August 30, 2024

The Division of Provider Services and Quality Assurance (DPSQA) 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 Services for Under 21. The Medicaid Manual for Inpatient Psychiatric Services for Under Age 21 was used in the completion of this report.

An incident occurred at the following service site that prompted an order for an additional review. Upon review of the policies relevant to the incident, the findings are noted below:

Woodridge of The Ozarks
2466 S 48th St, Ste B
Springdale, AR 72762-6683
Provider Medicaid Number: [redacted]
Onsite Inspection Date: August 27, 2024
Onsite Inspection Time: 8:47 a.m.

A summary of the policies reviewed, and findings are noted below:

Inspection of Care Summary

Health and Safety-Policy Review

This additionally ordered inspection was triggered by a complaint against Woodridge of The Ozarks (provider). Based on the nature of the incident, the following were requested for review:

- Policies for restraint and seclusion, staff ratios, and medication administration.
- Quality Assurance Meeting minutes
- Evidence of Critical Incident reporting
- Restraint and Seclusion log
- Schedules of shifts worked by staff
- Current and terminated (since March 1, 2024) staff records- to focus on training.

Policies and Procedures Findings:

Upon review of the identified policies, procedures, and certification requirement, the following deficiencies were noted:

Health and Safety Deficiencies:

Rule Found Deficient	Specific Rule Violation(s)	Reviewer Notes
Medicaid IP Sec. 2: 42 CFR: 482.130, 483.376	HR records did not indicate that all direct care personnel are currently certified in cardiopulmonary resuscitation (CPR).	The provider lacked evidence of all direct care personnel being currently certified in cardiopulmonary resuscitation (CPR).
Medicaid IP Sec. 2: 42 CFR: 482.130, 483.376	There is no documentation in the HR records that all direct care personnel are trained in the facility's Restraint and Seclusion	The provider lacked evidence of all direct care personnel being trained, as well as demonstrating competency in the facility's Restraint and Seclusion policy and appropriate procedures to be used in Restraint and Seclusion

	policy.	interventions.
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 facility's Director of Risk Management stated they have not been reporting critical events and incidents to the Office of Long-Term Care as required. They also have documentation of delays in reporting critical events and incidents of timeframes much greater than the immediate requirement for hotline calls and the 24-hour requirement for other Medicaid, state, and federal reporting requirements.
Medicaid IP Sec. 2: 221.801 42 CFR: 483.374	The facility has not submitted to Arkansas Medicaid a Letter of Attestation that the facility is in compliance with CMS standards regarding the use of Restraint and Seclusion.	The facility lacked evidence of submission to Arkansas Medicaid a Letter of Attestation that the facility is in compliance with CMS standards regarding the use of Restraint and Seclusion.
Medicaid IP Sec. 2: 221.804 42 CFR: 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 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: 221.804 42 CFR: 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.	The provider lacked evidence that all direct care personnel have ongoing education, training, and demonstrated knowledge 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: 241.200	Written Quality Assurance committee minutes were not available for review.	AFMC staff requested Quality Assurance committee meeting minutes from January 2024 through August 2024. Provider only provided minutes for May, June, July, and August 2024 stating there were no meeting minutes available prior to this date. AFMC staff noted that this has been an ongoing issue with previous inspections due to multiple changes over the last 2 years in Administration positions.
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 and profession and/or licensing authority.	The provider lacked evidence of current licenses for all positions that require licensing. One registered nurse reviewed did not have evidence of current licenses.

Facility Tour:

Upon arrival to facility, AFMC staff was greeted at the locked entrance by a staff nurse who stated they would let someone in administration know AFMC was onsite to conduct an Inspection of Care. AFMC staff signed the visitor log in the lobby while waiting. After several minutes the Director of Maintenance and the Chief Executive Officer entered the lobby to verify again the reason for the Inspection of Care visit. AFMC staff were informed that two other agencies (Licensing and Office of Long-Term Care) were also onsite and stated they were checking to see if the other agencies would accommodate AFMC staff in the Conference Room as there is limited space in the facility to set up for an inspection. A staff nurse came to the lobby and AFMC staff were taken to a conference room to begin the Inspection of Care. After an hour in the conference room, the Director of Risk Management came in and was given the Document Request Form and AFMC staff

discussed the requirements for the Inspection of Care. AFMC staff received the completed and signed consent form listing approval for access to the AFMC portal prior to arrival for site visit.

A tour of the facility was completed with the Chief Executive Officer and the Director of Risk Management. Areas toured included the seclusion room, medication room and nurses' station cafeteria, three girls' units, gymnasium, an outdoor courtyard, and the educational classroom unit. The three girls' units, Blue Unit, Orange Unit, and Green Unit, each have a day room with a television, a small table and several chairs. The area provides adequate space for group sessions and activities. Each unit also has five client rooms with two beds in each room. Each room includes a bathroom with a sink, toilet, and shower. Room [redacted] on the Orange Unit had client hygiene products with full size bottles of shampoo and body wash left in the bathroom shower. The CEO had facility staff remove bottles and place them back in the hygiene supply closet.

AFMC RN visited with the facility medication nurse who showed AFMC RN the facility policies and procedures regarding medication administration, narcotic count/reconciliation/handling, and medication discrepancies. Facility nurse was able to verbalize the step-by-step process of medication delivery including the demonstration of the five rights of medication administration, documentation of medication delivery, verification of client taking medication including mouth/cheek checks, how clients are educated about each medication, and verbalized the process utilized when a client refuses medication. The facility nurse was unable to describe the process of medication errors and the process if there is a discrepancy in the controlled substance count. In the medication refrigerator, there were two open multi-dose vials of TB skin test not dated or initialed upon opening per policy and standard practice. This was reported to the CEO during the facility tour. The medication room was well organized and clean.

On the Orange Unit there was a male staff member sitting with a female client at the table in the dayroom. The client was on unit restrictions for suicide precautions. The client was working on schoolwork and the staff member was appropriately interacting with client. Both the staff member and client were in direct view of the security camera.

Two educational classes were in session on the school unit. The CEO stated that one class that was in session is a new tutoring program that had just been started. She stated the clients really seemed to be enjoying the programing and had already started showing improvement in their classroom work. Both classrooms were staffed adequately and were in ratio. All clients appeared to be engaged in classroom activities and lectures. Staff members and teachers were calmly interacting with clients and providing a therapeutic environment that was conducive to learning.

Overall, the facility environment was noted to be clean and well-organized. Staff were able to answer questions regarding the facility. There were no immediate safety concerns found during the facility tour.

Personnel Records – Licenses, Certifications, Training:

Based on the nature of the incident, personnel records were reviewed. The findings are noted below:

Personnel Record Number	Rule	Credential Validated	Reviewer Notes
Medicaid IP Sec. 2: 221.804 42 CFR: 482.130, 483.376	Restraint and Seclusion Training (CPI)	SR017883	Last completed August 25, 2023.
		SR017884	No file received.
		SR017886	Last completed January 26, 2024.
		SR017887	No file received.
		SR017888	No file received.
		SR017889	No file received.
		SR017892	Last completed August 21, 2023.
		SR017894	No file received.

		SR017895 SR017896 SR017897 SR017898	Last completed January 23, 2024. Last completed August 21, 2023. Staff member was terminated on [redacted] 2024, for inappropriate restraint techniques occurring on [redacted] 2024. Last completed August 21, 2023. Staff member was terminated on [redacted] 2024, for inappropriate restraint techniques occurring on [redacted] 2024. Last completed August 25, 2023. Staff member was terminated on [redacted] 2024, for inappropriate restraint techniques occurring on [redacted] 2024.
Medicaid IP Sec. 2: 215.220, 218.000	Professional License or Certificate - IP Acute	SR017893	The provider lacked evidence of professional licenses within the personnel file.
Medicaid IP Sec. 2: 241.110B	Child Maltreatment	SR017893	No file received.
Medicaid IP Sec. 2: 241.110B	State Background Check	SR017885 SR017893 SR017895 SR017896	No file received.
Medicaid IP Sec. 2: 221.804C	CPR training	SR017883 SR017885 SR017887 SR017888 SR017890 SR017891 SR017893	No file received.

Clinical Review Deficiencies:

Based on the client being from out of state or assigned to a PASSE, no client records were reviewed.

Summary of Findings and Resolution:

- The Medication Error Policy does not state that the facility will report errors that cause physical harm or injury to appropriate state and federal agencies. The policy indicates they will be reported immediately to the Medical Director, Executive Director, and Director of Nursing.

- The personnel records reviewed all contained a signed mandated reporter statement.

- The incident reporting policy does not identify the requirement for reporting any incidents to state and/or federal agencies as required by law. The Director of Risk Management identified that they had not been reporting to the Office of Long-Term Care. This is something that AFMC has discussed with the provider on multiple occasions, specifically the Director of Nursing.

- The provider submitted a policy to identify Reporting Assaults to Juvenile Authorities- policy number 7.53. It is identified within procedure section A. “When a staff member is physically assaulted and injuries result, an incident report and a First Report of Injury will be completed. The employee may wish to press charges against the resident. If so, the employee must review with their supervisor and the notify the Executive Director prior to pressing charges.” The staff member at Woodridge of the Ozarks did not follow policy and procedure when she left during

shift to go file a police report, came back to the facility and called again to file another report regarding a second incident of assault.

- The provider has had a large turnover in staff including the Chief Executive Officer, Director of Risk Management, Clinical Director, and Human Resources manager.

- As a trend, AFMC has noticed that the Quality Assurance meeting minutes and other reportable information no longer exist after the exit of each Chief Executive Officer. The provider has had three Chief Executive Officers since the last inspection in December of 2023.

It is recommended that the provider train all staff and keep training and evidence of that training current. This training should include Handle with Care and Mandated Reporting requirements. It is recommended that the provider reports all critical incidents within the appropriate timeframes to the Office of Long-Term Care, Disability Rights, DHS and any other required entity.

Respectfully,

Inspection of Care Team
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Improving health care. Improving lives.

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