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

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October 16, 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: October 14, 2024
Onsite Inspection Time: 8:46 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. Based on the nature of the incident, the following were requested for review:

- Restraint and Seclusion Policy
- Staff Ratio Policy
- Incident Reporting Policy
- Quality Assurance Meeting minutes
- Evidence of Critical Incident reporting
- Restraint and Seclusion Log
- Schedules of shifts worked by staff
- Attestation Letter
- Personnel records for staff members involved in any incidents occurring on September 28, 2024, and September 29,2024
- Client records for three Arkansas PASSE clients involved in any incidents occurring on September 28, 2024, and September 29,2024

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: 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.	A serious occurrence occurred on September 29, 2024, and the report was not sent to the required reporting entities until September 30, 2024, at 6:36 p.m. Therefore, the provider was not in compliance with the

		reporting timeframe of the next business day.
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 the facility's Restraint and Seclusion policy.	The provider lacked evidence of semi-annual training for all direct care personnel, as well as demonstrated competency in facility's Restraint and Seclusion policy and appropriate procedures to be used in Restraint and Seclusion interventions.
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 of 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.

Observation:

AFMC conducted an additionally ordered inspection of care on August 27, 2024. At that time the provider lacked evidence of submission by July 21st of the current year to Arkansas Medicaid a Letter of Attestation that the facility is in compliance with CMS standards regarding the use of Restraint and Seclusion. The provider was able to show evidence that a current Letter of Attestation was signed by the CEO on 08/28/24 (the day after the last IOC) and was submitted by mail on 09/04/24.

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. Another staff member returned to the lobby and AFMC staff were taken to the conference room to begin the Inspection of Care. The Chief Executive Office and the Director of Human Resources came to the conference room immediately. Facility staff were 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.

AFMC staff requested a tour of the facility with the Director of Nursing. When questioned by the CEO regarding whether it had to be the Director of Nursing conduct the tour AFMC shared with the CEO that at the last several inspections of care the Director of Nursing had been unaccounted for either due to being on Paid Time Off or because they had chosen not to be engaged in the inspection of care. The CEO informed AFMC staff that the Director of Nursing had requested PTO for that day but had decided to come in to work.

A tour of the facility was completed with the Chief Executive Officer and the Director of Nursing. 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, Orange Unit (younger girls), Blue Unit (middle school aged girls), and Green Unit (teenage girls), 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. Beds are wooden frames that have previously had a piece of pressed wood holding the mattress within the solid wood frame. Recently, the Director of Maintenance has replaced the pressed wood with a solid piece of plywood as the clients were peeling back pieces of the pressed wood to use for self-harm. AFMC staff did observe graffiti with profanity on the wall of the day room on the Green Unit. The CEO immediately notified maintenance to remove/paint over graffiti.

AFMC staff observed one staff member standing at the central nurses' station yelling "hold on" several times over their shoulder at what appeared to be a client. Two other staff members were observed at the desk calmly completing tasks.

Staff and clients were noted in the outside courtyard in what appeared to be free time. Several clients were sitting with staff at a picnic table and were engaged in conversations. Several other clients were noted to be sitting on the ground quietly enjoying the cooler weather and fresh air. Staff members were noted to be calmly interacting with clients and providing a therapeutic environment. Staffing was in ratio with facility policy.

Another group of clients were noted in the cafeteria eating lunch. Staff were noted to be engaged with clients and helping with lunch. Clients were noted to be calm and quiet when AFMC staff walked through the cafeteria. After AFMC staff exited the cafeteria into the hallway outside the cafeteria the staff member that had been yelling previously in the nurses' station area was observed walking into the cafeteria with a client. Upon entering the cafeteria AFMC staff observed this staff member through the window interacting with clients in a way that appeared to upset the milieu causing some of the clients who had previously appeared calm to start getting up and moving around the cafeteria. AFMC staff did speak to the CEO and the Director of Risk Management in the exit summary regarding staff training in dealing appropriately with clients and making sure they understand how their body language and tone can be a trigger to escalating behaviors of clients.

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
SR018310	Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376	Restraint and Seclusion Training (CPI)	Training was last completed October 20, 2023. The requirement is for staff to be trained every six (6) months.
SR018323	241.100B	State Criminal Background Check	No file received.

Clinical Review Deficiencies:

Three Arkansas PASSE client records for being involved in the incidents occurring on September 28, 2024, and September 29, 2024, were chosen for record review. The provider uploaded records which were then reviewed for compliance with licensure standards. Based on the review of clinical components of licensure requirements, the following deficiencies were noted:

Rule Found Deficient	Specific Rule Violation(s)	Record	Reviewer Notes
RR0036387	IP Psych 217.000	There is no documentation of a Social Evaluation conducted by professional staff or the evaluation was not conducted within 60 hours of admission.	The Social Evaluation submitted for review was completed 85 hours after the client was admitted to the facility, which is greater than the requirement of 60 hours after admission.
RR0036388	IP Psych 217.000	There is no documentation of a Social Evaluation conducted by professional staff or the evaluation was not conducted within 60 hours of admission.	The Social Evaluation submitted for review was signed as completed 12 days after the client admitted to the facility, which is greater than the requirement of 60 hours after admission.
RR0036388	IP Psych 218.100	The Individual Plan of Care was not completed in the appropriate time frame.	The initial Individual Plan of Care was completed 17 days after the client's admission to the facility.

Observations: The following observations were noted with the clinical review portion of the IOC:

- Chart #RR0036387 reviewed had the psychiatric evaluation completed by a nurse practitioner on [redacted]24 at 8:00 p.m. but was not signed by physician until [redacted]24 at 11:00 a.m.
- Chart #RR0036388 reviewed had the psychiatric evaluation completed by the nurse practitioner on [redacted]24 at 6:50 p.m. but was not signed by physician until [redacted]24 at 4:59 p.m.

Summary of Findings and Resolution:

- Upon review of the Restraint and Seclusion Log of the previous 30 days a trend was noted that most occurrences of physical restraints, chemical restraints, and seclusion happens from 6:00 p.m. until 10:00 p.m. This trend was

shared with the CEO and Director of Risk Management who stated that evening shift change is a really hard time for staff and clients, and they have also noticed that trend.

- Upon review of the Restraint and Seclusion Log and the Emergency Safety Intervention Packets received for September 28, 2024, and September 29, 2024, the following observations were noted:
    - There were fourteen episodes of restraints and seclusion initiated during a one hour and thirty-four-minute time frame (from 7:53 p.m. until 9:27 p.m.) involving nine clients.
    - There were ten episodes of restraints and seclusion initiated during a one hour and twenty-five-minute time frame (from 7:11 p.m. until 8:36 p.m.) involving four clients.
    - The nursing narrative note in the Emergency Safety Intervention Packets were noted to be the same note copied and placed in multiple packets instead of being individualized to each client's behavior. The nursing narrative notes that were copied to multiple packets referred to all residents being dysregulated and verbally aggressive and "some became physically aggressive". The note describes the milieu as a whole and not the individual client that was restrained. By reading the nursing narrative, a physical restraint was not always warranted.
    - The front page of the Emergency Safety Intervention Packet has an area for short answer justification of why the restraint and seclusion of the client was needed. Documentation from nursing staff included statements such as, "physical aggression toward staff" or "resident had aggressive behavior", but the narrative note does not state any actual behaviors leading up to why they needed restraint or seclusion.
    - One nursing narrative note for September 29, 2024, it was noted that the nurse documented "the attitude and defiance toward staff has continued all day from last night", but no serious occurrences or incidents with any clients or staff requiring restraint or seclusion was documented on the dayshift.
- Upon review of the staffing versus client ratios for both dayshift and nightshift for September 28, 2024, and September 29, 2024, it was noted that all shifts were staffed within the facility's policy and the regulatory standard for staff to client ratio.
- AFMC staff did note that one of the Serious Occurrence Forms was not reported within the correct timeframe. The incident occurred on Sunday, September 29, 2024, at 1:00 a.m., where a client had a piece of wood and self-harmed, resulting in a laceration to the right forearm. The client was transported to [redacted] and received six stitches. The occurrence should have been reported within 24 hours on the next business day. The report was not received to the appropriate agencies until Tuesday, October 01, 2024, due to the Director of Risk Management did not send it before the close of business the next day. The Director of Risk Management stated that they did not realize that close of business meant receiving by 5:00 p.m.

Respectfully,

Inspection of Care Team
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