STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L112	A. BUILDING _____ B. WING _____	C 10/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA FAMILY HEALTH AND FITNESS CENTER FOR CHILDRE	815 E ST LOUIS HAMBURG, AR 71646

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. Compliant #AR00023632 was unsubstantiated.	N 000		
N 207	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of	N 207	N207 Facility Reporting Step 1 Corrective Action On 11-06-2019 upon notice of deficient practice the Program Director reported a serious occurrence involving clients #1 and #3 to the State designated Protection and Advocacy System to ensure the following: A. Serious occurrences are reported to the State designated Protection and Advocacy System for client #1 and #3. B. ON 10-29-2019 the facility Policy and Procedure Committee (Administrator,Program Director,Medical Director,Director of Nursing,Human Resources Director, CEO) reviewed and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 11-07-2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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N 207	Continued From page 1 business the next business day after a serious occurrence. The report must include - the name of the resident involved in the serious occurrence, - a description of the occurrence and, - the name, street address, and telephone number of the facility. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure serious occurrences which involved injury were reported to the state advocacy agency to allow for oversight as deemed necessary for 2 (Clients #1 and #3) of 3 (Clients #1, #2 and #3) sampled clients who were involved in an emergency safety situation. The findings are: 1. Client #1 had diagnoses of Major Depressive Disorder without Psychotic Features, Posttraumatic Stress Disorder, and Disruptive Mood Dysregulation Disorder. A Critical Incident Report Form dated 10/6/19 documented, "...Injury [checked], Physical Restraint [checked], Chemical Restraint [checked]...[at approximately] [4:36 p.m.] [Client#1] was outside and became angry when he seen [Client #2] kick [Client #3] in the face while [Client #3] was in a physical hold... [Client #1] and [Client #2] began to charge at each other with closed fists. [Behavior Coach #1/Shift Leader] tried to deescalate [Client #1]... continued being aggressive by trying to get to [Client#2]. Client #2 was calm. [Behavior Coach #2] attempted to explain to [Client #1]that if he continued walking toward [Client #2] with his fist balled up he would be placed in a physical hold...	N 207	N 207 Facility Reporting CFR(s) 483.374(b) continued. updated the facilities policy and procedures ensuring notification of serious occurrences are made to the State designated Protection and Advocacy System. No additional negative findings were found. Step 2 Identification of others with the potential of being affected. On 10-29-2019, Administrator reviewed the facilities policy and procedures and immediately identified all 22 residents as having the potential to be affected by the deficient practice. On 10-29-2019 the Director of Nursing reviewed the critical incident reports for 22 residents, to ensure serious occurrences are being reported to the State designated Protection and Advocacy System, to determine if those residents were affected. No additional negative findings were found. Step 3 To ensure the negative practice does not recur: On 10-29-2019, the Director of Nursing conducted a in service training with the nursing staff to ensure serious occurrences are reported to the State designated Protection and Advocacy System. On 10-29-2019, the Director of Human Resources conducted a in service training with all administrative staff to ensure serious occurrences were reported to the State	

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N 207	Continued From page 2 [Behavior Coach #2] attempted to open-hand escort [Client #1] away from [Client #2] where he became combative by hitting her on her chin and breast with his fist, elbowing and pulling away from her, trying to get to [Client #2]. Code Yellow was called and [Client #1] was placed in a physical hold... [Client #1] continued to be combative during the physical hold. [Client #1] hit Shift Leader in the face twice with closed fists and began to spit. [Client #1] then tucked his hands under his upper body refusing to untuck his arms and lay them flat. [Behavior Coach #2 and Shift Leader] struggled to get [Client #1's] arms from under his body while using his body weight to press down on his hands and arms on the ground. [Behavior Coach and Shift Leader] finally worked his arms from under his body to keep from [Client #1] harming himself. As we got [Client #1] arm from under his body, we noticed his pinky was bent and bleeding. Nurse on duty was notified... Nurse on Duty checked him out and decided he needed to have medical treatment at the ER [emergency room]..." 2. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Polysubstance Abuse and Victim of Abuse and Neglect. A Critical Incident Report Form dated 10/6/19 documented, "...Injury [checked], Client [checked], Physical Restraint [checked]...[at approximately] 4:30 p.m. [Client #3] began provoking his peer by calling them names... [Behavior Coach #3] told [Client #3] he would earn negatives for provoking his peer. [Client #3] then stated, 'I don't give a [expletive].' [Client #2] then walked over by the picnic area and [Client #3] ran toward [Client #2] and punched [Client #2]	N 207	N207 Facility Reporting CFR(s) 483.374(b) continued. designated Protection and Advocacy System and that it has been added to the facilities policy and procedures. Step 4 The facility Program Director will monitor to ensure serious occurrences which involve injury are reported to the State designated Protection and Advocacy system by observation and documenting on facility serious occurrence reporting compliance form, once a week for 8 weeks or until compliance is verified by OLTC. Any negative findings will be corrected immediately and the Administrator will be notified. Completion date 11-07-2019	

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N 207	Continued From page 3 in the face several times with a closed fist. [Behavior Coach #3] placed [Client #3] in a physical hold to keep from harming self or others. During the physical hold [Client #3] became more aggressive by hitting [Behavior Coach #3] in the head several times with a closed fist. [Client #2] then came up and kicked [Client #3] in the face. [Behavior Coach #4] then open-hand escorted [Client #2] out the way to another area. [Client #3] then worked his way out of the physical hold and began to punch [Behavior Coach #3] in the back of the head with closed fists. [Client #3] stated that [Behavior Coach #3] hit him in the face...Client was treated and released back to his hallway..." 3. On 10/09/19 at 12:53 p.m., the Administrator was asked who had been notified of the serious occurrences and the Administrator stated, "Child welfare licensing, the State Police, the Office of Long Term Care and the Guardians." The Administrator was asked if the State Advocacy group was notified, the Administrator stated, "No, we did not know we needed to." 4. The facility policy "Reporting Critical Incidents" provided by the Administrator with a revised date of August 2012 documented, "...The facility must report each serious occurrence that may be due to the use of restraint to both the State Medicaid Agency, Child Welfare Licensing Specialist, and the Child Abuse Hotline..." The policy did not address notification to the State Advocacy group.	N 207		