



**Division of Provider Services and Quality Assurance**  
**Office of Long Term Care**  
PO Box 8059, Slot S404  
Little Rock, AR 72203-8059  
Fax: 501-682-6159



June 7, 2019

Nathan Chennault, Administrator  
Millcreek Of Arkansas  
1810 Industrial Drive  
Fordyce, AR 71742

Dear Mr.Chennault,:

On June 4, 2019 a Recertification and 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 deficiency cited.

Sandra Broughton, Reviewer  
OLTC, Survey & Certification Section  
PO Box 8059, Slot S404  
Little Rock, AR 72201-4608  
Telephone (501) 320-6182; Fax (501) 682-6159  
or e-mail to Rodney.Raper@dha.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.

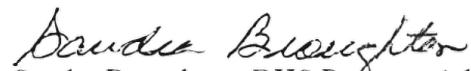
An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

Please submit your request to:

Becky Bennett, Section Chief  
Health Facility Services  
Arkansas Department of Health  
5800 West 10<sup>th</sup> Street, Suite 400  
Little Rock, AR 72204  
Fax (501) 661-2165

If you have any questions, please call Sandra Broughton, Program Administrator at 501-320-6182.

Sincerely,



Sandra Broughton, DHS Program Administrator  
Office of Long Term Care  
Survey & Certification Section

sgb

cc: Ombudsman  
DRC  
file

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

PRINTED: 06/07/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04L103</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>06/04/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>MILLCREEK OF ARKANSAS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1810 INDUSTRIAL DRIVE</b> <b>FORDYCE, AR 71742</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments  Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.	E 000			
N 000	The facility was in compliance with Emergency Preparedness of Psychiatric Residential Treatment Center.  Initial Comments  A Validation and complaint survey was conducted from 5/23/19 to 5/24/19.	N 000			
N 128	Complaint AR00022948 was substantiated, all or in part, with deficiencies cited at N128 and N196  The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center  PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3)	N 128			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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N 128	<p>Continued From page 1</p> <p>Restraint or seclusion must not result in harm or injury to the resident and must be used only-</p> <p>This ELEMENT is not met as evidenced by: Complaint AR00022948 was substantiated, all or in part, in these findings.</p> <p>Based on record review and interview, the facility failed to ensure an Emergency Safety Intervention (ESI) did not result in an injury for 1 of 1 (Resident #1) who was involved in an ESI. The findings are:</p> <p>Resident #1 had diagnoses of Disruptive Mood Dysregulation and Attention-Deficit/Hyperactivity Disorder.</p> <p>a. An "Emergency Safety Intervention and Debriefing" documented an ESI was initiated on 4/26/19 at 8:20 p.m. involving Resident #1. The resident was placed into a physical restraint in released from the physical restraint at 8:34 p.m. The form documented a physical assessment was completed by Registered Nurse (RN) #1 on 4/26/19 at 8:34 p.m. The assessment documented Resident #1 had an injury during restraints: "c/o [complained of] left knee pain-good ROM [range of motion] [no] swelling... First aid applied: Ibuprofen 400 mg [milligrams] po [orally]-refused ice pack. Medial Services, Describe: None Pain scale (0-10) [0 being no pain, 10 being the worst pain]: 5/10. Location of Pain Left knee..."</p> <p>b. An OLTC (Office of Long Term Care) Incident and Accident Report (I&amp;A) documented, " ...Date of I&amp;A 4/26/19 Time: 2020 [8:20 p.m.]... Summary of Incident... [Resident #1] refused all directives</p>	N 128			

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

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N 128	<p>Continued From page 2</p> <p>multiple times. She was eventually placed into a physical restraint for safety...Nursing evaluation: Complained of left knee pain, 5/10 [pain scale]. On 4/27/19, had a limp and complained of knee pain 8/10. [Resident #1] was evaluated by the doctor on 5/3/19. The doctor recommended [Resident #1] she an orthopedic doctor. The patient stated her knee went inward as she was taken down... "</p> <p>c. A Witness Statement completed RN #1 dated 5/13/19 documented, " ...On 4/26/19 called to [cottage] due to patient being aggressive [with] staff. Pt [Patient] placed in physical restraint due to continued ongoing aggressive behaviors... Pt continued to be aggressive while in physical restraint fighting against staff. When pt was calm released from physical restraint. Pt had good ROM in all extremities other than soreness in left knee. Pt walks to room. When assess pain level 5/10 Ibuprofen given. Pt got in bed. Reassessed one hour later pain 2/10. Went back down hall about an hour later pt in bed [with] eyes closed. [No] further complaints of pain. "</p> <p>d. On 5/23/19 at 12:19 p.m., the Director of Risk Management was asked "Did you get to see the video of the incident?" He stated, "No Ma'am. By the time I was told about it on the 10th, I went to look at the video, but it had been recorded over. The video had been reviewed by the patient advocate, as it shows on the restraint log I gave you." He was asked, "What did the patient advocate say about the restraint when you talked to her?" He stated, "She said she didn't see anything, but didn't really remember, said she didn't remember any details." He was asked "When was the staff suspended that was involved?" He stated, "On the 10th after I found</p>	N 128			

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N 128	Continued From page 3 out about the incident."	N 128			
N 196	<p><b>MEDICAL TREATMENT FOR INJURIES</b> CFR(s): 483.372(a)</p> <p>Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention.</p> <p>This STANDARD is not met as evidenced by: Complaint AR00022948 was substantiated, all or in part, in these findings.</p> <p>Based on interview and record review, the facility failed to ensure prompt medical treatment was obtained to prevent further potential complications for a 1 of 1 (Resident #1) sampled client who sustained an injury during an emergency safety intervention. The findings are:</p> <p>Resident #1 had diagnoses of Disruptive Mood Dysregulation and Attention-Deficit/Hyperactivity Disorder.</p> <p>a. An "Emergency Safety Intervention and Debriefing" documented an ESI was initiated on 4/26/19 at 8:20 p.m. involving Resident #1. The resident was placed into a physical restraint in released from the physical restraint at 8:34 p.m. The form documented a physical assessment was completed by Registered Nurse (RN) #1 on 4/26/19 at 8:34 p.m. The assessment documented Resident #1 had an injury during restraints: "c/o [complained of] left knee pain-good ROM [range of motion] [no] swelling... First aid applied: Ibuprofen 400 mg [milligrams] po [orally]-refused ice pack. Medial Services, Describe: None Pain scale (0-10) [0 being no</p>	N 196			

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N 196	<p>Continued From page 4</p> <p>pain, 10 being the worst pain]: 5/10. Location of Pain Left knee..."</p> <p>b. An OLTC (Office of Long Term Care) Incident and Accident Report (I&amp;A) documented, " ...Date of I&amp;A 4/26/19 Time: 2020 [8:20 p.m.]... Summary of Incident... [Resident #1] refused all directives multiple times. She was eventually placed into a physical restraint for safety...Nursing evaluation: Complained of left knee pain, 5/10 [pain scale]. On 4/27/19, had a limp and complained of knee pain 8/10. [Resident #1] was evaluated by the doctor on 5/3/19. The doctor recommended [Resident #1] she an orthopedic doctor. The patient stated her knee went inward as she was taken down... "</p> <p>c. Nurse ' s Note dated 4/26/19 at 8:20 p.m. documented, " ... [8:34 p.m.] pt released [from restraint] due to contracts to be calm and go to bed. [8:35 p.m.]. Pt complains of left knee pain 5/10 [pain scale]. Ibuprofen 400 mg given. Pt walking on knee complains ' it feels sore ' ... Will continue to watch it closely. "</p> <p>d. A Nurse ' s Note dated 4/27/19 at 7:15 p.m. documented, " Pt ambulates to nurse ' s station for HS [bed time] meds [medications]... Noticeable limp. Pt. c/o pain 8/10 to [left] knee. States injury occurred while in restraint. Requests to see MD [medical doctor]... Upon assessment pedal pulses present &amp; [and] equal. [No] edema. [No] s/s [signs or symptoms] inflammation noted. Medicated [with Ibuprofen 600 mg po. Instructed to go lay down &amp; nurse would check [after] med pass. Upon ambulation back to unit, pt noted with only slight limp. Will continue to monitor. "</p> <p>e. Nurse ' s notes dated 4/2719 at 8:45 p.m. until</p>	N 196			

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N 196	Continued From page 5 5/6/19 did not document any monitoring of knee pain.  f. Nurse ' s Note dated 5/6/19 at 6:45 a.m. documented, " Pt c/o 8/10 [pain scale] [left] knee pain... to schedule appt [appointment] [with] orthopedist this am [morning]. Medicated [with] Ibuprofen 600 mg [at] this time... "  g. A Consultation Form dated 5/3/19 and signed by the Advanced Practice Nurse documented, " ...Nurse ' s Note: C/O knee pain...HPI [history of previous illness]; Reports [left] knee pain. Fell to ground reports knee went inward & foot outward... Schedule [with] [orthopedic doctor... "  h. A Consultation Form dated 5/20/19 and signed by the Orthopedic physician documented, " ... Results of Examination: Effusion, medial joint tenderness + [plus] McMurray sign Diagnosis: Possible left medial meniscus tear... "	N 196			





**Division of Provider Services and Quality Assurance**  
**Office of Long Term Care**  
PO Box 8059, Slot S404  
Little Rock, AR 72203-8059  
Fax: 501-682-6159



June 24, 2019

Nathan Chennault, Administrator  
Millcreek Of Arkansas  
1810 Industrial Drive  
Fordyce, AR 71742

Dear Mr. Chennault :

On June 4, 2019, we conducted a recertification and complaint investigation 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 17, 2019.

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 at (501)320-6182.

Sincerely,

*Rodney Reper for*  
Sandra Broughton, Reviewer  
Survey & Certification Section  
Office of Long Term Care

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**Division of Provider Services and Quality Assurance**  
**Office of Long Term Care**  
PO Box 8059, Slot S404  
Little Rock, AR 72203-8059  
Fax: 501-682-6159



July 23, 2019

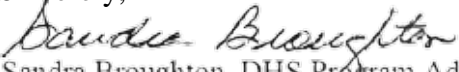
Nathan Chennault , Administrator  
Millcreek Of Arkansas  
1810 Industrial Drive  
Fordyce, AR 71742

Dear Mr. Chennault:

During the revisit conducted on July 23, 2019, your facility was found to be in compliance with program requirements. Your certification remains in effect unless terminated due to non-compliance with program requirements or voluntary withdrawal from the program. **A CMS 2567 is enclosed, indicating your facility's compliance status. Please sign and date the 2567 and fax to Sandra Broughton at (501) 682-6159 or email to Sandra.Broughton@dhs.arkansas.gov as soon as possible.**

If you have any questions please contact your reviewer at 501-320-6182.

Sincerely,

  
Sandra Broughton, DHS Program Administrator  
Office of Long Term Care  
Survey and Certification Section

sgb

cc: file

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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{N 000}	<p>Initial Comments</p> <p>Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.</p> <p>A revisit was conducted on July 23, 2019 for all deficiencies cited on June 4, 2019. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.</p>	{N 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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