



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 23, 2021

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

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Dear Mr. Kuchinski:

On May 11, 2021, a Complaint survey was conducted at your facility by the Office of Long Term Care to determine compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid program(s). This survey found your facility was not in substantial compliance with participation requirements. Please refer to our letter, dated May 20, 2021

A revisit was conducted on June 17, 2021, and your facility was still not in substantial compliance with the following participation requirement(s):

CFR 483.358(d) Orders for Use of Restraint or Seclusion CFR 483.358(e) Orders for Use of Restraint or Seclusion CFR 483.358(i) Orders for Use of Restraint or Seclusion CFR 483.362(c) Monitoring During and After Restraint

Plan of Correction (PoC)

A Plan of Correction (PoC) for the cited deficiencies must be submitted within 10 calendar days of receipt of this letter to:

, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
(501) 320-6182
email to Sandra.Broughton@dhs.arkansas.gov.

A revisit will be authorized after an acceptable PoC is received. A completion date for each deficiency cited must be included. Your Plan of Correction must also include the following:

- 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- 2. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system. At the revisit, the quality assurance plan is reviewed to determine the earliest date of compliance. If there is no evidence of quality assurance being implemented, the earliest correction date will be the date of the revisit; and
- 5. 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 and Human Services 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 concerning this letter, please contact your reviewer.

Sincerely,

Saudie Busieften Administrative Services Manager

DPSQA/Office of Long Term Care Survey & Certification Section

sgb

cc: DRA

PRINTED: 06/23/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	COM	E SURVEY PLETED
		04L101	B. WING _			R-C 5/ 17/2021
	ROVIDER OR SUPPLIER FOR YOUTH AND FAM	ILIES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 12TH STREET LITTLE ROCK, AR 72225	1 00	71772021
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{N 000}	is an official, legal do remain unchanged e correction, correction space. Any discrepal citation(s) will be rep Office (RO) for referr Inspector General (C information is inadve	7 (Statement of Deficiencies) ocument. All information must except for entering the plan of a dates, and the signature ency in the original deficiency orted to the Dallas Regional al to the Office of the DIG) for possible fraud. If rently changed by the estate Survey Agency (SA) mediately.	{N 00	00}		
N 143	Subpart G - Condition Psychiatric Residentic ORDERS FOR USE SECLUSION CFR(s): 483.358(d) If the order for restrative verbal order must be nurse or other license practical nurse, while intervention is being immediately after the ends. The physician permitted by the statement of the physician or other permitted by the statement of the physician or other permitted by the statement of the physician or other permitted by the statement of the permitted by the permit	of RESTRAINT OR int or seclusion is verbal, the received by a registered ed staff such as a licensed the emergency safety	N 1	43		
ARODATORY		SLIPPLIER REPRESENTATIVE'S SIGNATUR	=	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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED R-C		
		04L101	B. WING _			K-C 6/17/2021	
	ROVIDER OR SUPPLIER FOR YOUTH AND FAM	MILIES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 12TH STREET LITTLE ROCK, AR 72225		3/11/2021	
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N 143	-	ge 1 ency safety intervention.	N 1	43			
	Based on record re failed to ensure a ph the times of a restra client (Client #2) by restraint during the i	not met as evidenced by: view and interview, the facility hysician order was obtained at int the safety of one sample not obtaining an order for a restraint (a type of Emergency or immediately after the					
		oses of Disruptive Mood der and Disruptive Impulse tt Disorder.					
		afety Intervention (ESI) form d not document a physician'					
	Clinical Director was physician's order for	10:34 am, the Assistant saked if there was a the ESI on Client #2 on sked at the electronic medical tated, "No."					
	from the Assistant C "This should include documentation on the and the log." The pointerventions" docur available to order the 'IM' (intramuscular in	Interventions" was received clinical Director. She stated, the information on the ESI from, physician orders, blicy "Emergency Safety mented, "If the physician is not the use of physical holding or onjection or shot) in writing, the order must be obtained by a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, a Boile	_		R.	-C
		04L101	B. WING			06/	17/2021
	ROVIDER OR SUPPLIER FOR YOUTH AND FAMIL	LIES INC		6	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
N 143	the verbal/telephone section of the client re	d by staff. The nurse writes order in Physician's Order ecord"		143			
{N 144}	section of the client record" ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(e) Each order for restraint or seclusion must: (1) Be limited to no longer than the duration of the emergency safety situation; and (2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9. This ELEMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a physician's order was documented for 2 (Client #1 and #2) of 4 (Client #1, #2, #3 and #4) sampled clients who required an Emergency Safety Intervention. The findings are: 1Client #1 was admitted on 6/16/21 and had diagnoses Disruptive Mood Dysregulation		{N 1	44}			
	Form, dated 6/11/202 Restraints."Time Ini Time Ended: 1615 [4: 1647 [4:47 p.m.] Time p.m.]Time Initiated:	1710 [5:10 p.m.] Time m.]Time Initiated: 1724 ed: 1726 [5:26 p.m.]					

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '		(X3) DATE SURVEY COMPLETED R-C
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	MILIES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 12TH STREET LITTLE ROCK, AR 72225	1 00/11/2021
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION
Benadryl 25 mg (mi There was no docur Benadryl injection. b. A Physician's ord documented, "Init approved Emergence following behaviors others: 06/11/2121 kicking multiple staff student belongings Restraint: CPI Seatt restraints 1613 [4:12 [4:47 p.m.]-1648 [4:54 p.m.]-1654 [4:54 p.m.]-1654 [4:54 p.m.]-1654 [4:54 p.m.] medication: Medication: Medication: Medication: Medication in text be [now] Date: 06/11 was no other physician use. c. On 6/16/21 at 2: Director was asked for each restraint the She stated, "No, the doctor's order for each received from Director on 6/16/21 "If the physician is of physical holding of physical holding of the stated of the stated of the physician is of physical holding of the stated of the physician is of physical holding of the stated of the physician is of physical holding of the physical physi	lligram) IM STAT (now)" mented time of the IM der, dated 6/11/21, iate the following agency cy Safety Interventions for the that are dangerous to self or student was hitting and if, also destroying fellow as well as the dorm. Personal ed Medium Position multiple 3 p.m.]-1615 [4:15 p.m.]; 1647 48 p.m.]; 1649 [4:49 m.]; 1710 [5:10 p.m.]-1715 :24 p.m.]-1726 [5:26 p.m.]. I Time for Personal Restraint: er restraint PRN [as needed] tion Injection: (Include ox) Benadryl IM 25 mg STAT //2021, Time: 9:57 pm." There cian's orders documented for traint and emergency 19 p.m. the Assistant Clinical at many series and the series are should have been a ach time." regency Safety Interventions in the Assistant Clinical at 1:04 p.m., documented, is not available to order the use or "IM" in writing, the	{N 144		
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF SUMMARY S) (EACH DEFICIEN	ACORRECTION O4L101 ROVIDER OR SUPPLIER S FOR YOUTH AND FAMILIES INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Benadryl 25 mg (milligram) IM STAT (now)" There was no documented time of the IM Benadryl injection. b. A Physician's order, dated 6/11/21, documented, "Initiate the following agency approved Emergency Safety Interventions for the following behaviors that are dangerous to self or others: 06/11/2121 student was hitting and kicking multiple staff, also destroying fellow student belongings as well as the dorm. Personal Restraint: CPI Seated Medium Position multiple restraints 1613 [4:13 p.m.]-1615 [4:15 p.m.]; 1647 [4:47 p.m.]-1648 [4:48 p.m.]; 1649 [4:49 p.m.]-1654 [4:54 p.m.]; 1710 [5:10 p.m.]-1715 [5:15 p.m.]; 1724 [5:24 p.m.]-1726 [5:26 p.m.]. Maximum Approved Time for Personal Restraint: 10 min (minutes) per restraint PRN [as needed] Medication: Medication Injection: (Include medication in text box) Benadryl IM 25 mg STAT [now] Date: 06/11/2021, Time: 9:57 pm." There was no other physician's orders documented for the use of each restraint and emergency	ROVIDER OR SUPPLIER SERVING THE REGULATORY OR LSC IDENTIFICATION NUMBER: BEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Benadryl 25 mg (milligram) IM STAT (now)" There was no documented time of the IM Benadryl injection. b. A Physician's order, dated 6/11/21, documented, "Initiate the following agency approved Emergency Safety Interventions for the following behaviors that are dangerous to self or others: 06/11/2121 student was hitting and kicking multiple staff, also destroying fellow student belongings as well as the dorm. Personal Restraint: CPI Seated Medium Position multiple restraints 1613 [4:39 p.m.]-1615 [4:45 p.m.]; 1647 [4:47 p.m.]-1648 [4:48 p.m.]; 1649 [4:49 p.m.]-1755 [5:15 p.m.]; 1724 [5:24 p.m.]-1726 [5:26 p.m.]. Maximum Approved Time for Personal Restraint: 10 min (minutes) per restraint PRN [as needed] Medication: Medication Injection: (Include medication in text box) Benadryl IM 25 mg STAT [now] Date: 06/11/2021, Time: 9:57 pm." There was no other physician's orders documented for the use of each restraint that was used on 6/11/2021?" She stated, "No, there should have been a doctor's order for each time." d. The facility Emergency Safety Interventions policy, received from the Assistant Clinical Director was asked, "Is there a physician's order for each restraint that was used on 6/11/2021?" She stated, "No, there should have been a doctor's order for each time." d. The facility Emergency Safety Interventions policy, received from the Assistant Clinical Director on 6/16/21 at 1:04 p.m., documented, "If the physician is not available to order the use of physical holding or "IM" in writing, the physician's verbal order must be obtained by a nurse at the time the emergency safety	ROWIDER OR SUPPLIER B FOR YOUTH AND FAMILIES INC SUMMARY STATEMENT OF DEFICIENCIES (#ACH OFFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Benadryl 25 mg (milligram) IM STAT (now)" There was no documented time of the IM Benadryl injection. b. A Physician's order, dated 6/11/21, documented, "Initiate the following agency approved Emergency Safety Interventions for the following behaviors that are dangerous to self or others: 06/11/212 student was hitting and kicking multiple staff, also destroying fellow student belongings as well as the dorm. Personal Restraint: CPI Seated Medium Position multiple restraints 1613 [4:13 p.m.]-1615 [4:15 p.m.]-1715 [5:15 p.m.]; 1724 [5:24 p.m.]-1726 [5:26 p.m.]. Maximum Approved Time for Personal Restraint: 10 min (minutes) per restraint PRN [as needed] Medication: Medication Injection: (Include medication in text box) Benadryl IM 25 mg STAT [now] Date: 06/11/2021, Time: 9:57 pm." There was no other physician's orders documented for the use of each restraint and emergency medication use. c. On 6/16/21 at 2:19 p.m. the Assistant Clinical Director was asked, "Is there a physician's order for each restraint that was used on 6/11/2021?" She stated, "No, there should have been a doctor's order for each restraint that was used on 6/11/2021?" She stated, "No, there should have been a doctor's order for each restraint that was used on 6/11/2021?" She stated, "No, there should have been a doctor's order for each restraint that was used on 6/11/2021?" She stated, "No, there should have been a doctor's order for each restraint that was used on 6/11/2021?" She stated, "No, there should have been a doctor's order for each restraint that was used on 6/11/2021?" She stated, "No, there should have been a doctor's order for each restraint that was used on 6/11/2021?" She stated, "No, there should have been a doctor's order for each restraint that was used on 6/11/2021?" She stated, "No, there should have been a doctor's ord

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER FOR YOUTH AND FAMIL	LIES INC		6	STREET ADDRESS, CITY, STATE, ZIP CODE S501 W 12TH STREET LITTLE ROCK, AR 72225		
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{N 144}	and indicates: a. the cobtained; b. the name order; c. the specific contervention(s) ordere length of time authorize combined total of 30 magnetic programment in the process of the second and the secon	chone order in the cition of the client's record date and time the order was a of the physician issuing the emergency safety dincluding the maximum zed for use (not to exceed a minutes per order); d. e of the interventions;C. ectable Medication: A client idential programs may be ar (IM) injectable medication circumstances, in dard and accepted for the underlying medical on for which the patient is accordance with the A physician's order must be inistration" DF RESTRAINT OR Intain a record of each unation, the interventions mes It met as evidenced by: I we and interview the facility mergency Safety orm was completed for each client #1 and #2) of 4 (Client ampled clients who required the facility failed to ensure ye log of all restraints	{N 1	,			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMIL	LIES INC	6501 W 12TH STREET				
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{N 155}		Mood Dysregulation n-deficit/hyperactivity fety Intervention Reporting	{N 1	55}			
	Restraints Time Init Ended: 1615 [4:15 p.I [4:47 p.m.] Time Ende Initiated: 1710 [5:10 p [5:15 p.m.] Time Init Time Ended: 1726 [5: Medication IM [intram [milligram] IM STAT [r documented time of the	11, documented, "Multiple iated: 1613 [4:13 p.m.] Time m.] Time Initiated: 1647 ed: 1654 [4:54 p.m.]Time b.m.] Time Ended: 1715 tiated: 1724 [5:24 p.m.] 26 p.m.] Emergency suscular] Benadryl 25 mg mow]" There was no he IM Benadryl injection. ency Safety Intervention ed for each of the personal nical restraint.					
	Director was asked, ". [Client #1] on 6/11 on Intervention) log?" SI have been on the log.	55 a.m. the Assistant Clinical Are the restraints/holds for the ESI (Emergency Safety he stated, "No, they should , but I don't see them."					
	Director was asked, "Safety Intervention) redocumented 1724 [5:: a restraint?" She stathow I would read that just not clear." The Awas asked, "At 1724 m.] what happened? the restraint?" She stath to the Intervention of the Int	On the ESI (Emergency eport for 6/11/21, is the time 24 p.m.] to 1726 [5:26 p.m.] ted, "I would say yes, that's sif I was reading that. It's essistant Clinical Director [5:24 p.m.] to 1726 [5:26 p. What behaviors warranted tated, "My assumption would Benadryl injection." The ector was asked, "Can you ecifies the second restraint She stated, "No, it's not					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		04L101	B. WING			06/	17/2021
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{N 155}	"What about the cher "You just have to assibut it doesn't specify. clearly." The Assistar asked, "Should there (Emergency Safety Ir stated, "Yes." d. The facility Emerg policy, received from Director on 6/16/21 at "P. Documentation of am emergency saff documented on the E	Clinical Director was asked, nical restraint?" She stated, ume the behavior continued, It's not documented nt Clinical Director was have been separate ESI ntervention) reports?" She ency Safety Interventions the Assistant Clinical t 1:04 p.m. documented, Requirements 1. The use ety intervention is clearly imergency Safety ng form by the staff who	{N 1	55}			
	Dysregulation Disorde Control and Conduct a. A facility log of ESI 06/14/2021 was received Clinical Director. It did done on June 11, 202 b. An ESI report date the use of a restraint. c. On 06/16/2021 at 1 Clinical Director was an ESI on 06/11/2021 was then asked, "Is it log was shown to her	s dated from 03/25/2021 to lived from the Assistant d not include any ESIs being 21 for Client #2.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		04L101	B. WING				-C 17/2021
	ROVIDER OR SUPPLIER FOR YOUTH AND FAMI	LIES INC		6	STREET ADDRESS, CITY, STATE, ZIP CODE 6501 W 12TH STREET LITTLE ROCK, AR 72225		
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{N 155}	showing a log of the 0 and any policies regallog. d. On 06/16/2021 at 1	usked to bring any paperwork 06/11/2021 ESI for Client #2 ording maintaining an ESI 1:04 pm, the policy	{N 1	55}			
	from the Assistant Cli "This should include t documentation on the and the log." A review	nterventions" was received inical Director. She stated, the information on ESI from, physician orders, of the policy did not find rding log documentation.					
{N 167}		nich included the ESI for 121 was received from the NG AND AFTER	{N 1	67}			
	the resident's well-be emergency safety into	licensed practitioner e and the facility to evaluate ing and trained in the use of erventions, must evaluate ing immediately after the					
	Based on record revi failed to ensure an as	required the use of a					
	Client #1 was admitted diagnoses Disruptive	ed on 6/16/21 and had Mood Dysregulation					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY COMPLETED
		04L101	B. WING _			R-C 06/17/2021
	ROVIDER OR SUPPLIER FOR YOUTH AND FAMI			STREET ADDRESS, CITY, STATE, ZIP COL 6501 W 12TH STREET LITTLE ROCK, AR 72225	I	00/11//2021
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{N 167}	a. An Emergency Sa Form, dated 6/11/202 Restraints."Time In Time Ended: 1615 [4 1647 [4:47 p.m.] Time p.m.]Time Initiated: Ended: 1715 [5:15 p. [5:24 p.m.] Time End p.m.]Emergency M. Benadryl 25 mg [milli [now]Nursing Evalu Removal from Proceop.m.]" There was no record of a nursing as immediately after the 4:14 p.m., 5:15 p.m. ab. On 6/16/21 at 2:19 Director was asked, "nursing evaluation af discontinued at 1615 "No ma'am." The Asasked, "After the rest 1726 (5:26 p.m.)?" Seen re-evaluated." Director was asked, "of [Client #1] being evaluation ended to the saked of the sak	in-deficit/hyperactivity Infety Intervention Reporting 21, documented, "Multiple itiated: 1613 [4:13 p.m.] :15 p.m.]Time Initiated: the Ended: 1654 [4:54 1710 [5:10 p.m.] Time the Initiated: 1724 the Intervention Intervention Intervention the Intervention Intervention the I	{N 16	57}		





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

July 8, 2021

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

Dear Mr. Kuchinski:

On June 17, 2021, we conducted a revisit 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 July 17, 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,

DPSQA/Office of Long Term Care

Saudie Biseighten Administrative Services Manager

Survey & Certification Section

sgb

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED 06/23/2021 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			ОМЕ	NO 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		04L101	B WING _			R-C 06/17/2021
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP (ODE	
CENTERS	FOR YOUTH AND FAM	I IEC INC		6501 W 12TH STREET		
CENTENS	TORTOUTHANDIAW	LIEO MG		LITTLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFID TAG	PROMDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO " DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE
{ N 000}	Initial Comments		{N 0	00}		
	is an official, legal do remain unchanged e correction, correction space, Any discrepal citation(s) will be rep Office (RO) for referr Inspector General (C information is inadve	IG) for possible fraud If rtently changed by the State Survey Agency (SA)				
N 143	Subpart G - Condition Psychiatric Residenti ORDERS FOR USE SECLUSION CFR(s): 483.358(d) If the order for restrative verbal order must be nurse or other license practical nurse, while intervention is being immediately after the ends. The physician permitted by the statement or seclusion in a signed written food The physician or other permitted by the statement or seclusion in the permitted by the statement or seclusion in seclusion or other permitted by the statement or seclusion in the per	of RESTRAINT OR int or seclusion is verbal, the received by a registered ed staff such as a licensed the emergency safety	N 1	A training document has be the Assistant Clinical Direct educate nursing staff regar requirements for obtaining physician in a timely manne Emergency Safety Intervent initiated, documenting their duration of the hold allowed the order both on the ESI for Electronic Medical Record there should be separate the separate ESI forms completed. This training document is bouith all nursing staff by the Managers. Failure to comprequirement of the ESI prodisciplinary action with nursithe Nurse Managers.	tor to further ding the orders from the er when an ation (ESI) is maximum d, documenting orm and in the (EMR), and that rders and atted for separate at on 7/2/21. eing reviewed Nurse oly with this cess will result in	7/17/21

xxxxtant 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 disclosuble 90 days. following the date of survey whether or not a pian of correction is provided. For nursing homes, the above findings and pians 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

LABORATORY DIRECTOR'S OR PROMODER BUPPLIER REPRESENTATIVE'S SIGNATURE

linical

TITLE

PRINTED: 06/23/2021 FORM APPROVED OMB NO: 0938-0391

	CONTRACTOR CONTRACTOR	MEDIOMID OLIVICEO				CIVID INC. 00	00-0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURV COMPLETE	
		041404	8 WING			R-C	
***************************************		04L101	6 WING			06/17/2	021
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
en er a c 70- er en en	T/25 1/2017 4 1/15 5 1 1 1 1			65	01 W 12TH STREET		
CENIERS	FOR YOUTH AND FAMI	LIES INC		LI	TTLE ROCK, AR 72225		
	Chissasa Divicit	ATCMENT OF PREMIER		L			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI, LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)		(X5) MPLETION DATE
N 143 Continued From page 1		s 1	N	143	The Assistant Clinical Director has init	ated	
	period of the emergency safety intervention.		1.4	140	daily review of ESI forms in residential programs and is giving feedback regardany deficiencies in this area to Nurse		
	Based on record rev failed to ensure a phy the times of a restrain client (Client #2) by n restraint during the re	of met as evidenced by: iew and interview, the facility ysician order was obtained at not the safety of one sample not obtaining an order for a estraint (a type of Emergency or immediately after the	Manag / t		Management.	,	
	The findings are:						
		ses of Disruptive Mood er and Disruptive Impulse Disorder.					
		fety Intervention (ESI) form I not document a physician'					
	Clinical Director was physician's order for	the ESI on Client #2 on ked at the electronic medical					
	from the Assistant Ci "This should include documentation on the and the log." The pol Interventions" docum available to order the "IM" (intramuscular in	nterventions" was received inical Director. She stated,					

nurse at the time the emergency safety

C/C/17/C/10/10/11/10/11/05/05/1	F \ L (>	MEDICAID SCHAIGES				CIME IAC 0000.000:
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IX I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
						R-C
		04L101	8 WING		wyywywy dawladau madala dawlada	06/17/2021
NAME OF PROVIDER OR SUPPLIF		LIES INC		65	REET ADDRESS, CITY, STATE, ZIP CODE 801 W 12TH STREET ITTLE ROCK, AR 72225	•
PREFIX (EACH DEF	ICIENC	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 APPROPRIA DEFICIENCY)	
	nitiate	e 2 d by staff. The nurse writes order in Physician's Order	N	143		
section of the control (N 144) ORDERS FOR SECLUSION CFR(s): 483.35 Each order for (1) Be limited the emergency (2) Under not residents ages ages 9 to 19. This ELEMENT Based on reconfailed to ensure documented for #1, #2, #3 and an Emergency are: 1Client #1 was diagnoses Distributed Disorder and Adisorder. a. An Emerger Form, dated 6/ Restraints "T Time Ended: 111647 [4:47 p.m. p.m.]Time Initended: 1715 [5]	lient ru USE 8(e) restrai f to no safety circuit 18 to 7; or 1 is no rd rev 2 a phy 2 (CI #4) sa safety admit uptive titentio ncy Sa 11/202 me In 615 [4 .] Tim tiated: :15 p.	ocord" OF RESTRAINT OR Int or seclusion must:	{N .	:	A training document has been develop the Assistant Clinical Director to further educate nursing staff regarding the requirements for obtaining orders from physician in a timely manner when an Emergency Safety Intervention (ESI) is initiated, documenting the maximum duof the hold allowed, documenting order emergency medications, documenting orders both on the ESI form and in the Electronic Medical Record (EMR), and separate ESI forms completed for sepa holds. This was completed for sepa holds. This was completed on 7/2/2/2 This training document is being review with all nursing staff by the Nurse Mana Failure to comply with this requirement ESI process will result in disciplinary ac with nursing staff from the Nurse Mana. The Assistant Clinical Director has initially review of ESI forms in residential programs and is giving feedback regardany deficiencies in this area to Nurse Management.	the diration so for the that dirate 1. ed agers. of the strongers. ated

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L101	B WING		R-C 06/17/2021
	ROVIDER OR SUPPLIER FOR YOUTH AND FAM	LIES INC		STREET ADDRESS, CITY, STATE ZIP CODE 6501 W 12TH STREET LITTLE ROCK, AR 72225	(00,117,202)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFI TAG		HOULD BE COMPLETION
{N 144}	There was no docum Benadryl injection. b. A Physician's ordedocumented, "Initial approved Emergency following behaviors to others: 06/11/2121 skicking multiple staff, student belongings a Restraint: CPI Seate restraints 1613 [4:13 [4:47 p.m.]-1648 [4:4 p.m.]-1654 [4:54 p.m.] 1724 [5:2 Maximum Approved 10 min (minutes) per Medication: Medicati medication in text bo [now] Date: 06/11/2 was no other physici the use of each restraint tha She stated, "No, there doctor's order for each of the facility Emergication of 6/16/21 at 21 Director was asked, for each restraint that She stated, "No, there doctor's order for each of 16/21 at 21 Director was asked, for each restraint that She stated, "No, there doctor's order for each of 16/21 at 21 Director of 16/16/21 at 21	er, dated 6/11/21, the the following agency y Safety Interventions for the hat are dangerous to self or student was hitting and also destroying fellow s well as the dorm. Personal d Medium Position multiple p.m.]-1615 [4:15 p.m.]; 1647 8 p.m.]; 1649 [4:49 -]; 1710 [5:10 p.m.]-1715 24 p.m.]-1726 [5:26 p.m.]. Time for Personal Restraint: restraint PRN [as needed] on Injection: (Include x) Benadryl IM 25 mg STAT 2021, Time: 9:57 pm." There an's orders documented for aint and emergency 9 p.m. the Assistant Clinical "Is there a physician's order t was used on 6/11/2021?" re should have been a ch time." gency Safety Interventions the Assistant Clinical at 1:04 p.m., documented,	{N ·	144)	
	of physical holding o physician's verbal or nurse at the time the	der must be obtained by a			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A BUILDING			(X3) DATE SURVEY COMPLETED
		04L101	B WING		R-C 06/17/2021
	ROVIDER OR SUPPLIER	AILIES INC		STREET ADDRESS CITY STATE. ZIP CODE 6501 W 12TH STREET LITTLE ROCK, AR 72225	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	The state of
{N 144}	and indicates: a the obtained; b the nan order; c the specific intervention(s) orde length of time authoromatic combined total of 30 justification for the combined total of the combined in certain in given an intramuscular certain limited accordance with state treatment procedure or psychiatric conditioning treated, and infollowing policy: A. obtained prior to ad ORDERS FOR USE SECLUSION CFR(s): 483 358(i) The facility must make mergency safety sused, and their outcombined to ensure an intervention Report	ephone order in the ection of the client's record of date and time the order was the of the physician issuing the client end for use (not to exceed a community of the interventions;,C. injectable Medication: A client esidential programs may be ular (IM) injectable medication docircumstances, in andard and accepted es for the underlying medical tion for which the patient is an accordance with the A physician's order must be ministration" E OF RESTRAINT OR	{N 144		the sting SI cord ate
	#1, #2, #3, and #4) a use of a restraint. there was a cumula utilized. The finding	sampled clients who required The facility failed to ensure tive log of all restraints		on 7/2/21. This training document is b reviewed with all nursing staff by the Ni Managers. Failure to comply with this requirement of the ESI process will res disciplinary action with nursing staff fro Nurse Managers	urse ult in

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/23/2021 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			·	*	R-C
		04L101	B WING		06/17/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1. 50, () / 2023
				6501 W 12TH STREET	
CENTERS	FOR YOUTH AND FAMI	LIES INC	1	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
{N 155}	Continued From page	a 5	{N 155	The Assistant Clinical Director has in	itiated
,	diagnoses Disruptive		(14 135)	daily review of ESI forms in residentia	
		n-deficit/hyperactivity		programs and is giving feedback rega any deficiencies in this area to Nurse Management.	•
	Form, dated 6/11/202 Restraints Time Init Ended: 1615 [4:15 p. [4:47 p.m.] Time End Initiated: 1710 [5:10 p. [5:15 p.m.] Time Init Time Ended: 1726 [5 Medication IM [intram [milligram] IM STAT [documented time of t There was no Emerg Report Form complete restraints or the chen b. On 6/16/21 at 10:8 Director was asked, ' [Client #1] on 6/11 or Intervention) log?" S	afety Intervention Reporting 21, documented, "Multiple tiated: 1613 [4:13 p.m.] Time m.] Time Initiated: 1647 ed: 1654 [4:54 p.m.] Time p.m.] Time Ended: 1715 itiated: 1724 [5:24 p.m.] :26 p.m.] Emergency muscular] Benadryl 25 mg now]" There was no the IM Benadryl injection, ency Safety Intervention ted for each of the personal nical restraint.			
	Director was asked, 'Safety Intervention) r documented 1724 [5: a restraint?" She sta how I would read tha just not clear." The Awas asked, "At 1724 m.] what happened? the restraint?" She s be that would be the	P.m. the Assistant Clinical 'On the ESI (Emergency eport for 6/11/21, is the time 24 p.m.) to 1726 [5:26 p.m.] ted, "I would say yes, that's tif I was reading that. It's Assistant Clinical Director [5:24 p.m.] to 1726 [5:26 p. What behaviors warranted tated, "My assumption would Benadryl injection." The ector was asked, "Can you			

show me where it specifies the second restraint was done, initiated? She stated, "No, it's not

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/23/2021 FORM APPROVED OMB NO 0938-0391

CENTER	S FUR MEDICARE &	MEDICAID SERVICES	- No.		CIMP NO. 0930-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULT A BUILDII	TPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
					R-C
		04L101	8 WING_		06/17/2021
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY STATE, ZIP CODE	
				6501 W 12TH STREET	
CENTERS	FOR YOUTH AND FAMI	LIES INC		LITTLE ROCK, AR 72225	
				EITTE NOCK, AN 72223	
(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 CORR X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
{N 155}	Continued From page	e 6	{N 1	55}	
		t Clinical Director was asked,	•	•	
		mical restraint?" She stated,			
		ume the behavior continued,			
	but it doesn't specify.				
		nt Clinical Director was			
	asked, "Should there	have been separate ESI			
		ntervention) reports?" She			
	stated, "Yes."				
	d The facility Emero	ency Safety Interventions			
	policy, received from				
		it 1:04 p.m. documented,			
		Requirements 1. The use			
	of am emergency saf	fety intervention is clearly			
	documented on the E				
		ng form by the staff who			
	initiated the procedur	'e"			
<u> </u>					
	2. Client #2 had diag	noses of Disruptive Mood			
	Dysregulation Disord	er and Disruptive Impulse			
	Control and Conduct	Disorder.			
***************************************	a A facility lon of ES	Is dated from 03/25/2021 to			
		rived from the Assistant			
		id not include any ESIs being			
	done on June 11, 202	21 for Client #2.			
	h An Estroport data	ed 06/11/2021 documented			
***************************************	the use of a restraint.				
even even even even even even even even	c On 06/16/2021 at :	10:34 am, the Assistant			
		asked if he [Client #2] had			
		1. She stated, "Yes." She			
		t on the log?" The facility ESI			
		r at this time. She stated, No,			

but I have the paperwork on it that I can bring

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING.		(X3) DATE SURVEY COMPLETED
		04L101	a wing	Note that the second se	R-C 06/17/2021
	ROVIDER OR SUPPLIER FOR YOUTH AND FAMI	LIES INC	65	FREET ADDRESS, CITY, STATE, ZIP CODE 601 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)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{N 155}	showing a log of the and any policies regallog d. On 06/16/2021 at	usked to bring any paperwork 06/11/2021 ESI for Client #2 ording maintaining an ESI 1:04 pm, the policy	{N 155}		
	from the Assistant CI "This should include documentation on the and the log." A review	nterventions" was received inical Director. She stated, the information on a ESI from, physician orders, of the policy did not find rding log documentation.			
	•	nich included the ESI for 121 was received from the			
{N 167}	RESTRAINT CFR(s): 483.362(c) A physician, or other permitted by the state the resident's well-be	licensed practitioner e and the facility to evaluate ing and trained in the use of	(N 167)	A training document has been develop the Assistant Clinical Director regardin completion of ESI forms to include spe definitions and requirements of the timelines for completion of the evaluat of the resident immediately upon remo of a restraint. This was completed o 7/2/21. Nurse Management is review	ng ecific ion oval n
	• •	erventions, must evaluate ing immediately after the		this training with each nurse in the residential program. Failure to comply with any element of the requirements versult in disciplinary action.	1
	Based on record rev failed to ensure an as immediately after the (Client #1) of 4 (Clien	required the use of a		The Assistant Clinical Director has initiated daily review of ESI forms in residential programs and is giving feedback regarding any deficiencies in area to Nurse Management.	n this
		ed on 6/16/21 and had Mood Dysregulation			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OWR NO. 0838-0381
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
					R-C
		04L101	B WING		06/17/2021
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS CITY STATE, ZIP COD	E
CENTERS	COD VOLITH AND EARS	DIECINIC		6501 W 12TH STREET	
CENTERS	FOR YOUTH AND FAMI	LIES INC		LITTLE ROCK, AR 72225	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE COMPLETION DATE
{N 167}	Continued From page	e 8 n-deficit/hyperactivity	{N ·	167}	
	disorder.				
	Form, dated 6/11/202 Restraints."Time In Time Ended: 1615 [4 1647 [4:47 p.m.] Time p.m.]Time Initiated: Ended: 1715 [5:15 p. [5:24 p.m.] Time End p.m.]Emergency M Benadryl 25 mg [milli [now]Nursing Evalu Removal from Proce p.m.]" There was no record of a nursing a immediately after the 4:14 p.m., 5:15 p.m. b. On 6/16/21 at 2:15	: 1710 [5:10 p.m.] Time .m.]Time Initiated: 1724 led: 1726 [5:26 ledication IM [intramuscular] igram] IM STAT uation (Immediately Upon dure): Time: 1654 [4:54 documentation in the clinical ssessment of the client use of a restraints ending at and 5:26 p.m.=. 9 p.m. the Assistant Clinical "Do you see any immediate			
	discontinued at 1615 "No ma'am." The As asked, "After the rest 1726 (5:26 p m.)?" Seen re-evaluated." Director was asked, of [Client #1] being e	6 (4:15 p.m.)?" She stated, sistant Clinical Director was traint at 1715 (5:15 p.m.) and She stated, "He should have The Assistant Clinical "Is there any documentation evaluated at those times?" for that specific time."			





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

July 20, 2021

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

Dear Mr. Kuchinski:

During the Revisit survey conducted on July 19, 2021, your facility was found to be in compliance with program requirements. Please email the signed CMS 2567 Sandra.Broughton@dhs.arkansas.gov.

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

Sincerely,

DPSQA/Office of Long Term Care Survey and Certification Section

Saudie Biscifton Administrative Services Manager

sgb

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L101	B. WING			l	-C
NAME OF B		042101	B. WING	OTD	EET ADDRESS SITY STATE ZID SODE	07/	19/2021
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAM	ILIES INC			1 W 12TH STREET		
				LITT	TLE ROCK, AR 72225		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{N 000}	Initial Comments		{N 0	00}			
	is an official, legal do remain unchanged excorrection, correction space. Any discrepal citation(s) will be reproffice (RO) for referr Inspector General (Conformation is inadve provider/supplier, the should be notified im	eted on July 19, 2021 for all June 17, 2021. All en corrected, and no new found. The facility is in					
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.

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 Name					
04L101		CENTERS FOR YO	UTH	AND FAMILIES INC			
Type of Survey (select all that apply)	B D C Fe	Complaint Investigation Dumping Investigation Tederal Monitoring Tollow-up Visit Other	E F G H	Initial Certification Inspection of Care Validation Life Safety Code	I J K L	Recertification Sanctions/Hearing State License CHOW	
Extent of Survey (select all that apply)	B Exter C Partic	tine/Standard Survey (all provide nded Survey (HHA or Long Terr al Extended Survey (HHA) er 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. 2. (6), (b) (7) 3.	06/16/2021 06/16/2021	06/17/2021 06/17/2021	0.50 0.50	0.00	12.50 12.50	0.00 0.00	5.00 1.50	5.50 3.00
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.				_		_		
13.								
14.								

-						
Total SA Supervisory Review Hours	1.00)	Total RO Super	visory Review Ho	urs	0.00
Total SA Clerical/Data Entry Hours	0.50)	Total RO Clerio	cal/Data Entry Hou	rs	0.00

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

FORM CMS-670 (12-91) $_{102000}$ EventID: $_{B60C12}$ Facility ID: $_{3000}$ Page

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 Nar	ne		
04L101	CENTERS FOR YO	OUTH AND FAMILIES INC		
Type of Survey (select all that apply)	A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit M Other	E Initial CertificationF Inspection of CareG ValidationH Life Safety Code	I J K L	Recertification Sanctions/Hearing State License CHOW
Extent of Survey (select all that apply)	A Routine/Standard Survey (all provid B Extended Survey (HHA or Long Ter 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)
1. o)(6), (b) (7)	07/19/2021	07/19/2021	0.50	0.00	4.50	0.00	3.00	1.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours	0.25	Total RO Supervisory Review Hours	0.00
Total SA Clerical/Data Entry Hours	0.25	Total RO Clerical/Data Entry Hours	0.00

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

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