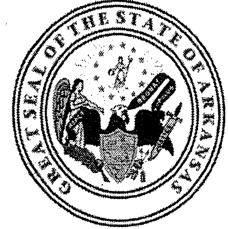
**Division of Provider Services and Quality Assurance**
**Office of Long Term Care**
http://humanservices.arkansas.gov/dms/Pages/oltcHome.aspx
PO Box 8059, Slot S404, Little Rock, AR 72203-8059
Fax: 501-682-6159




**CERTIFIED MAIL # 7017 0190 0000 3768 2157**

February 12, 2019

Dean Hill, Administrator
Delta Family Health And Fitness Center For Childre
815 E St Louis
Hamburg, AR 71646

**IMPORTANT NOTICE – PLEASE READ CAREFULLY**

Dear Mr. Hill:

On January 29, 2019 the Office of Long Term Care conducted a Complaint survey to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid program. This survey found that your facility was not in compliance with conditions of participation that resulted in Immediate Jeopardy conditions as specified in the attached CMS 2567. The Immediate Jeopardy was removed on January 29, 2019. The facility failed to meet the Condition of Participation for Use of Restraint and Seclusion. Specifically, the facility was not in compliance with the following requirements:

483.354 Use of Restraints and Seclusion
483.356 (a)(1) Protection of Residents
483.356 (a)(1)(3) Protection of Residents

The CMS 2567 "Statement of Deficiencies and Plan of Correction" with all deficiencies identified during the complaint survey on January 29, 2019 is enclosed.

**Remedies**
Based on the deficiencies cited, we are recommending to the State Medicaid Agency (SMA) the immediate imposition of the following remedies:

Termination of the provider agreement effective March 15, 2019 if substantial compliance is not achieved by that date.

**Plan of Correction**
**A Plan of Correction (PoC) must be submitted witin ten (10) calendar days of receipt of the fax trasnmission of the Statement of Deficienicies.** It is imperative that an acceptable plan of correction be received by this office by date to ensure a revisit can be conducted within 45 calendar days of the

survey. Termination will take place on March 15, 2019 if compliance is not achieved.

A revisit will be authorized after an acceptable PoC is received. The PoC must be faxed to:

Sandra Broughton, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
Telephone (501) **320-6182;** Fax (501) 682-6159

Your Plan of Correction must also include the following:

a. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice;

b. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

c. Address what measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur;

d. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.

e. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. Your facility is ultimately accountable for its own compliance. The plan of correction will serve as the facility's allegation of compliance. Unless otherwise stated on the PoC, the last completion date will be the date of alleged compliance.

**Informal Dispute Resolution**
In accordance with 42 CFR § 488.331, you have one opportunity to question deficiencies through an informal dispute resolution (IDR) process. To obtain an IDR, you must send your written request to Health Facility Services, Arkansas Department of Health within ten (10) calendar days from receipt of the Statement of Deficiencies. The request must state the specific deficiency the facility wishes to challenge. The request should also state whether the facility wants the IDR to be performed by a telephone conference call, record review, or a face-to-face meeting.

An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

Please submit your request via fax to:

Becky Bennett, Section Chief
Health Facility Services

Arkansas Department of Health
5800 West 10th Street, Suite 400
Little Rock, AR 72204
Fax (501) 661-2165

**Appeal Rights**
To appeal a sanction regarding licensure and certification, you or your legal counsel must make a written request to:

Director
Arkansas Department of Human Services
P.O. Box 1437, Slot 210
Little Rock, AR 72203-1437

Pursuant to Appendix A of the Long Term Care Provider Manual, the Chairman must receive the request within sixty (60) days of receipt of this letter. The request must state the basis for the appeal with supporting documentation attached.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

If you have any questions, please contact Sandra Broughton, Reviewer at 501-**320-6182.**

Sincerely,

Lori Hobbs, Nursing Manager
Office of Long Term Care
Survey & Certification Section

sgb

cc: Ombudsman
DRC
file

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 04L112 | A. BUILDING ______<br>B. WING ______ | C<br>01/29/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| DELTA FAMILY HEALTH AND FITNESS CENTER FOR CHILDRE | 815 E ST LOUIS<br>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 |
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| N 000 | Initial Comments<br><br>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.<br><br>Complaint #AR00022508 was substantiated, all or in part, with deficiencies cited at N100, N126, and N128.<br><br>The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Facilities. | N 000 | | |
| N 100 | USE OF RESTRAINT AND SECLUSION<br>CFR(s): 483.354<br><br>Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One.<br><br>This CONDITION is not met as evidenced by:<br>Complaint #AR00022508 was substantiated, all or in part, with these findings: | N 100 | | |

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

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 100 | Continued From page 1<br>Based on record review and interview, the facility failed to meet the requirements for the Condition of Participation of Restraints and Seclusion, as evidenced by the facility's failure to ensure an investigation was immediately initiated after a resident was placed in a personal restraint and sustained injury, failure to ensure the facility policy and procedures for the use of personal restraints was followed, failure to immediately and consistently protect residents from further potential injury by a staff member who was involved in a personal restraint which resulted in injury to a resident, and failure to immediately initiate staff retraining on the facility policy and procedures for the use of personal restraints for 1 (Resident #1) of 1 sampled resident who was involved in a physical restraint that resulted in injury. This failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death to Resident #1, who received a scalp laceration requiring staples during the use of a personal restraint. The Assistant Administrator and the Program Director were informed of the Immediate Jeopardy on 1/29/18 at 10:57 a.m. The findings are:<br><br>1. The facility failed to ensure a physical restraint was safely implemented to prevent injury, failed to immediately investigate an injury resulting from the use of a personal restraint, failed to protect residents from further potential injury, and failed to immediately retrain staff on the facility's policy and procedure for the use of personal restraints for 1 (Resident #1) of 1 sampled client who was involved in a physical restraint that resulted in injury. This failed practice resulted in immediate jeopardy, which caused or could have caused serious harm, injury or death to Resident #1, who sustained a scalp laceration requiring staples | N 100 | | |

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| N 100 | Continued From page 2<br>during the use of a personal restraint. Refer to N126 and N128.<br><br>2. The Immediate Jeopardy was removed on 1/291/9 at 12:45 p.m. when the facility implemented the following Plan of Removal:<br><br>"Effective date: 1-29-19 will continue indefinitely<br><br>Program Director, Behavior Coach Supervisor and shift leaders will ensure that these procedures are followed and will be reviewed by the Administrator and Assistant Administrator to ensure compliance.<br><br>In the event that a resident is injured during a CPI [Crisis Prevention Intervention] event the following procedures will be implemented.<br><br>This is a 23 bed capacity facility and currently has 19 Residents.<br><br>It has been determined that the policy in place with regard to restraint procedures is adequate to ensure the safety of the residents if conducted appropriately. Staff members are required to attend a refresher course of CPI techniques every 6 months. Staff members are now attending the January refresher course. New employees are required to attend the initial training of CPI prior to beginning work with the residents.<br><br>Investigation of the incident will begin immediately by the supervisor on shift and or the administrative personnel on duty. Documentation will contain information to determine if the situation required CPI or other techniques were used, the staff involved and the situation that led up to the CPI. | N 100 | | |

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| N 100 | Continued From page 3<br><br>If it is determined that CPI was done incorrectly or not according to policy and procedure the staff member involved will be removed from the schedule and will not be allowed to work until the investigation is complete.<br><br>An in-service will be conducted for all on shift employees, immediately, covering appropriate CPI techniques. All staff from the on-coming shift will receive an in-service covering the event that took place and appropriate CPI techniques during the staff shift briefing prior to going to the floor. This in-service will be noted on the shift brief. In-service covering CPI techniques will be continued during each shift briefing until all personnel have received the in-service. Staff members will sign the shift brief to document they attended the briefing.<br><br>Appropriate corrective action will be completed prior to the staffs return to the schedule to include but not limited to retraining, senior staff supervision, suspension and or termination depending on what the investigation conclusions are.<br><br>If the staff member is retained and retraining is completed, the senior staff assigned to work with the staff member under supervision will document work performance, response to crisis, de-escalation techniques and overall professionalism of their work on a daily basis. Staff member will remain under supervision until he is proven competent in carrying out his daily tasks in accordance with company policy. Documentation will be noted daily for as long as the staff member is under supervision and will be documented on the Delta Family Center | N 100 | | |

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| N 100 | Continued From page 4<br>Competency Assessment.<br><br>These assessments will be monitored by the Behavior Coach Supervisor and the Program Director and kept in the staff members personnel.<br><br>Upon completion of supervision the staff member will be reviewed quarterly to ensure competency and professionalism for one year. If in that year the staff member violates company policy and procedure he will be discharged for failure to comply. If the staff member has shown consistent adherence to company policy and procedure he will be removed from this additional supervision." | N 100 | | |
| N 126 | PROTECTION OF RESIDENTS<br>CFR(s): 483.356 (a)(1)<br><br>Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation.<br><br>This ELEMENT is not met as evidenced by:<br>Complaint #AR00022508 was substantiated, all or in part, with these findings:<br><br>Based on record review and interview, the facility failed to ensure a resident was free from the use of a physical restraint used as discipline, which resulted in injury for 1 (Resident #1) of 1 sampled resident who was placed in a physical restraint that resulted in injury.This failed practice resulted in immediate jeopardy, which caused or could have caused serious harm, injury or death to Resident #1, who was involved in a physical | N 126 | | |

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| N 126 | Continued From page 5 restraint that resulted in scalp laceration that required staples. The Assistant Administrator and the Program Director were informed of the Immediate Jeopardy on 1/29/18 at 10:57 a.m. The findings are:<br><br>1. Resident #1 was admitted on 12/12/18 and had diagnoses Major Depressive Disorder, Recurrent R/O (Rule out) Bipolar Disorder Physical & (and) Sexual Abuse, Post Traumatic Stress Disorder, and Polysubstance Abuse.<br><br>a. Facility Critical Incident Report Form dated 1/19/19 at 1:35 p.m. documented, "...[Resident #1] was instructed to be quiet in the day room during the movie or he would be asked to leave out. [Resident #1] and a few others were asked to leave out, due to not complying with instructions. [Resident #1] and his peers went to their room. [Behavioral Coach] walked down the hall to let the residents know that after 10 minutes they could come back in the day room. [Behavioral Coach] went back to the day room doorway to sit down when he saw [Resident #1] sitting in the day room. [Resident #1] was then instructed to come out the day room. [Resident #1] stated, 'Nah. I'm good.' [Behavioral Coach] entered in the dayroom attempting to open hand escort [Resident #1] out and back to his room. [Resident #1] refused to move therefore [Behavioral Coach] attempted to close hand escort [Resident #1] when he became combative balling up both his hands making a fist, swinging and punching, striking [Behavioral Coach] in the eye. [Behavioral Coach] called a code yellow as [Resident #1] continued hitting him. [Behavioral Coach] attempted to do CPI [Crisis Prevention Intervention]. [Resident #1] and [Behavioral Coach] fell to the floor causing [Resident #1] to hit | N 126 | | |

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| N 126 | Continued From page 6<br>his head on a desk that staff was using to write on documentation sheets. [Resident #1] was put in a physical hold to prevent harm to self and others. Should/Could This Incident Have Been Prevented/Anticipated? Yes. If yes please explain: If [Behavioral Coach] had followed policy and procedure of [Facility Name], which states that no staff member is allowed to enter into a room that's not visible to the camera without assistance unless is a threat to self or others... [Resident #1] was sent to [Hospital name] for injury, receiving 3 staples."<br><br>b. A report dated 1/21/19, sent to administration and signed by the Program Director documented, ..Subj (Subject): Incident involving [Resident #1] on 1-19-19; I met with [Resident #1] on the morning of 1-21-19 for his regular session to ask about the event that resulted in him receiving 3 staples for a laceration to the top of his head. [Resident #1] shared with me that after he and some of his peers were asked to leave the day room due to being too loud he returned to the day room without permission. When the behavior coach noticed that [Resident #1] had reentered the day room [Resident #1] reported that the behavior coach stated, 'go back to your [explicative] room.' [Resident #1] refused and the behavior coach attempted to closed hand escort him out of the dayroom at which point [Resident #1] began hitting the behavior coach with a closed hand. As the behavior coach attempted to put [Resident #1] into a physical hold both [Resident #1] and the behavior coach fell to the ground. As they were falling [Resident #1's] head hit a desk that was in the day room causing the laceration. When all aggression ceased the nurse on duty sent [Resident #1] and two staff members from the facility to the Emergency room | N 126 | | |

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| N 126 | Continued From page 7 | N 126 | | |

in [city name] to have [Resident #1's] injury treated..."

c. On 1/28/19 at 2:25 p.m., the Program Director was asked, "Did anyone else witness the incident?" He stated, "Not that I'm aware of; the rest of the kids were in their rooms. [Behavioral Coach] told them all to go to their rooms and then walked to the end of the hall and said, 'look, calm down and in ten minutes you can come back to the dayroom'. When he came back down the hall, he went to the day room and saw [Resident #1] was back in there." The Program Director was asked, "Did the closed hand restraint cause [Resident #1] to get agitated?" He stated, "Yes, as soon as [Behavioral Coach] placed his hands on him to restrain him that's when [Resident #1] hit him and when [Behavioral Coach] tried to restrain him, that's when he hit the corner of the desk." The Program Director was asked, "Have you completed any training on restraint policy and procedures?" He stated, "We haven't done that yet, but we will cover that tomorrow." There was no re-training of staff on the facility restraint policy and procedures for 10 days after the incident.

d. On 1/29/19 at 9:49 a.m., the Program Director was asked, "Did [Behavioral Coach] work after the incident on 1/19, until he was suspended on 1/21? He stated, "He was scheduled to work on the 20th." The Program Director was asked, "Was he supervised while he was here on the 20th?" He stated, "No." The Program Director was asked, "Did [Behavioral Coach] follow Policy and Procedures?" He stated, "No, he didn't." At 12:42 p.m. the Administrator stated, "Every staff member here knows that you don't go into a room by yourself with a resident; they have been told if the resident is off the hall, they are to have

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| N 126 | Continued From page 8 | N 126 | | |

someone else to go into a room with them."

e. A Corrective Action Plan regarding policy and procedure dated 1/21/19 documented, "On January 21, 2019 [Behavior Coach] will be suspended for 36 hours, 3 full work days, and receive a written warning as a result of breaking company Policy and Procedure by entering a room with one resident that placed himself off camera and initiating closed hand restraint unassisted. [Behavior Coach] received an in-service on appropriate de-escalation and in following company policy with regard to addressing defiant and aggressive residents as a team instead of individually... [Behavior Coach] suspension and in-service took place on this date and he was informed that if this happens again that he may be terminated immediately. 1-21-19". The Behavior Coach was allowed to work with residents unsupervised and without retraining on restraint policy and procedure on 1/20/19. An investigation into the incident which resulted in injury for [Resident #1] was not initiated until 1/21/19.

f. The facility Policy and Procedure for the use of Personal or Chemical Restraints, received from the Program Director on 1/29/19 at 9:35 a.m., documented, "Purpose: To insure the rights of the resident served in that all resident children and youth have the right of be free from réstraints as a means of coercion, discipline, convenience, or retaliation. To provide direction for staff in the safe and appropriate use of Physical Holds and Chemical Restraints... Restraints are used only with adequate justification, documentation, and regard for resident safety... Phase I (Verbal De-escalation) During the early stages of a crisis (non-compliant episode), staff should begin to

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| N 126 | Continued From page 9 verbally de-escalate the situation. Early consultation is an attempt at preventing the use of the restraint. 1. Remove the resident from the group. a. Ask the resident to go for a time out. b. Remove other residents from the situation. 2. During normal working hours direct care staff will call for a therapist, SBC or BC (Behavioral Coach) supervisor to try and assist the direct care staff in de-escalating the situation. 3. After normal business hours or on weekends the SBC or admin [administrative] personnel present will be called to assist the direct care staff... Phase II: If the resident refuses to calm down and continues to be verbally aggressive, the direct care staff will attempt to escort the resident to the time out room. If during the escort, or any other time, the resident becomes physically aggressive and attempts to harm self or others the direct care staff will call for a physical restraint and code yellow. (A physical restraint will only be utilized as a last resort to prevent harm to the resident or direct care staff.) Phase IV... Restraints are highly restrictive interventions and will be used only in an emergency when all other means of managing the resident have not been successful in maintaining the resident's safety... C. Personal Restraint (physical hold) is defined as: *The application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. *Use of personal restraint requires documented clinical justification. The rationale for the procedure must address and identify the less restrictive interventions that were attempted and failed. Less restrictive interventions would include verbal de-escalation, time-out, prompts, preventive teaching, allowing resident to verbalize feelings, decrease stimuli in the environment by removing the other residents, etc... D. Serious Injuries: | N 126 | | |

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| N 126 | Continued From page 10<br>*Serious injury means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, and injuries to internal organs, whether self-inflicted or inflicted by someone else. If any injury occurs during an intervention or any other time, contact the Administrator on call immediately. You will then be directed as to what steps to take, including completing a critical incident form... P. Training: *Leaders of [facility initials] communicate the philosophy of [facility initials] concerning restraints to all staff with direct care responsibility. *At a minimum the philosophy addresses: *[facility] commitment to prevent, reduce and hopefully, eliminate the use of any type of restraint. *The role of the verbal de-escalation as the preferred intervention to be utilized with individuals served. *The importance of limiting the use of these procedures to emergencies in which there is imminent risk of a resident physically harming him/herself or others, including staff...*To minimize the use of restraints, all staff (see above) receives ongoing training and demonstrate an understanding of the underlying causes of threatening behaviors exhibited by residents served..."<br><br>g. The facility Disciplinary Policy documented, "...The following list includes, but is not limited to, examples of misconduct and/or violation of rules that may warrant immediate termination: *Placing yourself one-on-one with a resident, out of view of the camera system, excluding medical personnel and therapist...*Touching, grabbing, pushing or holding residents is not permitted unless in the case of prevention, intervention, or an ordered restraint. Pats of the back, handshakes and 'high fives' are permitted at the appropriate times..." | N 126 | | |

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| N 126 | Continued From page 11 | N 126 | | |

2. The Immediate Jeopardy was removed on 1/291/9 at 12:45 p.m. when the facility implemented the following Plan of Removal:

"Effective date: 1-29-19 will continue indefinitely

Program Director, Behavior Coach Supervisor and shift leaders will ensure that these procedures are followed and will be reviewed by the Administrator and Assistant Administrator to ensure compliance.

In the event that a Resident is injured during a CPI [Crisis Prevention Intervention] event the following procedures will be implemented.

This is a 23 bed capacity facility and currently has 19 Residents.

It has been determined that the policy in place with regard to restraint procedures is adequate to ensure the safety of the Residents if conducted appropriately. Staff members are required to attend a refresher course of CPI techniques every 6 months. Staff members are now attending the January refresher course. New employees are required to attend the initial training of CPI prior to beginning work with the Residents.

Investigation of the incident will begin immediately by the supervisor on shift and or the administrative personnel on duty. Documentation will contain information to determine if the situation required CPI or other techniques were used, the staff involved and the situation that led up to the CPI.

If it is determined that CPI was done incorrectly or

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| N 126 | Continued From page 12<br>not according to policy and procedure the staff member involved will be removed from the schedule and will not be allowed to work until the investigation is complete.<br><br>An in-service will be conducted for all on shift employees, immediately, covering appropriate CPI techniques. All staff from the on-coming shift will receive an in-service covering the event that took place and appropriate CPI techniques during the staff shift briefing prior to going to the floor. This in-service will be noted on the shift brief. In-service covering CPI techniques will be continued during each shift briefing until all personnel have received the in-service. Staff members will sign the shift brief to document they attended the briefing.<br><br>Appropriate corrective action will be completed prior to the staffs return to the schedule to include but not limited to retraining, senior staff supervision, suspension and or termination depending on what the investigation conclusions are.<br><br>If the staff member is retained and retraining is completed, the senior staff assigned to work with the staff member under supervision will document work performance, response to crisis, de-escalation techniques and overall professionalism of their work on a daily basis. Staff member will remain under supervision until he is proven competent in carrying out his daily tasks in accordance with company policy. Documentation will be noted daily for as long as the staff member is under supervision and will be documented on the Delta Family Center Competency Assessment. | N 126 | | |

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| N 126 | Continued From page 13<br>These assessments will be monitored by the Behavior Coach Supervisor and the Program Director and kept in the staff members personnel.<br><br>Upon completion of supervision the staff member will be reviewed quarterly to ensure competency and professionalism for one year. If in that year the staff member violates company policy and procedure he will be discharged for failure to comply. If the staff member has shown consistent adherence to company policy and procedure he will be removed from this additional supervision." | N 126 | | |
| N 128 | PROTECTION OF RESIDENTS<br>CFR(s): 483.356(a)(3)<br><br>Restraint or seclusion must not result in harm or injury to the resident and must be used only-<br><br>This ELEMENT is not met as evidenced by:<br>Complaint #AR00022508 was substantiated, all or in part, with these findings:<br><br>Based on record review and interview, the facility failed to ensure a physical restraint was safely implemented, which resulted in injury for 1 (Resident #1) of 1 sampled resident who was placed in a physical restraint that resulted in an injury. This failed practice resulted in immediate jeopardy, which caused or could have caused serious harm, injury or death to Resident #1, who was involved in a physical restraint that resulted in a scalp laceration. The Assistant Administrator and the Program Director were informed of the Immediate Jeopardy on 1/29/18 at 10:57 a.m. The findings are:<br><br>1. Resident #1 was admitted on 12/12/18 and had | N 128 | | |

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| N 128 | Continued From page 14<br>diagnoses Major Depressive Disorder, Recurrent R/O (Rule out) Bipolar Disorder Physical & (and) Sexual Abuse, Post Traumatic Stress Disorder, and Polysubstance Abuse.<br><br>a. Facility Critical Incident Report Form dated 1/19/19 at 1:35 p.m. documented, "...[Resident #1] was instructed to be quiet in the day room during the movie or he would be asked to leave out. [Resident #1] and a few others were asked to leave out, due to not complying with instructions. [Resident #1] and his peers went to their room. [Behavioral Coach] walked down the hall to let the residents know that after 10 minutes they could come back in the day room. [Behavioral Coach] went back to the day room doorway to sit down when he saw [Resident #1] sitting in the day room. [Resident #1] was then instructed to come out the day room. [Resident #1] stated, 'Nah. I'm good.' [Behavioral Coach] entered in the dayroom attempting to open hand escort [Resident #1] out and back to his room. [Resident #1] refused to move therefore [Behavioral Coach] attempted to close hand escort [Resident #1] when he became combative balling up both his hands making a fist, swinging and punching, striking [Behavioral Coach] in the eye. [Behavioral Coach] called a code yellow as [Resident #1] continued hitting him. [Behavioral Coach] attempted to do CPI [Crisis Prevention Intervention]. [Resident #1] and [Behavioral Coach] fell to the floor causing [Resident #1] to hit his head on a desk that staff was using to write on documentation sheets. [Resident #1] was put in a physical hold to prevent harm to self and others. Should/Could This Incident Have Been Prevented/Anticipated? Yes. If yes please explain: If [Behavioral Coach] had followed policy and procedure of [Facility Name], which states | N 128 | | |

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| N 128 | Continued From page 15<br>that no staff member is allowed to enter into a room that's not visible to the camera without assistance unless is a threat to self or others... [Resident #1] was sent to [Hospital name] for injury, receiving 3 staples."<br><br>b. A report dated 1/21/19, sent to administration and signed by the Program Director documented, ..Subj (Subject): Incident involving [Resident #1] on 1-19-19; I met with [Resident #1] on the morning of 1-21-19 for his regular session to ask about the event that resulted in him receiving 3 staples for a laceration to the top of his head. [Resident #1] shared with me that after he and some of his peers were asked to leave the day room due to being too loud he returned to the day room without permission. When the behavior coach noticed that [Resident #1] had reentered the day room [Resident #1] reported that the behavior coach stated, 'go back to your [explicative] room.' [Resident #1] refused and the behavior coach attempted to closed hand escort him out of the dayroom at which point [Resident #1] began hitting the behavior coach with a closed hand. As the behavior coach attempted to put [Resident #1] into a physical hold both [Resident #1] and the behavior coach fell to the ground. As they were falling [Resident #1's] head hit a desk that was in the day room causing the laceration. When all aggression ceased the nurse on duty sent [Resident #1] and two staff members from the facility to the Emergency room in [city name] to have [Resident #1's] injury treated..."<br><br>c. On 1/28/19 at 2:25 p.m., the Program Director was asked, "Did anyone else witness the incident?" He stated, "Not that I'm aware of; the rest of the kids were in their rooms. [Behavioral | N 128 | | |

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| N 128 | Continued From page 16<br>Coach] told them all to go to their rooms and then walked to the end of the hall and said, 'look, calm down and in ten minutes you can come back to the dayroom'. When he came back down the hall, he went to the day room and saw [Resident #1] was back in there." The Program Director was asked, "Did the closed hand restraint cause [Resident #1] to get agitated?" He stated, "Yes, as soon as [Behavioral Coach] placed his hands on him to restrain him that's when [Resident #1] hit him and when [Behavioral Coach] tried to restrain him, that's when he hit the corner of the desk." The Program Director was asked, "Have you completed any training on restraint policy and procedures?" He stated, "We haven't done that yet, but we will cover that tomorrow." There was no re-training of staff on the facility restraint policy and procedures for 10 days after the incident.<br><br>d. On 1/29/19 at 9:49 a.m., the Program Director was asked, "Did [Behavioral Coach] work after the incident on 1/19, until he was suspended on 1/21? He stated, "He was scheduled to work on the 20th." The Program Director was asked, "Was he supervised while he was here on the 20th?" He stated, "No." The Program Director was asked, "Did [Behavioral Coach] follow Policy and Procedures?" He stated, "No, he didn't." At 12:42 p.m. the Administrator stated, "Every staff member here knows that you don't go into a room by yourself with a resident; they have been told if the resident is off the hall, they are to have someone else to go into a room with them."<br><br>e. A Corrective Action Plan regarding policy and procedure dated 1/21/19 documented, "On January 21, 2019 [Behavior Coach] will be suspended for 36 hours, 3 full work days, and receive a written warning as a result of breaking | N 128 | | |

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| N 128 | Continued From page 17<br>company Policy and Procedure by entering a room with one resident that placed himself off camera and initiating closed hand restraint unassisted. [Behavior Coach] received an in-service on appropriate de-escalation and in following company policy with regard to addressing defiant and aggressive residents as a team instead of individually... [Behavior Coach] suspension and in-service took place on this date and he was informed that if this happens again that he may be terminated immediately. 1-21-19". The Behavior Coach was allowed to work with residents unsupervised and without retraining on restraint policy and procedure on 1/20/19. An investigation into the incident which resulted in injury for [Resident #1] was not initiated until 1/21/19.<br><br>f. The facility Policy and Procedure for the use of Personal or Chemical Restraints, received from the Program Director on 1/29/19 at 9:35 a.m., documented, "Purpose: To insure the rights of the resident served in that all resident children and youth have the right of be free from restraints as a means of coercion, discipline, convenience, or retaliation. To provide direction for staff in the safe and appropriate use of Physical Holds and Chemical Restraints... Restraints are used only with adequate justification, documentation, and regard for resident safety... Phase I (Verbal De-escalation) During the early stages of a crisis (non-compliant episode), staff should begin to verbally de-escalate the situation. Early consultation is an attempt at preventing the use of the restraint. 1. Remove the resident from the group. a. Ask the resident to go for a time out. b. Remove other residents from the situation. 2. During normal working hours direct care staff will call for a therapist, SBC or BC (Behavioral | N 128 | | |

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| N 128 | Continued From page 18<br>Coach) supervisor to try and assist the direct care staff in de-escalating the situation. 3. After normal business hours or on weekends the SBC or admin [administrative] personnel present will be called to assist the direct care staff... Phase II: If the resident refuses to calm down and continues to be verbally aggressive, the direct care staff will attempt to escort the resident to the time out room. If during the escort, or any other time, the resident becomes physically aggressive and attempts to harm self or others the direct care staff will call for a physical restraint and code yellow. (A physical restraint will only be utilized as a last resort to prevent harm to the resident or direct care staff.) Phase IV... Restraints are highly restrictive interventions and will be used only in an emergency when all other means of managing the resident have not been successful in maintaining the resident's safety... C. Personal Restraint (physical hold) is defined as: *The application of physical force without the use of any device, for the purposes of restraining the free movement of a resident's body. *Use of personal restraint requires documented clinical justification. The rationale for the procedure must address and identify the less restrictive interventions that were attempted and failed. Less restrictive interventions would include verbal de-escalation, time-out, prompts, preventive teaching, allowing resident to verbalize feelings, decrease stimuli in the environment by removing the other residents, etc... D. Serious Injuries: *Serious injury means any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, and injuries to internal organs, whether self-inflicted or inflicted by someone else. If any injury occurs during an intervention or any | N 128 | | |

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| N 128 | Continued From page 19 | N 128 | | |

other time, contact the Administrator on call immediately. You will then be directed as to what steps to take, including completing a critical incident form... P. Training: *Leaders of [facility initials] communicate the philosophy of [facility initials] concerning restraints to all staff with direct care responsibility. *At a minimum the philosophy addresses: *[facility] commitment to prevent, reduce and hopefully, eliminate the use of any type of restraint. *The role of the verbal de-escalation as the preferred intervention to be utilized with individuals served. *The importance of limiting the use of these procedures to emergencies in which there is imminent risk of a resident physically harming him/herself or others, including staff...*To minimize the use of restraints, all staff (see above) receives ongoing training and demonstrate an understanding of the underlying causes of threatening behaviors exhibited by residents served..."

g. The facility Disciplinary Policy documented, "...The following list includes, but is not limited to, examples of misconduct and/or violation of rules that may warrant immediate termination: *Placing yourself one-on-one with a resident, out of view of the camera system, excluding medical personnel and therapist...*Touching, grabbing, pushing or holding residents is not permitted unless in the case of prevention, intervention, or an ordered restraint. Pats of the back, handshakes and 'high fives' are permitted at the appropriate times..."

2. The Immediate Jeopardy was removed on 1/291/9 at 12:45 p.m. when the facility implemented the following Plan of Removal:

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| N 128 | Continued From page 20<br>Program Director, Behavior Coach Supervisor and shift leaders will ensure that these procedures are followed and will be reviewed by the Administrator and Assistant Administrator to ensure compliance.<br><br>In the event that a Resident is injured during a CPI [Crisis Prevention Intervention] event the following procedures will be implemented.<br><br>This is a 23 bed capacity facility and currently has 19 Residents.<br><br>It has been determined that the policy in place with regard to restraint procedures is adequate to ensure the safety of the Residents if conducted appropriately. Staff members are required to attend a refresher course of CPI techniques every 6 months. Staff members are now attending the January refresher course. New employees are required to attend the initial training of CPI prior to beginning work with the Residents.<br><br>Investigation of the incident will begin immediately by the supervisor on shift and or the administrative personnel on duty. Documentation will contain information to determine if the situation required CPI or other techniques were used, the staff involved and the situation that led up to the CPI.<br><br>If it is determined that CPI was done incorrectly or not according to policy and procedure the staff member involved will be removed from the schedule and will not be allowed to work until the investigation is complete.<br><br>An in-service will be conducted for all on shift employees, immediately, covering appropriate | N 128 | | |

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| N 128 | Continued From page 21<br>CPI techniques. All staff from the on-coming shift will receive an in-service covering the event that took place and appropriate CPI techniques during the staff shift briefing prior to going to the floor. This in-service will be noted on the shift brief. In-service covering CPI techniques will be continued during each shift briefing until all personnel have received the in-service. Staff members will sign the shift brief to document they attended the briefing.<br><br>Appropriate corrective action will be completed prior to the staffs return to the schedule to include but not limited to retraining, senior staff supervision, suspension and or termination depending on what the investigation conclusions are.<br><br>If the staff member is retained and retraining is completed, the senior staff assigned to work with the staff member under supervision will document work performance, response to crisis, de-escalation techniques and overall professionalism of their work on a daily basis. Staff member will remain under supervision until he is proven competent in carrying out his daily tasks in accordance with company policy. Documentation will be noted daily for as long as the staff member is under supervision and will be documented on the Delta Family Center Competency Assessment.<br><br>These assessments will be monitored by the Behavior Coach Supervisor and the Program Director and kept in the staff members personnel.<br><br>Upon completion of supervision the staff member will be reviewed quarterly to ensure competency and professionalism for one year. If in that year | N 128 | | |

| 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 01/29/2019 |

| 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 128 | Continued From page 22<br>the staff member violates company policy and procedure he will be discharged for failure to comply. If the staff member has shown consistent adherence to company policy and procedure he will be removed from this additional supervision." | N 128 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| 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 ______ | R-C 03/14/2019 |

| 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** |

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|---|---|---|---|---|
| {N 000} | Initial Comments<br><br>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.<br><br>A revisit was conducted on March 14, 2019 for all deficiencies cited on January 29, 2019. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed. | {N 000} | | |

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

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.