



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

August 27, 2021

Craig Gammon, Administrator United Methodist Childrens Home 2002 S. Fillmore St. Little Rock, AR 72214-4848

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Dear Mr. Gammon:

On August 13, 2021, the Office of Long Term Care conducted a Complaint Investigation survey to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid (Title XIX) Program. The survey determined that your facility was not in compliance with the Condition of Participation for Restraint and Seclusion and that your facility had deficiencies requiring correction/substantial correction prior to a revisit as specified in the attached CMS-2567.

The CMS 2567 "Statement of Deficiencies and Plan of Correction" with all deficiencies identified during the Complaint Investigation survey on August 13, 2021 is enclosed.

Plan of Correction

A Plan of Correction (PoC) must be submitted witin ten (10) calendar days of receipt of the Statement of Deficiencies. A revisit will be authorized after an acceptable PoC is received. The PoC must be faxed to:

Sandra Broughton, 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@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 a 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 deficiency 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

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

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

Sincerely,

RN Manager

DPSQA/Office of Long Term Care Survey & Certification Section

Smande mosmith

sgb

cc: DRA





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

September 8, 2021

Craig Gammon, Administrator United Methodist Childrens Home 2002 S Fillmore St Little Rock, AR 72214-4848

Dear Mr.. Gammon:

On August 13, 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 September 15, 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,

Administrative Services Manager
DPSQA/Office of Long Term Care

Survey & Certification Section

sgb

Approved 09/08/2021 SGB

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

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 08/13/2021
	ROVIDER OR SUPPLIER	IS HOME		STREET ADDRESS, CITY, STATE, ZIP 2002 S FILLMORE ST LITTLE ROCK, AR 72214	CODE	00/10/2021
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N 000	is an official, legal of remain unchanged correction, corrections space. Any discrepacitation(s) will be recoffice (RO) for refe Inspector General (information is inadvivolar/supplier, the should be notified in The facility was not Subpart G - Condit Psychiatric Resider Complaint AR00026 in part, with deficier N129, N131, N140. Complaint AR00026 in part, with deficier N130, N131, N140, Complaint AR00026	in compliance with §483, tions of Participation for ntial Treatment Center. 6923 was substantiated, all or ncies cited at N100, N126, and N142. 6924 was substantiated, all or ncies cited at N126, N129, N142, N170, N188 and N189.	N C			
	N140, N188 and N2 Complaint AR00026 in part, with deficier N131, N142 and N2 Complaint AR00026 in part, with deficier	6926 was substantiated, all or ncies cited at N126, N129,				
ABORATORY	 DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	 RE	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

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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N 000	Continued From page	÷1	N (000			
	Complaint AR000269	34 was substantiated, all or			This deficiecy has the potential to impact all clients so the following ac	tions will be	
	in part, with deficienci	es cited at N126 and N129.			This deficiecy has the potential to impact all clients so the following ac completed and pertain to staff actions toward all clients. All existing di at the RTC will complete training on the appropriate use of restraint/se in terms of practicing techniques, but with regard to which techniques when to use restraint/seclusion or not use it and the emphasis on avoin whenever possible. This will be conducted by the administrator and on the contraction of the conducted by the administrator and on the conducted by the conducted by the	clusion, not are approved, ding restraint	
	Complaint AR00026935 was substantiated, all or				whenever possible. This will be conducted by the administrator and or consultants. The nurses will be required to complete an in-service revi- for what reasons restraint/seclusion are to be used as well as reason t allowed to justify its use. This training will also be provided to all new	the program ew of how and hat are not	
	in part, with a deficiency cited at N128.				allowed to justify its use. This training will also be provided to all new 3staff and nurses, respectively as part of their on the job training. This documented with training rosters initially and then included in documer completed OJT training going forward. 9-12-21	will be ntation of	
	Complaint AR00026937 was substantiated, all or				on place of a daming going to hard. O 1.2.2.		
	in part, with deficiencies cited at N130 and N131. Complaint AR00026939 was unsubstantiated. Complaint AR00026940 was substantiated, all or in part, with a deficiency cited at N128.						
	Complaint AR00026941 was substantiated, all or in part, with deficiencies cited at N126, N129, N130, N131, N140, N142, N149, N170, N188 and N189.						
N 100	USE OF RESTRAINT CFR(s): 483.354	AND SECLUSION	N ²	I 100	This finding summarizes the individual findings in N126 N128,N129,N130, N131, N132, N135, N136, N140, N1 N170, N188 and N189. The actions taken to address t are listed in the corresponding individual sections. It st	, N127, 42, N149, hese issues rould be	See individual sections
() () () () () () () () () ()	of Restraint and Seclu Residential Treatment Inpatient Psychiatric S	Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Expansion of Psychiatric Services for Individuals Under Age Twenty One.			noted that of the 12 residents reviewed and listed only is still in care.	resident #9	
	Based on observation interview, the facility frequirements of the C Protection of Residen facility's failure to mee requirements at N126 N131, N132, N135 and	ailed to meet the condition of Participation for ts, as evidenced by the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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N 100	to ensure there were restraint orders for 7 (#8, and #12), the faci occurred during a phy #5, #7, and #9), the face restraint and seclusion emergency situation ff #10, #11, and #12), the Emergency Safety Interpretation of the emergency situation ff #10, #11, and #12), the facility failed to ensure restraint and simultaneously to assign for 7 (Clients #1, #2, if the facility failed to enconducted in a safe aprevent potential injurtifacility failed to ensure parents / legal guardia for 6 (Clients #3, #8, if facility failed to ensure Restraint and Seclusion for 8 (Client #11, and #12) sample involved in physical a and or seclusion. This potential to affect all 2 a list provided by the 11:59 a.m. The finding The facility failed to expect the conducted in the facility failed to expect the finding facility failed to expect the facility failed the facility failed the facility failed facil	sipline purposed for 4 and #12), the facility failed no as needed chemical (Clients #1, #2, #4, #6, #7, lity failed to ensure no injury visical restraint for 3 (Clients acility failed to ensure n were only used in an for 6 (Clients # 1, #3, #9, ne facility failed to ensure an tervention was discontinued situation had ceased for 4 I #11), the facility failed to seclusion were not used sure the safety of the clients #3, #4, #9, #11, and #12), nsure a restraint was and appropriate manner to ry for 1 (Client #7), the e an Authorization / Consent was signed by the clients' an at the time of admission #9, #10 #11, and #12), the e a copy of the facility's on policy was received by gal guardian at the time of nt #1, #2, #3, #8, #9, #10 ed residents who were nd or chemical restraints is failed practice had the 23 clients as documented on Admimistrator on 8/02/21 at ngs are: nsure clients were free from sion use for discipline ts #9, #10, #11, and #12)	N	100	This deficiecy has the potential to impact all clients so the following ac completed and pertain to starf actions toward all clients. All existing districts the RTO will complete training on the appropriate use of restraints in terms of practicing techniques, but with regard to which techniques when to use restraint/seclusion or not use it and the emphasis on avoid whenever possible. This will be conducted by the administrator and or consultants. The nurses will be required to complete an in-service revitor by the reasons restraint/seclusion are to be used as well as reason allowed to justify its use. This training will also be provided to all new 3staff and nurses, respectively as part of their on the job training. This documented with training rosters initially and then included in documer completed OJT training going forward. 9-12	ions will be rect care staff clusion, not are approved, inig restraint the program even of how and hat are not direct care is will be station of	

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N 100	needed chemical res #1, #2, #4, #6, #7, #8 see N127 The facility failed to e during a physical res and #9) sampled clie The facility failed to e seclusion were only situation for 6 (Client #12) sampled clients The facility failed to e Intervention was discemergency situation #4, #9 and #11) sam The facility failed to e seclusion were not us the safety of the client #4, #9, #11, and #12 The facility failed to e conducted in a safe a prevent potential injuctients see N132 The facility failed to e Consent / Release declients' parents / legal admission for 6 (Clie #12) sampled clients The facility failed to e Restraint and Seclus the client's parents/legal	ensure there were no as traint orders for 7 (Clients 3, and #12) sampled clients ensure no injury occurred traint for 3 (Clients #5, #7, ents see N128 ensure restraint and used in an emergency s # 1, #3, #9, #10, #11, and see N129 ensure an Emergency Safety continued after the had ceased for 4 (Client #2, pled clients see N130 ensure restraint and sed simultaneously to assure nts for 7 (Clients #1, #2, #3,) sampled clients see N131 ensure a restraint was and appropriate manner to rry for 1 (Client #7) sampled ensure an Authorization / occument was signed by the all guardian at the time of nts #3, #8, #9, #10 #11, and	N	100			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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N 100	Continued From page	÷ 4	N 10	00			
	#11, and #12) sampled clients see N136						
N 126			N 12	clients so the following actions will completed and pertain to staff acti	be ons toward	9-15-21	
	restraint or seclusion,	dent has the right to be free from resclusion, of any form, used as a coercion, discipline, convenience, or description of the facility failed to ensure clients were restraint and or seclusion use for purposed for 4 (Clients #9, #10, #11, of 12 sampled clients who had the description of the facility failed to ensure clients who had the description of the facility failed to ensure clients who had the description of the facility failed to ensure clients who had the facility failed to be free from the facility failed to ensure clients were restraint and or seclusion. The		all clients. All existing direct care staff at the RTC will complete training on the appropriate use of restraint/seclusion, not in terms of practicing techniques, but with regard to which techniques are approved, when to use restraint/seclusion or not use it and the emphasis on avoiding restraint whenever possible. This will be conducted by the administrator and or the program consultants. The nurses will be required to complete an in-service review of how and for what reasons restraint/seclusion are to be used as well as reason that are not allowed to justify its use. This training will also be provided to all new direct care staff and nurses, respectively as part of their on the job training. This will be documented with training rosters initially and then included in documentation of completed OJT training going forward. 9-15-21			
	Based on observation review, the facility fail free from restraint and discipline purposed for and #12) of 12 samples.						
	1. Client #9 was adm diagnoses Disruptive Disorder, Oppositiona Posttraumatic Stress Attention-Deficit/Hype	al Defiant Disorder, Disorder, and					
	documented, "Rest and Time Initiated: 4/2 Time Ended: 4/28/21 demonstrated to justif transition from the da ran out of the boys ur three peers. Staff cal assistanceSeclusion	y use of procedure: During yroom to classroom client hit classroom exit doors with led for n and Restraint Observation n Beginning Time: 02:58 PM Restraint; Location:					

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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N 126	An Incident Report Fop.m. documented, " Observation Log Time (Chemical);Client B (Threatening)Time: Behavior: 8; Time: 3: (Seclusion); Location: Room);Client Behavior: 3; Location 7;Time 3:35; Proced Behavior: 7Time: 3: 3;Client Behavior: 7 from the seclusion rood Documentation indicathreatening with no dobehaviors at the time administered and was documented aggressibefore being released 2. Client #10 was addiagnoses Disruptive Disorder, Schizophrei Disorder, Attention-Dicombined Presentation. A Seclusion and Redocumented, "Date 4/28/2021 2:56 PM; Edward Lient Polyson of proceduthe boys day room to	ng Time: 3:05 PM; ; Location: Seclusion or: SittingEnding Time: orm dated 4/28/21 at 2:00 Behavioral Intervention a: 2:58; Procedure: 4 ehavior: 8 2:59; Procedure: 4;Client 05; Procedure: 3 : 3 (Seclusion vior: 7 (Sitting)Time: 3:20; n: 3;Client Behavior: dure: 3; Location: 3;Client 50; Procedure: 3; Location: dure: 3; Location: 3;Client 50; Procedure: 3; Location: dure: 3; Location: 3;Client so; Procedure: 3; Location: dure: 4;Client dure:	N	126				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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				2002 S FILLMORE ST			
UNITED M	ETHODIST CHILDRENS	HOME		LITTLE ROCK, AR 72214			
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N 126	Continued From page	e 6	N 12	26 Continued from previous page			
	peers. Staff called fo Chemical Restraint Documentation indica no documented aggre the chemical restraint	r assistanceProcedure: Client Behavior: Calm" Ited the client was calm, with essive behavior, at the time		This training will be completed by 9 Additionally all restraints or seclusic reviewed by the MCH Administrator Director or a designee and docume compliance with procedural and pol This will be effective as of 9-12-21 l been put in place.	ons will be r, the RTC nted as to icy requirements.		
	diagnosis Disruptive I Disorder.						
	documented, "Date PM; Date and Time E demonstrated to justif transition from the bo classroom, client ran classroom exit door w Time: 2:53 PM; Proce RestraintClient Beh Walking" Documen was threatening, walk aggressive behaviors the chemical restraint	out of the boys unit with three peersBeginning edure: Chemical avior: Threatening, itation indicated the client king, with no other documented, at the time					
	diagnoses Diisruptive	l Schizophrenia Spectrum Disorder and					
	documented, "Date 04/28/2021 2:53 PM; 04/28/2021 3:05 PM justify use of procedu the dayroom to classi boys unit classroom e Staff called for assista	clusion Form dated 4/28/21 e and Time Initiated: Date and Time Ended:Behavior demonstrated to re: During transition from room client ran out of the exit door with three peers. anceBeginning Time: 2:53 nical RestraintClient					

PRINTED: 09/02/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE COMP	SURVEY LETED
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UNITED METHODIST CHILDRENS F	HOME		2002 S FILLMORE ST			
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PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
Procedure: Seclusion: A Behavioral Interventi documented, "pm; 2: (chemical)Client Beh Procedure: 3 (seclusio (sitting)3:20 Procedur 73:35 Procedure: 3 Procedure: 3 Client B The Behavioral Interve documented the client seclusion and remaine minutes before being r 5. On 8/11/21 at 2:28 elopement and the ever Client #9, #10, #11 and the Administrator. At 2 the clients kicking oper outside out of view of the Administrator stated, "I am not sure why they go The Administrator was reason that you could stated, "There was not the nurse decided to go continued and at 2:49 entering the building at officers and are met by clients sit down on chattheir shoes and socks. Gets up from the chair Client #10 gets up from front of the hallway, at and the client is seen we down the hallway. At 2 observed sitting in a characteric sitt	eginning Time: 3:05 PM;Client Behavior: Calm" ion Observation Log :53; Procedure: 4 navior: 8 (threatening)3:05 in)Client Behavior: 7 Ire:3Client Behavior:Client Behavior: 73:50 Sehavior: 7, 2 (calm)" ention Observation Log was sitting when placed in id sitting, calm for 45 released. p.m., a video of the ents following it involving d #12 was reviewed with 2:02 p.m., the video showed in a door and running the camera. The l've watched that one and I gave them a chemical." asked, "There is no see why they gave it?" He indication I could see why ive it." The video was pm, the 4 clients are seen ccompanied by 2 police y 2 staff members. The hirs in the foyer and remove At 2:51 pm, Client #12 and walks into the hallway. In the chair, walks to the nurse administers a shot walking off camera view	N ·	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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N 126	a door, out of view of Administrator stated, [RN #2] follows him in incident is changed to pm, Client #11 comes circular bench in cent door, sits down, then then begins walking a sitting on the bench. at a table with a check at 3:05 p.m., Client # room. At 3:06 pm, Client #10 seclusion room stand Client #11 sits down Administrator was as behaviors that warrar "No, seclusion can't be precautions and the final calmly, that is not out been used. I don't knordered it, but if he di used. Same with the cases the clients were was asked, "The che used upstairs either? nothing I saw that wook, there is no other of to." 6. On 8/13/21 at 10:: stated, "We have a composition of the stated, "The stated, "We have a compo	s pockets and goes through the camera. The "He gets a shot in there. In there." The view of the Hallway 2 camera. At 2:55 Is into view and sits on ter of foyer, gets up, kicks a stands up near the bench, around and joins Client # 12 Client #9 is observed sitting exerboard talking with staff. It walks into the seclusion itent #12 is seen in the ling at the door. At 3:07 pm,	N.	126	Continued from previous page This training will be completed by 9 Additionally all restraints or seclusic reviewed by the MCH Administrator Director or a designee and docume compliance with procedural and pol This will be effective as of 9-12-21 been put in place.	ons will to the RT nted as icy requ	C to irements.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ETHODIST CHILDRENS	НОМЕ	2002 S FILLMORE ST LITTLE ROCK, AR 72214		002 S FILLMORE ST		
(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 APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
N 126	ready to comply and finave to last an hour if they should be removed. 7. The facility Seclus received from the Adr 12:36 p.m., document Restraint are highly rewill be used only in an means of managing the successful in maintain safetyCriteria & Gu RestraintSeclusion used as punishment of PROTECTION OF RECFR(s): 483.356(a)(2) An order for restraint written as a standing basis. This ELEMENT is not Based on record revifailed to ensure client were free of chemical as-needed (PRN) bas #6, #7, #8, and #12) of sampled clients who is chemical restraints. The client #8 was admit diagnosis of Major Defa. A Physician's Order a A Physician's Order a and indicated as and indicated as the complex of	follow directions. It doesn't if they have calmed down red." find & (and) Restraint policy ministrator on 8/2/21 at ted, "Seclusion and estrictive interventions and nemergency when all other the resident have not been ning the resident's idelines for Seclusion and or restraint may not be or convenience of staff" ESIDENTS) or seclusion must not be order or on an as-needed at met as evidenced by: ew and interview, the facility is medication regimens restraints ordered on an is for 7 (Clients #1, #2, #4, for 12 (Clients #1-#12) and orders for as needed The findings are: atted on 5/11/21 and had a expressive Disorder. r, dated 5/31/21 at 11:20 (no l), documented, "Vistaril 50 y mouth] Q [every] 6 hours		126	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing staff as they personnel who record and carry of physician orders. Also, this plan of correction complete with all action be reviewed by the RTC physician provide clarification on the issue of standing orders. All nurses will reand acknowledge the policy on reand seclusion. Also, they will reand acknowledge an in-service training definition and use of PRN medical pointing out the difference between medication used for ongoing anxiouse of a medication for the purpoor at the time of a client having a behavioral episode. At such a timic client is acting out, the use of a medication which can impact or cobehavior must be viewed as a cherestraint with all of the required or procedures and proper justification	are the put of swill as to of view straint ad and ag on tions en a ety or ersus se of the if the ontrol emical rders,	9-15-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			(
		U4L106	B. WING _			08/	13/2021
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
UNITED M	ETHODIST CHILDRENS	HOME			002 S FILLMORE ST		
				LI	ITTLE ROCK, AR 72214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 127	27 Continued From page 10 N 127 Conti		Continued from previous page				
	b. The June 2021 Me Record (MAR) docum administered six time 2. Client #12 was add diagnoses of Disrupti Disorder, Unspecified and Other Psychotic Attention-Deficit/Hypo a. A PRN MAR docum (Vistaril) 50 mg [millig [every] 6 hours PRN b. The February MAF Vistaril was administered	edication Administration mented the PRN Vistaril was es that month. Imitted on 4/19/21 and had live Mood Dysregulation d Schizophrenia Spectrum Disorder, and Unspecified eractivity Disorder. Imented, "Hydroxyzine gram] PO [by mouth] Q 4/4/21" R documented the PRN ered seven times. IAR documented the PRN ered nine times. IAR documented the PRN ered nine times.			This training will be completed by 9-12-21. Additionally all restraints or seclusions will b reviewed by the MCH Administrator, the RT Director or a designee and documented as compliance with procedural and policy requit This will be effective as of 9-12-21 but has a been put in place.	C o rements.	
	Dysregulation Disord Disorder. a. A Physician/Admis 3/12/21 documented,						
	[as needed] anxiety. b. A 15/30 Day Medic documented, "Vista 6 hours] PRN"	outh] [every 6 hours] PRN cation Review dated 8/1/21 aril 50 mg nightly and [every					
	4. Cheni #6 nad diag	grioses or Distublive Mood					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMP	SURVEY LETED
		04L106	B. WING				C 13/2021
	ROVIDER OR SUPPLIER			20	TREET ADDRESS, CITY, STATE, ZIP CODE 002 S FILLMORE ST ITTLE ROCK, AR 72214	1 00/	13/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
N 127	"Hydroxyzine Pamotake 1 capsule by moneeded for anxiety" b. The February 2021 Record documented, [every 6 hours] PRN administered on 2/11. 5. Client #7 had diag Dysregulation Disorder and Unspect Spectrum. a. A Physician's Order documented, "1. Vistaries of the properties	er and Epilepsy. sician's Order documented, pate 50 mg capsule (Vistaril) are 50 mg capsule (Vistaril) are 50 mg 1 tablet PO anxiety" and was initialed as /21 and 2/12/21. moses of Disruptive Mooder, Autism Spectrum iffied Schizophrenia ers dated 2/23/21 aril 50 mg PO [every 6" ledication Administration "Hydroxyzine Pamoate 50 l) take 1 capsule by mouth ded for anxiety" and was red on 3/9/21, 3/13/21, 3/19/21. moses of Severe Major Oppositional Defiant sorder, and Unspecified social Environment. cation Review" form roxyzine (Vistaril) po (by	N	127			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 8/13/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CO 2002 S FILLMORE ST LITTLE ROCK, AR 72214	•	0/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
N 127	on 8/12/21 at 12:16 dated 6/11/21 for Hy every 8 hours PRN f documented Register administered the PR 6/21/21, 6/30/21, 7/7 7. Client #2 had diagnosorder with Psychologopositional Defiant a. A "15/30 Day Med 3/30/21 and signed by documented, " Visitational and signed by documented and signed by was agitated, self-hamorning medications her left arm and scrather nails. She also h was laying on the coclient to sit up to preher throat. Client sather morning medications on 8. Client #3 had diagnosordericit/Hyperactivity	priporate Compliance Director PM documented an order droxyzine Pamoate 50 mg for anxiety. The record fered Nurse (RN) #4 N medication on 6/18/21, 7/21, 7/12/21, and 7/19/21. Ignoses of Major Depressive otic Features, and Disorder Ilication Review" form dated by RN #4 and the Physician staril 50 mg po every 6 hours Is Note dated 6/7/21 (no RN #3 documented, "Client farming, and refusing to take as. She was biting herself on atching her left forearm with ad a slight nosebleed. Client function the unit, RN advised event blood from going down up, calmed down and took tions along with a PRN farm cleaned and bandaged." Ignoses of Disruptive Mood der and Unspecified Attention Disorder. S Order documented, "Vistaril	N ·	127		
	asked, "Do you have	2 a.m., Consultant #1 was PRN antianxiety medication I, "Yes, some of our clients				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			C 08/13/2021	
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	<u> 06/</u>	13/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 127	have problems with a down. The psychiatri manager review it and Consultant was asked doctor for a prn med? ordered, and the doct the prn is prescribed. 10. On 8/13/21 at 9:5 (RN) #2 was asked, "have PRN antianxiety stated, "Yes, they hav Vistaril. That's some asked, "You do have it?" She stated, "Yes 11. On 8/13/21 at 10 stated, "Never have a When asked, "What i Manager stated, "Vist used for anxiety." At Manager was asked, Vistaril, is it an antian stated, "Yes, they dor it." 12. The facility policy Restraint, received fro 8/2/21 at 12:36 p.m., & Procedures B. Dr (chemical restraint) madministered to mana a way that reduces the or others. 2. Has the restricting the resider and 3. Is not a standaresident's medical or	some of our clients that nxiety or problems calming st and nurse and nurse d discuss it." The d, "You don't have to call the "She stated, "They are for has already ordered it, so fand on the log." 50 a.m., Registered Nurse Are there some kids that a medication orders?" She are a standing order for of the kids." RN #2 was it there, that you can give "." 114 a.m., the Nurse Manager a PRN for a chemical." Is Vistaril?" the Nurse staril is an antihistamine but 10:20 a.m., the Nurse "When they give PRN xiety medication?" She of thave to call the doctor for the documented, "Definitions and Used as a Restraint the eans any drug that- 1. Is age a resident's behavior in the safety risk to the resident temporary effect of the start of the safety risk to the resident temporary effect of the safety risk to the resident temporary effect of the safety risk to movement,	N	127			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			C 13/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	13/2021
				2002 S FILLMORE ST		
UNITED M	ETHODIST CHILDRENS	HOME		LITTLE ROCK, AR 72214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BI		(X5) COMPLETION DATE
N 127	or (PRN) order for an	e 14 y type of safety intervention, less restrictive intervention	N 12	27		
N 128	or for convenience of PROTECTION OF RE CFR(s): 483.356(a)(3 Restraint or seclusion	staff" ESIDENTS) must not result in harm or	N 12	This deficiency has the potential impact all clients so the following will be completed and pertain to nursing and direct care staff where the perform a restraint or seclusion	g actions all o might	9-15-21
	Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure no injury occurred during a physical restraint for 3 (Clients #5, #7, and #9) of 12 (Clients #1-#12) sampled clients who had documented use of restraints and or seclusion. The findings are: 1. Client #9 had diagnoses od Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder. a. A Seclusion and Restraint Form dated 7/27/2021 1:23 PM; Date and Time Initiated: 7/27/2021 1:23 PMBehavior demonstrated to justify use of procedure: Physically aggressive with staff, kicking doors/windows, attempting to elopeAssessment (Upon removal from procedure-time): 7/27/2021 2:00 PMPhysical Status Assessment: bruising on chin, swelling on cheek and bleeding from his nose1. Observation: Beginning Time: 1:23 PM; Procedure: Personal Restraint: Other (Location): hallwayClient Behavior: Cursing Threatening2. Observation: Beginning Time:			these identified staff members training on the appropriate use restraint/seclusion, not in terms practicing techniques, but with which techniques are approve use restraint/seclusion or not u and the emphasis on avoiding restraint and staff and avoiding restraints. This will be completed by the administrator the program consultants. This the will be documented with the restraint and then included documentation of completed Octraining going forward. Additionally all restraints or section will be reviewed by the MCH Administrator, the RTC Director designee and documented as the compliance with procedural and requirements. This will be effect 9-12-21 but has already been place.	vill attend of of egard to d, when to se it njuries to estraint and or raining d in IT usions or a o I policy tive as of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	042100	3	S	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	13/2021
	ETHODIST CHILDRENS	НОМЕ		2	002 S FILLMORE ST LITTLE ROCK, AR 72214		
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N 128	PM, documented, " on any door they could break out and elope. client and peer from reduction but client became verstaff, punching them, verbally aggressive. [Doctor] and order was chemical restraint by client tried to swing or client was put in restrest to still being aggressifittle bruising on his classwellen and nose bleed. C. On 8/12/21 at 3:41 reviewed with the Adriclient was observed keswinging at staff. At 1 door and walked dow following him, pacing doors. At 1:23:56 three and client fall to the fland is released from the pup and then sat on the hallway. The Administration went to the floor, they d. On 8/13/21 at 9:05 "How did [Client #9] on 7/27?" She stated big child. He was attaput him in a restraint floor and he got bruis on the floor. It was content of the second of the seco	client and peer were kicking ld, kicking windows, trying to Staff was able to keep making it out of the building y physically aggressive with pushing them, being This nurse notified the DR as received to give client a IM [Intramuscular]. After a staff with a closed fist, aint for 10 min [minutes] due weHe was noted to have a min and cheek was slightly d slightly" p.m., a facility video was ministrator. At 1:18:36, the clicking through a door and :19:23, the client kicked in the hallway with four staff with his head down, kicking the staff grabs the client, staff oor. The client is struggling the restraint at 1:30:42, sits the floor at the end of the strator stated, "When they is should have released him." To a.m., RN #2 was asked, the injured during a restraint at 1; "He's a very aggressive, acking staff and staff had to and he was taken to the ling. I could see the blood oming from his nose. When	N	128			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 08/13/2021
	ROVIDER OR SUPPLIER	В НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		00/10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE
N 128	Continued From page 16		N 1	128		
		e back and forth. He had a on his chin. His right cheek				
		gnoses of Severe Major and Oppositional Defiant				
	a.m. documented, "DisturbanceClie narrative description disrespectful to staff instructions As the [Client #5] was sitting staff walked over and to him. As staff react threw a punch and h a team control position also attempted to bit the floor. Staff continuaggressive behavior	nt-to-Staff7) Clear, conciseClient was very and refused to follow group was leaving the unit g on the floor behind a chair. d noticed he had a pen next ed to get the pen [Client #5] it this staff. He was placed in on and was combativeHe e staff on the leg and went to nued the restraint due to . he also moved his head bit staff during the floor				
	form dated 4/4/21 do scrapes/cuts (with ar front and back), bruis left wrists), cut (with	hysical Markings/Injuries ocumented, "Fresh rows pointing to shoulders ses (with circles at right and arrow to right back of hand), to lines drawn on mid-lower				
		gnoses of Disruptive Mood ler, Autism Spectrum cified Schizophrenia				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.125.			(C	
		04L106	B. WING			08/	13/2021	
	ROVIDER OR SUPPLIER	NS HOME	•	20	REET ADDRESS, CITY, STATE, ZIP CODE 02 S FILLMORE ST TTLE ROCK, AR 72214			
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N 128	documented, "(In shoulderDisturbal concise narrative do to raise his hand ar getting out of his set then proceeded to being acknowledge Client then became aggressive toward and hitting staff on placed in a basket loose by running for right shoulder into the data staff exit doors have been prevented client attempted to should have "tappe [Behavior Intervention de-escalate the situlative contacted the her that he observe BI should have re-tholds" b. An ID of Physica 2/28/21 documented [Patient] has an abilifront] shoulder claver. On 8/10/21 at 3: physical hold was readministrator. The a proper hold, not a "Was the client injus" yes, he had an abic clearly seen on the	port Form dated 2/28/2021 jury) ClientBruise on right nceClient-to-staff7) Clear, escription Client was asked and ask for permission before eat without permission. Client get up and walk out without and received correctives. Everbally and physically staff by close hand swinging the arm. Client was then hold but proceeded to cut rward, hitting his chest and the wall and corner of the gym . 8) Should/could this incident ed/anticipated? Yes - When hit the staff member, staff and out" and allowed another Bl ionist] to work with the client to uation. The Lead Bl should Consultant on call to inform and the improper hold. The Lead rained the Bl on CPI approved I Markings/Injuries form dated and, "Description of findings rasion to the right anterior vicle area" 11 p.m., the video of the eviewed with the Administrator stated, "No, not a CPI hold." When asked, red," the Administrator stated, rasion." The injury could be	N ·	128				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 1 13/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	13/2021	
UNITED M	ETHODIST CHILDRENS	HOME		2002 S FILLMORE ST			
UNITED M	ETHODIST CHILDRENS	HOME		LITTLE ROCK, AR 72214			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
N 128	Continued From page	÷ 18	N 1	28			
	the Administrator on 8 "Procedures:At n be utilized that cause risk to residents"	8/2/21 documented, o time shall any procedure s physical or psychological					
N 129	PROTECTION OF RICFR(s): 483.356(a)(3) To ensure the safety of during an emergency This ELEMENT is not Based on observation review, the facility fail seclusion were only usituation for 6 (Clients #12) of 12 (Clients #14) had restraints and / of are: 1. Client #9 had diagnous Disorder, Posttrauman Attention-Deficit/Hype a. A Seclusion and Rich Goumented, "Rest and Time Initiated 4/2 Time Ended: 4/21/202 Demonstrated: Client the foyer area with Client and peer used covers and used piece and Restraint Observ Beginning Time: 7:36 Restraint; Location: Exercise Processing Proces	of the resident or others safety situation; and the met as evidenced by: n, interview, and record ed to ensure restraint and sed in an emergency at 1, #3, #9, #10, #11, and - #12) sampled clients who resclusion. The findings noses of Disruptive Mood er, Oppositional Defiant tic Stress Disorder, and eractivity Disorder. estraint Form dated 4/21/21 traint and Seclusion Date and 21 8:54 PM Behavior became noncompliant in NA (Certified Nurse at started kicking doors. laundry basket to break light es to self harmSeclusion ation Log 21. Observation; PM; Procedure: Chemical	N 13	This deficiency has the pote impact all clients so the follo actions will be completed ar all nursing and direct care is might perform a restraint or All of these identified staff in attend training on the approof restraint/seclusion, not in practicing techniques, but with which techniques are approto use restraint/seclusion or and the emphasis on avoiding whenever possible. This will be documented with rosters initially and then incompleted training going forward. Nurspecifically will review the performance of the procedures have been put in document less restrictive at de-escalate a client prior to any kind. The above training includes the necessity of reclient from a hold or a seclution in the prose a safety risk. The and review will be completed the performance of the policy and review will be completed the performance of the perform	owing and pertain to taff who seclusion. The members will priate use terms of with regard to wed, when a not use it and restraint and or training cluded in the control of the median to the median to restraint to the posing an another to restraint of the galso deasing a sion calm and no his training		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		04L106	B. WING _			08/	13/2021	
NAME OF PR	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE			
LINITED M	ETHODIST CHILDRENS	HOME		20	002 S FILLMORE ST			
ONTILD	ETHODIST CHILDRENS	TIOME		L	ITTLE ROCK, AR 72214			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE	
N 129	Continued From page	e 19	N.	129	Continued from previous page			
	Observation; Beginning	ng Time: 7:54 PM;						
	Procedure: Seclusion	•						
	Seclusion Room; Clie				Additionally all restraints or seclus	sions		
	Cursing;Ending Tim				will be reviewed by the MCH			
	ο,				Administrator, the RTC Director o designee and documented as to	а		
	An Incident Report Fo	orm dated 4/21/21 at 7:15			compliance with procedural and p	olicy		
	p.m. documented, "				requirements. This will be effective			
	chemical restraint and	d seclusionBehavioral			9-12-21 but has already been put			
	Intervention Observat	tion LogTime 8:09 p.m.;			place.			
	Procedure: 3 (Seclusion	ion); Location: 3 (Seclusion						
	Room)Client Behav	rior: 2 (Calm)Time: 8:24						
	p.m.; Procedure: 3; Lo	ocation: 3Client Behavior:						
		rocedure: 3; Location:						
		28:54 p.m.; Procedure 3;						
		ehavior: 2" The client was						
	released from the sec	clusion room at 8:54 p.m.						
		ated client behavior for the						
		estraint and seclusion was						
	_	as calm when placed in						
		ed calm for 45 minutes						
	before being released	1.						
		estraint Form dated 4/28/21						
		traint and Seclusion; Date						
		28/2021 2:58 p.m. Date and						
		3:50 p.m Behavior						
	_	fy use of procedure: During						
		yroom to classroom client						
	•	nit classroom exit doors with						
	three peers. Staff cal							
		n and Restraint Observation						
		n Beginning Time: 02:58 PM						
	Procedure: Chemical	•						
	DayArea/Hall;Client							
	ThreateningEnding							
	Observation: Beginning							
	Procedure: Seclusion							
		or: SittingEnding Time:						
	3:50 PM"							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING		C 08/13/2021	
	ROVIDER OR SUPPLIER	1 11		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	00/13/2021	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
N 129	Continued From paç	ge 20	N 12	29		
	p.m. documented, ". Observation Log Tin (Chemical);Client (Threatening)Time Behavior: 8; Time: (Seclusion); Locatio Room);Client Behavior: 7;Time 3:35; Procedure: 3;Client Behavior: from the seclusion rouse the seclusion rouse the seclusion indicators at the time administered and was served.	e: 2:59; Procedure: 4;Client 3:05; Procedure: 3 n: 3 (Seclusion avior: 7 (Sitting)Time: 3:20; ion: 3;Client Behavior: edure: 3; Location: 3;Client 3:50; Procedure: 3; Location: 7" The client was released oom at 3:50 p.m. cated the client was documented aggressive e the chemical restraint was as 'sitting' with no sive behaviors for 45 minutes				
	documented, "Da 4/30/2021 7:11 PM; 4/30/2021 7:12 PM; justify use of proced with peer and staff Observation Log 2;. Time: 7:11 PM; Proc Other Location: Hall CombativeEnding An Incident Report I documented, "Clie altercation hitting a choke hold. Client v refused to let the clie the client go due to s					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2002 S FILLMORE ST LITTLE ROCK, AR 72214	E	08/13/2021	
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N 129	restraint @ (at) 711 p behaviorBehavioral LogTime: 7:11 Proc Location: Hallway;C Threatening;Time 7 5Client Behavior: 2 indicated the client the documented aggressi the chemical restraint calm one minute after administered. d. A Seclusion and Re documented, "Date 12:22 PM; Date and 1 Observation Beginnin Procedure: Seclusion Seclusion Room; Clie Cursing, Walking2. Time: 12:28 PM; Proc Other (Location): Sec Behavior: Cursing, Th A Nursing Progress N PM, documented, " 12:15 pm client starte and feeding off of a p client then started tryi doors. Staff tried to s physically aggressive put in a physical restr the DR (Doctor) and o client in seclusion and This nurse followed th Documentation indica chemical restraint who	Intervention Observation edure: 4 (Chemical); client Behavior: :12; Procedure: 4; Location: (Calm)" Documentation reatening, with no ve behaviors, at the time was administered and was the chemical restraint was estraint Form dated 5/25/21 and Time Initiated: 5/25/21 Time Ended: 1:22 PM1. g Time: 12:22 PM; ; Other (Location): nt Behavior: Combative, Observation Beginning redure: Chemical Restraint; lusion RoomClient reatening" Intervention of the furniture reatening of the furniture reatening off the furniture reatening off the furniture reatening twhen Client was then and this nurse called order was received to place of give a chemical restraint. The second of the client received a reatening with the orders" Intervention of the second of the second order was received to place of give a chemical restraint. The second of the second order was received a reatening with no documented order was received a reatening with no documented order was received a reatening with no documented orders was received to place or the second order was receiv	N 1	29			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	S HOME	,	2002 S F	ADDRESS, CITY, STATE, ZIP CODE FILLMORE ST ROCK, AR 72214	1 00/	10/2021
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N 129	documented, "Dat 6/11/2021 2:37 PM; 6/11/2021Seclusio Log 21. Observation Procedure: Chemical Cursing, Threatening An Incident Report F p.m., documented, "	Restraint Form dated 6/11/21 te and Time Initiated: Date and Time Ended: n and Restraint Observation on: Beginning Time 2:37 PM; Il RestraintClient Behavior: g" Form dated 6/11/21 at 5:18Behavioral Intervention	N ·	129			
	(Chemical); Location 2 (Calm)Time: 2:3' Location: 5;Client I Documentation indic when the chemical ref. A Seclusion and R	me: 2:37 p.m.; Procedure: 4 n: Hallway;Client Behavior: 7 p.m.; Procedure: 4; Behavior: 2" rated the client was calm restraint was administered. estraint Form dated 6/12/21 re and Time Initiated:					
	6/12/2021 7:45 PM; 6/12/2021 9:00 PM;. Client became non carea and started kick several doors and ag door. Client was esc continued to display Observation Beginni Procedure: Personal Calm3. Observation	Date and Time Ended:Behavior Demonstrated: compliant while in the Foyer king doors. Client kicked out ggressively tried to kick exit corted back to unit where he aggressive behaviors2.					
	p.m., documented, "Observation LogTi (Restraint) Location: 2 (Calm); Time: 8:10 (Seclusion);Client Behavioral Intervent	Behavior: 2" The					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	l	08/13/2021
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N 129	seclusion and remain 9:10 p.m. It was door for one hour while in 9:10 p.m. It was door for one hour while in 9:10 p.m. It was door for one hour while in 9:10 p.m. It was door for one hour while in 9:10 p.m. It was door for one hour while in 9:10 p.m. Seclusion in Gestraint Client Beh Procedure; Beginnin Procedure: Seclusion Observation: Beginnin Seclusion Client Bel Observation: Beginnin Seclusion Calm Robotumentation indicates when placed in seclus remained calm for on from seclusion at 9:10 p.m. A Seclusion and Robotumentated in Security Se	ed calm until his release at umented the client was calm seclusion. estraint Observation Log mented, "1 Observation: PM; Procedure: Personal tion): Foyer;Client Cursing;2. Observation: PM; Procedure: Personal avior: Calm;Release from ag Time: 8:10 PM;Client Behavior: Calm4. ag Time: 8:25 PM; havior: Calm5. ing Time: 9:10 PM; elease From Procedure" ated the client was calm sion at 8:10 PM and e hour until he was released 0 PM. estraint Observation Log, mented, "Date and Time 7:38 PM; Date and Time 39 PM;Behavior by use of procedure: and kicking open unit doors and kicking open unit doors observation: 7:38 PM; Restraint;Client Behavior: On Observation Log dated ag "Time: 7:38, Procedure: 7:39; Procedure: 4;Client	N 1	29		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER UNITED METHODIST CHILDRENS HOME				2002	ET ADDRESS, CITY, STATE, ZIP CODE S FILLMORE ST LE ROCK, AR 72214		
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N 129	unit, client became agkicked open the unit of client back in the foyer give client a chemical followed through" It client's behavior was documented aggress chemical restraint was calm one minute after restraint. i. A Seclusion and Redocumented, "Date 11:31 AM; Date and TAM;Behavior demo procedure: kicking una peer and self to elo aggressive with staff. Time: 11:31 AM; Procedure: 4 (Chemical Calm)Time: 11:32 ChemicalClient Behavioral Interventing Progress Not documented, "Client Behavior	ping and running around the ggressive with staff and door. Staff was able to get er and order was received to a restraint. Order was Documentation indicated the cursing, with no ive behavior, at the time the s administered and was receiving the chemical estraint Form dated 7/8/21, and Time Initiated: 7/8/21 Fime Ended: 7/8/21 11:32 instrated to justify use of it doors attempting to allow pe. Verbally and physically1. Observation: Beginning redure: Chemical avior: Calm"	N	129			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
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N 129	documented, " Date 07/09/2021; Date and 4:00 PM; Behavior of procedure: kicking to elope, physically a staff; Beginning Tim Chemical Restraint; Foyer Client Behavi indicated the client who documented aggrithe chemical restraint. 2. Client #10 had dia Dysregulation Disorder, I and Conduct Disorder, I and	estraint Form dated 7/9/21 e and Time Initiated: d Time Ended: 07/09/2021 demonstrated to justify use open unit doors attempting ggressive with le: 3:47 PM; Procedure: Other (location) or: Sitting" Documentation as sitting in the foyer, with lessive behavior, at the time at was administered. In the following the service of the ser	N 1	29				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED		
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N 129	7:45 PM; Date and PMBehavior demo procedure: [Client # doors repeatedlyB Procedure: Chemica Foyer;Client Beha Threatening;" A Behavioral Intervet 4/3/21 documented, Procedure: 3 (Seclu (Cursing), 8 (Threate Procedure: 3;Clier 9:00 pm; Procedure 2Time: 9:15 pm; P 2" The client was restrictive intervention chemical restraint which be A Seclusion and F documented, "Date 7:21 AM; Date and AMBehavior demo procedure: Physical with staff, kicking do property damageB Procedure: Seclusion Combative, Cursing Procedure: Chemica Seclusion Room;C A Report To Quality documented, "he is being non-compliant stop but he continue one of the doors, the	and Time Initiated: 4/3/2021 Fime Ended: 4/3/2021 9:15 Innstrated to justify use of 11] had been kicking the unit leginning Time: 7:45 PM; al Restraint; Other (Location): vior: Combative, Intion Observation Log dated "Time: 8:15 pm; sion);Client Behavior: 4 lening)Time 8:45 pm: at Behavior: 2 (Calm)Time at 3;Client Behavior: recedure: 3Client Behavior: released from seclusion at no documentation of less ons attempted before the las administered. Restraint Form dated 4/12/21, and Time Initiated; 4/12/2021 Fime Ended: 4/12/21 8:20 onstrated to justify use of ly and verbally aggressive ors, attempting to elope, Reginning Time: 7:23 AM;	N -	129				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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N 129	4/12/21 documented, Procedure: 3 (Seclusi (Calm)Time: 7:32 a (Chemical);Client B Procedure: 4Client Procedure: 3 (Seclusi 2Time 8:03 am; Procedure: 3:18 am; Procedure: 28:20 am; Procedure: 28:20 am; Procedure: 4:20 am; Procedure	tion Observation Log dated "Time 7:23 am; ion);Client Behavior: 2 m; Procedure: 4 ehavior: 2Time: 7:33 am; Behavior: 2Time: 7:48; ion)Client Behavior: ocedure: 3Client Behavior: re: 4et and Time Hehavior: re: 3Client Behavior: re: 3Client Behavior: re: 4et and Time he was restraint Form dated 4/27/21 re and Time Initiated: restraint Form dated 4/27/21 re and Time Initiated: re: Client was combative, re: Client was combative, re: Client was combative, re: Client with peers. Client ration with peer. Peer rethit client. Clients were	N	129	,		
	documented, "Date	estraint Form dated 4/28/21 e and Time Initiated: 2:53 inded: 4/28/21Behavior					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	NG	, ,	COMPLETED			
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N 129	demonstrated to justitransition from the boclassroom, client ran classroom exit door of time: 2:53 PM; Proce RestraintClient Bet Walking" Documer was threatening, wal aggressive behaviors the chemical restraint. 4. Client #12 had dia Dysregulation Disord Schizophrenia Spect Disorder and Attention Disorder. a. A Seclusion and R documented, "Dat 2/12/2021 9:00 am; I 2/12/2021 9:01 AM justify use of proceduphysicallyBeginning Chemical Restraint, FoyerClient Behave There was no documinterventions attempt restraint was administrated by A Restraint and Sedocumented, "Dat 04/12/2021 7:24 AM; justify use of procedurer by and physical staffBeginning Time SeclusionClient Bestraint Beginning Time SeclusionClient Bestraint Bestraint Beginning Time SeclusionClient Bestraint Be	ify use of procedure: During bys day room to the out of the boys unit with three peersBeginning edure: Chemical navior: Threatening, intation indicated the client king, with no other is documented, at the time it was administered. Agnoses of Disruptive Mood der, Unspecified frum and Other Psychotic on-Deficit/Hyperactivity Restraint Form dated 2/12/21 and Time Initiated: Date and Time Ended: Behavior demonstrated to ure: attacking staff and peers in g Time: 9:00 AM; Procedure: Other (Location) ior: Combative, Cursing" The nentation of less restrictive ted before the chemical stered. Belavior demonstrated to ure: Property destruction, lly aggressive with e: 7:24 AM; Procedure: thavior: CursingBeginning edure: Chemical Restraint;	N ·	129				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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N 129	client was placed in time a chemical rest the client was in sec c. A Restraint and S documented, " Da 04/21/2021 7:34 PM 04/21/2021 8:36 PM justify use of proced noncompliant in the doors to the unit. C open to unit and atte to escape. Client are basket to break the unit Beginning Tim Chemical Restraint. Cursing Beginning Seclusion Client Br. Threatening" The seclusion one minute restraint. There was increased aggressive of the chemical restraint and S documented, " Da 04/28/2021 2:53 PM justify use of proceed the dayroom to class boys unit classroom Staff called for assis PM; Procedure: Che Behavior: Cursing	Documentation indicated the seclusion and calm at the traint was administered while clusion. eclusion Form dated 4/21/21 te and Time Initiated: It pate and Time Ended: IBehavior demonstrated to ure: Client became foyer area and started kicking lient and peer kicked doors empted to break external door and peer also used laundry light covers on the e: 7:34 PM; Procedure: Client Behavior: Time: 7:35 PM; Procedure: ehavior: Cursing client was placed in e after receiving a chemical no documentation of e behavior to justify the use	N 12				
	A Behavioral Interve	ention Observation Log 2:53: Procedure: 4					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
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N 129	Procedure: 3 (seclusic (sitting)3:20 Procedore: 3 Procedure: 4 Procedure: 5 Proc	chavior: 8 (threatening)3:05 ion)Client Behavior: 7 dure:3Client Behavior: 73:50 Behavior: 7, 2 (calm)" vention Observation Log it was sitting when placed in ned sitting, calm for 45 i released. B p.m., a video of the vents following it involving ind #12 was reviewed with i 2:02 p.m., the video showed en a door and running if the camera. The "I've watched that one and I v gave them a chemical." is asked, "There is no id see why they gave it?" He o indication I could see why give it." The video was p pm, the 4 clients are seen accompanied by 2 police by 2 staff members. The nairs in the foyer and remove s. At 2:51 pm, Client #12 ir and walks into the hallway. om the chair, walks to the a nurse administers a shot it walking off camera view 2:56 p.m., Client #9 is chair in the entrance, at 2:58 goes down the hallway with s pockets and goes through	N ·	129				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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N 129	circular bench in cendoor, sits down, then then begins walking sitting on the bench. at a table with a check that 3:05 p.m., Client froom. At 3:06 pm, Client froom. At 3:06 p	s into view and sits on ter of foyer, gets up, kicks a stands up near the bench, around and joins Client # 12 Client #9 is observed sitting skerboard talking with staff. #11 walks into the seclusion ient #12 is seen in the ding at the door. At 3:07 pm,	N 12	29			
	Depressive Disorder Disorder, Conduct D Problem Related to S a. A Physician's Orde documented a chem The medication orde signed order. The orde restraint as, "Pt [patie verbally aggressive verbally aggressive verbally aggressive verbally properties or p	noses of Severe Major, Oppositional Defiant isorder, and Unspecified Social Environment. er dated 6/14/21 at 4:15 PM, ical restraint was ordered. red was not included on the der gave the reason for the ent] was physically and with staff and started to throw t and pick scabs on arms."					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING		(X3) DATE COMP	SURVEY LETED	
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N 129	[Patient] came out of throwing cards and the attempted to redirect self-harm by picking staff continue to verb turned over to nursing [4:15 p.m.] and order Benadryl 100 mg IM muscle] for aggressic [4:26 p.m.], was calmous chemical restraint." c. On 8/10/21 at 11:1 Emergency Safety In 6/14/21 was reviewed 3:55 PM on the video in a chair at a small to back to the camera, vat 3:56, Client #1 through the foyer. At 3:59, it a across the room said audio was available of staff members started unidentified staff mem directly around Client close to client's feet a moving cards on the cards closer to staff, staff. The Administrat #1] being aggressive Administrator stated, was asked, "Did it ap the client or tried any situation?" He stated the video, unless the	s note by RN #1 on on note, documented, "Pt phone booth and begin [sic] nreatening staff. When staff client, she begin [sic] to scabs off of old wounds. Fally deescalate client and g. On Call notified at 1615 ed Zyprexa 10 mg and [Intramuscularly, into on. Client received at 1626 in and compliant during	N	129			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		. ,	(X3) DATE SURVEY COMPLETED			
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N 129	across the room from the back, apptable, no negative the client continues on. The Administratintervening? Does arms?" He stated, usually pretty obvidasked, "Does it appeared to be a client #1 removed table with no negative that it is a client #1 removed table with no negative that is a client #1 removed table with no negative (RN) #1, ped 4:25:17 on the vide arm. While the injed left arm a second rinjection into the rigseated with no obside with no obside the video?" He staticalm at that mome to client #3 had dianguate the video?" He staticalm at that mome to client #3 had dianguate the video? The staticalm at the dianguate of the client #3 had dianguate the video? The staticalm at the mome to client #3 had dianguate the video? The staticalm at the mome to client #3 had dianguate the video? The staticalm at the mome to client #3 had dianguate the video? The staticalm at the mome to client #3 had dianguate the video? The staticalm at the properties of the video and the Administrator of chemical restraint of the video and the Administrator of the video and	to interact with each other om the client. The client, seen ears to continue to sit at the behaviors are observable, and is to have her long sleeve jacket tor is asked, "Is the staff it appear she is picking at her "When she is picking it is ous, it is not evident." He was opear staff is attempting any iniques?" The Administrator opear very intensive and if they overy long." At 4:25 PM, on the opear coming into the foyer. The Administrator is seen coming into the foyer. The Administrator, is seen at expect of the Administrator. The left cition is still being given in the nurse is seen giving an option of the injections. The asked, "Was a chemical based on what was seen on ted, "No, she was completely int and cooperative."	N	129		

MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
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042100		STREET ADDRESS, CITY, STATE, ZIP CODE		8/13/2021
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NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
ge 34	N 12	29		
ng it open and attempted to				
ed with the Administrator. At eo, Client #3 was in a hallway Hall 1 West 1), no staff is client #3 was seen running or which was out of camera seen quickly reentering hallway. At 2:20:03 on the seen walking in the hallway, on camera view. At 2:22:44, conist (BI) #3, per the seen walking past the client against the wall of the hallway. Was asked, "What is staff ed, "Probably shutting off the kips to 2:26, BI #3 and seen standing outside a seen standing outside a seen standing outside a seen standing outside a seen standing out of the re." At 2:27:10 on the video, rived coming out of the ropriate behaviors were seen walks calmly to the foyer then at shaped couch. Four staff is BI #3 and Consultant #2 are not client remained on the tive behaviors until 2:35 when it sat at a table in the foyer e walked calmly over to the 3 and LPN #1. The asked, "Was a chemical pased on the video we just				
	1 ' '	IDENTIFICATION NUMBER: 04L106 B. WING STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ID PREFIX TAG REST IDENTIFYING INFORMATION ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG IN 12 ID PREFIX TAG ID PREFIX TAG IN 12 ID PREFIX TAG ID PREFIX TAG IN 12 ID PREFIX TAG IN 12 ID PREFIX TAG ID PREFIX TAG ID PREFIX TAG IN 12 ID PREFIX TAG IN 12 ID PREFIX TAG I	A BUILDING 04L106 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214 STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) GROSS-REFERENCED TO THE. DEFICIENCY) GROSS-REFERENCED TO THE. DEFICIENCY) GROSS-REFERENCED TO THE. DEFICIENCY) GROSS-REFERENCED TO THE. DEFICIENCY N 129 REPORT OF THE STATE OF THE STAT	DENTIFICATION NUMBER: 04L106 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214 ID PREFIX TAG FRONDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO NEW TAG TAG BY WING BY WING ID PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG N 129 GE 34 IN 129 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) N 129 ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) N 129 ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) N 129 ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) N 129 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) N 129 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) N 129 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) N 129 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) N 129 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) N 129 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY TAG PROVIDER SHAPPOPPIATE DEFICIENCY ID PROVIDERS PLAN OF CORRE

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	IPLE CONSTRUCTION IG		OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	I	08/13/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
N 129	staff and sat calmly gloves on."	almly to the bathroom with while the nurse was getting on & (and) Restraint policy	N 1	29		
	12:36 p.m., docume Restraint are highly will be used only in a means of managing successful in mainta safetyDefinitions & as a Restraint (Cher drug that-1. Is admir	Iministrator on 8/2/21 at Inted, " Seclusion and restrictive interventions and an emergency when all other the resident have not been ining the resident's Procedures:B. Drug Used Inical restraint) means any histered to manage an a way that reduces the				
	safety risk to the restemporary effect of refreedom of moveme treatment for the rescondition. C. Seclus involuntary confiner area, which the resign from leaving for any	ident or others; 2. Has the estricting the resident's int, and 3. Is not a standard ident's medical or psychiatric ion is defined as: 1. The inent of a resident alone in any ident is physically prevented period of time. 2. Seclusion is prevent the resident from				
	disruption of the there only be used when a sufficient to protect the alternative measures serious disruption of 3. Seclusion require justification. The rate address the fact that were attempted and interventions must be Seclusion shall be designed.	or others or to prevent serious rapeutic environment. It shall alternative measures are not the resident or when are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative the therapeutic environment. It shall alternative the therapeutic environment. It shall alternative the documented clinical includes the procedure must be strictly environment. It shall alternative environment. It shall alternative environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It shall alternative measures are not sufficient to prevent the therapeutic environment. It sha				
		nterventions are no longer				

			LETED			
		04L106	B. WING			C 13/2021
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00/	10/2021
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
N 129	or Seclusion: 1. The ushould be evaluated at the earliest assessment and evaluated condition 2. At the reaches criteria for diemergency intervention ust be released" PROTECTION OF RICFR(s): 483.356(a)(3) Until the emergency sand the resident's saft can be ensured, ever order has not expired. This ELEMENT is not assed on record revifailed to ensure an Entervention was discemergency situation I #4, #9 and #11) of 12 clients who had docused seclusion. The findin 1. Client #9 had diagonated Disorder, Posttrauma Attention-Deficit/Hype a. A Seclusion and Redocumented, "Resand Time Initiated 4/2 Time Ended: 4/21/202	a for Discontinuing Restraint use of restraint or seclusion on a continual basis and possible time based on the uation of the resident's same time, if a resident scontinuation of an on in 30 minutes, he/she ESIDENTS)(ii) safety situation has ceased fety and the safety of others if the restraint or seclusion at met as evidenced by: we and interview, the facility mergency Safety ontinued after the nad ceased for 4 (Client #2, (Clients #1-#12) sampled mented restraint and or gs are: noses of Disruptive Mood er, Oppositional Defiant tic Stress Disorder, and eractivity Disorder. estraint Form dated 4/21/21 traint and Seclusion Date 21/2021 7:36 PM; Date and 21 8:54 PM Behavior became noncompliant in	N 129		will be and and an a identified on the ion, not but with proved, not use estraint conducted ogram ning eased as that a eated if it and and it in instrator, and and its.	9-15-21

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
		04L106	B. WING _			C 08/13/2021	
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
N 130	Client and peer used covers and used pied and Restraint Observed Beginning Time: 7:36 Restraint; Location: I Behavior: CursingE Observation; Beginning Procedure: Seclusion Seclusion Room; Clie Cursing;Ending Time An Incident Report F. p.m. documented, " chemical restraint an Intervention Observation Procedure: 3 (Seclus Room)Client Behavior: 2 (Seclus Room)Client Behavior: 3 (Seclus Room)Client Behavior: 2 (Seclus Room)Client Behavior: 3 (Seclus Room)Client Behavior: 4 (Seclus Room)Client Behavior: 4 (Seclus Room)Client Behavior: 4 (Seclus Room) Research Time Behavior: 4 (Seclus Room) Research Time Seclusion and Rocumented, "Research Time Initiated: 4 (Time Ended: 4/28/21 demonstrated to justit transition from the daran out of the boys unthree peers. Staff caassistanceSeclusion	Int started kicking doors. Ilaundry basket to break light bes to self harmSeclusion vation Log 21. Observation; BPM; Procedure: Chemical Day Area/Hall;Client Ending Time: 7:37 PM; 2. Ing Time: 7:54 PM; 10; Other (Location): Ine: 8:54 PM" In orm dated 4/21/21 at 7:15 Inc. Client was ordered a discussion inc. Behavioral tion LogTime 8:09 p.m.; Inc. Seclusion vior: 2 (Calm)Time: 8:24 Inc. Client Behavior: 10; Inc. Seclusion vior: 2 (Calm)Time: 8:24 Inc. Seclusion inc. 28:54 p.m.; Procedure 3; Behavior: 2" The client was clusion room at 8:54 p.m. Interest and seclusion was as calm when placed in the dealm for 45 minutes discussion; Date (28/2021 2:58 p.m. Date and 3:50 p.m Behavior fy use of procedure: During byroom to classroom exit doors with	N 1	30			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	042100	D. WINO		TREET ADDRESS, CITY, STATE, ZIP CODE	08/	13/2021
	ETHODIST CHILDRENS	HOME		2	002 S FILLMORE ST LITTLE ROCK, AR 72214		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 130	3:50 PM" An Incident Report For p.m. documented, " Observation Log Time (Chemical);Client B (Threatening)Time: Behavior: 8; Time: 3: (Seclusion); Location Room);Client Behav Procedure: 3; Location 7;Time 3:35; Proced Behavior: 7Time: 3: 3;Client Behavior: 7 from the seclusion roo Documentation indicathreatening with no dobehaviors at the time administered and was documented aggressibefore being released c. A Seclusion and Redocumented, "Date 6/12/2021 7:45 PM; E	Restraint; Location: Behavior: Time: 2:59 PM. 2. Ing Time: 3:05 PM; Location: Seclusion Ing Time: 3:00 Ing Time: 3:00 Ing Time: 3:00 Ing Time: 3:200 Ing Time: 3:200 Ing Time: 3:200 Ing Time: 3:20; Ing	N	130	,		
	Client became non co area and started kicki several doors and ago door. Client was esco continued to display a Observation Beginnin	Behavior Demonstrated: compliant while in the Foyer and doors. Client kicked out gressively tried to kick exit corted back to unit where he aggressive behaviors2. and Time: 8:07 PM; Restraint; Client Behavior:					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	ATE SURVEY DMPLETED
		04L106	B. WING			C 08/13/2021
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	<u> </u>	00/13/2021
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
N 130	Calm3. Observation Procedure: Seclusion Procedure: Seclusion An Incident Report Fp.m., documented, ". Observation LogTir (Restraint) Location: 2 (Calm); Time: 8:10; (Seclusion);Client Behavioral Interventidocumented the clier seclusion and remain 9:10 p.m. It was doc for one hour while in d. A Seclusion and R dated 6/14/21 docum Beginning Time: 8:05 Restraint; Other (Loc Behavior: Combative Beginning Time: 8:07 RestraintClient Ber ProcedureBeginning SeclusionClient Ber Observation: Beginning SeclusionClient Ber Observation: Beginning SeclusionCalmRed Documentation indication when placed in secluremained calm for or from seclusion at 9:1 2. Client #11 had a copyregulation Disord a. A Seclusion and Redocumented, "Date and Coumented, "Date and Coument	n: Beginning Time 8:10 PM; nClient Behavior: Calm" orm dated 6/12/21 at 8:30Behavioral Intervention me: 8:07; Procedure: 2 7 (Foyer);Client Behavior: Procedure: 3 Behavior: 2" The on Observation Log at was calm when placed in med calm until his release at umented the client was calm seclusion. estraint Observation Log mented, "1 Observation: FM; Procedure: Personal ation): FoyerClient , Cursing2. Observation: FM; Procedure: Personal ation): FoyerClient ation: 8:10 PM; Procedure: Phavior: Calm4. mg Time: 8:25 PM; havior: Calm5. ing Time: 9:10 PM; elease From Procedure" ated the client was calm sion at 8:10 PM and the hour until he was released to PM.	N 1	30		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 08/13/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP COL 2002 S FILLMORE ST LITTLE ROCK, AR 72214	•	90,10,2021	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
N 130	procedure: Physicall with staff, kicking do property damageB Procedure: Seclusion Combative, Cursing. Procedure: Chemica Seclusion Room;C A Report To Quality documented, "he being non-compliant stop but he continue one of the doors, the there client was place chemical" A Behavioral Interved 4/12/21 documented Procedure: 3 (Seclus (Calm)Time: 7:32 (Chemical);Client Procedure: 4Client Procedure: 3 (Seclus 2Time 8:03 am; Procedure 28:20 am; Procedure 28:20 am; Procedure 2seclus 2release from procindicated the client viplaced in seclusion,	instrated to justify use of y and verbally aggressive ors, attempting to elope, beginning Time: 7:23 AM; nClient Behavior:Beginning Time: 7:32 AM; al Restraint; Location: elient Behavior: Cursing" Assurance dated 4/12/21 began kicking doors and y client was asked by staff to d until he kicked and broke en urse was notified and from the died in seclusion and given a second of the control of the con	N -	130			
	b. A Seclusion and F documented, " Dar 9:49 AM; Date and T	remained calm for 57 as released. Restraint Form dated 5/4/21 te and Time Initiated: 5/4/21 Time Ended: 5/4/21 10:49 Instrated to justify use of					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING				C 42/2024
NAME OF P	ROVIDER OR SUPPLIER	042100	D. WIITO		STREET ADDRESS, CITY, STATE, ZIP CODE	08/	13/2021
	ETHODIST CHILDRENS	НОМЕ		2	2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 130	, .	e 41 pen unit doors attempting to uction, aggressive with	N	130			
	5/4/21 documented, " Procedure: 3 (Seclusi (Combative), 4 (Cursi am; Procedure: 3Cl (sitting)10:19 am; P Behavior: 7 (Sitting) 3Client Behavior: 7 3Client Behavior: 10 (Release from Procedindicated the client was	ion)Client Behavior: 3 ing), 8 (Threatening)10:04 ient Behavior: 10 rocedure: 3Client .10:34 am; Procedure:10:49 am; Procedure:					
	_	noses of Disruptive Mood er and Posttraumatic Stress					
	physically aggressive attempting to elope time: 11:15 a.m. Proc BehaviorHurting sel 11:16 a.m. 2. Observa a.m. Procedure:Sec seclusion roomCliet combative, cursing. S Response:observat Time: 12:17 p.m. 3. C 11:22 a.m. Procedure RestraintOther (loca roomClient BehaviorClient Behavior	"Behavior Demonstrated- with staff, kicking doors 1. Observation beginning edure:TransportClient If, combativeEnding Time: ation beginning time: 11:17 clusionOther (location) Int Behavior: threatening, Staff ion/no changeEnding Observation beginning time: e:Chemical ation) seclusion					

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			C 08/13/2021
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(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· ·	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
N 130	reviewed with the Act the video, Client #4 seclusion room by 2 Client #4 was kicking room. At 11:19 a.m., the door when staff and administered an was asked, "Should restraint and seclusie"No, should not do b was laying down on camera stopped deta Administrator was as come out?" and he sthreatening." When the Administrator state come out." The client 4. Client #2 had diagnosorder with Psycholoppositional Defiant a. A Seclusion and F 04/28/21 documente negativity with peers throwing it on doors be noncompliant and staff."	D p.m., the video was diministrator. At 11:16 a.m. on was transported to the male staff. At 11:17 a.m., go the door of the seclusion Client #4 was standing at entered the seclusion room injection. The Administrator simultaneous chemical on be used?" and he stated, oth." At 11:45 a.m., Client #4 the floor. At 11:56 a.m., the ecting motion due client. The ked, "What is the criteria to stated, "Calm not asked, "Is the client calm?" ited, "Yes, he calm, should not was released at 12:18 p.m. In gnoses of Major Depressive otic Features, and Disorder. Restraint Form 1 dated and, "Client was feeding into and wetting toilet tissue and and floor. Client continued to diverbally aggressive towards and Restraint Observation Log	N ·	130		
	TransportClient combative, walking a Procedure:Seclus	Behaviorthreatening, and cursing8:06 a.m. ionseclusion roomClient e and walking8:11 a.m.				

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
04L106	B. WING		C 08/13/2021
		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	08/13/2021
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
cal restraint and seclusion Client behaviorcombative m. ProcedureChemical n roomcalm and sitting" documented Client #2 was scalm, and was released sion & (and) Restraint policy dministrator on 8/2/21 at inted, "Seclusion and restrictive interventions and an emergency when all other the resident have not been ining the resident's safety ided as: 1. The involuntary ident alone in any area, physically prevented from d of time. 2. Seclusion shall tent the resident from injuring sor to prevent serious rapeutic environment. It shall alternative measures are not the resident or when sare not sufficient to prevent the therapeutic environment on shall be discontinued when avior of the resident resolves the interventions are no longer the designated by the tria for Discontinuing Restraint tuse of restraint or seclusion on a continual basis and the possible time based on the aluation of the resident's uple, if a resident was ordered 2-hour time frame, but has	N 13		
	` '	DENTIFICATION NUMBER: 04L106 B. WING TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL BLSC IDENTIFYING INFORMATION) DEPREFIX TAG N 13 cal restraint and seclusion Client behaviorcombative m. ProcedureChemical n roomcalm and sitting" documented Client #2 was s calm, and was released sion & (and) Restraint policy dministrator on 8/2/21 at nted, "Seclusion and restrictive interventions and an emergency when all other the resident have not been ining the resident's safety led as: 1. The involuntary sident alone in any area, physically prevented from do of time. 2. Seclusion shall rent the resident from injuring s or to prevent serious rapeutic environment. It shall alternative measures are not the resident or when s are not sufficient to prevent the therapeutic environment on shall be discontinued when avior of the resident resolves see interventions are no longer ne designated by the ria for Discontinuing Restraint use of restraint or seclusion on a continual basis and to possible time based on the aluation of the resident was ordered 2-hour time frame, but has unsafe and disruptive	A BUILDING D4L106 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214 ID PROVIDER'S PLAN OF CORRECT (ECAL CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRE DEFICIENCY) PREFIX TAG ID PROVIDER'S PLAN OF CORRECT (ECAL CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRE DEFICIENCY) N 130 D1 130

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE (COMPLE (
		04L106	B. WING			C 13/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2021
				2002 S FILLMORE ST		
UNITED M	ETHODIST CHILDRENS	HOME		LITTLE ROCK, AR 72214		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
N 130	Continued From page	e 44	N 130			
N 131	that the resident is the seclusion at the 1-hoo time, if a resident rea discontinuation of an 30 minutes, he/she m	en released from restraint or ur point. 2. At the same ches criteria for emergency intervention in ust be released"	N 13	1. This deficiency has the notential t	o impact	
N 131	Based on observation interview, the facility is seclusion were not us the safety of the clien #4, #9, #11, and #12) sampled clients who had were placed in a seclusion. The finding the safety of the sampled clients who had were placed in a seclusion. The finding the safety of the sa	on must not be used of met as evidenced by: n, record review and failed to ensure restraint and sed simultaneously to assure ts for 7 (Clients #1, #2, #3, of 12 (Clients #1 - #12) received a chemical restraint physical restraint and gs are: noses Disruptive Mood er, Oppositional Defiant tic Stress Disorder, and eractivity Disorder. estraint Form dated 4/21/21 int and Seclusion; Date and 17:36 PM; Date and Time PM Behavior became noncompliant in NA [Certified Nurse at started kicking doors. laundry basket to break light es to self-harm Seclusion ation Log 2 1.	N 13 ⁻	This deficiency has the potential tall clients so the following actions completed and pertain to all nursi All nurses will be required to revie acknowledge policy and procedur requires that restraint and seclusi not be used simultaneously. Ord seclusion and restraint must be o and or carried out as separate iss documentation and only after consideration of ongoing behavio client that pose a safety risk. If a requires a restraint, a seclusion mbe used unless consideration of the effectiveness of the restraint has given and if found ineffective and client remains a safety risk, then coptions including seclusion may be considered, ordered, and carried These separate procedures must considered individually and not at This review and acknowledgemer completed by 9-12-21. Additionally all seclusions will be by the MCH Administrator, the RDirector or a designee and document to compliance with procedural an requirements (inclusive on non-simultaneous use). This will effective as of 9-12-21 but has all been put in place.	will be ng staff. we and re which on must ers for btained ues with rs by a client nay not ne been the out. be one time one time one time other reviewed rc nented as d policy oe	

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ') MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 08/13/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODI 2002 S FILLMORE ST LITTLE ROCK, AR 72214			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
N 131	Time: 7:37 PM; 2. C 7:54 PM; Procedure Seclusion Room; Cli Ending Time: 8:54 P observations docum Restraint Form. An 4/21/21 at 7:15 p.m. the foyer area with a noncompliant and st Unit 'D'. Client and a door onto the hallwa the exit door. Client basket to toss up an Client used the broke covers to self-harm. poor impulse control was ordered a chem Behavioral Intervel 8:09 p.m.; Procedure [Seclusion Room] Time: 8:24 p.m.; Pro Client Behavior: 2 Location: 3; Client Procedure 3; Location The client was releas at 8:54 p.m. Docum was calm for 45 min There was no docun client was placed in restraint was administ b. A Seclusion and F documented, "Restra Time Initiated: 4/28/2/ demonstrated to just transition from the day	chavior: Cursing Ending observation; Beginning Time: c Seclusion; Other (Location): ent Behavior: Cursing M" There were no other ented on the Seclusion and Incident Report Form dated documented, "Client was in CNA when he became arted kicking the doors on a peer kicked through the y and continued to kick on and peer used a laundry d break out the light covers. en pieces from the light Client continued to display and be aggressive. Client ical restraint and seclusion intion Observation Log Time e: 3 [Seclusion]; Location: 3 Client Behavior: 2 [Calm] cedure: 3; Location: 3 Time 8:39 p.m.; Procedure: 3; Behavior: 2 8:54 p.m.; on: 3 Client Behavior: 2" sed from the seclusion room entation indicated the client utes before being released. inentation to justify why the seclusion after the chemical	N 1	31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		04L106	B. WING		C 08/13/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	, 33.10.202
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
N 131	Seclusion and Restr Observation Beginn Procedure: Chemica DayArea/Hall Clie Ending Time: 2:59 F Beginning Time: 3:0 Location: Seclusion Sitting Ending Tim Report Form dated a documented, "Ber Observation Log; Ti [Chemical] Client I Time: 2:59; Procedu [Seclusion Room] Time: 3:05; Procedu [Seclusion Room] Time: 3:20; Procedu Behavior: 7 Time: 3; Client Behavior 3; Location: 3 Clie was released from ti p.m. Documentation sitting, with no docu behaviors, for 45 mi There was no docur client was placed in restraint was admini c. A Seclusion and F documented, "Date 12:22 PM; Date and Observation Beginn Procedure: Seclusion Seclusion Room; Cl Cursing, Walking2 Time: 12:28 PM; Pro Other (Location): Se Behavior: Cursing, T	alled for assistance raint Observation Log 21. ring Time: 02:58 PM; al Restraint; Location: nt Behavior: Threatening restraint Procedure: Seclusion; Room Client Behavior: e: 3:50 PM" An Incident restraint Intervention restraint: Aller Behavior: 8; restraint: Aller Behavior: 8; restraint: Aller Behavior: 8; restraint: Aller Behavior: 7 [Sitting] restraint: Aller Behavior: 8; restraint: Aller Behavior: 7 [Sitting] restraint: Aller Behavior: 8; restraint: Aller Behavior: 8; restraint: Aller Behavior: 9 [Sitting] restraint: Form dated: 5/25/21 restraint: Form dated: 1:22 PM1. restraint: Porm dated: 1:22 PM1. restraint: Porm dated: Restraint: Porm	N 13	1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION IG	COMPLETED	
		04L106	B. WING		08/13/20	24
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	06/13/20	21
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMP	(X5) PLETION DATE
N 131	cursing and threatent Note dated 5/25/21 a aprox [approximately jumping off the furnitunegative behavior, w to kick open the unit when client became staff. Client was ther and this nurse called was received to place a chemical restraint. with the orders" Do client received a chemical restraint of the client received a chemical restraint. With the orders" Do client received a chemical restraint. With the orders" Do client received a chemical restraint. With the orders" Do client #11 was addiagnosis of Disruptive Disorder. 2. Client #11 was addiagnosis of Disruptive Disorder. a. A Seclusion and R documented, "Date and T. PMBehavior demonstrates and T. PMBehavior demonstrates and T. Pocedure: Chemical Foyer; Client Behavior. A Benavior. Client Behavior. Simple Received Threatening) Time 3; Client Behavior. Simple Procedure: 3; Client pm; Procedure: 3; Client pm; Procedure: 3, Client was released find the procedure was no documented.	nile in the seclusion room for ing. A Nursing Progress at 1:10 PM documented, "At 1:110 PM documented, "At 1:12:15 pm client started ure and feeding off of a peer hen client then started trying doors. Staff tried to stop it physically aggressive with a put in a physical restraint the DR [Doctor] and order eclient in seclusion and give. This nurse followed through ocumentation indicated the mical restraint while in the ursing and threatening. Imitted on 3/5/21 and had we Mood Dysregulation Testraint Form dated 4/3/2021 ime Ended: 4/3	N 1	31		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(
		04L106	B. WING			08/	13/2021
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
				2	2002 S FILLMORE ST		
UNITED M	ETHODIST CHILDRENS	HOME		ı	LITTLE ROCK, AR 72214		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
N 131	Continued From page	<u> </u>	N	131			
	restraint was adminis		''				
		ify why the client was placed					
	_	chemical restraint was					
	administered.						
	b. A Seclusion and Re	estraint Form dated 4/12/21					
		nd Time Initiated; 4/12/2021					
		me Ended: 4/12/21 8:20					
	AM Behavior demoi	nstrated to justify use of					
		and verbally aggressive					
		rs, attempting to elope,					
		eginning Time: 7:23 AM;					
	Procedure: Seclusion						
	_	. Beginning Time : 7:32 AM;					
	Procedure: Chemical	ient Behavior: Cursing" A					
		surance dated 4/12/21					
		egan kicking doors and					
		client was asked by staff to					
	_	until he kicked and broke					
	-	nurse was notified and from					
	there client was place	ed in seclusion and given a					
	chemical" A Behav						
		ed 4/12/21 documented,					
		cedure: 3 [Seclusion];					
	_	Calm]Time: 7:32 am;					
	Procedure: 4 [Chemic	= '					
		ocedure: 4Client Behavior:					
		dure: 3 (Seclusion)Client 03 am; Procedure: 3Client					
		; Procedure: 3Client					
		; Procedure: 3Client					
		; Procedure: 3Client					
	Behavior: 2release	•					
		Behavorial Intervention					
		cated the client was calm at					
	•	ed in seclusion, was calm at					
		stration of the chemical					
	restraint in the seclus	ion room and remained					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		04L106	B. WING _			C 08/13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDREN			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	<u> </u>	06/13/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
N 131	3. Client #12 had d Dysregulation Disor Schizophrenia Spec Disorder and Attenti Disorder. a. A Seclusion and I documented, "Date 8:40 AM; Date and AMOther Criteria wasn't placed in hol justify use of procec behavior, agitation, aggressive, threatel 8:53 AM; Procedure 8:53 AM; Procedure Seclusion; Location Behavior: Combativ ThreateningIndica Management/Emerg less restrictive inter successful: no; Clie to self: no; Client pro others: no; Persona hour): No" Docun was not an imminer when the chemical in	before he was released. iagnoses of Disruptive Mood der, Unspecified ctrum and Other Psychotic ion-Deficit/Hyperactivity Restraint Form dated 4/4/21 and Time Initiated: 4/4/2021 Time Ended: 4/4/21 8:40 not listed for release: Client dBehavior demonstrated to dure: Ongoing aggressive verbally and physically ning staffBeginning Time: e: Chemical Restraint, : Day Area/HallClient e, Cursing, ition for Behavior gency Safety Intervention; A ventions attempted and not int presents imminent danger esents imminent danger to I Restraint (Not to exceed one mentation indicated the client at danger to self or others restraint was administered.	N 1	,		
	04/12/2021 7:24 AM 04/12/2021 8:21 AM justify use of proced verbally and physica Beginning Time: 7:2 Client Behavior: Cu AM; Procedure: Che	All, Date and Time Ended: All. Behavior demonstrated to dure: Property destruction, ally aggressive with staff All AM; Procedure: Seclusion rsing Beginning Time: 7:29 emical Restraint; Other in RoomClient Behavior:				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	, ,	DATE SURVEY COMPLETED
		04L106	B. WING			C 08/13/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	<u> </u>	06/13/2021
(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 ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
N 131	Calm" The docume was placed in seclus a chemical restraint of client was in seclusid documentation to indichemical restraint. c. A Restraint and Secus adviced and commented, "Date and o4/21/2021 7:34 PM; 04/21/2021 8:36 PM. justify use of procedu noncompliant in the find doors to the unit. Cliopen to unit and attent to escape. Client and basket to break the linguitBeginning Time Chemical Restraint CursingBeginning SeclusionClient Be Threatening" The seclusion one minute restraint. There was increased aggressive of the chemical restraint.	entation indicated the client ion and was calm at the time was administered while the in. There is no icate the need for the eclusion Form dated 4/21/21 and Time Initiated: Date and Time Ended: Behavior demonstrated to ure: Client became over area and started kicking ent and peer kicked doors in the eclusion of the external door do peer also used laundry ght covers on the external door do peer also used laundry ght covers on the external covers. Client Behavior: Time: 7:35 PM; Procedure: Client Behavior: Cursing client was placed in after receiving a chemical no documentation of the behavior to justify the use aint.	N			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(
		04L106	B. WING			08/	13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	НОМЕ		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 131	Procedure: 3 [seclusion [sitting]3:20 Procedure: 3Client Behavioral Intervention documented the clien seclusion and remain minutes before being	2:53; Procedure: 4 havior: 8 [threatening]3:05 on]Client Behavior: 7 ure:3Client Behavior:Client Behavior: 73:50 Behavior: 7, 2 [calm]" The on Observation Log t was sitting when placed in ed sitting and calm for 45 released. There was no reased aggressive behavior	N	131			
	Dysregulation Disorder Disorder. a. A Seclusion and Re 6/15/21 documented, physically aggressive attempting to elope time: 11:15 a.m. Proc Behavior Hurting se Time: 11:16 a.m. 2. O 11:17 a.m. Procedure (location) seclusion re threatening, combativ observation/no charp.m. 3. Observation b Procedure: Chemic (location) seclusion re	"Behavior Demonstrated - with staff, kicking doors 1. Observation beginning edure:Transport Client elf, combative Ending observation beginning time: o:Seclusion Other oom Client Behavior: re, cursing. Staff Response: rege Ending Time: 12:17 reginning time: 11:22 a.m. al Restraint Other oom Client Behavior: sponse:Observation / No re: 11:23 a.m"					
		ministrator. At 11:16 a.m. on					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	` '	ATE SURVEY DMPLETED
		04L106	B. WING			C 08/13/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	'	30/10/2021
(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 CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
N 131	Client #4 was kicking room. At 11:19 a.m., the door when staff and administered ar was asked, "Should restraint and seclusis". No, should not do be was lying on the flood 12:18 p.m. 5. Client #1 had diagouperessive Disorder Disorder, Personal House Childhood, Conduct Problem Related to a. A Nursing Progres AM documented, "Costaff and self-harming restraint and continuplaced in seclusion at 8:05. Client was a seclusion. She refus Nurse] to see arms to be A Seclusion and Foundation of the client was a seclusion. She refus Nurse to see arms to be a Client #2 had diagouper with Psych Defiant Disorder, an Related to Child Negrouper and Related to	male staff. At 11:17 a.m., g the door of the seclusion Client #4 was standing at entered the seclusion room injection. The Administrator simultaneous chemical on be used?" and he stated, both." At 11:45 a.m., Client #4 or. The client was released at consistency of Physical Abuse in Disorder, and Unspecified Social Environment. Social Environm	N 13	31		
	_	ote dated 4/28/21 at 8:11 AM \$\frac{4}{2}\$ was in seclusion and then				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _				C 13/2021
	ROVIDER OR SUPPLIER	L		200	REET ADDRESS, CITY, STATE, ZIP CODE 2 S FILLMORE ST TLE ROCK, AR 72214	1 00/	13/2021
(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 131	documented as combinated as combinated at 8:12 A client was calm and s 7. Client #3 had diagous Dysregulation Disord Deficit/Hyperactivity In the land of the lan	estraint, with the client pative and sitting. One M, RN #4 documented the itting. noses of Disruptive Mood er and Unspecified Attention Disorder. s dated 5/12/21 arse was notified aprox [9:24 AM] that client had raint by the classroom for	N 1	31			
N 132	was in seclusion at 0s scream, cuss and pur Will continue to monit 8. Client #3 had diagroup Dysregulation Disord Deficit/Hyperactivity I An Observation Log of the client was in seclureceived a chemical received.	242. Client continues to yell, nch walls while in seclusion. For." Phoses of Disruptive Mood er and Unspecified Attention Disorder. Edated 5/18/21 documented usion at 10:43 PM, then estraint at 10:49 while still in was documented as ending	N 1	32	Corrective action begins on next	page	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ATION NUMBER: A. BUILDING COMPLETED			
		04L106	B. WING		0;	C 3/ 13/2021
	ROVIDER OR SUPPLIER	номе		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 132	safety intervention memanner that is safe, pappropriate to the set the resident's chronol age; size; gender; ph psychiatric condition; (including any history abuse). This ELEMENT is not Based on record revialled to ensure a ressafe and appropriate injury for 1 (Client #7 sampled clients who and / or seclusion. To Client #7 had diagnost Dysregulation Disord Disorder and Unspect Spectrum. a. An Incident Report documented, "(Injurt shoulder Disturbance Clear, concise narratic asked to raise his hard before getting out of It Client then proceeded without being acknown correctives. Client the physically aggressive swinging and hitting sthen placed in a bask	ervention. An emergency just be performed in a proportionate, and verity of the behavior, and logical and developmental sysical, medical, and and personal history of physical or sexual of the met as evidenced by: iew and interview, the facility traint was conducted in a manner to prevent potential of 12 (Clients #1-#12) were reviewed for restraint the findings are: sees of Disruptive Mood er, Autism Spectrum iffied Schizophrenia a. Form dated 2/28/21 ry) Client Bruise on right ce Client-to-staff 7) ive description Client was and and ask for permission his seat without permission. It to get up and walk out	N 13	This deficiency has the potential clients so the following act completed and pertain to all ridirect care staff who might perestraint or seclusion. All of the identified staff members will a on the appropriate use of resseclusion. This will include a instruction on the approved remethods and the need to use approved techniques. Also, the will stress the importance of applying the aforementioned avoiding hazards when performergency procedure and the notito engage in an emergential in the cannot be completed safe. This will be conducted by the and or the program consultar training and review will be consultar training rosters initially and the documentation of completed going forward. Additionally all restraints or some reviewed by the MCH Adrick RTC Director or a designed adocumented as to compliance procedural and policy require will be effective as of 9-12-21 already been put in place.	tions will be nursing and erform a nese attend training traint/ pecific estraint e only these the training safety when techniques, rming an e requiremen cy procedure ely. administrator by nented with nen included in OJT training eclusions will ministrator, the and e with ements. This	t

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · · ·	IPLE CONSTRUCTION	(X3) DATE	SURVEY
		04L106	B. WING			С
		04L106	B. WING_		08/	13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
N 132	and staff exit doors. 8 have been prevented client attempted to hit should have 'tapped of [Behavior Intervention de-escalate the situat have contacted the Cher that he observed BI should have re-train Prevention Institute] as b. An ID (Identification Injuries form dated 2/2"Description of finding abrasion to the right as clavicle area" c. On 8/10/21 at 3:11 physical hold on 2/28. Administrator. At 4:27 member grabs the client toward the door and lied Administrator stated, hold, not a CPI hold." client injured?" the Adhad an abrasion."	e wall and corner of the gym b) Should/could this incident /anticipated? Yes - When the staff member, staff out' and allowed another BI nist] to work with the client to cion. The Lead BI should consultant on call to inform the improper hold. The Lead ned the BI on CPI [Crisis approved holds" n) of Physical Markings / 28/21 documented, ngs [Patient] has an anterior [front] shoulder p.m., the video of the //21 was reviewed with the // p.m. in the video, the staff ent, swings him around	N	132		
N 135	the Administrator on 8 "Procedures:At n be utilized that cause risk to residents" PROTECTION OF RECFR(s): 483.356(c)(3	8/2/21 documented, o time shall any procedure s physical or psychological ESIDENTS)	N ´	This deficiency has the potential to all clients so the following actions completed and pertain to all staff i in the admissions process	vill be	9-15-21
	acknowledgment, in v	vriting, from the resident, or		Continued on next page		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	
		04L106	B. WING _			08/) 13/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2021
					002 S FILLMORE ST		
UNITED M	ETHODIST CHILDRENS	HOME			ITTLE ROCK, AR 72214		
					TITLE ROCK, AR 72214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 135	Continued From pag in the case of a mino guardian(s) that he of the facility's policy or seclusion during an estaff must file this ac resident's record; and This ELEMENT is not Based on record revisited to ensure an A Release document who parents / legal guard for 6 (Clients #3, #8, sampled clients who The findings are: 1. Client #8 was addraignosis Major Depusa. An Authorizations/document dated 5/11 guardian signature. b. On 8/13/21, at 10: reviewed the document dated 5/11 guardian signature. 2. Client #9 was addraignoses Disruptive Disorder, Opposition Posttraumatic Stress Attention-Deficit/Hyp	e 56 r, from the parent(s) or legal r she has been informed of the use of restraint or emergency safety situation. knowledgment in the described and interview, the facility authorization / Consent / vas signed by the clients' tian at the time of admission #9, #10 #11, and #12) were admitted to the facility. Consents/Releases /21 had no parent/legal 46 a.m., the Administrator ent and stated, "They gave a to actual signature." Initted on 4/16/21 and had a Mood Dysregulation al Defiant Disorder, Disorder, and eractivity Disorder.				are ts or te been One on ent or cy with ature opy. will also ans In the ent will sed of otained e essed ich will e ave the e ger, o n their gularly ion e	
	guardian signature.	Consents/Releases 6/21 had no parent/legal			will be reported to the MCH Administrand the RTC Director. Instructions of implementation of these forms and the actual implementation will be completely 15-21	trator on he	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	COMPLETED	
		04L106	B. WING			C 08/13/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1	00/10/2021
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
N 135	reviewed the docum consent on 4/16, but 3. Client #10 was addiagnoses Disruptive Disorder, Unspecifie and Other Psychotic Disruptive, Impulsed and Anxiety Disorder, Attention-Eand Anxiety Disorder a. An Authorizations document dated 3/3/guardian signature. b. On 8/13/21, at 10/2 reviewed the document of verbal [consessignature." 4. Client #11 was addiagnosis Disruptive Disorder. An Authorizations/Codated 3/4/21 had no signature. 5. Client #12 was addiagnoses Disruptive Disorder, Unspecifie and Other Psychotic Attention-Deficit/Hypura. An Authorizations document dated 12/3/guardian signature.	ent and stated, "A verbal in no signature." Imitted on 6/11/21 and had in Mood Dysregulation in Disorder, Unspecified Control and Conduct Deficit/ Hyperactivity Disorder in Mood Dysregulation in Mo	N 13	35		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		04L106	B. WING		C 08/13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	00/13/2021
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
N 135	consent 12/31/20. The no actual signature." 6. Client #3 was adm	nt and stated, "Verbal ney gave verbal consent, but	N 13	5	
	Dysregulation Disorded Deficit/Hyperactivity	er and Unspecified Attention Disorder. Consents / Releases form 7/21 did not document a			
	asked, "Was [Client # parent or guardian, in of the facility's policy seclusion?" The Adm paper copy of the corthe Electronic Medica	6 AM, the Administrator was [3's] consent signed by a dicating they were informed on the use of restraint or ninistrator reviewed the asent form, then looked in all Record for Client #3 and erbal and no signature from n on the consent."			
	was asked if the pare received / signed a co Authorizations/Conse stated, "I don't know i is read to them over t ability, we will e-mail				
N 136	PROTECTION OF RICFR(s): 483.356(c)(4)	N 13	This deficiency has the potential to all clients so the following actions w completed and pertain to all staff	
	-	ility must] provide a copy of e resident and in the case of		Continued on next page	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	
			A. BUILDI	NG _			,
		04L106	B. WING _			l '	, 13/2021
	ROVIDER OR SUPPLIER		,		TREET ADDRESS, CITY, STATE, ZIP CODE		
UNITED N	IETHODIST CHILDREN	S HOME		L	ITTLE ROCK, AR 72214		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R 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 136	guardian(s). This ELEMENT is not a Based on record refailed to ensure a count of an account of a sector of and Sectusion policy parents/legal guardia for 8 (Client #1, #2, of 12 (Clients #1-12) admitted to the faciliant of 1. Client #8 was addiagnosis of Major Description of 12. Client #9 was addiagnoses of Disruption of 12. Client #9 was addiagnoses of Disruption of 13. Client #10 was addiagnoses of Disruption of 14. Client #10 was addiagnoses of Disruption of 15. Client #11 was addiagnosis of Disruption of 15. Client #12 was addiagnoses of Disruption of	not met as evidenced by: view and interview, the facility by of the facility's Restraint v was received by the client's an at the time of admission #3, #8, #9, #10 #11, and #12)) sampled clients who were ty. The findings are: nitted on 5/11/21 and had a Depressive Disorder. nitted on 4/16/21 and had tive Mood Dysregulation hal Defiant Disorder, s Disorder, and Deractivity Disorder. Imitted on 6/11/21 and had tive Mood Dysregulation de Schizophrenia Spectrum c Disorder, Unspecified Control and Conduct Deficit/ Hyperactivity Disorder r. Imitted on 3/5/21 and had a live Mood Dysregulation dive Mood Dysregulation dive Mood Dysregulation s Disorder, Unspecified Control and Conduct Deficit/ Hyperactivity Disorder r. Imitted on 3/5/21 and had a live Mood Dysregulation dive Mood Dysregulation dive Mood Dysregulation des Schizophrenia Spectrum des Disorder, and	N ·	136	Continued from previous page involved in the admissions process where coand authorizations are reviewed and signed parents or guardians. Two separate forms horeated specifically for this purpose. One is the restraint and seclusion policy specifically as a parent or guardian copy for them to retath other is a copy of the same policy with a secparent/guardian signature acknowledging the of their copy. All other admissions and consents will also be provided to the parents or guardians and signification of admission. In the case of a verbal coath at consent will be properly documented an witnessed. The parents will be provided a coath ese documents and a signature obtained a as possible in addition to the verbal consent. For existing clients, a copy of the policy on u restraint and seclusion will be mailed, no late 9/9/21 with a self-addressed postage paid, renvelope, to each guardian. The cover letter will request that they sign and return the acknowledgement. They will also have the can and email or fax the acknowledgement by well. A list of the confirmed acknowledgement is continue until all clients have the acknowledgement acontinue until all clients have the acknowledgement for the RTC Case Manager, follow phone calls will be made to confirm receipt a continue until all clients have the acknowledgement for the RTH Health Information Management de to measure compliance. The results of these will be reported to the MCH Administrator an RTC Director. Instructions on implementation these forms and the actual implementation wompleted by 9-15-21	by client ave been a copy of identified in. The tion for a e receipt be need at the phase of extranger included option to pack as a ts will be well and perment in udited by epartment e audits d the n of	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONS	STRUCTION	(X3) DATE COMP	SURVEY LETED
		04L106	B. WING _				C 13/2021
NAME OF PR	ROVIDER OR SUPPLIER	0.2.00		STREET	ADDRESS, CITY, STATE, ZIP CODE	00/	13/2021
UNITED M	ETHODIST CHILDRENS	НОМЕ			FILLMORE ST E ROCK, AR 72214		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 136	Continued From page	÷ 60	N ²	36			
	and 5/06/21 and had Depressive Disorder, Disorder, Personal Hi Childhood, Conduct Deproblem Related to Section 7. Client #2 was admit 01/28/21, 4/21/21 and of Major Depressive Defeatures, Oppositiona Other Circumstances Personal History. 8. Client #3 was admit and had diagnoses of Dysregulation Disorded Deficit/Hyperactivity Deficit/Hyperactivity Deficit/Hyperactivity Deficity as asked, "Did the preceive a copy of the He stated, "It's in the they get a copy of the	istory of Physical Abuse in Disorder, and Unspecified ocial Environment. itted to the facility on d 5/10/21 and had diagnoses Disorder with Psychotic al Defiant Disorder, and Related to Child Neglect itted to the facility on 4/27/21 f Disruptive Mood er and Unspecified Attention Disorder. 6 a.m., the Administrator parent/legal guardians Restraint/Seclusion Policy?" handbook; I don't know if a policy."					
N 140	contain the Facility Ro ORDERS FOR USE (SECLUSION CFR(s): 483.358(a) Orders for restraint or physician, or other lic by the State and the f	/21 at 11:40 p.m., did not estraint/Seclusion Policy.	N ·	evid in sp action nurs both	on review of these identified issue lent that the physicians are no la pecifics given within their order for ons or medications. The difficult sing documentation of these order on at the time of	cking or y is in	9-15-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			08/	13/2021
	ROVIDER OR SUPPLIER	в НОМЕ		20	TREET ADDRESS, CITY, STATE, ZIP CODE 202 S FILLMORE ST ITTLE ROCK, AR 72214	•	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 140	CFR 441.151 require services for beneficial provided under the disprovided under the facility orders were obtained seclusion utilized for sample clients who his seclusion implements. 1. Client #4 had diagnous provided under the disprovided u	Federal regulations at 42 that inpatient psychiatric aries under age 21 are irection of a physician. Inot met as evidenced by: Inot, record review and failed to ensure physician and for all restraints and for all restraints and for all restraints and for all restraints and for eather than the findings are: Inoses of Disruptive Mood ler and Posttraumatic Stress Instraint Order dated for exceed one for specific drug information Intraint Form 1 dated for each, "Chemical incompanies and provided in the findings are in	N	140	receiving and within the system of documentation for charting. This deficiency could impact all clients correction is directed at all nursing All nurses will complete and in-sereview of the proper documentation requirements for seclusion and reorders. This will include emphasi complete documentation including specific medication information (ndosage, route given). This in-serbe presented by the Administrator completed by 9-15-21. All restraint and seclusion orders reviewed by the Health Information Management department on a regional seclusion orders will also be reviewed by the nurse manager second the week of 9-13-21. Continued results and results of reviews reported to the MCH Administrator.	so the g staff. rvice on straint s on g ame, vice will r and will be on gular estraint tarting need of ed upon will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			C 08/13/2021	
NAME OF P	ROVIDER OR SUPPLIER	042100	3		STREET ADDRESS, CITY, STATE, ZIP CODE	08/	13/2021
	ETHODIST CHILDRENS	HOME		2	2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 140	at 5:04 p.m. documer IM- not to exceed one specific drug informat A Seclusion and Rest documented, "Indic. Management/Emerge InterventionChemic IM x 1. Benadryl 50 rd. A Seclusion or Res 6/15/2021 at 11:22 a. "Chemical Restrain hour" There was not on the order. A Seclusion and Rest 6/15/2021 documented Management/Emerge InterventionChemical Restrain IM- not to express the second of the sec	traint Order dated 6/8/2021 ated, "Chemical Restraint a hour" There was no ion on the order. traint Form 1 dated 6/8/2021 ation for Behavior ency Safety al Restraint: Zyprexa 5 mg mg x 1" straint Order dated m. documented, t IM- not to exceed one to specific drug information traint Form 1 dated ad, "Indication for Behavior ency Safety al Restraint: Zyprexa 7.5 75 mg x 1" straint Order dated h. documented, "Chemical exceed one hour" There information on the order. traint Form 1 dated ad, "Indication for Behavior ency Safety Intervention Typrexa 7.5 mg IM x 1.	N	140			
	at 2:16 p.m. documer	traint Order dated 7/27/2021 nted, "Chemical Restraint e hour" There was no					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 08/13/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	'	00/10/2021
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
N 140	specific drug informal A Seclusion and Res 7/27/2021 document Management/Emerg InterventionCheming IM x 1. Benadry 2. Client #6 had dia Dysregulation Disord a. A Seclusion or Reat 10:22 a.m. docum IM- not to exceed or specific drug informal A Seclusion and Resdocumented, "Individual Management/EmerginterventionChemin IM x 1. Benadryl 50 b. A Seclusion or Resultant 2/10/2021 at 11:33 as "Chemical Restrait hour" There was non the order. A Seclusion and Resultant 2/10/2021 document Management/Emerging Chemical Restraint: Benadryl 50 mg x 1. 3. Client #7 had dia 1/27/2021 document Management/Emerging Chemical Restraint: Benadryl 50 mg x 1.	ation on the order. Straint Form 1 dated ted, "Indication for Behavior lency Safety cal Restraint: Zyprexa 10 I 50 mg x 1" I 50 mg x 1 Alter a set a se	N 1	40		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 08/13/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP C 2002 S FILLMORE ST LITTLE ROCK, AR 72214	•	30/13/2021
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
N 140	documented, "(Injushoulder Disturbar concise narrative debecame verbally and toward staff by close staff on the arm. Cliebasket hold but procrunning forward, hittishoulder into the wastaff exit doors. 8) Sbeen prevented/antiattempted to hit the shave 'tapped out' an [Behavior Intervention de-escalate the situative contacted the Cher that he observed BI should have re-tra Prevention Institute] There was no Physic restraint for this incident Report	tr Form dated 2/28/2021 Jury) Client Bruise on right Jury) Client Client then Jury) Client the gym and Jury) Client. Jury) Client The Lead Jury) Client The Lead Jury) Client The Lead Jury) Client The Lead Jury) Client then Jury) Client Jury) Clien	N -	140		
	Client-to-Staff 7) condescription Client they got into a physic client was in the hall at doors" On 8/10/2021 at 3:22 reviewed with the Action grabbed the client placed Client #7 in a Administrator stated	urbance Client-to-Client, lear, concise narrative threw a ball at another peer, cal altercation. Once the way he began to throw chairs 2 p.m., the video was diministrator. Staff pushed, ent and drug to the door, then hold at the door. The , "None, from the beginning, that was not an appropriate				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 08/13/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP (2002 S FILLMORE ST LITTLE ROCK, AR 72214		00/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
N 140	Continued From pag	e 65	N ·	140			
	There was no Physic restraint for this incide	cian's Order for a physical lent.					
	dated 3/18/2021 doc Incident [Client] was was using to draw w be scribe during fam got very upset, curse [Client] then threw powith it [Client] was the peer he hit with toutOnce [Client] w	as pulled away from client he f and he was placed in 2					
	There was no Physic restraint for this incid	cian's Order for a physical lent.					
		gnoses of Severe Major and Oppositional Defiant					
	a.m. documented, ". Client-to-Staff 7) Cdescription Client vand refused to follow was leaving the unit floor behind a chair. he had a pen next to the pen [Client #5] th staff. He was placed and was combative staff on the leg and vand continued the restrait behavior. he also mo	t Form dated 4/4/21 at 10:02Disturbance clear, concise narrative was very disrespectful to staff of instructions As the group [Client #5] was sitting on the staff walked over and noticed of him. As staff reacted to get arew a punch and hit this in a team control positionHe also attempted to bite went to the floor. Staff int due to aggressive oved his head side to side ing the floor hold. He also					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING		C 08/13/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00/10/2021
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
N 140	After that he was reattack staff and invastaff attempted a nesuccessfully compleand had to hold [Clicharm" b. Physician's Order "Zyprexa 5 mg [milli Benadryl 50 mg IM	restraint during the hold. leased. He continued to de staff personal space so w hold staff was not able to te a new hold due to fatigue ent #5's] arms to prevent rs dated 4/4/21 documented, grams] IM [intramuscular] Now. May place in seclusion."	N 14	0	
	Disorder. a. A Seclusion and I documented, "Date 6:55 PM; Date and Behavior demonstra procedure: Client ar argument that led to other. Staff separat different areas. And doors and attacked Beginning Time: 6:5 Restraint Chemica name, dose and rou Zydis 10 mg (milligra Physician's Order for restraint. b. An Incident Repo documented, "[Cliform peer [client init]	Restraint Form dated 5/15/21 and Time Initiated: 5/15/2021 Time Ended: 5/15/2021 ated to justify use of altercations of hitting each ed each client and put in other peer kicked through client 1. Observation: 0 PM; Procedure: Chemical al Restraint: (Medication ate of medication): Zyprexa am)" There was now the use of the chemical art Form dated 6/24/21 ent #8] was sitting across itals] during breakfast in the tials] was moving his hands			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		04L106	B. WING _			C 08/13/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		00/13/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 140	#8] start yelling and staff gave [Client #8 taking to tantrum for #8] then stood up in attacked [Client initia [Client initials] was percent [Client initials] was percent [Client #8] was very placed in a restraint no Physician's Order C. A Seclusion and documented, "Che name, dose and roumg (milligrams) IM (Benadryl 50 mg IM Restraint Order date "Order Type: Cher Exceed One Hour information on the order for the first place of the first p	[Client #8] got upset. [Client cursing at [Client initials],] correctives and he was continued behavior. [Client a aggressive manner and class]. Staff intervene and claced outside the cafeteria. aggressive with staff and was at 8:16 a.m" There was at 8:16 a.m" There was at 8:16 a.m" There was a for the use of the restraint. Restraint Form dated 6/8/21 cmical Restraint: (Medication the of medication) Zyprexa 5 Intramuscular) x (times) 1, x1" A Seclusion or ad 6/8/21 documented, comical Restraint Im-Not to the company of the	N 1.	40		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		COMPLETED	
		04L106	B. WING			C 08/43/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	08/13/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
N 140	Continued From pa	ge 68	N 14	40		
	documented, "Date 10:43 PM; Date and 11:10 PMBehavior of procedure: Elope with staff1. Obse PM; Procedure: Ch Observation: Begin Procedure: Persona Beginning Time: 11 Seclusion" There the use of the physic c. A Seclusion and documented, "Date 10:52 AM; Date and 11:58 AMBehavior of procedure: Elope face, kicking unit do Beginning Time: 10 Restraint2. Obse 10:56 AM; Procedu Observation: Begin Procedure: Seclusion	Restraint form dated 5/18/201 and Time Initiated: 5/18/2021 or demonstrated to justify use ement, physically aggressive rvation: Beginning Time: 10:43 emical Restraint2. ning Time: 10:47 PM; al Restraint3. Observation: :05 PM; Procedure: e were no Physician's Order for ical restraint. Restraint form dated 5/20/21 and Time Initiated: 5/20/2021 or demonstrated to justify use ement, punched staff in the tors1. Observation: :52 AM; Procedure: Personal rvation: Beginning Time: re: Chemical Restraint3. ning Time: 10:58 AM; on" There were no or the use of the personal				
	documented, "Date 7:45 PM; Date and PMBehavior dem procedure: Client be the Foyer area and kicked out several ckick exit door. Clien unit where he continuated in the continuate in the cont	Restraint form dated 6/12/21 and Time Initiated: 6/12/2021 Time Ended: 6/12/2021 9:00 constrated to justify use of ecame noncompliant while in started kicking doors. Client doors and aggressively tried to be the was escorted back to the nued to display aggressive ervation: Beginning Time: 8:05 resonal restraint3.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		04L106	B. WING			С	
NAME OF P	ROVIDER OR SUPPLIER	042100	D. WINO	STREET ADDRESS, CITY, STATE, ZIP CODE		08/	13/2021
	ETHODIST CHILDRENS	HOME		2	2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 140	restraint or seclusion. e. A Seclusion and Redated 6/14/21 docum 8:05 PM; Procedure:Beginning Time: 8:1 Seclusion" There is for the use of the personal reduction of the use of the personal reduction of the use of of the chemical reduction of the use of the chemical reduction of the use of the chemical reduction of the chemical	ng Time: 8:10 PM;" There were no the use of the personal estraint Observation Log ented, " Beginning Time: Personal Restraint 10 PM; Procedure: were no Physician's Order sonal restraint. Form dated 7/1/21 avioral Intervention me: 12:43 pm; Procedure: 2 was no Physician's Order for estraint. estraint Form dated 7/12/21 and Time Initiated: 7/12/2021 me Ended: 7/12/2021 9:25 anstrated to justify use of negative behavior, kicking estruction, physicallyBeginning Time: 9:24 AM; RestraintChemical an name, dose and route of 10 mg (milligram) IM less) 1; Benadryl 100 mg IM Physician Orders for the	N	140			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	, ZIP CODE	08/13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIA' ICIENCY)	5.75
N 140	information on the ord i. A Seclusion and Redocumented, "Chername, dose and routemg IM with Benadryl Restraint Order dated "Order Type: Chem Exceed One Hour" information on the ord information on t	straint Form dated 4/28/21 nical Restraint: (Medication of medication) Haldol 7.5 ng IM" A Seclusion or 14/28/21 documented, ical Restraint IM-Not to There was no specific drug der. straint Form dated 4/30/21 nical Restraint: (Medication of medication) Zyprexa 10 nical Restraint: (Medication of medication) Zyprexa 10 nical Restraint IM-Not to There was no specific drug der. estraint Form dated 5/18/21 nical Restraint: (Medication of medication) Zyprexa 5 ng x 1" A Seclusion or 15/18/21 documented, ical Restraint IM-Not to There was no specific drug der. estraint Form dated 5/20/21 nical Restraint: (Medication of medication) Zyprexa 10 nical Restraint IM-Not to There was no specific drug nical Restraint IM-Not to There was no specific drug	N 1	40		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 08/13/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CO 2002 S FILLMORE ST LITTLE ROCK, AR 72214	•	00/13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
N 140	name, dose and routing IM x1 Benadryl 1 Restraint Order date "Order Type: Chen Exceed One Hour" information on the or n. A Seclusion and Fidocumented, "Chename, dose and routing IM x1 Benadryl 1 or Restraint Order date "Order Type: Chenexceed One Hour" information on the or o. A Seclusion and Fidocumented, "Chename, dose and routing IM x1 Benadryl 7 Restraint Order date "Order Type: Chenexceed One Hour" information on the or p. A Seclusion and Fidocumented, "Chename, dose and routing IM x1 Benadryl 7 Restraint Order date "Order Type: Chenexceed One Hour" information on the or p. A Seclusion and Fidocumented, "Chename, dose and routing IM x1 Benadryl 1 Restraint Order date "Order Type: Chenexceed One Hour" information on the or	mical Restraint: (Medication e of medication) Zyprexa 10 00 mg x 1" A Seclusion or d 5/25/21 documented, nical Restraint IM-Not to There was no specific drug der. Restraint Form dated 6/11/21 mical Restraint: (Medication e of medication) Zyprexa 10 00 mg IM x 1" A Seclusion ated 6/11/21 documented, nical Restraint IM-Not to There was no specific drug der. Restraint Form dated 6/21/21 mical Restraint: (Medication e of medication) Zyprexa 7.5 5 mg x 1" A Seclusion or d 6/21/21 documented, nical Restraint IM-Not to There was no specific drug der. Restraint Form dated 7/8/21 mical Restraint IM-Not to There was no specific drug der. Restraint Form dated 7/8/21 mical Restraint: (Medication e of medication) Zyprexa 10 00 mg x 1" A Seclusion or d 7/8/21 documented, nical Restraint IM-Not to There was no specific drug der.	N	140		
	name, dose and rout	mical Restraint: (Medication e of medication) Zyprexa 10 1 Benadryl 100 mg PO x 1"				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _			C 08/13/2021	
	ROVIDER OR SUPPLIER	в номе		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		1 00/13/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 140	A Seclusion or Restri documented, "Ord PO-Not to Exceed C specific drug informator. A Seclusion and R documented, "Che name, dose and roum mg PO x1 Benadryl Seclusion or Restrait documented, "Ord PO-Not to Exceed C specific drug informator. A Seclusion and F documented, "Che name, dose and roum g IM x1 Benadryl for Restraint Order da"Order Type: Chem Exceed One Hour' information on the order. A Seclusion and R documented, "Che name, dose and roum g Benadryl 100 m Order dated 8/6/21 or Chemical Restraint I Hour" There was on the order. 7. Client #10 had dia Dysregulation Disord Schizophrenia Spectisorder, Unspecifie and Conduct Disorder documented Disorder.	aint Order dated 7/9/21 er Type: Chemical Restraint ne Hour" There was no ation on the order. estraint Form dated 7/12/21 mical Restraint: (Medication te of medication) Zyprexa 10 100 mg PO x 1" A nt Order dated 7/12/21 er Type: Chemical Restraint ne Hour" There was no ation on the order. destraint Form dated 7/27/21 mical Restraint: (Medication te of medication) Zyprexa 10 10 mg IM x 1" A Seclusion ated 7/27/21 documented, nical Restraint IM-Not to There was no specific drug der. destraint Form dated 8/6/21 mical Restraint: (Medication te of medication) Zyprexa 10 g" A Seclusion or Restraint locumented, " Order Type: M-Not to Exceed One no specific drug information gnoses of Disruptive Mood ler, Unspecified trum and Other Psychotic d Disruptive, Impulse-Control	N 1	40			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING		C 08/13/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00/10/2021	
(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 CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
N 140	a. A Seclusion and I documented, "Che name, dose and roumg IM with Benadry Restraint Order date "Order Type: Cher Exceed One Hour information on the ob. A Seclusion and I documented, "Che name, dose and roumg IM with Benadry Restraint Order date "Order Type: Cher Exceed One Hour information on the ob. A Seclusion and I documented, "Che name, dose and roumg IM x1 Benadryl or Restraint Order d"Order Type: Cher Exceed One Hour information on the observation of the observation on the observation of	Restraint Form dated 4/27/21 emical Restraint: (Medication te of medication) Zyprexa 10 I 100 mg IM" A Seclusion or ed 4/27/21 documented, mical Restraint IM-Not to "There was no specific drug order. Restraint Form dated 4/28/21 emical Restraint: (Medication te of medication) Zyprexa 10 I 75mg" A Seclusion or ed 4/28/21 documented, mical Restraint IM-Not to "There was no specific drug order. Restraint Form dated 5/3/21 emical Restraint: (Medication te of medication) Zyprexa 5 50 mg IM x1" A Seclusion ated 5/3/21 documented, mical Restraint IM-Not to "There was no specific drug order. There was no specific drug order. There was no specific drug order.	N 14	0		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			C 08/13/2021	
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	•	00/13/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 140	[by mouth]" There for the use of a chem b. A Seclusion and R documented, "Date a 8:50 AM; 4/4/2021 8: demonstrated to justi Physically and verba staff1. Observation Procedure: Chemical Physician's Order for restraint. c. A Seclusion and R documented, "Chemame, dose and routing IM Benadryl 100 Restraint Order date "Order Type: Chem Exceed One Hour" information on the ord. A Seclusion and R documented, "Chemame, dose and routing IM with Benadryl Restraint Order, date "Order Type: Cheme Exceed One Hour" information on the ord. Order Type: Cheme Exceed One Hour" information on the ord.	ion) Zyprexa Zydis 5 mg po were no Physician's Orders nical restraint or seclusion. Lestraint Form dated 4/4/21 and Time Initiated: 4/4/2021 51 AMBehavior ify use of procedure: Illy aggressive, threatening in Beginning Time 8:50 AM; I Restraint" There were no it the use of the chemical Lestraint Form dated 4/27/21 mical Restraint: (Medication le of medication) Zyprexa 10 lo mg IM" A Seclusion or id 4/27/21 documented, inical Restraint IM-Not to There was no specific drug ider. Lestraint Form dated 4/28/21 mical Restraint: (Medication le of medication) Zyprexa 10 75 mg IM" A Seclusion or id 4/28/21 documented, inical Restraint IM-Not to There was no specific drug ider. Lestraint IM-Not to There was no specific drug ider. Lestraint IM-Not to There was no specific drug ider. Lestraint IM-Not to There was no specific drug ider. Lestraint IM-Not to There was no specific drug ider. Lestraint IM-Not to There was no specific drug ider. Lestraint IM-Not to There was no specific drug ider.	N 14	10			
	Schizophrenia Spect Disorder, and Attention Disorder.	rum and Other Psychotic on-Deficit/Hyperactivity					
	$_{\parallel}$ a. A Seclusion and R	estraint Form dated 4/3/21					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING		C 08/13/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00/13/2021	
(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 CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICENCY)	ULD BE COMPLETION	
N 140	7:45 PM; Date and PMBehavior dem procedure: Aggress through doors1. Or 7:45 PM; Procedure: Observation Beginn Procedure: Seclusio (Medication name, or Zyprexa Zydis 5 mg There were no Physithe chemical restrain b. A Seclusion and I documented, "Date 8:40 AM; Date and AMBehavior dem procedure: Ongoing agitation, verbally at threatening staff1 Time: 8:53 AM; ProcedusionChemic name, dose and roung (milligram) IM (In no Physician's Orderestraint. c. A Nursing Progresioname, In Client #12] is a ROM (Range of Moresonal restraint documented, "Date documented, "Date of A Seclusion and I documented, "Date of A Seclusion and I documented, "Date of India and I	and Time Initiated: 4/3/2021 Time Ended: 4/3/2021 9:20 constrated to justify use of tive behavior, breaking Observation Beginning Time: Chemical Restraint 3. ing Time: 8:16 PM; con	N 14			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _				C / 13/2021	
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214			1 33/16/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
N 140	procedure: Client ber foyer area and starter. Client and peer kicker attempted to break er Client and peer also the light covers on the Beginning Time: 7:32 Restraint2. Obsert PM; Procedure: Secl Physician's Order for e. A Seclusion and Redocumented, "Date and TPMBehavior demorprocedure: Client begapparent reason. Clipeers and planned to kicking doors open in Observation Beginnin Seclusion" There we the use of seclusion. f. A Seclusion and Redocumented, "Che name, dose and routing Benadryl 50 mg Order dated 2/12/20 Chemical Restraint II Hour" There was on the order. g. A Seclusion or Redocumented, "Order IM-Not to Exceed Or specific drug informations."	onstrated to justify use of came noncompliant in the disching doors to the unit. In disching doors open to unit and external door to escape. In used laundry basket to break the unit1. Observation of PM; Procedure: Chemical vation Beginning Time: 7:35 usion" There was now the use of seclusion. It is the use of seclusion of the use of seclusion. It is the use of seclusion. It is the use of seclusion of the use of seclusion. It is the use of seclusion of the use of seclusion. It is the use of s	N ·	40				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _		,	C 08/13/2021
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
N 140	documented, "Orde IM-Not to Exceed On specific drug informa i. A Seclusion or Res documented, "Orde IM-Not to Exceed On specific drug informa j. A Seclusion and Redocumented, "Chen name, dose and rout mg IM Benadryl 50 Restraint Order dated "Order Type: Chem Exceed One Hour" information on the or k. A Seclusion and Redocumented, "Chen name, dose and rout mg with Benadryl 50 Seclusion or Restraint documented, "Order IM-Not to Exceed On specific drug informa I. A Seclusion and Redocumented, "Chen name, dose and rout mg IM with Benadryl Restraint Order dated "Order Type: Chem Exceed One Hour" information on the or m. A Seclusion or Redocumented, "Order Type: Chem Exceed One Hour" information on the or	er Type: Chemical Restraint te Hour" There was no tion on the order. traint Order, dated 3/8/21, er Type: Chemical Restraint te Hour" There was no tion on the order. estraint Form dated 4/12/21 mical Restraint: (Medication te of medication) Zyprexa 10 mg IM" A Seclusion or d 4/12/21 documented, nical Restraint IM-Not to There was no specific drug der. estraint Form dated 4/15/21 mical Restraint: (Medication te of medication) Zyprexa 5 to mg IM x1 dose each" A not Order dated 4/15/21 ter Type: Chemical Restraint te Hour" There was no tion on the order. estraint Form dated 4/21/21 mical Restraint: (Medication te Hour" There was no tion on the order. estraint Form dated 4/21/21 mical Restraint: (Medication te of medication) Zyprexa 10 50 mg IM" A Seclusion or d 4/21/21 documented, nical Restraint IM-Not to There was no specific drug	N 1-	40		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING		C 08/13/2021	
	ROVIDER OR SUPPLIER	IS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION	
N 140	documented, "Ch name, dose and roumg IM with Benadry Restraint Order date "Order Type: Che Exceed One Hour information on the co o. A Seclusion and documented, "Ch name, dose and roumg IMx1 Benadry or Restraint Order co "Order Type: Che	Restraint Form dated 4/28/21 emical Restraint: (Medication ute of medication) Zyprexa 10 yl 50 mg IM" A Seclusion or ed 4/28/21 documented, mical Restraint IM-Not to There was no specific drug order. Restraint Form dated 5/3/21 emical Restraint: (Medication ute of medication) Zyprexa 10 yl 50 mg IM x1" A Seclusion dated 5/3/21 documented, mical Restraint IM-Not to There was no specific drug	N 140			
	Depressive Disorder Disorder, Personal Childhood, Conduct Problem Related to a. Physician Orders Record (EMR) for Crestraints were orde 5/10/21, 4/28/21 at 4/12/21, 4/6/21 (at 2/3/2/21, and 2/10/21 included the names (medications) or do	ses to be given. estraint Logs documented				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING		C 08/13/2021	
	ROVIDER OR SUPPLIER	S HOME	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	00/13/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
N 140	Interventions on 7/2 (chemical), 4/6/21 (chemical), 4/6/21 (chemical). a physician order or 11. Client #2 had did Disorder with Psych Defiant Disorder, ar Related to Child Ne history of Neglect in a. Physician Orders documented on 6/1 4/26/21, 4/14/21, 4/ these orders include medicines to be given b. The "Seclusion a from the Administrated ocumented Client 4/29/21 and a chemical client #3 had did Dysregulation Disor Deficit/Hyperactivity a. A Seclusion and 1/5/21 to 7/27/21 w. Administrator on 8/2 had a chemical rest Physician's Order for the client's record. b. Physician Orders restraints ordered o	chemical at 12:30 PM) and None of these restraints had in the EMR. agnoses of Major Depressive notic Features, Oppositional and Other Circumstances glect Personal History (past in Childhood. for chemical restraints were 7/21, 6/7/21, 4/28/21, 4/27/21, 12/21, and 4/6/21. None of ead the names or doses of the en. and Restraint Log" received tor on 8/2/21 at 12:17 PM #2 had a personal restraint on nical restraint on 6/15/21 at for these restraints was found dis. agnoses of Disruptive Mood der and Unspecified Attention in Disorder. Restraint Log dated from as received from the 2/21. It documented Client #3	N 140			

AND DIAN OF CORRECTION IN IMPER		I ` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING			C 8/13/2021	
	ROVIDER OR SUPPLIER	S HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		1 00/10/2021		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
N 140	Compliance Directo orders for Client #3 AM for "Zyprexa 5 n now agitation; and 5 "Zyprexa 5 mg & Be Aggression". No oth to restraints or sective exit. 13. On 8/11/21 at 9 asked, "How do nur chemical restraint?" the doctor and informand the doctor decide Consultant was ask Physician's orders for anywhere else besign stated, "Those shouthe E [electronic] significant for a significant for	7 PM, the facility's Corporate r provided copies of physician as follows: 5/22/21 at 7:25 ng and Benadryl 25 mg IM 6/8/21 at 11:42 AM for enadryl 50 mg IM Now, ner Physician Orders related usions were provided prior to 1:52 a.m., Consultant #1 was see get the order for a She stated, "The nurse calls ms him of what's going on des what to order." The ed, "Is there any other or seclusion/restraints des in the orders?" She lid be the official orders with	N 14				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	PLE CONSTRUCTION G	(X3) DATE COMP	SURVEY PLETED
		04L106	B. WING			C 1 3/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		10/2021
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
N 140	physician" 17. A Physician Order Administration Policy Administrator on 8/12 "Procedure: 3. Or physician's order or with physician is required medication. b. Medicathe following: 1. The medication.	ers and Medication provided by the	N 14	40		
N 142	order" ORDERS FOR USE of SECLUSION CFR(s): 483.358(c) A physician or other lipermitted by the state restraint or seclusion restrictive emergency most likely to be effective.	censed practitioner and the facility to order must order the least safety intervention that is	N 14	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing staff. All nurses will be required to review and acknowledge policy and procedure which requires that restraint and seclusion must be used or after less restrictive measures have been attempted (barring an immediate safety issue). A check sheet the document this process and confirm actions inclusive less restrictive methods of de-escalation has been put in place. As of 9-3-2021. If a client requires a restrair or a seclusion there will be communication amongst direct care and nursing staff concluding that less restrictive options have been attempted and been ineffective. The exception to this would be an immediate escalation of a client into a situation posing an immediate threat to safety where less restrictive		
	Based on record revifailed to ensure the lessafety Intervention was restrictive measures of application of a restra (Clients #1, #2, #3, #8 - #12) sample clients. 1. Client #9 had diag Dysregulation Disorder.	5, and #12) of 12 (Clients #1 The findings are: noses of Disruptive Mooder, Oppositional Defiant tic Stress Disorder, and		actions might result in injury of a client of The checklist noted will be completed by duty and reviewed in conjunction with restraint procedures by the Nurse Mana Director and or the MCH Administrator. This review and acknowledgement will by 9-15-21	eview of nger, the RTC	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING				13/2021
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00/	13/2021
(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 142	documented, "Order IM [intramuscular inject 04/28/2021 2:26 PM. Order dated 4/28/21 of Seclusion Phone Of PM" The chemical ordered at the same of the sam	straint Order dated 4/28/21 or Type: Chemical Restraint oction] Phone Order Date:" A Seclusion or Restraint documented, " Order Type: rder Date: 04/28/2021 2:26 restraint and seclusion were cime. straint Order dated 6/18/21 or Type: Chemical der date: 05/18/2021 10:35 or Restraint Order dated " Order Type: Seclusion 5/18/2021 10:35 PM" The d seclusion were ordered at	N	142			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		COMPLETED		
	04L106	B. WING		C 08/13/2021		
	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00/13/2021		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION		
Phone Order Date: Seclusion or Restra documented, "Ord Restraint Phone O PM" The persona restraint were order 2. Client #11 had a Dysregulation Disor A Seclusion or Rest documented, "Ord Order Date: 4/12/20 Restraint Order date "Order Type: Chel Date: 04/12/2021 7: chemical restraint w 3. Client #12 had d Dysregulation Disor Schizophrenia Spec Disorder, and Unspec Attention-Deficit/Hyl a. A Seclusion or Red documented, "Ord Order Date: 04/12/2 or Restraint Order d "Order Type: Chel Date: 04/12/2021 7: chemical restraint w b. A Seclusion or Red documented, "Ord RestraintPhone O PM" A Seclusion 4/12/21 documented	or/27/2021 12:30 PM" A int Order dated 7/27/21 der Type: Chemical Order Date: 07/27/2021 12:30 der Extraint and chemical ed at the same time. diagnosis of Disruptive Mood der. diagnosis of Disruptive Mood der. raint Order dated 4/12/21 der Type: Seclusion Phone 21 7:20 AM" A Seclusion or ed 4/12/21 documented, mical Restraint Phone Order 20 AM" The seclusion and dere ordered at the same time. diagnoses of Disruptive Mood der, Unspecified deractivity Disorder. destraint Order dated 4/12/21 der Type: Seclusion Phone 021 7:20 AM" A Seclusion and dere ordered at the same time. destraint Order dated 4/12/21 der Type: Seclusion Phone 021 7:20 AM" A Seclusion ated 4/21/21 documented, mical Restraint Phone Order 20 AM" The seclusion and dere ordered at the same time. destraint Order dated 4/15/21 der Type: Chemical restraint Order dated 4/15/2021 4:30 or Restraint Order dated d., " Order Type: Seclusion	N 14	2			
	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF SECULATORY OF Phone Order Date: Seclusion or Restraint Phone OPM" The personal restraint were ordered. Continued From page Phone Order Date: 4/12/20 Restraint Order Date: 4/12/20 Restraint Order Date: 4/12/20 Restraint Order Type: Chen Date: 04/12/2017: chemical restraint was compared or Schizophrenia Spectoria Spectoria Schizophrenia Schizop	TIDENTIFICATION NUMBER: 04L106 ROVIDER OR SUPPLIER 1ETHODIST CHILDRENS HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ROVIDER OR SUPPLIER IETHODIST CHILDRENS HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 83 Phone Order Date: 07/27/2021 12:30 PM" A Seclusion or Restraint Order dated 7/27/21 documented, "Order Type: Chemical Restraint Phone Order Date: 07/27/2021 12:30 PM" The personal restraint and chemical restraint were ordered at the same time. 2. Client #11 had a diagnosis of Disruptive Mood Dysregulation Disorder. A Seclusion or Restraint Order dated 4/12/21 documented, "Order Type: Seclusion Phone Order Date: 4/12/2021 7:20 AM" A Seclusion or Restraint Order dated 4/12/21 documented, "Order Type: Chemical Restraint Phone Order Date: 04/12/2021 7:20 AM" The seclusion and chemical restraint were ordered at the same time. 3. Client #12 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, and Unspecified Attention-Deficit/Hyperactivity Disorder. a. A Seclusion or Restraint Order dated 4/12/21 documented, "Order Type: Seclusion Phone Order Date: 04/12/2021 7:20 AM" A Seclusion or Restraint Order dated 4/21/21 documented, "Order Type: Chemical Restraint Phone Order Date: 04/12/2021 7:20 AM" The seclusion and chemical restraint were ordered at the same time. b. A Seclusion or Restraint Order dated 4/15/21 documented, "Order Type: Chemical RestraintPhone Order Date: 04/15/2021 4:30 PM" A Seclusion or Restraint Order Date: 04/15/2021 4:30 PM" The	ROVIDER OR SUPPLIER 10		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D. WING			С	
		04L106	B. WING			08/	13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	НОМЕ		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST		
				L	LITTLE ROCK, AR 72214		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 142	the same time.		N	142			
	documented, "Orde RestraintPhone Ord AM PM" A Seclusio 4/22/21 documented, Phone Order Date: 04	traint Order dated 4/22/21 or Type: Chemical der Date: 04/22/2021 7:30 on or Restraint Order dated "Order Type: Seclusion 4/22/2021 7:30 AM" The eal restraint were ordered at					
	documented, "Orde Restraint Phone Or PM" A Seclusion of 4/28/21, documented Phone Order Date: 04	straint Order dated 4/28/21 or Type: Chemical der Date: 04/28/2021 2:26 or Restraint Order, dated or, "Order Type: Seclusion d/28/2021 2:26 PM" The sal restraint were ordered at					
	Depressive Disorder, Disorder, Personal Hi	story of Physical Abuse in Disorder, and Unspecified					
	PM documented, "Cliverbally and physicall self-harm. After seve [Behavioral Interventithe situation was turn MD notified. An order [milligrams] IM x [time seclusion room order but was ineffective and self-ball self-b	onist] to deescalate client, ed over to nursing, on call for Zyprexa 10 mg					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		PLETED
		04L106	B. WING _				C 13/2021
	ROVIDER OR SUPPLIER	НОМЕ		2002	S FILLMORE ST LE ROCK, AR 72214	1 00/	13/2021
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 142	able to calm down ar restraint and seclusion time. 5. Client #2 had diagon Disorder with Psychot Defiant Disorder, and Related to Child Negon A Report to Quality A at 7:45 AM document of the physical contacts seclusion and received 6. Client #3 had diagon Dysregulation Disord Deficit / Hyperactivity Physician's Orders didocumented Register	and get back on task." The on were ordered at the same consistency of Major Depressive tic Features, Oppositional of Other Circumstances lect Personal History. Surance form dated 4/28/21 ted, "What was the nature cot? Client was transported to ed a chemical" Thouses of Disruptive Mood er and Unspecified Attention Disorder. Sated 5/18/21 at 10:35 PM ared Nurse (RN) #2 received the seclusion and chemical	N ·	142			
	Depressive Disorder Disorder. a. An Incident Report a.m. documented, " Client-to-Staff 7) Cl description Client wand refused to follow was leaving the unit [floor behind a chair. In noticed he had a pen	ear, concise narrative vas very disrespectful to staff instructions As the group Client #5] was sitting on the Staff walked over and next to him. As staff reacted #5] threw a punch and hit					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		04L106	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	08/13/2021
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
N 142	position and was com to bite staff on the leg continued the restrain behavior. he also move trying to bite staff duri received a chemical received and invadistaff attempted a new successfully complete and had to hold [Clier harm" b. Physician's Orders "Zyprexa 5 mg [milligr Benadryl 50 mg IM Now 18. On 8/13/21 at 10:2 was asked, "Do you grestraint and a physic time?" She stated, "Y The Nurse Manager verthe doctor twice? You She stated, "Yes."	and went to the floor. Staff to the due to aggressive and went to the floor. Staff to the floor hold. He also the estraint during the hold. The assed. He continued to the estaff personal space so thold staff was not able to the anew hold due to fatigue to the fact and the floor hold. The following the floor hold staff was not able to the anew hold due to fatigue the fact and the floor hold. The floor hold The floo	N 14		
N 145	"Do you ask for a che order at the same time ask him [physician] fo can I get an IM [intran because he [client] is ORDERS FOR USE (SECLUSION CFR(s): 483.358(f) Within 1 hour of the insafety intervention a part of the safety intervention as part of the same time as the same tim	5 a.m., RN #2 was asked, mical and physical restraint e?" She stated, "When I r the order [for restraint], nuscular] for the order, in a restraint right now." DF RESTRAINT OR	N 14	This deficiency has the potential to i all clients so the following actions wi completed and pertain to all nursing Continued on next page	ill be

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			C / 13/2021
NAME OF PE	ROVIDER OR SUPPLIER	0.2.00		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	13/2021
	10115211 011 001 1 21211			2002 S FILLMORE ST		
UNITED M	ETHODIST CHILDRENS	HOME		LITTLE ROCK, AR 72214		
			I	<u> </u>		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
N 145			N 145	Continued from previous page		
N 145	safety interventions a and the facility to asse psychological wellbein conduct a face-to-face physical and psychological	and permitted by the state less the physical and less the physical and less the physical and less the physical and less the assessment of the less less less less less less less le	N 148	All nurses will be required to reviacknowledge policy and procedurequires that a face to face assessmust be completed by an RN withour of any restraint or seclusion procedures are already in place will be a review of those practice compliance with the required asstime frame will be tracked by the Information Management departing reports of compliance levels goin Nurse Manager, RTC Director ar Administrator. This will be in plane review completed by 9-12-2021	re which ssment hin one . These and this s. The essment Health ment, with g to the id MCH	
	1. The Seclusion and by the Administrator of documented, "Defin Face to Face Evaluat involved in a restraint in-person evaluation to one hour of the interv	Restraint policy provided on 8/2/2021 at 12:45 p.m. iitions & Procedures: L. ions 2. If a resident was , he/she must receive the for that intervention within ention"				
	Dysregulation Disorde A Seclusion and Rest					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	' '	ATE SURVEY DMPLETED
		04L106	B. WING _			C 08/13/2021
	ROVIDER OR SUPPLIER	В НОМЕ		STREET ADDRESS, CITY, STATE, ZIP COI 2002 S FILLMORE ST LITTLE ROCK, AR 72214		3071072021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
N 145	Procedure: Personal Assessment Date an p.m" The face-to-f	e 88 a Beginning Time 11:21 a.m. Restraint Face to Face ad Time: 1/26/21 12:30 ace assessment was ur after the restraint was	N 1	45		
	Depressive Disorder Disorder, Personal H Childhood, Conduct Problem Related to S a. The seclusion and the client's Electronic documented Emerge (ESI) on 7/22/21 (chemical), 6/15/21 (chemical), 4/29/21 (pand chemical), 4/6/2 (personal). There we face-to-face assessmafter initiation of these	restraint documentation in c Medical Record (EMR) ency Safety Interventions emical), 6/17/21 (personal or chemical), 6/8/21 (personal or personal), 4/27/21 (personal 1 (chemical), and 3/24/21 as no documentation of a ment conducted within 1 hour				
	AM documented, "RI completing the Face Nurse (LPN) #1]." 3. Client #3 had diag Dysregulation Disord Deficit/Hyperactivity a. The Seclusion and Client #3 had Emerg	N [Registered Nurse] to Face: [Licensed Practical gnoses of Disruptive Mood ler and Unspecified Attention Disorder. d Restraint Log documented ency Safety Interventions 9:22 AM and 6/15/21 at 2:27				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _				C 13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	НОМЕ		200	REET ADDRESS, CITY, STATE, ZIP CODE 02 S FILLMORE ST ITLE ROCK, AR 72214		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 145	b. Physician Orders of personal restraint ord chemical restraint ord Progress Note dated EMR for Client #3 doc [approximately] 0830 brought back to the unacting out in the class and physically aggress unit client physically aggress unit client physically applaced in a physical remaining Progress Note documented, "Client was then taken where he began kicking aggressive with staff, was given a Chemica calm down and is curn Will continue to monit assessment was documented Emergen performed on 7/12/21 (chemical), 5/18/21 (processive with staff), 12/2 PM) 4/30/21 (chemical). To the documented at 1:22 PM) 4/30/21 (chemical).	lated 5/18/21 documented a er at 8:38 AM and a ler at 1:22 PM. A Nursing 05/18/21 (not timed) in the cumented, "At aprox this morning, client was nit because he had been sroom and being verbally sive with staff. While on the attack several staff and was estraint. This nurse notified Will continue to monitor." A te on 05/18/21 by RN #2 was on the unit when talking slick, client reached in the side of the head. It to the hallway by staffing doors, being physically trying to self -harm. Client I Restraint and was able to rently resting in the foyer. For. Who face to face the umented within one hour of mented ESIs. Fraint documentation in the ecord for Client #3 may Safety Interventions (chemical), 6/15/21 personal at 8:38 AM and personal at 8	N 1		Corrective action on next page		
		-		1	Corrective action on next page		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		04L106	B. WING			08/) 13/2021	
	ROVIDER OR SUPPLIER	НОМЕ		200	REET ADDRESS, CITY, STATE, ZIP CODE 02 S FILLMORE ST TTLE ROCK, AR 72214	1 00/	13/2021	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
N 149	SECLUSION CFR(s): 483.358(h) Staff must document resident's record. The completed by the end intervention occurs. If end during the shift in documentation must I shift in which it ends. include all of the follow. This ELEMENT is not Based on record revifailed to ensure Emer were documented and assure an accurate an events leading up to, intervention for 11 (Cl #8, #9, #10, #11 and sampled clients who is Safety Intervention (E. 1. Client #8 had a dia Disorder. a. An Incident Report documented, "[Client from [peer] during bre [Peer] was moving his [Client #8] got upset. and cursing at [peer], correctives and he was continued behavior. I an aggressive manner intervene and [peer] was filtered and care intervene and [peer] was filtered and	the intervention in the at documentation must be of the shift in which the intervention does not a which it began, be completed during the Documentation must wing: If the met as evidenced by: If we and interview, the facility record to the clients' record to the during, and after the during, and after the record and the clients #1, #2, #3, #4, #5, #7, #12) of 12 (Clients #1 - #12) required an Emergency ESI). The Findings are	N 1-	S	This deficiency has the potential to impact all so the following actions will be completed an to all nursing staff. Nursing staff will complet in-service/procedure review detailing the req that all seclusion and restraint documentation completed by the end of the shift on which the seclusion or restraint is concluded. This in-s be presented by the Administrator and comp 9-15-21. The compliance with completion of Seclusion and restraint documentation will be by the Health Information Management depa with reports of compliance levels going to the Manager, RTC Director and MCH Administration of the Manager of the Man	d pertain e an uirement n must be e ervice will leted by e tracked rtment, e Nurse	9-15-21	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING			C 8/13/2021	
	ROVIDER OR SUPPLIER	S HOME	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 0		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
N 149		ge 91 was no documentation of this ntervention in the client's	N 14	49			
	Dysregulation Disor Disorder, Posttraum Attention-Deficit/Hyp a. A Seclusion and I dated 6/14/21 docur 8:05 PM; Procedure Beginning Time: 8:1 Seclusion" There	Restraint Observation Log 2 mented, "Beginning Time: :: Personal Restraint					
	documented, "Clienthallway being noncodors, threatening of client became aggrecausing the client to There was no docur Safety Intervention in 3. Client #12 had dia Dysregulation Disor Schizophrenia Special policy in the second	rt Form dated 7/1/21 t and his peer were in the ompliant continuously kicking other peers, upon separation essive and swung at staff be placed in restraint" mentation of this Emergency in the client's record. agnoses of Disruptive Mood der, Unspecified etrum and Other Psychotic cion-Deficit/Hyperactivity					
	a. An Incident Repo documented, "Clien peers two separate displayed noncompl unit doors and instig a chemical restraint	rt Form dated 2/13/21 t was observed attacking times this evening. He also iant bx [behaviors] by kicking jating peers Client received due to behavior" There ion of this Emergency Safety					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _			C 08/13/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		00/13/2021	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
N 149	documented, "Ord Restraint" There is Emergency Safety In record. c. An Incident Report documented, "Typ Property Damage' Order dated 3/8/21 a "Chemical Restrait documentation of the Intervention in the off	estraint Order dated 2/19/21 er Type: Chemical was no documentation of this intervention in the client's "It Form dated 3/8/21 e of Incident: Disturbance, "A Seclusion or Restraint at 8:00 PM documented, int" There was no e Emergency Safety ient's record. "Ses Note dated 4/11/21 at 2:35 "EN [Registered Nurse] face 4-11-21 at 2:35 pm. [Client d x [times] 3. Full ROM No injury noted. Personal erty damage" There was if the Emergency Safety ient's record. "It Form dated 4/22/21 Int was placed in seclusion	N 1				
	Restraint Order date documented, "Che was no documentati Intervention in the cl	straint Order dated 4/22/21 at ed, "Seclusion" There on of the Emergency Safety					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			0.5	C 3/13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	HOME		2002 S FILL	DRESS, CITY, STATE, ZIP CODE MORE ST DCK, AR 72214	1 00	3 10/2021
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
N 149	Continued From page	e 93	N ²	49			
		gnoses of Disruptive Mood er and Posttraumatic Stress					
	a. A Seclusion or Res 3/16/21.	straint Order was dated					
	Client to Staff 7) Cl Description Client to behavior by pushing strongly shoving. Clie by kicking doors arou placed in a restraint a There was no Seclus Nurses' Progress No addressing the restra	esignation of Incident ear, Concise Narrative began to show aggressive staff, threatening and ent then was trying to elope and the unit. He was then and seclusion room" sion and Restraint Form or te in the client record aint and / or seclusion.					
		gnoses of Severe Major and Oppositional Defiant					
	"Zyprexa 5 mg [mil	s dated 4/4/21 documented, ligrams] IM [intramuscular] low. May place in seclusion. e"					
	documented, "Secl	traint Form 1 dated 4/4/21 usion and Restraint" vations documented on the d in the client record.					
	6. Client #7 had diag Dysregulation Disord Disorder and Unspec Spectrum.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 08/13/2021
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CO 2002 S FILLMORE ST LITTLE ROCK, AR 72214	•	5071372021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
N 149	Continued From pag	e 94 dent Report Form dated	N 1	149		
	right shoulder Distuction Clear, concise narrate asked to raise his has before getting out of permission Client to physically aggressive swinging and hitting then placed in a basis. There was no Seclus Nurses' Progress No addressing the restration. A handwritten Inci. 3/12/21 documented Client-to-Client, Client narrative description.	hen became verbally and e toward staff by close hand staff on the arm. Client was ket hold" sion and Restraint Form or te in the client record aint and / or seclusion. dent Report Form dated				
	On 8/10/21 at 3:22 p incident was reviewed	.m., the video of the 3/12/21 d with the Administrator. in a physical hold prior to				
		sion and Restraint Form or te in the client record aint and or seclusion.				
	dated 3/18/21 docum Incident [Client] was was using to draw wi be scribe during fam got very upset, curse	nort to Quality Assurance nented, "Description of instructed to give the pen he th to his peer so they could ily conference. [Client] then ed staff and his peer as well. en at his peer and hit him				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	В НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00/13/2021	
(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 CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
N 149	by the peer he hit wir Once [Client] was pustarted to attack staffman control position. There was no Seclus Nurses' Progress Not addressing the restration of the peer state	then grabbed from behind th the pen and cursed out illed away from client he f and he was placed in 2" sion and Restraint Form or a te in the client record aint and or seclusion. m., the Administrator stated, 21] didn't get properly of thappened, so I pulled the but the nurses didn't cord." gnoses of Severe Major , Oppositional Defiant distory of Physical Abuse in Disorder, and Unspecified Social Environment. Restraint Log dated 4/6/21 at led by the Administrator on documented a chemical l. No documentation of this ne client's record. ackets received from f/21 at 12:08 PM, owing ESIs for Client #1, mented in the client's EMR	N 1	49		
	Behavioral Interventi	rt Packet dated 3/24/21 by onist (BI) #4 documented, " ver to peer and began hitting ver her head. Client				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _			C 08/13/2021	
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		1 00/13/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
N 149	Client threw staff phostaff attempted a resat staff until being pla 2.) An Incident Repo #4 documented, "c aggressive with staff and pulled staff by he a restraint and receivaggressive behavior. 3.) An Incident Repo #2 documented, "[Going to attack staff. walk by and attempte placed in a physical inchemical." 4.) An Incident Repo #2 documented, "t staff to help her frien [Crisis Prevention Insibegan trying to self-recombative and off tas 5.) An Incident Repo Behavior Instructor (I"When staff attempself-harm, [Client #1] was placed in a physichemical when negal [Client #1] then calm 6.) An Incident Repo documented, "Client room. Once client erself-harm. When staff eself-harm.	for after staff intervened. In one on the floor and while traint client hit and grabbed ace in a restraint." In Packet dated 4/11/21 by Bl lient became verbally I client bit staff in the face er hair. Client was placed in red a chemical due to her Int Form dated 4/27/21 by Bl client #1] stated she was I client #1] waited on staff to red to swing. [Client #1] was restraint and given a Int Form dated 4/29/21 by LBI men started charging toward d and was placed in CPI stitute personal restraint] and rearm while being defiant sk". Int dated 6/8/21 by Life LBI) #1 documented, the documented, the documented attacked staff. [Client #1] icical restraint and given a tive behavior did not stop.	N 1-	49			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		04L106	B. WING		08/13/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
N 149	placed in a restain [Client received a chbecame compliant." c. On 08/04/21 at 12 asked if the above I related documentati record also. She straint and Selection of the EMR. 8. Client #2 had dia Disorder with Psych Defiant Disorder, and Related to Child New A Seclusion and Readministrator on 8/0 documented Client; administration of a cat 4:05 PM. No doc found under the Sec in the EMR. 9. Client #3 had dia Dysregulation Disor Deficit / Hyperactivitia. A Restraint and Selection of the Restraint Section of Progress Notes. b. A Restraint and Selection of Progress Notes.	to close the door. Client was sic] due to continue behavior. emical and calmed down and 2:08 PM, Consultant #1 was neident Report Forms and on were kept in the client's ated, "No, these are kept in a gnoses of Major Depressive otic Features, Oppositional d Other Circumstances glect Personal History. Straint Log provided by the 12/21 at 12:17 PM 12/24 and ESI involving themical restraint on 6/15/21 umentation of this ESI was clusion and Restraint section gnoses of Disruptive Mood der and Unspecified Attention	N 14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED	
		04L106	B. WING _			C / 13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(X4) ID PREFIX TAG					BE	(X5) COMPLETION DATE
N 149	section of the Electron had areas for docume Safety Interventions (Emergency Safety Int ESI, end time of the Ebehavior demonstrate interventions attempte assessment at time of the sections for documentation, of ESIs, post interventions taff, and documentation assessments post interventian the restraint and section on the Electronic Seclusion and Restra "Yes, that should be the e-signatures." ORDERS FOR USE OSECLUSION CFR(s): 483.358(i)	d Restraint documentation nic Medical Record (EMR) entation of Emergency ESIs), including the time the ervention is initiated, type of ESI, criteria for release, ed, less restrictive ed, criteria for the ESI, and for removal. It also contained menting any injuries, observation log for all types tion debriefing for client and ion of Face to Face ervention. On 8/12/21 at estrator was asked, "Should usion documentation be compared to Medical Record under the int Section?" He stated, the official documentation, the official orders with the	N 1	This deficiency has the potential to all clients so the following actions v completed and pertain to all nursin. Nursing staff in both units have been provided with the correct cumulativ	vill be g staff. en	9-15-21
	This ELEMENT is no Based on interview a failed to ensure all En Interventions (ESIs) we cumulative log to enainterventions used an	nation, the interventions mes t met as evidenced by: nd record review, the facility nergency Safety vere documented on a ble tracking of the		restraint and seclusion log to be us tracking emergency procedures. T forms containing all needed inform will be completed after each emerg procedure. The forms will be audit weekly by the Nurse Manager and person absence by the RTC Direct MCH administrator. The results of audits will be reported to the RTC I and MCH Administrator.	ed in These ation pency ed in that or or the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _			C 08/13/2021	
	NAME OF PROVIDER OR SUPPLIER UNITED METHODIST CHILDRENS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		1 00/10/2021	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 155	ESIs performed. The 1. Client #1 had diag Depressive Disorder, Disorder, Personal Hi Childhood, Conduct I Problem Related to S a. Individual Seclusio dated from 1/11/21 to the Administrator on 8 Administrator stated, clients. I know it is no sheet, we are working the wrong form in the all together and not o The individual log she Client #1 on 7/22/21, 4/12/21, 4/11/21, 4/6/ b. Individual Behavior documented Client # 6/14/21, 6/12/21, 6/8/ 3/24/21, 3/19/21, 3/19 were not documented and Restraint Log she Administrator. 2. Client #2 had diag Disorder with Psycho Defiant Disorder, and Related to Child Negl a. Individual Seclusio dated from 1/11/21 to for Client #2 on 6/15/3	ampled clients who had findings are: noses of Severe Major Oppositional Defiant story of Physical Abuse in Disorder, and Unspecified ocial Environment. n and Restraint Log sheets 7/22/21 were received from 8/2/2021 at 12:17 PM. The "This is the log for female t all together on one log g on that. Some people have facility. I know it should be n separate sheets of paper." sets documented ESIs for 7/21/21, 6/15/21, 5/10/21, 21, 03/2/21, and 1/19/21. all Intervention Log sheets I also had ESIs on 6/17/21, 21, 4/29/21, 4/27/21, 4/4/21, 5/21, and 2/10/21, which I on the individual Seclusion sets provided by the noses of Major Depressive tic Features, Oppositional Other Circumstances	N 1	55			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 08/13/2021
	ROVIDER OR SUPPLIER	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1	00/10/2021
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
N 155	b. Physician Orders in Record documented performed on 6/17/21 were not reflected on Logs. 3. Client #3 had diag Dysregulation Disord Deficit/Hyperactivity I a. On 8/02/21 at 12:1 Restraint Log was read Administrator, who st male clients; you can much by month." b. Individual Behavior dated 6/22/21, 6/12/25/17/21, 5/12/21, and for Client #3 which we Seclusion and Restra 4. Client #4 had diag Dysregulation Disord Disorder. a. A Seclusion or Res 3/16/2021. b. A Seclusion or Res 3/21/2021. c. A Seclusion or Res 4/30/2021 at 7:26 p.m.	the Electronic Medical Client #2 also had ESIs , 4/14/21, and 4/6/21, which the Seclusion and Restraint noses of Disruptive Mood er and Unspecified Attention Disorder. 7 PM, a Seclusion and beived from the ated, "This is the log for see it is all together, pretty ral Intervention Log sheets 1, 5/22/21, 5/19/21/ 5/18/21, 5/8/21 documented ESIs ere not documented on the aint Log. noses of Disruptive Mood er and Posttraumatic Stress straint Order was dated straint Order was dated straint Order was dated the not documented on the er not documented on the er not documented on the	N 1	55		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		COMPLETED		
		04L106	B. WING _			C 08/13/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		, 68.16.262.	
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 155	5. Client #5 had dia Depressive Disorder. a. A Seclusion and Id 4/4/2021. b. This entry was not Seclusion and Restrict #6 had dia Dysregulation Disorda. A Seclusion and Id 1/26/2021. b. A Seclusion and Id 1/28/2021. c. A Seclusion and Id 1/28/2021. d. These entries we Seclusion and Restrict #7 had dia Dysregulation Disorder and Unspective Spectrum. a. An Incident Report	Ignoses of Severe Major r and Oppositional Defiant Restraint Form 1 was dated It documented on the raint Log. Ignoses of Disruptive Mood der and Epilepsy. Restraint Form 1 was dated Restraint Form 1 was dated Restraint Form 1 was dated	N 1				
	3/18/2021.	ty Assurance was dated re not documented on the raint Log.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l l		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _				C / 13/2021
	ROVIDER OR SUPPLIER	НОМЕ		2	TREET ADDRESS, CITY, STATE, ZIP CODE 002 S FILLMORE ST .ITTLE ROCK, AR 72214	1 00/	13/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 155	Continued From page	e 102	N -	155			
	8. Client #8 had a dia Disorder.	agnosis of Major Depressive					
	client had Emergency documented for 5/15/	int Forms 1 documented the Safety Interventions 21, 6/8/21, and 6/24/21, on the facility Seclusion and					
	9. Client #9 had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder.						
	client had ESIs perfor 5/5/21, 5/18/21, 5/20/ 6/12/21, 6/14/21, 7/1/	int Forms 1 documented the med on 4/28/21, 4/30/21, 21, 5/25/21, 6/11/216, 21 and 7/8/21, which were ty's Seclusion and Restraint					
	Dysregulation Disorder Schizophrenia Spectr Disorder, Unspecified and Conduct Disorder	um and Other Psychotic Disruptive, Impulse-Control					
	client had ESIs perfor	int Forms 1 documented the med on 4/19/21, 4/27/21, ere not listed on the facility's int Log.					
	11. Client #11 had a Mood Dysregulation [diagnosis of Disruptive Disorder.					

AND DIAN OF CORRECTION INDESTRUCTION NUMBERS		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _		C 08/13/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
N 155	Seclusion and Restra client had ESIs perfor 4/27/21, and 4/28/21, facility's Seclusion an 12. Client #12 had di Dysregulation Disorder Schizophrenia Spectr Disorder, and Attentic Disorder. Seclusion and Restra client had ESIs perfor 2/19/21, 4/3/21, 4/4/2 4/27/21, 4/28/21, 5/3/	int Forms 1 documented the med on 4/3/21, 4/4/21, which were not listed on the d Restraint Log. agnoses of Disruptive Mood	N 1	55	
N 170	asked, "Are the Seclucumulative?" He stat working on that since we should have been we have done that for "When did the facility cumulative logs?" The been in the last month brought to our attention MONITORING DURING SECLUSION CFR(s): 483.364(a) Clinical staff, trained is safety interventions, ror immediately outsid continually assessing the physical and psyconical staff.	on." NG AND AFTER In the use of emergency In the Use Physically present in	N 1	This deficiency has the potential to impact so the following actions will be completed pertain to all nursing and direct care staff perform a restraint or seclusion. All iden will complete an in-service training provice MCH administrator on proper techniques requirements of monitoring a client during seclusion. This will include direct eyes-omonitoring as well as the appropriate restrequirement for discontinuation of a section a client has become calm and no longer safety risk. The in-service will be at varied but will be completed by 9-15-21. Continued on next page	d and i who might iffied staff ded by the and g a n ponse and usion when posing a

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	ATE SURVEY OMPLETED
		04L106	B. WING_			C
NAME OF D	OVIDED OD CLIDDLIED	042100	12::::::0_	CTREET ADDRESS OFF STATE ZID COD		08/13/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	=	
UNITED M	ETHODIST CHILDRENS	HOME		2002 S FILLMORE ST		
0				LITTLE ROCK, AR 72214		
(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 170	Continued From page	: 104	N 1	70 Continued from previous pa	ge	
	meet this requirement	t.				
	This STANDARD is r Based on record revi failed to ensure staff p monitoring while clien rooms to assure the p well-being of the clien	not met as evidenced by: ew and interview, the facility provided continuous visual ts were in the seclusion physical and psychological tt for 3 (Clients #4, #9 and ents who had been placed in		Additionally all seclusions we by the MCH Administrator, to Director or a designee and of to compliance with procedur requirements. This will be effectively but has already been seen as a second of the second of	he RTC documented a ral and policy ffective as of	as
	Client #4 had diagnoses of Disruptive Mood Dysregulation Disorder and Posttraumatic Stress Disorder.					
	documented, "Beha physically aggressive attempting to elope time: 11:15 a.m. Proc Behavior Hurting se Time: 11:16 a.m. 2. C 11:17 a.m. Procedure (location) seclusion ro threatening, combativ observation/no char p.m. 3. Observation b Procedure:Chemica (location) seclusion ro combative Staff Res	A Seclusion and Restraint Form dated 6/15/21 ocumented, "Behavior Demonstrated - psysically aggressive with staff, kicking doors tempting to elope 1. Observation beginning me: 11:15 a.m. Procedure:Transport Client enavior Hurting self, combative Ending me: 11:16 a.m. 2. Observation beginning time: 17 a.m. Procedure:Seclusion Other ocation) seclusion room Client Behavior: reatening, combative, cursing. Staff Response: observation/no change Ending Time: 12:17 m. 3. Observation beginning time: 11:22 a.m. occedure:Chemical Restraint Other ocation) seclusion room Client Behavior: ombative Staff Response:Observation/No mange Ending Time: 11:23 a.m"				
	the video, Client #4 w seclusion room by 2 r Client #4 was kicking	volving Client #4 was ninistrator.At 11:16 a.m. on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			C 08/13/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	<u> </u>	00/13/2021
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
N 170	and administered ar was asked, "Should restraint and seclusing." No, should not do be was lying on the floor no staff at the window Administrator confirmation of the seclus should monitoring the seclus hould monitoring or continuous? He stawas asked, "What is He stated, "Calm, no "Is the client calm?" "Yes, he's calm, show was released at 12:	entered the seclusion room in injection. The Administrator simultaneous chemical on be used?" and he stated, both." At 11:45 a.m., Client #4 or. At 11:56 a.m., there was ow of the seclusion room. The med there was no staff usion room and was asked, if the seclusion rooms be ted "Yes." The Administrator is the criteria to come out?" of threatening." When asked, The Administrator stated, build come out." The client 18 p.m. 14 a.m., the Nurse Manager are supposed to be observed	N 17	70		
	Dysregulation Disord Disorder, Posttraum Attention-Deficit/Hyp A Seclusion and Redocumented, "Restr Time Initiated: 4/28/2 demonstrated to justransition from the dran out of the boys' three peers. Staff c Seclusion and Restr Observation Beginn	gnoses of Disruptive Mood der, Oppositional Defiant atic Stress Disorder, and peractivity Disorder. straint Form dated 4/28/21 aint and Seclusion; Date and 2021 2:58 p.m. Date and 1 3:50 p.m Behavior tify use of procedure: During ayroom to classroom client unit classroom exit doors with alled for assistance raint Observation Log 21. ing Time: 02:58 PM; al Restraint; Location: Day				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		04L106	B. WING			C 08/13/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	ı	06/13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
N 170	Ending Time: 2:59 P Beginning Time: 3:08 Location: Seclusion I SittingEnding Time Report Form dated 4 documented, "Beh. Observation Log; Tim (Chemical) Client E Time: 2:59; Procedur Time: 3:05; Procedur (Seclusion Room) Time: 3:20; Procedur Behavior: 7 Time 3 3 Client Behavior: Location: 3 Client E released from the se Documentation indic with no documented minutes before being 3. Client #11 was ac diagnosis of Disruption Disorder. a. A Seclusion and R documented, "Time a 04/28/2021 2:53 PM 04/28/2021 2:54 P.M the boys' day room to out of the boys' unit of three peers Proced b. On 8/13/21, at 9:5 incident on 4/28/21 v Corporate Complianc Client #9 and #11 was elevator vestibule with	dehavior: Threatening M. 2. Observation, Depth Procedure: Seclusion; RoomClient Behavior: 3:50 PM" An Incident /28/21 at 2:00 p.m. devioral Intervention Dece 2:58; Procedure: 4 Dehavior: 8 (Threatening) Dece 3 (Seclusion); Location: 3 Client Behavior: 7 (Sitting) Dece 3; Location: 3 Client Dehavior: 3; Location: The client was clusion room at 3:50; Procedure: 3; Dehavior: 7" The client was clusion room at 3:50 p.m. Determined the client was sitting, Default on 3/5/21 and had a we Mood Dysregulation Destraint Form dated 4/28/21	N 1	70		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _		0	C 8/13/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	<u> </u>	0/13/2021
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 170	was administered by 2:54 PM, both clients elevator, exited the earound the circular b PM, both clients wer 2:59 PM, both clients vestibule with staff. the vestibule and wa PM, Client #11 exited into the unit. Client the foyer, then got up vestibule and was tal exited the vestibule is seclusion room at 3: walks away from secseen monitoring the #11 walked into the swere walking around visually monitoring the PM, the video stopped observed monitoring 3:05 PM through 3:00 A. Client #2 had diagnosorder with Psychologiant Disorder, and Related to Child Negative An entry dated 4/28/Electronic Medical R. Log by Registered N. Client #2 was in section chemical restraint, withing. One minute documented the clients	p on the wall and an injection the nurse to both clients. At a and staff entered the elevator, and walked to and ench in the foyer. At 2:58 e kicking the unit doors. At a went into the elevator At 3:01 PM, Client #9 exited liked into the unit. At 3:03 d the vestibule and walked #9 was sitting on a chair in a and walked into the liking to staff. The client into the foyer, then into the 05 PM. At 3:05 PM, staff elusion room and no staff are client. At 3:05 PM, Client seclusion room, and staff in the unit. No staff were in esclusion room. At 3:08 ed, and there were no staff the seclusion rooms from 8 PM when the video ended.	N 1	70		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	
		04L106	B. WING			08/	13/2021
	ROVIDER OR SUPPLIER	НОМЕ	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		002 S FILLMORE ST		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 170	AM. At that time, RN was calm and was rel 5. The facility Seclus received from the Adr 12:36 PM, documente Residents: 1. Clinical emergency safety into Direct Care Staff (Bel physically present (if door looking in), 2. comonitoring the physic well-being of the reside POST INTERVENTION (CFR(s): 483.370(a)) Within 24 hours after seclusion, staff involvintervention and their face-to-face discussioniclude all staff involviwhen the presence of may jeopardize the word (the tree guardian(s)) may partity when it is deemed apfacility must conduct slanguage that is under by the resident's pare The discussion must and staff the opporturicircumstances resultins seclusion and strateg	re documented until 9:06 #4 documented Client #2 leased from seclusion. ion & (and) Restraint policy, ministrator on 8/2/21 at ed, "Monitoring of staff training in the use of ervention must include that havior Instructors) are: 1. seclusion, right outside the entinually assessing and al and psychological dent" DN DEBRIEFINGS the use of the restraint or red in an emergency safety esident must have a on. This discussion must red in the intervention except f a particular staff person ellbeing of the resident. sident's parent(s) or legal cipate in the discussion propriate by the facility. The such discussion in a erstood by the resident and ent(s) or legal guardian(s). provide both the resident nity to discuss the ing in the use of restraint or ies to be used by the staff, is that could prevent the		170	This deficiency has the potential to in all clients so the following actions will completed and pertain to all nursing direct care staff who might perform a restraint or seclusion. All identified swill complete an in-service training or proper procedure for conducting a client debriefing. This will include who must be preser what to do if a staff member must be excused, and the goals of the procedure frames required for completion also be covered. Debriefing docume will be reviewed by the program supervisors and compliance reported RTC Director and the MCH Administ This in-service will be completed by 9-12-21	Il be and a staff on nt, e ss. will entation d to the	9-15-21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _			C 08/13/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		00/10/2021	
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 188	Based on observation interview, the facility participated in Emeric (ESI) were present of provide the client an analyze the events of determine if any chaplans were needed if #9, #10, and #12) of ESIs performed. The selection of ES	not met as evidenced by: on, record review and failed to ensure all staff who gency Safety Intervention during the client debriefing to d staff with an opportunity to surrounding the ESI and nges in the clients' treatment for 7 (Clients #1, #3, #4, #6, 12 sampled clients who had de findings are: gnoses of Disruptive Mood der, Oppositional Defiant atic Stress Disorder, and peractivity Disorder. Restraint Form dated 4/21/21 nt became noncompliant in ENA [Certified Nursing ent started kicking doors all Restraint Staff in ered Nurse (RN) #7], tionist (BI) #8], [RN #2]" dated 4/21/21 documented, ames of Others Involved or Instructor (LBI) #1] Staff embers present: [BI #8], [BI o other names of those who e Client Debriefing. Restraint Form dated 4/28/21 ing transition from the m client ran out of the boys loors with three peers all Restraint Seclusion Consultant #2, [LBI #2], [BI	N 1	88			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		04L106	B. WING			C		
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STAT 2002 S FILLMORE ST LITTLE ROCK, AR 72214		08/13/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	((EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)	5.475		
N 188	Involved [BI #13] Members present [I #2]". There were no attended listed on the c. An Incident Report "Roles & Names [Consultant #1], [BI # jumped into a physica and placing a peer in received a chemical In Debriefing conducted members present: [C #1], [RN #2]" There those who attended in Debriefing.	Staff Debriefing Staff Consultant #2], [BI #6], [RN other names of those who e Client Debriefing. dated 4/30/21 documented, of Ohers Involved 14], [Consultant #2] Client al altercation hitting a peer a choke hold Client restraint Staff Debriefing I by: [Consultant #2]; Staff onsultant #2], [Consultant e were no other names of	N ·	88				
	"Roles& Names of [BI #11] Client because the foyer area and standing the foyer area and standing to the foyer area and standing the foyer area and standing the foyer area and standing the foyer and the foyer attended listed on the standing the foyer and the f	of Others Involved [BI #8], ame noncompliant while in arted kicking the doors. eral doors and aggressively oor Client was placed in a lordered seclusion Staff embers Present: [BI #8], [BI Name any staff who ervention and were excused N/A [Not applicable]"						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING		C 08/13/2021		
	ROVIDER OR SUPPLIER	S HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		06/13/2021		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
N 188	were no other name listed on the Client I f. An Incident Repor "Roles & Names [LBI #1], [BI #18]C destroy property, jur placed in a physical [LBI #1], [Nurse #1], other names of thos Client Debriefing. g. An Incident Report documented, "Role Involved [BI #7], [Gill #1] Client Debriefing By: [BI #7], Staff Me #13]; Name any statintervention and were debriefing: No" The those who attended Debriefing. 2. Client #10 had did Dysregulation Disorder, Unspecificand Conduct Disord Hyperactivity Disord Hyperactivity Disord Hyperactivity Disord A Seclusion and Readocumented, "Dur day room to the class the boys' unit classing peers Procedure: Incident Report date "Roles & Names	is of those who attended Debriefing. It dated 6/24/21 documented, of Others Involved: [BI #3], of [Client] was attempting to mping on furniture was restraint Staff Debriefing [BI #3]" There were no e who attended listed on the extraction of the who attended listed on the consultant #2], [Consultant ng Debriefing Conducted extraction of the execused from the ere were no other names of listed on the Client expectation of the client expectation of the consultant had not be recovered from the ere were no other names of listed on the Client expectation of the client expectation of the psychotic expectation of the psychotic expectation of the control of the cont	N 18	8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER	042100] B. Wille		TREET ADDRESS, CITY, STATE, ZIP CODE	08/	13/2021
UNITED M	ETHODIST CHILDRENS	HOME		LITTLE ROCK, AR 72214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 188	Continued From page	e 112	N ·	188			
	no other names of the the Client Debriefing.	ose who attended listed on					
	Dysregulation Disord Schizophrenia Specti	ignoses of Disruptive Mood er, Unspecified rum and Other Psychotic on-Deficit/Hyperactivity					
	"Roles & Names of [BI #12], [Nurse #2]; attacking peers two seems that also displayed no doors and instigating due to behavior Stamembers present: [CManager Name any intervention and were	reparate times this evening. Incompliance by kicking unit Incompliance by kicking unit Incompliance by kicking unit Incompliance by kicking unit Incompliance In					
	"Roles & Names [BI #7] Client was we upon finishing client was stay seated, client non-compliant was given a chemical S Members present: [B staff who participated excused from the determination of the staff who participated excused from the determination of the staff who participated excused from the determination of the staff who participated excused from the determination of the staff who participated excused from the determination of the staff was a staff who participated the staff was a staff who participated the staff was a staff who participated the staff was a staff was a staff who participated the staff was a st	dated 4/22/21 documented, of Others Involved: [RN #2], woke up for hygiene and would not follow instructions began to get upset and placed in seclusion and taff Debriefing Staff I #7], [BI #8] Name any I in the intervention and were priefingN/A" There were use who attended listed on					
	4. Client #4 had diag	noses of Disruptive Mood					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		041.406	B. WING			C	
		04L106	B. WING			08/	13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	номе		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 188	Dysregulation Disorder. a. An Incident Report "6) Roles & Name #1], [BI #4], [BI #6] ar narrative description peers when he and a altercation. Client bed and was placed in a pub. The Post-Intervention 4/30/21 documented, 4/30/21 (not timed) Si #8]" There were not the Client Debriefing. 5. Client #6 had diag Dysregulation Disorder a. An Incident Report documented, "Distured Roles & Names of Central Englishment of the Post-Intervention 1/26/21 documented, 1/26/21 12:43 p.m. Si #1] and [BI #7] Namin the intervention and debriefing because his jeopardize the well-beapplicable]" There elisted on the Client Debriefing because his jeopardize the well-beapplicable]" There listed on the Client Debriefing because his jeopardize the well-beapplicable]" There listed on the Client Debriefing because his jeopardize the well-beapplicable]" There listed on the Client Debriefing because his jeopardize the well-beapplicable]" There listed on the Client Debriefing because his jeopardize the well-beapplicable]" There listed on the Client Debriefing because his jeopardize the well-beapplicable]" There listed on the Client Debriefing because his jeopardize the well-beapplicable]" There listed on the Client Debriefing because his jeopardize the well-beapplicable]"	dated 4/30/21 documented, as of others involved [LBI and [BI #8] 7) Clear, concise client was in the gym with peer got into a physical same extremely aggressive obysical restraint" Ion Debriefing form dated " Staff Debriefing taff Members present: [BI to other staff names listed on others involved [LBI #1], Debriefing form dated " Staff Debriefing taff Members present: [LBI to other staff names listed on other staff names staff of the client: N/A [not were no other staff names ebriefing.	N	188			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _				C / 13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	НОМЕ		20	TREET ADDRESS, CITY, STATE, ZIP CODE 002 S FILLMORE ST TITLE ROCK, AR 72214	1 00/	13/2021
(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) COMPLETION DATE
N 188	2/8/21 documented, "Debriefing conducted present: [blank]. Namin the intervention and debriefing because hi jeopardize the well-bether were no other in Debriefing. 6. Client #1 had diag Depressive Disorder, Disorder, Personal Hi Childhood, Conduct In Problem Related to Some Seclusion and Reat 9:25 p.m. documer and verbally aggressi attempting to self-har Nurse (LPN) #1], [Black contraband" The clonly Bl #11 as particip	Debriefing form dated Client Debriefing 2/8/21 by [BI #7]. Staff Members ne any staff who participated d were excused from the s/her presence would eing of the client: [blank]" names listed on the Client noses of Severe Major Oppositional Defiant story of Physical Abuse in Disorder, and Unspecified ocial Environment. estraint form dated 6/12/21 nted, "Client was physically ve towards staff and m [Licensed Practical #8], and [BI #11] checked for ient debriefing documented oating. noses of Disruptive Mood er and Unspecified Attention	N 1	188			
N 189	at 10:02 a.m. docume self-harming, physica RN #2 was document ESI for Client #3 but v participating in the Cli	ent Debriefing.	N 1	189	Corrective action begins on next p	age	

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	COMP	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING _			C 1 3/2021	
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	номе		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
N 189	seclusion, all staff inv safety intervention, ar and administrative sta debriefing session that review and discussion 483.370(b)(1) The ent that required the inter	the use of restraint or olved in the emergency and appropriate supervisory aff, must conduct a at includes, at a minimum, a n of -	N 1	This deficiency has the potential to the following actions will be comple all nursing and direct care staff who restraint or seclusion. All identified an in-service training provided by the Consultants and or the Administrate procedure for conducting a staff del This will include who must be prese staff member must be excused, and process. Time frames required for be covered, including order of clien debriefing meetings. Debriefing do reviewed by the program supervisor poprted to the RTC Director and the Administrator. This in-service will be include all shifts but will be comple	ted and pertain to omight perform a staff will complete per program or, on proper briefing. In the goals of the completion will also t and staff cumentation will be rs and compliance per MCH eart various times to	9-10-21	
	Based on observation failed to ensure all state Emergency Safety Interpresent during the state staff with an opportung surrounding the ESI and changes in the clients needed for 6 (Clients #12) of 12 (Clients #1 clients who had ESIs are: 1. Client #9 had diag Dysregulation Disorder, Posttrauma Attention-Deficit/Hypea. A Seclusion and Redocumented, "Cliented Interpretation of the state of t	dervention (ESI) were aff debriefing to provide the lity to analyze the events and determine if any treatment plans were #1, #4, #6, #9, #10, and through #12) sampled performed. The findings moses of Disruptive Mooder, Oppositional Defiant tic Stress Disorder, and eractivity Disorder.					
	the foyer area with Cl	NA [Certified Nursing It started kicking doors					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L106	B. WING				C 1 3/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	HOME		2002 S FILL	PRESS, CITY, STATE, ZIP CODE MORE ST PCK, AR 72214	1 00/	10/2021
(X4) ID PREFIX TAG	(-, -, -, -, -, -, -, -, -, -, -, -, -, -		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
N 189	The Incident Report "Roles & [and] Ni [BI #8], [Life Behavior Debriefing Staff Me #12]". There were ni who attended the Sta b. A Seclusion and Ri documented, "Duri dayroom to classrooi unit classroom exit d Procedure: Chemica Staff in Attendance: 6 #6]". An Incident Re documented, "Role Involved [BI #13] Members present [#2]". There were no who attended the Sta c. An Incident Repor "Roles & Names [Consultant #1], [BI # jumped into a physic and placing a peer in received a chemical Debriefing conducted members present: [C #1], [RN #2]" Ther of staff who attended d. An Incident Repor "Roles & Names [BI #2], [Consultant #	red Nurse (RN) #7], ionist (BI) #8], [RN #2]" dated 4/21/21 documented, ames of Others Involved r Instructor (LBI) #1] Staff embers present: [BI #8], [BI to other names listed of staff aff Debriefing. restraint Form dated 4/28/21 ring transition from the m client ran out of the boys restraint Seclusion Consultant #2, [LBI #2], [BI port dated 4/28/21 ris & Names of Others Staff Debriefing Staff Consultant #2], [BI #6], [RN rother names listed of staff aff Debriefing.	N	189			
	to take shoes off whi	le in laundry area he ripped nges Client was given a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _				C 13/2021	
	ROVIDER OR SUPPLIER	НОМЕ		STREET ADDRESS, CI 2002 S FILLMORE ST LITTLE ROCK, AR	т	1 00/	10/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD FERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
N 189	Members present: [B [Nurse Manager], [BI names listed of staff Debriefing. e. An Incident Repor "Roles& Names of [BI #11] Client becathe foyer area and st	Staff Debriefing Staff I #15], [Consultant #2], #7]" There were no other who attended the Staff it dated 6/12/21 documented, of Others Involved [BI #8], ame noncompliant while in arted kicking the doors.	N ·	89				
	tried to kick out exit of physical restraint and Debriefing Staff Me #17], [Consultant #1] participated in the interior the debriefing There were no other	th kicked out several doors and aggressively to kick out exit door Client was placed in a ical restraint and ordered seclusion Staff iefing Staff Members Present: [BI #8], [BI [Consultant #1]. Name any staff who cipated in the intervention and were excused the debriefing N/A [Not applicable]" e were no other names listed of staff who ded the Staff Debriefing.						
	documented, "Aggropen unit doors atter Chemical Restraint 6/21/21 documented Others Involved [Bl Debriefing Staff Me Health Therapist (MH	restraint Form dated 6/21/21 ressive with staff and kicking repting to elope Procedure: " The Incident Report dated "Roles& Names of #3], [Consultant #2] Staff rembers Present: [Mental HT] #1], [BI #3]" There						
	"Roles & Names [LBI #1], [BI #18]C1 destroy property, jum placed in a physical I [LBI #1], [Nurse #1],	dated 6/24/21 documented, of Others Involved: [BI #3], [Client] was attempting to ping on furniture was restraint Staff Debriefing [BI #3]" There were no staff who attended the Staff						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _			C / 13/2021
	ROVIDER OR SUPPLIER	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		10/2021
(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 COME (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
N 189	Continued From page	e 118 dated 7/27/21 documented,	N 1	89		
	"Roles& Names of #2], [LBI #1], [BI #6] receiving correctives after staff prompted heing up without permevery door and kickin window ct was give Debriefing Staff Me #2], [RN #2]" There of staff who attended 2. Client #10 had dia Dysregulation Disorder, Unspecified and Conduct Disorder Hyperactivity Disord	Others Involved: [Consultant . Ct peer was upset after for not following instructions im to have a seat while nission Ct started kicking g the glass to the cafeteria n a chemical Staff mbers present: [Consultant e were no other names listed the Staff Debriefing. gnoses of Disruptive Mood er, Unspecified rum and Other Psychotic I Disruptive, Impulse-Control r, Attention-Deficit/ r and Anxiety Disorder. Traint Form dated 4/28/21 ng transition from the boys' room the client ran out of om exit door with three hemical Restraint" The I 4/28/21 documented, of Others Involved: [BI g Staff Members present: 6], [RN #2]" There were I of staff who attended the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _			C 08/13/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CO 2002 S FILLMORE ST LITTLE ROCK, AR 72214	•	00/10/2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
N 189	[BI #12], [Nurse #2]; attacking peers two He also displayed n doors and instigating due to behavior S members present: [I Manager" There is staff who attended to b. An Incident Repo "Roles & Names [BI #7] Client was upon finishing client to stay seated, clien non-compliant war given a chemical Members present: [I	of Others Involved: [BI #11], c Client was observed separate times this evening. concompliance by kicking unit g peers received a chemical taff Debriefing Staff Consultant #2], [BI #1], Nurse were no other names listed of	N ·	189			
	Dysregulation Disor Disorder. a. An Incident Repo "6) Roles & Nam #1], [BI #4], [BI #6] a narrative descriptior peers when he and altercation. Client be and was placed in a b. The Post-Interver 4/30/21 documented 4/30/21 (not timed)	agnoses of Disruptive Mood der and Posttraumatic Stress art dated 4/30/21 documented, nes of others involved [LBI and [BI #8] 7) Clear, concise n client was in the gym with a peer got into a physical ecame extremely aggressive physical restraint" Intion Debriefing form dated d., " Staff Debriefing Staff Members present: [BI no other staff names listed on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		04L106	B. WING				C 13/2021
	ROVIDER OR SUPPLIER	НОМЕ		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		10,202
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 189	a. An Incident Report documented, "Distured Roles & Names of a [BI #7] and [BI #9]" The Post-Intervention 1/26/21 documented, 1/26/21 12:43 p.m. S #1] and [BI #7]" The names listed on the S b. An Incident Report documented, "Injury hitting walls, doors ar Client-to-Client, Client Roles & Names of and [BI #9]" The Post-Intervention 2/6/21 documented, "(not timed) Staff Mem There were no other staff Debriefing. 6. Client #1 had diag Depressive Disorder, Disorder, Personal H Childhood, Conduct I Problem Related to S The Seclusion and R	proses of Disruptive Mood er and Epilepsy. Form dated 1/26/21 properties involved [LBI #1], Debriefing form dated " Staff Debriefing Staff Members present: [LBI pere were no other staff of Baff Debriefing. Form dated 2/6/21 y [Client] self-harmed and floors Disturbance protection of the staff of the sta	N	189			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING		1	C / 13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00	10,2021
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
N 189	Nurse (LPN) #1], [BI accontraband Staff Definition of Staff Definition of Staff documentation of Staff document	m [Licensed Practical #8], and [BI #11] checked for ebriefing Conducted by [BI designated for ff members who were ebriefing did not include	N 18			
N 202	that results in an injur meet with supervisory	mergency safety intervention ry to a resident or staff must r staff and evaluate the aused the injury and develop	N 20	This deficiency has the potential clients so the following action completed and pertain to all numbers direct care staff who might perform restraint or seclusion. All restricts seclusions are now being review MCH Administrator, the RTC Didesignee and documented as a compliance with procedural and requirements. As part of this reprocess needed feedback or of	ens will be a price and form a paints and a price and a policy a p	9-15-21
	Based on observation interview, the facility to involved in an Emerging (ESI) that resulted in supervisory staff to exthat caused the injurity implemented a plan to injuries for 1 (Client as	failed to ensure staff ency Safety Intervention client injuries met with valuate the circumstances es and developed and o prevent further potential nd #9) 3 (Clients #5, #7 and vho received an injury during		are noted. This is then passed supervisor who meets with the involved to evaluate the circum and discuss needed actions. The staff involved then sign an acknowledgment of this meetir information. This will be effect of 9-12-21.	staff istances d ig and	
	Dysregulation Disorder Disorder, Posttrauma Attention-Deficit/Hype a. A Seclusion and Redocumented, "Date a 1:23 PM; Date and Ti	ses of Disruptive Mood er, Oppositional Defiant tic Stress Disorder, and eractivity Disorder. estraint Form dated 7/27/21 nd Time Initiated: 7/27/2021 me Ended: 7/27/2021 1:33 nstrated to justify use of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER	U4L100	B. WING	S	TREET ADDRESS, CITY, STATE, ZIP CODE	08/	13/2021
	ETHODIST CHILDRENS	HOME		2	002 S FILLMORE ST ITTLE ROCK, AR 72214		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
N 202	kicking doors / window Assessment (Upon re time): 7/27/2021 2:00 Assessment: bruising and bleeding from his Beginning Time: 1:23 Restraint: Other (Loca Behavior: Cursing The Beginning Time: 1:24 Restraint" b. A Nursing Progress PM documented, "Con any door they coul break out and elope. client and peer from re but client became ver staff, punching them, verbally aggressive. [Doctor] and order was chemical restraint by After client tried to sw fist, client was put in re due to still being aggre have a little bruising of slightly swollen and ne c. On 8/12/21 at 3:41 Administrator reviewe the 7/27/21 incidents following findings: At 1:18:36, the client swung at staff. At 1:19:23, the client	aggressive with staff, ws, attempting to elope emoval from procedure - PM Physical Status on chin, swelling on cheek is nose1. Observation: PM; Procedure: Personal ation): hallway Client reatening 2. Observation: PM; Procedure: Chemical So Note dated 7/27/21 at 3:00 Client and peer were kicking Id, kicking windows, trying to Staff was able to keep making it out of the building, y physically aggressive with pushing them, being This nurse notified the DR as received to give client a IM [intramuscular injection). Aing on staff with a closed restraint for 10 min [minutes] ressive He was noted to son his chin and cheek was ose bled slightly" PM, the Surveyor and ad the surveillance video for involving Client #9, with the kicked a door and walked in four staff following him,	N	202			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING		C 08/13/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	00/13/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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 APPROPRIA DEFICIENCY)	5.475
N 202	, , , , , , , , , , , , , , , , , , ,		N 20	2	
	staff and client fell to a struggling and was re 1:30:42. The client the position on the floor a The Administrator stat the floor, they should				
	(RN) #2 was asked, "injured during a restration injured during a restration injured during a restration injured staff, and strestraint, and he was bruising. I could see was coming from his to assess him, I saw it wasn't really flowing little swollen, but he was back and forth. He had on his chin. His right The RN was asked, "I	a.m., Registered Nurse How did [Client #9] get hint on 7/27?" She stated, we, big child. He was aff had to put him in a taken to the floor and he got the blood on the floor. It hose. When he allowed me t was coming from his nose. I, it was just some; it was a was able to move his nose ad a nickel-sized abrasion cheek was a little swollen." Have you had any retraining fter this?" She stated, "No."			
N 207	was asked, "Have you on CPI [Crisis Preven wide?" She stated, "N		N 20	7	
IN 207	CFR(s): 483.374(b) Reporting of serious of The facility must report to both the State Med	occurrences. rt each serious occurrence icaid agency and, unless w, the State designated acy system.	N 20	As nurses are the staff charged with determithe consultation of other medical staff) the seriousness of any injury and assessing risk suicide gestures or ideations, the nursing staresponsible for this reporting. This will be eit directly by completing the incident report or be documented communication with the prograr consultant (supervisor) who will then complereport and submit it within the required time f serious occurrence reports will be sent to the Medicaid Agency(Office of Long-Term Care) Disability Rights Arkansas. Continued on next page	from 5-13-21 from ff will be her by n te the trame. All state

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _				C 13/2021
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214		1 00/	10/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		3E	(X5) COMPLETION DATE
N 207	section §483.352 of t - a resident's suici (1) Staff must report involving a resident to agency and the State Advocacy system by business the next bus occurrence. The report - the name of the serious occurrence, - a description of t	ch; to a resident as defined in this part; and tide attempt. any serious occurrence to both the State Medicaid to designated Protection and no later than close of siness day after a serious ort must include resident involved in the the occurrence and, address, and telephone	N 2	2207	Continued from previous page Nursing reporting will be monitored by the N Manager, and all incident reports are review MCH administrator. To be assured that the requirements are cle understood, this information will be included in-service review provided by the MCH Adm that all nurses will complete no later than 9-	arly in an inistrator	
	This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a serious occurrence was reported to the State Agency as required, to enable the agency to provide any needed oversight of the facility's investigation for 1 (Client #1) of 12 (Clients #1 through #12) sampled clients whose records were reviewed for serious occurrences. The findings are: Client #1 had diagnoses of Severe Major Depressive Disorder, Oppositional Defiant Disorder, Personal History of Physical Abuse in Childhood, Conduct Disorder, and Unspecified Problem Related to Social Environment. a. Nursing Progress Notes dated 7/22/21 (not timed) by the Nurse Manager documented, "Client was physically attacked by two peers, bite mark to left upper arm and left shoulder patient						
	mark to left upper arr						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG	(.	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 2002 S FILLMORE ST LITTLE ROCK, AR 72214	CODE	08/13/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE	
N 207	administer Tylenol or pack and continue to b. A Radiology Interp 7/23/21 documented #1's right index finger index finger P3 [third finger] fracture". c. On 8/13/21 at 10:4 Compliance Director [Client #1's] finger brosure, but I will find that d. On 08/13/21 at 11: was asked, "Was a smade and sent to the [Client #1's] broken fi happened was, she vevening, the nurse dibroken she [Client # next day and complai was sent for X-rays, a broken. The nurse didoing the incident repreport was not done, you, DHS [Departmer Administrator was as now?" He stated, "The nurse of the stated, "The stated state	IBU [ibuprofen] and give ice monitor."	N:	207			





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

October 6, 2021

Craig Gammon, Administrator United Methodist Childrens Home 2002 S Fillmore St Little Rock, AR 72214-4848

IMPORTANT NOTICE - PLEASE READ CAREFULLY

Dear Mr.. Gammon:

On August 13, 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 August 27, 2021.

A revisit was conducted on September 30, 2021, and your facility was still not in substantial compliance with the following participation requirement(s):

N0135 - Protection of Residents N0149 0 Orders of Use of Restraint or Seclusion N0207- Facility Reporting

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
(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

Craig Gammon - United Methodist Childrens Home - 10/06/2021 - (AOLTC - PRTF CNC) Page 2]

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

Sincerely,

Saudie Bisington. Administrative Services Manager

DPSQA/Office of Long Term Care Survey & Certification Section

sgb

cc: DRA

PRINTED: 10/06/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDI	110		R-C	
		04L106	B. WING _			09/	30/2021
NAME OF PR	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
					2002 S FILLMORE ST		
UNITED M	ETHODIST CHILDRENS	HOME		LITTLE ROCK, AR 72214			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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170			IAG		DEFICIENCY)		
{N 000}	Initial Comments		{N 0	000	}		
	Nets The ONO OF	7 (Ot-ttf-D-fii)					
		7 (Statement of Deficiencies)					
		cument. All information must scept for entering the plan of					
		dates, and the signature					
		ncy in the original deficiency					
		orted to the Dallas Regional					
	Office (RO) for referra						
	Inspector General (O	IG) for possible fraud. If					
		tently changed by the					
		State Survey Agency (SA)					
	should be notified imr	mediately.					
	A revisit survey was o	conducted from 09/28/2021					
	to 09/30/2021.						
	The facility was not in	compliance with §483,					
	Subpart G - Conditio						
	Psychiatric Residentia						
{N 135}			{N 1	35	}		
, ,	CFR(s): 483.356(c)(3)					
	[At admission the fac	sility mustl obtain an					
	[At admission, the fac	writing, from the resident, or					
		r, from the parent(s) or legal					
		r she has been informed of					
		the use of restraint or					
	, , ,	mergency safety situation.					
	Staff must file this ack						
	resident's record; and						
	This FI FMFNT is no	ot met as evidenced by:					
	THIS ELEIVILIVE IS HU						
LABORATORY	DIDECTOR'S OF PROVIDERS	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING			R-C 09/30/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2002 S FILLMORE ST LITTLE ROCK, AR 72214		J9/30/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
{N 135}	failed to ensure an A /Release document f Interventions (ESIs) parents/legal guardia for 4 (Clients 1, 2, 4, were admitted to the 1. Client #2 was adm 09/19/2021 and had Mood Dysregulation Schizophrenia spectr Disorder, Tourette's I Attention-Deficit/Hyp Unspecified Feeding a. On 09/28/2021 at medical records were Consent/ Release for her parents/legal guardiand. b. On 09/28/21 at 2:2 stated, "I forgot to tel we are putting their min the document libra Medical Records]." Hound on the EMR for asked, "Would it be at Client #2's EMR at one in fact is unforturide what happened there. You picked the the weekend, but that got the same training should have it."	iew and interview, the facility uthorization/ Consent or use of Emergency Safety was signed by the client's in at the time of admission and 5) sampled clients who facility. The findings are: iitted to the facility on diagnoses of Disruptive Disorder, Unspecified rum and Other Psychotic Disorder, Unspecified eractivity disorder, and or Eating Disorder. 11:30 a.m., Client #2's reviewed for Authorization/ the use of ESIs, signed by ardian. No consent was 11 p.m., the Administrator I you that with the new kids, estraint/seclusion consents ry on the EMRs [Electronic le was told, "No consent was anywhere else?" He looked at this time, then stated, "That mately missing. I have no to [Client #2], why it isn't e one that isn't there. It was t is no excuse because they peveryone else did, we	{N 13	35}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		E SURVEY PLETED
		04L106	B. WING			1	R-C
NAME OF PI	ROVIDER OR SUPPLIER	0.2.00		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	08	/30/2021
UNITED M	ETHODIST CHILDRENS	В НОМЕ			S FILLMORE ST LE ROCK, AR 72214		
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{N 135}	Continued From page Disorder, Opposition Posttraumatic Stress 3. Client #4 was adm 04/16/2021, and had Mood Dysregulation Defiant Disorder, Po and Attention-Deficit 4. Client #5 was adm 06/03/2021, and had Mood Dysregulation Schizophrenia Spect Disorder, and Unspect Attention-Deficit/Hyp 5. According to a list Administrator on 09/parents or guardians been sent the facility Time-Out Policy on 0 responded. The Adm log of who did not had when we reviewed the time and that we had consent. What we are copies of the policy of their review, one for them to sign and retunot have consents of	e 2 al Defiant Disorder, and a Disorder. hitted to the facility on I diagnoses of Disruptive Disorder, Oppositional straumatic Stress Disorder (Hyperactivity Disorder. hitted to the facility on I diagnoses of Disruptive Disorder, Unspecified trum and Other Psychotic scified eractivity Disorder. received from the 29/2021 at 10:22 a.m., the of Clients #1, 4, and 5, had Seclusion, Restraint, and	{N 1	35}	DEFICIENCY)		
	returned the signaturnaven't. We are plan request or calling the asked, "So, you still parental or guardian should they have on was asked, "Have you	re sheets, but a number who ning on sending out another em to get it done." He was have several clients without consents on their charts, e?" He answered, "Yes." He ou followed up with the since they were initially sent					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		04L106	B. WING _		R-C 09/30	/2021
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 03/00	72021
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
{N 135}	wanted to give them going to start following	ne 3 ator replied, "Not yet. We time to respond, but we are ng up. One even had an d was returned to us	{N 13	35}		
{N 149}		e have to figure that out." OF RESTRAINT OR	{N 14	19}		
	resident's record. The completed by the en intervention occurs. end during the shift in documentation must	be completed during the Documentation must				
	Based on record reversal failed to ensure an Electric Intervention (ESI) was client's record to assess complete record of the during, and after the #1) sampled client was admitted 10/29/2020, and had Depressive Disorder, and Posttra. The facility Seclus received from the Act 10:44 a.m. It docume	as documented and in the sure an accurate and the events leading up to, intervention for 1 of (Client who had ESI. The findings are: ed to the facility on a diagnoses of Major of Oppositional Defiant aumatic Stress Disorder. Sion and Restraint Log was a diministrator on 09/28/2021 at cented Client #1 was in a estraint from 4:07 to 4:08				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
		04L106	B. WING		09/30/2021	
	ROVIDER OR SUPPLIER	S HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	1 00.00.2021	
(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 CROSS-REFERENCED TO THE APPROPRIED FOR THE APPR	D BE COMPLETION	
{N 149}	restraint of Zyprexa, Benadryl 100 mg pod 4:23 p.m. b. A verbal order da received by Registe documented, "Zypre Benadryl 100 mg pod order at the same till [Local Psychiatric H suicidal thoughts and her neck and stating c. A Physician Orde p.m. by RN #2 documented to forder in minutes d. A Physician Orde p.m. by RN #2 documented p.m. by RN #2 d	#1 received a chemical (Zydis 10 mg (milligrams) and o (by mouth) on 09/24/21 at ted 09/24/2021 at 4:00 p.m. red Nurse (RN) #1 exa 10 mg po x [times] 1 and o x 1." RN #1 wrote a second me to "Transfer to Acute Care ospital] due to self harming, d wrapping clothes around g she wants to kill herself." If dated 09/24/2021 at 4:07 mented, "Personal Restraint o Exceed One Hour. Duration 1." If dated 09/24/2021 at 4:23 mented a Chemical Restraint exceed a Chemical Restraint in the record for a personal/physical 1. If 11:40 a.m., the Seclusion mentation for Client #1 was 1 for the chemical restraint 4/2021 at 4:23 p.m. There ion behaviors demonstrated,	{N 149			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING _			R-C 09/30/2021	
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214	<u> </u>	03/00/2021	
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{N 149}	facility video at the tir for the physical and of #1 on 09/24/2021 was Administrator presenshe has her shirt off, hurt herself by tying i had to take it away fronly in her bra." At 4: staff members [Beha #2 and BI #3 are see camera, Client #1 cashe is standing unde and #3 walk towards place Client #1 in a hdropping to the floor back in hold while sh Client #1 is seen spit towards her and hittin 4:08: 51, Client #1 is BIs #2 and #3. BI #4 the client is in hold. If floor again and is relef #1 walks back and si the documented chein of seen on the video at 4:37 p.m. en accompanied by BI # f. On 09/30/21 at 11: was asked, "Was the personal restraints of didn't find any on the there wasn't any, the an order though. [RN still learning the documented cock.]	ardian. 55 p.m., a review of the me documented on the log chemical restraints of Client is done with the t. He stated, "You will see this is because she tried to t around her neck, so they om her, that's why she is 07 p.m. on the video, two vioral Interventionalist (BI) in in the hallway facing the in not be seen well because rneath the camera. BI #2 her location and appear to iold. Client#1 is seen and staff does not place her is on the floor. At 4:08:29, ting at BI #1, heading ing the wall next to her. At placed back into a hold by enters camera view while the client then drops to the eased from restraint. Client ands under the camera, and mical restraint at 4:23 p.m. is of Client was seen again on itering the foyer	{N 14	19}			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 ti Boilebi	_		R	-C
		04L106	B. WING			09/	30/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	НОМЕ		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 S FILLMORE ST LITTLE ROCK, AR 72214		
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{N 149}	of 1 minute. Should it Wasn't the restraint to minutes?" He stated, minutes wasn't it. I as was in and out of rest "Is the staff still just as orders for the time the restraint?" He answer should be for one hou "Was the nurse in the listed." The Administrated. "The Administrated." The Surveyor himself or excuse him stated, "I can follow us to put himself." FACILITY REPORTINGER(s): 483.374(b) Reporting of serious of The facility must report to both the State Med prohibited by State land Protection and Advoct Serious occurrences include; a resident's deatl a resident's deatl a resident's suicie (1) Staff must report	ras only written for a duration have been written that way? vice for a total of 2 "No, the restraint was two sume that was a typo. She raints." He was next asked, sking the physician for enurse is told the client is in red, "They shouldn't be, it ur." He was also asked, debriefings? He wasn't ator replied, "He did the estated, "But he didn't list inself." The Administrator p on that, he probably forgot IG Deccurrences. rt each serious occurrence icaid agency and, unless w, the State designated acy system. that must be reported n; o a resident as defined in his part; and	{N 1				
	Advocacy system by business the next bus occurrence. The repo	siness day after a serious					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY DMPLETED
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{N 207}	- the name, street number of the facility This ELEMENT is no	he occurrence and, address, and telephone	{N 2	07}		
	enable the agency to oversight of the facilit	Agency as required, to				
	Client #3 was admitte 01/31/2021, and had Depressive Disorder, Severe), Oppositiona Reactive Attachment	diagnoses of Major (Recurrent episode, Il Defiant Disorder, and				
	was asked, "Have the occurrences or death survey?" He stated, "	9:50 a.m., the Administrator ere been any serious is in the facility since the last No deaths. No serious one, where an X-ray was				
	stated, "We did have serious occurrence o X-ray. On the 6th [Se was hopping around, hurt her ankle. An X- was notified. They sa everyone, but they [E #1] don't have a fax of	a.m., the Administrator one serious occurrence, a f a sprained ankle with an eptember 6, 2021], [Client #3] jumped up and down, and ray was done after the nurse hid they faxed it into behavioral Interventionalist confirmation, our machine one. For whatever reason				
	The Incident Report I	Form from Behavioral				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		04L106	B. WING	_		1	-C
NAME OF D	ROVIDER OR SUPPLIER	042100	B. Willo	9	TREET ADDRESS, CITY, STATE, ZIP CODE	09/	30/2021
	ETHODIST CHILDRENS	НОМЕ		2	002 S FILLMORE ST LITTLE ROCK, AR 72214		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{N 207}	and Time of Incident (Client #3) was obserced coming from water platransition from the fow was in line client was as client landed, she twisting her ankle. Cli Nurse assessed the asome pain medication received an X-ray arounce. On 09/28 at 11:02 a Form was received from the stated, "This is the for your office, and at form, the one hand-wown something to show it the problem is, even us the last time you wow we have tried them. I Office of Long-Term Costart emailing them in figure out a better was "When did you talk to -Term Care]?" He stated week or so ago." He would have proof of that, erstated, "Let me keep the d. On 09/28 at 11:19 a "Communication Man received from the Adris the fax log, and the Disability Rights number. I was faxed, but there is even though the incident.	#1 documented, " Date 9/6/2021 at 12:39 p.m wed being excited after ay. Client was in line to wer to the day room. As client jumping up and down and landed on her right foot ent was crying and in pain. ankle and offered client in to help with the pain. Client bund 2:00 p.m." a.m., an Incident Report come the Administrator, and exercious occurrence form tached is the facility report ritten. We are looking for was faxed to your office. the fax numbers you gave were here don't work when had talked to [staff at the Care], and she said we could . I guess we will have to y. He was then asked, [staff at the Office of Long ted, "Oh, maybe about a was then asked, "Do you mailing the report?" He	{N 2	207}			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		04L106	B. WING				-C 30/2021
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS	HOME		2	TREET ADDRESS, CITY, STATE, ZIP CODE 002 S FILLMORE ST .ITTLE ROCK, AR 72214		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{N 207}	was a serious occurred didn't show a fracture matter, fracture or now had to go out for an X e. On 9/29/21 at 2:37 asked, after he was go "Has the serious occubeen sent to the Office the 'NG' on the transing of through? Because Number says 'OK'?" "The staff tried to sen prints confirmations a know they tried sever the numbers don't wo you gave us last time at the Office of Longing going to e-mailing the know if the NG stands follow up on this. It low was also asked, "Haw since I first entered for about it?" He stated, know it has been sen f. A copy of an e-mail [Program Manager at Care] was received fro 9/30/21 at 8:56 a.m. discovered that the at Occurrence Report for transmitted when the 9-8-21. I tried several numbers we have an	posed to fax it, didn't think it ence because the X-ray I had to tell her that didn't the because [Client #3] still (Cray." p.m. the Administrator was iven the fax log to review, arrence from 9/6 actually the of Long Term Care? Does mitted fax log mean it didn't the Disability Rights The Administrator stated, dit, sometimes our fax and sometimes it doesn't. I all times, they told me, but the possibility Rights The Administrator stated, dit, sometimes it doesn't. I all times, they told me, but the possibility Rights Term Care], and we plan on the form to your office. I don't the story office. I don't the story office. I don't the story office with the didn't send." He se you e-mailed the report of the review and asked "I'm not sure, but I don't that the someone is working on it." sent 09/29 at 5:33 p.m. to the Office of Long Term om the Administrator on . It stated, "It was tached report [Serious or Client #3] had not been fax attempt was made on times at both of the did on two different machines. Ith. I am sending it now as	{N 2	207}			

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	(X3) DATE SURVEY COMPLETED	
		041.400			R-C		
NAME OF BR	20//255 05 0//25//55	04L106	B. WING _		0	9/30/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
UNITED MI	ETHODIST CHILDRENS	HOME		2002 S FILLMORE ST			
				LITTLE ROCK, AR 72214			
(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 AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	





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

October 27, 2021

Craig Gammon, Administrator United Methodist Childrens Home 2002 S Fillmore St Little Rock, AR 72214-4848

Dear Mr. Gammon:

On September 30, 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 October 24, 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 Bisciston Administrative Services Manager

Survey & Certification Section

sgb





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

November 4, 2021

Craig Gammon, Administrator United Methodist Childrens Home 2002 S Fillmore St Little Rock, AR 72214-4848

Dear Mr. Gammon:

During the revisit survey conducted on November 3, 2021, your facility was found to be in compliance with program requirements. Please email the signed CMS 2567 to Sandra.Broughton@dhs.arkansas.gov.

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

Sincerely,

DPSQA/Office of Long Term Care

Saudie Biscifton Administrative Services Manager

Survey and Certification Section

sgb

PRINTED: 11/04/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		04L106	B. WING _			R-C 11/03/2021	
	ROVIDER OR SUPPLIER ETHODIST CHILDRENS		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 S FILLMORE ST LITTLE ROCK, AR 72214				03/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{N 000}	is an official, legal doremain unchanged excorrection, correction space. Any discrepancitation(s) will be reported (RO) for referra Inspector General (Oinformation is inadver provider/supplier, the should be notified immated and the specific that the should be notified immated and the specific that the should be notified immated and the specific that t	ed on November 3, 2021 for on September 30, 2021. All en corrected, and no new ound. The facility is in	{N 0	00)			
		CUDDI IED DEDDECENTATIVE'S SIGNATUDE	<u> </u>	TITLE			(Y6) DATE

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

LE (X6) DAT

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.

Facility ID: 3005

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 Nan	Provider/Supplier Name					
04L106	UNITED METHODIST CHILDRENS HOME						
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 provide B Extended Survey (HHA or Long Ten 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.	08/02/2021	08/13/2021	1.00	0.00	61.25	0.00	8.00	47.00
2.)(6), (b) (7	08/02/2021	08/13/2021	0.50	1.00	61.25	0.00	8.00	8.75
3.	08/02/2021	08/13/2021	1.00	0.00	61.25	0.00	5.00	47.00
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

•						1
Total SA Supervisory Review Hours	5.	.00	Total RO Super	visory Review Ho	urs	0.00
Total SA Clerical/Data Entry Hours	1.	00	Total RO Cleric	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) EventID: 3BJZ11 Facility ID: 3005 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 Name							
04L106		UNITED METHODIST CHILDRENS HOME							
Type of Survey (select all that apply)	A B C D	Complaint Investigation Dumping Investigation Federal Monitoring Follow-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 Ex C Par	Routine/Standard Survey (all providers/suppliers) Extended Survey (HHA or Long Term Care Facility) Partial Extended Survey (HHA) 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.)(6), (b) (7	09/28/2021	09/30/2021	1.00	0.00	19.00	0.00	4.00	7.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								_
14.								

Total SA Supervisory Review Hours	0.50	Total RO Supervisory Review Hours	0.00
Total SA Clerical/Data Entry Hours	0.50	Total RO Clerical/Data Entry Hours	0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... ${\bf No}$

FORM CMS-670 (12-91) EventID: 3BJZ12 Facility ID: 3005 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 Name								
04L106	UNITED METH	UNITED METHODIST CHILDRENS HOME							
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)	• \ 1								

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.	11/03/2021 11/03/2021	11/03/2021 11/03/2021	0.50 0.50	0.00 0.00	6.25 6.25	0.00 0.00	0.50 0.50	0.00 1.00
4. 5.								
6. 7.								
8. 9.								
10.								
12.								
14.								

-						
Total SA Supervisory Review Hours	0.2	25	Total RO Super	visory Review Ho	urs	0.00
Total SA Clerical/Data Entry Hours	0.2	25	Total RO Cleric	al/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: 3BJZ13 Facility ID: 3005 Page