ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059
P: 501.320.6182
F: 501.682.6159

April 13, 2021

Gary Sneed, Administrator
Millcreek Of Arkansas
P.O. Box 727
Fordyce, AR 71742

Dear Mr. Sneed:

On April 1, 2021 a Recertification and COVID-19 survey was conducted at your facility by the Office of Long Term Care to determine if your facility was in compliance with Federal requirements for Intermediate Care Facilities for Individuals with Intellectual Disabilities participating in the Medicaid (Title XIX) Program. This survey found that your facility had deficiencies requiring correction/substantial correction prior to a revisit as specified in the attached CMS-2567.

Plan of Correction
A POC must be submitted within 10 calendar days of your receipt of the Statement of Deficiencies. Failure to submit a POC may result in termination. Include a completion date for each deficieny cited.

Connie Lowe, RN, MPH, Reviewer
OLTC, Survey & Certification Section
Telephone (501) **320-3932;**
email to Connie.Lowe@dhs.arkansas.gov

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 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 deficiencies 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 to:

IDR/IIDR Program Coordinator
Health Facilities Services
5800 West 10th Street, Suite 400
Little Rock, AR 72204
Phone: 501-661-2201
Fax: 501-661-2165
ADH.HFS@Arkansas.gov

If you have any questions, please call your Reviewer.

Sincerely,

Amanda McSmith

RN Manager
DPSQA/Office of Long Term Care
Survey & Certification Section

cl

cc: DRA
DDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G011	A. BUILDING **01** B. WING _____	**04/01/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	**1810 INDUSTRIAL DRIVE** **FORDYCE, AR 71742**

(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
E 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. The facility was in compliance with §483.73 - Emergency Preparedness Requirements for Long-Term Care Facilities.	E 000		
K 000	INITIAL COMMENTS The facility was in compliance with Title 42, Code of Federal Regulations §483.90(a), life safety from fire.	K 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.

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W 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. A Focused Fundamental survey was conducted from March 29, 2021 through April 1, 2021.	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure walls were repaired and new paint added, paneling and trim were repaired, sinks were cleaned and free of dark substances, sheetrock was replastered and free from gouges, air/heating vents were repaired and exits sign were secured in 1 (Oak Creek) residence; Failed to ensure missing cabinets in the dining room were replaced, cabinet doors were hung correctly, and bottom cabinet shelves were in good repair, a used grease container was empty and in good repair, a plexiglass was mounted correctly and was free of tape, window sills were	W 104		

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W 104	Continued From page 1 repaired and painted, dining room walls and doors were painted, the base boards were intact, edging on cabinets were replaced, linoleum was replaced, heating vents were cleaned, the refrigerator was repaired to stop leakage and a hole behind a pipe in the kitchen was repaired and foam pipe sealant was applied correctly in 1 (Boys Ranch) residence. Failed to ensure chairs and couches were free from cracks, tears and holes in the seat cushions, backyard equipment was repaired and or removed from premises, multiple floor tiles throughout the residence were free of discoloration or replaced, air vents were free from dust and dirt and shower walls were clean and free form black discoloration in 1 (Willow Creek) residence and; Failed to ensure mattresses were in good condition or replaced and vent covering were secured to maintain a comfortable, safe environment for 1 (Haley House) residence. The findings are: 1. On 3/30/2021 at 11:25 a.m., in the Oak Creek residence, the following was observed: a. There was a shelf located in the living room with multiple areas of paint missing. b. At 11:37 a.m., there was an approximately 18-inch-long and 1-inch wide piece of paneling that had pulled away from the wall. This area was in the living room, next to the above shelf. c. At 11:44 a.m., in the bathroom located to the right of the entrance door to the living room, there was a dark unknown substance on the bathroom sink counter.	W 104		

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W 104	Continued From page 2 d. At 11:48 a.m., a section of corner trim was damaged and had some of the trim missing in the hall to the right of the entrance door to the living room. The area missing was approximately 18 inches long by 1/4 inch wide. e. At 11:55 a.m., in bedroom #3, there was a gouge in the sheetrock by the bed. This gouged area measured approximately 18 inches by 3 inches. f. At 12:00 p.m., the air return vent next to the dining room was damaged and bent. g. At 12:05 p.m., the heating vent in the floor of the kitchen was bent down into the duct work. h. At 12:15 p.m., in the bathroom near room #8, there was a dark substance on the back wall of the shower. It measures approximately 6 inches by 1/4 inch. There were also multiple areas with dark substance on the wall above the shower stall. i. At 12:20 p.m., the exit sign between room #4 and the living room was loose. One corner of the sign was hanging approximately 1 1/2 inches down from the ceiling and a screw was exposed on that corner. j. At 12:50 a.m., the countertop in the kitchen near the refrigerator had 2 visible broken tiles. One tile measured 6 inches by 4 inches and the second tile measured approximately 6 inches on the side and 3 inches on the top of the counter and had a missing tile piece in this area. 2. On 3/30/21 at 10:24 a.m., in the Boys Ranch house, the following was observed.	W 104		

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W 104	Continued From page 3 a. One of six doors on a cabinet, outside of the kitchen in the dining room, was missing, and coats were stuffed into the open cabinet. The Dietary Manager was asked, how long has the door been off? She stated, "A long time. It used to be a soda fountain that sat here, but now it's gone, and it's turned into a lost and found storage cabinet." b. At 10:43 a.m., a black cooking oil bin was located outside in the back of the cafeteria. There was a buildup of a black greasy substance on the top of the bin and a black greasy substance was running from the bin into a field behind it. (pictures were taken at this time). On 3/31/21 at 4:31 p.m., the Administrator was asked, "When has the bin been emptied, is it still being used?" He stated, "I don't know." The Administrator was asked, "Should it be emptied?" He stated, "Those things are through a contract, so I don't know if it's being used and it's leaking. Then it needs to be removed and the dirt excavated, and new dirt brought in. You can't leave the grease out there. It's not going to go away." c. At 11:23 a.m., a Plexiglas window located in the living area had tape across the bottom and approximately 8 inches up the right side. The window had been screwed into the frame. Behavioral Health Assistant (BHA) #7 was asked, "Why is this taped?" She stated, "The edging came off and they put tape to keep the wind, cold out. The BHA was asked, "How long has that tape been there?" She stated, "They put it up there when it snowed to keep the snow out." The windowsill had areas of missing paint exposing the wood. (Pictures were taken at this time).	W 104		

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W 104	Continued From page 4 d. The dining room walls, from the floor to approximately halfway up the walls, and the base boards had areas of missing and chipped paint. The swing door separating the kitchen and the dining room had areas of missing paint. (Pictures were taken at this time). e. At the entrance to the dining room the linoleum was missing and an area approximately one foot in diameter, in front of the cabinets in the kitchen, was missing. (Pictures were taken at this time) f. The edging around the bar, to the right of the entrance to the kitchen, had edging missing, exposing the wood. (Pictures were taken at this time). g. The heating vent in the dining room had a build-up of dust and a black substance. (Pictures were taken at this time). h. On 3/31/21 at 7:55 a.m., a towel was on the bottom shelf inside the refrigerator. Cook #1 was asked, "Why is that towel across the bottom of the shelf?" She stated, "Because it leaks, sometimes it leaks in the back and runs to the front and we have to put a towel on the side to keep it from running out in the floor." The cook was asked, "How long has it been doing that?" She stated, "It started last year." The Cook was asked, "Have you told anyone?" She stated, "Yes, and I imagine she did a maintenance request on it." There was a brown discoloration on the bottom shelf of the refrigerator. The Cook stated, "That's the reason the bottom is rusted, because it is leaking." (Pictures were taken at this time).	W 104		

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W 104	Continued From page 5 i. The bottom of the cabinet on the end, near the storage area, which contained the pots and pans was discolored with a black substance and had a strong moldy, stale smell. Cook #1 stated, "That's where the pipe was leaking. The maintenance fixed the pipe, but that was left." The Cook was asked, "How long ago was that?" She stated, "Ten months." (Pictures were taken at this time). j. There was a piece of linoleum, triangle shaped, coming loose from the left top side of the cabinet. k. A black pipe, which came down from the ceiling, through the top cabinets on the left side of the sink, had a hole behind it in the wall that had aluminum foil stuffed into the hole. The bottom edge of the pipe, which ran through the back of the countertop, had a foam sealant around the bottom which ran down onto the cabinet. (Pictures were taken at this time). l. The front of the dishwasher had a buildup of an unknown brown substance. 3. On 3/30/21 at 8:03 a.m., the following observations were made in the Willow Creek residence. a. A chair outside the medication room had multiple cracks in the back and seat cushions. (Picture was taken). A vent and light fixture in the bathroom by the medication room had dirt and or dust on them. (Picture was taken). b. At 10:12 a.m., equipment in the backyard area was in disrepair. This equipment included an old ramp, within 25 feet of a basketball court used by	W 104		

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W 104	Continued From page 6 the clients, with railing leaning and in pieces, and ramp itself with multiple areas missing, torn up, and pieces hanging from bottom of the ramp. (Pictures were taken). A piece of outdoor equipment with a slide, rope climb and other attachments with rotten boards and screws sticking out. (Pictures taken). A wooden swing, within 10 feet of a swing used by the clients, had holes in the metal frame which holds the swing, and multiple boards missing in the swing itself resulting in large holes in the seat of the swing. (Pictures were taken). Two wooden structures resembling pieces of a train, had black discoloration, board pieces missing from the decorative wheels resulting in rough surfaces and rusty screws sticking out. (Pictures were taken). None of the equipment was marked as "keep off," "unsafe", or blocked off in any way to prevent clients from getting on them. The back of the house to the right of the gate and close to the air conditioner unit had an approximately 5-foot patch of black appearing substance and moss on the lower bricks and concrete. (Pictures were taken). c. On 3/30/21 at 10:12 a.m., Unit Coordinator #2 was asked, "How do you keep the clients away from the equipment in the backyard that is falling apart?" She stated, "They don't go over there. They mainly go to the basketball court and the swings, but they don't go over there. That stuff came from a different unit, Boys Ranch. It was falling apart 5 years ago when I was over there, and then they just moved it over here." d. On 3/31/21 at 7:06 a.m., in a couch by the single window in the living room area, there were holes and tears present in all 3 seat cushions. (Picture was taken). A chair next to this couch,	W 104		

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W 104	Continued From page 7 against the wall, had cracks in the seat cushion. There was a couch by the TV, that had holes and a large circular indention in the left seat cushion. (Picture were taken). e. At 9:51 a.m., Multiple floor tiles present in the dining room had gray discoloration (pictures taken). In the hallway past the dining room, the vent covering of the air filter was dirty and dusty. (Picture taken). Down the same hallway, the first bedroom to the right had gray discoloration of floor tiles inside the doorway. There were patches of thick dried on black substance in front of the closet door area. (Pictures were taken). Floor tiles were dirty and discolored inside door of back (last bedroom) down same hallway (picture taken). Large areas of black colored substance were present on the walls above the shower in the bathroom attached to the back bedroom. (Pictures were taken). 4. On 03/30/21 at 3:46 p.m., the following observations were made in the Haley House: a. In bedroom #7, a bed, under the window, had a large, circular appearing indention in the middle of the mattress. (Picture taken). Bedroom #8 had 2 beds appearing to have indentions, running down the mid-center of the mattresses. (Pictures taken). b. On 3/30/21 at 3:56 p.m., a vent cover in the sitting room was hanging from the ceiling by the screw in one end. (Picture taken). c. On 4/1/2021 at 9:08 a.m., Unit Coordinator #1 (UC #1) was asked, "Have there been any complaints or concerns by the clients or staff about the condition of any of the mattresses in	W 104		

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W 104	Continued From page 8 this house?" She stated, "I know some of them need to be replaced, are in pretty bad shape. I was just going to place a purchase order for them." She was then asked, "Do any of them have tears or holes in them to your knowledge?" She answered, "Not to my knowledge, the staff checks them every week when the linen is changed, and they would tell me if there were any holes or tears. It is just the general state of the mattresses." She was asked if she would accompany the surveyor to all the client bedrooms in Haley House to identify mattresses needing replacement. In bedroom 8, which belongs to 2 female clients, she was asked, "Do these 2 mattresses need replacing?" She stated, "Yes, and I know there are some in the boy's rooms that do too." In bedroom #7 (also a female client bedroom), while looking at the bed under the window UC #1 was asked, "Should this bed have the large crater appearing dip in the middle of the mattress? Should it be replaced?" She stated, "No, that shouldn't be there, it needs to be replaced." In each of the bedrooms belonging to male clients, the UC was asked to identify mattresses needing replacement. UC #1 identified mattresses in bedroom #1 (2 mattresses), bedroom #3 (2 mattress), bedroom #4 (1 mattresses), bedroom #5 (1 mattress). After the UC identified 9 mattresses needing replacement, she stated, "I will place a purchase order after you show the list to [Administrator]." d. On 4/1/21 at 3:15 pm, while being shown the pictures of the environment at Willow Creek, the Administrator was asked, "How do you ensure the clients stay off of the unsafe equipment in the back yard of Willow Creek?" He answered, "They know it is off limits."	W 104		

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W 159	Continued From page 9	W 159		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Qualified Intellectual Disability Professional (QIDP) documented observations based on client needs to ensure the clients' active treatment program was current for 3 (Client #1, #2, and #6) case mix clients. The findings are: 1. Client #6 had diagnoses of Mild Intellectual Disabilities, Disruptive Mood Dysregulation Disorder Combined Presentation, Hypothyroidism and Enuresis. a. On 3/31/2021 the client's chart was reviewed. The most recent QIDP observation documented in the client's chart was dated 10/6/2020. b. On 3/31/2021 at 10:45 a.m. the Administrator was asked if there were any documentation of QIDP observations more recent than 10/6/2020. At 10:55 a.m., more documentation was provided with a date of 10/26/20. c. As of 4/1/21 at 4:00 p.m., there was no more information provided by the facility of more recent QIDP documentation. 2. Client #2 had diagnoses of Mild Intellectual Disabilities, Disruptive Mood Dysregulation Disorder, Posttraumatic Stress Disorder, and Attention Deficit Hyperactivity Disorder Combined Presentation.	W 159		

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W 159	Continued From page 10 a. On 3/31/2021 the client's chart was reviewed. The most recent QIDP observation documented in the client's chart was dated 10/7/2020. b. On 3/31/2021 at 3:20 p.m., the Administrator was asked if there was any documentation of QIDP observations more recent than 10/7/2020. c. As of 4/1/2021 at 4:00 p.m., there was no more information provided by the facility of more recent QIDP observations/documentation. 3. Client #1 had a diagnosis of Moderate Intellectual Disabilities. a. On 4/1/2021 the client's chart was reviewed. The most recent QIDP observation documented in the client's chart was dated 10/6/2020. b. On 3/31/2021 at 3:20 p.m., the Administrator was asked if there was any documentation of QIDP observations more recent than 10/6/2020. The Administrator stated, "We don't have them."	W 159		
W 341	NURSING SERVICES CFR(s): 483.460(c)(5)(ii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff had temperatures taken and	W 341		

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W 341	Continued From page 11 were screened for COVID prior to working in 2 residences and failed to ensure staff wore mask to prevent the potential spread of the COVID-19 virus. The findings are: 1. On 03/30/2021 at 8:35 a.m., Behavior Health Associate (BHA) #2 was asked, "Were you screened for COVID this morning before starting work?" She answered, "I did screening on the main campus." She was asked, "Do you go to the office before coming to work?" She stated, "Yes, we go to the main office and get screened." 2. On 03/30/21 at 9:25 a.m., the Administrator was asked, "Where are staff screened in the office in the morning before starting their shift in the houses?" The Administrator stated, "They are screened at their houses before they can go in and be with the clients. I wouldn't expect the staff from Boys Ranch to come all the way in here, so they do it in the houses." He was asked, "Staff aren't screened here in the office in the early morning?" He stated, "No." 3. On 03/30/2021 at 9:40 a.m., BHA #3 was asked, "Where are you screened for COVID before you come in the house?" She answered, "We are not really, we were at one time." She was asked, "How long has it been since you were screened, or your temperature taken?" She stated, "Not for months maybe." She was asked, "Do you have a temperature documented for this morning?" She answered, "No it wasn't taken." She was asked, "Is there any paperwork showing recent screening in the house?" She looked in a folder with screening forms, showed that all were blank, and then stated, "No." 4. On 03/30/2021 at 9:44 a.m., Unit Coordinator	W 341		

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W 341	Continued From page 12 (UC) #2, was asked, "Who should take temperatures before the staff come in the residence?" She answered, "We normally have the nurse, or I check, but my thermometer isn't working, so I'm going to get another one." 5. On 03/30/2021 at 10:34 a.m., UC #1 was asked, "How were you screened for COVID this morning?" She stated, "I took my temperature, we have to take our own. I got here at 9, my temperature was 97.4 and I wrote it here on this sheet [Sheet titled "Employee Pre-work disease prevention clearance worksheet dated 3/30/21]." UC #1 was then asked, "Who else is working in the house today?" She identified the staff members, including Behavior Health Associate (BHA) #1. She was then asked, "Why is there no temperature or screening by her name?" She answered, "It should be on here. I get here at 9 and I try to check. She is in the classroom, not here right now." 6. On 03/30/2021 at 11:20 a.m., BHA #1 was asked, "What time did you get to the house and start working this morning?" She replied, "7:05." She was asked, "How were you screened for COVID this morning before entering the residence?" She stated, "You mean like my temperature? We can either go to the nurse or we can take it ourselves. I prefer to go to the nurse." She was asked, "Did you get your temperature taken this morning?" After thinking about it, she then stated, "No, I guess I didn't. We were busy this morning." She was asked, "Should you have been screened and had your temperature taken before starting work according to policy?" She answered, "Yes." 7. A document from the facility infection control	W 341		

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W 341	Continued From page 13 policy and procedure manual titled, "Prevention Strategies for Transmission of the Coronavirus in Healthcare Settings", was received from the Administrator on 04/01/2021 at 3:30 pm., documented, " ...Utilize a screening tool to assure an adequate screen is performed to enter the facility." 8. A document received from the Administrator on 04/01/2021 at 3:30 pm, titled "Happy Holidays from Infection Control and Employee Health" included: "Continue to take your temperature before reporting to work." 9. On 3/30/2021 at 12:08 p.m., during the lunch meal, Developmental Trainer (DT) #1 walked through the dining room, talking to clients who were at the dining room tables, coming within 2 feet of the clients and was not wearing a mask. The DT was asked, "What have they told you about wearing masks around the clients?" He stated, "We don't have to have them on when eating, but if we are around them, we have to have them on." The DT was asked, "I saw you walking around and talking to the clients in the dining room, "Should you have had the mask on while walking through there talking to the clients?" He stated, "Probably should have, yes." 10. On 3/30/2021 at 12:13 p.m., during the lunch meal, Behavioral Tech (BT) #1 who did not have a mask on, was sitting at the dining room table between two clients who were eating. The two clients were approximately 2 feet away from her on each side. The BT was asked, "What have they told you about wearing masks?" She stated, "You are always supposed to have them on at all times."	W 341		

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W 341	Continued From page 14 11. On 3/30/2021 at 2:10 p.m., Teacher #1 was in class, at her desk without a mask on from 2:10 p.m. to 2:52 p.m. Two clients went up to the teacher's desk, within 3 feet of the teacher during this time. Teacher #1 was asked why she was not wearing a mask. The teacher stated, "My mouth was sore, and the mask was tight on me." 12. On 3/30/2021 at 5:35 p.m., two Behavioral Health Associates (BHA) were eating supper at the table with 3 clients without social distancing. BHA #5 was sitting on the side of the table. 1 client was sitting across the table from BHA #5, approximately 2 feet away. Another client was sitting at the end of the table, approximately 2 feet away. BHA #6 was sitting on the other end of the table. A client was sitting on the side of the table to her left side, approximately 2 feet away. 13. On 3/30/2021 at 5:50 p.m. and 5:55 p.m., BHA #6 and BH #5 were asked if they usually ate with the clients. They both responded "Yes." 14. A facility memorandum note provided by the Administrator on 4/1/2021 at 3:30 p.m., documented, "Happy Holidays from Infection Control and Employee Health . . . you will be required to wear your mask at all times."	W 341		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.	W 371		

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W 371	Continued From page 15 This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the active treatment medication objective was conducted to increase potential in meeting individual objectives for 4 sampled clients (Clients #1, #5, #7 and #8) who were observed on medication pass. The findings are: 1. Client #7 had diagnoses of Intellectual Disability Mild and Disruptive Mood Dysregulation Disorder. a. On 3/30/2021 at 12:15 p.m., Licensed Practical Nurse (LPN) #2 administered medication (meds) to the client. The LPN did not ask the client any questions or give the client any information/teaching related to his medication during this time. b. The Medication (Med) Teaching - March 2021 sheet in the medication room documented, "[Client #1] will state shape of meds without assistance." 2. Client #8 had diagnoses of Intellectual Disability: Mild, Unspecified Mood Disorder, and Other Conduct Disorders. a. On 3/30/2021 at 12:25 p.m., LPN #2 administered the client medication. The LPN did not ask the client any questions or give the client any information/teaching related to his medication during this time. b The Med Teaching - March 2021 sheet in the medication room documented, "[Client #8] will give times meds taken without assistance."	W 371		

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W 371	Continued From page 16 3. Client #1 had a diagnosis of Intellectual Disability: Moderate. a. On 3/30/2021 at 7:40 p.m., LPN #3 administered the client medication. The LPN did not ask the client any questions or give the client any information/teaching related to his medication during this time. b. The Med Teaching - March 2021 sheet in the medication room documented, "[Client #1] state name without assistance." 4. On 3/31/2021 at 8:25 a.m., LPN #2 was asked about the objectives for medication teaching and why she did not do any teaching related to the objectives for Client #7 and Client #8 during the medication pass on 3/30/2021. The LPN stated the objectives were on a sheet that was posted on the inside of the door to the medication closet. LPN #2 also stated that she did most of her teaching in the mornings. 5. Client #5 had diagnoses of Moderate Intellectual Development Disorder, and Disruptive Mood Dysregulation Disorder (a mental disorder with frequent temper outbursts). a. On 03/31/2021 at 9:00 a.m., LPN #1 administered medication to Client #5 in the Haley House. Client #5 was calm, cooperative, and alert. She was handed a cup of medication and a cup of water with laxative when she came to the nurse's station window. The client did not participate in the medication process in any other way and stated nothing about her medications. The nurse did not provide any teaching or other discussion about the medications.	W 371		

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W 371	Continued From page 17 b. On 03/31/2021 at 9:05 a.m., LPN #1 was asked, "What is [Client #5's] SAMs (Self Administration of Medications) objective?" The LPN replied, "I don't think they want her giving her own medication, she has a history of drug seeking." LPN #1 was asked, "What about an objective to learn about her medications so she can participate and become more independent?" The LPN stated, "I don't know what it is." The LPN proceeded to find a clipboard with papers on a shelf, then stated, "It says here she is supposed to name her meds." The LPN was asked, "Did you have her do that this morning." She stated, "No." c. On 04/01/2021 at 8:50 a.m., LPN#1 again administered medication in The Haley House and had just finished with Client #5. LPN #1 was asked for a copy of the medication training objectives for Client #5. The March objectives were no longer present on the clipboard, only medication teaching sheet dated for April (Picture was taken). The April training objective on the "House Med Teaching -April 2021 document the objective for Client #5 was "Name am meds without assistance." LPN #1 was asked, "If this is the second day you are in this house giving medications in the morning, and [Client #5] is supposed to be getting training on her AM medications according to this teaching plan, how is she getting trained on them if you aren't doing it?" She stated, "I teach at Boys Ranch, the other nurse does it." She was asked, "The nurse in the PM does it?" She stated, "Yes." She was asked, "If the objective is for [Client #5] to learn her morning medicines, how does the nurse in the evening do it? Isn't that confusing for [Client #5]?" LPN #1 answered, "She goes over the evening	W 371		

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W 371	Continued From page 18 medications, they are the same, or about the same as the morning medicines." d. On 04/01/2021 at 9:45 a.m., a document named, "Haley House Med Teaching -March 2021", was received from the Assistant Director of Nursing (ADON). It documented Client #5 was to "Name am [morning] meds without assistance." The ADON was asked, "Is this objective part of the master treatment or active treatment plan?" She stated, "Yes." She was asked, "What is the process for developing this objective?" She answered, "Every month I get the sheets from the nurses on how the client is doing with their objective. Then I look at this guide ["Nursing written training program reference"], and I use it to develop the next month's objective." She was then asked, "Should each nurse work with the client every time they administer medicines to help the client achieve their objective?" She stated, "Yes, unless there is some reason not to, like the client is having a bad day."	W 371		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food was stored and labeled to maintain freshness in 1 (Willow Creek) of 4 (Willow Creek, Oak Creek, Boys Ranch and Haley House) residences to prevent the potential for food borne illness. The findings are:	W 454		

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W 454	Continued From page 19 1. On 03/30/2021 at 8:23 a.m., the refrigerator, freezer and kitchen in Willow Creek were inspected with the following findings: a. The freezer had 7 shopping bags wrapped around unlabeled, undated items (Pictures were taken); Behavior Health Associate (BHA) #2 was asked, "Are these shopping bags wrapped around food?" She stated, "Yes." She was asked, "Should all these undated, unlabeled foods be in the freezer?" She stated, "No, I'm getting ready to throw them away." She was then asked, "What about the butter and cheese in the refrigerator with no date?" She stated, "Same." b. In the refrigerator there were 10 squeeze bottles, (not original containers), stored in the refrigerator door, none of which had caps on the tips. (Picture was taken). One bottle was labeled "Mayo 4/28/20", one was labeled "Barbeque 2020". Four of the squeeze bottles had no labels. (Pictures were taken). None of the squeeze bottles had expiration or use by dates on them. BHA #2 was asked, "Should all the bottles that are unlabeled, undated be in the refrigerator?" She stated, "No, except the kids remove them at lunch time." She was then asked, "What about the bottles dated 2020?" She replied, "No." c. A large plastic jar of ketchup was found on the kitchen counter, close to the refrigerator. Around the bottom of the jar lid was a large thick ring of dried red substance appearing to be ketchup (picture taken). BHA #2 was asked, "Should it have been left this way?" She stated, No, I'll throw it out." d. On 04/01/2021 at 3:33 p.m., the Administrator	W 454		

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W 454	Continued From page 20 provided a document with the facility name titled "Chapter 16 - Nutrition Services." It documented, "All reusable food products should be stored using the proper procedures, legibly labeled, and dated."	W 454		