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

May 20/2021

David Kuchinski, Administrator
Centers For Youth And Families Inc
6501 W 12th Street
Little Rock, AR 72225-1970

Dear Mr. Kuchinski:

On May 11, 2021 a Complaint 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 Psychiatric Residential Treatment Facilities 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 you receipt of the Statement of Deficiencies. Failure to submit a POC may result in termination. Include a completion date for each deficieny cited.

Sandra Broughton, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
Telephone (501) **320-6182**
email to Sandra.Broughton@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 Sandra Broughton, Program Administrator at 501-320-6182.

Sincerely,

Sandra Broughton
Administrative Services Manager

DPSQA/Office of Long Term Care
Survey & Certification Section

sgb

cc: DRA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L101	A. BUILDING _____ B. WING _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

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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. Complaint #AR00026502 was substantiated. Complaint #AR00026504 was substantiated. Complaint #AR00026552 was unsubstantiated.	N 000		
N 128	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a client did not sustain an injury as a result of a restraint for 1 of 1 (Client #4) sampled client who sustained an	N 128		

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

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injury during the use of a physical restraint. The findings are:

Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall... Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..."

b. A Medical Progress Note, dated 5/2/21 at 6:00 p.m., signed by RN (Registered Nurse) #1 documented, "Most of the shift client was irate, unstable and disrespectful to staff. Client was cursing at staff, threatening staff, hitting staff and peers while on the unit. Client refused to eat breakfast because she was upset. Client was climbing in the window seal and this nurse and several staff members tried their best to talk with the client to see is she could turn her day around. This nurse tried to get the client to calm down and follow directions in order to get to go on another unit with a particular staff member. Informed client that if she kept up self harm and aggressive behaviors this nurse would have to call [Doctor]. Client was trying to take her clothes off while in the unit as well. Tried bringing the client into the nurses station a few hours later and speak with the client and the client ran around the day area and she eventually came to the nurse's station. While trying to speak with the client about her behavior client ran and locked herself in the nurse's station bathroom after trying to elope from the nurse's station. This nurse asked for assistance from a QBHP (Qualified Behavior Health Professional) after client went and attempted to lock herself in the nurse's station

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bathroom. The QBHP came and assisted after the client tried to push him out with the door. Per QBHP report the client attempted to punch him which resulted in him performing a HWC (Handle With Care) wall restraint. The restraint lasted from 1037 a.m.-1040 a.m. The restraint was done to the best of staff ability based on training and the least restrictive restraint used at the time of the incident. Client was hollering about her face at which time the staff pulled the client back so that her face was not touching the wall and she continued to scream about her face at which time this nurse informed her that her face was no longer touching the wall. After release client complained of right arm pain and stated she could not feel her arm. Client rated her pain level at 9/10 (9 out of 10) and this nurse did a ROM (Range of Motion assessment. Neurological check). Client arm did appear swollen and red. After ROM assessment was done this nurse noticed a clicking noise and what felt like grinding near/at the right elbow. [Doctor] was called and ordered for the client to be sent out to [Hospital] for further evaluation. Client guardian was called several times and reassured that she would be contacted every time this nurse received new information regarding the status of the client. Around 1251 (12:51 p.m.) received report from staff that client right humerus was broken and she would need surgery..."

c. On 5/3/21 at 1:11 p.m. the Assistant Clinical Director stated, "Everybody is no longer to do the Handle With Care hold anymore, they are to do CPI (Crisis Prevention Intervention) only." The Assistant Clinical Director was asked, how are staff notified that the Handle with Care is not to be utilized? She stated, "They emailed that to all employees, the email and memos to all

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employees this morning and the program manager." The Assistant Clinical Director was asked, how are staff monitored to ensure they are not using the Handle With Care holds? She stated, "The nurse and the program manager, they are monitoring directly and we are also doing video review of each restraint. They are here and are present when they are doing the hold and make sure they are doing CPI." The Assistant Clinical Director was asked, when were the notified, this morning? She stated, "Yes. The staff in the children's program, ages six to twelve, were told about two months ago, because of the size difference to use the CPI." The Assistant Clinical Director was asked, [Client #4] is ten years old? She stated, "Yes." The Assistant Clinical Director was asked, was she in the [Building]? She stated, "Yes." The Assistant Clinical Director was asked, when she was restrained, was she placed in the Handle With Care position? She stated, "She was in the bathroom so there is no video, but documentation says that he used the Handle With Care position." The Assistant Clinical Manager was asked, so he used a hold he was told he was not to use? She stated, "Correct." The Assistant Clinical Manager was asked, where is he now? She stated, "He was suspended immediately after the hold? The Assistant Clinical Manager was asked, yesterday? She stated, "Yes." At 2:57 p.m. the Assistant Clinical Manager stated, "[Chief Clinical Officer] is telling me they also suspended the nurse." An in-service and refresher training in the CPI was being conducted during the investigation.

d. On 5/5/21, at 9:04 a.m. the video with audio was viewed. The video with audio only showed the hall which leads to the nurse's station and

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treatment room. The timing on the video did not reflect the actual time of the incident. The client was viewed coming through the door into the hall, then the client goes back out. The nurse goes out, out of view of the camera, then comes back into the hall with the client, shutting the door behind them. The client was seen attempting to get past the nurse and open the door. The nurse blocks the way and the client was seen pulling on the nurse at which time the nurse stated, "Back up. If you grab me you are going to the ground." The nurse was seen with a syringe in her hand. The client then goes into the nurse's station, out of view of the camera, and the nurse is seen on her phone. A male staff member enters the hall and then goes into the nurse's station, out of view of the camera. You can hear the client yelling "ow' and screaming "my face, my face, my arm, my arm. At this time the nurse enters into the nurse's station, out of view of the camera. A voice is heard saying, "you need to calm down." There was more screaming and you can hear the client saying "Yes sir." The male staff member was seen exiting the nurse's station and the client is heard saying, "I can't move my arm." There was more screaming and the client was heard saying, "Please don't hurt it." There was a female voice heard saying, "If it hurts and you can't move it I have to touch it." The male staff member exited the room, went out the door, came back in with a cup in his hand, and went into the nurse's station, out of camera view. There was crying and hard breathing heard. The nurse and client come out of nurse's station into the hallway and the client was seen holding her arm.

e. On 5/5/21 at 9:33 a.m. the video with no audio was viewed. The client was seen going into the nurse's station then into the bathroom. The male

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staff was viewed coming into the nurse's station and then into the bathroom. The nurse goes to the door of the bathroom and then goes out of the nurse's station into the medication room, out of the line of vision of the restraint, then one minute later comes back into the nurse's station to the bathroom door. The nurse then comes out of the bathroom, looks at a monitor on the desk, goes back to the bathroom, comes back out and sits in a chair at the desk, takes a drink from a cup, gets up and goes back into the bathroom. The male staff exits bathroom then walks out of camera view, comes back with a cup in his hand and goes into the bathroom. The nurse, client and male staff come out of the bathroom, the nurse examines clients arm. The client, nurse and staff member leave the nurse's station and go to the treatment room. The restraint was not viewable from either camera.

f. On 5/5/21 at 10:04 a.m. the Training Coordinator was asked, "If you do a Handle With Care hold, and it is done correctly, should there be any injuries?" She stated, "No." The Training Coordinator was shown a picture of the male staff and the client standing in the nurse's station together. The Training Coordinator was asked, "With the picture you just saw with the staff and client, would the Handle With Care be an appropriate hold?" She stated, "I would have placed them in a child control hold."

g. The facility Emergency Safety Interventions policy, received from the Assistant Clinical Director on 5/3/21 at 1:03 p.m., documented, "...General Principles...G. An emergency safety intervention must be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the client's

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N 128	Continued From page 6 chronological and developmental age; size; gender; physical, medical and psychiatric condition; and personal history (including any history or physical or sexual abuse.)...I. Verbal de-escalation interventions will be exhausted before a more restrictive intervention is initiated...."	N 128		
N 132	PROTECTION OF RESIDENTS CFR(s): 483.356(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a physical restraint was performed safely and was appropriate for the client's and size for 1 (Client #4) of 5 (Client #1, 2, 3, 4 and 6) sampled clients who were physically restrained. The findings are: Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall...Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..."	N 132		

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b. A Medical Progress Note, dated 5/2/21 at 6:00 p.m., signed by RN (Registered Nurse) #1 documented, "Most of the shift client was irate, unstable and disrespectful to staff. Client was cursing at staff, threatening staff, hitting staff and peers while on the unit. Client refused to eat breakfast because she was upset. Client was climbing in the window seal and this nurse and several staff members tried their best to talk with the client to see is she could turn her day around. This nurse tried to get the client to calm down and follow directions in order to get to go on another unit with a particular staff member. Informed client that if she kept up self harm and aggressive behaviors this nurse would have to call [Doctor]. Client was trying to take her clothes off while in the unit as well. Tried bringing the client into the nurses station a few hours later and speak with the client and the client ran around the day area and she eventually came to the nurse's station. While trying to speak with the client about her behavior client ran and locked herself in the nurse's station bathroom after trying to elope from the nurse's station. This nurse asked for assistance from a QBHP (Qualified Behavior Health Professional) after client went and attempted to lock herself in the nurse's station bathroom. The QBHP came and assisted after the client tried to push him out with the door. Per QBHP report the client attempted to punch him which resulted in him performing a HWC (Handle With Care) wall restraint. The restraint lasted from 1037 a.m.-1040 a.m. The restraint was done to the best of staff ability based on training and the least restrictive restraint used at the time of the incident. Client was hollering about her face at which time the staff pulled the client back so that her face was not touching the wall and she continued to scream about her face at which

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time this nurse informed her that her face was no longer touching the wall. After release client complained of right arm pain and stated she could not feel her arm. Client rated her pain level at 9/10 (9 out of 10) and this nurse did a ROM (Range of Motion assessment. Neurological check). Client arm did appear swollen and red. After ROM assessment was done this nurse noticed a clicking noise and what felt like grinding near/at the right elbow. [Doctor] was called and ordered for the client to be sent out to [Hospital] for further evaluation. Client guardian was called several times and reassured that she would be contacted every time this nurse received new information regarding the status of the client. Around 1251 (12:51 p.m.) received report from staff that client right humerus was broken and she would need surgery..."

c. On 5/3/21 at 1:11 p.m. the Assistant Clinical Director stated, "Everybody is no longer to do the Handle With Care hold anymore, they are to do CPI (Crisis Prevention Intervention) only." The Assistant Clinical Director was asked, how are staff notified that the Handle with Care is not to be utilized? She stated, "They emailed that to all employees, the email and memos to all employees this morning and the program manager." The Assistant Clinical Director was asked, how are staff monitored to ensure they are not using the Handle With Care holds? She stated, "The nurse and the program manager, they are monitoring directly and we are also doing video review of each restraint. They are here and are present when they are doing the hold and make sure they are doing CPI." The Assistant Clinical Director was asked, when were the notified, this morning? She stated, "Yes. The staff in the children's program, ages six to twelve,

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were told about two months ago, because of the size difference to use the CPI." The Assistant Clinical Director was asked, [Client #4] is ten years old? She stated, "Yes." The Assistant Clinical Director was asked, was she in the [Building]? She stated, "Yes." The Assistant Clinical Director was asked, when she was restrained, was she placed in the Handle With Care position? She stated, "She was in the bathroom so there is no video, but documentation says that he used the Handle With Care position." The Assistant Clinical Manager was asked, so he used a hold he was told he was not to use? She stated, "Correct." The Assistant Clinical Manager was asked, where is he now? She stated, "He was suspended immediately after the hold? The Assistant Clinical Manager was asked, yesterday? She stated, "Yes." At 2:57 p.m. the Assistant Clinical Manager stated, "[Chief Clinical Officer] is telling me they also suspended the nurse." An in-service and refresher training in the CPI was being conducted during the investigation.

d. On 5/5/21, at 9:04 a.m. the video with audio was viewed. The video with audio only showed the hall which leads to the nurse's station and treatment room. The timing on the video did not reflect the actual time of the incident. The client was viewed coming through the door into the hall, then the client goes back out. The nurse goes out, out of view of the camera, then comes back into the hall with the client, shutting the door behind them. The client was seen attempting to get past the nurse and open the door. The nurse blocks the way and the client was seen pulling on the nurse at which time the nurse stated, "Back up. If you grab me you are going to the ground." The nurse was seen with a syringe in her hand.

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The client then goes into the nurse's station, out of view of the camera, and the nurse is seen on her phone. A male staff member enters the hall and then goes into the nurse's station, out of view of the camera. You can hear the client yelling "ow' and screaming "my face, my face, my arm, my arm. At this time the nurse enters into the nurse's station, out of view of the camera. A voice is heard saying, "you need to calm down." There was more screaming and you can hear the client saying "Yes sir." The male staff member was seen exiting the nurse's station and the client is heard saying, "I can't move my arm." There was more screaming and the client was heard saying, "Please don't hurt it." There was a female voice heard saying, "If it hurts and you can't move it I have to touch it." The male staff member exited the room, went out the door, came back in with a cup in his hand, and went into the nurse's station, out of camera view. There was crying and hard breathing heard. The nurse and client come out of nurse's station into the hallway and the client was seen holding her arm.

e. On 5/5/21 at 9:33 a.m. the video with no audio was viewed. The client was seen going into the nurse's station then into the bathroom. The male staff was viewed coming into the nurse's station and then into the bathroom. The nurse goes to the door of the bathroom and then goes out of the nurse's station into the medication room, out of the line of vision of the restraint, then one minute later comes back into the nurse's station to the bathroom door. The nurse then comes out of the bathroom, looks at a monitor on the desk, goes back to the bathroom, comes back out and sits in a chair at the desk, takes a drink from a cup, gets up and goes back into the bathroom. The male staff exits bathroom then walks out of camera

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(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 132	Continued From page 11 view, comes back with a cup in his hand and goes into the bathroom. The nurse, client and male staff come out of the bathroom, the nurse examines clients arm. The client, nurse and staff member leave the nurse's station and go to the treatment room. The restraint was not viewable from either camera. f. On 5/5/21 at 10:04 a.m. the Training Coordinator was asked, if you do a Handle With Care hold, and it is done correctly, should there be any injuries? She stated, "No." The Training Coordinator was shown a picture of the male staff and the client standing in the nurse's station together. The Training Coordinator was asked, with the picture you just saw with the staff and client, would the Handle With Care be an appropriate hold? She stated, "I would have placed them in a child control hold." g. The facility Emergency Safety Interventions policy, received from the Assistant Clinical Director on 5/3/21 at 1:03 p.m., documented, "...General Principles...G. An emergency safety intervention must be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the client's chronological and developmental age; size; gender; physical, medical and psychiatric condition; and personal history (including any history or physical or sexual abuse.)...I. Verbal de-escalation interventions will be exhausted before a more restrictive intervention is initiated...."	N 132		
N 136	PROTECTION OF RESIDENTS CFR(s): 483.356(c)(4) [At admission, the facility must] provide a copy of	N 136		

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the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s).

This ELEMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure a copy of the facility's restraint policy was received by the guardian at admission for 1 (Client #4) of 1 (Client #4) sampled clients. The findings are:

Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder.

a. The facility Consent For Admission And Treatment, signed by Client #4's guardian on 3/3/21, documented, "...Section IV (four): Consent For Behavior Management And Emergency Safety Interventions a. I have reviewed the [Facility] behavior management and emergency safety interventions as outlined in agency policy. I give my consent and permission for [Facility] to utilize these procedures as clinically indicated in the course of treatment...b. I authorize my child's participation in the Center's behavior management and treatment interventions related to the target behaviors that were identified..."

b. On 5/3/21 at 4:42 p.m. the Chief Clinical Officer was asked, did [Client #4's] guardian get a copy of the facility policy on behavior management and emergency safety interventions? He stated, "I think when we switched over to Doc-U-Signed we omitted that." The Chief Clinical Officer was shown the signed consent at this time and was asked, this consent

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N 136	Continued From page 13 is all they are getting related to safety interventions? He stated, "Yes."	N 136		
N 144	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(e) Each order for restraint or seclusion must: (1) Be limited to no longer than the duration of the emergency safety situation; and (2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9. This ELEMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a Physician's Order for a restraint was documented for 1 (Client #4) of 1 (Client #4) sampled clients. This failed practice had the potential to affect 46 facility clients as documented on a list provided by the Assistant Clinical Director on 5/3/21 at 1:43 p.m. The findings are: Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall...Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..." There was no Physician's Order found for the use of the restraint. b. On 5/3/21, at 2:57 p.m., the Assistant Clinical Director was asked, where is the Physician's	N 144		

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N 144	Continued From page 14 Order for the restraint on 5/2? She stated, "I didn't see one for that one. The only order for an ESI (Emergency Safety Intervention) was on the twenty fifth." The Assistant Clinical Director was asked, that was April twenty fifth, right? She stated, "Yes."	N 144		
N 145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention. This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a face to face assessment was conducted within one-hour of the start of the restraint for 4 (Clients #1, #2, #4 and #6) of 5 (Clients #1, #2, #3, #4 and #6) sampled clients who had been restrained. The findings are:	N 145		

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N 145	Continued From page 15 1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 9/28/20 documented, "...Time initiated 1434 [2:34 p.m.] Time ended 1437 [2:37 p.m.]...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour indicated No. If no, reason why- RN [Registered Nurse] not on duty..." The Face-to-Face section of the form was signed, dated and timed as completed on 9/29/20 at 12:37 p.m. 2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 10/7/20 documented, "...Time initiated 1256 [12:56 p.m.] Time ended 1305 [1:05 p.m.]...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour indicated No. If no, reason why- No RN on duty..." The Face-to-Face section of the form was signed and dated on 10/7/20. The time is not clear but starts with 18 to indicate within the 6 p.m. hour. 3. Client #6 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 4/30/21 documented, "...Time initiated 10:30 a.m. Time ended 10:34 a.m. ...The Face-to-Face Assessment form must be completed within one hour of initiation of	N 145		

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Emergency Safety Intervention- Face-to-Face was completed within one hour... If no, reason why- Client Refused..." The Face-to-Face section of the form had a line through the section and documented "Client refused face-to-face."

b. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...Time initiated 1312 [1:12 p.m.] Time ended 1314 [1:14 p.m.]...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour indicated Yes..." The Face-to-Face section of the form was signed, dated and timed as completed on 5/3/21 at 1425 [2:25 p.m.].

4. On 5/5/21 at 1:30 p.m., RN #2 stated, "The Face-to-Face is one hour to get it. The RN has to do assessment. The LPN [Licensed Practical Nurse] maybe working so I have to get it done in one hour." When asked what the facility policy was for Face-to-Face assessments, RN #1 stated, "It's not policy for it not to get done, it's not permissible."

5. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer was asked, "When should the Face-to-Face assessment be completed?" The Chief Clinical Officer stated, "Face-to-Face in an hour with an RN."

6. On 5/11/21 at 8: 55 a.m., the Assistant Clinical Director was asked how a client could refuse a Face-to-Face assessment and the Assistant Clinical Director stated, "I seen that. No, they should be able to complete."

7. The facility Emergency Safety Interventions

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policy received on 5/3/21 form the Assistant Clinical Director documented, "...Psychiatric Residential Treatment...E. Post Intervention Procedures- A. Within one hour of the initiation of the emergency safety intervention, a physician, an RN, or a licensed independent practitioner trained by the physician and competent to perform the assessment, must conduct a face-to-face assessment of the physical and psychological well being of the resident..."

8. Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form, dated 4/25/21, documented, "HWC (Handle With Care)-Primary Restraint Technique; Wall...Time Initiated 1600 (4:00 p.m.); Time Ended 1603 (4:03 p.m.)...5. Nursing Assessment (Upon Removal from Procedure): Time:1730 (5:30 p.m.)..."

b. The Face-To-Face Assessment For Emergency Safety Interventions documented, "The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention..." There was no date or time documented to indicate when the Face-to-Face Assessment was completed.

c. On 5/5/21, at 2:08 p.m., the CCO (Chief Clinical Officer) was asked, the ESI (Emergency Safety Intervention) dated 4/25 shows an assessment was done at 1730 (5:30 p.m.), time restraint had ended was 1603 (4:03 p.m.). When should that have been done? He stated, "Within an hour." The CCO was asked, is that when the face to face assessment was done? He stated, "I

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N 145	Continued From page 18 can't tell. It's not reliable information."	N 145		
N 148	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(g)(3) [Each order for restraint or seclusion must include] the emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use. This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the specific time limit for the restraint order was on the physician's order for 4 (Clients #1, #2, #3, and #4) of 5 (Clients #1, #2, #3, #4 and #6) sampled clients who had Emergency Safety Interventions (ESI) orders. The findings are: 1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI dated 8/19/20 documented, "...Personal Restraint: Handle with Care Solo Takedown (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. b. A Physicians Orders for ESI dated 8/24/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Techniques (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. c. A Physicians Orders for ESI dated 9/28/20	N 148		

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documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order.

2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/7/20 documented, "...Personal Restraint: Handle with Care Two Person Takedown (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order.

b. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/9/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order.

c. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/10/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order.

d. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/13/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order.

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N 148	Continued From page 20 e. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/14/20 documented, "...Personal Restraint: Handle with Care Solo Takedown (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. f. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/15/20 documented, "...Personal Restraint: Handle with Care Two Person Takedown (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. g. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/23/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. 3. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer stated, "The doctor gives permission for length of a hold." When asked if that time was on the physician order, he stated, "It should be." 4. The facility Emergency Safety Interventions policy received on 5/3/21 form the Assistant Clinical Director documented, "...Psychiatric Residential Treatment...Physician's Orders...e. ...i. The nurse writes the verbal/telephone order in Physician's Order section of the client record and indicates:...c. the specific emergency intervention(s) ordered including the maximum length of time authorized for use..." 5. Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation	N 148		

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N 148	Continued From page 21 Disorder. a. An Emergency Safety Intervention Reporting Form, dated 4/25/21, documented, "HWC (Handle With Care)-Primary Restraint Technique; Wall...Time Initiated 1600 (4:00 p.m.); Time Ended 1603 (4:03 p.m.)..." b. A Physician's Orders for ESI (Emergency Safety Intervention), dated 4/25/21 at 6:05 PM, documented, "...Personal Restraint: Handle With Care Personal Restraint Technique (standing) (Include maximum time in minutes in text box) 1600 (4:00 p.m.)-(to) 1603 (4:03 p.m.) (2-3 minutes)...." The Physician's Order stated the length of time the client was in the restraint, but did not document the length of time the physician authorized the use of the restraint. c. On 5/5/21, at 2:46 p.m., the Chief Clinical Officer was asked, is there a time limit for the ESI on 4/25 documented on the Physician's order? He stated, "I don't see one, just the time in the restraint." 6. Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and Unspecified Schizophrenia and other Psychotic Disorders. a. A physicians Orders for ESI dated 3/31/21 documented, "...Personal Restraint: Handle With Care Four Person Takedown (include maximum time in minutes in test box)... " The time limit for the restraint order was not documented on the order.	N 148		

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N 148	Continued From page 22 b. A physicians Orders for ESI dated 3/23/21 documented, "...Personal Restraint: Handle With Care Four Person Takedown (include maximum time in minutes in test box)... " The time limit for the restraint order was not documented on the order. c. A physicians Orders for ESI dated 3/11/21 documented, "...Personal Restraint: Handle With Care Two Person Takedown (include maximum time in minutes in test box)... " The time limit for the restraint order was not documented on the order. d. A physicians Orders for ESI dated 3/4/21 documented, "...Personal Restraint: Handle With Care Personal Restraint Technique (standing) (include maximum time in minutes in test box)... Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order. e. A physicians Orders for ESI dated 2/5/21 documented, "...Personal Restraint: Handle With Care Personal Restraint Technique (standing) (include maximum time in minutes in test box)... Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order. f. A physicians Orders for ESI dated 1/3/21 documented, "...Personal Restraint: Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order.	N 148		

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N 148	Continued From page 23 g. A physicians Orders for ESI dated 11/25/20 documented, "...Personal Restraint: Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order. h. A physicians Orders for ESI dated 10/24/20 documented, "...Personal Restraint: Handle With Care Solo takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order.	N 148		
N 152	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(h)(3) [Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the date and time of the 1-hour assessment was documented for 1 (Client #3) of 4 sampled clients (Clients #1, #2, #3, 4 and 6) who were physically restrained. The findings are: Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and Unspecified Schizophrenia and other Psychotic Disorders. The EMERGENCY SAFETY INTERVENTION REPORTING FORM dated 1/3/21...FACE_TO_FACE ASSESSMENT FOR EMERGENCY SAFETY	N 152		

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N 152	Continued From page 24 INTERVENTION...Date:___Time:___ , were not filled in by the RN (Registered Nurse).	N 152		
N 155	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain documented records for Emergency Safety Interventions (ESI) reports for 1 (Client #2) of 5 (Clients #1, #2, #3, #4 and #6) sampled clients who had ESI implemented. The findings are: Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/10/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box) 8 minutes..." b. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/14/20 documented, "...Personal Restraint: Handle with Care Solo Takedown (include maximum time in minutes in text box) 1121-1130 [11:21 a.m.-11:30 a.m.] ..." c. On 5/3/21 at 12:57 p.m., the Assistant Clinical Director was asked to provide the two missing ESI reports, and the Assistant Clinical Director	N 155		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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 155	Continued From page 25 stated, "We're still looking but have not found the other two reports." d. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer was asked if he was aware of the missing ESI reports and he stated, "Yes." When asked if ESIs were supposed to be on the clinical record, the Chief Clinical Officer stated, "Supposed to be, yes."	N 155		
N 156	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician signed an order for a physical restraint as soon as possible to ensure restraint orders were accurate and appropriate and update the treatment plan as needed for 3 (Clients #1, #2 and #3) of 5 (Clients #1 - #4 and #6) sampled residents who had a restraint ordered. The findings are: 1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI (Emergency Safety Intervention) dated 9/28/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 9/28/2020 at 5:32 p.m.. There was no physician's	N 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 156	Continued From page 26 signature on the order. 2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/7/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/7/2020 at 1:46 p.m.. There was no physician's signature on the order. b. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/9/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/9/2020 at 5:48 p.m.. There was no physician's signature on the order. c. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/10/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/10/2020 at 7:45 p.m.. There was no physician's signature on the order. d. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/14/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/14/2020 at 11:58 a.m.. There was no physician's signature on the order. e. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/23/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/24/2020 at 10:44 a.m.. There was no physician's signature on the order.	N 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 156	Continued From page 27 3. On 5/5/21 at 1:30 p.m., Registered Nurse (RN) #1 was shown one of the orders and asked if the physician had signed it, and RN #1 stated, "No." She was asked "Is it supposed to be signed?" She stated, "Yes." 4. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer was asked if he was aware the physician's orders were supposed to be signed and he stated, "I may have known but don't recall." 5. The facility Emergency Safety Interventions policy received on 5/3/21 form the Assistant Clinical Director documented, "...Psychiatric Residential Treatment...Physician's Orders...f. The physician's verbal order must be followed with the physician's signature verifying the verbal order within 5 days..." 6. Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and Unspecified Schizophrenia and other Psychotic Disorders. A Physicians Orders for ESI dated 1/3/21 documented, "Personal Restraint...an was signed by the LPN on 1/3/2021 at 7:58 p.m. There was no physician's signature on the order.	N 156		
N 165	MONITORING DURING AND AFTER RESTRAINT CFR(s): 483.362(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing, and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration	N 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 165	Continued From page 28	N 165		

of the emergency safety intervention.

This STANDARD is not met as evidenced by:
Based on observation, record review and interview the facility failed to ensure a nurse was physically present to continually assess the safety of a restraint and continuously monitor a client during the use of a physical restraint for 1 (Client #4) of 5 (Client #1, 2, 3, 4, 6) sampled clients who were physically restrained. The findings are:

Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall...Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..."

b. On 5/5/21 at 9:33 a.m. the video of the restraint, for Client #4 on 5/2/21 at 10:37 a.m., was viewed. The video had no audio. The client is seen going into the nurse's station then into the bathroom. The male staff is viewed coming into the nurse's station and then into the bathroom. The nurse goes to the door of the bathroom and then goes out of the nurse's station into the medication room, out of the line of vision of the restraint, then one minute later comes back into the nurse's station to the bathroom door. The nurse then comes out of the bathroom, looks at a monitor on the desk, goes back to the bathroom, comes back out, sits in a chair at the desk, takes a drink from a cup, out of the line of vision of the restraint, gets up and goes back into the bathroom. The male staff exits bathroom then walks out of camera view, comes back into view

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N 165	Continued From page 29 with a cup in his hand and goes into the bathroom. The nurse, client and male staff come out of the bathroom, and the nurse examines client's arm. The client, nurse and staff member leave the nurse's station and go to the treatment room. The restraint, which was applied in the bathroom, was not viewable from either camera. The nurse failed to be consistently within the view of the physical restraint, to monitor and assess the client and to assess for the safety of the restraint. d. On 5/4/21, at 3:52 p.m., the Assistant Clinical Director was asked, shouldn't the nurse be monitoring the restraint? She stated, "She should be. She goes back and forth numerous times, but we would expect continuous monitoring and observation.	N 165		
N 167	MONITORING DURING AND AFTER RESTRAINT CFR(s): 483.362(c) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a physician, or other licensed practitioner permitted by the state and the facility and trained in the use of emergency safety interventions evaluated the resident's well-being immediately after the restraint was removed for 5 of 5 (Clients #1, #2, #3, #4 and #6)sampled	N 167		

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N 167	Continued From page 30	N 167		

residents who had been restrained. The findings are:

1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form dated 8/19/20 documented, "...Time initiated 8:15 Time ended 8:17...Nursing Assessment (Upon Removal from Procedure): Time 9:00..."

b. An Emergency Safety Intervention Reporting Form dated 9/28/20 documented, "...Time initiated 1434 [2:34 p.m.] Time ended 1437 [2:37 p.m.]...Nursing Assessment (Upon Removal from Procedure): Time 1530 [3:30 p.m.]..."

2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form dated 10/9/20 documented, "...Time initiated 1733 [5:33 p.m.] Time ended 1741 [5:41 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1755 [5:55 p.m.] ..."

b. An Emergency Safety Intervention Reporting Form dated 10/13/20 documented, "...Time initiated 12:12 Time ended 12:17...Nursing Assessment (Upon Removal from Procedure): Time 12:25..."

3. Client #6 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form dated 4/23/21 documented, "CPI High 2 person...Time initiated 2101 [9:01 p.m.] Time

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N 167	Continued From page 31	N 167		

ended 2104 [9:04 p.m.] Time initiated 2105 [9:05 p.m.] Time ended 2107 [9:07 p.m.]... HWC [Handle with Care] 2 person Wall Escort...Time initiated 2112 [9:12 p.m.] Time ended 2115 [9:15 p.m.] Time initiated 2115 [9:15 p.m.] Time ended 2115 [9:15 p.m.]...Nursing Assessment (Upon Removal from Procedure): Time 2140 [9:40 p.m.]..."

b. An Emergency Safety Intervention Reporting Form dated 4/25/21 documented, "...Time initiated 1809 [6:09 p.m.] Time ended 1818 [6:18 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1900 [7:00 p.m.] ..."

c. An Emergency Safety Intervention Reporting Form dated 4/26/21 documented, "...HWC 1 person wall Time initiated 10:06 Time ended 10:08 ... HWC- Take Down 1 person...Time initiated 10:12 Time ended 10:15... Nursing Assessment (Upon Removal from Procedure): Time 10:55 ..."

d. An Emergency Safety Intervention Reporting Form dated 4/30/21 documented, "...Time initiated 10:30 a.m. Time ended 10:34 a.m. ...Nursing Assessment (Upon Removal from Procedure): Time 11:09 ..."

e. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...Time initiated 1207 Time ended 1207 ...Nursing Assessment (Upon Removal from Procedure): Time 1256 ..."

f. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...Time initiated 1312 [1:12 p.m.] Time ended 1314 [1:14 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1425 [2:25 p.m.] ..."

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N 167	Continued From page 32 g. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...CPI seated position medium...Time initiated 1340 [1:40 p.m.] Time ended 1342 [1:42 p.m.] ... Emergency medication -[Intramuscular] ...Time initiated 1356 [1:56 p.m.] Time ended 1356 [1:56 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1425 [2:25 p.m.] ..." h. An Emergency Safety Intervention Reporting Form dated 5/4/21 documented, "...CPI seated medium...Time initiated 10:38 a.m. Time ended 10:39 a.m. Time initiated 10:41 a.m. Time ended 10:43 a.m....CPI Team Control Position...Time initiated 10:39 a.m. Time ended 10:41 a.m. ...Nursing Assessment (Upon Removal from Procedure): Time 11:22 ..." i. An Emergency Safety Intervention Reporting Form dated 5/4/21 documented, "...CPI seated medium...Time initiated 1139 Time ended 1139 ...CPI Team Control Position...Time initiated 1135 Time ended 1136 Time initiated 1138 Time ended 1139 Time initiated 1139 Time ended 1141 Time initiated 1144 Time ended 1144 ...Nursing Assessment (Upon Removal from Procedure): Time 1200 ..." 4. The facility Emergency Safety Interventions policy received on 5/3/21 form the Assistant Clinical Director documented, "...Psychiatric Residential Treatment...E. Post Intervention Procedures ...c. ...2. A physician or a nurse trained in the use of emergency safety interventions must evaluate the client's well being immediately after the restraint is discontinued..." 4. Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation	N 167		

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Disorder.

a. An Emergency Safety Intervention Reporting Form, dated 4/25/21, documented, "HWC (Handle With Care)-Primary Restraint Technique; Wall...Time Initiated 1600 (4:00 p.m.); Time Ended 1603 (4:03 p.m.)...5. Nursing Assessment (Upon Removal from Procedure): Time:1730 (5:30 p.m.)..."

b. The Face-To-Face Assessment For Emergency Safety Interventions documented, "The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention..." There was no date or time documented to indicate when the Face-to-Face Assessment was completed.

c. On 5/5/21, at 2:08 p.m., the CCO (Chief Clinical Officer) was asked, the ESI (Emergency Safety Intervention) dated 4/25 shows an assessment was done at 1730 (5:30 p.m.), time restraint had ended was 1603 (4:03 p.m.). When should that have been done? He stated, "Within an hour." The CCO was asked, is that when the face to face assessment was done? He stated, "I can't tell. It's not reliable information."

5. Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and Unspecified Schizophrenia and other Psychotic Disorders.

a. An Emergency Safety Reporting Form Dated 3/31/2 documented, "...Time initiated 1710 [5:10 p.m.] Time ended 1720 [5:20 p.m.]...Nursing Assessment (Upon Removal from Procedure): "Time: 1730 [5:30 p.m.]

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N 167	Continued From page 34 b. An Emergency Safety Reporting Form Dated 3/23/21 documented, "...Time initiated 1622 [4:32 p.m.] Time ended 1632 [4:32 p.m.]...Nursing Assessment (Upon Removal from Procedure): "Time: 1646 [4:46 p.m.]	N 167		

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N 000	Initial Comments This CMS 2567 survey report supercedes the report sent on May 20, 2021. 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. Complaint #AR00026502 was substantiated, all or in part, with no deficiencies cited. Complaint #AR00026504 was substantiated, all or in part, with no deficiencies cited. Complaint #AR00026505 was substantiated, all or in part,, with deficiencies cited at N148, N152, N156, and N167. Complaint #AR00026506 was unsubstantiated. Complaint #AR00026516 was substantiated, all or in part, with deficiencies cited at N128, N132, N136, N144, N145, N148, N165, and N167. Complaint AR00026524 was substantiated, all or in part, with deficiencies cited at N128, N132, N136, N144, N145, N148, N165, and N167. Complaint #AR00026552 was unsubstantiated. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000		
N 128	PROTECTION OF RESIDENTS	N 128		6/11/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/07/2021

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N 128	Continued From page 1 CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a client did not sustain an injury as a result of a restraint for 1 of 1 (Client #4) sampled client who sustained an injury during the use of a physical restraint. The findings are: Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall... Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..." b. A Medical Progress Note, dated 5/2/21 at 6:00 p.m., signed by RN (Registered Nurse) #1 documented, "Most of the shift client was irate, unstable and disrespectful to staff. Client was cursing at staff, threatening staff, hitting staff and peers while on the unit. Client refused to eat breakfast because she was upset. Client was climbing in the window seal and this nurse and several staff members tried their best to talk with the client to see is she could turn her day around. This nurse tried to get the client to calm down and follow directions in order to get to go on another unit with a particular staff member. Informed client that if she kept up self harm and aggressive behaviors this nurse would have to call [Doctor]. Client was trying to take her clothes off while in the unit as well. Tried bringing the client into the	N 128		

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nurses station a few hours later and speak with the client and the client ran around the day area and she eventually came to the nurse's station. While trying to speak with the client about her behavior client ran and locked herself in the nurse's station bathroom after trying to elope from the nurse's station. This nurse asked for assistance from a QBHP (Qualified Behavior Health Professional) after client went and attempted to lock herself in the nurse's station bathroom. The QBHP came and assisted after the client tried to push him out with the door. Per QBHP report the client attempted to punch him which resulted in him performing a HWC (Handle With Care) wall restraint. The restraint lasted from 1037 a.m.-1040 a.m. The restraint was done to the best of staff ability based on training and the least restrictive restraint used at the time of the incident. Client was hollering about her face at which time the staff pulled the client back so that her face was not touching the wall and she continued to scream about her face at which time this nurse informed her that her face was no longer touching the wall. After release client complained of right arm pain and stated she could not feel her arm. Client rated her pain level at 9/10 (9 out of 10) and this nurse did a ROM (Range of Motion assessment. Neurological check). Client arm did appear swollen and red. After ROM assessment was done this nurse noticed a clicking noise and what felt like grinding near/at the right elbow. [Doctor] was called and ordered for the client to be sent out to [Hospital] for further evaluation. Client guardian was called several times and reassured that she would be contacted every time this nurse received new information regarding the status of the client. Around 1251 (12:51 p.m.) received report from staff that client right humerus was broken and

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N 128	Continued From page 3 she would need surgery..." c. On 5/3/21 at 1:11 p.m. the Assistant Clinical Director stated, "Everybody is no longer to do the Handle With Care hold anymore, they are to do CPI (Crisis Prevention Intervention) only." The Assistant Clinical Director was asked, how are staff notified that the Handle with Care is not to be utilized? She stated, "They emailed that to all employees, the email and memos to all employees this morning and the program manager." The Assistant Clinical Director was asked, how are staff monitored to ensure they are not using the Handle With Care holds? She stated, "The nurse and the program manager, they are monitoring directly and we are also doing video review of each restraint. They are here and are present when they are doing the hold and make sure they are doing CPI." The Assistant Clinical Director was asked, when were the notified, this morning? She stated, "Yes. The staff in the children's program, ages six to twelve, were told about two months ago, because of the size difference to use the CPI." The Assistant Clinical Director was asked, [Client #4] is ten years old? She stated, "Yes." The Assistant Clinical Director was asked, was she in the [Building]? She stated, "Yes." The Assistant Clinical Director was asked, when she was restrained, was she placed in the Handle With Care position? She stated, "She was in the bathroom so there is no video, but documentation says that he used the Handle With Care position." The Assistant Clinical Manager was asked, so he used a hold he was told he was not to use? She stated, "Correct." The Assistant Clinical Manager was asked, where is he now? She stated, "He was suspended immediately after the hold? The Assistant Clinical Manager was asked,	N 128		

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yesterday? She stated, "Yes." At 2:57 p.m. the Assistant Clinical Manager stated, "[Chief Clinical Officer] is telling me they also suspended the nurse." An in-service and refresher training in the CPI was being conducted during the investigation.

d. On 5/5/21, at 9:04 a.m. the video with audio was viewed. The video with audio only showed the hall which leads to the nurse's station and treatment room. The timing on the video did not reflect the actual time of the incident. The client was viewed coming through the door into the hall, then the client goes back out. The nurse goes out, out of view of the camera, then comes back into the hall with the client, shutting the door behind them. The client was seen attempting to get past the nurse and open the door. The nurse blocks the way and the client was seen pulling on the nurse at which time the nurse stated, "Back up. If you grab me you are going to the ground." The nurse was seen with a syringe in her hand. The client then goes into the nurse's station, out of view of the camera, and the nurse is seen on her phone. A male staff member enters the hall and then goes into the nurse's station, out of view of the camera. You can hear the client yelling "ow' and screaming "my face, my face, my arm, my arm. At this time the nurse enters into the nurse's station, out of view of the camera. A voice is heard saying, "you need to calm down." There was more screaming and you can hear the client saying "Yes sir." The male staff member was seen exiting the nurse's station and the client is heard saying, "I can't move my arm." There was more screaming and the client was heard saying, "Please don't hurt it." There was a female voice heard saying, "If it hurts and you can't move it I have to touch it." The male staff member

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exited the room, went out the door, came back in with a cup in his hand, and went into the nurse's station, out of camera view. There was crying and hard breathing heard. The nurse and client come out of nurse's station into the hallway and the client was seen holding her arm.

e. On 5/5/21 at 9:33 a.m. the video with no audio was viewed. The client was seen going into the nurse's station then into the bathroom. The male staff was viewed coming into the nurse's station and then into the bathroom. The nurse goes to the door of the bathroom and then goes out of the nurse's station into the medication room, out of the line of vision of the restraint, then one minute later comes back into the nurse's station to the bathroom door. The nurse then comes out of the bathroom, looks at a monitor on the desk, goes back to the bathroom, comes back out and sits in a chair at the desk, takes a drink from a cup, gets up and goes back into the bathroom. The male staff exits bathroom then walks out of camera view, comes back with a cup in his hand and goes into the bathroom. The nurse, client and male staff come out of the bathroom, the nurse examines clients arm. The client, nurse and staff member leave the nurse's station and go to the treatment room. The restraint was not viewable from either camera.

f. On 5/5/21 at 10:04 a.m. the Training Coordinator was asked, "If you do a Handle With Care hold, and it is done correctly, should there be any injuries?" She stated, "No." The Training Coordinator was shown a picture of the male staff and the client standing in the nurse's station together. The Training Coordinator was asked, "With the picture you just saw with the staff and client, would the Handle With Care be an

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N 128	Continued From page 6 appropriate hold?" She stated, "I would have placed them in a child control hold." g. The facility Emergency Safety Interventions policy, received from the Assistant Clinical Director on 5/3/21 at 1:03 p.m., documented, "...General Principles...G. An emergency safety intervention must be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the client's chronological and developmental age; size; gender; physical, medical and psychiatric condition; and personal history (including any history or physical or sexual abuse.)...I. Verbal de-escalation interventions will be exhausted before a more restrictive intervention is initiated...."	N 128		
N 132	PROTECTION OF RESIDENTS CFR(s): 483.356(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a physical restraint was performed safely and was appropriate for the client's and size for 1 (Client #4) of 5 (Client #1, 2, 3, 4 and 6) sampled clients who were physically restrained. The findings are:	N 132		6/11/21

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Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall...Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..."

b. A Medical Progress Note, dated 5/2/21 at 6:00 p.m., signed by RN (Registered Nurse) #1 documented, "Most of the shift client was irate, unstable and disrespectful to staff. Client was cursing at staff, threatening staff, hitting staff and peers while on the unit. Client refused to eat breakfast because she was upset. Client was climbing in the window seal and this nurse and several staff members tried their best to talk with the client to see is she could turn her day around. This nurse tried to get the client to calm down and follow directions in order to get to go on another unit with a particular staff member. Informed client that if she kept up self harm and aggressive behaviors this nurse would have to call [Doctor]. Client was trying to take her clothes off while in the unit as well. Tried bringing the client into the nurses station a few hours later and speak with the client and the client ran around the day area and she eventually came to the nurse's station. While trying to speak with the client about her behavior client ran and locked herself in the nurse's station bathroom after trying to elope from the nurse's station. This nurse asked for assistance from a QBHP (Qualified Behavior Health Professional) after client went and attempted to lock herself in the nurse's station bathroom. The QBHP came and assisted after the client tried to push him out with the door. Per

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QBHP report the client attempted to punch him which resulted in him performing a HWC (Handle With Care) wall restraint. The restraint lasted from 1037 a.m.-1040 a.m. The restraint was done to the best of staff ability based on training and the least restrictive restraint used at the time of the incident. Client was hollering about her face at which time the staff pulled the client back so that her face was not touching the wall and she continued to scream about her face at which time this nurse informed her that her face was no longer touching the wall. After release client complained of right arm pain and stated she could not feel her arm. Client rated her pain level at 9/10 (9 out of 10) and this nurse did a ROM (Range of Motion assessment. Neurological check). Client arm did appear swollen and red. After ROM assessment was done this nurse noticed a clicking noise and what felt like grinding near/at the right elbow. [Doctor] was called and ordered for the client to be sent out to [Hospital] for further evaluation. Client guardian was called several times and reassured that she would be contacted every time this nurse received new information regarding the status of the client. Around 1251 (12:51 p.m.) received report from staff that client right humerus was broken and she would need surgery..."

c. On 5/3/21 at 1:11 p.m. the Assistant Clinical Director stated, "Everybody is no longer to do the Handle With Care hold anymore, they are to do CPI (Crisis Prevention Intervention) only." The Assistant Clinical Director was asked, how are staff notified that the Handle with Care is not to be utilized? She stated, "They emailed that to all employees, the email and memos to all employees this morning and the program manager." The Assistant Clinical Director was

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asked, how are staff monitored to ensure they are not using the Handle With Care holds? She stated, "The nurse and the program manager, they are monitoring directly and we are also doing video review of each restraint. They are here and are present when they are doing the hold and make sure they are doing CPI." The Assistant Clinical Director was asked, when were the notified, this morning? She stated, "Yes. The staff in the children's program, ages six to twelve, were told about two months ago, because of the size difference to use the CPI." The Assistant Clinical Director was asked, [Client #4] is ten years old? She stated, "Yes." The Assistant Clinical Director was asked, was she in the [Building]? She stated, "Yes." The Assistant Clinical Director was asked, when she was restrained, was she placed in the Handle With Care position? She stated, "She was in the bathroom so there is no video, but documentation says that he used the Handle With Care position." The Assistant Clinical Manager was asked, so he used a hold he was told he was not to use? She stated, "Correct." The Assistant Clinical Manager was asked, where is he now? She stated, "He was suspended immediately after the hold? The Assistant Clinical Manager was asked, yesterday? She stated, "Yes." At 2:57 p.m. the Assistant Clinical Manager stated, "[Chief Clinical Officer] is telling me they also suspended the nurse." An in-service and refresher training in the CPI was being conducted during the investigation.

d. On 5/5/21, at 9:04 a.m. the video with audio was viewed. The video with audio only showed the hall which leads to the nurse's station and treatment room. The timing on the video did not reflect the actual time of the incident. The client

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was viewed coming through the door into the hall, then the client goes back out. The nurse goes out, out of view of the camera, then comes back into the hall with the client, shutting the door behind them. The client was seen attempting to get past the nurse and open the door. The nurse blocks the way and the client was seen pulling on the nurse at which time the nurse stated, "Back up. If you grab me you are going to the ground." The nurse was seen with a syringe in her hand. The client then goes into the nurse's station, out of view of the camera, and the nurse is seen on her phone. A male staff member enters the hall and then goes into the nurse's station, out of view of the camera. You can hear the client yelling "ow' and screaming "my face, my face, my arm, my arm. At this time the nurse enters into the nurse's station, out of view of the camera. A voice is heard saying, "you need to calm down." There was more screaming and you can hear the client saying "Yes sir." The male staff member was seen exiting the nurse's station and the client is heard saying, "I can't move my arm." There was more screaming and the client was heard saying, "Please don't hurt it." There was a female voice heard saying, "If it hurts and you can't move it I have to touch it." The male staff member exited the room, went out the door, came back in with a cup in his hand, and went into the nurse's station, out of camera view. There was crying and hard breathing heard. The nurse and client come out of nurse's station into the hallway and the client was seen holding her arm.

e. On 5/5/21 at 9:33 a.m. the video with no audio was viewed. The client was seen going into the nurse's station then into the bathroom. The male staff was viewed coming into the nurse's station and then into the bathroom. The nurse goes to

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the door of the bathroom and then goes out of the nurse's station into the medication room, out of the line of vision of the restraint, then one minute later comes back into the nurse's station to the bathroom door. The nurse then comes out of the bathroom, looks at a monitor on the desk, goes back to the bathroom, comes back out and sits in a chair at the desk, takes a drink from a cup, gets up and goes back into the bathroom. The male staff exits bathroom then walks out of camera view, comes back with a cup in his hand and goes into the bathroom. The nurse, client and male staff come out of the bathroom, the nurse examines clients arm. The client, nurse and staff member leave the nurse's station and go to the treatment room. The restraint was not viewable from either camera.

f. On 5/5/21 at 10:04 a.m. the Training Coordinator was asked, if you do a Handle With Care hold, and it is done correctly, should there be any injuries? She stated, "No." The Training Coordinator was shown a picture of the male staff and the client standing in the nurse's station together. The Training Coordinator was asked, with the picture you just saw with the staff and client, would the Handle With Care be an appropriate hold? She stated, "I would have placed them in a child control hold."

g. The facility Emergency Safety Interventions policy, received from the Assistant Clinical Director on 5/3/21 at 1:03 p.m., documented, "...General Principles...G. An emergency safety intervention must be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the client's chronological and developmental age; size; gender; physical, medical and psychiatric

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N 132	Continued From page 12 condition; and personal history (including any history or physical or sexual abuse.)...I. Verbal de-escalation interventions will be exhausted before a more restrictive intervention is initiated...."	N 132		
N 136	PROTECTION OF RESIDENTS CFR(s): 483.356(c)(4) [At admission, the facility must] provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s). This ELEMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a copy of the facility's restraint policy was received by the guardian at admission for 1 (Client #4) of 1 (Client #4) sampled clients. The findings are: Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. The facility Consent For Admission And Treatment, signed by Client #4's guardian on 3/3/21, documented, "...Section IV (four): Consent For Behavior Management And Emergency Safety Interventions a. I have reviewed the [Facility] behavior management and emergency safety interventions as outlined in agency policy. I give my consent and permission for [Facility] to utilize these procedures as clinically indicated in the course of treatment...b. I authorize my child's participation in the Center's behavior management and treatment interventions related to the target behaviors that	N 136		6/11/21

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N 136	Continued From page 13 were identified..." b. On 5/3/21 at 4:42 p.m. the Chief Clinical Officer was asked, did [Client #4's] guardian get a copy of the facility policy on behavior management and emergency safety interventions? He stated, "I think when we switched over to Doc-U-Signed we omitted that." The Chief Clinical Officer was shown the signed consent at this time and was asked, this consent is all they are getting related to safety interventions? He stated, "Yes."	N 136		
N 144	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(e) Each order for restraint or seclusion must: (1) Be limited to no longer than the duration of the emergency safety situation; and (2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9. This ELEMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a Physician's Order for a restraint was documented for 1 (Client #4) of 1 (Client #4) sampled clients. This failed practice had the potential to affect 46 facility clients as documented on a list provided by the Assistant Clinical Director on 5/3/21 at 1:43 p.m. The findings are: Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder.	N 144		6/11/21

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N 144	Continued From page 14 a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall...Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..." There was no Physician's Order found for the use of the restraint. b. On 5/3/21, at 2:57 p.m., the Assistant Clinical Director was asked, where is the Physician's Order for the restraint on 5/2? She stated, "I didn't see one for that one. The only order for an ESI (Emergency Safety Intervention) was on the twenty fifth." The Assistant Clinical Director was asked, that was April twenty fifth, right? She stated, "Yes."	N 144		
N 145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and	N 145		6/11/21

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(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 145	Continued From page 15 (4) Any complications resulting from the intervention. This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a face to face assessment was conducted within one-hour of the start of the restraint for 4 (Clients #1, #2, #4 and #6) of 5 (Clients #1, #2, #3, #4 and #6) sampled clients who had been restrained. The findings are: 1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 9/28/20 documented, "...Time initiated 1434 [2:34 p.m.] Time ended 1437 [2:37 p.m.]...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour indicated No. If no, reason why- RN [Registered Nurse] not on duty..." The Face-to-Face section of the form was signed, dated and timed as completed on 9/29/20 at 12:37 p.m. 2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 10/7/20 documented, "...Time initiated 1256 [12:56 p.m.] Time ended 1305 [1:05 p.m.]...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour indicated No. If no, reason why- No RN on duty..." The Face-to-Face section of the form was signed and dated on 10/7/20. The time is not clear but starts	N 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 145	Continued From page 16	N 145		

with 18 to indicate within the 6 p.m. hour.

3. Client #6 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form dated 4/30/21 documented, "...Time initiated 10:30 a.m. Time ended 10:34 a.m. ...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour... If no, reason why- Client Refused..." The Face-to-Face section of the form had a line through the section and documented "Client refused face-to-face."

b. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...Time initiated 1312 [1:12 p.m.] Time ended 1314 [1:14 p.m.]...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour indicated Yes..." The Face-to-Face section of the form was signed, dated and timed as completed on 5/3/21 at 1425 [2:25 p.m.].

4. On 5/5/21 at 1:30 p.m., RN #2 stated, "The Face-to-Face is one hour to get it. The RN has to do assessment. The LPN [Licensed Practical Nurse] maybe working so I have to get it done in one hour." When asked what the facility policy was for Face-to-Face assessments, RN #1 stated, "It's not policy for it not to get done, it's not permissible."

5. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer was asked, "When should the Face-to-Face assessment be completed?" The

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N 145	Continued From page 17	N 145		

Chief Clinical Officer stated, "Face-to-Face in an hour with an RN."

6. On 5/11/21 at 8: 55 a.m., the Assistant Clinical Director was asked how a client could refuse a Face-to-Face assessment and the Assistant Clinical Director stated, "I seen that. No, they should be able to complete."

7. The facility Emergency Safety Interventions policy received on 5/3/21 form the Assistant Clinical Director documented, "...Psychiatric Residential Treatment...E. Post Intervention Procedures- A. Within one hour of the initiation of the emergency safety intervention, a physician, an RN, or a licensed independent practitioner trained by the physician and competent to perform the assessment, must conduct a face-to-face assessment of the physical and psychological well being of the resident..."

8. Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form, dated 4/25/21, documented, "HWC (Handle With Care)-Primary Restraint Technique; Wall...Time Initiated 1600 (4:00 p.m.); Time Ended 1603 (4:03 p.m.)...5. Nursing Assessment (Upon Removal from Procedure): Time:1730 (5:30 p.m.)..."

b. The Face-To-Face Assessment For Emergency Safety Interventions documented, "The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention..." There was no date or time documented to indicate when the

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N 145	Continued From page 18 Face-to-Face Assessment was completed. c. On 5/5/21, at 2:08 p.m., the CCO (Chief Clinical Officer) was asked, the ESI (Emergency Safety Intervention) dated 4/25 shows an assessment was done at 1730 (5:30 p.m.), time restraint had ended was 1603 (4:03 p.m.). When should that have been done? He stated, "Within an hour." The CCO was asked, is that when the face to face assessment was done? He stated, "I can't tell. It's not reliable information."	N 145		
N 148	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(g)(3) [Each order for restraint or seclusion must include] the emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use. This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the specific time limit for the restraint order was on the physician's order for 4 (Clients #1, #2, #3, and #4) of 5 (Clients #1, #2, #3, #4 and #6) sampled clients who had Emergency Safety Interventions (ESI) orders. The findings are: 1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI dated 8/19/20 documented, "...Personal Restraint: Handle with Care Solo Takedown (include maximum time in minutes in text box)..." The time limit for the	N 148		6/11/21

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restraint order was not documented on the order.

b. A Physicians Orders for ESI dated 8/24/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Techniques (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order.

c. A Physicians Orders for ESI dated 9/28/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order.

2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/7/20 documented, "...Personal Restraint: Handle with Care Two Person Takedown (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order.

b. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/9/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order.

c. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/10/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..."

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N 148	Continued From page 20 The time limit for the restraint order was not documented on the order. d. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/13/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. e. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/14/20 documented, "...Personal Restraint: Handle with Care Solo Takedown (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. f. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/15/20 documented, "...Personal Restraint: Handle with Care Two Person Takedown (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. g. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/23/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. 3. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer stated, "The doctor gives permission for length of a hold." When asked if that time was on the physician order, he stated, "It should be." 4. The facility Emergency Safety Interventions	N 148		

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policy received on 5/3/21 form the Assistant Clinical Director documented, "...Psychiatric Residential Treatment...Physician's Orders...e. ...i. The nurse writes the verbal/telephone order in Physician's Order section of the client record and indicates:...c. the specific emergency intervention(s) ordered including the maximum length of time authorized for use..."
5. Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form, dated 4/25/21, documented, "HWC (Handle With Care)-Primary Restraint Technique; Wall...Time Initiated 1600 (4:00 p.m.); Time Ended 1603 (4:03 p.m.)..."

b. A Physician's Orders for ESI (Emergency Safety Intervention), dated 4/25/21 at 6:05 PM, documented, "...Personal Restraint: Handle With Care Personal Restraint Technique (standing) (Include maximum time in minutes in text box) 1600 (4:00 p.m.)-(to) 1603 (4:03 p.m.) (2-3 minutes)...." The Physician's Order stated the length of time the client was in the restraint, but did not document the length of time the physician authorized the use of the restraint.

c. On 5/5/21, at 2:46 p.m., the Chief Clinical Officer was asked, is there a time limit for the ESI on 4/25 documented on the Physician's order? He stated, "I don't see one, just the time in the restraint."

6. Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and

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N 148	Continued From page 22 Unspecified Schizophrenia and other Psychotic Disorders. a. A physicians Orders for ESI dated 3/31/21 documented, "...Personal Restraint: Handle With Care Four Person Takedown (include maximum time in minutes in test box)... " The time limit for the restraint order was not documented on the order. b. A physicians Orders for ESI dated 3/23/21 documented, "...Personal Restraint: Handle With Care Four Person Takedown (include maximum time in minutes in test box)... " The time limit for the restraint order was not documented on the order. c. A physicians Orders for ESI dated 3/11/21 documented, "...Personal Restraint: Handle With Care Two Person Takedown (include maximum time in minutes in test box)... " The time limit for the restraint order was not documented on the order. d. A physicians Orders for ESI dated 3/4/21 documented, "...Personal Restraint: Handle With Care Personal Restraint Technique (standing) (include maximum time in minutes in test box)... Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order. e. A physicians Orders for ESI dated 2/5/21 documented, "...Personal Restraint: Handle With Care Personal Restraint Technique (standing) (include maximum time in minutes in test box)... Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time	N 148		

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N 148	Continued From page 23 limit for the restraint order was not documented on the order. f. A physicians Orders for ESI dated 1/3/21 documented, "...Personal Restraint: Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order. g. A physicians Orders for ESI dated 11/25/20 documented, "...Personal Restraint: Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order. h. A physicians Orders for ESI dated 10/24/20 documented, "...Personal Restraint: Handle With Care Solo takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order.	N 148		
N 152	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(h)(3) [Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the date and time of the 1-hour assessment was documented for 1 (Client #3) of 4 sampled clients (Clients #1, #2, #3, 4 and 6) who were physically restrained. The findings are:	N 152		6/11/21

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N 152	Continued From page 24 Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and Unspecified Schizophrenia and other Psychotic Disorders. The EMERGENCY SAFETY INTERVENTION REPORTING FORM dated 1/3/21...FACE_TO_FACE ASSESSMENT FOR EMERGENCY SAFETY INTERVENTION...Date:___Time:___ , were not filled in by the RN (Registered Nurse).	N 152		
N 155	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain documented records for Emergency Safety Interventions (ESI) reports for 1 (Client #2) of 5 (Clients #1, #2, #3, #4 and #6) sampled clients who had ESI implemented. The findings are: Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/10/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box) 8 minutes..."	N 155		6/11/21

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N 155	Continued From page 25 b. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/14/20 documented, "...Personal Restraint: Handle with Care Solo Takedown (include maximum time in minutes in text box) 1121-1130 [11:21 a.m.-11:30 a.m.] ..." c. On 5/3/21 at 12:57 p.m., the Assistant Clinical Director was asked to provide the two missing ESI reports, and the Assistant Clinical Director stated, "We're still looking but have not found the other two reports." d. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer was asked if he was aware of the missing ESI reports and he stated, "Yes." When asked if ESIs were supposed to be on the clinical record, the Chief Clinical Officer stated, "Supposed to be, yes."	N 155		
N 156	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician signed an order for a physical restraint as soon as possible to ensure restraint orders were accurate and appropriate and update the treatment plan as needed for 3 (Clients #1, #2 and #3) of 5 (Clients #1 - #4 and #6) sampled residents who had a restraint	N 156		6/11/21

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ordered. The findings are:

1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. A Physicians Orders for ESI (Emergency Safety Intervention) dated 9/28/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 9/28/2020 at 5:32 p.m.. There was no physician's signature on the order.

2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/7/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/7/2020 at 1:46 p.m.. There was no physician's signature on the order.

b. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/9/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/9/2020 at 5:48 p.m.. There was no physician's signature on the order.

c. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/10/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/10/2020 at 7:45 p.m.. There was no physician's signature on the order.

d. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/14/2020 documented, "Personal Restraint..." and was

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signed by the Licensed Practical Nurse on 10/14/2020 at 11:58 a.m.. There was no physician's signature on the order.

e. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/23/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/24/2020 at 10:44 a.m.. There was no physician's signature on the order.

3. On 5/5/21 at 1:30 p.m., Registered Nurse (RN) #1 was shown one of the orders and asked if the physician had signed it, and RN #1 stated, "No." She was asked "Is it supposed to be signed?" She stated, "Yes."

4. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer was asked if he was aware the physician's orders were supposed to be signed and he stated, "I may have known but don't recall."

5. The facility Emergency Safety Interventions policy received on 5/3/21 form the Assistant Clinical Director documented, "...Psychiatric Residential Treatment...Physician's Orders...f. The physician's verbal order must be followed with the physician's signature verifying the verbal order within 5 days..."

6. Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and Unspecified Schizophrenia and other Psychotic Disorders.

A Physicians Orders for ESI dated 1/3/21 documented, "Personal Restraint...an was signed by the LPN on 1/3/2021 at 7:58 p.m. There was no physician's signature on the order.

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	04L101	A. BUILDING _____ B. WING _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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 165	MONITORING DURING AND AFTER RESTRAINT CFR(s): 483.362(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing, and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a nurse was physically present to continually assess the safety of a restraint and continuously monitor a client during the use of a physical restraint for 1 (Client #4) of 5 (Client #1, 2, 3, 4, 6) sampled clients who were physically restrained. The findings are: Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall...Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..." b. On 5/5/21 at 9:33 a.m. the video of the restraint, for Client #4 on 5/2/21 at 10:37 a.m., was viewed. The video had no audio. The client is seen going into the nurse's station then into the bathroom. The male staff is viewed coming into the nurse's station and then into the bathroom. The nurse goes to the door of the bathroom and then goes out of the nurse's station into the medication room, out of the line of vision of the restraint, then one minute later comes back into	N 165		6/11/21

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N 165	Continued From page 29 the nurse's station to the bathroom door. The nurse then comes out of the bathroom, looks at a monitor on the desk, goes back to the bathroom, comes back out, sits in a chair at the desk, takes a drink from a cup, out of the line of vision of the restraint, gets up and goes back into the bathroom. The male staff exits bathroom then walks out of camera view, comes back into view with a cup in his hand and goes into the bathroom. The nurse, client and male staff come out of the bathroom, and the nurse examines client's arm. The client, nurse and staff member leave the nurse's station and go to the treatment room. The restraint, which was applied in the bathroom, was not viewable from either camera. The nurse failed to be consistently within the view of the physical restraint, to monitor and assess the client and to assess for the safety of the restraint. d. On 5/4/21, at 3:52 p.m., the Assistant Clinical Director was asked, shouldn't the nurse be monitoring the restraint? She stated, "She should be. She goes back and forth numerous times, but we would expect continuous monitoring and observation.	N 165		
N 167	MONITORING DURING AND AFTER RESTRAINT CFR(s): 483.362(c) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.	N 167		6/11/21

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N 167	Continued From page 30	N 167		

This ELEMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a physician, or other licensed practitioner permitted by the state and the facility and trained in the use of emergency safety interventions evaluated the resident's well-being immediately after the restraint was removed for 5 of 5 (Clients #1, #2, #3, #4 and #6)sampled residents who had been restrained. The findings are:

1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form dated 8/19/20 documented, "...Time initiated 8:15 Time ended 8:17...Nursing Assessment (Upon Removal from Procedure): Time 9:00..."

b. An Emergency Safety Intervention Reporting Form dated 9/28/20 documented, "...Time initiated 1434 [2:34 p.m.] Time ended 1437 [2:37 p.m.]...Nursing Assessment (Upon Removal from Procedure): Time 1530 [3:30 p.m.]..."

2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form dated 10/9/20 documented, "...Time initiated 1733 [5:33 p.m.] Time ended 1741 [5:41 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1755 [5:55 p.m.] ..."

b. An Emergency Safety Intervention Reporting Form dated 10/13/20 documented, "...Time initiated 12:12 Time ended 12:17...Nursing Assessment (Upon Removal from Procedure):

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N 167	Continued From page 31 Time 12:25..." 3. Client #6 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 4/23/21 documented, "CPI High 2 person...Time initiated 2101 [9:01 p.m.] Time ended 2104 [9:04 p.m.] Time initiated 2105 [9:05 p.m.] Time ended 2107 [9:07 p.m.]... HWC [Handle with Care] 2 person Wall Escort...Time initiated 2112 [9:12 p.m.] Time ended 2115 [9:15 p.m.] Time initiated 2115 [9:15 p.m.] Time ended 2115 [9:15 p.m.]...Nursing Assessment (Upon Removal from Procedure): Time 2140 [9:40 p.m.]..." b. An Emergency Safety Intervention Reporting Form dated 4/25/21 documented, "...Time initiated 1809 [6:09 p.m.] Time ended 1818 [6:18 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1900 [7:00 p.m.] ..." c. An Emergency Safety Intervention Reporting Form dated 4/26/21 documented, "...HWC 1 person wall Time initiated 10:06 Time ended 10:08 ... HWC- Take Down 1 person...Time initiated 10:12 Time ended 10:15... Nursing Assessment (Upon Removal from Procedure): Time 10:55 ..." d. An Emergency Safety Intervention Reporting Form dated 4/30/21 documented, "...Time initiated 10:30 a.m. Time ended 10:34 a.m. ...Nursing Assessment (Upon Removal from Procedure): Time 11:09 ..." e. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...Time initiated	N 167		

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N 167	Continued From page 32	N 167		

1207 Time ended 1207 ...Nursing Assessment (Upon Removal from Procedure): Time 1256 ..."

f. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...Time initiated 1312 [1:12 p.m.] Time ended 1314 [1:14 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1425 [2:25 p.m.] ..."

g. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...CPI seated position medium...Time initiated 1340 [1:40 p.m.] Time ended 1342 [1:42 p.m.] ... Emergency medication -[Intramuscular] ...Time initiated 1356 [1:56 p.m.] Time ended 1356 [1:56 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1425 [2:25 p.m.] ..."

h. An Emergency Safety Intervention Reporting Form dated 5/4/21 documented, "...CPI seated medium...Time initiated 10:38 a.m. Time ended 10:39 a.m. Time initiated 10:41 a.m. Time ended 10:43 a.m....CPI Team Control Position...Time initiated 10:39 a.m. Time ended 10:41 a.m. ...Nursing Assessment (Upon Removal from Procedure): Time 11:22 ..."

i. An Emergency Safety Intervention Reporting Form dated 5/4/21 documented, "...CPI seated medium...Time initiated 1139 Time ended 1139 ...CPI Team Control Position...Time initiated 1135 Time ended 1136 Time initiated 1138 Time ended 1139 Time initiated 1139 Time ended 1141 Time initiated 1144 Time ended 1144 ...Nursing Assessment (Upon Removal from Procedure): Time 1200 ..."

4. The facility Emergency Safety Interventions policy received on 5/3/21 form the Assistant

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N 167	Continued From page 33	N 167		

Clinical Director documented, "...Psychiatric Residential Treatment...E. Post Intervention Procedures ...c. ...2. A physician or a nurse trained in the use of emergency safety interventions must evaluate the client's well being immediately after the restraint is discontinued..."
4. Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder.

a. An Emergency Safety Intervention Reporting Form, dated 4/25/21, documented, "HWC (Handle With Care)-Primary Restraint Technique; Wall...Time Initiated 1600 (4:00 p.m.); Time Ended 1603 (4:03 p.m.)...5. Nursing Assessment (Upon Removal from Procedure): Time:1730 (5:30 p.m.)..."

b. The Face-To-Face Assessment For Emergency Safety Interventions documented, "The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention..." There was no date or time documented to indicate when the Face-to-Face Assessment was completed.

c. On 5/5/21, at 2:08 p.m., the CCO (Chief Clinical Officer) was asked, the ESI (Emergency Safety Intervention) dated 4/25 shows an assessment was done at 1730 (5:30 p.m.), time restraint had ended was 1603 (4:03 p.m.). When should that have been done? He stated, "Within an hour." The CCO was asked, is that when the face to face assessment was done? He stated, "I can't tell. It's not reliable information."

5. Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and

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N 167	Continued From page 34 Unspecified Schizophrenia and other Psychotic Disorders. a. An Emergency Safety Reporting Form Dated 3/31/2 documented, "...Time initiated 1710 [5:10 p.m.] Time ended 1720 [5:20 p.m.]...Nursing Assessment (Upon Removal from Procedure): "Time: 1730 [5:30 p.m.] b. An Emergency Safety Reporting Form Dated 3/23/21 documented, "...Time initiated 1622 [4:32 p.m.] Time ended 1632 [4:32 p.m.]...Nursing Assessment (Upon Removal from Procedure): "Time: 1646 [4:46 p.m.]	N 167		

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
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June 7, 2021

David Kuchinski, Administrator
Centers For Youth And Families Inc
6501 W 12th Street
Little Rock, AR 72225-1970

Dear Mr. Kuchinski:

On May 11, 2021, we conducted a Complaint survey at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and have approved your plan of correction and presume that you will achieve substantial correction by June 11, 2021.

We will be conducting a revisit of your facility to verify that substantial correction has been achieved and maintained.

If you have any questions, please contact your reviewer:**Sandra Broughton at 501-320-6182 or email to Sandra.Broughton@dhs.arkansas.gov.**

Sincerely,

Sandra Broughton
Administrative Services Manager

DPSQA/Office of Long Term Care
Survey & Certification Section

sgb

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

PRINTED: 07/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 000	Initial Comments This CMS 2567 survey report supercedes the report sent on May 20, 2021. 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. Complaint #AR00026502 was substantiated, all or in part, with no deficiencies cited. Complaint #AR00026504 was substantiated, all or in part, with no deficiencies cited. Complaint #AR00026505 was substantiated, all or in part,, with deficiencies cited at N148, N152, N156, and N167. Complaint #AR00026506 was unsubstantiated. Complaint #AR00026516 was substantiated, all or in part, with deficiencies cited at N128, N132, N136, N144, N145, N148, N165, and N167. Complaint AR00026524 was substantiated, all or in part, with deficiencies cited at N128, N132, N136, N144, N145, N148, N165, and N167. Complaint #AR00026552 was unsubstantiated. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000		
N 128	PROTECTION OF RESIDENTS	N 128		6/11/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Asst Clinical Director — TITLE — (X6) DATE: 06/07/2021

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 128	Continued From page 1 CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a client did not sustain an injury as a result of a restraint for 1 of 1 (Client #4) sampled client who sustained an injury during the use of a physical restraint. The findings are: Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall... Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..." b. A Medical Progress Note, dated 5/2/21 at 6:00 p.m., signed by RN (Registered Nurse) #1 documented, "Most of the shift client was irate, unstable and disrespectful to staff. Client was cursing at staff, threatening staff, hitting staff and peers while on the unit. Client refused to eat breakfast because she was upset. Client was climbing in the window seal and this nurse and several staff members tried their best to talk with the client to see is she could turn her day around. This nurse tried to get the client to calm down and follow directions in order to get to go on another unit with a particular staff member. Informed client that if she kept up self harm and aggressive behaviors this nurse would have to call [Doctor]. Client was trying to take her clothes off while in the unit as well. Tried bringing the client into the	N 128	As the injuries sustained to our clients at Centers have involved Handle With Care (HWC) holds, HWC is no longer used as a restraint technique in Center's residential programs to include Destiny House, Elizabeth Mitchell Adolescent Center (EMAC), and Elizabeth Mitchell Children's Center (EMCC), as of 5/3/21. Admissions to all programs have been halted until all staff in these programs have participated in a full course of Nonviolent Crisis Prevention Intervention (CPI). The expected completion date for all staff to be retrained in CPI is 6/5/21. CPI emphasizes the use of deescalation and that a hold should be used as a last resort. Additional staff have been certified as CPI trainers in the Advanced Course. This has enabled Centers to retrain all staff in a more timely manner, and going forward, this will allow for increased oversight in the programs and feedback on a real time basis to further ensure that we are moving toward the goal of being more trauma informed in all of our residential programs.	

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N 128	Continued From page 2 nurses station a few hours later and speak with the client and the client ran around the day area and she eventually came to the nurse's station. While trying to speak with the client about her behavior client ran and locked herself in the nurse's station bathroom after trying to elope from the nurse's station. This nurse asked for assistance from a QBHP (Qualified Behavior Health Professional) after client went and attempted to lock herself in the nurse's station bathroom. The QBHP came and assisted after the client tried to push him out with the door. Per QBHP report the client attempted to punch him which resulted in him performing a HWC (Handle With Care) wall restraint. The restraint lasted from 1037 a.m.-1040 a.m. The restraint was done to the best of staff ability based on training and the least restrictive restraint used at the time of the incident. Client was hollering about her face at which time the staff pulled the client back so that her face was not touching the wall and she continued to scream about her face at which time this nurse informed her that her face was no longer touching the wall. After release client complained of right arm pain and stated she could not feel her arm. Client rated her pain level at 9/10 (9 out of 10) and this nurse did a ROM (Range of Motion assessment. Neurological check). Client arm did appear swollen and red. After ROM assessment was done this nurse noticed a clicking noise and what felt like grinding near/at the right elbow. [Doctor] was called and ordered for the client to be sent out to [Hospital] for further evaluation. Client guardian was called several times and reassured that she would be contacted every time this nurse received new information regarding the status of the client. Around 1251 (12:51 p.m.) received report from staff that client right humerus was broken and	N 128	To further advance the effort to increase use of de-escalation techniques and use holds as a last resort, a video review session is conducted daily by administrative staff and CPI training staff to review any holds done in the residential programs during the previous day. Feedback regarding possible prevention of the hold, techniques used during the hold, staff/client interactions, and any other pertinent feedback is provided to the Program Managers in writing. Program Managers may watch video with Qualified Behavioral Health Provider (QBHP) staff to provide feedback, and CPI trainers may assist with providing additional training, if needed. Disciplinary action could be taken, if warranted. Emergency Safety Intervention (ESI) written forms and ESI orders in the electronic medical record (EMR) have been revised with only CPI holds as options. ESI written forms were revised by the Assistant Clinical Director. EMR forms were revised by Centers' Credible Team at the request of the Assistant Clinical Director. This was completed by 5/14/21. To monitor the use of holds and assess trends in a timely manner, data regarding dates, types, frequency of CPI holds and associated injuries will be gathered by Risk Management staff and reviewed monthly in the Process Improvement Committee meeting. Upward trends will be addressed as needed. It should also be noted that both staff involved in this incident, the QBHP and the nurse, have been terminated.	

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N 128	Continued From page 3 she would need surgery..." c. On 5/3/21 at 1:11 p.m. the Assistant Clinical Director stated, "Everybody is no longer to do the Handle With Care hold anymore, they are to do CPI (Crisis Prevention Intervention) only." The Assistant Clinical Director was asked, how are staff notified that the Handle with Care is not to be utilized? She stated, "They emailed that to all employees, the email and memos to all employees this morning and the program manager." The Assistant Clinical Director was asked, how are staff monitored to ensure they are not using the Handle With Care holds? She stated, "The nurse and the program manager, they are monitoring directly and we are also doing video review of each restraint. They are here and are present when they are doing the hold and make sure they are doing CPI." The Assistant Clinical Director was asked, when were the notified, this morning? She stated, "Yes. The staff in the children's program, ages six to twelve, were told about two months ago, because of the size difference to use the CPI." The Assistant Clinical Director was asked, [Client #4] is ten years old? She stated, "Yes." The Assistant Clinical Director was asked, was she in the [Building]? She stated, "Yes." The Assistant Clinical Director was asked, when she was restrained, was she placed in the Handle With Care position? She stated, "She was in the bathroom so there is no video, but documentation says that he used the Handle With Care position." The Assistant Clinical Manager was asked, so he used a hold he was told he was not to use? She stated, "Correct." The Assistant Clinical Manager was asked, where is he now? She stated, "He was suspended immediately after the hold? The Assistant Clinical Manager was asked,	N 128		

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CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

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N 128	Continued From page 4 yesterday? She stated, "Yes." At 2:57 p.m. the Assistant Clinical Manager stated, "[Chief Clinical Officer] is telling me they also suspended the nurse." An in-service and refresher training in the CPI was being conducted during the investigation. d. On 5/5/21, at 9:04 a.m. the video with audio was viewed. The video with audio only showed the hall which leads to the nurse's station and treatment room. The timing on the video did not reflect the actual time of the incident. The client was viewed coming through the door into the hall, then the client goes back out. The nurse goes out, out of view of the camera, then comes back into the hall with the client, shutting the door behind them. The client was seen attempting to get past the nurse and open the door. The nurse blocks the way and the client was seen pulling on the nurse at which time the nurse stated, "Back up. If you grab me you are going to the ground." The nurse was seen with a syringe in her hand. The client then goes into the nurse's station, out of view of the camera, and the nurse is seen on her phone. A male staff member enters the hall and then goes into the nurse's station, out of view of the camera. You can hear the client yelling "ow' and screaming "my face, my face, my arm, my arm. At this time the nurse enters into the nurse's station, out of view of the camera. A voice is heard saying, "you need to calm down." There was more screaming and you can hear the client saying "Yes sir." The male staff member was seen exiting the nurse's station and the client is heard saying, "I can't move my arm." There was more screaming and the client was heard saying, "Please don't hurt it." There was a female voice heard saying, "If it hurts and you can't move it I have to touch it." The male staff member	N 128		

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N 128	Continued From page 5 exited the room, went out the door, came back in with a cup in his hand, and went into the nurse's station, out of camera view. There was crying and hard breathing heard. The nurse and client come out of nurse's station into the hallway and the client was seen holding her arm. e. On 5/5/21 at 9:33 a.m. the video with no audio was viewed. The client was seen going into the nurse's station then into the bathroom. The male staff was viewed coming into the nurse's station and then into the bathroom. The nurse goes to the door of the bathroom and then goes out of the nurse's station into the medication room, out of the line of vision of the restraint, then one minute later comes back into the nurse's station to the bathroom door. The nurse then comes out of the bathroom, looks at a monitor on the desk, goes back to the bathroom, comes back out and sits in a chair at the desk, takes a drink from a cup, gets up and goes back into the bathroom. The male staff exits bathroom then walks out of camera view, comes back with a cup in his hand and goes into the bathroom. The nurse, client and male staff come out of the bathroom, the nurse examines clients arm. The client, nurse and staff member leave the nurse's station and go to the treatment room. The restraint was not viewable from either camera. f. On 5/5/21 at 10:04 a.m. the Training Coordinator was asked, "If you do a Handle With Care hold, and it is done correctly, should there be any injuries?" She stated, "No." The Training Coordinator was shown a picture of the male staff and the client standing in the nurse's station together. The Training Coordinator was asked, "With the picture you just saw with the staff and client, would the Handle With Care be an	N 128		

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N 128	Continued From page 6 appropriate hold?" She stated, "I would have placed them in a child control hold." g. The facility Emergency Safety Interventions policy, received from the Assistant Clinical Director on 5/3/21 at 1:03 p.m., documented, "...General Principles...G. An emergency safety intervention must be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the client's chronological and developmental age; size; gender; physical, medical and psychiatric condition; and personal history (including any history or physical or sexual abuse.)...I. Verbal de-escalation interventions will be exhausted before a more restrictive intervention is initiated...."	N 128		
N 132	PROTECTION OF RESIDENTS CFR(s): 483.356(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a physical restraint was performed safely and was appropriate for the client's and size for 1 (Client #4) of 5 (Client #1, 2, 3, 4 and 6) sampled clients who were physically restrained. The findings are:	N 132	As of 5/3/21, HWC is no longer used as a restraint technique in Center's residential programs to include Destiny House, EMAC, and EMCC. Admissions to all programs have been halted until all staff in these programs have participated in a full course of CPI. CPI emphasizes the use of deescalation and that a hold should be used as a last resort. CPI training includes holds that are specifically for use on clients smaller in comparison to staff. Additional staff have been certified as CPI trainers in the Advanced Course. This has enabled Centers to retrain all staff in a more timely manner, and going forward, this will allow for increased oversight in the programs and feedback on a real time basis.	6/11/21

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N 132	Continued From page 7 Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall...Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..." b. A Medical Progress Note, dated 5/2/21 at 6:00 p.m., signed by RN (Registered Nurse) #1 documented, "Most of the shift client was irate, unstable and disrespectful to staff. Client was cursing at staff, threatening staff, hitting staff and peers while on the unit. Client refused to eat breakfast because she was upset. Client was climbing in the window seal and this nurse and several staff members tried their best to talk with the client to see is she could turn her day around. This nurse tried to get the client to calm down and follow directions in order to get to go on another unit with a particular staff member. Informed client that if she kept up self harm and aggressive behaviors this nurse would have to call [Doctor]. Client was trying to take her clothes off while in the unit as well. Tried bringing the client into the nurses station a few hours later and speak with the client and the client ran around the day area and she eventually came to the nurse's station. While trying to speak with the client about her behavior client ran and locked herself in the nurse's station bathroom after trying to elope from the nurse's station. This nurse asked for assistance from a QBHP (Qualified Behavior Health Professional) after client went and attempted to lock herself in the nurse's station bathroom. The QBHP came and assisted after the client tried to push him out with the door. Per	N 132	A video review session is conducted daily by administrative staff and CPI training staff to review any holds done in the residential programs during the previous day. Feedback regarding possible prevention of the hold, technique during the hold, staff/ client interactions, and any other pertinent feedback is provided to the Program Managers in writing. Program Managers may watch video with QBHP staff to provide feedback, and CPI trainers may assist with providing additional training, if needed. Disciplinary action could be taken, if warranted. ESI written forms and ESI orders in the EMR have been updated with only CPI holds as options, as of 5/14/21. The ESI written form was revised by the Assistant Clinical Director and the Physician ESI order form in the EMR was revised by the Credible Team at the request of the Assistant Clinical Director. Data regarding dates, types, frequency of CPI holds and associated injuries will be gathered and reviewed monthly in the Process Improvement Committee meeting. Upward trends will be addressed as needed It should also be noted that both staff involved in this incident, the QBHP and the nurse, have been terminated.	

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N 132	Continued From page 8	N 132		

QBHP report the client attempted to punch him which resulted in him performing a HWC (Handle With Care) wall restraint. The restraint lasted from 1037 a.m.-1040 a.m. The restraint was done to the best of staff ability based on training and the least restrictive restraint used at the time of the incident. Client was hollering about her face at which time the staff pulled the client back so that her face was not touching the wall and she continued to scream about her face at which time this nurse informed her that her face was no longer touching the wall. After release client complained of right arm pain and stated she could not feel her arm. Client rated her pain level at 9/10 (9 out of 10) and this nurse did a ROM (Range of Motion assessment. Neurological check). Client arm did appear swollen and red. After ROM assessment was done this nurse noticed a clicking noise and what felt like grinding near/at the right elbow. [Doctor] was called and ordered for the client to be sent out to [Hospital] for further evaluation. Client guardian was called several times and reassured that she would be contacted every time this nurse received new information regarding the status of the client. Around 1251 (12:51 p.m.) received report from staff that client right humerus was broken and she would need surgery..."

c. On 5/3/21 at 1:11 p.m. the Assistant Clinical Director stated, "Everybody is no longer to do the Handle With Care hold anymore, they are to do CPI (Crisis Prevention Intervention) only." The Assistant Clinical Director was asked, how are staff notified that the Handle with Care is not to be utilized? She stated, "They emailed that to all employees, the email and memos to all employees this morning and the program manager." The Assistant Clinical Director was

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N 132	Continued From page 9 asked, how are staff monitored to ensure they are not using the Handle With Care holds? She stated, "The nurse and the program manager, they are monitoring directly and we are also doing video review of each restraint. They are here and are present when they are doing the hold and make sure they are doing CPI." The Assistant Clinical Director was asked, when were the notified, this morning? She stated, "Yes. The staff in the children's program, ages six to twelve, were told about two months ago, because of the size difference to use the CPI." The Assistant Clinical Director was asked, [Client #4] is ten years old? She stated, "Yes." The Assistant Clinical Director was asked, was she in the [Building]? She stated, "Yes." The Assistant Clinical Director was asked, when she was restrained, was she placed in the Handle With Care position? She stated, "She was in the bathroom so there is no video, but documentation says that he used the Handle With Care position." The Assistant Clinical Manager was asked, so he used a hold he was told he was not to use? She stated, "Correct." The Assistant Clinical Manager was asked, where is he now? She stated, "He was suspended immediately after the hold? The Assistant Clinical Manager was asked, yesterday? She stated, "Yes." At 2:57 p.m. the Assistant Clinical Manager stated, "[Chief Clinical Officer] is telling me they also suspended the nurse." An in-service and refresher training in the CPI was being conducted during the investigation. d. On 5/5/21, at 9:04 a.m. the video with audio was viewed. The video with audio only showed the hall which leads to the nurse's station and treatment room. The timing on the video did not reflect the actual time of the incident. The client	N 132		

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N 132	Continued From page 10 was viewed coming through the door into the hall, then the client goes back out. The nurse goes out, out of view of the camera, then comes back into the hall with the client, shutting the door behind them. The client was seen attempting to get past the nurse and open the door. The nurse blocks the way and the client was seen pulling on the nurse at which time the nurse stated, "Back up. If you grab me you are going to the ground." The nurse was seen with a syringe in her hand. The client then goes into the nurse's station, out of view of the camera, and the nurse is seen on her phone. A male staff member enters the hall and then goes into the nurse's station, out of view of the camera. You can hear the client yelling "ow' and screaming "my face, my face, my arm, my arm. At this time the nurse enters into the nurse's station, out of view of the camera. A voice is heard saying, "you need to calm down." There was more screaming and you can hear the client saying "Yes sir." The male staff member was seen exiting the nurse's station and the client is heard saying, "I can't move my arm." There was more screaming and the client was heard saying, "Please don't hurt it." There was a female voice heard saying, "If it hurts and you can't move it I have to touch it." The male staff member exited the room, went out the door, came back in with a cup in his hand, and went into the nurse's station, out of camera view. There was crying and hard breathing heard. The nurse and client come out of nurse's station into the hallway and the client was seen holding her arm. e. On 5/5/21 at 9:33 a.m. the video with no audio was viewed. The client was seen going into the nurse's station then into the bathroom. The male staff was viewed coming into the nurse's station and then into the bathroom. The nurse goes to	N 132		

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N 132	Continued From page 11 the door of the bathroom and then goes out of the nurse's station into the medication room, out of the line of vision of the restraint, then one minute later comes back into the nurse's station to the bathroom door. The nurse then comes out of the bathroom, looks at a monitor on the desk, goes back to the bathroom, comes back out and sits in a chair at the desk, takes a drink from a cup, gets up and goes back into the bathroom. The male staff exits bathroom then walks out of camera view, comes back with a cup in his hand and goes into the bathroom. The nurse, client and male staff come out of the bathroom, the nurse examines clients arm. The client, nurse and staff member leave the nurse's station and go to the treatment room. The restraint was not viewable from either camera. f. On 5/5/21 at 10:04 a.m. the Training Coordinator was asked, if you do a Handle With Care hold, and it is done correctly, should there be any injuries? She stated, "No." The Training Coordinator was shown a picture of the male staff and the client standing in the nurse's station together. The Training Coordinator was asked, with the picture you just saw with the staff and client, would the Handle With Care be an appropriate hold? She stated, "I would have placed them in a child control hold." g. The facility Emergency Safety Interventions policy, received from the Assistant Clinical Director on 5/3/21 at 1:03 p.m., documented, "...General Principles...G. An emergency safety intervention must be performed in a manner that is safe, proportionate and appropriate to the severity of the behavior, and the client's chronological and developmental age; size; gender; physical, medical and psychiatric	N 132		

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N 132	Continued From page 12 condition; and personal history (including any history or physical or sexual abuse.)...I. Verbal de-escalation interventions will be exhausted before a more restrictive intervention is initiated...."	N 132		
N 136	PROTECTION OF RESIDENTS CFR(s): 483.356(c)(4) [At admission, the facility must] provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent(s) or legal guardian(s). This ELEMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a copy of the facility's restraint policy was received by the guardian at admission for 1 (Client #4) of 1 (Client #4) sampled clients. The findings are: Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. The facility Consent For Admission And Treatment, signed by Client #4's guardian on 3/3/21, documented, "...Section IV (four): Consent For Behavior Management And Emergency Safety Interventions a. I have reviewed the [Facility] behavior management and emergency safety interventions as outlined in agency policy. I give my consent and permission for [Facility] to utilize these procedures as clinically indicated in the course of treatment...b. I authorize my child's participation in the Center's behavior management and treatment interventions related to the target behaviors that	N 136	An instruction document for completing the consent forms was created that summarizes the policies, and it was added to the set of consent forms that are sent out through Docusign. The full policies are attached with forms being sent to guardians during the admissions process. The full Docusign document signed and returned by guardians prior to admission, including the restraint policy, will be attached in the client record in the EMR. The documents are embedded in the Admissions Consents to ensure that they are always included with information provided to family during the admissions process and that families are aware of the behavior management and ESI policy at Centers. The Access Department staff, under direction of the Access Department Director, will not move forward with an admission to the residential program until the Docusign documents have been signed, returned, and placed in the client's EMR record. Centers' Access Department Director, has instructed her staff to email the guardians of all current residential clients a copy of the restraint policy, as well as all other policies referred to on the Admission Consent forms. Client #4 discharged on the day of the incident resulting in injury on 5/2/21, and they were not sent the restraint policy after 5/3/21, as she had discharged.	6/11/21

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N 136	Continued From page 13 were identified..." b. On 5/3/21 at 4:42 p.m. the Chief Clinical Officer was asked, did [Client #4's] guardian get a copy of the facility policy on behavior management and emergency safety interventions? He stated, "I think when we switched over to Doc-U-Signed we omitted that." The Chief Clinical Officer was shown the signed consent at this time and was asked, this consent is all they are getting related to safety interventions? He stated, "Yes."	N 136		
N 144	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(e) Each order for restraint or seclusion must: (1) Be limited to no longer than the duration of the emergency safety situation; and (2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9. This ELEMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a Physician's Order for a restraint was documented for 1 (Client #4) of 1 (Client #4) sampled clients. This failed practice had the potential to affect 46 facility clients as documented on a list provided by the Assistant Clinical Director on 5/3/21 at 1:43 p.m. The findings are: Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder.	N 144	Although the ESI order was written on the ESI form completed by the RN on duty at the time, (order received at 1052 on 5/2/21), there was not a corresponding order in the EMR. On 5/10/21, Nursing Management initiated an ESI audit daily to ensure completion of all elements of the ESI process. This includes review of forms to ensure all areas are filled out accurately and completely and there is a corresponding order in the EMR. Nursing Management has developed an ESI protocol (completed 6/4/21), and all nursing staff will sign off on the protocol by 6/11/21. This training includes direction on all steps of the ESI process to include documentation of the physician's order on the written ESI form and in the EMR. This training will also be used with new nurses as part on the orientation process in residential programs.	6/11/21

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N 144	Continued From page 14 a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall...Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..." There was no Physician's Order found for the use of the restraint. b. On 5/3/21, at 2:57 p.m., the Assistant Clinical Director was asked, where is the Physician's Order for the restraint on 5/2? She stated, "I didn't see one for that one. The only order for an ESI (Emergency Safety Intervention) was on the twenty fifth." The Assistant Clinical Director was asked, that was April twenty fifth, right? She stated, "Yes."	N 144		
N 145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and	N 145	Nursing staff has been provided specific instruction regarding requirements for the face-to-face assessment within 1 hour of initiation of an ESI. Specifically, nursing staff was provided instruction and modeling of how the assessment may be completed and documented, given that a client is not agreeable or cooperative. Instruction was provided through e-mail on 5/6/21 by the Director of Nursing. Instruction was provided by email on 6/1/21 by the Nurse Manager. Individual feedback and modeling of assessing a client who is not cooperative has been done by the Assistant Clinicial Director and the Nurse Manager in the programs with nurses when auditing of ESI forms has shown a need starting on 5/10/21. All elements of the face-to-face listed here are included in the ESI form that is to be completed by the licensed practitioner.	6/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L101	A. BUILDING _____ B. WING _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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 145	Continued From page 15 (4) Any complications resulting from the intervention. This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a face to face assessment was conducted within one-hour of the start of the restraint for 4 (Clients #1, #2, #4 and #6) of 5 (Clients #1, #2, #3, #4 and #6) sampled clients who had been restrained. The findings are: 1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 9/28/20 documented, "...Time initiated 1434 [2:34 p.m.] Time ended 1437 [2:37 p.m.]...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour indicated No. If no, reason why- RN [Registered Nurse] not on duty..." The Face-to-Face section of the form was signed, dated and timed as completed on 9/29/20 at 12:37 p.m. 2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 10/7/20 documented, "...Time initiated 1256 [12:56 p.m.] Time ended 1305 [1:05 p.m.]...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour indicated No. If no, reason why- No RN on duty..." The Face-to-Face section of the form was signed and dated on 10/7/20. The time is not clear but starts	N 145	On 5/10/21, Nursing Management initiated an ESI audit daily to ensure completion of all elements of the ESI process. This includes review of ESI forms to ensure all areas are filled out accurately and completely, the face-to-face assessment is completed in a timely manner, and there is a corresponding order in the EMR. Nursing Management has developed an ESI protocol (completed 6/4/21) and all nursing staff will sign off on the protocol by 6/11/21. This training will also be used with new nurses as part on the orientation process in residential programs.	

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N 145	Continued From page 16 with 18 to indicate within the 6 p.m. hour. 3. Client #6 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 4/30/21 documented, "...Time initiated 10:30 a.m. Time ended 10:34 a.m. ...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour... If no, reason why- Client Refused..." The Face-to-Face section of the form had a line through the section and documented "Client refused face-to-face." b. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...Time initiated 1312 [1:12 p.m.] Time ended 1314 [1:14 p.m.]...The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention- Face-to-Face was completed within one hour indicated Yes..." The Face-to-Face section of the form was signed, dated and timed as completed on 5/3/21 at 1425 [2:25 p.m.]. 4. On 5/5/21 at 1:30 p.m., RN #2 stated, "The Face-to-Face is one hour to get it. The RN has to do assessment. The LPN [Licensed Practical Nurse] maybe working so I have to get it done in one hour." When asked what the facility policy was for Face-to-Face assessments, RN #1 stated, "It's not policy for it not to get done, it's not permissible." 5. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer was asked, "When should the Face-to-Face assessment be completed?" The	N 145		

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N 145	Continued From page 17 Chief Clinical Officer stated, "Face-to-Face in an hour with an RN." 6. On 5/11/21 at 8: 55 a.m., the Assistant Clinical Director was asked how a client could refuse a Face-to-Face assessment and the Assistant Clinical Director stated, "I seen that. No, they should be able to complete." 7. The facility Emergency Safety Interventions policy received on 5/3/21 form the Assistant Clinical Director documented, "...Psychiatric Residential Treatment...E. Post Intervention Procedures- A. Within one hour of the initiation of the emergency safety intervention, a physician, an RN, or a licensed independent practitioner trained by the physician and competent to perform the assessment, must conduct a face-to-face assessment of the physical and psychological well being of the resident..." 8. Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form, dated 4/25/21, documented, "HWC (Handle With Care)-Primary Restraint Technique; Wall...Time Initiated 1600 (4:00 p.m.); Time Ended 1603 (4:03 p.m.)...5. Nursing Assessment (Upon Removal from Procedure): Time:1730 (5:30 p.m.)..." b. The Face-To-Face Assessment For Emergency Safety Interventions documented, "The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention..." There was no date or time documented to indicate when the	N 145		

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N 145	Continued From page 18 Face-to-Face Assessment was completed. c. On 5/5/21, at 2:08 p.m., the CCO (Chief Clinical Officer) was asked, the ESI (Emergency Safety Intervention) dated 4/25 shows an assessment was done at 1730 (5:30 p.m.), time restraint had ended was 1603 (4:03 p.m.). When should that have been done? He stated, "Within an hour." The CCO was asked, is that when the face to face assessment was done? He stated, "I can't tell. It's not reliable information."	N 145		
N 148	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(g)(3) [Each order for restraint or seclusion must include] the emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use. This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the specific time limit for the restraint order was on the physician's order for 4 (Clients #1, #2, #3, and #4) of 5 (Clients #1, #2, #3, #4 and #6) sampled clients who had Emergency Safety Interventions (ESI) orders. The findings are: 1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI dated 8/19/20 documented, "...Personal Restraint: Handle with Care Solo Takedown (include maximum time in minutes in text box)..." The time limit for the	N 148	The form used for Physician ESI orders in the EMR has been revised to make the documentation of the time limit for the restraint a mandatory field. This element must be documented to complete the form. The revision of the Physician ESI order was completed by the Credible Team at the request of the Assistant Clinical Director. This was completed on 5/14/21. The written ESI form has been revised to add an option for a 10 minute time limit, at the request of Centers' Medical Director. This will make documentation of that time limit more efficient for nursing staff. The revision of this form was completed by the Assistant Clinical Director on 5/14/21. On 5/10/21, Nursing Management initiated an ESI audit daily to ensure completion of all elements of the ESI process. This includes review of forms to ensure all areas are filled out accurately and completely and there is a corresponding order in the EMR with the time limit for the restraint documented.	6/11/21

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N 148	Continued From page 19 restraint order was not documented on the order. b. A Physicians Orders for ESI dated 8/24/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Techniques (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. c. A Physicians Orders for ESI dated 9/28/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order. 2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/7/20 documented, "...Personal Restraint: Handle with Care Two Person Takedown (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. b. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/9/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. c. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/10/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..."	N 148	Nursing Management has developed an ESI protocol (completed 6/4/21) and all nursing staff will sign off on the protocol by 6/11/21. This training will also be used with new nurses as part on the orientation process in residential programs.	

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N 148	Continued From page 20 The time limit for the restraint order was not documented on the order. d. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/13/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. e. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/14/20 documented, "...Personal Restraint: Handle with Care Solo Takedown (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. f. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/15/20 documented, "...Personal Restraint: Handle with Care Two Person Takedown (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. g. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/23/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box)..." The time limit for the restraint order was not documented on the order. 3. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer stated, "The doctor gives permission for length of a hold." When asked if that time was on the physician order, he stated, "It should be." 4. The facility Emergency Safety Interventions	N 148		

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N 148	Continued From page 21 policy received on 5/3/21 form the Assistant Clinical Director documented, "...Psychiatric Residential Treatment...Physician's Orders...e. ...i. The nurse writes the verbal/telephone order in Physician's Order section of the client record and indicates:...c. the specific emergency intervention(s) ordered including the maximum length of time authorized for use..." 5. Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form, dated 4/25/21, documented, "HWC (Handle With Care)-Primary Restraint Technique; Wall...Time Initiated 1600 (4:00 p.m.); Time Ended 1603 (4:03 p.m.)..." b. A Physician's Orders for ESI (Emergency Safety Intervention), dated 4/25/21 at 6:05 PM, documented, "...Personal Restraint: Handle With Care Personal Restraint Technique (standing) (Include maximum time in minutes in text box) 1600 (4:00 p.m.)-(to) 1603 (4:03 p.m.) (2-3 minutes)...." The Physician's Order stated the length of time the client was in the restraint, but did not document the length of time the physician authorized the use of the restraint. c. On 5/5/21, at 2:46 p.m., the Chief Clinical Officer was asked, is there a time limit for the ESI on 4/25 documented on the Physician's order? He stated, "I don't see one, just the time in the restraint." 6. Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and	N 148		

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N 148	Continued From page 22 Unspecified Schizophrenia and other Psychotic Disorders. a. A physicians Orders for ESI dated 3/31/21 documented, "...Personal Restraint: Handle With Care Four Person Takedown (include maximum time in minutes in test box)... " The time limit for the restraint order was not documented on the order. b. A physicians Orders for ESI dated 3/23/21 documented, "...Personal Restraint: Handle With Care Four Person Takedown (include maximum time in minutes in test box)... " The time limit for the restraint order was not documented on the order. c. A physicians Orders for ESI dated 3/11/21 documented, "...Personal Restraint: Handle With Care Two Person Takedown (include maximum time in minutes in test box)... " The time limit for the restraint order was not documented on the order. d. A physicians Orders for ESI dated 3/4/21 documented, "...Personal Restraint: Handle With Care Personal Restraint Technique (standing) (include maximum time in minutes in test box)... Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order. e. A physicians Orders for ESI dated 2/5/21 documented, "...Personal Restraint: Handle With Care Personal Restraint Technique (standing) (include maximum time in minutes in test box)... Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time	N 148		

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N 148	Continued From page 23 limit for the restraint order was not documented on the order. f. A physicians Orders for ESI dated 1/3/21 documented, "...Personal Restraint: Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order. g. A physicians Orders for ESI dated 11/25/20 documented, "...Personal Restraint: Handle With Care Two Person Takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order. h. A physicians Orders for ESI dated 10/24/20 documented, "...Personal Restraint: Handle With Care Solo takedown (include maximum time in minutes in test box)..." The time limit for the restraint order was not documented on the order.	N 148		
N 152	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(h)(3) [Documentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the date and time of the 1-hour assessment was documented for 1 (Client #3) of 4 sampled clients (Clients #1, #2, #3, 4 and 6) who were physically restrained. The findings are:	N 152	On 5/10/21, Nursing Management initiated an ESI audit daily to ensure completion of all elements of the ESI process. This includes review of forms to ensure all areas are filled out accurately and completely, to include results of the 1-hour assessment, and there is a corresponding order in the EMR. Nursing Management has developed an ESI protocol (completed 6/4/21) and all nursing staff will sign off on the protocol by 6/11/21. This training will also be used with new nurses as part on the orientation process in residential programs.	6/11/21

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N 152	Continued From page 24 Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and Unspecified Schizophrenia and other Psychotic Disorders. The EMERGENCY SAFETY INTERVENTION REPORTING FORM dated 1/3/21...FACE_TO_FACE ASSESSMENT FOR EMERGENCY SAFETY INTERVENTION...Date:___Time:___ , were not filled in by the RN (Registered Nurse).	N 152		
N 155	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain documented records for Emergency Safety Interventions (ESI) reports for 1 (Client #2) of 5 (Clients #1, #2, #3, #4 and #6) sampled clients who had ESI implemented. The findings are: Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/10/20 documented, "...Personal Restraint: Handle with Care Personal Restraint Technique (standing) (include maximum time in minutes in text box) 8 minutes..."	N 155	The routing process for ESI forms has been changed to ensure that the forms do not leave the building for review or sign off. The change in this process was initiated by the Assistant Clinical Director, on 5/14/21. On 5/10/21, Nursing Management initiated an ESI audit daily to ensure completion of all elements of the ESI process. This includes review of forms to ensure all areas are filled out accurately and completely and there is a corresponding order in the EMR. Nursing Management has developed an ESI protocol (completed 6/4/21) and all nursing staff will sign off on the protocol by 6/11/21. This training will also be used with new nurses as part on the orientation process in residential programs. The "Behavior Log," the log where ESI's in each program are documented, has been revised to add a column to document the date an ESI form has been scanned into the EMR. This was completed by the Assistant Clinical Director on 6/1/21.	6/11/21

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N 155	Continued From page 25 b. A Physicians Orders for ESI (Emergency Safety Interventions) dated 10/14/20 documented, "...Personal Restraint: Handle with Care Solo Takedown (include maximum time in minutes in text box) 1121-1130 [11:21 a.m.-11:30 a.m.] ..." c. On 5/3/21 at 12:57 p.m., the Assistant Clinical Director was asked to provide the two missing ESI reports, and the Assistant Clinical Director stated, "We're still looking but have not found the other two reports." d. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer was asked if he was aware of the missing ESI reports and he stated, "Yes." When asked if ESIs were supposed to be on the clinical record, the Chief Clinical Officer stated, "Supposed to be, yes."	N 155		
N 156	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician signed an order for a physical restraint as soon as possible to ensure restraint orders were accurate and appropriate and update the treatment plan as needed for 3 (Clients #1, #2 and #3) of 5 (Clients #1 - #4 and #6) sampled residents who had a restraint	N 156	The routing process for ESI forms has been changed, and the forms no longer leave the program for review or signature, and they remain in a designated ESI box in the programs. The Medical Director/physician ordering the restraint will check the boxes in the programs several times weekly to ensure the forms are signed within 5 days of the restraint, as per Centers policy. On 5/10/21, Nursing Management initiated an ESI audit daily to ensure completion of all elements of the ESI process. This includes review of forms to monitor for the physician's signature within 5 days. The Support Staff will also audit forms for all signatures, including the physician signature within 5 days, prior to scanning ESI forms into the EMR.	6/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L101	A. BUILDING _____ B. WING _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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 156	Continued From page 26 ordered. The findings are: 1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI (Emergency Safety Intervention) dated 9/28/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 9/28/2020 at 5:32 p.m.. There was no physician's signature on the order. 2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/7/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/7/2020 at 1:46 p.m.. There was no physician's signature on the order. b. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/9/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/9/2020 at 5:48 p.m.. There was no physician's signature on the order. c. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/10/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/10/2020 at 7:45 p.m.. There was no physician's signature on the order. d. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/14/2020 documented, "Personal Restraint..." and was	N 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 156	Continued From page 27 signed by the Licensed Practical Nurse on 10/14/2020 at 11:58 a.m.. There was no physician's signature on the order. e. A Physicians Orders for ESI (Emergency Safety Intervention) dated 10/23/2020 documented, "Personal Restraint..." and was signed by the Licensed Practical Nurse on 10/24/2020 at 10:44 a.m.. There was no physician's signature on the order. 3. On 5/5/21 at 1:30 p.m., Registered Nurse (RN) #1 was shown one of the orders and asked if the physician had signed it, and RN #1 stated, "No." She was asked "Is it supposed to be signed?" She stated, "Yes." 4. On 5/5/21 at 1:55 p.m., the Chief Clinical Officer was asked if he was aware the physician's orders were supposed to be signed and he stated, "I may have known but don't recall." 5. The facility Emergency Safety Interventions policy received on 5/3/21 form the Assistant Clinical Director documented, "...Psychiatric Residential Treatment...Physician's Orders...f. The physician's verbal order must be followed with the physician's signature verifying the verbal order within 5 days..." 6. Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and Unspecified Schizophrenia and other Psychotic Disorders. A Physicians Orders for ESI dated 1/3/21 documented, "Personal Restraint...an was signed by the LPN on 1/3/2021 at 7:58 p.m. There was no physician's signature on the order.	N 156		

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CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

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N 165	MONITORING DURING AND AFTER RESTRAINT CFR(s): 483.362(a) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing, and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure a nurse was physically present to continually assess the safety of a restraint and continuously monitor a client during the use of a physical restraint for 1 (Client #4) of 5 (Client #1, 2, 3, 4, 6) sampled clients who were physically restrained. The findings are: Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form, dated 5/2/21, documented, "...Primary Restraint Technique Wall...Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.)..." b. On 5/5/21 at 9:33 a.m. the video of the restraint, for Client #4 on 5/2/21 at 10:37 a.m., was viewed. The video had no audio. The client is seen going into the nurse's station then into the bathroom. The male staff is viewed coming into the nurse's station and then into the bathroom. The nurse goes to the door of the bathroom and then goes out of the nurse's station into the medication room, out of the line of vision of the restraint, then one minute later comes back into	N 165	On 5/10/21, Nursing Management initiated an ESI audit daily to ensure completion of all elements of the ESI process to include continuous monitoring during a hold. ESI forms will be reviewed daily to include documentation of continuous monitoring and observation to ensure that clients are remaining safe during ESI's and that any holds are done in a safe manner. A video review session is conducted daily by administrative staff and CPI training staff to review any holds done during the previous day. Feedback regarding the event, to include the presence of or lack of continuous observation and monitoring, along with other pertinent information is provided to Program Managers and Nursing Managers. Additional training may be done with staff as needed. Nursing Management has developed an ESI protocol (completed 6/4/21) and all nursing staff will sign off on the protocol by 6/11/21. This training will also be used with new nurses as part on the orientation process in residential programs.	6/11/21

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N 165	Continued From page 29 the nurse's station to the bathroom door. The nurse then comes out of the bathroom, looks at a monitor on the desk, goes back to the bathroom, comes back out, sits in a chair at the desk, takes a drink from a cup, out of the line of vision of the restraint, gets up and goes back into the bathroom. The male staff exits bathroom then walks out of camera view, comes back into view with a cup in his hand and goes into the bathroom. The nurse, client and male staff come out of the bathroom, and the nurse examines client's arm. The client, nurse and staff member leave the nurse's station and go to the treatment room. The restraint, which was applied in the bathroom, was not viewable from either camera. The nurse failed to be consistently within the view of the physical restraint, to monitor and assess the client and to assess for the safety of the restraint. d. On 5/4/21, at 3:52 p.m., the Assistant Clinical Director was asked, shouldn't the nurse be monitoring the restraint? She stated, "She should be. She goes back and forth numerous times, but we would expect continuous monitoring and observation.	N 165		
N 167	MONITORING DURING AND AFTER RESTRAINT CFR(s): 483.362(c) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.	N 167	Nursing staff has been provided specific instruction regarding requirements for an immediate evaluation upon removal of a restraint. Specifically, nursing staff was provided instruction and modeling of how the assessment should be completed and documented. Instruction was provided through e-mail on 5/6/21 by the Director of Nursing. Instruction was provided by email on 6/1/21 by the Nurse Manager. Individual feedback has been done by both Nurse Managers in the programs with nurses when auditing of ESI forms has shown a need starting on 5/10/21.	6/11/21

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CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

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N 167	Continued From page 30 This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a physician, or other licensed practitioner permitted by the state and the facility and trained in the use of emergency safety interventions evaluated the resident's well-being immediately after the restraint was removed for 5 of 5 (Clients #1, #2, #3, #4 and #6)sampled residents who had been restrained. The findings are: 1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 8/19/20 documented, "...Time initiated 8:15 Time ended 8:17...Nursing Assessment (Upon Removal from Procedure): Time 9:00..." b. An Emergency Safety Intervention Reporting Form dated 9/28/20 documented, "...Time initiated 1434 [2:34 p.m.] Time ended 1437 [2:37 p.m.]...Nursing Assessment (Upon Removal from Procedure): Time 1530 [3:30 p.m.]..." 2. Client #2 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 10/9/20 documented, "...Time initiated 1733 [5:33 p.m.] Time ended 1741 [5:41 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1755 [5:55 p.m.] ..." b. An Emergency Safety Intervention Reporting Form dated 10/13/20 documented, "...Time initiated 12:12 Time ended 12:17...Nursing Assessment (Upon Removal from Procedure):	N 167	On 5/10/21, Nursing Management initiated an ESI audit daily to ensure completion of all elements of the ESI process. This includes review of forms to ensure all areas are filled out accurately and completely and there is a corresponding order in the EMR. Nursing Management has developed an ESI protocol (completed 6/4/21), and all nursing staff will sign off on the protocol by 6/11/21. This training will also be used with new nurses as part on the orientation process in residential programs.	

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N 167	Continued From page 31 Time 12:25..." 3. Client #6 had a diagnosis of Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form dated 4/23/21 documented, "CPI High 2 person...Time initiated 2101 [9:01 p.m.] Time ended 2104 [9:04 p.m.] Time initiated 2105 [9:05 p.m.] Time ended 2107 [9:07 p.m.]... HWC [Handle with Care] 2 person Wall Escort...Time initiated 2112 [9:12 p.m.] Time ended 2115 [9:15 p.m.] Time initiated 2115 [9:15 p.m.] Time ended 2115 [9:15 p.m.]...Nursing Assessment (Upon Removal from Procedure): Time 2140 [9:40 p.m.]..." b. An Emergency Safety Intervention Reporting Form dated 4/25/21 documented, "...Time initiated 1809 [6:09 p.m.] Time ended 1818 [6:18 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1900 [7:00 p.m.] ..." c. An Emergency Safety Intervention Reporting Form dated 4/26/21 documented, "...HWC 1 person wall Time initiated 10:06 Time ended 10:08 ... HWC- Take Down 1 person...Time initiated 10:12 Time ended 10:15... Nursing Assessment (Upon Removal from Procedure): Time 10:55 ..." d. An Emergency Safety Intervention Reporting Form dated 4/30/21 documented, "...Time initiated 10:30 a.m. Time ended 10:34 a.m. ...Nursing Assessment (Upon Removal from Procedure): Time 11:09 ..." e. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...Time initiated	N 167		

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N 167	Continued From page 32 1207 Time ended 1207 ...Nursing Assessment (Upon Removal from Procedure): Time 1256 ..." f. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...Time initiated 1312 [1:12 p.m.] Time ended 1314 [1:14 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1425 [2:25 p.m.] ..." g. An Emergency Safety Intervention Reporting Form dated 5/3/21 documented, "...CPI seated position medium...Time initiated 1340 [1:40 p.m.] Time ended 1342 [1:42 p.m.] ... Emergency medication -[Intramuscular] ...Time initiated 1356 [1:56 p.m.] Time ended 1356 [1:56 p.m.] ...Nursing Assessment (Upon Removal from Procedure): Time 1425 [2:25 p.m.] ..." h. An Emergency Safety Intervention Reporting Form dated 5/4/21 documented, "...CPI seated medium...Time initiated 10:38 a.m. Time ended 10:39 a.m. Time initiated 10:41 a.m. Time ended 10:43 a.m....CPI Team Control Position...Time initiated 10:39 a.m. Time ended 10:41 a.m. ...Nursing Assessment (Upon Removal from Procedure): Time 11:22 ..." i. An Emergency Safety Intervention Reporting Form dated 5/4/21 documented, "...CPI seated medium...Time initiated 1139 Time ended 1139 ...CPI Team Control Position...Time initiated 1135 Time ended 1136 Time initiated 1138 Time ended 1139 Time initiated 1139 Time ended 1141 Time initiated 1144 Time ended 1144 ...Nursing Assessment (Upon Removal from Procedure): Time 1200 ..." 4. The facility Emergency Safety Interventions policy received on 5/3/21 form the Assistant	N 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 167	Continued From page 33 Clinical Director documented, "...Psychiatric Residential Treatment...E. Post Intervention Procedures ...c. ...2. A physician or a nurse trained in the use of emergency safety interventions must evaluate the client's well being immediately after the restraint is discontinued..." 4. Client #4 was admitted on 3/4/20 and had diagnosis Disruptive Mood Dysregulation Disorder. a. An Emergency Safety Intervention Reporting Form, dated 4/25/21, documented, "HWC (Handle With Care)-Primary Restraint Technique; Wall...Time Initiated 1600 (4:00 p.m.); Time Ended 1603 (4:03 p.m.)...5. Nursing Assessment (Upon Removal from Procedure): Time:1730 (5:30 p.m.)..." b. The Face-To-Face Assessment For Emergency Safety Interventions documented, "The Face-to-Face Assessment form must be completed within one hour of initiation of Emergency Safety Intervention..." There was no date or time documented to indicate when the Face-to-Face Assessment was completed. c. On 5/5/21, at 2:08 p.m., the CCO (Chief Clinical Officer) was asked, the ESI (Emergency Safety Intervention) dated 4/25 shows an assessment was done at 1730 (5:30 p.m.), time restraint had ended was 1603 (4:03 p.m.). When should that have been done? He stated, "Within an hour." The CCO was asked, is that when the face to face assessment was done? He stated, "I can't tell. It's not reliable information." 5. Client #3 had a diagnoses of Disruptive Mood Disorder, Reactive Attachment Disorder, and	N 167		

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N 167	Continued From page 34 Unspecified Schizophrenia and other Psychotic Disorders. a. An Emergency Safety Reporting Form Dated 3/31/2 documented, "...Time initiated 1710 [5:10 p.m.] Time ended 1720 [5:20 p.m.]...Nursing Assessment (Upon Removal from Procedure): "Time: 1730 [5:30 p.m.] b. An Emergency Safety Reporting Form Dated 3/23/21 documented, "...Time initiated 1622 [4:32 p.m.] Time ended 1632 [4:32 p.m.]...Nursing Assessment (Upon Removal from Procedure): "Time: 1646 [4:46 p.m.]	N 167		

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
04L101	CENTERS FOR YOUTH AND FAMILIES INC

Type of Survey (select all that apply)

A				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. [redacted]	04/30/2021	05/05/2021	1.00	0.00	23.50	0.00	10.00	16.00
2. [redacted]	04/30/2021	05/11/2021	1.00	0.00	32.00	0.00	5.00	6.50
3. [redacted]	05/03/2021	05/05/2021	0.50	0.00	18.00	0.00	8.50	5.00
4.								
5.								
6.								
7.								
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9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 5.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.50

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**