



**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 11, 2019

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

**IMPORTANT NOTICE - PLEASE READ CAREFULLY**

Dear Mr. Chennault:

On June 4, 2019, a Validation 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 June 7, 2019.

A Complaint survey was conducted on June 28, 2019, and your facility was still not in substantial compliance with the following participation requirement(s):

**483.356(a)(3) Protection of Residents**

**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:

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  
e-mail to Rodney.Raper@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.

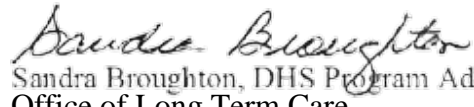
An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

**Please submit your request to:**

**Fax (501) 661-2165**  
**Becky Bennett, Director**  
**Health Facility Services**  
**Arkansas Department of Health**  
**5800 W 10th Street,**  
**Suite 400**  
**Little Rock, AR 72204**  
**Phone (501) 661-2201**

If you have any questions concerning this letter, please contact your reviewer.

Sincerely,



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

sgb

cc: DRC  
file

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

PRINTED: 07/11/2019  
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>06/28/2019</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	
N 000	Initial Comments  Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.  The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000			
N 128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3)  Restraint or seclusion must not result in harm or injury to the resident and must be used only-  This ELEMENT is not met as evidenced by: Complaint #AR00023153 was substantiated, all or in part, with these findings:  Based on observation, record review and interview, the facility failed to ensure a client that was placed in a physical restraint did not sustain an injury for 1 of 1 (Resident #1) sampled client who was physically restrained. The findings are:  Client #1 was admitted on 6/24/19 and had	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.

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>06/28/2019</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	
N 128	<p>Continued From page 1</p> <p>diagnoses Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation; Disinhibited Attachment Disorder of Childhood; and Conduct Disorders.</p> <p>a. A Social History Prior to Admission to MOA [Millcreek of Arkansas] updated 6/21/19 documented, "...He is having escalating verbal and physical aggression. During the past week, the patient has attacked multiple staff members and his therapist. He threatened to kill the nurse practitioner on the day of admission. He was placed in a hold due to escalating aggression. He attacked his therapist and mother on the day of admission in the office..."</p> <p>b. OLTC (Office of Long Term Care) Incident And Accident Report, dated 6/25/19 at 8:40 p.m., documented, "...Location: [Home] Hallway: On 6/25/19 [Resident #1] was provoking peers and being non-compliant to staff directives. [Resident #1] was directed multiple times to stop. [Resident #1] then became physically aggressive towards staff by punching/kicking and throwing his shoes directly at staff. Staff separated from [Resident #1]. [Resident #1] continued to be aggressive and target staff. Nurse and supervisor notified. [Resident #1] was placed in a physical restraint for safety of self and others. During the physical restraint patient continued to display strong aggression and resistance by lifting his upper body off the floor. [Resident #1] also refused to comply to any directives given by the nurse and supervisor. Nursing Evaluation: Per [LPN (Licensed Practical Nurse) #1]: bruising and redness to right shoulder petechiae to right leg and redness to right leg. ROM [Range-of-motion] to right shoulder. Sent to [Hospital] for evaluation. [Staff #1] was located on right</p>	N 128			

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>06/28/2019</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	
N 128	<p>Continued From page 2</p> <p>shoulder where patient was badly bruised."</p> <p>c. Nurse's Note, dated 6/25/19 at 4:46 p.m., documented, "Pt [patient] may be placed in a physical restraint not to exceed 20 minutes d/t [due to] physical aggression towards staff and refusing to calm. While in physical restraint pt refused to calm and tried to remove self from restraint and attempting to bite staff. Pt was able to calm on own and was released at 1656 [4:56 p.m.] When nurse walked into hall, pt was already in supine 3 man tci [Therapeutic Crisis Intervention] hold. After pt was released bruising and redness were noted to R [right] shoulder, petechiae noted to R [right] leg and redness noted to R leg. Pt rates pain 10/10 [ten of ten] and has no ROM [range-of-motion] to R [right] shoulder and refuses to move it. Full ROM noted to all other extremities. Pt declines ice pack and declines pain meds [medications] @ [at] this time. (1719) [5:19 p.m.] pt being sent to ER [emergency room] for evaluation of pain to R shoulder..."</p> <p>d. On 6/28/19 at 2:14 p.m., RN (Registered Nurse) #1 and LPN #1 were asked, "Can you tell me what happened when [Resident #1] was restrained?" [LPN #1] stated, "They called a code green and when we got down there he was already in the three man restraint." [RN #1] stated, "We could hear him hollering, let me up, let me up, I'll be good. Then I bent down and said you need to calm down and count to ten. Then he started to try to count to ten and started to bite one of them and I told him don't bite, don't bite." RN #1 and LPN #1 were asked, "Was he fighting?" LPN #1 stated, "He was trying to come up with his body and his legs were coming out of the restraint, so just kinda wiggle wormed." RN</p>	N 128			

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

PRINTED: 07/11/2019  
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>06/28/2019</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	
N 128	<p>Continued From page 3</p> <p>#1 and LPN #1 were asked, "Is bruising normal during a restraint?" LPN #1 stated, "You can get some bruising right there in the crease [indicating crease between the junction of the upper arm and shoulder], that is pretty normal, but not to that extent." Both RN #1 and LPN #1 stated, "Not to that extent." RN #1 and LPN #1 were asked, "Was it caused by undo pressure on his shoulder?" LPN #1 stated, "Yeah, I never seen a restraint look like that."</p> <p>e. On 6/28/19 at 2:24 p.m., Resident #1 was asked, "Can you tell me what happened when you were restrained?" Resident #1 stated, "Do you want to see my bruises?" Resident #1 had on shorts and he pointed out a penny size, fading, light brown bruise on the upper right thigh. Resident #1 moved the neck of his t-shirt down exposing the right shoulder where a fading brown, green and yellow bruise, approximately 3 inches in width and 4 to 5 inches in length was observed. The Surveyor stated, "That's a pretty good bruise." Resident #5 stated, "Yeah, that's where they were holding me down. They kept pushing harder and harder, then the nurse told me to count to ten and they pushed down harder. I tried to bite them." Resident #1 was asked, "Were you trying to get out of the restraint?" He stated, "Yeah, when they were pushing down so hard, it was hurting."</p>	N 128			



**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

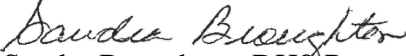
Dear Mr. Chennault:

On June 28, 2019, 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 July 22, 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,

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

sgb





**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,

A handwritten signature in cursive that reads "Sandra Broughton".

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

sgb

cc: file

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

PRINTED: 07/23/2019  
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>R-C</b> <b>07/23/2019</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	
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 a deficiency cited on June 28, 2019. The deficiency has 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.