



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 deficient 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,

Administrative Services Manager

DPSQA/Office of Long Term Care Survey & Certification Section

sgb

cc:

DRA

						APPROVED
		MEDICAID SERVICES				D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	 PLETED
		04L101	B. WING			C 11/2021
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
CENTERS	FOR YOUTH AND FAMI	LIES INC			01 W 12TH STREET TTLE ROCK, AR 72225	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments	7 (Statement of Deficiencies)	N C	000		
	is an official, legal door remain unchanged ex correction, correction space. Any discrepan	cument. All information must accept for entering the plan of dates, and the signature cy in the original deficiency orted to the Dallas Regional				
	Office (RO) for referra Inspector General (Of information is inadver	al to the Office of the IG) for possible fraud. If tently changed by the State Survey Agency (SA)				
	Complaint #AR00026	502 was substantiated. 504 was substantiated. 552 was unsubstantiated.				
N 128	The facility was not in Subpart G - Condition Psychiatric Residentia PROTECTION OF RE CFR(s): 483.356(a)(3	al Treatment Center ESIDENTS	N 1	28		
		nust not result in harm or and must be used only-				
	Based on observation interview the facility fa not sustain an injury a	t met as evidenced by: n, record review and ailed to ensure a client did as a result of a restraint for 1 ed client who sustained an				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/20/2021 APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		04L101	B. WING			(05/	; 11/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI			6501 W 12TH STREET			
GENTERS				LITTLE ROCK, AR 722	25		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
N 128	Continued From page	• 1	N 12	28			
		of a physical restraint. The					
	Client #4 was admitte diagnosis Disruptive I Disorder.						
	Form, dated 5/2/21, d Restraint Technique V	fety Intervention Reporting ocumented, "Primary Vall Time Initiated 1037 ded 1040 (10:40 a.m.)"					
	p.m., signed by RN (F documented, "Most of unstable and disrespe- cursing at staff, threat peers while on the un breakfast because sh climbing in the window several staff members the client to see is she This nurse tried to ge follow directions in or unit with a particular sc client that if she kept behaviors this nurse w Client was trying to ta the unit as well. Tried nurses station a few f the client and the clie and she eventually ca While trying to speak behavior client ran an nurse's station. T assistance from a QB Health Professional) a	f the shift client was irate, ectful to staff. Client was tening staff, hitting staff and it. Client refused to eat e was upset. Client was w seal and this nurse and s tried their best to talk with e could turn her day around. t the client to calm down and der to get to go on another staff member. Informed up self harm and aggressive would have to call [Doctor]. ke her clothes off while in d bringing the client into the nours later and speak with nt ran around the day area ame to the nurse's station. with the client about her d locked herself in the om after trying to elope from this nurse asked for HP (Qualified Behavior					

Facility ID: 3000

If continuation sheet Page 2 of 35

	-	D HUMAN SERVICES					FORM): 05/20/2021 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	LETED
		04L101	B. WING			_		C 11/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			501 W 12TH STREET ITTLE ROCK, AR 7222	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 128	the client tried to push QBHP report the client which resulted in him With Care) wall restra from 1037 a.m1040 done to the best of sta and the least restrictive of the incident. Client face at which time the so that her face was r she continued to scree time this nurse inform longer touching the w complained of right ar could not feel her arm at 9/10 (9 out of 10) a (Range of Motion ass check). Client arm did After ROM assessme noticed a clicking nois near/at the right elbow ordered for the client for for further evaluation. several times and rea contacted every time information regarding Around 1251 (12:51 p staff that client right h she would need surger c. On 5/3/21 at 1:11 p Director stated, "Ever Handle With Care hol CPI (Crisis Preventior Assistant Clinical Dire staff notified that the F	P came and assisted after a him out with the door. Per at attempted to punch him performing a HWC (Handle int. The restraint lasted a.m. The restraint lasted a.m. The restraint was aff ability based on training re restraint used at the time was hollering about her a staff pulled the client back not touching the wall and am about her face at which ed her that her face was no all. After release client m pain and stated she b. Client rated her pain level nd this nurse did a ROM essment. Neurological d appear swollen and red. Int was done this nurse se and what felt like grinding v. [Doctor] was called and to be sent out to [Hospital] Client guardian was called ssured that she would be this nurse received new the status of the client. b.m. the Assistant Clinical ybody is no longer to do the d anymore, they are to do n Intervention) only." The actor was asked, how are handle with Care is not to add, "They emailed that to all	Ν	128				

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ATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	O. 0938-03	
d plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	CON	IPLETED	
		04L101	B. WING			С	
	ROVIDER OR SUPPLIER	042101	D. WING	STREET ADDRESS, CITY, STATE, ZIP CO		5/11/2021	
IAME OF PI	ROVIDER OR SUPPLIER			6501 W 12TH STREET			
ENTERS	FOR YOUTH AND FAMI	LIES INC		LITTLE ROCK, AR 72225			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
N 128	Continued From page	. 2		0			
IN 120	Continued From page		N 12	8			
	employees this morni						
		tant Clinical Director was monitored to ensure they are					
		With Care holds? She					
		id the program manager,					
		irectly and we are also doing					
		restraint. They are here and					
	are present when the	y are doing the hold and					
	make sure they are d	oing CPI." The Assistant					
		asked, when were the					
	-	? She stated, "Yes. The					
		program, ages six to twelve,					
		nonths ago, because of the					
		the CPI." The Assistant					
		asked, [Client #4] is ten d, "Yes." The Assistant					
	•	asked, was she in the					
		d, "Yes." The Assistant					
		asked, when she was					
		laced in the Handle With					
		stated, "She was in the					
		no video, but documentation					
	-	Handle With Care position."					
		Manager was asked, so he					
		old he was not to use? She					
		e Assistant Clinical Manager					
		he now? She stated, "He					
	Assistant Clinical Mar	ediately after the hold? The					
		ed, "Yes." At 2:57 p.m. the					
		nager stated, "[Chief Clinical					
		hey also suspended the					
		and refresher training in the					
	CPI was being condu	-					
	investigation.						
	d. On 5/5/21, at 9:04	a.m. the video with audio					
	was viewed. The vide	eo with audio only showed					
	the hall which leads to			1		1	

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED	/EY
	2
04L101 B. WING 05/11/202	021
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	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	(X5) MPLETION DATE
N 128 Continued From page 4 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 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 sit." The male staff member was seen exting 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, "I't intrust 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 halway and the client was seen holding her arm. e. On 5/5/21 at 9:33 a.m. the video with no audio was wiewed. The client was seen going into the	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		04L101	B. WING				C / 11/2021
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
N 128	staff was viewed com and then into the bath the door of the bath nurse's station into th the line of vision of th later comes back into bathroom door. The bathroom, looks at a back to the bathroom a chair at the desk, ta up and goes back into staff exits bathroom th view, comes back wit goes into the bathroo male staff come out of examines clients arm member leave the nu treatment room. The from either camera. f. On 5/5/21 at 10:04 Coordinator was aske Care hold, and it is do be any injuries?" She Coordinator was show and the client standin together. The Trainin "With the picture you client, would the Hand appropriate hold?" S placed them in a child g. The facility Emerg policy, received from Director on 5/3/21 at "General Principles intervention must be	ing into the nurse's station froom. The nurse goes to oom and then goes out of the e medication room, out of e restraint, then one minute the nurse's station to the monitor on the desk, goes , comes back out and sits in kes a drink from a cup, gets o the bathroom. The male then walks out of camera h a cup in his hand and m. The nurse, client and f the bathroom, the nurse . The client, nurse and staff rse's station and go to the e restraint was not viewable a.m. the Training ed, "If you do a Handle With one correctly, should there e stated, "No." The Training vn a picture of the male staff g in the nurse's station g Coordinator was asked, just saw with the staff and dle With Care be an he stated, "I would have a control hold." ency Safety Interventions the Assistant Clinical 1:03 p.m., documented, G. An emergency safety performed in a manner that and appropriate to the	N	128	3		

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION		O. 0938-039
	FCORRECTION	IDENTIFICATION NUMBER:	· ,		· · · ·	IPLETED
						С
		04L101	B. WING		0	5/11/2021
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAM	ILIES INC		01 W 12TH STREET TTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
N 128	Continued From pag	e 6	N 128			
	gender; physical, me condition; and person history or physical or	nal history (including any sexual abuse.)I. Verbal ntions will be exhausted				
N 132	PROTECTION OF R CFR(s): 483.356(b)	ESIDENTS	N 132			
	safety intervention m manner that is safe, appropriate to the se the resident's chrono age; size; gender; ph psychiatric condition;	verity of the behavior, and logical and developmental				
	Based on observation interview the facility for restraint was perform appropriate for the cl #4) of 5 (Client #1, 2	ot met as evidenced by: on, record review and failed to ensure a physical ned safely and was ient's and size for 1 (Client , 3, 4 and 6) sampled clients restrained. The findings are:				
	Client #4 was admitte diagnosis Disruptive Disorder.	ed on 3/4/20 and had Mood Dysregulation				
	Form, dated 5/2/21, o Restraint Technique	afety Intervention Reporting documented, "Primary WallTime Initiated 1037 nded 1040 (10:40 a.m.)"				

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		MEDICAID SERVICES				O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	· · ·	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		CON	
						С
		04L101	B. WING		0	5/11/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
				6501 W 12TH STREET		
CENTERS	FOR YOUTH AND FAM			LITTLE ROCK, AR 72225		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETIO
N 132	Continued From pag	e 7	N 13	2		
	1 5	ss Note, dated 5/2/21 at 6:00				
		Registered Nurse) #1				
		of the shift client was irate,				
	-	bectful to staff. Client was				
	-	atening staff, hitting staff and				
	-	nit. Client refused to eat				
		he was upset. Client was				
		by seal and this nurse and				
	0	rs tried their best to talk with				
		ne could turn her day around.				
		et the client to calm down and				
		rder to get to go on another				
		staff member. Informed				
	-	up self harm and aggressive				
		would have to call [Doctor].				
		ake her clothes off while in				
		d bringing the client into the				
		hours later and speak with				
		ent ran around the day area				
		ame to the nurse's station.				
		with the client about her				
		nd locked herself in the				
		oom after trying to elope from				
	the nurse's station.					
		BHP (Qualified Behavior				
		after client went and				
		rself in the nurse's station				
		IP came and assisted after				
		sh him out with the door. Per				
		ent attempted to punch him				
		n performing a HWC (Handle				
		aint. The restraint lasted				
	,) a.m. The restraint was				
	done to the best of s	taff ability based on training				
		ive restraint used at the time				
	of the incident. Clier	nt was hollering about her				
		e staff pulled the client back				
	so that her face was	-				
		not touching the wall and				

Facility ID: 3000

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/20/2021 M APPROVED D. 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		04L101	B. WING				C / 11/2021
NAME OF PRO	VIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				65	01 W 12TH STREET		
CENTERS F	OR YOUTH AND FAMII			LI	TTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
ti kko co a ((co A n n co fr s co iii A s s co E H CO A s b e e n a n s ti v a a () co a a () co a a () co a a () co a a () co a a () co a a () co a a () co a a () co a a () co a a () co () co a () co a () co co () co (co (onger touching the w complained of right ar sould not feel her arm it 9/10 (9 out of 10) a Range of Motion ass heck). Client arm did fer ROM assessme toticed a clicking nois hear/at the right elbow ordered for the client to or further evaluation. everal times and rea contacted every time formation regarding would 1251 (12:51 p taff that client right h he would need surge contacted, "Ever landle With Care hol CPI (Crisis Preventior Assistant Clinical Director stated, "Ever landle With Care hol CPI (Crisis Preventior assistant Clinical Director taff notified that the H be utilized? She state employees, the email moloyees this morning hanager." The Assis asked, how are staff r tot using the Handle V tated, "The nurse an hey are monitoring di ideo review of each to the present when they nake sure they are do Clinical Director was a notified, this morning?	ed her that her face was no all. After release client im pain and stated she b. Client rated her pain level ind this nurse did a ROM essment. Neurological d appear swollen and red. int was done this nurse se and what felt like grinding w. [Doctor] was called and to be sent out to [Hospital] Client guardian was called ssured that she would be this nurse received new the status of the client. b.m.) received report from umerus was broken and ery" b.m. the Assistant Clinical ybody is no longer to do the d anymore, they are to do in Intervention) only." The sector was asked, how are Handle with Care is not to ed, "They emailed that to all and memos to all	N	132			

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM): 05/20/2021 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		04L101	B. WING		-	(05/) 11/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		-
0511750				6501 W 12TH STREET			
CENTER	S FOR YOUTH AND FAMI			LITTLE ROCK, AR 7222	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
N 132	were told about two m size difference to use Clinical Director was a years old? She state Clinical Director was a [Building]? She state Clinical Director was a restrained, was she p Care position? She st bathroom so there is f says that he used the The Assistant Clinical used a hold he was to stated, "Correct." The was asked, where is f was suspended imme Assistant Clinical Mar yesterday? She state Assistant Clinical Mar Officer] is telling me th nurse." An in-service CPI was being condu investigation. d. On 5/5/21, at 9:04 was viewed. The vide the hall which leads to treatment room. The reflect the actual time was viewed coming th then the client goes b out, out of view of the into the hall with the client get past the nurse and blocks the way and the the nurse at which tim up. If you grab me you	honths ago, because of the the CPI." The Assistant asked, [Client #4] is ten d, "Yes." The Assistant asked, was she in the d, "Yes." The Assistant asked, when she was laced in the Handle With tated, "She was in the no video, but documentation Handle With Care position." Manager was asked, so he old he was not to use? She e Assistant Clinical Manager ne now? She stated, "He ediately after the hold? The hager was asked, ed, "Yes." At 2:57 p.m. the hager stated, "[Chief Clinical hey also suspended the and refresher training in the	N 132				

Facility ID: 3000

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/20/2021 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		04L101	B. WING		_	(05/) 11/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
CENTERS				6501 W 12TH STREET			
CENTERS	FOR YOUTH AND FAMI			LITTLE ROCK, AR 7222	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
N 132	Continued From page The client then goes in of view of the camera her phone. A male st and then goes into the of the camera. You c "ow' and screaming "h my arm. At this time in nurse's station, out of voice is heard saying. There was more screa- client saying "Yes sir. was seen exiting the is heard saying, "I car was more screaming saying, "Please don't voice heard saying, "I it I have to touch it." exited the room, went with a cup in his hand station, out of camera and hard breathing he come out of nurse's s the client was seen he e. On 5/5/21 at 9:33 a was viewed. The clie nurse's station then in staff was viewed com and then into the bath the door of the bathroo nurse's station into th the line of vision of the later comes back into	e 10 nto the nurse's station, out , and the nurse is seen on aff member enters the hall e nurse's station, out of view an hear the client yelling my face, my face, my arm, the nurse enters into the view of the camera. A , "you need to calm down." aming and you can hear the " The male staff member nurse's station and the client n't move my arm." There and the client was heard hurt it." There was a female f it hurts and you can't move The male staff member to ut the door, came back in and went into the nurse's a view. There was crying eard. The nurse and client tation into the hallway and	N 132	D			
	back to the bathroom a chair at the desk, ta up and goes back into	monitor on the desk, goes , comes back out and sits in ,kes a drink from a cup, gets o the bathroom. The male nen walks out of camera					

Facility ID: 3000

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION		SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · · · · · · · · · · · · · · · · · ·		PLETED
							С
		04L101	B. WING			05	/11/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
N 132	Continued From page	e 11	N	132	2		
		h a cup in his hand and					
		m. The nurse, client and					
		of the bathroom, the nurse					
		. The client, nurse and staff rse's station and go to the					
		e restraint was not viewable					
	from either camera.						
	f. On 5/5/21 at 10:04	a.m. the Training ed, if you do a Handle With					
		one correctly, should there					
		stated, "No." The Training					
		wn a picture of the male staff					
		ig in the nurse's station					
	-	ng Coordinator was asked, ust saw with the staff and					
	client, would the Han						
		ne stated, "I would have					
	placed them in a child	d control hold."					
	a The facility Emerg	ency Safety Interventions					
	policy, received from						
		1:03 p.m., documented,					
		G. An emergency safety					
		performed in a manner that and appropriate to the					
	severity of the behavi						
	-	velopmental age; size;					
	gender; physical, me						
	· · ·	nal history (including any					
		sexual abuse.)I. Verbal ntions will be exhausted					
	before a more restrict						
	initiated"						
N 136			N	136	6		
	CFR(s): 483.356(c)(4	•)					
	At admission, the fac	cility must] provide a copy of					

Facility ID: 3000

If continuation sheet Page 12 of 35

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/20/2021 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COME	E SURVEY PLETED
		04L101	B. WING				C /11/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
N 136	a minor, to the reside guardian(s). This ELEMENT is no Based on record rev failed to ensure a cop policy was received b for 1 (Client #4) of 1 (The findings are: Client #4 was admitted diagnosis Disruptive ID Disorder. a. The facility Conse Treatment, signed by 3/3/21, documented, Consent For Behavio Emergency Safety Intreviewed the [Facility emergency safety intre agency policy. I give for [Facility] to utilize clinically indicated in authorize my child's p behavior management interventions related were identified" b. On 5/3/21 at 4:42	e resident and in the case of nt's parent(s) or legal of met as evidenced by: iew and interview the facility by of the facility's restraint by the guardian at admission Client #4) sampled clients. ed on 3/4/20 and had Mood Dysregulation nt For Admission And Client #4's guardian on "Section IV (four): r Management And terventions a. I have] behavior management and erventions as outlined in my consent and permission these procedures as the course of treatmentb. I participation in the Center's	N	136			
	copy of the facility po management and em interventions? He sta switched over to Doc The Chief Clinical Off	licy on behavior					

Facility ID: 3000

If continuation sheet Page 13 of 35

		MEDICAID SERVICES		ECONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · · ·	MPLETED
						С
		04L101	B. WING		0	5/11/2021
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
			e	5501 W 12TH STREET		
CENTERS	S FOR YOUTH AND FAM		I	LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 136	Continued From pag	le 13	N 136			
	is all they are getting interventions? He st					
N 144		OF RESTRAINT OR	N 144			
	Each order for restraint or seclusion must:					
	the emergency safet (2) Under no circu residents ages 18 to	o longer than the duration of y situation; and Imstances exceed 4 hours for 21; 2 hours for residents 1 hour for residents under age				
		view and interview the facility hysician's Order for a restraint 1 (Client #4) of 1 (Client #4) is failed practice had the facility clients as t provided by the Assistant				
		ed on 3/4/20 and had Mood Dysregulation				
	Form, dated 5/2/21, Restraint Technique (10:37 a.m.) Time El	afety Intervention Reporting documented, "Primary WallTime Initiated 1037 nded 1040 (10:40 a.m.)" cian's Order found for the use				
	b. On 5/3/21, at 2:5 Director was asked,	7 p.m., the Assistant Clinical				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/20/2021 APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		04L101	B. WING		_		C 11/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC		501 W 12TH STREET ITTLE ROCK, AR 7222	25		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 144	didn't see one for that ESI (Emergency Safe twenty fifth." The Ass asked, that was April stated, "Yes." ORDERS FOR USE (SECLUSION CFR(s): 483.358(f) Within 1 hour of the ir safety intervention a p practitioner trained in safety interventions a and the facility to asse psychological wellbein conduct a face-to-face physical and psycholo resident, including but (1) The resident's p status; (2) The resident's b (3) The appropriate measures; and (4) Any complication intervention. This ELEMENT is no Based on interview a failed to ensure a face	a on 5/2? She stated, "I a one. The only order for an ety Intervention) was on the distant Clinical Director was twenty fifth, right? She OF RESTRAINT OR nitiation of the emergency obysician, or other licensed the use of emergency nd permitted by the state ess the physical and ng of residents, must e assessment of the ogical wellbeing of the t not limited to-	N 144				
	(Clients #1, #2, #3, #4	#1, #2, #4 and #6) of 5 4 and #6) sampled clients ned. The findings are:					

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		ID HUMAN SERVICES				FORM	D: 05/20/2021 MAPPROVED D. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` í		CONSTRUCTION	(X3) DATE		
AND I LAN OF	CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG _			C
		04L101	B. WING				11/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			501 W 12TH STREET ITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
N 145	Continued From page	9 15	N ·	145			
	1. Client #1 had a dia Dysregulation Disorde	gnosis of Disruptive Mood er.					
	 a. An Emergency Saff Form dated 9/28/20 d initiated 1434 [2:34 p. p.m.]The Face-to-F be completed within of Emergency Safety Int was completed within no, reason why- RN [duty" The Face-to- was signed, dated an 9/29/20 at 12:37 p.m. 2. Client #2 had a dia Dysregulation Disorded a. An Emergency Saff Form dated 10/7/20 d initiated 1256 [12:56 p p.m.]The Face-to-F be completed within of Emergency Safety Int was completed within no, reason why- No F Face-to-Face section dated on 10/7/20. Th with 18 to indicate wit 3. Client #6 had a dia Dysregulation Disorded 	ety Intervention Reporting locumented, " Time m.] Time ended 1437 [2:37 ace Assessment form must one hour of initiation of tervention- Face-to-Face one hour indicated No. If Registered Nurse] not on Face section of the form d timed as completed on gnosis of Disruptive Mood er. ety Intervention Reporting locumented, " Time o.m.] Time ended 1305 [1:05 ace Assessment form must one hour of initiation of tervention- Face-to-Face one hour indicated No. If RN on duty" The of the form was signed and e time is not clear but starts hin the 6 p.m. hour. gnosis of Disruptive Mood er.					
		ime ended 10:34 a.mThe ment form must be					

Facility ID: 3000

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE		
AND I LAN OI	CONNECTION	DENTIFICATION NOMBER.	A. BUILDIN	1G		C		
		04L101	B. WING				/11/2021	
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
CENTERS	FOR YOUTH AND FAMI	LIES INC		65	01 W 12TH STREET			
				LI	TTLE ROCK, AR 72225		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
N 145	 was completed within why- Client Refused of the form had a line documented "Client refu- b. An Emergency Safe Form dated 5/3/21 do 1312 [1:12 p.m.] Time p.m.]The Face-to-Face be completed within of Emergency Safety Int was completed within The Face-to-Face sec dated and timed as co [2:25 p.m.]. 4. On 5/5/21 at 1:30 p Face-to-Face is one f do assessment. The Nurse] maybe working one hour." When ask was for Face-to-Face stated, "It's not policy permissible." 5. On 5/5/21 at 1:55 p Officer was asked, "W Face-to-Face assess Chief Clinical Officer s hour with an RN." 6. On 5/11/21 at 8: 55 Director was asked he Face-to-Face assess Clinical Director state should be able to com 	ervention- Face-to-Face one hour If no, reason ." The Face-to-Face section through the section and efused face-to-face." ety Intervention Reporting cumented, " Time initiated e ended 1314 [1:14 ace Assessment form must one hour of initiation of rervention- Face-to-Face one hour indicated Yes" ction of the form was signed, ompleted on 5/3/21 at 1425 o.m., RN #2 stated, "The hour to get it. The RN has to LPN [Licensed Practical g so I have to get it done in red what the facility policy assessments, RN #1 for it not to get done, it's not o.m., the Chief Clinical /hen should the ment be completed?" The stated, "Face-to-Face in an 6 a.m., the Assistant Clinical ow a client could refuse a ment and the Assistant d, "I seen that. No, they	N 1	45	DEFICIENCY)			

Facility ID: 3000

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE COMF	
		04L101	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
N 145	policy received on 5/3 Clinical Director docu Residential Treatmen Procedures- A. Within the emergency safety an RN, or a licensed trained by the physici perform the assessme face-to-face assessme psychological well be 8. Client #4 was adm diagnosis Disruptive I Disorder. a. An Emergency Sa Form, dated 4/25/21, (Handle With Care)-F WallTime Initiated 1 Ended 1603 (4:03 p.m (Upon Removal from (5:30 p.m.)" b. The Face-To-Face Emergency Safety Int "The Face-to-Face As completed within one Emergency Safety Int date or time documer Face-to-Face Assess c. On 5/5/21, at 2:08 Clinical Officer) was a Safety Intervention) d assessment was dom restraint had ended w should that have been an hour." The CCO	 B/21 form the Assistant mented, "Psychiatric tE. Post Intervention on one hour of the initiation of printervention, a physician, independent practitioner an and competent to ent, must conduct a ent of the physical and ing of the resident" bitted on 3/4/20 and had Mood Dysregulation fety Intervention Reporting documented, "HWC Primary Restraint Technique; 600 (4:00 p.m.); Time n.)5. Nursing Assessment Procedure): Time:1730 Assessment For terventions documented, seessment form must be hour of initiation of tervention" There was no nted to indicate when the ment was completed. p.m., the CCO (Chief asked, the ESI (Emergency 	Ν	145	5		

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CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
OVIDER OR SUPPLIER			3		
OVIDER OR SUPPLIER	04L101	B. WING			
OVIDER OR OOT LIER	042101		STREET ADDRESS, CITY, STATE, ZIP CO		11/2021
			6501 W 12TH STREET		
FOR YOUTH AND FAMI	LIES INC		LITTLE ROCK, AR 72225		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
Continued From page	e 18	N 14	15		
	OF RESTRAINT OR	N 14	18		
)				
Each order for restra	int or soclusion must				
-					
ordered, including the	e length of time for which the				
-	-				
This ELEMENT is no	t met as evidenced by:				
Based on interview a	and record review, the facility				
-					
	terventions (ESI) orders.				
	5				
b. A Physicians Order	rs for ESI dated 8/24/20				
documented, "Perso	onal Restraint: Handle with				
	(EACH DEFICIENC REGULATORY OR I REGULATORY OR I Continued From page can't tell. It's not relia ORDERS FOR USE of SECLUSION CFR(s): 483.358(g)(3 [Each order for restration include] the emergent ordered, including the physician or other lice by the state and the f seclusion authorized This ELEMENT is not Based on interview a failed to ensure the sp restraint order was or (Clients #1, #2, #3, at #3, #4 and #6) sampl Emergency Safety Int The findings are: 1. Client #1 had a dia Dysregulation Disorded a. A Physicians Orded documented, "Perst Care Solo Takedown minutes in text box) restraint order was not b. A Physicians Orded documented, "Perst Care Personal Restration (include maximum tin The time limit for the documented on the o	 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 	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 18 N 14 can't tell. It's not reliable information." ORDERS FOR USE OF RESTRAINT OR SECLUSION N 14 CFR(s): 483.358(g)(3) IEach 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. N 14 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	IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG CROSS-REPERENCED TO TD CROSS-REPERENCED TO TD DEFICIENC Continued From page 18 can't tell. It's not reliable information." N 145 N 145 Continued From page 18 can't tell. It's not reliable information." N 145 N 145 ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(g)(3) N 148 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. N 148 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: I. 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	LECKI DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG CECKIC CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICENCY) Continued From page 18 can't tell. It's not reliable information." N 145 N 145 CARDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(g)(3) N 148 [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. N 148 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 #5) sampled clients who had Emergency Safety Interventions (ESI) orders. The findings are: 1. Client #1 had a diagnosis of Disruptive Mood Dysregulation Disorder. A Physicians Orders for ESI dated 8/19/20 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. A Physicians Orders for ESI dated 8/24/20 documented, "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.

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMF	
		04L101	B. WING			05	/11/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
N 148	documented, "Perso Care Personal Restra (include maximum tim The time limit for the in documented on the or 2. Client #2 had a dia Dysregulation Disorder Safety Interventions) "Personal Restraint Person Takedown (inter- minutes in text box) restraint order was not b. A Physicians Order Safety Interventions) "Personal Restraint Restraint Technique (time in minutes in text the restraint order was order. c. A Physicians Order Safety Interventions) documented, "Perso Care Personal Restra (include maximum tim The time limit for the or d. A Physicians Order Safety Interventions) documented, "Perso Care Personal Restra (include maximum tim The time limit for the or documented, "Perso Care Personal Restra (include maximum tim	onal Restraint: Handle with int Technique (standing) ne in minutes in test box)" restraint order was not rder. gnosis of Disruptive Mood er. 's for ESI (Emergency dated 10/7/20 documented, : Handle with Care Two clude maximum time in " The time limit for the of documented on the order. 's for ESI (Emergency dated 10/9/20 documented, : Handle with Care Personal standing) (include maximum t box)" The time limit for s not documented on the 's for ESI (Emergency dated 10/10/20 onal Restraint: Handle with int Technique (standing) ne in minutes in text box)" restraint order was not rder. 's for ESI (Emergency dated 10/13/20 onal Restraint: Handle with int Technique (standing) ne in minutes in text box)" restraint order was not rder.	N	148			

Facility ID: 3000

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		04L101	B. WING				C 11/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
CENTERS	FOR YOUTH AND FAMI	LIES INC			5501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
N 148	Continued From page	≥ 20	N	148			
	Safety Interventions) documented, "Perso Care Solo Takedown minutes in text box) restraint order was not f. A Physicians Order Interventions) dated 1 "Personal Restraint Person Takedown (im- minutes in text box) restraint order was not g. A Physicians Order Safety Interventions) documented, "Perso Care Personal Restra (include maximum tim The time limit for the documented on the o 3. On 5/5/21 at 1:55 p Officer stated, "The d length of a hold." Wh the physician order, h 4. The facility Emerge policy received on 5/3 Clinical Director docu Residential Treatmen i. The nurse writes to Physician's Order sec indicates:c. the spe intervention(s) ordere length of time authorit	onal Restraint: Handle with (include maximum time in " The time limit for the of documented on the order. s for ESI (Emergency Safety 10/15/20 documented, : Handle with Care Two clude maximum time in " The time limit for the of documented on the order. rs for ESI (Emergency dated 10/23/20 onal Restraint: Handle with aint Technique (standing) ne in minutes in text box)" restraint order was not rder. o.m., the Chief Clinical octor gives permission for then asked if that time was on the stated, "It should be." ency Safety Interventions 8/21 form the Assistant mented, "Psychiatric tPhysician's Orderse. the verbal/telephone order in ction of the client record and cific emergency ed including the maximum zed for use" nitted on 3/4/20 and had					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY LETED	
		04L101	B. WING			05/11/2021		
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		-	
CENTERS	FOR YOUTH AND FAMI	LIES INC			5501 W 12TH STREET LITTLE ROCK, AR 72225			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
N 148	Form, dated 4/25/21, (Handle With Care)-P WallTime Initiated 1 Ended 1603 (4:03 p.m b. A Physician's Orde Safety Intervention), o documented, "Perso Care Personal Restra (Include maximum tim 1600 (4:00 p.m.)-(to) minutes)" The Phy length of time the clie did not document the authorized the use of c. On 5/5/21, at 2:46 Officer was asked, is on 4/25 documented of He stated, "I don't see restraint." 6. Client #3 had a dia Disorder, Reactive At Unspecified Schizoph Disorders. a. A physicians Order documented, "Perso Care Four Person Tal	fety Intervention Reporting documented, "HWC rimary Restraint Technique; 600 (4:00 p.m.); Time n.)" ers for ESI (Emergency dated 4/25/21 at 6:05 PM, onal Restraint: Handle With int Technique (standing) ne in minutes in text box) 1603 (4:03 p.m.) (2-3 rsician's Order stated the nt was in the restraint, but length of time the physician	N	148				
	the restraint order wa order.	s not documented on the						

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 05/20/2021 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		04L101	B. WING			_	(05/	C 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			501 W 12TH STREET ITTLE ROCK, AR 7222	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 148	documented, "Perso Care Four Person Tak time in minutes in test the restraint order was order. c. A physicians Order documented, "Perso Care Two Person Tak time in minutes in test the restraint order was order. d. A physicians Order documented, "Perso Care Personal Restra (include maximum tim Handle With Care Two maximum time in minu- limit for the restraint of on the order. e. A physicians Order documented, "Perso Care Personal Restra (include maximum tim Handle With Care Two maximum time in minu- limit for the restraint of on the order. e. A physicians Order documented, "Perso Care Personal Restra (include maximum tim Handle With Care Two maximum time in minu- limit for the restraint of on the order. f. A physicians Orders documented, "Perso Care Two Person Tak time in minutes in test	s for ESI dated 3/23/21 boal Restraint: Handle With kedown (include maximum box) " The time limit for s not documented on the s for ESI dated 3/11/21 boal Restraint: Handle With edown (include maximum box) " The time limit for s not documented on the s for ESI dated 3/4/21 boal Restraint: Handle With int Technique (standing) he in minutes in test box) b Person Takedown (include utes in test box)" The time rder was not documented s for ESI dated 2/5/21 boal Restraint: Handle With int Technique (standing) he in minutes in test box) b Person Takedown (include utes in test box)" The time rder was not documented	Ν	148				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		04L101	B. WING	_			_ 11/2021
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
CENTERS	FOR YOUTH AND FAMI	LIES INC			501 W 12TH STREET ITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 148	documented, "Perso Care Two Person Tak time in minutes in test the restraint order wa order. h. A physicians Order documented, "Perso Care Solo takedown (minutes in test box) restraint order was no ORDERS FOR USE (SECLUSION CFR(s): 483.358(h)(3) [Documentation must results of the 1-hour a paragraph (f) of this s This ELEMENT is no Based on record revit failed to ensure that the 1-hour assessment w #3) of 4 sampled clier 6) who were physicall are: Client #3 had a diagn Disorder, Reactive At Unspecified Schizoph Disorders. The EMERGENCY SA REPORTING FORM 1/3/21FACE_TO_F/	 s for ESI dated 11/25/20 onal Restraint: Handle With redown (include maximum t box)" The time limit for s not documented on the s for ESI dated 10/24/20 onal Restraint: Handle With (include maximum time in " The time limit for the ot documented on the order. OF RESTRAINT OR) include] the time and assessment required in ection. t met as evidenced by: ew and interview, the facility he date and time of the as documented for 1 (Client nts (Clients #1, #2, #3, 4 and by restrained. The findings oses of Disruptive Mood tachment Disorder, and arenia and other Psychotic AFETY INTERVENTION dated ACE ASSESSMENT FOR 	N 1				
	EMERGENCY SAFE	ΙY					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/20/2021 MAPPROVED D: 0938-0391
STATEMENT (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		04L101	B. WING				C 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			501 W 12TH STREET		
				L	ITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
N 152	Continued From page	24	N	152			
N 155		te:Time: , were not egistered Nurse).		155			
14 100	SECLUSION CFR(s): 483.358(i)			100			
	The facility must mair emergency safety situ used, and their outco	uation, the interventions					
	Based on interview a failed to maintain doc Emergency Safety Int 1 (Client #2) of 5 (Clie	at met as evidenced by: and record review, the facility umented records for terventions (ESI) reports for ents #1, #2, #3, #4 and #6) and ESI implemented. The					
	Client #2 had a diagn Dysregulation Disorde	osis of Disruptive Mood er.					
	Safety Interventions) documented, "Pers Care Personal Restra	rs for ESI (Emergency dated 10/10/20 onal Restraint: Handle with nint Technique (standing) ne in minutes in text box) 8					
	Safety Interventions) documented, "Pers Care Solo Takedown	rs for ESI (Emergency dated 10/14/20 onal Restraint: Handle with (include maximum time in 121-1130 [11:21 a.m11:30					
	Director was asked to	p.m., the Assistant Clinical provide the two missing Assistant Clinical Director					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SUI COMPLET	
		04L101	B. WING				_ 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CENTERS	FOR YOUTH AND FAMI	LIES INC			5501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 155	other two reports." d. On 5/5/21 at 1:55 p Officer was asked if h ESI reports and he st ESIs were supposed	e 25 king but have not found the o.m., the Chief Clinical he was aware of the missing ated, "Yes." When asked if to be on the clinical record, cer stated, "Supposed to be,	N	155			
N 156	yes." ORDERS FOR USE (SECLUSION CFR(s): 483.358(j) The physician or othe permitted by the state restraint or seclusion		N	156			
	Based on record revi failed to ensure the pl a physical restraint as restraint orders were and update the treatm (Clients #1, #2 and #3 #6) sampled residents ordered. The findings	s are:					
	Dysregulation Disorder a. A Physicians Order Safety Intervention) d documented, "Person signed by the License	rs for ESI (Emergency ated 9/28/2020 al Restraint" and was					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	
		04L101	B. WING				_ 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			501 W 12TH STREET ITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 156	signature on the orde 2. Client #2 had a dia Dysregulation Disorda a. A Physicians Ordel Safety Intervention) d documented, "Persor signed by the License 10/7/2020 at 1:46 p.m signature on the orde b. A Physicians Ordel Safety Intervention) d documented, "Persor signed by the License 10/9/2020 at 5:48 p.m signature on the orde c. A Physicians Ordel Safety Intervention) d documented, "Persor signed by the License 10/10/2020 at 7:45 p. physician's signature d. A Physicians Ordel Safety Intervention) d	r. gnosis of Disruptive Mood er. rs for ESI (Emergency lated 10/7/2020 nal Restraint" and was ed Practical Nurse on n There was no physician's r. rs for ESI (Emergency lated 10/9/2020 nal Restraint" and was ed Practical Nurse on n There was no physician's r. rs for ESI (Emergency lated 10/10/2020 nal Restraint" and was ed Practical Nurse on m There was no on the order. rs for ESI (Emergency lated 10/14/2020 nal Restraint" and was	N	156	DEFICIENCY)		
	10/14/2020 at 11:58 a physician's signature e. A Physicians Order Safety Intervention) d	a.m There was no on the order. rs for ESI (Emergency lated 10/23/2020 nal Restraint" and was ed Practical Nurse on a.m There was no					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE	ECONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
AND FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDII	NG _			C
		04L101	B. WING _			05/	11/2021
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			501 W 12TH STREET .ITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
N 156	Continued From page	27	N ²	156			
	#1 was shown one of physician had signed	o.m., Registered Nurse (RN) the orders and asked if the it, and RN #1 stated, "No." supposed to be signed?"					
		-					
	policy received on 5/3 Clinical Director docu Residential Treatmen The physician's verba	ency Safety Interventions 6/21 form the Assistant mented, "Psychiatric tPhysician's Ordersf. Il order must be followed ignature verifying the verbal					
	Disorder, Reactive At	gnoses of Disruptive Mood tachment Disorder, and renia and other Psychotic					
N 165		al Restraintan was signed 21 at 7:58 p.m. There was ıre on the order.	N ·	165			
	safety interventions m continually assessing and psychological we	n the use of emergency nust be physically present, , and monitoring the physical II-being of the resident and int throughout the duration					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETED C 05/11/2021 3, CITY, STATE, ZIP CODE REET AR 72225 ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE	
		04L101	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	COMPLETION
N 165	Continued From page of the emergency safe		N	165	5		
	Based on observatio interview the facility fa physically present to of a restraint and con during the use of a ph #4) of 5 (Client #1, 2,	not met as evidenced by: n, record review and ailed to ensure a nurse was continually assess the safety tinuously monitor a client hysical restraint for 1 (Client 3, 4, 6) sampled clients who hined. The findings are:					
	Client #4 was admitte diagnosis Disruptive I Disorder.						
	Form, dated 5/2/21, d Restraint Technique V	fety Intervention Reporting locumented, "Primary VallTime Initiated 1037 ded 1040 (10:40 a.m.)"					
	was viewed. The vide seen going into the m bathroom. The male the nurse's station an The nurse goes to the then goes out of the r medication room, out restraint, then one mi the nurse's station to nurse then comes our monitor on the desk, comes back out, sits	on 5/2/21 at 10:37 a.m., to had no audio. The client is urse's station then into the staff is viewed coming into d then into the bathroom. e door of the bathroom and nurse's station into the of the line of vision of the nute later comes back into the bathroom door. The t of the bathroom, looks at a goes back to the bathroom, in a chair at the desk, takes it of the line of vision of the					
	bathroom. The male	staff exits bathroom then view, comes back into view					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S COMPLE		
		04L101	B. WING			OMB NO. 0938- (X3) DATE SURVEY COMPLETED C 05/11/2021	-	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
CENTERS	FOR YOUTH AND FAMI	LIES INC			5501 W 12TH STREET LITTLE ROCK, AR 72225			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
N 165	 with a cup in his hand bathroom. The nurse out of the bathroom, a client's arm. The client leave the nurse's stat room. The restraint, bathroom, was not vie The nurse failed to be of the physical restrain the client and to asse restraint. d. On 5/4/21, at 3:52 Director was asked, s monitoring the restrain be. She goes back an but we would expect of observation. MONITORING DURIN RESTRAINT CFR(s): 483.362(c) A physician, or other the resident's well-beint emergency safety inter the resident's well-beint restraint is removed. This ELEMENT is no Based on record revint failed to ensure a phy practitioner permitted and trained in the use interventions evaluated 	and goes into the c, client and male staff come and the nurse examines it, nurse and staff member ion and go to the treatment which was applied in the exable from either camera. c consistently within the view it, to monitor and assess ss for the safety of the p.m., the Assistant Clinical houldn't the nurse be nt? She stated, "She should ind forth numerous times, continuous monitoring and NG AND AFTER licensed practitioner and the facility to evaluate ing and trained in the use of erventions, must evaluate ing immediately after the t met as evidenced by: ew and interview, the facility sician, or other licensed by the state and the facility e of emergency safety ed the resident's well-being restraint was removed for 5		165				

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		ID HUMAN SERVICES				FORM	M APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE COMF	PLETED
		04L101	B. WING				C / 11/2021
NAME OF PF	ROVIDER OR SUPPLIER		I		STREET ADDRESS, CITY, STATE, ZIP CODE		-
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
N 167	are: 1. Client #1 had a dia Dysregulation Disorde a. An Emergency Saf Form dated 8/19/20 d initiated 8:15 Time en Assessment (Upon R Time 9:00" b. An Emergency Saf Form dated 9/28/20 d initiated 1434 [2:34 p. p.m.]Nursing Assess Procedure): Time 153 2. Client #2 had a dia Dysregulation Disorde a. An Emergency Saf Form dated 10/9/20 d initiated 1733 [5:33 p. p.m.]Nursing Assess Procedure): Time 175 b. An Emergency Saf Form dated 10/13/20 initiated 12:12 Time en Assessment (Upon R Time 12:25" 3. Client #6 had a dia Dysregulation Disorde	en restrained. The findings gnosis of Disruptive Mood er. ety Intervention Reporting locumented, "Time ded 8:17Nursing emoval from Procedure): ety Intervention Reporting locumented, "Time m.] Time ended 1437 [2:37 sment (Upon Removal from 30 [3:30 p.m.]" gnosis of Disruptive Mood er. ety Intervention Reporting locumented, "Time m.] Time ended 1741 [5:41 ssment (Upon Removal from 55 [5:55 p.m.]" ety Intervention Reporting documented, "Time m.] Time ended 1741 [5:41 ssment (Upon Removal from 55 [5:55 p.m.]"	N	16			
	Form dated 4/23/21 d	ety Intervention Reporting locumented, "CPI High 2 d 2101 [9:01 p.m.] Time					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
		04L101	B. WING				
NAME OF P	ROVIDER OR SUPPLIER		- 1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
					6501 W 12TH STREET		
CENTERS	FOR YOUTH AND FAMI				LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 167	 p.m.] Time ended 210 [Handle with Care] 2 p initiated 2112 [9:12 p. p.m.] Time initiated 2 2115 [9:15 p.m.]Nur Removal from Procect p.m.]" b. An Emergency Saff Form dated 4/25/21 d initiated 1809 [6:09 p. p.m.]Nursing Assess Procedure): Time 190 c. An Emergency Saff Form dated 4/26/21 d person wall Time initia 10:08 HWC- Take 1 initiated 10:12 Time ended 4/20/21 d initiated 10:12 Time ended 10:12 Time ended 4/30/21 d initiated 10:30 a.m. Time 10:55" d. An Emergency Saff Form dated 4/30/21 d initiated 10:30 a.m. Time 11:0 e. An Emergency Saff Form dated 5/3/21 do 1207 Time ended 120 (Upon Removal from f. An Emergency Saff Form dated 5/3/21 do 1312 [1:12 p.m.] Time 	 n.] Time initiated 2105 [9:05 07 [9:07 p.m.] HWC person Wall EscortTime m.] Time ended 2115 [9:15 1115 [9:15 p.m.] Time ended rsing Assessment (Upon dure): Time 2140 [9:40 Time ended 1818 [6:18 sement (Upon Removal from 00 [7:00 p.m.]" ety Intervention Reporting locumented, "HWC 1 ated 10:06 Time ended Down 1 personTime ended 10:15 Nursing emoval from Procedure): ety Intervention Reporting locumented, "Time inded 10:34 a.m. at (Upon Removal from 09" ety Intervention Reporting locumented, "Time ime ended 10:34 a.m. at (Upon Removal from 09" ety Intervention Reporting coumented, "Time initiated 07Nursing Assessment Procedure): Time 1256" ety Intervention Reporting coumented, "Time initiated a ended 1314 [1:14 p.m.] at (Upon Removal from 	N	167	7		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/20/202 MAPPROVEI D. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		SURVEY PLETED
		04L101	B. WING				U 11/2021
	ROVIDER OR SUPPLIER FOR YOUTH AND FAMI	LIES INC		65	REET ADDRESS, CITY, STATE, ZIP CODE 01 W 12TH STREET TTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
N 167	Continued From page	e 32	N	167			
	Form dated 5/3/21 dc position mediumTin Time ended 1342 [1:4 medication -[Intramus [1:56 p.m.] Time ended Nursing Assessmer Procedure): Time 142 h. An Emergency Saf Form dated 5/4/21 dc mediumTime initiat 10:43 a.mCPI Tear initiated 10:39 a.m. T Nursing Assessmer Procedure): Time 11: i. An Emergency Safe Form dated 5/4/21 dc mediumTime initiat CPI Tear Control F Time ended 1136 Tir ended 1139 Time initiat Time initiated 1144 Ti Assessment (Upon R Time 1200" 4. The facility Emerge policy received on 5/3 Clinical Director docu Residential Treatment Proceduresc2.4 trained in the use of e interventions must ev immediately after the	nt (Upon Removal from 25 [2:25 p.m.]" fety Intervention Reporting boumented, "CPI seated ed 10:38 a.m. Time ended ated 10:41 a.m. Time ended m Control PositionTime ime ended 10:41 a.m. nt (Upon Removal from 22" ety Intervention Reporting boumented, "CPI seated ed 1139 Time ended 1139 PositionTime initiated 1135 ne initiated 1138 Time tiated 1139 Time ended 1141 ime ended 1144Nursing temoval from Procedure): ency Safety Interventions 3/21 form the Assistant imented, "Psychiatric itE. Post Intervention A physician or a nurse emergency safety raluate the client's well being restraint is discontinued" nitted on 3/4/20 and had					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		04L101	B. WING				0 /11/2021
NAME OF P	ROVIDER OR SUPPLIER		•	:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
N 167	Form, dated 4/25/21, (Handle With Care)-F WallTime Initiated 1 Ended 1603 (4:03 p.m (Upon Removal from (5:30 p.m.)" b. The Face-To-Face Emergency Safety Int "The Face-to-Face As completed within one Emergency Safety Int date or time documer Face-to-Face Assess c. On 5/5/21, at 2:08 Clinical Officer) was a Safety Intervention) d assessment was dom restraint had ended w should that have been an hour." The CCO face to face assessm can't tell. It's not relia 5. Client #3 had a dia Disorder, Reactive At	fety Intervention Reporting documented, "HWC Primary Restraint Technique; 600 (4:00 p.m.); Time n.)5. Nursing Assessment Procedure): Time:1730 Assessment For terventions documented, ssessment form must be hour of initiation of tervention" There was no need to indicate when the ment was completed. p.m., the CCO (Chief asked, the ESI (Emergency lated 4/25 shows an e at 1730 (5:30 p.m.), time vas 1603 (4:03 p.m.). When n done? He stated, "Within was asked, is that when the ent was done? He stated, "I	N	167	,		
	3/31/2 documented, " p.m.] Time ended 172	fety Reporting Form Dated Time initiated 1710 [5:10 20 [5:20 p.m.]Nursing emoval from Procedure): n.]					

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		ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MU		CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					LETED
							C
		04L101	B. WING			05/	11/2021
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			501 W 12TH STREET ITTLE ROCK, AR 72225		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
					DEFICIENCY)		
N 167	Continued From page	- 34		167			
	Continued i rom page	5.04	IN IN	107			
	b. An Emergency Saf	fety Reporting Form Dated					
		"Time initiated 1622 [4:32					
		32 [4:32 p.m.]Nursing emoval from Procedure):					
	"Time: 1646 [4:46 p.n						
		-					

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	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
		04L101	B. WING				C / 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI			650	01 W 12TH STREET		
CENTERS				LIT	ITLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
N 000	Initial Comments		N 0	00			
	This CMS 2567 surv report sent on May 20	ey report supercedes the 0, 2021.					
	is an official, legal do remain unchanged ex correction, correction space. Any discrepar citation(s) will be repo Office (RO) for referra Inspector General (O information is inadver	IG) for possible fraud. If rtently changed by the State Survey Agency (SA)					
	or in part, with no def Complaint #AR00026 or in part, with no def Complaint #AR00026 or in part,, with deficie N156, and N167. Complaint #AR00026 or in part, with deficie N136, N144, N145, N Complaint AR000265 in part, with deficienc N136, N144, N145, N	504 was substantiated, all					
N 128	-		N 1	28			6/11/21
LABORATORY	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE	 E		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.

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		04L101	B. WING				C / 11/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
					6501 W 12TH STREET		
CENTERS	FOR YOUTH AND FAMI			1	LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
N 128	Continued From page CFR(s): 483.356(a)(3 Restraint or seclusion injury to the resident a This ELEMENT is no Based on observatio interview the facility fa not sustain an injury a of 1 (Client #4) sampl injury during the use of findings are: Client #4 was admitted diagnosis Disruptive for Disorder. a. An Emergency Sa Form, dated 5/2/21, d Restraint Technique V (10:37 a.m.) Time En- b. A Medical Progress p.m., signed by RN (F documented, "Most o unstable and disrespe cursing at staff, threat peers while on the un breakfast because sh	e 1) n must not result in harm or and must be used only- of met as evidenced by: n, record review and ailed to ensure a client did as a result of a restraint for 1 led client who sustained an of a physical restraint. The ed on 3/4/20 and had Mood Dysregulation fety Intervention Reporting locumented, "Primary Wall Time Initiated 1037 ded 1040 (10:40 a.m.)" as Note, dated 5/2/21 at 6:00 Registered Nurse) #1 f the shift client was irate, ectful to staff. Client was tening staff, hitting staff and it. Client refused to eat ue was upset. Client was		128	DEFICIENCY)		
	several staff members the client to see is sho This nurse tried to ge follow directions in or unit with a particular s client that if she kept behaviors this nurse v Client was trying to ta	w seal and this nurse and s tried their best to talk with e could turn her day around. t the client to calm down and der to get to go on another staff member. Informed up self harm and aggressive would have to call [Doctor]. the her clothes off while in d bringing the client into the					

Facility ID: 3000

If continuation sheet Page 2 of 35

	S FOR MEDICARE &					O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′			E SURVEY IPLETED	
			A. BUILDING	G		0	
		041 404	B. WING			С	
		04L101	B. WING			5/11/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	ATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	ILIES INC		6501 W 12TH STREET			
				LITTLE ROCK, AR 72225			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5) COMPLETION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	DATE	
				DEFICIENCE)		
N 128	Continued From page	e 2	N 12	28			
		hours later and speak with					
		ent ran around the day area					
		ame to the nurse's station.					
		with the client about her					
		nd locked herself in the					
		pom after trying to elope from					
	the nurse's station. 1						
	assistance from a QE	3HP (Qualified Behavior					
	Health Professional)						
		self in the nurse's station					
	bathroom. The QBH	P came and assisted after					
	the client tried to pus	h him out with the door. Per					
	QBHP report the clie	nt attempted to punch him					
	which resulted in him	performing a HWC (Handle					
	With Care) wall restra	aint. The restraint lasted					
	from 1037 a.m1040	a.m. The restraint was					
	done to the best of st	aff ability based on training					
		ve restraint used at the time					
		t was hollering about her					
		e staff pulled the client back					
		not touching the wall and					
		eam about her face at which					
		ned her that her face was no					
	0 0	vall. After release client					
		rm pain and stated she					
		n. Client rated her pain level					
		and this nurse did a ROM					
		sessment. Neurological					
		id appear swollen and red. ent was done this nurse					
		se and what felt like grinding					
		w. [Doctor] was called and					
		to be sent out to [Hospital]					
		. Client guardian was called					
		assured that she would be					
		this nurse received new					
		the status of the client.					
		p.m.) received report from					
	,					1	

Facility ID: 3000

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			0.00			IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION	· · · ·	E SURVEY
	001112011011		A. BUILDING			
		0.01.404				С
		04L101	B. WING			5/11/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
CENTERS	FOR YOUTH AND FAM			6501 W 12TH STREET		
OLNILKO				LITTLE ROCK, AR 72225		
(X4) ID	-	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETION
N 128	Continued From page	e 3	N 12	8		
	she would need surg			-		
		ory				
	c. On 5/3/21 at 1:11	p.m. the Assistant Clinical				
	Director stated, "Ever	rybody is no longer to do the				
	Handle With Care ho	ld anymore, they are to do				
	CPI (Crisis Preventio	n Intervention) only." The				
	Assistant Clinical Dire	ector was asked, how are				
	staff notified that the	Handle with Care is not to				
		ed, "They emailed that to all				
	employees, the emai					
	employees this morn					
	-	stant Clinical Director was				
		monitored to ensure they are				
	-	With Care holds? She				
		nd the program manager,				
		lirectly and we are also doing				
		restraint. They are here and				
		ey are doing the hold and				
		loing CPI." The Assistant				
		asked, when were the				
		? She stated, "Yes. The				
		program, ages six to twelve,				
		nonths ago, because of the				
		e the CPI." The Assistant				
		asked, [Client #4] is ten				
	•	ed, "Yes." The Assistant asked, was she in the				
		ed, "Yes." The Assistant				
		asked, when she was				
		blaced in the Handle With				
		stated, "She was in the				
	· ·	no video, but documentation				
		e Handle With Care position."				
		I Manager was asked, so he				
		old he was not to use? She				
		e Assistant Clinical Manager				
		he now? She stated, "He				
		ediately after the hold? The				

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				10.0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
	OUNTEONON	BENTI IGATION NOWBER.	A. BUILDING			
			5.4/10.0			С
		04L101	B. WING		05/11/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIF		DE	
CENTERS	FOR YOUTH AND FAMI			6501 W 12TH STREET		
				LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
N 128	Continued From page	a 1	N 12	0		
11 120			N 12	0		
		ed, "Yes." At 2:57 p.m. the nager stated, "[Chief Clinical				
		hager stated, [Chief Clinical				
		e and refresher training in the				
	CPI was being condu					
	investigation.					
	d. On 5/5/21, at 9:04	a.m. the video with audio				
	was viewed. The vid	eo with audio only showed				
		o the nurse's station and				
		timing on the video did not				
		e of the incident. The client				
		hrough the door into the hall,				
		back out. The nurse goes				
		e camera, then comes back				
		client, shutting the door ent was seen attempting to				
		id open the door. The nurse				
		ne client was seen pulling on				
		ne the nurse stated, "Back				
		ou are going to the ground."				
		with a syringe in her hand.				
		into the nurse's station, out				
		a, and the nurse is seen on				
		taff member enters the hall				
		e nurse's station, out of view				
		can hear the client yelling				
	-	my face, my face, my arm,				
	-	the nurse enters into the				
		f view of the camera. A				
		, "you need to calm down."				
		aming and you can hear the " The male staff member				
		nurse's station and the client				
		n't move my arm." There				
		and the client was heard				
		hurt it." There was a female				
		If it hurts and you can't move				
	it I have to touch it."					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			l	FORM APPROVED B NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3)) DATE SURVEY COMPLETED C
		04L101	B. WING			05/11/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CENTERS	FOR YOUTH AND FAMI	LIES INC		6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETION DATE
N 128	exited the room, went with a cup in his hand station, out of camera and hard breathing he come out of nurse's s the client was seen he e. On 5/5/21 at 9:33 a was viewed. The clien nurse's station then in staff was viewed com and then into the bath the door of the bathron nurse's station into th the line of vision of th later comes back into bathroom, looks at a back to the bathroom a chair at the desk, ta up and goes back wit goes into the bathroo male staff come out of examines clients arm member leave the nu treatment room. The from either camera. f. On 5/5/21 at 10:04 Coordinator was aske Care hold, and it is do be any injuries?" She Coordinator was show and the client standin together. The Trainin	tout the door, came back in d, and went into the nurse's a view. There was crying eard. The nurse and client tation into the hallway and olding her arm. a.m. the video with no audio int was seen going into the not the bathroom. The male ing into the nurse's station froom. The nurse goes to oom and then goes out of the e medication room, out of e restraint, then one minute the nurse's station to the nurse then comes out of the monitor on the desk, goes , comes back out and sits in tkes a drink from a cup, gets o the bathroom. The male hen walks out of camera h a cup in his hand and m. The nurse, client and of the bathroom, the nurse . The client, nurse and staff rse's station and go to the e restraint was not viewable a.m. the Training ed, "If you do a Handle With one correctly, should there e stated, "No." The Training wn a picture of the male staff g in the nurse's station ig Coordinator was asked, just saw with the staff and	N 1			

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMP	
		04L101	B. WING				/11/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
CENTERS	FOR YOUTH AND FAMI	LIES INC			5501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 128	appropriate hold?" Si placed them in a child g. The facility Emergy policy, received from Director on 5/3/21 at "General Principles intervention must be p is safe, proportionate severity of the behavi chronological and dev gender; physical, med condition; and person history or physical or de-escalation interver before a more restrict initiated" PROTECTION OF RE CFR(s): 483.356(b) Emergency safety intervention mut manner that is safe, p appropriate to the sev the resident's chronol age; size; gender; phy psychiatric condition; (including any history abuse). This ELEMENT is no Based on observatio interview the facility far restraint was perform appropriate for the cli #4) of 5 (Client #1, 2,	he stated, "I would have a control hold." ency Safety Interventions the Assistant Clinical 1:03 p.m., documented, G. An emergency safety berformed in a manner that and appropriate to the or, and the client's velopmental age; size; dical and psychiatric al history (including any sexual abuse.)I. Verbal ntions will be exhausted ive intervention is ESIDENTS ervention. An emergency ust be performed in a proportionate, and verity of the behavior, and ogical and developmental ysical, medical, and and personal history of physical or sexual		128			6/11/21

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/20/2021 APPROVED). 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		04L101	B. WING		_		C 11/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		-	
				5501 W 12TH STREET				
CENTERS	FOR YOUTH AND FAMI			LITTLE ROCK, AR 7222	5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
N 132	Continued From page	- 7	N 132					
	Client #4 was admitte diagnosis Disruptive M Disorder.							
	Form, dated 5/2/21, d Restraint Technique V	fety Intervention Reporting ocumented, "Primary VallTime Initiated 1037 ded 1040 (10:40 a.m.)"						
	p.m., signed by RN (F documented, "Most of unstable and disrespe cursing at staff, threat	f the shift client was irate, actful to staff. Client was ening staff, hitting staff and						
	breakfast because sh climbing in the window several staff members the client to see is she	it. Client refused to eat e was upset. Client was v seal and this nurse and s tried their best to talk with e could turn her day around.						
	follow directions in ord unit with a particular s client that if she kept	the client to calm down and der to get to go on another taff member. Informed up self harm and aggressive vould have to call [Doctor].						
	Client was trying to ta the unit as well. Tried nurses station a few h	ke her clothes off while in I bringing the client into the ours later and speak with nt ran around the day area						
	and she eventually ca While trying to speak behavior client ran an	me to the nurse's station. with the client about her d locked herself in the						
	the nurse's station. T assistance from a QB Health Professional) a	HP (Qualified Behavior after client went and						
	bathroom. The QBH	self in the nurse's station P came and assisted after n him out with the door. Per						

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		ND HUMAN SERVICES MEDICAID SERVICES					RINTED: 07/20/2 FORM APPROV MB NO: 0938-03	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	()	(X3) DATE SURVEY COMPLETED	
		04L101	B. WING			C 05/11/2021		
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	EET ADDRESS, CITY, STATE, ZIP COD	E		
CENTERS	FOR YOUTH AND FAM	LIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE	
N 132	QBHP report the client which resulted in him With Care) wall restra from 1037 a.m1040 done to the best of st and the least restricti of the incident. Client face at which time the so that her face was she continued to scre- time this nurse inform longer touching the w complained of right a could not feel her arm at 9/10 (9 out of 10) a (Range of Motion ass check). Client arm di After ROM assessme noticed a clicking noi near/at the right elbor ordered for the client for further evaluation several times and rea contacted every time information regarding Around 1251 (12:51) staff that client right h she would need surg c. On 5/3/21 at 1:11 Director stated, "Even Handle With Care ho CPI (Crisis Preventio Assistant Clinical Dire staff notified that the be utilized? She stat employees this morn	nt attempted to punch him performing a HWC (Handle aint. The restraint lasted a.m. The restraint was aff ability based on training ve restraint used at the time t was hollering about her e staff pulled the client back not touching the wall and eam about her face at which hed her that her face was no vall. After release client rm pain and stated she n. Client rated her pain level and this nurse did a ROM sessment. Neurological id appear swollen and red. ent was done this nurse se and what felt like grinding w. [Doctor] was called and to be sent out to [Hospital] . Client guardian was called assured that she would be this nurse received new g the status of the client. b.m.) received report from numerus was broken and ery" p.m. the Assistant Clinical rybody is no longer to do the ld anymore, they are to do n Intervention) only." The ector was asked, how are Handle with Care is not to ed, "They emailed that to all I and memos to all	N	132				

Facility ID: 3000

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 07/20/202 RM APPROVE O. 0938-039	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		04L101	B. WING		05	C 5/11/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
				6501 W 12TH STREET			
CENTERS	FOR YOUTH AND FAMI			LITTLE ROCK, AR 72225			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
N 132	asked, how are staff in not using the Handle stated, "The nurse are they are monitoring d video review of each are present when the make sure they are d Clinical Director was notified, this morning' staff in the children's were told about two m size difference to use Clinical Director was years old? She state Clinical Director was restrained, was she p Care position? She state Clinical Director was restrained, was she p Care position? She state The Assistant Clinical used a hold he was to stated, "Correct." Th was asked, where is was suspended imme Assistant Clinical Man yesterday? She state CPI was being condu- investigation. d. On 5/5/21, at 9:04 was viewed. The vid- the hall which leads to treatment room. The	monitored to ensure they are With Care holds? She ad the program manager, irectly and we are also doing restraint. They are here and y are doing the hold and oing CPI." The Assistant asked, when were the ? She stated, "Yes. The program, ages six to twelve, nonths ago, because of the the CPI." The Assistant asked, [Client #4] is ten d, "Yes." The Assistant asked, was she in the ed, "Yes." The Assistant asked, when she was blaced in the Handle With stated, "She was in the no video, but documentation e Handle With Care position." I Manager was asked, so he old he was not to use? She e Assistant Clinical Manager he now? She stated, "He ediately after the hold? The nager was asked, ed, "Yes." At 2:57 p.m. the nager stated, "[Chief Clinical hey also suspended the and refresher training in the	N 13	2			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/20/2021 APPROVED 0: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		04L101	B. WING		-	(05/	C 11/2021
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
05117500			e	501 W 12TH STREET			
CENTERS	FOR YOUTH AND FAMI	LIES INC	L	ITTLE ROCK, AR 7222	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
TAG N 132	Continued From page was viewed coming the then the client goes be out, out of view of the into the hall with the client get past the nurse and blocks the way and the the nurse at which time up. If you grab me you The nurse was seen with the nurse was seen with the client then goes in of view of the camera her phone. A male st and then goes into the of the camera. You client 'ow' and screaming "r my arm. At this time to nurse's station, out of voice is heard saying, There was more screa- client saying "Yes sir." was seen exiting the to is heard saying, "I car was more screaming saying, "Please don't voice heard saying, "I it I have to touch it." exited the room, went with a cup in his hand station, out of camera and hard breathing here	a 10 rrough the door into the hall, ack out. The nurse goes camera, then comes back lient, shutting the door ent was seen attempting to d open the door. The nurse e client was seen pulling on he the nurse stated, "Back bu are going to the ground." with a syringe in her hand. nto the nurse's station, out , and the nurse is seen on aff member enters the hall e nurse's station, out of view an hear the client yelling my face, my face, my arm, the nurse enters into the view of the camera. A "you need to calm down." aming and you can hear the " The male staff member nurse's station and the client n't move my arm." There and the client was heard hurt it." There was a female f it hurts and you can't move The male staff member cout the door, came back in and went into the nurse's view. There was crying eard. The nurse and client tation into the hallway and	N 132	D			
	e. On 5/5/21 at 9:33 a was viewed. The clie nurse's station then in staff was viewed com	n.m. the video with no audio nt was seen going into the ito the bathroom. The male ing into the nurse's station iroom. The nurse goes to					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		04L101	B. WING				0 /11/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
N 132	the door of the bathron nurse's station into the later comes back into bathroom door. The bathroom, looks at a back to the bathroom a chair at the desk, ta up and goes back into staff exits bathroom the view, comes back wit goes into the bathroo male staff come out of examines clients arm member leave the nut treatment room. The from either camera. f. On 5/5/21 at 10:04 Coordinator was aske Care hold, and it is do be any injuries? She Coordinator was show and the client standin together. The Trainin with the picture you ju client, would the Hand appropriate hold? She placed them in a child g. The facility Emerg policy, received from Director on 5/3/21 at "General Principles intervention must be is safe, proportionate severity of the behavi	oom and then goes out of the e medication room, out of e restraint, then one minute the nurse's station to the monitor on the desk, goes , comes back out and sits in tkes a drink from a cup, gets o the bathroom. The male hen walks out of camera h a cup in his hand and m. The nurse, client and of the bathroom, the nurse . The client, nurse and staff rse's station and go to the e restraint was not viewable a.m. the Training ed, if you do a Handle With one correctly, should there stated, "No." The Training wn a picture of the male staff g in the nurse's station g Coordinator was asked, ust saw with the staff and dle With Care be an the stated, "I would have d control hold." ency Safety Interventions the Assistant Clinical 1:03 p.m., documented, G. An emergency safety performed in a manner that and appropriate to the or, and the client's velopmental age; size;	N	132	2		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/20/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		04L101	B. WING		C 05/11/2021
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	
CENTERS	FOR YOUTH AND FAMI	LIES INC		6501 W 12TH STREET LITTLE ROCK, AR 72225	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
N 132	history or physical or	nal history (including any sexual abuse.)I. Verbal ntions will be exhausted	N 13	2	
N 136	CFR(s): 483.356(c)(4 [At admission, the fac the facility policy to th		N 13	6	6/11/21
	Based on record rev failed to ensure a cop policy was received b	ot met as evidenced by: iew and interview the facility by of the facility's restraint by the guardian at admission (Client #4) sampled clients.			
	Client #4 was admitte diagnosis Disruptive Disorder.				
	Treatment, signed by 3/3/21, documented, Consent For Behavio Emergency Safety In reviewed the [Facility emergency safety int agency policy. I give for [Facility] to utilize clinically indicated in authorize my child's p behavior management	or Management And terventions a. I have] behavior management and erventions as outlined in my consent and permission these procedures as the course of treatmentb. I participation in the Center's			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 04L101 B. WING 05/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 12TH STREET LITTLE ROCK, AR 72225 6501 W 12TH STREET LITTLE ROCK, AR 72225 VX4) ID		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
O4L101 B. WING O5/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC ITTLE ROCK, AR 72225 ITTLE ROCK, AR 72225 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE N 136 Continued From page 13 N 136	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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 136 Continued From page 13 N 136			04L101	B. WING _				-
CENTERS FOR YOUTH AND FAMILIES INC 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 136 Continued From page 13 N 136 N 136	NAME OF PF	ROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE N 136 Continued From page 13 N 136	CENTERS	FOR YOUTH AND FAMI	LIES INC					
	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
 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 Do-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 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 16 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under ages 9 to 17; or 1 hour for residents 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. 		were identified" b. On 5/3/21 at 4:42 Officer was asked, did copy of the facility pol management and em interventions? He sta switched over to Doc- The Chief Clinical Off consent at this time a is all they are getting interventions? He sta ORDERS FOR USE O SECLUSION CFR(s): 483.358(e) Each order for restrain (1) Be limited to no the emergency safety (2) Under no circur residents ages 18 to 2 ages 9 to 17; or 1 9. This ELEMENT is no Based on record revi failed to ensure a Phy was documented for sampled clients. This potential to affect 46 f documented on a list Clinical Director on 5/ findings are: Client #4 was admitted diagnosis Disruptive f	p.m. the Chief Clinical d [Client #4's] guardian get a licy on behavior ergency safety ated, "I think when we -U-Signed we omitted that." icer was shown the signed nd was asked, this consent related to safety ated, "Yes." OF RESTRAINT OR nt or seclusion must: longer than the duration of v situation; and mstances exceed 4 hours for 21; 2 hours for residents hour for residents under age of met as evidenced by: iew and interview the facility visician's Order for a restraint 1 (Client #4) of 1 (Client #4) a failed practice had the facility clients as provided by the Assistant (3/21 at 1:43 p.m. The					6/11/21

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		04L101	B. WING				C / 11/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			01 W 12TH STREET TTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 144	Continued From page	2 14	N 1	144			
N 145	Form, dated 5/2/21, d Restraint Technique W (10:37 a.m.) Time Em There was no Physici of the restraint. b. On 5/3/21, at 2:57 Director was asked, w Order for the restraint didn't see one for that ESI (Emergency Safe twenty fifth." The Ass asked, that was April stated, "Yes." ORDERS FOR USE O SECLUSION CFR(s): 483.358(f) Within 1 hour of the ir safety intervention a p practitioner trained in safety interventions a and the facility to ass psychological wellbeil conduct a face-to-face physical and psycholo resident, including bu (1) The resident's p status; (2) The resident's the	nitiation of the emergency obysician, or other licensed the use of emergency nd permitted by the state ess the physical and ng of residents, must e assessment of the ogical wellbeing of the t not limited to-	N 1	145			6/11/21

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE	
		04L101	B. WING	-			C 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTERS	FOR YOUTH AND FAMI				6501 W 12TH STREET		
CENTERS				1	LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 145	 (4) Any complication (4) Any complication intervention. This ELEMENT is not Based on interview at failed to ensure a face conducted within one restraint for 4 (Clients (Clients #1, #2, #3, #4 who had been restraint 1. Client #1 had a dia Dysregulation Disorder a. An Emergency Saft Form dated 9/28/20 dinitiated 1434 [2:34 p. p.m.]The Face-to-F be completed within the mergency Safety Infi was completed within no, reason why- RN [duty" The Face-to-was signed, dated an 9/29/20 at 12:37 p.m. 2. Client #2 had a dia Dysregulation Disorder a. An Emergency Saft Form dated 10/7/20 dinitiated 1256 [12:56 p.m.]The Face-to-F be completed within the face-to-F be completed within	ons resulting from the at met as evidenced by: and record review, the facility e to face assessment was -hour of the start of the 5 #1, #2, #4 and #6) of 5 4 and #6) sampled clients ned. The findings are: gnosis of Disruptive Mood er. Time ended 1437 [2:37 ace Assessment form must one hour of initiation of tervention- Face-to-Face one hour indicated No. If Registered Nurse] not on Face section of the form d timed as completed on gnosis of Disruptive Mood er. Time ended 1305 [1:05 ace Assessment form must one hour of initiation of tervention- Face-to-Face one hour indicated No. If Registered Nurse] not on Face section of the form d timed as completed on	N	145			
	Face-to-Face section	of the form was signed and time is not clear but starts					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED C
		04L101	B. WING			05	5/11/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
N 145	Dysregulation Disorde a. An Emergency Saf Form dated 4/30/21 d initiated 10:30 a.m. T Face-to-Face Assess completed within one Emergency Safety Int was completed within why- Client Refused of the form had a line documented "Client re b. An Emergency Saf Form dated 5/3/21 do 1312 [1:12 p.m.] Time p.m.]The Face-to-F be completed within The Face-to-Face sed dated and timed as co [2:25 p.m.]. 4. On 5/5/21 at 1:30 p Face-to-Face is one f do assessment. The Nurse] maybe workin one hour." When ask was for Face-to-Face stated, "It's not policy permissible."	hin the 6 p.m. hour. gnosis of Disruptive Mood er. ety Intervention Reporting locumented, " Time ime ended 10:34 a.m The ment form must be hour of initiation of tervention- Face-to-Face one hour If no, reason ." The Face-to-Face section through the section and efused face-to-face." ety Intervention Reporting boumented, " Time initiated the ended 1314 [1:14 ace Assessment form must one hour of initiation of tervention- Face-to-Face one hour indicated Yes" ction of the form was signed, ompleted on 5/3/21 at 1425 b.m., RN #2 stated, "The hour to get it. The RN has to LPN [Licensed Practical g so I have to get it done in ted what the facility policy	N	145			
	Officer was asked, "V						

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	-	D HUMAN SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		04L101	B. WING				C 11/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		-
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 145	 Chief Clinical Officer a hour with an RN." 6. On 5/11/21 at 8: 55 Director was asked he Face-to-Face assessic Clinical Director state should be able to com 7. The facility Emerger policy received on 5/3 Clinical Director docu Residential Treatmen Procedures- A. Within the emergency safety an RN, or a licensed it trained by the physici perform the assessment face-to-face assessment psychological well be 8. Client #4 was adm diagnosis Disruptive form, dated 4/25/21, (Handle With Care)-F WallTime Initiated 1 Ended 1603 (4:03 p.m (Upon Removal from (5:30 p.m.)" b. The Face-To-Face Ascompleted within one Emergency Safety Inference for the face-to-face form (Completed within one Emergency Safety Inference). 	stated, "Face-to-Face in an a.m., the Assistant Clinical by a client could refuse a ment and the Assistant d, "I seen that. No, they pplete." ency Safety Interventions 3/21 form the Assistant mented, "Psychiatric tE. Post Intervention n one hour of the initiation of r intervention, a physician, independent practitioner an and competent to ent, must conduct a ent of the physical and ing of the resident" witted on 3/4/20 and had Mood Dysregulation fety Intervention Reporting documented, "HWC trimary Restraint Technique; 600 (4:00 p.m.); Time n.)5. Nursing Assessment Procedure): Time:1730 e Assessment For rerventions documented, ssessment form must be	N	145			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			F	ORM APPROVED 3 NO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		DATE SURVEY COMPLETED C	
		04L101	B. WING			05/11/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
CENTERS	FOR YOUTH AND FAMI	LIES INC		6501 W 12TH STREET LITTLE ROCK, AR 72225			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 145	Face-to-Face Assess c. On 5/5/21, at 2:08 Clinical Officer) was a Safety Intervention) d assessment was done restraint had ended w should that have beer an hour." The CCO face to face assessme can't tell. It's not relia ORDERS FOR USE (SECLUSION CFR(s): 483.358(g)(3) [Each order for restra include] the emergence ordered, including the physician or other lice by the state and the fa- seclusion authorized in This ELEMENT is no Based on interview a failed to ensure the sp restraint order was or (Clients #1, #2, #3, ar #3, #4 and #6) sample Emergency Safety Int The findings are: 1. Client #1 had a dia Dysregulation Disorder documented, "Perso Care Solo Takedown	ment was completed. p.m., the CCO (Chief asked, the ESI (Emergency ated 4/25 shows an e at 1730 (5:30 p.m.), time vas 1603 (4:03 p.m.). When n done? He stated, "Within was asked, is that when the ent was done? He stated, "I bble information." OF RESTRAINT OR) int or seclusion must cy safety intervention e length of time for which the ensed practitioner permitted acility to order restraint or its use. It met as evidenced by: and record review, the facility pecific time limit for the n the physician's order for 4 and #4) of 5 (Clients #1, #2, ed clients who had terventions (ESI) orders.	N 14			6/11/21	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMF	PLETED
		04L101	B. WING				C 11/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	11/2021
					6501 W 12TH STREET		
CENTERS	FOR YOUTH AND FAMI	LIES INC			LITTLE ROCK, AR 72225		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG			IAG		DEFICIENCY)		
N 148	Continued From page	e 19	N	148	3		
	restraint order was no	ot documented on the order.					
	h A Physicians Orde	rs for ESI dated 8/24/20					
		onal Restraint: Handle with					
	-	aint Techniques (standing)					
		ne in minutes in text box)"					
		restraint order was not					
	documented on the o	rder.					
	c. A Physicians Order	rs for ESI dated 9/28/20					
	-	onal Restraint: Handle with					
	Care Personal Restra	aint Technique (standing)					
		ne in minutes in test box)"					
		restraint order was not					
	documented on the o	rder.					
		gnosis of Disruptive Mood					
	Dysregulation Disord	er.					
	a. A Physicians Orde	rs for ESI (Emergency					
	-	dated 10/7/20 documented,					
	"Personal Restraint	: Handle with Care Two					
		clude maximum time in					
		" The time limit for the ot documented on the order.					
	restraint order was no	of accumented on the order.					
	b. A Physicians Orde	rs for ESI (Emergency					
	-	dated 10/9/20 documented,					
	"Personal Restraint	: Handle with Care Personal					
		(standing) (include maximum					
		t box)" The time limit for					
		is not documented on the					
	order.						
	c. A Physicians Order	rs for ESI (Emergency					
	Safety Interventions)	,					
		onal Restraint: Handle with					
		aint Technique (standing)					
	(include maximum tin	ne in minutes in text box)"					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		04L101	B. WING				C / 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTERS	FOR YOUTH AND FAMI	LIES INC			5501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
N 148	Continued From page	e 20	N	148			
	The time limit for the documented on the o	restraint order was not rder.					
	Safety Interventions)						
	Care Personal Restra	onal Restraint: Handle with aint Technique (standing)					
	· ·	ne in minutes in text box)" restraint order was not					
	documented on the o						
	Safety Interventions)	rs for ESI (Emergency dated 10/14/20 onal Restraint: Handle with					
	Care Solo Takedown	(include maximum time in					
	,	" The time limit for the ot documented on the order.					
		s for ESI (Emergency Safety I0/15/20 documented,					
	"Personal Restraint	: Handle with Care Two					
		clude maximum time in " The time limit for the					
	,	ot documented on the order.					
	Safety Interventions)						
		onal Restraint: Handle with					
		aint Technique (standing) ne in minutes in text box)"					
		restraint order was not					
	documented on the o	rder.					
		p.m., the Chief Clinical					
		octor gives permission for en asked if that time was on					
		he stated, "It should be."					
	4. The facility Emerge	ency Safety Interventions					

Facility ID: 3000

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDI	NG _			C
		04L101	B. WING				_ 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI			e	6501 W 12TH STREET		
OENTERO				L	LITTLE ROCK, AR 72225		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	1				2		
N 148	Continued From page	21	N	148			
		3/21 form the Assistant		140			
		mented, "Psychiatric					
		tPhysician's Orderse.					
		the verbal/telephone order in ction of the client record and					
	indicates:c. the spe						
		ed including the maximum					
	length of time authoriz						
	diagnosis Disruptive I	hitted on 3/4/20 and had Mood Dysregulation					
	Disorder.						
		fatic later cention Depending					
	Form, dated 4/25/21,	fety Intervention Reporting documented. "HWC					
		Primary Restraint Technique;					
		600 (4:00 p.m.); Time					
	Ended 1603 (4:03 p.n	n.)"					
	b. A Physician's Orde	ers for ESI (Emergency					
		dated 4/25/21 at 6:05 PM,					
		onal Restraint: Handle With aint Technique (standing)					
		ne in minutes in text box)					
	1600 (4:00 p.m.)-(to)	1603 (4:03 p.m.) (2-3					
	, · ·	sician's Order stated the					
		nt was in the restraint, but length of time the physician					
	authorized the use of						
		p.m., the Chief Clinical there a time limit for the ESI					
		on the Physician's order?					
	He stated, "I don't see	e one, just the time in the					
	restraint."						
		gnoses of Disruptive Mood					
	uisorder, Reactive At [tachment Disorder, and					

If continuation sheet Page 22 of 35

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-000 TATEMENT OF DEFICIENCES (27) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (27) MULTIPLE CONSTRUCTION A BUILDING C MARE OF PROVIDER OR SUPPLIER CENTERS FOR YOUTH AND FAMILIES INC STREET ADDRESS, CITY, STATE, ZIP CODE 5601 W 12TH STREET COMB NO. 0938-000 CENTERS FOR YOUTH AND FAMILIES INC STREET ADDRESS, CITY, STATE, ZIP CODE 5601 W 12TH STREET CODE CONSTRUCTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC LIEWIFFING INFORMATION) THE PROVIDERS PLAN OF CORRECTION (EACH OPERCINC ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC LIEWIFFING INFORMATION) IN 148 N 148 COMMENT: STATEMENT OF DEFICIENCES (FAGS SHEETER) IN 148 N 148 CONTINUES TO THE APPROPRIATE DEFICIENCY OPENDER COMMENT: TAG N 148 N 148 N 148 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. 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 limi		-	ND HUMAN SERVICES				FOR	M APPROVED
C MAME OF PROVIDER OR SUPPLIER CENTERS FOR YOUTH AND FAMILIES INC SUMMARY STATEMENT OF DEFICIENCY CENTERS FOR YOUTH AND FAMILIES INC CENTERS FOR YOUTH AND FAMILIES INC (24) ID PREFIX Image: Colspan="2">OUTH AND FAMILIES INC CONTENT OF CORRECTION Image: Colspan="2">PREFIX PREFIX Image: Colspan="2">PREFIX Image: Colspan="2">Image: Colspan="2">Continued From page 22 Image: Colspan="2">Image: Colspan="2">Image: Colspan="2">Image: Colspan="2">Colspan="2">Continued From page 22 Image: Colspan="2">Image: Colspan="2">Image: Colspan="2">Colspan="2"Colspan="2" Imade: Colspan="2"Colspan=	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2/P CODE CENTERS FOR YOUTH AND FAMILIES INC STREET ADDRESS, CITY, STATE, 2/P CODE PREEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) D N 148 Continued From page 22 Unspecified Schizophrenia and other Psychotic Disorders. n 148 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 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. Aphysicians Orders for ESI dated 3/12/21 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. Aphysicians Orders for ESI dated 3/11/21 documented, "Personal Restraint: Handle With Care Tow Person Takedown (include maximum time in minutes in test box)" The time limit for the restraint order was not documented on the order.			041 101		ING _			-
CENTERS FOR YOUTH AND FAMILIES INC U(x) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MISE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S FUAN OF CORRECTIVA ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CORSS.REFERENCED TO THE APPROPRIATE DEFICIENCY) OWLETK UDATE N 148 Continued From page 22 Unspecified Schizophrenia and other Psychotic Disorders. N 148 N 148 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 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. 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. 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.			042101	<u> </u>			05	/11/2021
CENTERS FOR YOUTH AND FAMILLES INC LITTLE ROCK, AR 72225 Value SUMMARY STATEMENT OF DEFICIENCIES (EAD HOEFICIENCY WINT E PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PRETX TAG PROVIDER'S PLAN OF CORRECTION (RACH CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 000 OUPLITK (RACH CORRECTION DEFICIENCY) N 148 Continued From page 22 Unspecified Schizophrenia and other Psychotic Disorders. N 148 N 148 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 N 148 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. Stated 3/21/21 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. Stated 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. Stated 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. Stated 3/11/21 documented, "Person Takedown (include maximum time in minutes in t		KONDER OR SOLT EIER						
Prefrix TAG (EACH DEFICIENCY MUST EE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMPLETE DATE N 148 Continued From page 22 Unspecified Schizophrenia and other Psychotic Disorders. N 148 N 148 Image: Complete temperature DEFICIENCY DEFICIENCY) 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 Image: Complete temperature Complete temperatetemperatetemperature Complete temperat	CENTERS	FOR YOUTH AND FAMI	LIES INC					
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. 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.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION
 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) 	N 148	 Unspecified Schizoph Disorders. a. A physicians Order documented, "Perso Care Four Person Tal time in minutes in tes the restraint order wa order. b. A physicians Order documented, "Perso Care Four Person Tal time in minutes in tes the restraint order wa order. c. A physicians Order documented, "Perso Care Two Person Tak time in minutes in tes the restraint order wa order. d. A physicians Order documented, "Perso Care Personal Restra (include maximum tim Handle With Care Tw maximum time in min limit for the restraint of on the order. e. A physicians Order documented, "Perso Care Personal Restra (include maximum tim Handle With Care Tw maximum time in min limit for the restraint of on the order. 	rs for ESI dated 3/31/21 onal Restraint: Handle With kedown (include maximum t box) " The time limit for is not documented on the rs for ESI dated 3/23/21 onal Restraint: Handle With kedown (include maximum t box) " The time limit for is not documented on the rs for ESI dated 3/11/21 onal Restraint: Handle With kedown (include maximum t box) " The time limit for is not documented on the rs for ESI dated 3/4/21 onal Restraint: Handle With kedown (include maximum t box) " The time limit for is not documented on the rs for ESI dated 3/4/21 onal Restraint: Handle With aint Technique (standing) me in minutes in test box) to Person Takedown (include butes in test box)" The time proder was not documented rs for ESI dated 2/5/21 onal Restraint: Handle With aint Technique (standing) me in minutes in test box) to Person Takedown (include	N	148	3		

Facility ID: 3000

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 093 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVICES 04L101 B. WING C C	C
	-
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	
	(X5) COMPLETION DATE
N 148 Continued From page 23 N 148 limit for the restraint order was not documented on the order. N 148 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. 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 152 N 152 ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.356(h)(3) N 152 IDocumentation must include] the time and results of the 1-hour assessment required in paragraph (f) of this section. N 152 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 sempled clients (Clients #1, #2, #3, 4 and 6) who were physically restrained. The findings are:	6/11/21

Facility ID: 3000

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		04L101	B. WING				(11/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			5501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 152	Continued From page	24	N	152			
	Disorder, Reactive At	oses of Disruptive Mood tachment Disorder, and Irenia and other Psychotic					
N 155	REPORTING FORM 1/3/21FACE_TO_F/ EMERGENCY SAFE	ACE ASSESSMENT FOR TY te:Time: , were not egistered Nurse).	N	155			6/11/21
	CFR(s): 483.358(i) The facility must main	ation, the interventions					
	Based on interview a failed to maintain doc Emergency Safety Int 1 (Client #2) of 5 (Clie	t met as evidenced by: nd record review, the facility umented records for erventions (ESI) reports for ents #1, #2, #3, #4 and #6) nad ESI implemented. The					
	Client #2 had a diagn Dysregulation Disorde	osis of Disruptive Mood er.					
	Safety Interventions) documented, "Perso Care Personal Restra	rs for ESI (Emergency dated 10/10/20 onal Restraint: Handle with int Technique (standing) ne in minutes in text box) 8					

Facility ID: 3000

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	
		04L101	B. WING				(11/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1	
CENTERS	FOR YOUTH AND FAMI				6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 155	 b. A Physicians Order Safety Interventions) documented, "Perso Care Solo Takedown minutes in text box) 1 a.m.]" c. On 5/3/21 at 12:57 Director was asked to ESI reports, and the A stated, "We're still loo other two reports." d. On 5/5/21 at 1:55 p Officer was asked if h ESI reports and he st ESIs were supposed the Chief Clinical Offic yes." ORDERS FOR USE O SECLUSION CFR(s): 483.358(j) The physician or othe permitted by the state restraint or seclusion seclusion order in the as possible. This ELEMENT is no Based on record revi failed to ensure the pl a physical restraint as restraint orders were and update the treatm 	s for ESI (Emergency dated 10/14/20 onal Restraint: Handle with (include maximum time in 121-1130 [11:21 a.m11:30 p.m., the Assistant Clinical provide the two missing Assistant Clinical Director king but have not found the o.m., the Chief Clinical e was aware of the missing ated, "Yes." When asked if to be on the clinical record, cer stated, "Supposed to be, DF RESTRAINT OR r licensed practitioner and the facility to order must sign the restraint or resident's record as soon t met as evidenced by: ew and interview, the facility hysician signed an order for a soon as possible to ensure accurate and appropriate hent plan as needed for 3 B) of 5 (Clients #1 - #4 and		15			6/11/21

Facility ID: 3000

If continuation sheet Page 26 of 35

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		04L101	B. WING					
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
CENTERS	FOR YOUTH AND FAMI	LIES INC			5501 W 12TH STREET LITTLE ROCK, AR 72225			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
N 156	ordered. The findings 1. Client #1 had a dia Dysregulation Disorda a. A Physicians Order Safety Intervention) d documented, "Persor signed by the License 9/28/2020 at 5:32 p.m signature on the order 2. Client #2 had a dia Dysregulation Disorda a. A Physicians Order Safety Intervention) d documented, "Persor signed by the License 10/7/2020 at 1:46 p.m signature on the order b. A Physicians Order Safety Intervention) d documented, "Persor signed by the License 10/7/2020 at 5:48 p.m signature on the order c. A Physicians Order Safety Intervention) d ocumented, "Persor	s are: gnosis of Disruptive Mood er. rs for ESI (Emergency lated 9/28/2020 nal Restraint" and was ed Practical Nurse on n There was no physician's r. gnosis of Disruptive Mood er. rs for ESI (Emergency lated 10/7/2020 nal Restraint" and was ed Practical Nurse on n There was no physician's r. rs for ESI (Emergency lated 10/9/2020 nal Restraint" and was ed Practical Nurse on n There was no physician's r. rs for ESI (Emergency lated 10/9/2020 nal Restraint" and was ed Practical Nurse on n There was no physician's r. rs for ESI (Emergency lated 10/10/2020 nal Restraint" and was ed Practical Nurse on n There was no physician's r.	N	156				
	physician's signature d. A Physicians Order Safety Intervention) d	on the order. rs for ESI (Emergency						

Facility ID: 3000

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		04L101	B. WING				C /11/2021	
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
N 156	signed by the License 10/14/2020 at 11:58 a physician's signature e. A Physicians Order Safety Intervention) d documented, "Person signed by the License 10/24/2020 at 10:44 a physician's signature 3. On 5/5/21 at 1:30 p #1 was shown one of physician had signed She was asked "Is it s She stated, "Yes." 4. On 5/5/21 at 1:55 p Officer was asked if h orders were suppose stated, "I may have ku 5. The facility Emerge policy received on 5/3 Clinical Director docu Residential Treatmen The physician's verba with the physician's s order within 5 days' 6. Client #3 had a dia Disorder, Reactive At Unspecified Schizoph Disorders. A Physicians Orders f documented, "Person	ed Practical Nurse on a.m There was no on the order. rs for ESI (Emergency lated 10/23/2020 hal Restraint" and was ed Practical Nurse on a.m There was no on the order. o.m., Registered Nurse (RN) the orders and asked if the it, and RN #1 stated, "No." supposed to be signed?" o.m., the Chief Clinical he was aware the physician's d to be signed and he nown but don't recall." ency Safety Interventions 8/21 form the Assistant mented, "Psychiatric tPhysician's Ordersf. al order must be followed ignature verifying the verbal ' gnoses of Disruptive Mood tachment Disorder, and herenia and other Psychotic	N	156	5			

Facility ID: 3000

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		04L101	B. WING				11/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
N 165	RESTRAINT CFR(s): 483.362(a) Clinical staff trained ir safety interventions m continually assessing and psychological we the safe use of restrai of the emergency safe This STANDARD is m Based on observation interview the facility fa physically present to b of a restraint and com during the use of a ph #4) of 5 (Client #1, 2, were physically restraint Client #4 was admitted diagnosis Disruptive M Disorder. a. An Emergency Sa Form, dated 5/2/21, d Restraint Technique W (10:37 a.m.) Time Eme b. On 5/5/21 at 9:33 restraint, for Client #4 was viewed. The vide seen going into the m bathroom. The male the nurse's station an The nurse goes to the then goes out of the r medication room, out	n the use of emergency nust be physically present, , and monitoring the physical II-being of the resident and int throughout the duration ety intervention. Not met as evidenced by: n, record review and ailed to ensure a nurse was continually assess the safety tinuously monitor a client hysical restraint for 1 (Client 3, 4, 6) sampled clients who hined. The findings are: ed on 3/4/20 and had Mood Dysregulation fety Intervention Reporting locumented, "Primary VallTime Initiated 1037 ded 1040 (10:40 a.m.)"	N	165			6/11/21

Facility ID: 3000

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/20/2021 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L101	B. WING _				C 11/2021
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMIL						
				LI	TTLE 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 165	Continued From page	29	N 1	165			
N 165	the nurse's station to nurse then comes out monitor on the desk, g comes back out, sits i a drink from a cup, ou restraint, gets up and bathroom. The male walks out of camera w with a cup in his hand bathroom. The nurse out of the bathroom, a client's arm. The clien leave the nurse's stati room. The restraint, bathroom, was not vie The nurse failed to be of the physical restrai the client and to asser restraint. d. On 5/4/21, at 3:52 Director was asked, s monitoring the restrain be. She goes back at	the bathroom door. The c of the bathroom, looks at a goes back to the bathroom, n a chair at the desk, takes it of the line of vision of the goes back into the staff exits bathroom then riew, comes back into view and goes into the , client and male staff come and the nurse examines nt, nurse and staff member ion and go to the treatment which was applied in the ewable from either camera. c consistently within the view nt, to monitor and assess ss for the safety of the p.m., the Assistant Clinical	N 1	165			
N 167	observation. MONITORING DURIN RESTRAINT CFR(s): 483.362(c)	-	N 1	167			6/11/21
	the resident's well-bei emergency safety inte	icensed practitioner and the facility to evaluate ng and trained in the use of erventions, must evaluate ng immediately after the					

Facility ID: 3000

If continuation sheet Page 30 of 35

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILD	ING	i		C
		04L101	B. WING				/11/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
N 167	This ELEMENT is no Based on record revi failed to ensure a phy practitioner permitted and trained in the use interventions evaluate immediately after the of 5 (Clients #1, #2, # residents who had be are: 1. Client #1 had a dia Dysregulation Disorde a. An Emergency Saf Form dated 8/19/20 d initiated 8:15 Time en Assessment (Upon R Time 9:00" b. An Emergency Saf Form dated 9/28/20 d initiated 1434 [2:34 p. p.m.]Nursing Asses Procedure): Time 153 2. Client #2 had a dia Dysregulation Disorde a. An Emergency Saf Form dated 10/9/20 d initiated 1733 [5:33 p. p.m.]Nursing Asses Procedure): Time 175 b. An Emergency Saf Form dated 10/9/20 d initiated 1733 [5:33 p.	et met as evidenced by: ew and interview, the facility rsician, or other licensed by the state and the facility of emergency safety ed the resident's well-being restraint was removed for 5 3, #4 and #6)sampled en restrained. The findings gnosis of Disruptive Mood er. ety Intervention Reporting locumented, " Time ided 8:17Nursing emoval from Procedure): ety Intervention Reporting locumented, " Time im.] Time ended 1437 [2:37 sment (Upon Removal from 30 [3:30 p.m.]" gnosis of Disruptive Mood er. ety Intervention Reporting locumented, " Time in.] Time ended 1741 [5:41 asment (Upon Removal from 55 [5:55 p.m.]" ety Intervention Reporting locumented, " Time	N	167	7		

Facility ID: 3000

If continuation sheet Page 31 of 35

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		04L101	B. WING				_ 11/2021
NAME OF PI	ROVIDER OR SUPPLIER	l			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
N 167	Dysregulation Disorda a. An Emergency Saf Form dated 4/23/21 of personTime initiated ended 2104 [9:04 p.m p.m.] Time ended 210 [Handle with Care] 2 initiated 2112 [9:12 p. p.m.] Time initiated 2 2115 [9:15 p.m.]Nu Removal from Proceed p.m.]" b. An Emergency Saf Form dated 4/25/21 of initiated 1809 [6:09 p. p.m.]Nursing Asses Procedure): Time 190 c. An Emergency Saf Form dated 4/26/21 of person wall Time initia 10:08 HWC- Take initiated 10:12 Time e Assessment (Upon R Time 10:55" d. An Emergency Saf Form dated 4/30/21 of initiated 10:30 a.m. T	gnosis of Disruptive Mood er. Tety Intervention Reporting focumented, "CPI High 2 d 2101 [9:01 p.m.] Time n.] Time initiated 2105 [9:05 07 [9:07 p.m.] HWC person Wall Escort Time rm.] Time ended 2115 [9:15 2115 [9:15 p.m.] Time ended rsing Assessment (Upon dure): Time 2140 [9:40 Tety Intervention Reporting focumented, " Time .m.] Time ended 1818 [6:18 ssment (Upon Removal from 00 [7:00 p.m.]" Tety Intervention Reporting focumented, " HWC 1 ated 10:06 Time ended Down 1 person Time ended 10:15 Nursing .emoval from Procedure): Tety Intervention Reporting focumented, " Time anded 10:34 a.m. of (Upon Removal from	N	167			
		ety Intervention Reporting ocumented, "Time initiated					

Facility ID: 3000

If continuation sheet Page 32 of 35

	-	D HUMAN SERVICES					FORM): 07/20/2021 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	LETED
		04L101	B. WING					C 11/2021
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STA	TE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			1 W 12TH STREET	-		
					TLE ROCK, AR 7222			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
N 167	Continued From page	32	N 1	67				
)7Nursing Assessment Procedure): Time 1256"						
	Form dated 5/3/21 do 1312 [1:12 p.m.] Time	ety Intervention Reporting cumented, "Time initiated e ended 1314 [1:14 p.m.] it (Upon Removal from 25 [2:25 p.m.]"						
	Form dated 5/3/21 do position mediumTim Time ended 1342 [1:4 medication -[Intramus [1:56 p.m.] Time ender	t (Upon Removal from						
	Form dated 5/4/21 do mediumTime initiate 10:39 a.m. Time initia 10:43 a.mCPI Tean initiated 10:39 a.m. Ti	t (Upon Removal from						
	Form dated 5/4/21 do mediumTime initiate CPI Team Control P Time ended 1136 Tim ended 1139 Time init Time initiated 1144 Ti Assessment (Upon R Time 1200"	ety Intervention Reporting cumented, "CPI seated ed 1139 Time ended 1139 PositionTime initiated 1135 ne initiated 1138 Time iated 1139 Time ended 1141 me ended 1144Nursing emoval from Procedure):						
		/21 form the Assistant						

Facility ID: 3000

If continuation sheet Page 33 of 35

		ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION		D. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMF	PLETED
		04L101	B. WING				C / 11/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	05/	/11/2021
CENTERS				6	6501 W 12TH STREET		
CENTERS	FOR YOUTH AND FAMI			I	LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
N 167	Residential Treatmen Proceduresc2.4 trained in the use of e interventions must ev immediately after the 4. Client #4 was adm diagnosis Disruptive I Disorder. a. An Emergency Sa Form, dated 4/25/21, (Handle With Care)-F WallTime Initiated 1 Ended 1603 (4:03 p.r (Upon Removal from (5:30 p.m.)" b. The Face-To-Face Emergency Safety Int "The Face-to-Face As completed within one Emergency Safety Int date or time documer Face-to-Face Assess c. On 5/5/21, at 2:08 Clinical Officer) was a Safety Intervention) d assessment was don restraint had ended w should that have been an hour." The CCO face to face assessm can't tell. It's not relia	mented, "Psychiatric tE. Post Intervention A physician or a nurse emergency safety aluate the client's well being restraint is discontinued" hitted on 3/4/20 and had Mood Dysregulation fety Intervention Reporting documented, "HWC Primary Restraint Technique; 1600 (4:00 p.m.); Time n.)5. Nursing Assessment Procedure): Time:1730 e Assessment For terventions documented, ssessment form must be hour of initiation of tervention" There was no need to indicate when the ment was completed. p.m., the CCO (Chief asked, the ESI (Emergency lated 4/25 shows an e at 1730 (5:30 p.m.), time vas 1603 (4:03 p.m.). When n done? He stated, "Within was asked, is that when the ent was done? He stated, "I	N	167			

Facility ID: 3000

If continuation sheet Page 34 of 35

		D HUMAN SERVICES MEDICAID SERVICES					FORM): 07/20/2021 APPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		04L101	B. WING				C 05/11/2021		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	TE, ZIP CODE			
CENTERS	FOR YOUTH AND FAMI	LIES INC			501 W 12TH STREET ITTLE ROCK, AR 72225	i			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
N 167	Disorders. a. An Emergency Sa 3/31/2 documented, " p.m.] Time ended 172 Assessment (Upon R "Time: 1730 [5:30 p.m b. An Emergency Saf 3/23/21 documented, p.m.] Time ended 163	renia and other Psychotic fety Reporting Form Dated Time initiated 1710 [5:10 20 [5:20 p.m.]Nursing emoval from Procedure): n.] ety Reporting Form Dated "Time initiated 1622 [4:32 32 [4:32 p.m.]Nursing emoval from Procedure):	N	167					

Facility ID: 3000

If continuation sheet Page 35 of 35





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

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,

Saudie Busieton Administrative Services Manager

DPSQA/Office of Long Term Care Survey & Certification Section

sgb

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				D: 07/20/2021
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BUILDING			c
		04L101	B. WING			/11/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC		501 W 12TH STREET		
				ITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	BE	(X5) COMPLETION DATE
				DEFICIENCY)		
N 000	Initial Comments		N 000			
	This CMS 2567 surv	ey report supercedes the				
	report sent on May 20	• • •				
	Note: The CMS-2567	(Statement of Deficiencies)				
	is an official, legal do	cument. All information must				
	•	cept for entering the plan of dates, and the signature				
		ncy in the original deficiency				
	citation(s) will be repo Office (RO) for referra	orted to the Dallas Regional			Í	
	· ·	IG) for possible fraud. If				
		tently changed by the				
	should be notified im	State Survey Agency (SA) mediately.				
	Compleint #4 D00026					
	or in part, with no def	502 was substantiated, all iciencies cited.				
	•	504 was substantiated, all				
	or in part, with no def Complaint #AR00026	iciencies cited. i505 was substantiated, all				
	or in part,, with deficie	encies cited at N148, N152,				
	N156, and N167.	506 was unsubstantiated.				
	Complaint #AR00026	516 was substantiated, all				
	• •	ncies cited at N128, N132,				
		148, N165, and N167. 24 was substantiated, all or				
	•	ies cited at N128, N132,				
		1148, N165, and N167. 552 was unsubstantiated.				
	The facility was not in	o compliance with §483,				
	Subpart G - Conditio	ns of Participation for				
NI 400	Psychiatric Residentia		NI 400			0144104
N 128	PROTECTION OF R	ESIDENTS	N 128			6/11/21
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	. 07	TITLE		(X6) DATE
Cior	STAL	Asst Clu	nical	Duecto		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 safeguaros 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

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

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

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMPI	
. THE F LAN UP			A, BUILDI	NG			;
		04L101	B. WING			05/*	11/2021
		LIES INC		65	TREET ADDRESS, CITY, STATE, ZIP CODE 501 W 12TH STREET		
GENTERO					ITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 128	 CFR(s): 483.356(a)(3 Restraint or seclusion injury to the resident a This ELEMENT is not Based on observatio interview the facility fanot sustain an injury a of 1 (Client #4) samp injury during the use findings are: Client #4 was admitted diagnosis Disruptive Disorder. a. An Emergency Sa Form, dated 5/2/21, or Restraint Technique 10(10:37 a.m.) Time Entited b. A Medical Progress p.m., signed by RN (documented, "Most or unstable and disresp cursing at staff, threat peers while on the urbreakfast because sh climbing in the windor several staff member the client to see is sh This nurse tried to ge follow directions in or unit with a particular client that if she kept behaviors this nurse Client was trying to the several staff. 	and must not result in harm or and must be used only- of met as evidenced by: n, record review and ailed to ensure a client did as a result of a restraint for 1 led client who sustained an of a physical restraint. The ed on 3/4/20 and had Mood Dysregulation afety Intervention Reporting documented, "Primary Wall Time Initiated 1037 ided 1040 (10:40 a.m.)" as Note, dated 5/2/21 at 6:00 Registered Nurse) #1 of the shift client was irate, ectful to staff. Client was itening staff, hitting staff and nit. Client refused to eat ne was upset. Client was we seal and this nurse and rs tried their best to talk with the could turn her day around. at the client to calm down and rder to get to go on another staff member. Informed up self harm and aggressive would have to call [Doctor]. ake her clothes off while in d bringing the client into the		128 FE	As the injuries sustained to our clients Centers have involved Handle With C (HWC) holds, HWC is no longer used restraint technique in Center's resider programs to include Destiny House, Elizabeth Mitchell Adolescent Center (EMAC), and Elizabeth Mitchell Childs Center (EMCC), as of 5/3/21. Admissions to all programs have been halted until all staff in these programs participated in a full course of Nonviol Crisis Prevention Intervention (CPI). expected completion date for all staff retrained in CPI is 6/5/21. CPI empha the use of deescalation and that a ho should be used as a last resort. Addi staff have been certified as CPI trained the Advanced Course. This has enabled Centers to retrain a in a more timely manner, and going forward, this will allow for increased oversight in the programs and feedba a real time basis to further ensure that are moving toward the goal of being of trauma informed in all of our resident programs.	are as a ntial ren's n have lent The to be sizes ld tional ers in Il staff ack on at we more ial	eet Page 2 of 35

2

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

PRINTED: 07/20/2021 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY
012/11/0	CONTECTION	IDENTITION TO MODELL.	A. BUILDIN	NG		CON	
		04L101	B. WING			0	C 5/11/2021
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
PENTED	FOR YOUTH AND FAMI			65	01 W 12TH STREET		
	FOR TOOTH AND FAMIL			LF	TTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
N 128	nurses station a few f the client and the client and she eventually ca While trying to speak behavior client ran an nurse's station bathro the nurse's station. T assistance from a QB Health Professional) a attempted to lock here bathroom. The QBHF the client tried to push QBHP report the client which resulted in him With Care) wall restra from 1037 a.m1040 done to the best of sta and the least restrictiv of the incident. Client face at which time the so that her face was r she continued to scre time this nurse inform longer touching the w complained of right ar could not feel her arm at 9/10 (9 out of 10) a (Range of Motion assis check). Client arm did After ROM assessme noticed a clicking nois near/at the right elbow ordered for the client f for further evaluation. several times and rea contacted every time f information regarding Around 1251 (12:51 p	nours later and speak with nt ran around the day area ame to the nurse's station. with the client about her id locked herself in the som after trying to elope from this nurse asked for BHP (Qualified Behavior	N 1	128	To further advance the effort to incluse of de-escalation techniques an holds as a last resort, a video revier session is conducted daily by administrative staff and CPI training review any holds done in the reside programs during the previous day. Feedback regarding possible preverse the hold, techniques used during the staff/client interactions, and any oth pertinent feedback is provided to the Program Managers in writing. Prog Managers may watch video with Q Behavioral Health Provider (QBHP provide feedback, and CPI trainers assist with providing additional train needed. Disciplinary action could taken, if warranted. Emergency Safety Intervention (ES written forms and ESI orders in the electronic medical record (EMR) habeen revised with only CPI holds a options. ESI written forms were revised by Centers' Credible the request of the Assistant Clinica Director. EM were revised by Centers' Credible 5 To monitor the use of holds and astrends in a timely manner, data reg dates, types, frequency of CPI hold associated injuries will be gathered Risk Management staff and review monthly in the Process Improveme Committee meeting. Upward trends addressed as needed. It should also be noted that both st involved in this incident, the QBHP nurse, have been terminated.	d use w g staff to initial ntion of e hold, er e gram ualified i staff to may ing, if be l) ive s vised by R forms Feam at 14/21. sess arding s and by ed int s will be	

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &					O. 0938-03	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN UP	CORRECTION	DENTIFICATION NOMBER.	A. BUILD	NG			
							С
		04L101	B. WING			05	5/11/2021
NAME OF PI	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				65	01 W 12TH STREET		
CENTERS	FOR YOUTH AND FAM	LIES INC		LI'	TTLE ROCK, AR 72225		
	CUMMADY ST			L	PROVIDER'S PLAN OF CORRECTION)N	(X5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IX	(EACH CORRECTIVE ACTION SHOUL		COMPLETIO
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROF	RIATE	DATE
					DEFICIENCY)		
N 128			N	128			
	she would need surg	егу"					
		p.m. the Assistant Clinical					
		rybody is no longer to do the					
		ld anymore, they are to do		- 1			
	N N	n Intervention) only." The					
		ector was asked, how are					
		Handle with Care is not to					
		ted, "They emailed that to all		- 1			
	employees, the emai						
	employees this morn	ing and the program		- 1			
	manager." The Assis	stant Clinical Director was					
		monitored to ensure they are					
	not using the Handle	With Care holds? She					
		nd the program manager,					
	they are monitoring of	lirectly and we are also doing					
	video review of each	restraint. They are here and					
	are present when the	ey are doing the hold and					
	make sure they are o	toing CPI." The Assistant					
	Clinical Director was	asked, when were the					
	notified, this morning	? She stated, "Yes. The					
		program, ages six to twelve,					
	were told about two	months ago, because of the		- 1			
	size difference to use	e the CPI." The Assistant					
	Clinical Director was	asked, [Client #4] is ten					
	years old? She state	ed, "Yes." The Assistant					
		asked, was she in the					
		ed, "Yes." The Assistant					
		asked, when she was					
		placed in the Handle With					
		stated, "She was in the					
		no video, but documentation					
		e Handle With Care position."	6				
		al Manager was asked, so he					
		told he was not to use? She					
		ne Assistant Clinical Manager					
		he now? She stated, "He					
		ediately after the hold? The					
	Assistant Clinical Ma	-					
							100

PRINTED: 07/20/2021 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMF	SURVEY
		04L101	B. WING				C / 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS.	CITY, STATE, ZIP CODE	1 05	11/2021
CENTERS	FOR YOUTH AND FAM	ILIES INC		6501 W 12TH STRE	EET		
			1				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORREC I CORRECTIVE ACTION SHO REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
N 128	Continued From page 4		N	128			
N 128	yesterday? She stat Assistant Clinical Ma Officer] is telling me in nurse." An in-service CPI was being condu- investigation. d. On 5/5/21, at 9:04 was viewed. The vid- the hall which leads of treatment room. The reflect the actual time was viewed coming to then the client goes to out, out of view of the into the hall with the behind them. The cli- get past the nurse ar blocks the way and to the nurse at which tir up. If you grab me y The nurse was seen The client then goes of view of the camera her phone. A male s and then goes into the of the camera. You co "ow' and screaming " my arm. At this time nurse's station, out o voice is heard saying There was more scre- client saying "Yes sir was seen exiting the	ed, "Yes." At 2:57 p.m. the nager stated, "[Chief Clinical they also suspended the e and refresher training in the acted during the the arm. the video with audio eo with audio only showed to the nurse's station and e timing on the video did not e of the incident. The client hrough the door into the hall, back out. The nurse goes e camera, then comes back client, shutting the door tent was seen attempting to ad open the door. The nurse he client was seen pulling on me the nurse's station, out a, and the nurse's station, out a, and the nurse is seen on taff member enters the hall te nurse's station, out of view can hear the client yelling my face, my face, my arm, the nurse enters into the f view of the camera. A h, "you need to calm down." teaming and you can hear the ." The male staff member nurse's station and the client	Ν	128			
	was more screaming saying, "Please don't voice heard saying, "	n't move my arm." There and the client was heard hurt it." There was a female If it hurts and you can't move					
	it I have to touch it." 7(02-99) Previous Versions Ob	The male staff member		Facility ID: 3000		f continuation cha	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С B. WING 04L101 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC LITTLE ROCK, AR 72225 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 128 Continued From page 5 N 128 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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VENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		04L101	B. WING		C
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	05/11/2021
				501 W 12TH STREET	
CENTERS	FOR YOUTH AND FAM	ILIES INC		ITTLE ROCK, AR 72225	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES THE VERTIES AND A DEFICIENCIES THE ADDATE OF THE ADDATE OF THE ADDATE OF THE ADDATE OF	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
N 128	appropriate hold?" S placed them in a chil g. The facility Emerge policy, received from Director on 5/3/21 at "General Principles intervention must be is safe, proportionate severity of the behav chronological and de gender; physical, me condition; and person history or physical or de-escalation interve before a more restrice initiated" PROTECTION OF R CFR(s): 483.356(b) Emergency safety intervention m manner that is safe, j appropriate to the se the resident's chrono age; size; gender; ph psychiatric condition; (including any history abuse). This ELEMENT is no Based on observatio interview the facility f restraint was perform appropriate for the cl	She stated, "I would have d control hold." gency Safety Interventions the Assistant Clinical 1:03 p.m., documented, G. An emergency safety performed in a manner that a and appropriate to the ior, and the client's velopmental age; size; dical and psychiatric hal history (including any sexual abuse.)I. Verbal ntions will be exhausted tive intervention is ESIDENTS tervention. An emergency ust be performed in a proportionate, and verity of the behavior, and logical and developmental pysical, medical, and and personal history of physical or sexual	N 128	As of 5/3/21, HWC is no longer used restraint technique in Center's resider programs to include Destiny House, E and EMCC. Admissions to all programs have beer until all staff in these programs have participated in a full course of CPI. CF emphasizes the use of deescalation a a hold should be used as a last resort training includes holds that are specif use on clients smaller in comparison a Additional staff have been certified as trainers in the Advanced Course. This has enabled Centers to retrain a a more timely manner, and going forw this will allow for increased oversight programs and feedback on a real time	ntial EMAC, n halted Pl and that t. CPI to staff. s CPI Il staff in vard, in the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С B. WING 04L101 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC LITTLE ROCK, AR 72225 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) A video review session is conducted daily by N 132 Continued From page 7 N 132 administrative staff and CPI training staff to review any holds done in the residential Client #4 was admitted on 3/4/20 and had programs during the previous day. diagnosis Disruptive Mood Dysregulation Feedback regarding possible prevention of Disorder. the hold, technique during the hold, staff/ client interactions, and any other pertinent a. An Emergency Safety Intervention Reporting feedback is provided to the Program Form, dated 5/2/21, documented, "...Primary Managers in writing. Program Managers may watch video with QBHP staff to provide Restraint Technique Wall...Time Initiated 1037 (10:37 a.m.) Time Ended 1040 (10:40 a.m.) ... " feedback, and CPI trainers may assist with providing additional training, if needed. Disciplinary action could be taken, if b. A Medical Progress Note, dated 5/2/21 at 6:00 warranted. p.m., signed by RN (Registered Nurse) #1 documented, "Most of the shift client was irate, ESI written forms and ESI orders in the EMR unstable and disrespectful to staff. Client was have been updated with only CPI holds as cursing at staff, threatening staff, hitting staff and options, as of 5/14/21. The ESI written form peers while on the unit. Client refused to eat was revised by the Assistant Clinical breakfast because she was upset. Client was Director and the Physician ESI order form in climbing in the window seal and this nurse and the EMR was revised by the Credible Team several staff members tried their best to talk with at the request of the Assistant Clinical the client to see is she could turn her day around. Director. This nurse tried to get the client to calm down and follow directions in order to get to go on another Data regarding dates, types, frequency of unit with a particular staff member. Informed CPI holds and associated injuries will be gathered and reviewed monthly in the client that if she kept up self harm and aggressive Process Improvement Committee meeting. behaviors this nurse would have to call [Doctor]. Upward trends will be addressed as needed Client was trying to take her clothes off while in the unit as well. Tried bringing the client into the It should also be noted that both staff nurses station a few hours later and speak with involved in this incident, the QBHP and the the client and the client ran around the day area nurse, have been terminated. 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: B60C11 Facility ID: 3000 If continuation sheet Page 8 of 35

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		04L101	B, WING				C 11/2021
NAME OF P	ROVIDER OR SUPPLIER		1)	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS				6	501 W 12TH STREET		
CENTERS	FOR YOUTH AND FAM	ILIES INC		L	ITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
N 132	QBHP report the client which resulted in him With Care) wall restra from 1037 a.m1040 done to the best of st and the least restricti of the incident. Client face at which time the so that her face was she continued to scre- time this nurse inform longer touching the w complained of right a could not feel her arm at 9/10 (9 out of 10) a (Range of Motion ass check). Client arm di After ROM assessmen noticed a clicking noi near/at the right elbor ordered for the client for further evaluation several times and rea contacted every time information regarding Around 1251 (12:51 staff that client right h she would need surg c. On 5/3/21 at 1:11 Director stated, "Even Handle With Care ho CPI (Crisis Preventio Assistant Clinical Dire staff notified that the be utilized? She stat employees this morn	nt attempted to punch him performing a HWC (Handle aint. The restraint lasted a.m. The restraint lasted a.m. The restraint was taff ability based on training ve restraint used at the time t was hollering about her e staff pulled the client back not touching the wall and eam about her face at which hed her that her face was no vall. After release client rm pain and stated she n. Client rated her pain level and this nurse did a ROM sessment. Neurological id appear swollen and red. ent was done this nurse se and what felt like grinding w. [Doctor] was called and to be sent out to [Hospital] . Client guardian was called assured that she would be this nurse received new g the status of the client. p.m.) received report from numerus was broken and ery" p.m. the Assistant Clinical rybody is no longer to do the Id anymore, they are to do n Intervention) only." The ector was asked, how are Handle with Care is not to red, "They emailed that to all I and memos to all	N	132			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING С 04L101 B. WING 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC LITTLE ROCK, AR 72225 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 132 Continued From page 9 N 132 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 vears 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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PRINTED: 07/20/2021 FORM APPROVED OMB NO: 0938-0391

GENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		04L101	B. WING				C / 11/2021
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI			650	1 W 12TH STREET		
CENTERS	FOR TOUTH AND FAMI			ЦП	TLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
N 132	was viewed coming the then the client goes bout, out of view of the into the hall with the of behind them. The cli- get past the nurse an blocks the way and the the nurse at which time up. If you grab me you The nurse was seen with the client then goes in of view of the camera her phone. A male st and then goes into the of the camera. You of "ow' and screaming "In my arm. At this time" nurse's station, out of voice is heard saying. There was more scree client saying "Yes sir. was seen exiting the is heard saying, "I can was more screaming saying, "Please don't voice heard saying, "I it I have to touch it." exited the room, went with a cup in his hand station, out of camera and hard breathing he come out of nurse's s the client was seen he e. On 5/5/21 at 9:33 a was viewed. The clien nurse's station then in	hrough the door into the hall, back out. The nurse goes e camera, then comes back client, shutting the door ent was seen attempting to d open the door. The nurse he client was seen pulling on he the nurse stated, "Back bu are going to the ground." with a syringe in her hand. into the nurse's station, out a, and the nurse is seen on traff member enters the hall e nurse's station, out of view tan hear the client yelling my face, my face, my arm, the nurse enters into the f view of the camera. A , "you need to calm down." aming and you can hear the " The male staff member nurse's station and the client n't move my arm." There and the client was heard hurt it." There was a female if it hurts and you can't move The male staff member to ut the door, came back in a view. There was crying eard. The nurse and client tation into the hallway and	Ν	132	DEFICIENCY)		

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		MEDICAID SERVICES					NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION		ATE SURVEY MPLETED
			A. BUILDII	NG			с
		04L101	B. WING				-
		042101		STREE	T ADDRESS, CITY, STATE, ZIP CODE		05/11/2021
ME OF PI	ROVIDER OR SUPPLIER				V 12TH STREET		
INTERS	FOR YOUTH AND FAN	IILIES INC			E ROCK, AR 72225		
X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
N 132	Continued From pag	ue 11	N	132			
		oom and then goes out of the					
		he medication room, out of					
		he restraint, then one minute					
		o the nurse's station to the					
	bathroom door. The	e nurse then comes out of the					
	bathroom, looks at a	i monitor on the desk, goes					
		n, comes back out and sits in					
		akes a drink from a cup, gets					
		to the bathroom. The male					
		then walks out of camera					
		ith a cup in his hand and					
	-	om. The nurse, client and of the bathroom, the nurse					
		n. The client, nurse and staff					
		urse's station and go to the					
		he restraint was not viewable					
	from either camera.						
	f. On 5/5/21 at 10:04						
		(ed, if you do a Handle With					
		done correctly, should there					
		e stated, "No." The Training					
		own a picture of the male staff					
		ng in the nurse's station					
		ing Coordinator was asked, just saw with the staff and					
		ndle With Care be an					
		She stated, "I would have					
	placed them in a chi						
		gency Safety Interventions					
		n the Assistant Clinical					
		t 1:03 p.m., documented,					
		sG. An emergency safety					
		e performed in a manner that					
		e and appropriate to the					
	severity of the beha						
		evelopmental age; size;					

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		MEDICAID SERVICES				D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		04L101	B. WING			C / 11/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05	11/2021
				5501 W 12TH STREET		
CENTERS	S FOR YOUTH AND FAM	LIES INC		LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
N 132	condition; and persor history or physical or de-escalation interver before a more restrict initiated"	nal history (including any sexual abuse.)I. Verbal ntions will be exhausted tive intervention is	N 132			
N 136	the facility policy to the a minor, to the reside guardian(s). This ELEMENT is no Based on record revi failed to ensure a cop policy was received b for 1 (Client #4) of 1 (The findings are: Client #4 was admitted diagnosis Disruptive I Disorder. a. The facility Conse Treatment, signed by 3/3/21, documented, Consent For Behavio Emergency Safety Int reviewed the [Facility] emergency safety inte agency policy. I give for [Facility] to utilize a clinically indicated in a authorize my child's p behavior managemer	b) cility must] provide a copy of the resident and in the case of nt's parent(s) or legal the met as evidenced by: iew and interview the facility by of the facility's restraint by the guardian at admission Client #4) sampled clients. ed on 3/4/20 and had Mood Dysregulation the For Admission And Client #4's guardian on "Section IV (four): r Management And terventions a. I have I behavior management and erventions as outlined in my consent and permission these procedures as the course of treatmentb. I participation in the Center's	N 136	 An instruction document for compliconsent forms was created that suit the policies, and it was added to the consent forms that are sent out the Docusign. The full policies are atta forms being sent to guardians duri admissions process. The full Docu document signed and returned by prior to admission, including the repolicy, will be attached in the client the EMR. The documents are embe the Admissions Consents to ensure they are always included with infor provided to family during the admiss process and that families are awar behavior management and ESI po Centers. The Access Department under direction of the Access Department under direction of the Access Department under direction of the client's record. Centers' Access Department Direct instructed her staff to email the gual l current residential clients a copy restraint policy, as well as all other referred to on the Admission Cons Client #4 discharged on the day of incident resulting in injury on 5/2/2 they were not sent the restraint po 5/3/21, as she had discharged. 	mmarizes e set of ough ched with ng the usign guardians straint record in edded in e that mation scions e of the licy at staff, artment n an m until en signed, EMR tor, has ardians of y of the policies ent forms.	6/11/21

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С 04L101 B. WING 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC LITTLE ROCK, AR 72225 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 136 Continued From page 13 N 136 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." Although the ESI order was written on the 6/11/21 ORDERS FOR USE OF RESTRAINT OR N 144 N 144 ESI form completed by the RN on duty at the SECLUSION time, (order received at 1052 on 5/2/21), CFR(s): 483.358(e) there was not a corresponding order in the ÉMR. Each order for restraint or seclusion must: On 5/10/21, Nursing Management initiated (1) Be limited to no longer than the duration of an ESI audit daily to ensure completion of all the emergency safety situation; and elements of the ESI process. This includes (2) Under no circumstances exceed 4 hours for review of forms to ensure all areas are filled residents ages 18 to 21; 2 hours for residents out accurately and completely and there is a ages 9 to 17; or 1 hour for residents under age corresponding order in the EMR. 9. Nursing Management has developed an ESI protocol (completed 6/4/21), and all nursing This ELEMENT is not met as evidenced by: staff will sign off on the protocol by 6/11/21. Based on record review and interview the facility This training includes direction on all steps of failed to ensure a Physician's Order for a restraint the ESI process to include documentation of was documented for 1 (Client #4) of 1 (Client #4) the physician's order on the written ESI form sampled clients. This failed practice had the and in the EMR. This training will also be potential to affect 46 facility clients as used with new nurses as part on the documented on a list provided by the Assistant orientation process in residential programs. 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.

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

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	E CONSTRUCTION	CAUSE CONTRACT	0. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·			PLETED
		04L101	B, WING		05	C / 11/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
N 144	Continued From page	: 14	N 14	4		
N 145	Form, dated 5/2/21, d Restraint Technique V (10:37 a.m.) Time End There was no Physici of the restraint. b. On 5/3/21, at 2:57 Director was asked, w Order for the restraint didn't see one for that ESI (Emergency Safe twenty fifth." The Ass asked, that was April stated, "Yes." ORDERS FOR USE O SECLUSION CFR(s): 483.358(f) Within 1 hour of the ir safety intervention a p practitioner trained in safety interventions at and the facility to asse psychological wellbeir conduct a face-to-face physical and psycholo resident, including but (1) The resident's p status; (2) The resident's b	itiation of the emergency obysician, or other licensed the use of emergency nd permitted by the state eass the physical and ng of residents, must e assessment of the origical wellbeing of the anot limited to-	N 14	Nursing staff has been provided instruction regarding requireme face-to-face assessment within initiation of an ESI. Specifically was provided instruction and m how the assessment may be co documented, given that a client agreeable or cooperative. Instr provided through e-mail on 5/6/ Director of Nursing. Instruction by email on 6/1/21 by the Nurse Individual feedback and modeli assessing a client who is not co been done by the Assistant Clir and the Nurse Manager in the p nurses when auditing of ESI for shown a need starting on 5/10// elements of the face-to-face list included in the ESI form that is completed by the licensed prac	nts for the 1 hour of nursing staff odeling of mpleted and is not uction was 21 by the was provided Manager. ng of opperative has nicial Director orograms with ms has 21. All ted here are to be	6/11/21

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A BUILDING С 04L101 B, WING 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC LITTLE ROCK, AR 72225 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) On 5/10/21, Nursing Management initiated N 145 Continued From page 15 N 145 an ESI audit daily to ensure completion of all (4) Any complications resulting from the elements of the ESI process. This includes intervention. review of ESI forms to ensure all areas are filled out accurately and completely, the This ELEMENT is not met as evidenced by: face-to-face assessment is completed in a Based on interview and record review, the facility timely manner, and there is a corresponding failed to ensure a face to face assessment was order in the EMR. conducted within one-hour of the start of the Nursing Management has developed an ESI restraint for 4 (Clients #1, #2, #4 and #6) of 5 protocol (completed 6/4/21) and all nursing (Clients #1, #2, #3, #4 and #6) sampled clients staff will sign off on the protocol by 6/11/21. who had been restrained. The findings are: This training will also be used with new nurses as part on the orientation process in 1. Client #1 had a diagnosis of Disruptive Mood residential programs. 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

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN OI	FCORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPLETED
		04L101	B, WING		C
NAME OF P	ROVIDER OR SUPPLIER	042101		TREET ADDRESS, CITY, STATE, ZIP CODE	05/11/2021
				501 W 12TH STREET	
CENTERS	FOR YOUTH AND FAM			ITTLE ROCK, AR 72225	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLET
N 145	with 18 to indicate wi 3. Client #6 had a dia Dysregulation Disord a. An Emergency Sa Form dated 4/30/21 o initiated 10:30 a.m. T Face-to-Face Assess completed within one Emergency Safety In	thin the 6 p.m. hour agnosis of Disruptive Mood er. fety Intervention Reporting documented, " Time Time ended 10:34 a.m The sment form must be hour of initiation of tervention- Face-to-Face	N 145		
	why- Client Refused. of the form had a line documented "Client r b. An Emergency Sa Form dated 5/3/21 do 1312 [1:12 p.m.] Tim p.m.]The Face-to-F be completed within Emergency Safety In was completed within The Face-to-Face se	fety Intervention Reporting ocumented, " Time initiated e ended 1314 [1:14 Face Assessment form must one hour of initiation of tervention- Face-to-Face n one hour indicated Yes" ction of the form was signed,			
	 [2:25 p.m.]. 4. On 5/5/21 at 1:30 Face-to-Face is one do assessment. The Nurse] maybe workin one hour." When asl was for Face-to-Face stated, "It's not policy permissible." 5. On 5/5/21 at 1:55 Officer was asked, "W 	ompleted on 5/3/21 at 1425 o.m., RN #2 stated, "The hour to get it. The RN has to LPN [Licensed Practical ig so I have to get it done in ked what the facility policy e assessments, RN #1 for it not to get done, it's not o.m., the Chief Clinical When should the ment be completed?" The			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING С 04L101 B. WING 05/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC LITTLE ROCK, AR 72225 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING С 04L101 B. WING 05/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC LITTLE ROCK, AR 72225 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 145 Continued From page 18 N 145 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." The form used for Physician ESI orders in ORDERS FOR USE OF RESTRAINT OR N 148 N 148 6/11/21 the EMR has been revised to make the SECLUSION documentation of the time limit for the CFR(s): 483.358(g)(3) restraint a mandatory field. This element must be documented to complete the form. [Each order for restraint or seclusion must The revision of the Physician ESI order was include] the emergency safety intervention completed by the Credible Team at the ordered, including the length of time for which the request of the Assistant Clinical Director. physician or other licensed practitioner permitted This was completed on 5/14/21. by the state and the facility to order restraint or seclusion authorized its use. The written ESI form has been revised to add an option for a 10 minute time limit, at This ELEMENT is not met as evidenced by: the request of Centers' Medical Director. Based on interview and record review, the facility This will make documentation of that time limit more efficient for nursing staff. The failed to ensure the specific time limit for the revision of this form was completed by the restraint order was on the physician's order for 4 Assistant Clinical Director on 5/14/21. (Clients #1, #2, #3, and #4) of 5 (Clients #1, #2, #3, #4 and #6) sampled clients who had On 5/10/21, Nursing Management initiated Emergency Safety Interventions (ESI) orders. an ESI audit daily to ensure completion of The findings are: all elements of the ESI process. This includes review of forms to ensure all areas 1. Client #1 had a diagnosis of Disruptive Mood are filled out accurately and completely and Dysregulation Disorder. there is a corresponding order in the EMR with the time limit for the restraint a. A Physicians Orders for ESI dated 8/19/20 documented. documented, "...Personal Restraint: Handle with Care Solo Takedown (include maximum time in minutes in text box) ... " The time limit for the

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

Image: Continued From page 19 (X1) PROVIDERVSUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SL COMPLE B NAME OF PROVIDER OR SUPPLIER 04L101 STREET ADDRESS, CITY, STATE, ZIP CODE 6604 W 12TH STREET LITTLE ROCK, AR 72225 CODE 6604 W 12TH STREET LITTLE ROCK, AR 72225 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S LAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY TAG PROVIDER'S LAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY TAG Image: CROSS-REFRENCED TO THE APPROPRIATE DEFICIENCY N 148 Continued From page 19 restraint order was not documented on the order. 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. C A Physicians Orders for ESI dated 8/24/20 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. N 148 2. Client #2 had a diagnosis of Disuptive Mood Client #2 had a diagnosis of Disuptive Mood	
04L101 B. WING 05/11 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6601 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC SUMMARY STATEMENT OF DEFICIENCIES LITTLE ROCK, AR 72225 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE N 148 Continued From page 19 restraint order was not documented on the order 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. C A Physicians Orders for ESI dated 9/28/20 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. N 148 C A Physicians Orders for ESI dated 9/28/20 documented on the order. A Physicians Orders for ESI dated 9/28/20 documented on the order. ID A Physicians Orders for ESI dated 9/28/20 documented on the order. C A Physicians Orders for ESI dated 9/28/20 documented on the order. ID A Physicians Orders for ESI dated 9/28/20 documented on the order. ID A Physicians Orders for ESI date	
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 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 PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY N 148 Continued From page 19 restraint order was not documented on the order. 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. C A Physicians Orders for ESI dated 9/28/20 documented, "Personal Restraint Technique (standing) (include maximum time in minutes in text box)" The time limit for the restraint order was not 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.	
W1/D TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 148 Continued From page 19 restraint order was not documented on the order. 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. C. A Physicians Orders for ESI dated 9/28/20 documented on the order. 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. 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 text box)" The time limit for the restraint order was not documented on the order. N 148 Deficiency of the approximation of the order was not documented on the order. N 148	
 IN 140 Continued From page 19 IN 140 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. IN 140 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. IN 140 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. IN 140 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. IN 140 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. 	(X5) COMPLETIC DATE
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	

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

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES					O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		E SURVEY IPLETED
		04L101	B. WING			04	C 5/11/2021
NAME OF F	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		J/11/2021
CENTER	S FOR YOUTH AND FAMI			6501	W 12TH STREET		
GENTER	SFOR TOOTH AND FAMIL			LITT	LE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
		restraint order was not	N	148			
	 d. A Physicians Order Safety Interventions) documented, "Person Care Personal Restrat (include maximum tim The time limit for the a documented on the orein e. A Physicians Order Safety Interventions) documented, "Person Care Solo Takedown minutes in text box) restraint order was not f. A Physicians Orders Interventions) dated 1 "Personal Restraint Person Takedown (interventions) documented, "Person g. A Physicians Order Safety Interventions) documented, "Person Care Personal Restration (include maximum tim The time limit for the ind documented on the orein 3. On 5/5/21 at 1:55 p Officer stated, "The delength of a hold." Wh the physician order, herein the time stated or the orein the physician order, herein the time stated or the orein the physician order, herein the time physican order the time physica	rs for ESI (Emergency dated 10/13/20 onal Restraint: Handle with aint Technique (standing) ne in minutes in text box)" restraint order was not rder. rs for ESI (Emergency dated 10/14/20 onal Restraint: Handle with (include maximum time in " The time limit for the ot documented on the order. s for ESI (Emergency Safety 10/15/20 documented, : Handle with Care Two clude maximum time in " The time limit for the ot documented on the order. rs for ESI (Emergency dated 10/23/20 onal Restraint: Handle with aint Technique (standing) ne in minutes in text box)" restraint order was not					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С 04L101 B. WING 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC LITTLE ROCK, AR 72225 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 148 Continued From page 21 N 148 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 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 860C11 Facility ID: 3000 If continuation sheet Page 22 of 35

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		MEDICAID SERVICES				OMB NC	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		CONSTRUCTION	(X3) DATE COMP	SURVEY
		04L101	B. WING				C 11/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAM	LIES INC			01 W 12TH STREET TTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFi TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 148	 Unspecified Schizoph Disorders. a. A physicians Order documented, "Pers Care Four Person Tai time in minutes in tes the restraint order wa order. b. A physicians Order documented, "Pers Care Four Person Tai time in minutes in tes the restraint order wa order. c. A physicians Order documented, "Pers Care Two Person Tak time in minutes in tes the restraint order wa order. d. A physicians Order documented, "Pers Care Personal Restra (include maximum tim Handle With Care Tw maximum time in min limit for the restraint or on the order. e. A physicians Order documented, "Pers Care Personal Restra (include maximum tim Handle With Care Tw 	e 22 nrenia and other Psychotic rs for ESI dated 3/31/21 onal Restraint: Handle With kedown (include maximum t box) " The time limit for is not documented on the rs for ESI dated 3/23/21 onal Restraint: Handle With kedown (include maximum t box) " The time limit for is not documented on the rs for ESI dated 3/11/21 onal Restraint: Handle With kedown (include maximum t box) " The time limit for is not documented on the rs for ESI dated 3/4/21 onal Restraint: Handle With kedown (include maximum t box) " The time limit for is not documented on the rs for ESI dated 3/4/21 onal Restraint: Handle With aint Technique (standing) ne in minutes in test box) o Person Takedown (include utes in test box)" The time order was not documented rs for ESI dated 2/5/21 onal Restraint: Handle With aint Technique (standing) ne in minutes in test box) o Person Takedown (include utes in test box) The time	Ν	148			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С B. WING 04L101 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC LITTLE ROCK, AR 72225 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 148 Continued From page 23 N 148 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. On 5/10/21, Nursing Management initiated an ORDERS FOR USE OF RESTRAINT OR 6/11/21 N 152 N 152 ESI audit daily to ensure completion of all SECLUSION elements of the ESI process. This includes CFR(s): 483.358(h)(3) review of forms to ensure all areas are filled out accurately and completely, to include [Documentation must include] the time and results of the 1-hour assessment, and there results of the 1-hour assessment required in is a corresponding order in the EMR. paragraph (f) of this section. Nursing Management has developed an ESI protocol (completed 6/4/21) and all nursing This ELEMENT is not met as evidenced by: staff will sign off on the protocol by 6/11/21. Based on record review and interview, the facility This training will also be used with new failed to ensure that the date and time of the nurses as part on the orientation process in 1-hour assessment was documented for 1 (Client residential programs. #3) of 4 sampled clients (Clients #1, #2, #3, 4 and 6) who were physically restrained. The findings are:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		MEDICAID SERVICES			IB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION (X3	DATE SURVEY COMPLETED
		04∟101	B. WING		C 05/11/2021
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	OUT THE DET
CENTERS	FOR YOUTH AND FAMI	LIES INC		501 W 12TH STREET ITTLE ROCK, AR 72225	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
N 152	Continued From page	24	N 152		
	Disorder, Reactive At	oses of Disruptive Mood tachment Disorder, and trenia and other Psychotic			
REPORTING 1/3/21FACI EMERGENC INTERVENT filled in by the	REPORTING FORM 1/3/21FACE_TO_F/ EMERGENCY SAFE	ACE ASSESSMENT FOR TY te:Time: , were not			
N 155	ORDERS FOR USE O SECLUSION CFR(s): 483.358(i) The facility must main		N 155	The routing process for ESI forms has bee changed to ensure that the forms do not leave the building for review or sign off. Th change in this process was initiated by the Assistant Clinical Director, on 5/14/21.	e
	used, and their outco	uation, the interventions mes it met as evidenced by:		On 5/10/21, Nursing Management initiated ESI audit daily to ensure completion of all elements of the ESI process. This include review of forms to ensure all areas are fille	s
	failed to maintain doc	nd record review, the facility umented records for terventions (ESI) reports for		out accurately and completely and there is corresponding order in the EMR.	а
	1 (Client #2) of 5 (Clie	ents #1, #2, #3, #4 and #6) had ESI implemented. The		Nursing Management has developed an E 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	g
	Client #2 had a diagn Dysregulation Disorde	osis of Disruptive Mood er.		nurses as part on the orientation process in residential programs.	n
	Safety Interventions) documented, "Pers Care Personal Restra	rs for ESI (Emergency dated 10/10/20 onal Restraint: Handle with aint Technique (standing) ne in minutes in text box) 8		The "Behavior Log," the log where ESI's in each program are documented, has been revised to add a column to document the co an ESI form has been scanned into the EN This was completed by the Assistant Clinic Director on 6/1/21.	late /R.

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

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

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				NR NO	. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X	3) DATE COMPI	LETED
		04L101	B. WING			05/*	C 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			501 W 12TH STREET ITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE
N 155	 b. A Physicians Order Safety Interventions) documented, "Persy Care Solo Takedown minutes in text box) 1 a.m.]" c. On 5/3/21 at 12:57 Director was asked to ESI reports, and the / stated, "We're still loc other two reports." d. On 5/5/21 at 1:55 p Officer was asked if F ESI reports and he st ESIs were supposed the Chief Clinical Offi yes." ORDERS FOR USE (SECLUSION CFR(s): 483.358(j) The physician or othe permitted by the state restraint or seclusion seclusion order in the as possible. This ELEMENT is no Based on record rev failed to ensure the p a physical restraint as restraint orders were and update the treatmageneric section of the state of the sta	rs for ESI (Emergency dated 10/14/20 onal Restraint: Handle with (include maximum time in 121-1130 [11:21 a.m11:30 p.m., the Assistant Clinical provide the two missing Assistant Clinical Director king but have not found the o.m., the Chief Clinical re was aware of the missing ated, "Yes." When asked if to be on the clinical record, cer stated, "Supposed to be, OF RESTRAINT OR or licensed practitioner e and the facility to order must sign the restraint or resident's record as soon of resident's record as soon the timet as evidenced by: iew and interview, the facility hysician signed an order for a soon as possible to ensure accurate and appropriate ment plan as needed for 3 3) of 5 (Clients #1 - #4 and		155	The routing process for ESI forms has be changed, and the forms no longer leave program for review or signature, and they remain in a designated ESI box in the programs. The Medical Director/physicia ordering the restraint will check the boxe the programs several times weekly to en the forms are signed within 5 days of the restraint, as per Centers policy. On 5/10/21, Nursing Management initiate an ESI audit daily to ensure completion of elements of the ESI process. This include review of forms to monitor for the physicis signature within 5 days. The Support Sta will also audit forms for all signatures, including the physician signature within 5 days, prior to scanning ESI forms into the EMR.	the y an s in sure of all des ian's aff	6/11/21

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DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING С 04L101 B. WING 05/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 12TH STREET CENTERS FOR YOUTH AND FAMILIES INC LITTLE ROCK, AR 72225 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) N 156 Continued From page 26 N 156 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

documented, "Personal Restraint..." and was FORM CMS-2567(02-99) Previous Versions Obsolete

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICE	<u>S</u>			ONB	NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM		2) MULTIPL BUILDING	E CONSTRUCTION		ATE SURVEY OMPLETED
		04L101	В.	WING			C 05/11/2021
NAME OF PI	ROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP CODE		
OFNITEDO					6501 W 12TH STREET		
CENTERS	FOR YOUTH AND FAMI	LIESINC			LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION 3 CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 156	Continued From page signed by the License 10/14/2020 at 11:58 a physician's signature e. A Physicians Order Safety Intervention) d documented, "Persor signed by the License 10/24/2020 at 10:44 a physician's signature 3. On 5/5/21 at 1:30 g #1 was shown one of physician had signed She was asked "Is it a She stated, "Yes." 4. On 5/5/21 at 1:55 g Officer was asked if h orders were suppose stated, "I may have k 5. The facility Emerge policy received on 5/3 Clinical Director docu Residential Treatmen The physician's verba with the physician's s order within 5 days" 6. Client #3 had a dia Disorder, Reactive At Unspecified Schizoph Disorders. A Physicians Orders documented, "Persor by the LPN on 1/3/20	ed Practical Nurse on a.m There was no on the order. rs for ESI (Emergence lated 10/23/2020 nal Restraint" and w ed Practical Nurse on a.m There was no on the order. o.m., Registered Nurse the orders and asked it, and RN #1 stated, supposed to be signe o.m., the Chief Clinica ne was aware the phy d to be signed and he nown but don't recall. ency Safety Interventi 3/21 form the Assistar imented, "Psychiatr itPhysician's Orders al order must be follow ignature verifying the " order SI dated 1/3/21 nal Restraintan was	as e (RN) d if the "No." d?" d?" d sician's e " ons ont ic sf. ved verbal Mood nd hotic signed	N 15			
EORM CMS OF	no physician's signat	ure on the order.	Event ID: B60C11		Facility 1D: 3000	If continuation	sheet Page 28 of 35
FURINI UNIS-25	67(02-99) Previous Versions Ob:	301613	LAGULUD' DOOC LI		during iD. 0000	a continuation	anderrage zo 0135

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		MEDICAID SERVICES				OMB NO	D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		04L101	B. WING				C / 11/2021
	PROVIDER OR SUPPLIER			S' 6	TREET ADDRESS, CITY, STATE, ZIP CODE 501 W 12TH STREET ITTLE ROCK, AR 72225	1 05	/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
N 165	RESTRAINT CFR(s): 483.362(a) Clinical staff trained i safety interventions in continually assessing and psychological we the safe use of restra of the emergency safe This STANDARD is in Based on observation interview the facility fi physically present to of a restraint and com during the use of a pl #4) of 5 (Client #1, 2, were physically restra Client #4 was admitted diagnosis Disruptive Disorder. a. An Emergency Saf Form, dated 5/2/21, of Restraint Technique M (10:37 a.m.) Time Em b. On 5/5/21 at 9:33 restraint, for Client #4 was viewed. The vide seen going into the n bathroom. The male the nurse goes to the then goes out of the m medication room, out	n the use of emergency nust be physically present, g, and monitoring the physical ell-being of the resident and int throughout the duration fety intervention. not met as evidenced by: on, record review and ailed to ensure a nurse was continually assess the safety thinuously monitor a client hysical restraint for 1 (Client 3, 4, 6) sampled clients who ained. The findings are: ed on 3/4/20 and had Mood Dysregulation	Ν	165	On 5/10/21, Nursing Management init an ESI audit daily to ensure completio all elements of the ESI process to incl continuous monitoring during a hold. forms will be reviewed daily to include documentation of continuous monitori and observation to ensure that clients remaining safe during ESI's and that a holds are done in a safe manner. A video review session is conducted of by administrative staff and CPI training to review any holds done during the previous day. Feedback regarding the event, to include the presence of or la continuous observation and monitorir along with other pertinent information provided to Program Managers and Nursing Managers. Additional training be done with staff as needed. Nursing Management has developed ESI protocol (completed 6/4/21) and a nursing staff will sign off on the protoco 6/11/21. This training will also be used new nurses as part on the orientation process in residential programs.	n of ude ESI are any daily g staff e ck of ng, is g may an all col by	6/11/21

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				ONB NO	. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		LETED
		04∟101	B, WING	_		05/) 11/2021
NAME OF PR	ROVIDER OR SUPPLIER		-	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				65	01 W 12TH STREET		
CENTERS	FOR YOUTH AND FAMI			ц	TTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
N 165	the nurse's station to nurse then comes ou monitor on the desk, comes back out, sits a drink from a cup, ou restraint, gets up and bathroom. The male walks out of camera with a cup in his hand bathroom. The nurse out of the bathroom, i client's arm. The clie leave the nurse's stat room. The restraint	the bathroom door. The t of the bathroom, looks at a goes back to the bathroom, in a chair at the desk, takes ut of the line of vision of the goes back into the staff exits bathroom then view, comes back into view	N	165			
N 167	The nurse failed to be of the physical restra the client and to asser restraint. d. On 5/4/21, at 3:52 Director was asked, s monitoring the restra be. She goes back a but we would expect observation. MONITORING DURI RESTRAINT CFR(s): 483.362(c) A physician, or other permitted by the state the resident's well-be emergency safety int	e consistently within the view int, to monitor and assess iss for the safety of the p.m., the Assistant Clinical shouldn't the nurse be int? She stated, "She should and forth numerous times, continuous monitoring and NG AND AFTER	N	167	Nursing staff has been provided specifi instruction regarding requirements for immediate evaluation upon removal of restraint. Specifically, nursing staff wa provided instruction and modeling of h assessment should be completed and documented. Instruction was provided through e-mail on 5/6/21 by the Director Nursing. Instruction was provided by o on 6/1/21 by the Nurse Manager. Indir feedback has been done by both Nurse Managers in the programs with nurses auditing of ESI forms has shown a new starting on 5/10/21.	an a s ow the or of email vidual e s when	6/11/21

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Facility ID: 3000

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMP	SURVEY
		04L101	B, WING				C 11/2021
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	THEOLI
CENTERS	FOR YOUTH AND FAMI			6	501 W 12TH STREET		
				L	ITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
N 167	Based on record rev failed to ensure a phy practitioner permitted and trained in the use interventions evaluate immediately after the of 5 (Clients #1, #2, # residents who had be are: 1. Client #1 had a dia Dysregulation Disord a. An Emergency Saf Form dated 8/19/20 c initiated 8:15 Time er Assessment (Upon R Time 9:00" b. An Emergency Saf Form dated 9/28/20 c initiated 1434 [2:34 p p.m.]Nursing Asses Procedure): Time 153 2. Client #2 had a dia Dysregulation Disord a. An Emergency Saf Form dated 10/9/20 c initiated 1733 [5:33 p p.m.]Nursing Asses Procedure): Time 175 b. An Emergency Saf Form dated 10/9/20 c initiated 1733 [5:33 p p.m.]Nursing Asses	at met as evidenced by: iew and interview, the facility visician, or other licensed by the state and the facility e of emergency safety ed the resident's well-being restraint was removed for 5 i3, #4 and #6)sampled een restrained. The findings gnosis of Disruptive Mood er. fety Intervention Reporting locumented, " Time inded 8:17Nursing emoval from Procedure): fety Intervention Reporting locumented, " Time 	Ν	167	On 5/10/21, Nursing Management init an ESI audit daily to ensure completio elements of the ESI process. This inc review of forms to ensure all areas are out accurately and completely and the corresponding order in the EMR. Nurs Management has developed an ESI p (completed 6/4/21), and all nursing sta sign off on the protocol by 6/11/21. The training will also be used with new nur part on the orientation process in resid programs.	n of all dudes e filled ere is a sing rotocol aff will is ses as	

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

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		_		ONB NO	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
		04L101	B. WING			05/	C 11/2021
NAME OF PE	ROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP CODE		
				Ł	6501 W 12TH STREET		
CENTERS	FOR YOUTH AND FAMI	LIES INC			LITTLE ROCK, AR 72225		
04.0.15		ATEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
11.407							
N 167	Continued From page	ə 31		16	1		
	Time 12:25"		1				
	3 Client #6 had a dia	gnosis of Disruptive Mood					
	Dysregulation Disord						
	a An Emergency Sat	fety Intervention Reporting					
		locumented, "CPI High 2					
		d 2101 [9:01 p.m.] Time					
		n.] Time initiated 2105 [9:05					
		07 [9:07 p.m.] HWC person Wall EscortTime					
		.m.] Time ended 2115 [9:15					
		2115 [9:15 p.m.] Time ended					
		rsing Assessment (Upon					
	Removal from Procee	dure): Time 2140 [9:40					
	p.m.j						
	b. An Emergency Sa	fety Intervention Reporting					
	Form dated 4/25/21 of						
		.m.] Time ended 1818 [6:18					
	Procedure): Time 19	ssment (Upon Removal from					
	Those durey. Time to	66 [7:66 p.m.]					
		fety Intervention Reporting					
		documented, "HWC 1					
		iated 10:06 Time ended					
		Down 1 personTime ended 10:15 Nursing					
		Removal from Procedure):					
	Time 10:55"						
	d. An Emergency Sa	fety Intervention Reporting					
	Form dated 4/30/21 (documented, "Time					
		Time ended 10:34 a.m.					
		nt (Upon Removal from					
	Procedure): Time 11:	.UA					
	e. An Emergency Sa	fety Intervention Reporting					
		ocumented, " Time initiated					
				_			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD				SURVEY PLETED
		04L101	B. WING				C / 11/2021
NAME OF PI	ROVIDER OR SUPPLIER			T	STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMI	LIES INC			6501 W 12TH STREET LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
N 167	(Upon Removal from f. An Emergency Safe Form dated 5/3/21 do 1312 [1:12 p.m.] Time Nursing Assessmer Procedure): Time 142 g. An Emergency Saf Form dated 5/3/21 do position mediumTim Time ended 1342 [1:4 medication -[Intramus [1:56 p.m.] Time ende Nursing Assessmer Procedure): Time 142 h. An Emergency Saf Form dated 5/4/21 do mediumTime initiate 10:39 a.m. Time initiate 10:39 a.m. Time initiate 10:39 a.m. Time initiate 10:43 a.mCPI Tear initiated 10:39 a.m. Ti Nursing Assessmer Procedure): Time 11:3 i. An Emergency Safe Form dated 5/4/21 do mediumTime initiate CPI Team Control F Time ended 1136 Tim ended 1139 Time init Time initiated 1144 Ti Assessment (Upon R Time 1200"	 b7Nursing Assessment Procedure): Time 1256" ety Intervention Reporting cumented, "Time initiated ended 1314 [1:14 p.m.] et (Upon Removal from 25 [2:25 p.m.]" ety Intervention Reporting cumented, "CPI seated ne initiated 1340 [1:40 p.m.] 2 p.m.] Emergency cular]Time initiated 1356 ed 1356 [1:56 p.m.] ety Intervention Reporting cumented, "CPI seated ad 1356 [1:56 p.m.] tt (Upon Removal from 25 [2:25 p.m.]" ety Intervention Reporting cumented, "CPI seated ad 10:38 a.m. Time ended ted 10:41 a.m. Time ended ne Control PositionTime me ended 10:41 a.m. tt (Upon Removal from 22" ety Intervention Reporting cumented, "CPI seated ad 1139 Time ended 1139 PositionTime initiated 1135 ne initiated 1138 Time iated 1139 Time ended 1141 me ended 1144Nursing emoval from Procedure): 	N	167			
		Incy Safety Interventions 1/21 form the Assistant			facility ID: 3000		

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMP	LETED
		04L101	B. WING			, 11/2021
	ROVIDER OR SUPPLIER	LIES INC	650	REET ADDRESS, CITY, STATE, ZIP CODE 1 W 12TH STREET TLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
N 167	Clinical Director docu Residential Treatmen Proceduresc2 trained In the use of e interventions must ev immediately after the 4. Client #4 was adm diagnosis Disruptive I Disorder. a. An Emergency Sa Form, dated 4/25/21, (Handle With Care)-F WallTime Initiated Ended 1603 (4:03 p.r (Upon Removal from (5:30 p.m.)" b. The Face-To-Face Emergency Safety In "The Face-to-Face A completed within one Emergency Safety In date or time documen Face-to-Face Assess c. On 5/5/21, at 2:08 Clinical Officer) was a Safety Intervention) of assessment was don restraint had ended v should that have bee an hour." The CCO face to face assessm can't tell. It's not relia	 Immented, " Psychiatric itE. Post Intervention A physician or a nurse emergency safety valuate the client's well being restraint is discontinued" nitted on 3/4/20 and had Mood Dysregulation Ifety Intervention Reporting documented, "HWC Primary Restraint Technique; 1600 (4:00 p.m.); Time m.)5. Nursing Assessment Procedure): Time:1730 Assessment For terventions documented, ssessment form must be a hour of initiation of tervention" There was no nited to indicate when the sment was completed. Imment, the CCO (Chief asked, the ESI (Emergency dated 4/25 shows an te at 1730 (5:30 p.m.), time vas 1603 (4:03 p.m.). When in done? He stated, "Within was asked, is that when the nent was done? He stated, "I able information." 	N 167			
		agnoses of Disruptive Mood ttachment Disorder, and				-

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

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

CENTER	OT ON MEDICANE &	VIEDICAID SERVICES	-r			UNB NO.	0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		04L101	B. WING			C 05/1	: 1/2021
NAME OF PROVIDER OR SUPPLIER CENTERS FOR YOUTH AND FAMILIES INC				STREET ADDRESS 6501 W 12TH STF LITTLE ROCK,		1 03/1	1/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BI REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 167	Disorders. a. An Emergency Sat 3/31/2 documented, " p.m.] Time ended 172 Assessment (Upon Re "Time: 1730 [5:30 p.m b. An Emergency Saf 3/23/21 documented, p.m.] Time ended 163	renia and other Psychotic fety Reporting Form Dated Time initiated 1710 [5:10 20 [5:20 p.m.]Nursing emoval from Procedure): 1.] ety Reporting Form Dated "Time initiated 1622 [4:32 32 [4:32 p.m.]Nursing emoval from Procedure):	N	167			
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID: B600	;11	Facility ID: 3000	If continu	uation sheet	Page 35 of 35

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier N	Provider/Supplier Name CENTERS FOR YOUTH AND FAMILIES INC					
04L101	CENTERS FOR						
Type of Survey (select all that apply)	A Complaint Investigation	E Initial Certification	Ι	Recertification			
	B Dumping Investigation	F Inspection of Care	J	Sanctions/Hearing			
A	C Federal Monitoring	G Validation	Κ	State License			
	D Follow-up Visit	H Life Safety Code	L	CHOW			
	M Other						
Extent of Survey (select all that apply)	A Routine/Standard Survey (all pro-	** /					
	B Extended Survey (HHA or Long Term Care Facility)						
D	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.	04/30/2021	05/05/2021	1.00	0.00	23.50	0.00	10.00	16.00
2.)(6), (b) (7)	04/30/2021	05/11/2021	1.00	0.00	32.00	0.00	5.00	6.50
3.	05/03/2021	05/05/2021	0.50	0.00	18.00	0.00	8.50	5.00
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
Total SA Supervisory Re	view Hours	5	.00		Total RO Super	visory Review Ho	urs	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?.... \mathbf{No}

1