff reviewed the restraint policy evidenced with a signed attestation. Ongoing, staff will receive review of policy during the 6 month training. This is tracked on the HR spreadsheet to ensure training is provided within 6 months of prior training.**
Person Responsible	**Director of Human Resources**
Completion Date	**5/26/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	**Facility has made the transition to a new ESI technique model, Handle With Care. All staff have been trained on Handle With Care to include verbal de-escalation and physical intervention techniques. Evidence of training is filed in the employee's training file. Ongoing, Director of Human Resources will maintain a tracking spreadsheet to ensure de-escalation training as well as imminent danger situations that require physical intervention is scheduled within 6 months of prior training.**

Person Responsible	**Director of Human Resources**
Completion Date	**5/26/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	**Facility has made the transition to a new ESI technique model, Handle With Care. All staff have been trained on Handle With Care to include verbal de-escalation and physical intervention techniques. Evidence of training is filed in the employee's training file. Ongoing, Director of Human Resources will maintain a tracking spreadsheet to ensure de-escalation training is scheduled within 6 months of prior training.**
Person Responsible	**Director of Human Resources**
Completion Date	**5/26/2023**

Med Pass/Administration

Origin	**Survey**
Regulation	
Instances	**1**
Corrective Action	**Employee Health Nurse responsible for administration of TB skin test was re-educated on the multi-dose vial policy. Additional training provided to all nursing staff to re-enforce policy requirements. DON will audit all multi-dose vials on a weekly basis to ensure policy is being followed.**
Person Responsible	**Director of Nursing**
Completion Date	**5/15/2023**

Deficiencies

DEF-0076124

Status	**Accepted**
Related To	**SR013515**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: The employees certification uploaded indicates that the certification expires on 06/30/2023, however it does not indicate when to training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 06/30/2021.**

DEF-0076125

Status	**Accepted**
Related To	**SR013517**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: The employees certification uploaded indicates that the certification expires on 12/15/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 10/10/2020.**

DEF-0076126

Status	**Accepted**
Related To	**SR013519**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: The employees certification uploaded indicates that the certification expires on 06/30/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 06/30/2021.**

DEF-0076186

Status	**Accepted**

Related To	**SR013521**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: The employees certification uploaded indicates that the certification expires on 12/15/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 02/16/2022.**

DEF-0076188

Status	**Accepted**
Related To	**SR013522**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: The employees certification uploaded indicates that the certification expires on 04/01/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 09/28/2022.**

DEF-0076207

Status	**Accepted**
Related To	**SR013524**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: The employees certification uploaded indicates that the certification expires on 11/16/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 11/14/2022.**

DEF-0076211

Status	**Accepted**
Related To	**SR013528**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: The employees certification uploaded indicates that the certification expires on 12/15/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 10/21/2021.**

DEF-0076209

Status	**Accepted**
Related To	**SR013527**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: The employees certification uploaded indicates that the certification expires on 06/30/2023, however it does not indicate when training was completed to ensure that the staff has completed a refresher course at least every six months. The Comprehensive Performance Assessment uploaded indicates the training occurred on 07/09/2020.**

DEF-0076212

Status	**Accepted**
Related To	**SR013514**
Regulation	**215.220, 218.000**
Deficiency Statement	**Failed Validation**
Service Details	**No File Received**

DEF-0076216

Status	**Accepted**

Related To	**SURVEY-0006283**
Regulation	**Medicaid IP Sec. 2: 215.220, 218.000 42 CFR: 441.156**
Deficiency Statement	**There is no documentation that all direct care personnel hold current licenses, as required by their position and profession and/or licensing authority.**
Service Details	**Out of the professionals chosen for file review, the provider lacked evidence of professional licenses for one of them. That individual was identified as a therapist on the staff list.**

DEF-0076217

Status	**Accepted**
Related To	**SURVEY-0006283**
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	**The provider lacked evidence in the personnel records records that all direct care personnel are trained, as well as demonstrate competency, in facility's Restraint and policy and appropriate procedures to be used in Restraint and Seclusion interventions on a semi annual basis.**

DEF-0076218

Status	**Accepted**
Related To	**SURVEY-0006283**
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	**The provider lacked evidence that all personnel 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-0076219

Status	**Accepted**
Related To	**SURVEY-0006283**
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	**On some of the certifications for staff uploaded it was unidentifiable if the staff had training in 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.**

DEF-0075912

Status	**Accepted**
Related To	**SURVEY-0006284**
Regulation	
Deficiency Statement	**Multi-dose vial facility policy was not followed.**
Service Details	**Multi-dose vial of TB skin test opened but not dated or initialed.**

CAP History

6/22/2023 10:08 AM

User	**Ladeana Bell**
Action	**Changed Next Step:. Changed Record Type from Submitted to Completed. Changed CAP Response Notes. Changed Approved Date to 6/22/2023. Changed Approved By to Ladeana Bell. Changed Status from Submitted to Approved.**

6/21/2023 9:44 AM

User	**Rebecca Thomas**
Action	**Changed Submitted Date to 6/21/2023. Changed Submitted By to Rebecca Thomas. Changed Next Step:. Changed Record Type from Requested to Submitted. Changed Status from Requested to Submitted.**

4/18/2023 3:16 PM

User	**Shelley Ruth**
Action	**Changed Next Step:. Changed Record Type from New to Requested. Changed Date Requested to 4/18/2023. Changed Status from New to Requested.**

4/18/2023 3:15 PM

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

Copyright © 2000-2023 salesforce.com, inc. All rights reserved.