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.

<u>Plan of Correction</u>

A Plan of Correction (PoC) must be submitted witin ten (10) calendar days of receipt of the Statement of Deficienicies. 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.

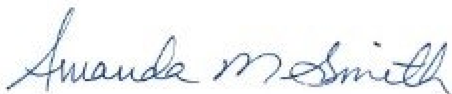
Please submit your request to:

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

sgb

cc: DRA

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059
P: 501.320.6182
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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,

DPSQA/Office of Long Term Care
Survey & Certification Section

sgb

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING ______ B. WING ______	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	2002 S FILLMORE ST LITTLE ROCK, AR 72214

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N 000	Initial Comments	N 000		

Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately.

The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.

Complaint AR00026923 was substantiated, all or in part, with deficiencies cited at N100, N126, N129, N131, N140 and N142.

Complaint AR00026924 was substantiated, all or in part, with deficiencies cited at N126, N129, N130, N131, N140, N142, N170, N188 and N189.

Complaint AR00026925 was substantiated, all or in part, with deficiencies cited at N126, N129, N140, N188 and N189.

Complaint AR00026926 was substantiated, all or in part, with deficiencies cited at N126, N129, N131, N142 and N170.

Complaint AR00026927 was substantiated, all or in part, with deficiencies cited at N126 and N129.

Complaint AR00026933 was unsubstantiated.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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N 000	Continued From page 1 Complaint AR00026934 was substantiated, all or in part, with deficiencies cited at N126 and N129. Complaint AR00026935 was substantiated, all or in part, with a deficiency cited at N128. Complaint AR00026937 was substantiated, all or 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 000	This deficiecy has the potential to impact all clients so the following actions will be completed and pertain to staff actions toward 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 3staff 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. 9-12-21	
N 100	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Based on observation, record review and interview, the facility failed to meet the requirements of the Condition of Participation for Protection of Residents, as evidenced by the facility's failure to meet the regulatory requirements at N126, N127, N128, N129, N130, N131, N132, N135 and N136. The facility failed to ensure clients were free from restraint and or	N 100	This finding summarizes the individual findings in N126, N127, N128,N129,N130, N131, N132, N135, N136, N140, N142, N149, N170, N188 and N189. The actions taken to address these issues are listed in the corresponding individual sections. It should be noted that of the 12 residents reviewed and listed only resident #9 is still in care.	See individual sections

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N 100	Continued From page 2 seclusion use for discipline purposed for 4 (Clients #9, #10, #11, and #12), the facility failed to ensure there were no as needed chemical restraint orders for 7 (Clients #1, #2, #4, #6, #7, #8, and #12), the facility failed to ensure no injury occurred during a physical restraint for 3 (Clients #5, #7, and #9), the facility failed to ensure restraint and seclusion were only used in an emergency situation for 6 (Clients # 1, #3, #9, #10, #11, and #12), the facility failed to ensure an Emergency Safety Intervention was discontinued after the emergency situation had ceased for 4 (Client #2, #4, #9 and #11), the facility failed to ensure restraint and seclusion were not used simultaneously to assure the safety of the clients for 7 (Clients #1, #2, #3, #4, #9, #11, and #12), the facility failed to ensure a restraint was conducted in a safe and appropriate manner to prevent potential injury for 1 (Client #7), the facility failed to ensure an Authorization / Consent / Release document was signed by the clients' parents / legal guardian at the time of admission for 6 (Clients #3, #8, #9, #10 #11, and #12), the facility failed to ensure a copy of the facility's Restraint and Seclusion policy was received by the client's parents/legal guardian at the time of admission for 8 (Client #1, #2, #3, #8, #9, #10 #11, and #12) sampled residents who were involved in physical and or chemical restraints and or seclusion. This failed practice had the potential to affect all 23 clients as documented on a list provided by the Admimistrator on 8/02/21 at 11:59 a.m. The findings are: The facility failed to ensure clients were free from restraint and or seclusion use for discipline purposed for 4 (Clients #9, #10, #11, and #12) sampled clients.- see N126	N 100	This deficiecy has the potential to impact all clients so the following actions will be completed and pertain to staff actions toward 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 3staff 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. 9-12	

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N 100	Continued From page 3 The facility failed to ensure there were no as needed chemical restraint orders for 7 (Clients #1, #2, #4, #6, #7, #8, and #12) sampled clients.- see N127 The facility failed to ensure no injury occurred during a physical restraint for 3 (Clients #5, #7, and #9) sampled clients.- see N128 The facility failed to ensure restraint and seclusion were only used in an emergency situation for 6 (Clients # 1, #3, #9, #10, #11, and #12) sampled clients.- see N129 The facility failed to ensure an Emergency Safety Intervention was discontinued after the emergency situation had ceased for 4 (Client #2, #4, #9 and #11) sampled clients.- see N130 The facility failed to ensure restraint and seclusion were not used simultaneously to assure the safety of the clients for 7 (Clients #1, #2, #3, #4, #9, #11, and #12) sampled clients.- see N131 The facility failed to ensure a restraint was conducted in a safe and appropriate manner to prevent potential injury for 1 (Client #7) sampled clients.- see N132 The facility failed to ensure an Authorization / Consent / Release document was signed by the clients' parents / legal guardian at the time of admission for 6 (Clients #3, #8, #9, #10 #11, and #12) sampled clients.- see N135 The facility failed to ensure a copy of the facility's Restraint and Seclusion policy was received by the client's parents/legal guardian at the time of admission for 8 (Client #1, #2, #3, #8, #9, #10	N 100		

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N 100	Continued From page 4 #11, and #12) sampled clients.- see N136	N 100		
N 126	PROTECTION OF RESIDENTS CFR(s): 483.356 (a)(1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation. This ELEMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure clients were free from restraint and or seclusion use for discipline purposed for 4 (Clients #9, #10, #11, and #12) of 12 sampled clients who had documented restraint and or seclusion. The findings are: 1. Client #9 was admitted on 4/16/21 and had diagnoses Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder. a. A Seclusion and Restraint Form dated 4/28/21 documented, " ...Restraint and Seclusion; Date and Time Initiated: 4/28/2021 2:58 p.m. Date and Time Ended: 4/28/21 3:50 p.m.... Behavior demonstrated to justify use of procedure: During transition from the dayroom to classroom client ran out of the boys unit classroom exit doors with three peers. Staff called for assistance...Seclusion and Restraint Observation Log 2...1. Observation Beginning Time: 02:58 PM Procedure: Chemical Restraint; Location: DayArea/Hall;...Client Behavior: Threatening...Ending Time: 2:59 PM. 2.	N 126	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to staff actions toward 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	9-15-21

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N 126	Continued From page 5	N 126		

Observation: Beginning Time: 3:05 PM; Procedure: Seclusion; Location: Seclusion Room...Client Behavior: Sitting...Ending Time: 3:50 PM..."

An Incident Report Form dated 4/28/21 at 2:00 p.m. documented, "...Behavioral Intervention Observation Log Time: 2:58; Procedure: 4 (Chemical);...Client Behavior: 8 (Threatening)...Time: 2:59; Procedure: 4;...Client Behavior: 8; Time: 3:05; Procedure: 3 (Seclusion); Location: 3 (Seclusion Room);...Client Behavior: 7 (Sitting)...Time: 3:20; Procedure: 3; Location: 3;..Client Behavior: 7;...Time 3:35; Procedure: 3; Location: 3;...Client Behavior: 7...Time: 3:50; Procedure: 3; Location: 3;...Client Behavior: 7..." The client was released from the seclusion room at 3:50 p.m. Documentation indicated the client was threatening with no documented aggressive behaviors at the time the chemical restraint was administered and was 'sitting' with no documented aggressive behaviors for 45 minutes before being released.

2. Client #10 was admitted on 6/15/21 and had diagnoses Disruptive Mood Dysregulation Disorder, Schizophrenia and Other Psychotic Disorder, Disruptive Impulse-Control and Conduct Disorder, Attention-Deficit/Hyperactivity Disorder Combined Presentation, and Anxiety Disorder.

a. A Seclusion and Restraint Form dated 4/28/21 documented, " ...Date and Time Initiated: 4/28/2021 2:56 PM; Date and Time Ended: 4/28/2021 2:57 PM;...Behavior demonstrated to justify use of procedure: During transition from the boys day room to the classroom the client ran out of the boys unit classroom exit door with three

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N 126	Continued From page 6 peers. Staff called for assistance...Procedure: Chemical Restraint...Client Behavior: Calm..." Documentation indicated the client was calm, with no documented aggressive behavior, at the time the chemical restraint was administered. 3. Client #11 was admitted on 3/5/21 and had diagnosis Disruptive Mood Dysregulation Disorder. a. A Seclusion and Restraint Form dated 4/28/21 documented, " ...Date and Time Initiated: 2:53 PM; Date and Time Ended: 4/28/21...Behavior demonstrated to justify use of procedure: During transition from the boys day room to the classroom, client ran out of the boys unit classroom exit door with three peers...Beginning Time: 2:53 PM; Procedure: Chemical Restraint...Client Behavior: Threatening, Walking..." Documentation indicated the client was threatening, walking, with no other aggressive behaviors documented, at the time the chemical restraint was administered. 4. Client #12 was admitted on 4/19/21 and had diagnoses Diisruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder and Attention-Deficit/Hyperactivity Disorder. a. A Restraint and Seclusion Form dated 4/28/21 documented, " ...Date and Time Initiated: 04/28/2021 2:53 PM; Date and Time Ended: 04/28/2021 3:05 PM...Behavior demonstrated to justify use of procedure: During transition from the dayroom to classroom client ran out of the boys unit classroom exit door with three peers. Staff called for assistance...Beginning Time: 2:53 PM; Procedure: Chemical Restraint...Client	N 126	Continued from previous page This training will be completed by 9-12-21. Additionally all restraints or seclusions will be reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements. This will be effective as of 9-12-21 but has already been put in place.	

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N 126	Continued From page 7	N 126		

Behavior: Cursing...Beginning Time: 3:05 PM; Procedure: Seclusion: ...Client Behavior: Calm..."

A Behavioral Intervention Observation Log documented, "...pm; 2:53; Procedure: 4 (chemical)...Client Behavior: 8 (threatening)...3:05 Procedure: 3 (seclusion)...Client Behavior: 7 (sitting)...3:20 Procedure:3...Client Behavior: 7...3:35 Procedure: 3...Client Behavior: 7...3:50 Procedure: 3...Client Behavior: 7, 2 (calm)..." The Behavioral Intervention Observation Log documented the client was sitting when placed in seclusion and remained sitting, calm for 45 minutes before being released.

5. On 8/11/21 at 2:28 p.m., a video of the elopement and the events following it involving Client #9, #10, #11 and #12 was reviewed with the Administrator. At 2:02 p.m., the video showed the clients kicking open a door and running outside out of view of the camera. The Administrator stated, "I've watched that one and I am not sure why they gave them a chemical." The Administrator was asked, "There is no reason that you could see why they gave it?" He stated, "There was no indication I could see why the nurse decided to give it." The video was continued and at 2:49 pm, the 4 clients are seen entering the building accompanied by 2 police officers and are met by 2 staff members. The clients sit down on chairs in the foyer and remove their shoes and socks. At 2:51 pm, Client #12 gets up from the chair and walks into the hallway. Client #10 gets up from the chair, walks to the front of the hallway, a nurse administers a shot and the client is seen walking off camera view down the hallway. At 2:56 p.m., Client #9 is observed sitting in a chair in the entrance, at 2:58 p.m. he gets up and goes down the hallway with

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N 126	Continued From page 8 the nurse, empties his pockets and goes through a door, out of view of the camera. The Administrator stated, "He gets a shot in there. [RN #2] follows him in there." The view of the incident is changed to Hallway 2 camera. At 2:55 pm, Client #11 comes into view and sits on circular bench in center of foyer, gets up, kicks a door, sits down, then stands up near the bench, then begins walking around and joins Client # 12 sitting on the bench. Client #9 is observed sitting at a table with a checkerboard talking with staff. At 3:05 p.m., Client #11 walks into the seclusion room. At 3:06 pm, Client #12 is seen in the seclusion room standing at the door. At 3:07 pm, Client #11 sits down on the floor. The Administrator was asked, "Did you see any behaviors that warranted seclusion?" He stated, "No, seclusion can't be used as elopement precautions and the fact that they went in there so calmly, that is not our policy and shouldn't have been used. I don't know whether the doctor ordered it, but if he did it should not have been used. Same with the chemicals upstairs, in both cases the clients were calm." The Administrator was asked, "The chemical should not have been used upstairs either?" He stated, "No, there was nothing I saw that would warrant it. No, that is not ok, there is no other conclusion you can come to." 6. On 8/13/21 at 10:20 a.m., the Nurse Manager stated, "We have a couple of kids that kick doors. So when they kick the doors to try to elope they are put in seclusion and given a chemical." The Nurse Manager was asked, "To keep them from eloping?" She stated, "Yes." The Nurse Manager was asked, "When do you release a client from seclusion?" She stated, "At the time the client is	N 126	Continued from previous page This training will be completed by 9-151. Additionally all restraints or seclusions will be reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements. This will be effective as of 9-12-21 but has already been put in place.	

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UNITED METHODIST CHILDRENS HOME	**2002 S FILLMORE ST LITTLE ROCK, AR 72214**

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N 126	Continued From page 9 ready to comply and follow directions. It doesn't have to last an hour if they have calmed down they should be removed." 7. The facility Seclusion & (and) Restraint policy received from the Administrator on 8/2/21 at 12:36 p.m., documented, " ...Seclusion and Restraint are highly restrictive interventions and will be used only in an emergency when all other means of managing the resident have not been successful in maintaining the resident's safety....Criteria & Guidelines for Seclusion and Restraint ...Seclusion or restraint may not be used as punishment or convenience of staff ..."	N 126		
N 127	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(2) An order for restraint or seclusion must not be written as a standing order or on an as-needed basis. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure clients' medication regimens were free of chemical restraints ordered on an as-needed (PRN) basis for 7 (Clients #1, #2, #4, #6, #7, #8, and #12) of 12 (Clients #1-#12) sampled clients who had orders for as needed chemical restraints. The findings are: 1. Client #8 was admitted on 5/11/21 and had a diagnosis of Major Depressive Disorder. a. A Physician's Order, dated 5/31/21 at 11:20 (no a.m. or p.m. indicated), documented, "Vistaril 50 mg [milligrams] po [by mouth] Q [every] 6 hours PRN [as needed] anxiety."	N 127	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing staff as they are the personnel who record and carry out physician orders. Also, this plan of correction complete with all actions will be reviewed by the RTC physicians to provide clarification on the issue of standing orders. All nurses will review and acknowledge the policy on restraint and seclusion. Also, they will read and acknowledge an in-service training on definition and use of PRN medications pointing out the difference between a medication used for ongoing anxiety or other diagnosed medical issue versus use of a medication for the purpose of or at the time of a client having a behavioral episode. At such a time if the client is acting out, the use of a medication which can impact or control behavior must be viewed as a chemical restraint with all of the required orders, procedures and proper justifications.	9-15-21

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b. The June 2021 Medication Administration Record (MAR) documented the PRN Vistaril was administered six times that month.

2. Client #12 was admitted on 4/19/21 and had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, and Unspecified Attention-Deficit/Hyperactivity Disorder.

a. A PRN MAR documented, "...Hydroxyzine (Vistaril) 50 mg [milligram] PO [by mouth] Q [every] 6 hours PRN 4/4/21..."

b. The February MAR documented the PRN Vistaril was administered seven times.

c. The March 2021 MAR documented the PRN Vistaril was administered nine times.

d. The April 2021 MAR documented the PRN Vistaril was administered eight times.

3. Client #4 had diagnoses of Disruptive Mood Dysregulation Disorder and Posttraumatic Stress Disorder.

a. A Physician/Admission Orders form dated 3/12/21 documented, "...Vistaril 50 mg [milligrams] po [by mouth] [every 6 hours] PRN [as needed] anxiety.

b. A 15/30 Day Medication Review dated 8/1/21 documented, "...Vistaril 50 mg nightly and [every 6 hours] PRN..."

4. Client #6 had diagnoses of Disruptive Mood

Provider's plan of correction (continued):

This training will be completed by 9-12-21. Additionally all restraints or seclusions will be reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements. This will be effective as of 9-12-21 but has already been put in place.

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Dysregulation Disorder and Epilepsy.

a. A March 2021 Physician's Order documented, "...Hydroxyzine Pamoate 50 mg capsule (Vistaril) take 1 capsule by mouth every 6 hours as needed for anxiety..."

b. The February 2021 Medication Administration Record documented, "Vistaril 50 mg 1 tablet PO [every 6 hours] PRN anxiety" and was initialed as administered on 2/11/21 and 2/12/21.

5. Client #7 had diagnoses of Disruptive Mood Dysregulation Disorder, Autism Spectrum Disorder and Unspecified Schizophrenia Spectrum.

a. A Physician's Orders dated 2/23/21 documented, "1. Vistaril 50 mg PO [every 6 hours] PRN anxiety..."

b. The March 2021 Medication Administration Record documented, "Hydroxyzine Pamoate 50 mg capsule (...Vistaril) take 1 capsule by mouth every 6 hours as needed for anxiety" and was initialed as administered on 3/9/21, 3/13/21, 3/14/21, 3/18/21 and 3/19/21.

6. Client #1 had diagnoses of Severe Major Depressive Disorder, Oppositional Defiant Disorder, Conduct Disorder, and Unspecified Problem Related to Social Environment.

a. A "15/30 Day Medication Review" form documented, " ...Hydroxyzine (Vistaril) po (by mouth) every 8 hours PRN ..."

b. A paper MAR dated from 6/9/21 to July 2021,

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received from the Corporate Compliance Director on 8/12/21 at 12:16 PM documented an order dated 6/11/21 for Hydroxyzine Pamoate 50 mg every 8 hours PRN for anxiety. The record documented Registered Nurse (RN) #4 administered the PRN medication on 6/18/21, 6/21/21, 6/30/21, 7/7/21, 7/12/21, and 7/19/21.

7. Client #2 had diagnoses of Major Depressive Disorder with Psychotic Features, and Oppositional Defiant Disorder

a. A "15/30 Day Medication Review" form dated 3/30/21 and signed by RN #4 and the Physician documented, " ...Vistaril 50 mg po every 6 hours as needed ..."

b. A Nursing Progress Note dated 6/7/21 (no time) and signed by RN #3 documented, "Client was agitated, self-harming, and refusing to take morning medications. She was biting herself on her left arm and scratching her left forearm with her nails. She also had a slight nosebleed. Client was laying on the couch on the unit, RN advised client to sit up to prevent blood from going down her throat. Client sat up, calmed down and took her morning medications along with a PRN Vistaril. Abrasion on arm cleaned and bandaged."

8. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit/Hyperactivity Disorder.

A 5/12/21 Physician's Order documented, "Vistaril 50 mg po q 6 hours PRN anxiety."

9. On 8/11/21 at 9:52 a.m., Consultant #1 was asked, "Do you have PRN antianxiety medication orders?" She stated, "Yes, some of our clients

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have orders for prn's, some of our clients that have problems with anxiety or problems calming down. The psychiatrist and nurse and nurse manager review it and discuss it." The Consultant was asked, "You don't have to call the doctor for a prn med?" She stated, "They are ordered, and the doctor has already ordered it, so the prn is prescribed and on the log."

10. On 8/13/21 at 9:50 a.m., Registered Nurse (RN) #2 was asked, "Are there some kids that have PRN antianxiety medication orders?" She stated, "Yes, they have a standing order for Vistaril. That's some of the kids." RN #2 was asked, "You do have it there, that you can give it?" She stated, "Yes."

11. On 8/13/21 at 10:14 a.m., the Nurse Manager stated, "Never have a PRN for a chemical." When asked, "What is Vistaril?" the Nurse Manager stated, "Vistaril is an antihistamine but used for anxiety." At 10:20 a.m., the Nurse Manager was asked, "When they give PRN Vistaril, is it an antianxiety medication?" She stated, "Yes, they don't have to call the doctor for it."

12. The facility policy for Seclusion & (and) Restraint, received from the Administrator on 8/2/21 at 12:36 p.m., documented, "...Definitions & Procedures... B. Drug Used as a Restraint (chemical restraint) means any drug that- 1. Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others. 2. Has the temporary effect of restricting the resident's freedom of movement, and 3. Is not a standard treatment for the resident's medical or psychiatric condition... J. Orders... 7. There must never be an "as needed"

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N 127	Continued From page 14 or (PRN) order for any type of safety intervention, or for punishment, as less restrictive intervention or for convenience of staff..."	N 127		
N 128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: 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 7/27/21, documented, "Date and Time Initiated: 7/27/2021 1:23 PM; Date and Time Ended: 7/27/2021 1:33 PM...Behavior demonstrated to justify use of procedure: Physically aggressive with staff, kicking doors/windows, attempting to elope...Assessment (Upon removal from procedure-time): 7/27/2021 2:00 PM...Physical Status Assessment: bruising on chin, swelling on cheek and bleeding from his nose...1. Observation: Beginning Time: 1:23 PM; Procedure: Personal Restraint: Other (Location): hallway...Client Behavior: Cursing Threatening...2. Observation: Beginning Time: 1:24 PM; Procedure: Chemical Restraint..."	N 128	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing and direct care staff who might perform a restraint or seclusion. All of these identified staff members will attend 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 injuries to clients and staff and avoiding restraint whenever possible. This will be conducted by the administrator and or the program consultants. This training will be completed by 9-12-21. This will be documented with training rosters initially and then included in documentation of completed OJT training going forward. Additionally all restraints or seclusions will be reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements. This will be effective as of 9-12-21 but has already been put in place.	9-15-21

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b. A Nursing Progress Note dated 7/27/21 at 3:00 PM, documented, "...Client and peer were kicking on any door they could, kicking windows, trying to break out and elope. Staff was able to keep client and peer from making it out of the building but client became very physically aggressive with staff, punching them, pushing them, being verbally aggressive. This nurse notified the DR [Doctor] and order was received to give client a chemical restraint by IM [Intramuscular]. After client tried to swing on staff with a closed fist, client was put in restraint for 10 min [minutes] due to still being aggressive...He was noted to have a little bruising on his chin and cheek was slightly swollen and nose bled slightly..."

c. On 8/12/21 at 3:41 p.m., a facility video was reviewed with the Administrator. At 1:18:36, the client was observed kicking through a door and swinging at staff. At 1:19:23, the client kicked door and walked down the hallway with four staff following him, pacing with his head down, kicking doors. At 1:23:56 three staff grabs the client, staff and client fall to the floor. The client is struggling and is released from the restraint at 1:30:42, sits up and then sat on the floor at the end of the hallway. The Administrator stated, "When they went to the floor, they should have released him."

d. On 8/13/21 at 9:05 a.m., RN #2 was asked, "How did [Client #9] get injured during a restraint on 7/27?" She stated, "He's a very aggressive, big child. He was attacking staff and staff had to put him in a restraint and he was taken to the floor and he got bruising. I could see the blood on the floor. It was coming from his nose. When he allowed me to assess him, I saw it was coming from his nose. It wasn't really flowing, it was just some, it was a little swollen, but he was

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able to move his nose back and forth. He had a nickel size abrasion on his chin. His right cheek was a little swollen."

2. Client #5 had diagnoses of Severe Major Depressive Disorder and Oppositional Defiant Disorder.

a. An Incident Report Form dated 4/4/21 at 10:02 a.m. documented, "...Disturbance...Client-to-Staff...7) Clear, concise narrative description...Client was very disrespectful to staff and refused to follow instructions... As the group was leaving the unit [Client #5] was sitting on the floor behind a chair. staff walked over and noticed he had a pen next to him. As staff reacted to get the pen [Client #5] threw a punch and hit this staff. He was placed in a team control position and was combative...He also attempted to bite staff on the leg and went to the floor. Staff continued the restraint due to aggressive behavior. he also moved his head side to side trying to bit staff during the floor hold..."

b. An [Acute] ID of Physical Markings/Injuries form dated 4/4/21 documented, "...Fresh scrapes/cuts (with arrows pointing to shoulders front and back), bruises (with circles at right and left wrists), cut (with arrow to right back of hand), redness (with arrow to lines drawn on mid-lower back)..."

3. Client #7 had diagnoses of Disruptive Mood Dysregulation Disorder, Autism Spectrum Disorder and Unspecified Schizophrenia Spectrum.

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N 128	Continued From page 17 a. An Incident Report Form dated 2/28/2021 documented, "...(Injury) Client...Bruise on right shoulder...Disturbance...Client-to-staff...7) Clear, concise narrative description... Client was asked to raise his hand and ask for permission before getting out of his seat without permission. Client then proceeded to get up and walk out without being acknowledged and received correctives. Client then became verbally and physically aggressive toward staff by close hand swinging and hitting staff on the arm. Client was then placed in a basket hold but proceeded to cut loose by running forward, hitting his chest and right shoulder into the wall and corner of the gym and staff exit doors. 8) Should/could this incident have been prevented/anticipated? Yes - When client attempted to hit the staff member, staff should have "tapped out" and allowed another BI [Behavior Interventionist] to work with the client to de-escalate the situation. The Lead BI should have contacted the Consultant on call to inform her that he observed the improper hold. The Lead BI should have re-trained the BI on CPI approved holds..." b. An ID of Physical Markings/Injuries form dated 2/28/21 documented, "...Description of findings... [Patient] has an abrasion to the right anterior [front] shoulder clavicle area..." c. On 8/10/21 at 3:11 p.m., the video of the physical hold was reviewed with the Administrator. The Administrator stated, "No, not a proper hold, not a CPI hold." When asked, "Was the client injured," the Administrator stated, "Yes, he had an abrasion." The injury could be clearly seen on the video. 4. The Seclusion & Restraint Policy provided by	N 128		

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N 128	Continued From page 18 the Administrator on 8/2/21 documented, "...Procedures: ...At no time shall any procedure be utilized that causes physical or psychological risk to residents..."	N 128		
N 129	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3)(i) To ensure the safety of the resident or others during an emergency safety situation; and This ELEMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure restraint and seclusion were only used in an emergency situation for 6 (Clients #1, #3, #9, #10, #11, and #12) of 12 (Clients #1 - #12) sampled clients who had restraints and / or seclusion. The findings are: 1. Client #9 had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder. a. A Seclusion and Restraint Form dated 4/21/21 documented, " ...Restraint and Seclusion Date and Time Initiated 4/21/2021 7:36 PM; Date and Time Ended: 4/21/2021 8:54 PM... Behavior Demonstrated: Client became noncompliant in the foyer area with CNA (Certified Nurse Assistant) staff. Client started kicking doors. Client and peer used laundry basket to break light covers and used pieces to self harm...Seclusion and Restraint Observation Log 2...1. Observation; Beginning Time: 7:36 PM; Procedure: Chemical Restraint; Location: Day Area/Hall;...Client Behavior: Cursing...Ending Time: 7:37 PM; 2.	N 129	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing and direct care staff who might perform a restraint or seclusion. All of these identified staff members will attend 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. This will be documented with training rosters initially and then included in documentation of completed OJT training going forward. Nurses specifically will review the pertinent policy and acknowledge the need to never administer chemical restraints to a client who is calm and not posing an immediate safety risk. Additional procedures have been put in place to document less restrictive attempts to de-escalate a client prior to restraint of any kind. The above training also includes the necessity of releasing a client from a hold or a seclusion immediately if they appear calm and no longer pose a safety risk. This training and review will be completed by 9-12-21. Continued on next page	9-15-21

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N 129	Continued From page 19 Observation; Beginning Time: 7:54 PM; Procedure: Seclusion; Other (Location): Seclusion Room; Client Behavior: Cursing;...Ending Time: 8:54 PM..." An Incident Report Form dated 4/21/21 at 7:15 p.m. documented, "...Client was ordered a chemical restraint and seclusion ...Behavioral Intervention Observation Log...Time 8:09 p.m.; Procedure: 3 (Seclusion); Location: 3 (Seclusion Room)...Client Behavior: 2 (Calm)...Time: 8:24 p.m.; Procedure: 3; Location: 3...Client Behavior: 2...Time 8:39 p.m.; Procedure: 3; Location: 3;...Client Behavior: 2...8:54 p.m.; Procedure 3; Location: 3;...Client Behavior: 2..." The client was released from the seclusion room at 8:54 p.m. Documentation indicated client behavior for the use of the chemical restraint and seclusion was cursing. The client was calm when placed in seclusion and remained calm for 45 minutes before being released. b. A Seclusion and Restraint Form dated 4/28/21 documented, " ...Restraint and Seclusion; Date and Time Initiated: 4/28/2021 2:58 p.m. Date and Time Ended: 4/28/21 3:50 p.m.... Behavior demonstrated to justify use of procedure: During transition from the dayroom to classroom client ran out of the boys unit classroom exit doors with three peers. Staff called for assistance...Seclusion and Restraint Observation Log 2...1. Observation Beginning Time: 02:58 PM Procedure: Chemical Restraint; Location: DayArea/Hall;...Client Behavior: Threatening...Ending Time: 2:59 PM. 2. Observation: Beginning Time: 3:05 PM; Procedure: Seclusion; Location: Seclusion Room...Client Behavior: Sitting...Ending Time: 3:50 PM..."	N 129	Continued from previous page Additionally all restraints or seclusions will be reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements. This will be effective as of 9-12-21 but has already been put in place.	

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An Incident Report Form dated 4/28/21 at 2:00 p.m. documented, "...Behavioral Intervention Observation Log Time: 2:58; Procedure: 4 (Chemical);...Client Behavior: 8 (Threatening)...Time: 2:59; Procedure: 4;...Client Behavior: 8; Time: 3:05; Procedure: 3 (Seclusion); Location: 3 (Seclusion Room);...Client Behavior: 7 (Sitting)...Time: 3:20; Procedure: 3; Location: 3;..Client Behavior: 7;...Time 3:35; Procedure: 3; Location: 3;...Client Behavior: 7...Time: 3:50; Procedure: 3; Location: 3;...Client Behavior: 7..." The client was released from the seclusion room at 3:50 p.m. Documentation indicated the client was threatening with no documented aggressive behaviors at the time the chemical restraint was administered and was 'sitting' with no documented aggressive behaviors for 45 minutes before being released.

c. A Seclusion and Restraint Form dated 4/30/21 documented, " ...Date and Time Initiated: 4/30/2021 7:11 PM; Date and Time Ended: 4/30/2021 7:12 PM;...Behavior demonstrated to justify use of procedure: Physically aggressive with peer and staff...Seclusion and Restraint Observation Log 2;...1. Observation; Beginning Time: 7:11 PM; Procedure: Chemical Restraint; Other Location: Hallway;...Client Behavior: Combative...Ending Time: 7:12 PM..."

An Incident Report Form dated 4/30/21 documented, "...Client jumped into a physical altercation hitting a peer and placing the peer in a choke hold. Client was very aggressive and refused to let the client go. Client eventually let the client go due to staff intervening by continuing to talk with the client...Client received a chemical

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restraint @ (at) 711 pm for his aggressive behavior...Behavioral Intervention Observation Log...Time: 7:11 Procedure: 4 (Chemical); Location: Hallway;...Client Behavior: Threatening;...Time 7:12; Procedure: 4; Location: 5...Client Behavior: 2 (Calm)..." Documentation indicated the client threatening, with no documented aggressive behaviors, at the time the chemical restraint was administered and was calm one minute after the chemical restraint was administered.

d. A Seclusion and Restraint Form dated 5/25/21 documented, " ...Date and Time Initiated: 5/25/21 12:22 PM; Date and Time Ended: 1:22 PM...1. Observation Beginning Time: 12:22 PM; Procedure: Seclusion; Other (Location): Seclusion Room; Client Behavior: Combative, Cursing, Walking...2. Observation Beginning Time: 12:28 PM; Procedure: Chemical Restraint; Other (Location): Seclusion Room...Client Behavior: Cursing, Threatening..."

A Nursing Progress Note, dated 5/25/21 at 1:10 PM, documented, "...At approx [approximately] 12:15 pm client started jumping off the furniture and feeding off of a peer negative behavior, when client then started trying to kick open the unit doors. Staff tried to stop it when Client became physically aggressive with staff. Client was then put in a physical restraint and this nurse called the DR (Doctor) and order was received to place client in seclusion and give a chemical restraint. This nurse followed through with the orders..." Documentation indicated the client received a chemical restraint while in the seclusion room for cursing and threatening with no documented aggressive behaviors.

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e. A Seclusion and Restraint Form dated 6/11/21 documented, " ...Date and Time Initiated: 6/11/2021 2:37 PM; Date and Time Ended: 6/11/2021...Seclusion and Restraint Observation Log 2...1. Observation: Beginning Time 2:37 PM; Procedure: Chemical Restraint...Client Behavior: Cursing, Threatening..."

An Incident Report Form dated 6/11/21 at 5:18 p.m., documented, "...Behavioral Intervention Observation Log...Time: 2:37 p.m.; Procedure: 4 (Chemical); Location: Hallway;...Client Behavior: 2 (Calm)...Time: 2:37 p.m.; Procedure: 4; Location: 5;...Client Behavior: 2..." Documentation indicated the client was calm when the chemical restraint was administered.

f. A Seclusion and Restraint Form dated 6/12/21 documented, " ...Date and Time Initiated: 6/12/2021 7:45 PM; Date and Time Ended: 6/12/2021 9:00 PM;...Behavior Demonstrated: Client became non compliant while in the Foyer area and started kicking doors. Client kicked out several doors and aggressively tried to kick exit door. Client was escorted back to unit where he continued to display aggressive behaviors...2. Observation Beginning Time: 8:07 PM; Procedure: Personal Restraint; Client Behavior: Calm...3. Observation: Beginning Time 8:10 PM; Procedure: Seclusion...Client Behavior: Calm..."

An Incident Report Form dated 6/12/21 at 8:30 p.m., documented, "...Behavioral Intervention Observation Log...Time: 8:07; Procedure: 2 (Restraint) Location: 7 (Foyer);...Client Behavior: 2 (Calm); Time: 8:10; Procedure: 3 (Seclusion);...Client Behavior: 2..." The Behavioral Intervention Observation Log documented the client was calm when placed in

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seclusion and remained calm until his release at 9:10 p.m. It was documented the client was calm for one hour while in seclusion.

g. A Seclusion and Restraint Observation Log dated 6/14/21, documented, "...1 Observation: Beginning Time: 8:05 PM; Procedure: Personal Restraint; Other(Location): Foyer;...Client Behavior: Combative, Cursing;...2. Observation: Beginning Time: 8:07 PM; Procedure: Personal Restraint...Client Behavior: Calm;..Release from Procedure;...Beginning Time: 8:10 PM; Procedure: Seclusion..Client Behavior: Calm...4. Observation: Beginning Time: 8:25 PM; Seclusion...Client Behavior: Calm...5. Observation: Beginning Time: 9:10 PM; Seclusion;...Calm...Release From Procedure..." Documentation indicated the client was calm when placed in seclusion at 8:10 PM and remained calm for one hour until he was released from seclusion at 9:10 PM.

h. A Seclusion and Restraint Observation Log, dated 6/21/21, documented, " ...Date and Time Initiated: 06/21/2021 7:38 PM; Date and Time Ended: 06/21/2021 7:39 PM;...Behavior demonstrated to justify use of procedure: Aggressive with staff and kicking open unit doors attempting to elope..1. Observation: 7:38 PM; Procedure: Chemical Restraint;...Client Behavior: Cursing..."

A Behavior Intervention Observation Log dated 6/21/21, documented, "...Time: 7:38, Procedure: 4 (Chemical)...Time: 7:39; Procedure: 4;...Client Behavior: 2 (Calm)..."

A Nursing Progress Note, dated 6/21/21 at 8:00 PM, documented, "...Client and another peer

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were off task and jumping and running around the unit, client became aggressive with staff and kicked open the unit door. Staff was able to get client back in the foyer and order was received to give client a chemical restraint. Order was followed through..." Documentation indicated the client's behavior was cursing, with no documented aggressive behavior, at the time the chemical restraint was administered and was calm one minute after receiving the chemical restraint.

i. A Seclusion and Restraint Form dated 7/8/21, documented, "...Date and Time Initiated: 7/8/21 11:31 AM; Date and Time Ended: 7/8/21 11:32 AM;...Behavior demonstrated to justify use of procedure: kicking unit doors attempting to allow a peer and self to elope. Verbally and physically aggressive with staff...1. Observation: Beginning Time: 11:31 AM; Procedure: Chemical Restraint...Client Behavior: Calm..."

A Behavioral Intervention Observation Log, dated 7/8/21, documented, "...Time: 11:31 am; Procedure: 4 (Chemical)...Client Behavior: 2 (Calm)...Time: 11:32 am; Procedure: Chemical...Client Behavior: 2..."

Nursing Progress Note, dated 7/8/21 at 1:07 PM, documented, "Client was in the foyer with a peer when he started following the negative behavior that peer was displaying by running around the unit, jumping off furniture, kicking doors and attempting to elope. This nurse notified the DR [Doctor] and order was received to give client a PO [by mouth] chemical restraint to help calm down and keep from eloping. Client received the chemical..." Documentation indicated the client was calm at the time the chemical restraint was

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administered.

j. A Seclusion and Restraint Form dated 7/9/21 documented, " ...Date and Time Initiated: 07/09/2021; Date and Time Ended: 07/09/2021 4:00 PM;...Behavior demonstrated to justify use of procedure: kicking open unit doors attempting to elope, physically aggressive with staff;...Beginning Time: 3:47 PM; Procedure: Chemical Restraint; Other (location) Foyer...Client Behavior: Sitting..." Documentation indicated the client was sitting in the foyer, with no documented aggressive behavior, at the time the chemical restraint was administered.

2. Client #10 had diagnoses of Disruptive Mood Dysregulation Disorder, Schizophrenia and Other Psychotic Disorder, Disruptive Impulse-Control and Conduct Disorder, Attention-Deficit/Hyperactivity Disorder Combined Presentation, and Anxiety Disorder.

A Seclusion and Restraint Form dated 4/28/21 documented, " ...Date and Time Initiated: 4/28/2021 2:56 PM; Date and Time Ended: 4/28/2021 2:57 PM;...Behavior demonstrated to justify use of procedure: During transition from the boys day room to the classroom the client ran out of the boys unit classroom exit door with three peers. Staff called for assistance...Procedure: Chemical Restraint...Client Behavior: Calm..." Documentation indicated the client was calm, with no documented aggressive behavior, at the time the chemical restraint was administered.

3. Client #11 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. A Seclusion and Restraint Form, dated 4/3/21,

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documented, "Date and Time Initiated: 4/3/2021 7:45 PM; Date and Time Ended: 4/3/2021 9:15 PM...Behavior demonstrated to justify use of procedure: [Client #11] had been kicking the unit doors repeatedly...Beginning Time: 7:45 PM; Procedure: Chemical Restraint; Other (Location): Foyer;...Client Behavior: Combative, Threatening;..."

A Behavioral Intervention Observation Log dated 4/3/21 documented, "...Time: 8:15 pm; Procedure: 3 (Seclusion);...Client Behavior: 4 (Cursing), 8 (Threatening)...Time 8:45 pm: Procedure: 3;...Client Behavior: 2 (Calm)...Time 9:00 pm; Procedure: 3;...Client Behavior: 2...Time: 9:15 pm; Procedure: 3...Client Behavior: 2..." The client was released from seclusion at 9:15 pm. There was no documentation of less restrictive interventions attempted before the chemical restraint was administered.

b. A Seclusion and Restraint Form dated 4/12/21, documented, "Date and Time Initiated; 4/12/2021 7:21 AM; Date and Time Ended: 4/12/21 8:20 AM...Behavior demonstrated to justify use of procedure: Physically and verbally aggressive with staff, kicking doors, attempting to elope, property damage...Beginning Time: 7:23 AM; Procedure: Seclusion...Client Behavior: Combative, Cursing...Beginning Time : 7:32 AM; Procedure: Chemical Restraint; Location: Seclusion Room;...Client Behavior: Cursing..."

A Report To Quality Assurance dated 4/12/21 documented, "...he began kicking doors and being non-compliant, client was asked by staff to stop but he continued until he kicked and broke one of the doors, the nurse was notified and from there client was placed in seclusion and given a

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chemical..."

A Behavioral Intervention Observation Log dated 4/12/21 documented, "...Time 7:23 am; Procedure: 3 (Seclusion); ...Client Behavior: 2 (Calm)...Time: 7:32 am; Procedure: 4 (Chemical);...Client Behavior: 2...Time: 7:33 am; Procedure: 4...Client Behavior: 2...Time: 7:48; Procedure: 3 (Seclusion)...Client Behavior: 2...Time 8:03 am; Procedure: 3...Client Behavior: 2...8:03 am; Procedure: 3...Client Behavior: 2...8:18 am; Procedure: 3...Client Behavior: 2...8:20 am; Procedure: 3...Client Behavior: 2...release from procedure ...." Documentation indicated the client was calm at the time he was placed in seclusion, was calm at the time of the administration of the chemical restraint in the seclusion room and remained calm for 57 minutes before he was released.

c. A Seclusion and Restraint Form dated 4/27/21 documented, " ...Date and Time Initiated: 4/27/2021 6:06 PM; Date and Time Ended: 4/27/2021 6:06 PM;...Behavior demonstrated to justify use of procedure: Client was combative, kicking doors. Client continued to be noncompliant and instigate with peers. Client was in a verbal altercation with peer. Peer charged at client and hit client. Clients were separated. Client received a chemical...Beginning Time: 6:06 PM; Procedure: Chemical Restraint...Client Behavior: Calm, Walking..." Documentation indicated the client was calm at the time the chemical restraint was administered.

d. A Seclusion and Restraint Form dated 4/28/21 documented, " ...Date and Time Initiated: 2:53 PM; Date and Time Ended: 4/28/21...Behavior

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demonstrated to justify use of procedure: During transition from the boys day room to the classroom, client ran out of the boys unit classroom exit door with three peers...Beginning Time: 2:53 PM; Procedure: Chemical Restraint...Client Behavior: Threatening, Walking..." Documentation indicated the client was threatening, walking, with no other aggressive behaviors documented, at the time the chemical restraint was administered.

4. Client #12 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder and Attention-Deficit/Hyperactivity Disorder.

a. A Seclusion and Restraint Form dated 2/12/21 documented, " ...Date and Time Initiated: 2/12/2021 9:00 am; Date and Time Ended: 2/12/2021 9:01 AM...Behavior demonstrated to justify use of procedure: attacking staff and peers physically...Beginning Time: 9:00 AM; Procedure: Chemical Restraint, Other (Location) Foyer...Client Behavior: Combative, Cursing..." There was no documentation of less restrictive interventions attempted before the chemical restraint was administered.

b. A Restraint and Seclusion Form dated 4/12/21 documented, " ...Date and Time Initiated: 04/12/2021 7:24 AM; Date and Time Ended: 04/12/2021 8:21 AM...Behavior demonstrated to justify use of procedure: Property destruction, verbally and physically aggressive with staff...Beginning Time: 7:24 AM; Procedure: Seclusion...Client Behavior: Cursing...Beginning Time: 7:29 AM; Procedure: Chemical Restraint; Other (location): Seclusion Room...Client

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N 129	Continued From page 29 Behavior: Calm..." Documentation indicated the client was placed in seclusion and calm at the time a chemical restraint was administered while the client was in seclusion. c. A Restraint and Seclusion Form dated 4/21/21 documented, " ...Date and Time Initiated: 04/21/2021 7:34 PM; Date and Time Ended: 04/21/2021 8:36 PM...Behavior demonstrated to justify use of procedure: Client became noncompliant in the foyer area and started kicking doors to the unit. Client and peer kicked doors open to unit and attempted to break external door to escape. Client and peer also used laundry basket to break the light covers on the unit...Beginning Time: 7:34 PM; Procedure: Chemical Restraint...Client Behavior: Cursing...Beginning Time: 7:35 PM; Procedure: Seclusion...Client Behavior: Cursing Threatening..." The client was placed in seclusion one minute after receiving a chemical restraint. There was no documentation of increased aggressive behavior to justify the use of the chemical restraint. d. A Restraint and Seclusion Form dated 4/28/21 documented, " ...Date and Time Initiated: 04/28/2021 2:53 PM; Date and Time Ended: 04/28/2021 3:05 PM...Behavior demonstrated to justify use of procedure: During transition from the dayroom to classroom client ran out of the boys unit classroom exit door with three peers. Staff called for assistance...Beginning Time: 2:53 PM; Procedure: Chemical Restraint...Client Behavior: Cursing...Beginning Time: 3:05 PM; Procedure: Seclusion: ...Client Behavior: Calm..." A Behavioral Intervention Observation Log documented, "...pm; 2:53; Procedure: 4	N 129		

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N 129	Continued From page 30 (chemical)...Client Behavior: 8 (threatening)...3:05 Procedure: 3 (seclusion)...Client Behavior: 7 (sitting)...3:20 Procedure:3...Client Behavior: 7...3:35 Procedure: 3...Client Behavior: 7...3:50 Procedure: 3...Client Behavior: 7, 2 (calm)..." The Behavioral Intervention Observation Log documented the client was sitting when placed in seclusion and remained sitting, calm for 45 minutes before being released. 5. On 8/11/21 at 2:28 p.m., a video of the elopement and the events following it involving Client #9, #10, #11 and #12 was reviewed with the Administrator. At 2:02 p.m., the video showed the clients kicking open a door and running outside out of view of the camera. The Administrator stated, "I've watched that one and I am not sure why they gave them a chemical." The Administrator was asked, "There is no reason that you could see why they gave it?" He stated, "There was no indication I could see why the nurse decided to give it." The video was continued and at 2:49 pm, the 4 clients are seen entering the building accompanied by 2 police officers and are met by 2 staff members. The clients sit down on chairs in the foyer and remove their shoes and socks. At 2:51 pm, Client #12 gets up from the chair and walks into the hallway. Client #10 gets up from the chair, walks to the front of the hallway, a nurse administers a shot and the client is seen walking off camera view down the hallway. At 2:56 p.m., Client #9 is observed sitting in a chair in the entrance, at 2:58 p.m. he gets up and goes down the hallway with the nurse, empties his pockets and goes through a door, out of view of the camera. The Administrator stated, "He gets a shot in there. [RN #2] follows him in there." The view of the incident is changed to Hallway 2 camera. At 2:55	N 129		

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pm, Client #11 comes into view and sits on circular bench in center of foyer, gets up, kicks a door, sits down, then stands up near the bench, then begins walking around and joins Client # 12 sitting on the bench. Client #9 is observed sitting at a table with a checkerboard talking with staff. At 3:05 p.m., Client #11 walks into the seclusion room. At 3:06 pm, Client #12 is seen in the seclusion room standing at the door. At 3:07 pm, Client #11 sits down on the floor. The Administrator was asked, "Did you see any behaviors that warranted seclusion?" He stated, "No, seclusion can't be used as elopement precautions and the fact that they went in there so calmly, that is not our policy and shouldn't have been used. I don't know whether the doctor ordered it, but if he did it should not have been used. Same with the chemicals upstairs, in both cases the clients were calm." The Administrator was asked, "The chemical should not have been used upstairs either?" He stated, "No, there was nothing I saw that would warrant it. No, that is not ok, there is no other conclusion you can come to."

6. Client #1 had diagnoses of Severe Major Depressive Disorder, Oppositional Defiant Disorder, Conduct Disorder, and Unspecified Problem Related to Social Environment.

a. A Physician's Order dated 6/14/21 at 4:15 PM, documented a chemical restraint was ordered. The medication ordered was not included on the signed order. The order gave the reason for the restraint as, "Pt [patient] was physically and verbally aggressive with staff and started to throw cards around the unit and pick scabs on arms."

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b. A Nursing Progress note by RN #1 on 06/14/2021, no time on note, documented, " ...Pt [Patient] came out of phone booth and begin [sic] throwing cards and threatening staff. When staff attempted to redirect client, she begin [sic] to self-harm by picking scabs off of old wounds. Staff continue to verbally deescalate client and turned over to nursing. On Call notified at 1615 [4:15 p.m.] and ordered Zyprexa 10 mg and Benadryl 100 mg IM [Intramuscularly, into muscle] for aggression. Client received at 1626 [4:26 p.m.], was calm and compliant during chemical restraint."

c. On 8/10/21 at 11:10 am, a video of the Emergency Safety Intervention (ESI) from 6/14/21 was reviewed with the Administrator. At 3:55 PM on the video, Client #1 was seen sitting in a chair at a small table in the foyer with her back to the camera, wearing a long sleeve jacket. At 3:56, Client #1 threw some cards then swiped cards off the table, scattering the cards across the foyer. At 3:59, it appeared the staff members across the room said something to the client (no audio was available on the video), and then 3 staff members started picking up cards. An unidentified staff member picked up the cards directly around Client #1's feet with her head close to client's feet and chair. The client is seen moving cards on the floor with her feet to get cards closer to staff, but not kicking or hitting at staff. The Administrator was asked, "Was [Client #1] being aggressive with staff at this time?" The Administrator stated, "Not that can be seen." He was asked, "Did it appear staff tried to talk with the client or tried anything to de-escalate the situation?" He stated, "Not that could be seen on the video, unless the staff across the room was trying to talk with her." At 4:11 PM, the same staff

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is seen, appearing to interact with each other across the room from the client. The client, seen from the back, appears to continue to sit at the table, no negative behaviors are observable, and the client continues to have her long sleeve jacket on. The Administrator is asked, "Is the staff intervening? Does it appear she is picking at her arms?" He stated, "When she is picking it is usually pretty obvious, it is not evident." He was asked, "Does it appear staff is attempting any de-escalation techniques?" The Administrator said, "It did not appear very intensive and if they did, it didn't go on very long." At 4:25 PM, on the video two nurses are seen coming into the foyer. Client #1 removed her jacket while sitting at the table with no negative behaviors. Registered Nurse (RN) #1, per the Administrator, is seen at 4:25:17 on the video giving a shot into the left arm. While the injection is still being given in the left arm a second nurse is seen giving an injection into the right arm. Client #1 remains seated with no observable negative behaviors while the nurses are giving the injections. The Administrator was asked, "Was a chemical restraint indicated based on what was seen on the video?" He stated, "No, she was completely calm at that moment and cooperative."

7. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit/Hyperactivity Disorder.

a. The Seclusion and Restraint Log provided by the Administrator on 8/2/21 documented a chemical restraint on 6/15/21 at 2:27 PM.

b. A "Post -Intervention Debriefing" form dated 6/15/21 documented " ...Client Debriefing ...Client became very aggressive, he charged at the exit

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N 129	Continued From page 34 door full force kicking it open and attempted to elope ..." c. On 8/11/21 at 3:56 PM, a video of the ESI on 6/15/21 was reviewed with the Administrator. At 2:19 PM on the video, Client #3 was in a hallway (on camera labeled Hall 1 West 1), no staff is seen in the video. Client #3 was seen running towards the exit door which was out of camera view. Client #3 was seen quickly reentering camera view in the hallway. At 2:20:03 on the video, Client #3 was seen walking in the hallway, no staff was seen in camera view. At 2:22:44, Behavior Interventionist (BI) #3, per the Administrator, was seen walking past the client who was standing against the wall of the hallway. The Administrator was asked, "What is staff doing?" He answered, "Probably shutting off the alarm." The video skips to 2:26, BI #3 and Consultant #2 are seen standing outside a bedroom door on the same hallway, Client #3 was not seen. The Administrator was asked, "Is that Client #3's bedroom?" He stated, "I think it was, but I'm not sure." At 2:27:10 on the video, Client #3 was observed coming out of the bedroom. No inappropriate behaviors were seen at that time. Client walks calmly to the foyer then sits on the doughnut shaped couch. Four staff members, including BI #3 and Consultant #2 are seen in the area. The client remained on the couch with no negative behaviors until 2:35 when he walked over and sat at a table in the foyer area. At 2:37 PM, he walked calmly over to the bathroom, with BI #3 and LPN #1. The Administrator was asked, "Was a chemical restraint indicated based on the video we just watched?" He stated, "There was no behavior that warranted that when it was given. There was no behavior before that that warranted that.	N 129		

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N 129	Continued From page 35 [Client #3] walked calmly to the bathroom with staff and sat calmly while the nurse was getting gloves on." The facility Seclusion & (and) Restraint policy received from the Administrator on 8/2/21 at 12:36 p.m., documented, "... Seclusion and Restraint are highly restrictive interventions and will be used only in an emergency when all other means of managing the resident have not been successful in maintaining the resident's safety...Definitions & Procedures:...B. Drug Used as a Restraint (Chemical restraint) means any drug that-1. Is administered to manage a resident's behavior in a way that reduces the safety risk to the resident or others; 2. Has the temporary effect of restricting the resident's freedom of movement, and 3. Is not a standard treatment for the resident's medical or psychiatric condition. C. Seclusion is defined as: 1. The involuntary confinement of a resident alone in any area, which the resident is physically prevented from leaving for any period of time. 2. Seclusion shall only be used to prevent the resident from injuring him/herself or others or to prevent serious disruption of the therapeutic environment. It shall only be used when alternative measures are not sufficient to protect the resident or when alternative measures are not sufficient to prevent serious disruption of the therapeutic environment. 3. Seclusion requires documented clinical justification. The rationale for the procedure must address the fact that less restrictive interventions were attempted and failed. These less restrictive interventions must be documented. 4. Use of Seclusion shall be discontinued when the condition or behavior of the resident resolves to the point that these interventions are no longer needed, or at the time designated by the	N 129		

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N 129	Continued From page 36 physician... G. Criteria for Discontinuing Restraint or Seclusion: 1. The use of restraint or seclusion should be evaluated on a continual basis and ended at the earliest possible time based on the assessment and evaluation of the resident's condition ... 2. At the same time, if a resident reaches criteria for discontinuation of an emergency intervention in 30 minutes, he/she must be released ..."	N 129		
N 130	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3)(ii) Until the emergency safety situation has ceased and the resident's safety and the safety of others can be ensured, even if the restraint or seclusion order has not expired. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an Emergency Safety Intervention was discontinued after the emergency situation had ceased for 4 (Client #2, #4, #9 and #11) of 12 (Clients #1-#12) sampled clients who had documented restraint and or seclusion. The findings are: 1. Client #9 had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder. a. A Seclusion and Restraint Form dated 4/21/21 documented, " ...Restraint and Seclusion Date and Time Initiated 4/21/2021 7:36 PM; Date and Time Ended: 4/21/2021 8:54 PM... Behavior Demonstrated: Client became noncompliant in the foyer area with CNA (Certified Nurse	N 130	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing and direct care staff who might perform a restraint or seclusion. All of these identified staff members will attend 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. An aspect of this training specifies that a client must be released as soon as they are calm or safe and that a restraint restraint must not be initiated if it cannot be done safely. This training and review will be completed by 9-12-21. This will be documented with training rosters initially and then included in documentation of completed OJT training going forward. Additionally all restraints or seclusions will be reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements. This will be effective as of 9-12-21 but has already been put in place.	9-15-21

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N 130	Continued From page 37 Assistant) staff. Client started kicking doors. Client and peer used laundry basket to break light covers and used pieces to self harm...Seclusion and Restraint Observation Log 2...1. Observation; Beginning Time: 7:36 PM; Procedure: Chemical Restraint; Location: Day Area/Hall;...Client Behavior: Cursing...Ending Time: 7:37 PM; 2. Observation; Beginning Time: 7:54 PM; Procedure: Seclusion; Other (Location): Seclusion Room; Client Behavior: Cursing;...Ending Time: 8:54 PM..." An Incident Report Form dated 4/21/21 at 7:15 p.m. documented, "...Client was ordered a chemical restraint and seclusion ...Behavioral Intervention Observation Log...Time 8:09 p.m.; Procedure: 3 (Seclusion); Location: 3 (Seclusion Room)...Client Behavior: 2 (Calm)...Time: 8:24 p.m.; Procedure: 3; Location: 3...Client Behavior: 2...Time 8:39 p.m.; Procedure: 3; Location: 3;...Client Behavior: 2...8:54 p.m.; Procedure 3; Location: 3;...Client Behavior: 2..." The client was released from the seclusion room at 8:54 p.m. Documentation indicated client behavior for the use of the chemical restraint and seclusion was cursing. The client was calm when placed in seclusion and remained calm for 45 minutes before being released. b. A Seclusion and Restraint Form dated 4/28/21 documented, " ...Restraint and Seclusion; Date and Time Initiated: 4/28/2021 2:58 p.m. Date and Time Ended: 4/28/21 3:50 p.m.... Behavior demonstrated to justify use of procedure: During transition from the dayroom to classroom client ran out of the boys unit classroom exit doors with three peers. Staff called for assistance...Seclusion and Restraint Observation Log 2...1. Observation Beginning Time: 02:58 PM	N 130		

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N 130	Continued From page 38 Procedure: Chemical Restraint; Location: DayArea/Hall;...Client Behavior: Threatening...Ending Time: 2:59 PM. 2. Observation: Beginning Time: 3:05 PM; Procedure: Seclusion; Location: Seclusion Room...Client Behavior: Sitting...Ending Time: 3:50 PM..." An Incident Report Form dated 4/28/21 at 2:00 p.m. documented, "...Behavioral Intervention Observation Log Time: 2:58; Procedure: 4 (Chemical);...Client Behavior: 8 (Threatening)...Time: 2:59; Procedure: 4;...Client Behavior: 8; Time: 3:05; Procedure: 3 (Seclusion); Location: 3 (Seclusion Room);...Client Behavior: 7 (Sitting)...Time: 3:20; Procedure: 3; Location: 3;..Client Behavior: 7;...Time 3:35; Procedure: 3; Location: 3;...Client Behavior: 7...Time: 3:50; Procedure: 3; Location: 3;...Client Behavior: 7..." The client was released from the seclusion room at 3:50 p.m. Documentation indicated the client was threatening with no documented aggressive behaviors at the time the chemical restraint was administered and was 'sitting' with no documented aggressive behaviors for 45 minutes before being released. c. A Seclusion and Restraint Form dated 6/12/21 documented, " ...Date and Time Initiated: 6/12/2021 7:45 PM; Date and Time Ended: 6/12/2021 9:00 PM;...Behavior Demonstrated: Client became non compliant while in the Foyer area and started kicking doors. Client kicked out several doors and aggressively tried to kick exit door. Client was escorted back to unit where he continued to display aggressive behaviors...2. Observation Beginning Time: 8:07 PM; Procedure: Personal Restraint; Client Behavior:	N 130		

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Calm...3. Observation: Beginning Time 8:10 PM; Procedure: Seclusion...Client Behavior: Calm..."

An Incident Report Form dated 6/12/21 at 8:30 p.m., documented, "...Behavioral Intervention Observation Log...Time: 8:07; Procedure: 2 (Restraint) Location: 7 (Foyer);...Client Behavior: 2 (Calm); Time: 8:10; Procedure: 3 (Seclusion);...Client Behavior: 2..." The Behavioral Intervention Observation Log documented the client was calm when placed in seclusion and remained calm until his release at 9:10 p.m. It was documented the client was calm for one hour while in seclusion.

d. A Seclusion and Restraint Observation Log dated 6/14/21 documented, "...1 Observation: Beginning Time: 8:05 PM; Procedure: Personal Restraint; Other (Location): Foyer...Client Behavior: Combative, Cursing...2. Observation: Beginning Time: 8:07 PM; Procedure: Personal Restraint...Client Behavior: Calm ...Release from Procedure...Beginning Time: 8:10 PM; Procedure: Seclusion ...Client Behavior: Calm...4. Observation: Beginning Time: 8:25 PM; Seclusion...Client Behavior: Calm...5. Observation: Beginning Time: 9:10 PM; Seclusion...Calm...Release From Procedure..." Documentation indicated the client was calm when placed in seclusion at 8:10 PM and remained calm for one hour until he was released from seclusion at 9:10 PM.

2. Client #11 had a diagnosis of Disruptive Mood Dysregulation Disorder.

a. A Seclusion and Restraint Form dated 4/12/21, documented, "Date and Time Initiated; 4/12/2021 7:21 AM; Date and Time Ended: 4/12/21 8:20

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AM...Behavior demonstrated to justify use of procedure: Physically and verbally aggressive with staff, kicking doors, attempting to elope, property damage...Beginning Time: 7:23 AM; Procedure: Seclusion...Client Behavior: Combative, Cursing...Beginning Time : 7:32 AM; Procedure: Chemical Restraint; Location: Seclusion Room;...Client Behavior: Cursing..."

A Report To Quality Assurance dated 4/12/21 documented, "...he began kicking doors and being non-compliant, client was asked by staff to stop but he continued until he kicked and broke one of the doors, the nurse was notified and from there client was placed in seclusion and given a chemical..."

A Behavioral Intervention Observation Log dated 4/12/21 documented, "...Time 7:23 am; Procedure: 3 (Seclusion); ...Client Behavior: 2 (Calm)...Time: 7:32 am; Procedure: 4 (Chemical);...Client Behavior: 2...Time: 7:33 am; Procedure: 4...Client Behavior: 2...Time: 7:48; Procedure: 3 (Seclusion)...Client Behavior: 2...Time 8:03 am; Procedure: 3...Client Behavior: 2...8:03 am; Procedure: 3...Client Behavior: 2...8:18 am; Procedure: 3...Client Behavior: 2...8:20 am; Procedure: 3...Client Behavior: 2...release from procedure ...." Documentation indicated the client was calm at the time he was placed in seclusion, was calm at the time of the administration of the chemical restraint in the seclusion room and remained calm for 57 minutes before he was released.

b. A Seclusion and Restraint Form dated 5/4/21 documented, " ...Date and Time Initiated: 5/4/21 9:49 AM; Date and Time Ended: 5/4/21 10:49 AM...Behavior demonstrated to justify use of

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procedure: Kicking open unit doors attempting to elope, property destruction, aggressive with peers..."

A Behavioral Intervention Observation Log dated 5/4/21 documented, "...Time: 9:49 am; Procedure: 3 (Seclusion)...Client Behavior: 3 (Combative), 4 (Cursing), 8 (Threatening)...10:04 am; Procedure: 3...Client Behavior: 10 (sitting)...10:19 am; Procedure: 3...Client Behavior: 7 (Sitting)...10:34 am; Procedure: 3..Client Behavior: 7...10:49 am; Procedure: 3...Client Behavior: 10; Staff Response: 2 (Release from Procedure)..." Documentation indicated the client was sitting, walking for 45 minutes before his release from the seclusion room.

3. Client #4 had diagnoses of Disruptive Mood Dysregulation Disorder and Posttraumatic Stress Disorder.

a. A Seclusion and Restraint Form 1 dated 6/15/21 documented, "...Behavior Demonstrated- physically aggressive with staff, kicking doors attempting to elope...1. Observation beginning time: 11:15 a.m. Procedure: ...Transport...Client Behavior...Hurting self, combative...Ending Time: 11:16 a.m. 2. Observation beginning time: 11:17 a.m. Procedure:...Seclusion...Other (location) seclusion room...Client Behavior: threatening, combative, cursing. Staff Response:...observation/no change...Ending Time: 12:17 p.m. 3. Observation beginning time: 11:22 a.m. Procedure: ...Chemical Restraint...Other (location) seclusion room...Client Behavior: combative...Staff Response: ...Observation/No Change...Ending

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N 130	Continued From page 42 Time: 11:23 a.m..." b. On 8/11/21 at 4:30 p.m., the video was reviewed with the Administrator. At 11:16 a.m. on the video, Client #4 was transported to the seclusion room by 2 male staff. At 11:17 a.m., Client #4 was kicking the door of the seclusion room. At 11:19 a.m., Client #4 was standing at the door when staff entered the seclusion room and administered an injection. The Administrator was asked, "Should simultaneous chemical restraint and seclusion be used?" and he stated, "No, should not do both." At 11:45 a.m., Client #4 was laying down on the floor. At 11:56 a.m., the camera stopped detecting motion due client. The Adminstrator was asked, "What is the criteria to come out?" and he stated, "Calm not threatening." When asked, "Is the client calm?" the Administrator stated, "Yes, he calm, should come out." The client was released at 12:18 p.m. 4. Client #2 had diagnoses of Major Depressive Disorder with Psychotic Features, and Oppositional Defiant Disorder. a. A Seclusion and Restraint Form 1 dated 04/28/21 documented, " ...Client was feeding into negativity with peers and wetting toilet tissue and throwing it on doors and floor. Client continued to be noncompliant and verbally aggressive towards staff." b. The Seclusion and Restraint Observation Log 2 documented, " ...8:03 a.m. Procedure ...Transport ...Client Behavior ...threatening, combative, walking and cursing ...8:06 a.m. Procedure: ...Seclusion ...seclusion room ...Client Behavior ...combative and walking ...8:11 a.m.	N 130		

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N 130	Continued From page 43 Procedure: ...chemical restraint and seclusion ...seclusion room ...Client behavior ...combative and sitting ...8:12 a.m. Procedure ...Chemical Restraint ...seclusion room ...calm and sitting ..." At 9:06 a.m., RN #4 documented Client #2 was still in seclusion, was calm, and was released from the procedure. 5. The facility Seclusion & (and) Restraint policy received from the Administrator on 8/2/21 at 12:36 p.m., documented, "...Seclusion and Restraint are highly restrictive interventions and will be used only in an emergency when all other means of managing the resident have not been successful in maintaining the resident's safety... C. Seclusion is defined as: 1. The involuntary confinement of a resident alone in any area, which the resident is physically prevented from leaving for any period of time. 2. Seclusion shall only be used to prevent the resident from injuring him/herself or others or to prevent serious disruption of the therapeutic environment. It shall only be used when alternative measures are not sufficient to protect the resident or when alternative measures are not sufficient to prevent serious disruption of the therapeutic environment ... 4. Use of Seclusion shall be discontinued when the condition or behavior of the resident resolves to the point that these interventions are no longer needed, or at the time designated by the physician... G. Criteria for Discontinuing Restraint or Seclusion: 1. The use of restraint or seclusion should be evaluated on a continual basis and ended at the earliest possible time based on the assessment and evaluation of the resident's condition. For example, if a resident was ordered into seclusion for a 2-hour time frame, but has recovered from their unsafe and disruptive behavior in 1 hour instead, it is the expectation	N 130		

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N 130	Continued From page 44 that the resident is then released from restraint or seclusion at the 1-hour point. 2. At the same time, if a resident reaches criteria for discontinuation of an emergency intervention in 30 minutes, he/she must be released..."	N 130		
N 131	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(4) Restraint and seclusion must not be used simultaneously. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure restraint and seclusion were not used simultaneously to assure the safety of the clients for 7 (Clients #1, #2, #3, #4, #9, #11, and #12) of 12 (Clients #1 - #12) sampled clients who received a chemical restraint and were placed in a physical restraint and seclusion. The findings are: 1. Client #9 had diagnoses Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder. a. A Seclusion and Restraint Form dated 4/21/21 documented, "Restraint and Seclusion; Date and Time Initiated 4/21/21 7:36 PM; Date and Time Ended: 4/21/21 8:54 PM... Behavior Demonstrated: Client became noncompliant in the foyer area with CNA [Certified Nurse Assistant] staff. Client started kicking doors. Client and peer used laundry basket to break light covers and used pieces to self-harm... Seclusion and Restraint Observation Log 2... 1. Observation; Beginning Time: 7:36 PM; Procedure: Chemical Restraint; Location: Day	N 131	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 not be used simultaneously. Orders for seclusion and restraint must be obtained and or carried out as separate issues with documentation and only after consideration of ongoing behaviors by a client that pose a safety risk. If a client requires a restraint, a seclusion may not be used unless consideration of the effectiveness of the restraint has been given and if found ineffective and the client remains a safety risk, then other options including seclusion may be considered, ordered, and carried out. These separate procedures must be considered individually and not at one time. This review and acknowledgement will be completed by 9-12-21. Additionally all seclusions will be reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements(inclusive on non-simultaneous use). This will be effective as of 9-12-21 but has already been put in place.	9-15-21

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N 131	Continued From page 45 Area/Hall... Client Behavior: Cursing... Ending Time: 7:37 PM; 2. Observation; Beginning Time: 7:54 PM; Procedure: Seclusion; Other (Location): Seclusion Room; Client Behavior: Cursing... Ending Time: 8:54 PM..." There were no other observations documented on the Seclusion and Restraint Form. An Incident Report Form dated 4/21/21 at 7:15 p.m. documented, "...Client was in the foyer area with a CNA when he became noncompliant and started kicking the doors on Unit 'D'. Client and a peer kicked through the door onto the hallway and continued to kick on the exit door. Client and peer used a laundry basket to toss up and break out the light covers. Client used the broken pieces from the light covers to self-harm. Client continued to display poor impulse control and be aggressive. Client was ordered a chemical restraint and seclusion ...Behavioral Intervention Observation Log... Time 8:09 p.m.; Procedure: 3 [Seclusion]; Location: 3 [Seclusion Room]... Client Behavior: 2 [Calm]... Time: 8:24 p.m.; Procedure: 3; Location: 3... Client Behavior: 2...Time 8:39 p.m.; Procedure: 3; Location: 3;... Client Behavior: 2... 8:54 p.m.; Procedure 3; Location: 3... Client Behavior: 2..." The client was released from the seclusion room at 8:54 p.m. Documentation indicated the client was calm for 45 minutes before being released. There was no documentation to justify why the client was placed in seclusion after the chemical restraint was administered. b. A Seclusion and Restraint Form dated 4/28/21 documented, "Restraint and Seclusion; Date and Time Initiated: 4/28/2021 2:58 p.m. Date and Time Ended: 4/28/21 3:50 p.m... Behavior demonstrated to justify use of procedure: During transition from the dayroom to classroom client ran out of the boys unit classroom exit doors with	N 131		

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N 131	Continued From page 46 three peers. Staff called for assistance... Seclusion and Restraint Observation Log 2...1. Observation Beginning Time: 02:58 PM; Procedure: Chemical Restraint; Location: DayArea/Hall... Client Behavior: Threatening... Ending Time: 2:59 PM. 2. Observation, Beginning Time: 3:05 PM; Procedure: Seclusion; Location: Seclusion Room... Client Behavior: Sitting... Ending Time: 3:50 PM..." An Incident Report Form dated 4/28/21 at 2:00 p.m. documented, "...Behavioral Intervention Observation Log; Time: 2:58; Procedure: 4 [Chemical]... Client Behavior: 8 [Threatening]... Time: 2:59; Procedure: 4... Client Behavior: 8; Time: 3:05; Procedure: 3 [Seclusion]; Location: 3 [Seclusion Room]... Client Behavior: 7 [Sitting]... Time: 3:20; Procedure: 3; Location: 3;..Client Behavior: 7... Time 3:35; Procedure: 3; Location: 3;... Client Behavior: 7... Time: 3:50; Procedure: 3; Location: 3... Client Behavior: 7..." The client was released from the seclusion room at 3:50 p.m. Documentation indicated the client was sitting, with no documented aggressive behaviors, for 45 minutes before being released. There was no documentation to justify why the client was placed in seclusion after the chemical restraint was administered. c. A Seclusion and Restraint Form dated 5/25/21 documented, "Date and Time Initiated: 5/25/21 12:22 PM; Date and Time Ended: 1:22 PM...1. Observation Beginning Time: 12:22 PM; Procedure: Seclusion; Other (Location): Seclusion Room; Client Behavior: Combative, Cursing, Walking...2. Observation Beginning Time: 12:28 PM; Procedure: Chemical Restraint; Other (Location): Seclusion Room...Client Behavior: Cursing, Threatening..." Documentation indicated the client received a	N 131		

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N 131	Continued From page 47	N 131		

chemical restraint while in the seclusion room for cursing and threatening. A Nursing Progress Note dated 5/25/21 at 1:10 PM documented, "...At aprox [approximately] 12:15 pm client started jumping off the furniture and feeding off of a peer negative behavior, when client then started trying to kick open the unit doors. Staff tried to stop it when client became physically aggressive with staff. Client was then put in a physical restraint and this nurse called the DR [Doctor] and order was received to place client in seclusion and give a chemical restraint. This nurse followed through with the orders..." Documentation indicated the client received a chemical restraint while in the seclusion room for cursing and threatening.

2. Client #11 was admitted on 3/5/21 and had diagnosis of Disruptive Mood Dysregulation Disorder.

a. A Seclusion and Restraint Form dated 4/3/21 documented, "Date and Time Initiated: 4/3/2021 7:45 PM; Date and Time Ended: 4/3/2021 9:15 PM...Behavior demonstrated to justify use of procedure: [Client #11] had been kicking the unit doors repeatedly...Beginning Time: 7:45 PM; Procedure: Chemical Restraint; Other (Location): Foyer;... Client Behavior: Combative, Threatening;..." A Behavioral Intervention Observation Log dated 4/3/21 documented, "...Time: 8:15 pm; Procedure: 3 (Seclusion);...Client Behavior: 4 (Cursing), 8 (Threatening)...Time 8:45 pm: Procedure: 3;...Client Behavior: 2 (Calm)...Time 9:00 pm; Procedure: 3;...Client Behavior: 2...Time: 9:15 pm; Procedure: 3...Client Behavior: 2..." The client was released from seclusion at 9:15 p.m. There was no documentation of less restrictive interventions attempted before the chemical

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N 131	Continued From page 48 restraint was administered. There was no documentation to justify why the client was placed in seclusion after the chemical restraint was administered. b. A Seclusion and Restraint Form dated 4/12/21 documented, "Date and Time Initiated; 4/12/2021 7:21 AM; Date and Time Ended: 4/12/21 8:20 AM... Behavior demonstrated to justify use of procedure: Physically and verbally aggressive with staff, kicking doors, attempting to elope, property damage... Beginning Time: 7:23 AM; Procedure: Seclusion... Client Behavior: Combative, Cursing... Beginning Time : 7:32 AM; Procedure: Chemical Restraint; Location: Seclusion Room;...Client Behavior: Cursing..." A Report To Quality Assurance dated 4/12/21 documented, "...he began kicking doors and being non-compliant, client was asked by staff to stop but he continued until he kicked and broke one of the doors, the nurse was notified and from there client was placed in seclusion and given a chemical..." A Behavioral Intervention Observation Log dated 4/12/21 documented, "...Time 7:23 am; Procedure: 3 [Seclusion]; ...Client Behavior: 2 [Calm]...Time: 7:32 am; Procedure: 4 [Chemical];...Client Behavior: 2...Time: 7:33 am; Procedure: 4...Client Behavior: 2...Time: 7:48; Procedure: 3 (Seclusion)...Client Behavior: 2...Time 8:03 am; Procedure: 3...Client Behavior: 2...8:03 am; Procedure: 3...Client Behavior: 2...8:18 am; Procedure: 3...Client Behavior: 2...8:20 am; Procedure: 3...Client Behavior: 2...release from procedure". Documentation on the Behavorial Intervention Observation Log indicated the client was calm at the time he was placed in seclusion, was calm at the time of the administration of the chemical restraint in the seclusion room and remained	N 131		

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calm for 57 minutes before he was released.

3. Client #12 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder and Attention-Deficit/Hyperactivity Disorder.

a. A Seclusion and Restraint Form dated 4/4/21 documented, "Date and Time Initiated: 4/4/2021 8:40 AM; Date and Time Ended: 4/4/21 8:40 AM...Other Criteria not listed for release: Client wasn't placed in hold...Behavior demonstrated to justify use of procedure: Ongoing aggressive behavior, agitation, verbally and physically aggressive, threatening staff...Beginning Time: 8:53 AM; Procedure: Chemical Restraint, Seclusion; Location: Day Area/Hall...Client Behavior: Combative, Cursing, Threatening...Indication for Behavior Management/Emergency Safety Intervention; A less restrictive interventions attempted and not successful: no; Client presents imminent danger to self: no; Client presents imminent danger to others: no; Personal Restraint (Not to exceed one hour): No..." Documentation indicated the client was not an imminent danger to self or others when the chemical restraint was administered.

b. A Restraint and Seclusion dated 4/12/21 documented, "Date and Time Initiated: 04/12/2021 7:24 AM; Date and Time Ended: 04/12/2021 8:21 AM... Behavior demonstrated to justify use of procedure: Property destruction, verbally and physically aggressive with staff... Beginning Time: 7:24 AM; Procedure: Seclusion... Client Behavior: Cursing... Beginning Time: 7:29 AM; Procedure: Chemical Restraint; Other (location): Seclusion Room...Client Behavior:

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Calm..." The documentation indicated the client was placed in seclusion and was calm at the time a chemical restraint was administered while the client was in seclusion. There is no documentation to indicate the need for the chemical restraint.

c. A Restraint and Seclusion Form dated 4/21/21 documented, "Date and Time Initiated: 04/21/2021 7:34 PM; Date and Time Ended: 04/21/2021 8:36 PM... Behavior demonstrated to justify use of procedure: Client became noncompliant in the foyer area and started kicking doors to the unit. Client and peer kicked doors open to unit and attempted to break external door to escape. Client and peer also used laundry basket to break the light covers on the unit...Beginning Time: 7:34 PM; Procedure: Chemical Restraint... Client Behavior: Cursing...Beginning Time: 7:35 PM; Procedure: Seclusion...Client Behavior: Cursing Threatening..." The client was placed in seclusion one minute after receiving a chemical restraint. There was no documentation of increased aggressive behavior to justify the use of the chemical restraint.

d. A Restraint and Seclusion Form dated 4/28/21 documented, "Date and Time Initiated: 04/28/2021 2:53 PM; Date and Time Ended: 04/28/2021 3:05 PM... Behavior demonstrated to justify use of procedure: During transition from the dayroom to classroom client ran out of the boys' unit classroom exit door with three peers. Staff called for assistance... Beginning Time: 2:53 PM; Procedure: Chemical Restraint... Client Behavior: Cursing...Beginning Time: 3:05 PM; Procedure: Seclusion: ...Client Behavior: Calm..." A Behavioral Intervention Observation Log

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documented, "...pm; 2:53; Procedure: 4 [chemical]...Client Behavior: 8 [threatening]...3:05 Procedure: 3 [seclusion]...Client Behavior: 7 [sitting]...3:20 Procedure:3...Client Behavior: 7...3:35 Procedure: 3...Client Behavior: 7...3:50 Procedure: 3...Client Behavior: 7, 2 [calm]..." The Behavioral Intervention Observation Log documented the client was sitting when placed in seclusion and remained sitting and calm for 45 minutes before being released. There was no documentation of increased aggressive behavior to justify the use of a chemical restraint.

4. Client #4 had diagnoses of Disruptive Mood Dysregulation Disorder and Posttraumatic Stress Disorder.

a. A Seclusion and Restraint Form 1 dated 6/15/21 documented, "...Behavior Demonstrated - physically aggressive with staff, kicking doors attempting to elope... 1. Observation beginning time: 11:15 a.m. Procedure: ...Transport... Client Behavior... Hurting self, combative... Ending Time: 11:16 a.m. 2. Observation beginning time: 11:17 a.m. Procedure: ...Seclusion... Other (location) seclusion room... Client Behavior: threatening, combative, cursing. Staff Response: ...observation/no change... Ending Time: 12:17 p.m. 3. Observation beginning time: 11:22 a.m. Procedure: ...Chemical Restraint... Other (location) seclusion room... Client Behavior: combative... Staff Response: ...Observation / No Change... Ending Time: 11:23 a.m..."

b. On 8/11/21 at 4:30 p.m., the video was reviewed with the Administrator. At 11:16 a.m. on the video, Client #4 was transported to the

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N 131	Continued From page 52 seclusion room by 2 male staff. At 11:17 a.m., Client #4 was kicking the door of the seclusion room. At 11:19 a.m., Client #4 was standing at the door when staff entered the seclusion room and administered an injection. The Administrator was asked, "Should simultaneous chemical restraint and seclusion be used?" and he stated, "No, should not do both." At 11:45 a.m., Client #4 was lying on the floor. The client was released at 12:18 p.m. 5. 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. A Nursing Progress Note dated 4/28/21 at 9:34 AM documented, "Client was aggressive with staff and self-harming. She was placed in a restraint and continued to fight staff. Client was placed in seclusion and administered a chemical at 8:05. Client was assessed upon release from seclusion. She refused to allow RN [Registered Nurse] to see arms to assess." b. A Seclusion and Restraint Log dated 4/28/21 documented the client was placed in seclusion at 8:02 PM, then given a chemical restraint at 8:05 PM. 6. Client #2 had diagnoses of Major Depressive Disorder with Psychotic Features, Oppositional Defiant Disorder, and Other Circumstances Related to Child Neglect Personal History. A Nurse Progress Note dated 4/28/21 at 8:11 AM documented Client #2 was in seclusion and then	N 131		

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N 131	Continued From page 53 received a chemical restraint, with the client documented as combative and sitting. One minute later at 8:12 AM, RN #4 documented the client was calm and sitting. 7. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit/Hyperactivity Disorder. Nurse Progress Notes dated 5/12/21 documented, "This nurse was notified aprox [approximately] 0924 [9:24 AM] that client had been placed in a restraint by the classroom for kicking unit doors attempting to elope, self-harming and being physically aggressive with staff. Upon arrival, this nurse witnessed client continuing to be verbally aggressive with staff even while in his restraint. Client was let out of his restraint at 0927 and immediately ran towards the door and started kicking again trying to get out of the doors. This nurse notified the MD and order was received for Seclusion and chemical restraint of Zyprexa 10 mg IM [intramuscular injection] with Benadryl 50 mg IM which was given while client was in seclusion at 0942. Client continues to yell, scream, cuss and punch walls while in seclusion. Will continue to monitor." 8. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit/Hyperactivity Disorder. An Observation Log dated 5/18/21 documented the client was in seclusion at 10:43 PM, then received a chemical restraint at 10:49 while still in seclusion. Seclusion was documented as ending at 10:54 PM.	N 131		
N 132	PROTECTION OF RESIDENTS	N 132	Corrective action begins on next page...	

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N 132	Continued From page 54 CFR(s): 483.356(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a restraint was conducted in a safe and appropriate manner to prevent potential injury for 1 (Client #7) of 12 (Clients #1-#12) sampled clients who were reviewed for restraint and / or seclusion. The findings are: Client #7 had diagnoses of Disruptive Mood Dysregulation Disorder, Autism Spectrum Disorder and Unspecified Schizophrenia Spectrum. a. An Incident Report Form dated 2/28/21 documented, "...(Injury) Client... Bruise on right shoulder... Disturbance... Client-to-staff... 7) Clear, concise narrative description... Client was asked to raise his hand and ask for permission before getting out of his seat without permission. Client then proceeded to get up and walk out without being acknowledged and received correctives. Client then became verbally and physically aggressive toward staff by close hand swinging and hitting staff on the arm. Client was then placed in a basket hold but proceeded to cut loose by running forward, hitting his chest and	N 132	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing and direct care staff who might perform a restraint or seclusion. All of these identified staff members will attend training on the appropriate use of restraint/ seclusion. This will include specific instruction on the approved restraint methods and the need to use only these approved techniques. Also, the training will stress the importance of safety when applying the aforementioned techniques, avoiding hazards when performing an emergency procedure and the requirement not to engage in an emergency procedure if it cannot be completed safely. This will be conducted by the administrator and or the program consultants. This training and review will be completed by 9-12-21. This will be documented with training rosters initially and then included in documentation of completed OJT training going forward. Additionally all restraints or seclusions will be reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements. This will be effective as of 9-12-21 but has already been put in place.	9-15-21

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N 132	Continued From page 55 right shoulder into the wall and corner of the gym and staff exit doors. 8) Should/could this incident have been prevented/anticipated? Yes - When client attempted to hit the staff member, staff should have 'tapped out' and allowed another BI [Behavior Interventionist] to work with the client to de-escalate the situation. The Lead BI should have contacted the Consultant on call to inform her that he observed the improper hold. The Lead BI should have re-trained the BI on CPI [Crisis Prevention Institute] approved holds..." b. An ID (Identification) of Physical Markings / Injuries form dated 2/28/21 documented, "...Description of findings... [Patient] has an abrasion to the right anterior [front] shoulder clavicle area..." c. On 8/10/21 at 3:11 p.m., the video of the physical hold on 2/28/21 was reviewed with the Administrator. At 4:27 p.m. in the video, the staff member grabs the client, swings him around toward the door and lifts him upward. The Administrator stated, "No, that was not a proper hold, not a CPI hold." When asked, "Was the client injured?" the Administrator stated, "Yes, he had an abrasion." d. The Seclusion & Restraint Policy provided by the Administrator on 8/2/21 documented, "...Procedures: ...At no time shall any procedure be utilized that causes physical or psychological risk to residents..."	N 132		
N 135	PROTECTION OF RESIDENTS CFR(s): 483.356(c)(3) [At admission, the facility must] obtain an acknowledgment, in writing, from the resident, or	N 135	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all staff involved in the admissions process Continued on next page	9-15-21

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in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and

This ELEMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure an Authorization / Consent / Release document was signed by the clients' parents / legal guardian at the time of admission for 6 (Clients #3, #8, #9, #10 #11, and #12) sampled clients who were admitted to the facility. The findings are:

1. Client #8 was admitted on 5/11/21 and had diagnosis Major Depressive Disorder.

a. An Authorizations/Consents/Releases document dated 5/11/21 had no parent/legal guardian signature.

b. On 8/13/21, at 10:46 a.m., the Administrator reviewed the document and stated, "They gave a verbal consent, but no actual signature."

2. Client #9 was admitted on 4/16/21 and had diagnoses Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder.

a. An Authorizations/Consents/Releases document dated 4/16/21 had no parent/legal guardian signature.

b. On 8/13/21, at 10:46 a.m., the Administrator

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where consents and authorizations are reviewed and signed by client parents or guardians. Two separate forms have been created specifically for this purpose. One is a copy of the restraint and seclusion policy specifically identified as a parent or guardian copy for them to retain.
The other is a copy of the same policy with a section for a parent/guardian signature acknowledging the receipt of their copy.

All other admissions and consents will also be provided to the parents or guardians and signed at the time of admission. In the case of a verbal consent, that consent will be properly documented and witnessed. The parents will be provided a copy of these documents and a signature obtained as soon as possible in addition to the verbal consent.
For existing clients, a copy of the policy on use of restraint and seclusion will be mailed, no later than 9/9/21 with a self-addressed postage paid, return envelope, to each guardian. The cover letter included will request that they sign and return the acknowledgement. They will also have the option to scan and email or fax the acknowledgment back as well. A list of the confirmed acknowledgements will be maintained by the RTC Case Manager, follow-up phone calls will be made to confirm receipt and continue until all clients have the acknowledgement in their records or have discharged.

Admission documentation will be regularly audited by the MFH Health Information Management department to measure compliance. The results of these audits will be reported to the MCH Administrator and the RTC Director. Instructions on implementation of these forms and the actual implementation will be completed by 9-15-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING ______ B. WING ______	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 135	Continued From page 57	N 135		

reviewed the document and stated, "A verbal consent on 4/16, but no signature."

3. Client #10 was admitted on 6/11/21 and had diagnoses Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Unspecified Disruptive, Impulse-Control and Conduct Disorder, Attention-Deficit/ Hyperactivity Disorder and Anxiety Disorder.

a. An Authorizations/Consents/Releases document dated 3/3/21 had no parent/legal guardian signature.

b. On 8/13/21, at 10:46 a.m., the Administrator reviewed the document and stated, "There is a note of verbal [consent] on 3/3/21, but no signature."

4. Client #11 was admitted on 3/5/21 and had diagnosis Disruptive Mood Dysregulation Disorder.

An Authorizations/Consents/Releases document dated 3/4/21 had no parent/legal guardian signature.

5. Client #12 was admitted on 12/31/20 and had diagnoses Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, and Attention-Deficit/Hyperactivity Disorder.

a. An Authorizations/Consents/Releases document dated 12/31/20 had no parent/legal guardian signature.

b. On 8/13/21, at 10:46 a.m., the Administrator

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 135	Continued From page 58 reviewed the document and stated, "Verbal consent 12/31/20. They gave verbal consent, but no actual signature." 6. Client #3 was admitted to the facility on 4/27/21 and had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit/Hyperactivity Disorder. a. An Authorizations / Consents / Releases form for Client #3 dated 5/7/21 did not document a parent or guardian signature. b. On 8/13/21 at 10:46 AM, the Administrator was asked, "Was [Client #3's] consent signed by a parent or guardian, indicating they were informed of the facility's policy on the use of restraint or seclusion?" The Administrator reviewed the paper copy of the consent form, then looked in the Electronic Medical Record for Client #3 and stated, "There is no verbal and no signature from the parent or guardian on the consent." 7. On 8/13/21 at 10:46 a.m., the Administrator was asked if the parents / legal guardians received / signed a copy of the Authorizations/Consents/Releases Policy. He stated, "I don't know if they get a copy of one. It is read to them over the phone. If they have the ability, we will e-mail or fax a copy to them, have them sign it and send it back, but it is read to them".	N 135		
N 136	PROTECTION OF RESIDENTS CFR(s): 483.356(c)(4) [At admission, the facility must] provide a copy of the facility policy to the resident and in the case of	N 136	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all staff.. Continued on next page	9-15-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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a minor, to the resident's parent(s) or legal guardian(s).

This ELEMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a copy of the facility's Restraint and Seclusion policy was received by the client's parents/legal guardian at the time of admission for 8 (Client #1, #2, #3, #8, #9, #10 #11, and #12) of 12 (Clients #1-12) sampled clients who were admitted to the facility. The findings are:

1. Client #8 was admitted on 5/11/21 and had a diagnosis of Major Depressive Disorder.

2. Client #9 was admitted on 4/16/21 and had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder.

3. Client #10 was admitted on 6/11/21 and had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Unspecified Disruptive, Impulse-Control and Conduct Disorder, Attention-Deficit/ Hyperactivity Disorder and Anxiety Disorder.

4. Client #11 was admitted on 3/5/21 and had a diagnosis of Disruptive Mood Dysregulation Disorder.

5. Client #12 was admitted on 12/31/20 and had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, and Attention-Deficit/Hyperactivity Disorder.

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Continued from previous page....

involved in the admissions process where consents and authorizations are reviewed and signed by client parents or guardians. Two separate forms have been created specifically for this purpose. One is a copy of the restraint and seclusion policy specifically identified as a parent or guardian copy for them to retain. The other is a copy of the same policy with a section for a parent/guardian signature acknowledging the receipt of their copy.

All other admissions and consents will also be provided to the parents or guardians and signed at the time of admission. In the case of a verbal consent, that consent will be properly documented and witnessed. The parents will be provided a copy of these documents and a signature obtained as soon as possible in addition to the verbal consent.

For existing clients, a copy of the policy on use of restraint and seclusion will be mailed, no later than 9/9/21 with a self-addressed postage paid, return envelope, to each guardian. The cover letter included will request that they sign and return the acknowledgement. They will also have the option to scan and email or fax the acknowledgment back as well. A list of the confirmed acknowledgements will be maintained by the RTC Case Manager, follow-up phone calls will be made to confirm receipt and continue until all clients have the acknowledgement in their records or have discharged.
Admission documentation will be regularly audited by the MFH Health Information Management department to measure compliance. The results of these audits will be reported to the MCH Administrator and the RTC Director. Instructions on implementation of these forms and the actual implementation will be completed by 9-15-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	**2002 S FILLMORE ST** **LITTLE ROCK, AR 72214**

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N 136	Continued From page 60 6. Client #1 was admitted to the facility on 1/11/21 and 5/06/21 and 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. 7. Client #2 was admitted to the facility on 01/28/21, 4/21/21 and 5/10/21 and had diagnoses of Major Depressive Disorder with Psychotic Features, Oppositional Defiant Disorder, and Other Circumstances Related to Child Neglect Personal History. 8. Client #3 was admitted to the facility on 4/27/21 and had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit/Hyperactivity Disorder. 9. On 8/13/21 at 10:46 a.m., the Administrator was asked, "Did the parent/legal guardians receive a copy of the Restraint/Seclusion Policy?" He stated, "It's in the handbook; I don't know if they get a copy of the policy." 10. The Client Handbook, provided by the Administrator on 8/13/21 at 11:40 p.m., did not contain the Facility Restraint/Seclusion Policy.	N 136		
N 140	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(a) Orders for restraint or seclusion must be by a physician, or other licensed practitioner permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency	N 140	Upon review of these identified issues, it is evident that the physicians are no lacking in specifics given within their order for actions or medications. The difficulty is in nursing documentation of these orders both at the time of.... Continued on next page	9-15-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 140	Continued From page 61 safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure physician orders were obtained for all restraints and seclusion utilized for 12 (Clients #1 - #12) of 12 sample clients who had restraints and / or seclusion implemented. The findings are: 1. Client #4 had diagnoses of Disruptive Mood Dysregulation Disorder and Posttraumatic Stress Disorder. a. A Seclusion or Restraint Order dated 4/30/2021 at 9:08 a.m. documented, "...Chemical Restraint IM [intramuscular]- not to exceed one hour..." There was no specific drug information on the order. A Seclusion and Restraint Form 1 dated 4/30/2021 documented, "...Indication for Behavior Management/Emergency Safety Intervention... Chemical Restraint: ... Zyprexa 5 mg [milligrams] IM [intramuscular] x [times] 1. Benadryl 50 mg x 1..." b. A Seclusion or Restraint Order dated 4/30/2021 at 7:26 p.m. documented, "...Chemical Restraint IM- not to exceed one hour..." There was no specific drug information on the order. A Seclusion and Restraint Form 1 dated 4/30/2021 documented, "...Indication for Behavior Management/Emergency Safety Intervention... Chemical Restraint: ... Zyprexa 10 mg IM x 1.	N 140	Continued from previous page... receiving and within the system of documentation for charting. This deficiency could impact all clients so the correction is directed at all nursing staff. All nurses will complete and in-service review of the proper documentation requirements for seclusion and restraint orders. This will include emphasis on complete documentation including specific medication information (name, dosage, route given). This in-service will be presented by the Administrator and completed by 9-15-21. All restraint and seclusion orders will be reviewed by the Health Information Management department on a regular basis. For the first 4 weeks the restraint and seclusion orders will also be reviewed by the nurse manager starting the week of 9-13-21. Continued need of that review will be evaluated based upon the results. All results of reviews will be reported to the MCH Administrator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 140	Continued From page 62 Benadryl 50 mg x 1..." c. A Seclusion or Restraint Order dated 6/8/2021 at 5:04 p.m. documented, "...Chemical Restraint IM- not to exceed one hour..." There was no specific drug information on the order. A Seclusion and Restraint Form 1 dated 6/8/2021 documented, "...Indication for Behavior Management/Emergency Safety Intervention...Chemical Restraint:... Zyprexa 5 mg IM x 1. Benadryl 50 mg x 1..." d. A Seclusion or Restraint Order dated 6/15/2021 at 11:22 a.m. documented, "...Chemical Restraint IM- not to exceed one hour..." There was no specific drug information on the order. A Seclusion and Restraint Form 1 dated 6/15/2021 documented, "...Indication for Behavior Management/Emergency Safety Intervention...Chemical Restraint:... Zyprexa 7.5 mg IM x 1. Benadryl 75 mg x 1..." e. A Seclusion or Restraint Order dated 7/19/2021 at 2:23 p.m. documented, "...Chemical Restraint IM- not to exceed one hour..." There was no specific drug information on the order. A Seclusion and Restraint Form 1 dated 7/19/2021 documented, "...Indication for Behavior Management/Emergency Safety Intervention... Chemical Restraint: ... Zyprexa 7.5 mg IM x 1. Benadryl 75 mg x 1..." f. A Seclusion or Restraint Order dated 7/27/2021 at 2:16 p.m. documented, "...Chemical Restraint IM- not to exceed one hour..." There was no	N 140		

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specific drug information on the order.

A Seclusion and Restraint Form 1 dated 7/27/2021 documented, "...Indication for Behavior Management/Emergency Safety Intervention...Chemical Restraint: ... Zyprexa 10 mg IM x 1. Benadryl 50 mg x 1..."

2. Client #6 had diagnoses of Disruptive Mood Dysregulation Disorder and Epilepsy.

a. A Seclusion or Restraint Order dated 2/8/2021 at 10:22 a.m. documented, "...Chemical Restraint IM- not to exceed one hour..." There was no specific drug information on the order.

A Seclusion and Restraint Form 1 dated 2/8/2021 documented, "...Indication for Behavior Management/Emergency Safety Intervention...Chemical Restraint: ... Haldol 5 mg IM x 1. Benadryl 50 mg x 1..."

b. A Seclusion or Restraint Order dated 2/10/2021 at 11:33 a.m. documented, "...Chemical Restraint IM- not to exceed one hour..." There was no specific drug information on the order.

A Seclusion and Restraint Form 1 dated 2/10/2021 documented, "...Indication for Behavior Management/Emergency Safety Intervention... Chemical Restraint: ... Zyprexa 10 mg IM x 1. Benadryl 50 mg x 1..."

3. Client #7 had diagnoses of Disruptive Mood Dysregulation Disorder, Autism Spectrum Disorder and Unspecified Schizophrenia Spectrum.

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	04L106	A. BUILDING ______ B. WING ______	C 08/13/2021

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N 140	Continued From page 64	N 140		

a. An Incident Report Form dated 2/28/2021 documented, "...(Injury) Client... Bruise on right shoulder... Disturbance... Client-to-staff...7) Clear, concise narrative description...Client then became verbally and physically aggressive toward staff by close hand swinging and hitting staff on the arm. Client was then placed in a basket hold but proceeded to cut loose by running forward, hitting his chest and right shoulder into the wall and corner of the gym and staff exit doors. 8) Should/could this incident have been prevented/anticipated? Yes - When client attempted to hit the staff member, staff should have 'tapped out' and allowed another BI [Behavior Interventionist] to work with the client to de-escalate the situation. The Lead BI should have contacted the Consultant on call to inform her that he observed the improper hold. The Lead BI should have re-trained the BI on CPI [Crisis Prevention Institute] approved holds..."

There was no Physician's Order for a physical restraint for this incident.

b. An Incident Report Form dated 3/12/2021 documented, "...Disturbance... Client-to-Client, Client-to-Staff... 7) clear, concise narrative description... Client threw a ball at another peer, they got into a physical altercation. Once the client was in the hallway he began to throw chairs at doors..."

On 8/10/2021 at 3:22 p.m., the video was reviewed with the Administrator. Staff pushed, then grabbed the client and drug to the door, then placed Client #7 in a hold at the door. The Administrator stated, "None, from the beginning, was appropriate. No, that was not an appropriate hold."

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There was no Physician's Order for a physical restraint for this incident.

c. A handwritten Report to Quality Assurance dated 3/18/2021 documented, "...Description of Incident [Client] was instructed to give the pen he was using to draw with to his peer so they could be scribe during family conference. [Client] then got very upset, cursed staff and his peer as well. [Client] then threw pen at his peer and hit him with it... [Client] was then grabbed from behind by the peer he hit with the pen and cursed out...Once [Client] was pulled away from client he started to attack staff... and he was placed in 2 man control position..."

There was no Physician's Order for a physical restraint for this incident.

4. Client #5 had diagnoses of Severe Major Depressive Disorder and Oppositional Defiant Disorder.

a. An Incident Report Form dated 4/4/21 at 10:02 a.m. documented, "...Disturbance... Client-to-Staff... 7) Clear, concise narrative description... Client was very disrespectful to staff and refused to follow instructions... As the group was leaving the unit [Client #5] was sitting on the floor behind a chair. staff walked over and noticed he had a pen next to him. As staff reacted to get the pen [Client #5] threw a punch and hit this staff. He was placed in a team control position and was combative...He also attempted to bite staff on the leg and went to the floor. Staff continued the restraint due to aggressive behavior. he also moved his head side to side trying to bit staff during the floor hold. He also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 140	Continued From page 66 received a chemical restraint during the hold. After that he was released. He continued to attack staff and invade staff personal space so staff attempted a new hold... staff was not able to successfully complete a new hold due to fatigue and had to hold [Client #5's] arms to prevent harm..." b. Physician's Orders dated 4/4/21 documented, "Zyprexa 5 mg [milligrams] IM [intramuscular] Benadryl 50 mg IM Now. May place in seclusion." There was no Physician's Order for a physical restraint for this incident. 5. Client #8 had a diagnosis of Major Depressive Disorder. a. A Seclusion and Restraint Form dated 5/15/21 documented, "Date and Time Initiated: 5/15/2021 6:55 PM; Date and Time Ended: 5/15/2021... Behavior demonstrated to justify use of procedure: Client and peer got into a verbal argument that led to altercations of hitting each other. Staff separated each client and put in different areas. Another peer kicked through doors and attacked client... 1. Observation: Beginning Time: 6:50 PM; Procedure: Chemical Restraint... Chemical Restraint: (Medication name, dose and route of medication): Zyprexa Zydis 10 mg (milligram)..." There was no Physician's Order for the use of the chemical restraint. b. An Incident Report Form dated 6/24/21 documented, "...[Client #8] was sitting across form peer [client initials] during breakfast in the cafeteria. [Client initials] was moving his hands	N 140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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around on the table, [Client #8] got upset. [Client #8] start yelling and cursing at [Client initials], staff gave [Client #8] correctives and he was taking to tantrum for continued behavior. [Client #8] then stood up in a aggressive manner and attacked [Client initials]. Staff intervene and [Client initials] was placed outside the cafeteria. [Client #8] was very aggressive with staff and was placed in a restraint at 8:16 a.m...." There was no Physician's Order for the use of the restraint.

c. A Seclusion and Restraint Form dated 6/8/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 5 mg (milligrams) IM (Intramuscular) x (times) 1, Benadryl 50 mg IM x1..." A Seclusion or Restraint Order dated 6/8/21 documented, "...Order Type: Chemical Restraint Im-Not to Exceed One Hour..." There was no specific drug information on the order.

6. Client #9 had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder.

a. A Seclusion and Restraint form dated 4/21/21 documented, "Date and Time Initiated: 4/21/2021 7:36 PM; Date and Time Ended: 4/21/2021 8:54 PM ...Client became noncompliant in the foyer area with CNA [Certified Nurse Assistant] staff. Client started kicking doors. Client and peer used laundry basket to break light covers and used pieces to self-harm with ...1. Observation: Beginning Time: 7:36 PM: Procedure: Chemical Restraint... Client Behavior: Cursing ...2. Observation: Beginning Time: 7:54 PM: Procedure: Seclusion..." There was no Physician's Order for the use of seclusion.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING ______ B. WING ______	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

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b. A Seclusion and Restraint form dated 5/18/21 documented, "Date and Time Initiated: 5/18/2021 10:43 PM; Date and Time Ended: 5/18/2021 11:10 PM ...Behavior demonstrated to justify use of procedure: Elopement, physically aggressive with staff ...1. Observation: Beginning Time: 10:43 PM; Procedure: Chemical Restraint ...2. Observation: Beginning Time: 10:47 PM; Procedure: Personal Restraint ...3. Observation: Beginning Time: 11:05 PM; Procedure: Seclusion..." There were no Physician's Order for the use of the physical restraint.

c. A Seclusion and Restraint form dated 5/20/21 documented, "Date and Time Initiated: 5/20/2021 10:52 AM; Date and Time Ended: 5/20/2021 11:58 AM ...Behavior demonstrated to justify use of procedure: Elopement, punched staff in the face, kicking unit doors ...1. Observation: Beginning Time: 10:52 AM; Procedure: Personal Restraint ...2. Observation: Beginning Time: 10:56 AM; Procedure: Chemical Restraint ...3. Observation: Beginning Time: 10:58 AM; Procedure: Seclusion..." There were no Physician's Order for the use of the personal restraint.

d. A Seclusion and Restraint form dated 6/12/21 documented, "Date and Time Initiated: 6/12/2021 7:45 PM; Date and Time Ended: 6/12/2021 9:00 PM ...Behavior demonstrated to justify use of procedure: Client became noncompliant while in the Foyer area and started kicking doors. Client kicked out several doors and aggressively tried to kick exit door. Client was escorted back to the unit where he continued to display aggressive behaviors ...1. Observation: Beginning Time: 8:05 PM; Procedure: Personal restraint ...3.

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N 140	Continued From page 69 Observation: Beginning Time: 8:10 PM; Procedure: Seclusion ..." There were no Physician's Order for the use of the personal restraint or seclusion. e. A Seclusion and Restraint Observation Log dated 6/14/21 documented, "...Beginning Time: 8:05 PM; Procedure: Personal Restraint ...Beginning Time: 8:10 PM; Procedure: Seclusion..." There were no Physician's Order for the use of the personal restraint. f. An Incident Report Form dated 7/1/21 documented, "...Behavioral Intervention Observation Log ...Time: 12:43 pm; Procedure: 2 (restraint) ..." There was no Physician's Order for the use of personal restraint. g. A Seclusion and Restraint Form dated 7/12/21 documented, "Date and Time Initiated: 7/12/2021 9:24 AM; Date and Time Ended: 7/12/2021 9:25 AM ...Behavior demonstrated to justify use of procedure: continued negative behavior, kicking unit doors, property destruction, physically aggressive with staff ...Beginning Time: 9:24 AM; Procedure: Chemical Restraint ...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg (milligram) IM (intramuscular) X (times) 1; Benadryl 100 mg IM x1..." There were no Physician Orders for the use of the chemical restraint. h. A Seclusion and Restraint Form dated 4/21/21 documented, "...Chemical Restraint: Medication name, dose and route of medication) Zyprexa 10 mg IM with Benadryl 50 mg IM..." A Seclusion or Restraint Order dated 4/21/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour...." There was no specific drug	N 140		

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information on the order.

i. A Seclusion and Restraint Form dated 4/28/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Haldol 7.5 mg IM with Benadryl 75 mg IM..." A Seclusion or Restraint Order dated 4/28/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

j. A Seclusion and Restraint Form dated 4/30/21 documented, "...Chemical Restraint: (Medication mane, dose and route of medication) Zyprexa 10 mg IM x 1 Benadryl 50 mg IM x 1..." A Seclusion or Restraint Order, dated 4/30/21, documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

k. A Seclusion and Restraint Form dated 5/18/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 5 mg IM x1 Benadryl 50 mg x 1..." A Seclusion or Restraint Order dated 5/18/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

l. A Seclusion and Restraint Form dated 5/20/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM x1 Benadryl 100 mg x 1..." A Seclusion or Restraint Order dated 5/20/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

m. A Seclusion and Restraint Form dated 5/25/21

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N 140	Continued From page 71 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM x1 Benadryl 100 mg x 1..." A Seclusion or Restraint Order dated 5/25/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order. n. A Seclusion and Restraint Form dated 6/11/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM x1 Benadryl 100 mg IM x 1..." A Seclusion or Restraint Order dated 6/11/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order. o. A Seclusion and Restraint Form dated 6/21/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 7.5 mg IM x1 Benadryl 75 mg x 1..." A Seclusion or Restraint Order dated 6/21/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order. p. A Seclusion and Restraint Form dated 7/8/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM x1 Benadryl 100 mg x 1..." A Seclusion or Restraint Order dated 7/8/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order. q. A Seclusion and Restraint Form dated 7/9/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg PO (by mouth) x1 Benadryl 100 mg PO x 1..."	N 140		

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A Seclusion or Restraint Order dated 7/9/21 documented, "...Order Type: Chemical Restraint PO-Not to Exceed One Hour..." There was no specific drug information on the order.

r. A Seclusion and Restraint Form dated 7/12/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg PO x1 Benadryl 100 mg PO x 1..." A Seclusion or Restraint Order dated 7/12/21 documented, "...Order Type: Chemical Restraint PO-Not to Exceed One Hour..." There was no specific drug information on the order.

s. A Seclusion and Restraint Form dated 7/27/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM x1 Benadryl 50 mg IM x 1..." A Seclusion or Restraint Order dated 7/27/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

t. A Seclusion and Restraint Form dated 8/6/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg Benadryl 100 mg..." A Seclusion or Restraint Order dated 8/6/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

7. Client #10 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Unspecified Disruptive, Impulse-Control and Conduct Disorder, Attention-Deficit/ Hyperactivity Disorder and Anxiety Disorder.

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N 140	Continued From page 73 a. A Seclusion and Restraint Form dated 4/27/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM with Benadryl 100 mg IM..." A Seclusion or Restraint Order dated 4/27/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order. b. A Seclusion and Restraint Form dated 4/28/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM with Benadryl 75mg..." A Seclusion or Restraint Order dated 4/28/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order. c. A Seclusion and Restraint Form dated 5/3/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 5 mg IM x1 Benadryl 50 mg IM x1..." A Seclusion or Restraint Order dated 5/3/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order. 8. Client #11 had diagnosis Disruptive Mood Dysregulation Disorder. a. A Seclusion and Restraint Form dated 4/3/21 documented, "Date and Time Initiated: 4/3/2021 7:45 PM; Date and Time Ended: 4/3/2021 9:15 PM ...Behavior demonstrated to justify use of procedure: [Client #11] had been kicking the unit doors repeatedly ...1. Observation: Beginning Time: 7:45 PM; Procedure: Chemical Restraint ...Beginning Time: 8:16 PM; Procedure: Seclusion ...Chemical Restraint: (Medication name, dose	N 140		

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and route of medication) Zyprexa Zydis 5 mg po [by mouth]..." There were no Physician's Orders for the use of a chemical restraint or seclusion.

b. A Seclusion and Restraint Form dated 4/4/21 documented, "Date and Time Initiated: 4/4/2021 8:50 AM; 4/4/2021 8:51 AM ...Behavior demonstrated to justify use of procedure: Physically and verbally aggressive, threatening staff ...1. Observation Beginning Time 8:50 AM; Procedure: Chemical Restraint..." There were no Physician's Order for the use of the chemical restraint.

c. A Seclusion and Restraint Form dated 4/27/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM Benadryl 100 mg IM ..." A Seclusion or Restraint Order dated 4/27/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

d. A Seclusion and Restraint Form dated 4/28/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM with Benadryl 75 mg IM ..." A Seclusion or Restraint Order, dated 4/28/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

9. Client #12 had diagnoses Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, and Attention-Deficit/Hyperactivity Disorder.

a. A Seclusion and Restraint Form dated 4/3/21

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documented, "Date and Time Initiated: 4/3/2021 7:45 PM; Date and Time Ended: 4/3/2021 9:20 PM ...Behavior demonstrated to justify use of procedure: Aggressive behavior, breaking through doors ...1. Observation Beginning Time: 7:45 PM; Procedure: Chemical Restraint... 3. Observation Beginning Time: 8:16 PM; Procedure: Seclusion ...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa Zydis 5 mg (milligram) po (by mouth)..." There were no Physician's Order for the use of the chemical restraint or seclusion.

b. A Seclusion and Restraint Form, dated 4/4/21, documented, "Date and Time Initiated: 4/4/2021 8:40 AM; Date and Time Ended: 4/4/2021 8:40 AM ...Behavior demonstrated to justify use of procedure: Ongoing aggressive behavior, agitation, verbally and physically aggressive, threatening staff ...1. Observation Beginning Time: 8:53 AM; Procedure: Chemical Restraint, Seclusion ...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 5 mg (milligram) IM (Intramuscular)..." There were no Physician's Order for the use of the chemical restraint.

c. A Nursing Progress Note, dated 4/11/21, documented, " ...Progress/Affect: RN (Registered Nurse) face to face assessment 4-11-21 at 235 pm. [Client #12] is alert, oriented x (times) 3. Full ROM (Range of Motion). No injury noted. Personal restraint due to property destruction..." There were no Physician's Order for the use of the personal restraint.

d. A Seclusion and Restraint Form dated 4/21/21 documented, "Date and Time Initiated: 4/21/2021 7:34 PM; Date and Time Ended: 4/22/2021 8:36

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N 140	Continued From page 76 PM ...Behavior demonstrated to justify use of procedure: Client became noncompliant in the foyer area and started kicking doors to the unit. Client and peer kicked doors open to unit and attempted to break external door to escape. Client and peer also used laundry basket to break the light covers on the unit ...1. Observation Beginning Time: 7:34 PM; Procedure: Chemical Restraint ...2. Observation Beginning Time: 7:35 PM; Procedure: Seclusion..." There was no Physician's Order for the use of seclusion. e. A Seclusion and Restraint Form dated 5/3/21 documented, "Date and Time Initiated: 5/3/2021 6:47 PM; Date and Time Ended: 5/3/2021 7:48 PM ...Behavior demonstrated to justify use of procedure: Client began acting out for no apparent reason. Client gathered some of his peers and planned to act out. Client then started kicking doors open in an attempt to elope ...1. Observation Beginning Time 6:47 PM; Procedure: Seclusion..." There was no Physician's Order for the use of seclusion. f. A Seclusion and Restraint Form dated 2/12/20 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg Benadryl 50 mg ..." A Seclusion or Restraint Order dated 2/12/20 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order. g. A Seclusion or Restraint Order dated 2/13/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order. h. A Seclusion or Restraint Order, dated 2/19/21,	N 140		

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documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

i. A Seclusion or Restraint Order, dated 3/8/21, documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

j. A Seclusion and Restraint Form dated 4/12/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM Benadryl 50 mg IM ..." A Seclusion or Restraint Order dated 4/12/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

k. A Seclusion and Restraint Form dated 4/15/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 5 mg with Benadryl 50 mg IM x1 dose each ..." A Seclusion or Restraint Order dated 4/15/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

l. A Seclusion and Restraint Form dated 4/21/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM with Benadryl 50 mg IM..." A Seclusion or Restraint Order dated 4/21/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

m. A Seclusion or Restraint Order dated 4/22/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no

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specific drug information on the order.

n. A Seclusion and Restraint Form dated 4/28/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IM with Benadryl 50 mg IM..." A Seclusion or Restraint Order dated 4/28/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

o. A Seclusion and Restraint Form dated 5/3/21 documented, "...Chemical Restraint: (Medication name, dose and route of medication) Zyprexa 10 mg IMx1 Benadryl 50 mg IM x1..." A Seclusion or Restraint Order dated 5/3/21 documented, "...Order Type: Chemical Restraint IM-Not to Exceed One Hour..." There was no specific drug information on the order.

10. 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. Physician Orders in the Electronic Medical Record (EMR) for Client #1 indicated chemical restraints were ordered on 6/14/21, 6/12/21, 5/10/21, 4/28/21 at 7:59 AM and 9:12 AM, 4/12/21, 4/6/21 (at 2:20 PM), 3/19/21, 3/15/21, 3/2/21, and 2/10/21. None of these orders included the names of the chemicals (medications) or doses to be given.

b. Seclusion and Restraint Logs documented Client #1 received Emergency Safety

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Interventions on 7/22/21 (chemical), 6/15/21 (chemical), 4/6/21 (chemical at 12:30 PM) and 1/19/21 (chemical). None of these restraints had a physician order on the EMR.

11. Client #2 had diagnoses of Major Depressive Disorder with Psychotic Features, Oppositional Defiant Disorder, and Other Circumstances Related to Child Neglect Personal History (past history of Neglect in Childhood.

a. Physician Orders for chemical restraints were documented on 6/17/21, 6/7/21, 4/28/21, 4/27/21, 4/26/21, 4/14/21, 4/12/21, and 4/6/21. None of these orders included the names or doses of the medicines to be given.

b. The "Seclusion and Restraint Log" received from the Administrator on 8/2/21 at 12:17 PM documented Client #2 had a personal restraint on 4/29/21 and a chemical restraint on 6/15/21 at 5:05 PM. No order for these restraints was found in the client's records.

12. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit/Hyperactivity Disorder.

a. A Seclusion and Restraint Log dated from 1/5/21 to 7/27/21 was received from the Administrator on 8/2/21. It documented Client #3 had a chemical restraint on 6/15/21. No Physician's Order for this restraint was found in the client's record.

b. Physician Orders documented chemical restraints ordered on 7/12/21, 7/9/21, 7/8/21, 5/18/21 at 1:22 PM and 5/18 at 10:35 PM, 5/12/21, 5/5/21, and 4/30/21. None of the orders

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included the chemicals or doses to be administered.

c. On 8/12/21 at 1:47 PM, the facility's Corporate Compliance Director provided copies of physician orders for Client #3 as follows: 5/22/21 at 7:25 AM for "Zyprexa 5 mg and Benadryl 25 mg IM now agitation; and 5/8/21 at 11:42 AM for "Zyprexa 5 mg & Benadryl 50 mg IM Now, Aggression". No other Physician Orders related to restraints or seclusions were provided prior to exit.

13. On 8/11/21 at 9:52 a.m., Consultant #1 was asked, "How do nurses get the order for a chemical restraint?" She stated, "The nurse calls the doctor and informs him of what's going on and the doctor decides what to order." The Consultant was asked, "Is there any other Physician's orders for seclusion/restraints anywhere else besides in the orders?" She stated, "Those should be the official orders with the E [electronic] signature."

14. On 8/13/21, at 9:05 a.m., RN #2 was asked, "When you get an order for restraint/seclusion where do you document it?" She stated, "On Care Logic, I was told not to write it on paper."

15. On 8/13/21 at 10:20 a.m., the Nurse Manager was asked, "When you get an order for a chemical restraint should the name of the chemical be on the order?" She stated, "Yes."

16. A Seclusion & Restraint Policy provided by the Administrator on 8/2/21 documented, "...Procedures... J. Orders 1. Any restraint or seclusion procedure must be used and continued pursuant to an order from the attending

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N 140	Continued From page 81 physician..." 17. A Physician Orders and Medication Administration Policy provided by the Administrator on 8/12/21 documented, "...Procedure: ... 3. Ordering Medication... a. A physician's order or written prescription from the physician is required before administration of any medication. b. Medication orders must specify the following: 1. The name of the drug... 5. The signature of the physician 6. Date and time of order..."	N 140		
N 142	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the least restrictive Emergency Safety Intervention was ordered and that less restrictive measures were attempted prior to application of a restraint or seclusion for 5 (Clients #1, #2, #3, #5, and #12) of 12 (Clients #1 - #12) sample clients. The findings are: 1. Client #9 had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit / Hyperactivity Disorder.	N 142	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 only after less restrictive measures have been attempted (barring an immediate safety issue). A check sheet to document this process and confirm actions inclusive of less restrictive methods of de-escalation has been put in place. As of 9-3-2021. If a client requires a restraint, 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 actions might result in injury of a client or others. The checklist noted will be completed by the nurse on duty and reviewed in conjunction with review of restraint procedures by the Nurse Manager, the RTC Director and or the MCH Administrator. This review and acknowledgement will be completed by 9-15-21	9-15-21

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N 142	Continued From page 82	N 142		

a. A Seclusion or Restraint Order dated 4/28/21 documented, "...Order Type: Chemical Restraint IM [intramuscular injection]... Phone Order Date: 04/28/2021 2:26 PM..." A Seclusion or Restraint Order dated 4/28/21 documented, "...Order Type: Seclusion... Phone Order Date: 04/28/2021 2:26 PM..." The chemical restraint and seclusion were ordered at the same time.

b. A Seclusion or Restraint Order dated 6/18/21 documented, "...Order Type: Chemical Restraint... Phone Order date: 05/18/2021 10:35 PM..." A Seclusion or Restraint Order dated 6/18/21 documented, "...Order Type: Seclusion... Phone Order Date: 05/18/2021 10:35 PM..." The chemical restraint and seclusion were ordered at the same time.

c. A Seclusion or Restraint Order dated 5/20/21 documented, "...Order Type: Chemical Restraint...Phone Order date: 05/20/2021 10:52 AM..." A Seclusion or Restraint Order dated 5/20/21 documented, "...Order Type: Seclusion... Phone Order Date: 05/20/2021 10:52 AM..." The chemical restraint and seclusion were ordered at the same time.

d. A Seclusion or Restraint Order dated 5/25/21 documented, "...Order Type: Seclusion... Phone Order Date: 05/20/2021 12:24 PM..." A Seclusion or Restraint Order dated 5/25/21 documented, "...Order Type: Chemical Restraint... Phone Order Date: 05/25/2021 12:24 PM..." The chemical restraint and seclusion were ordered at the same time.

e. A Seclusion or Restraint Order dated 7/27/21 documented, "...Order Type: Personal Restraint...

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N 142	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 Restraint...Phone Order Date: 04/15/2021 4:30 PM..." A Seclusion or Restraint Order dated 4/12/21 documented, "...Order Type: Seclusion... Phone Order Date: 04/15/2021 4:30 PM..." The seclusion and chemical restraint were ordered at	N 142		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 142	Continued From page 84 the same time. c. A Seclusion or Restraint Order dated 4/22/21 documented, "...Order Type: Chemical Restraint...Phone Order Date: 04/22/2021 7:30 AM PM..." A Seclusion or Restraint Order dated 4/22/21 documented, "...Order Type: Seclusion... Phone Order Date: 04/22/2021 7:30 AM..." The seclusion and chemical restraint were ordered at the same time. d. A Seclusion or Restraint Order dated 4/28/21 documented, "...Order Type: Chemical Restraint... Phone Order Date: 04/28/2021 2:26 PM..." A Seclusion or Restraint Order, dated 4/28/21, documented, "...Order Type: Seclusion... Phone Order Date: 04/28/2021 2:26 PM..." The seclusion and chemical restraint were ordered at the same time. 4. 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 Note dated 6/12/21 at 6:22 PM documented, "Client became aggressive verbally and physically to staff and attempted to self-harm. After several attempts by BI [Behavioral Interventionist] to deescalate client, the situation was turned over to nursing, on call MD notified. An order for Zyprexa 10 mg [milligrams] IM x [times] 1 Now and 1-hour seclusion room ordered. Client received restraint but was ineffective and client was placed in seclusion room for 1 hour. Client was eventually	N 142		

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N 142	Continued From page 85	N 142		

able to calm down and get back on task." The restraint and seclusion were ordered at the same time.

5. Client #2 had diagnoses of Major Depressive Disorder with Psychotic Features, Oppositional Defiant Disorder, and Other Circumstances Related to Child Neglect Personal History.

A Report to Quality Assurance form dated 4/28/21 at 7:45 AM documented, "...What was the nature of the physical contact? Client was transported to seclusion and received a chemical..."

6. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit / Hyperactivity Disorder.

Physician's Orders dated 5/18/21 at 10:35 PM documented Registered Nurse (RN) #2 received a verbal order for both seclusion and chemical restraint for Client #3.

7. Client #5 had diagnoses of Severe Major Depressive Disorder and Oppositional Defiant Disorder.

a. An Incident Report Form dated 4/4/21 at 10:02 a.m. documented, "...Disturbance... Client-to-Staff... 7) Clear, concise narrative description... Client was very disrespectful to staff and refused to follow instructions... As the group was leaving the unit [Client #5] was sitting on the floor behind a chair. Staff walked over and noticed he had a pen next to him. As staff reacted to get the pen [Client #5] threw a punch and hit this staff. He was placed in a team control

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N 142	Continued From page 86 position and was combative...He also attempted to bite staff on the leg and went to the floor. Staff continued the restraint due to aggressive behavior. he also moved his head side to side trying to bite staff during the floor hold. He also received a chemical restraint during the hold. After that he was released. He continued to attack staff and invade staff personal space so staff attempted a new hold... staff was not able to successfully complete a new hold due to fatigue and had to hold [Client #5's] arms to prevent harm..." b. Physician's Orders dated 4/4/21 documented, "Zyprexa 5 mg [milligrams] IM [intramuscular] Benadryl 50 mg IM Now. May place in seclusion." 8. On 8/13/21 at 10:20 a.m., the Nurse Manager was asked, "Do you get an order for a chemical restraint and a physical restraint at the same time?" She stated, "Yes, from the physician." The Nurse Manager was asked, "You do not call the doctor twice? You get both orders together?" She stated, "Yes." 9. On 8/13/21, at 9:05 a.m., RN #2 was asked, "Do you ask for a chemical and physical restraint order at the same time?" She stated, "When I ask him [physician] for the order [for restraint], can I get an IM [intramuscular] for the order, because he [client] is in a restraint right now."	N 142		
N 145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency	N 145	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing staff. Continued on next page...	9-15-21

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N 145	Continued From page 87 safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a face-to-face assessment was conducted within one hour after initiating a restraint to protect client rights for 3 (Clients #6, #1 and #3) of 12 (Clients #1-#12) sampled clients who had been restrained. The findings are: 1. The Seclusion and Restraint policy provided by the Administrator on 8/2/2021 at 12:45 p.m. documented, "...Definitions & Procedures: ... L. Face to Face Evaluations... 2. If a resident was involved in a restraint, he/she must receive the in-person evaluation for that intervention within one hour of the intervention..." 2. Client #6 had diagnoses of Disruptive Mood Dysregulation Disorder and Epilepsy. A Seclusion and Restraint Form 1 dated 1/26/21 documented, "...Date and Time initiated 11:21	N 145	Continued from previous page... All nurses will be required to review and acknowledge policy and procedure which requires that a face to face assessment must be completed by an RN within one hour of any restraint or seclusion. These procedures are already in place and this will be a review of those practices. The compliance with the required assessment time frame will be tracked by the Health Information Management department, with reports of compliance levels going to the Nurse Manager, RTC Director and MCH Administrator. This will be in place with review completed by 9-12-2021	

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N 145	Continued From page 88 a.m... 1. Observation Beginning Time 11:21 a.m. Procedure: Personal Restraint... Face to Face Assessment Date and Time: 1/26/21 12:30 p.m..." The face-to-face assessment was conducted over 1 hour after the restraint was initiated. 2. 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. The seclusion and restraint documentation in the client's Electronic Medical Record (EMR) documented Emergency Safety Interventions (ESI) on 7/22/21 (chemical), 6/17/21 (personal or chemical), 6/15/21 (chemical), 6/8/21 (personal or chemical), 4/29/21 (personal), 4/27/21 (personal and chemical), 4/6/21 (chemical), and 3/24/21 (personal). There was no documentation of a face-to-face assessment conducted within 1 hour after initiation of these ESIs. b. A Face to Face form dated 6/12/21 at 10:45 AM documented, "RN [Registered Nurse] completing the Face to Face: [Licensed Practical Nurse (LPN) #1]." 3. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit/Hyperactivity Disorder. a. The Seclusion and Restraint Log documented Client #3 had Emergency Safety Interventions (ESIs) on 7/12/21 at 9:22 AM and 6/15/21 at 2:27 PM. No face-to-face assessment was	N 145		

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N 145	Continued From page 89 documented within one hour of the initiation of these ESIs. b. Physician Orders dated 5/18/21 documented a personal restraint order at 8:38 AM and a chemical restraint order at 1:22 PM. A Nursing Progress Note dated 05/18/21 (not timed) in the EMR for Client #3 documented, "At aprox [approximately] 0830 this morning, client was brought back to the unit because he had been acting out in the classroom and being verbally and physically aggressive with staff. While on the unit client physically attack several staff and was placed in a physical restraint. This nurse notified MD [Medical Doctor]. Will continue to monitor." A Nursing Progress Note on 05/18/21 by RN #2 documented, "Client was on the unit when another peer started talking slick, client reached up and punched peer in the side of the head. Client was then taken to the hallway by staff where he began kicking doors, being physically aggressive with staff, trying to self -harm. Client was given a Chemical Restraint and was able to calm down and is currently resting in the foyer. Will continue to monitor." No face to face assessment was documented within one hour of initiation of the documented ESIs. c. Seclusion and restraint documentation in the Electronic Medical Record for Client #3 documented Emergency Safety Interventions performed on 7/12/21 (chemical), 6/15/21 (chemical), 5/18/21 (personal at 8:38 AM and chemical at 1:22 PM), 5/5/21 (chemical), and 4/30/21 (chemical). There was no documentation of a face-to-face assessment conducted within 1 hour after initiating these ESIs.	N 145		
N 149	ORDERS FOR USE OF RESTRAINT OR	N 149	Corrective action on next page...	

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N 149	Continued From page 90 SECLUSION CFR(s): 483.358(h) Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following: This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Emergency Safety Interventions were documented and in the clients' record to assure an accurate and complete record of the events leading up to, during, and after the intervention for 11 (Clients #1, #2, #3, #4, #5, #7, #8, #9, #10, #11 and #12) of 12 (Clients #1 - #12) sampled clients who required an Emergency Safety Intervention (ESI). The Findings are 1. Client #8 had a diagnosis Major Depressive Disorder. a. An Incident Report Form dated 6/24/21 documented, "...[Client #8] was sitting across from [peer] during breakfast in the cafeteria. [Peer] was moving his hands around on the table, [Client #8] got upset. [Client #8] started yelling and cursing at [peer], staff gave [Client #8] correctives and he was taking to tantrum for continued behavior. [Client #8] then stood up in an aggressive manner and attacked [peer]. Staff intervene and [peer] was placed outside the cafeteria. [Client #8] was very aggressive with staff and was placed in a restraint at 8:16 a.m. for	N 149	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing staff. Nursing staff will complete an in-service/procedure review detailing the requirement that all seclusion and restraint documentation must be completed by the end of the shift on which the seclusion or restraint is concluded. This in-service will be presented by the Administrator and completed by 9-15-21. The compliance with completion of Seclusion and restraint documentation will be tracked by the Health Information Management department, with reports of compliance levels going to the Nurse Manager, RTC Director and MCH Administrator.	9-15-21

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2 minutes..." There was no documentation of this Emergency Safety Intervention in the client's record.

2. Client #9 had diagnoses Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder.

a. A Seclusion and Restraint Observation Log 2 dated 6/14/21 documented, "...Beginning Time: 8:05 PM; Procedure: Personal Restraint... Beginning Time: 8:10 PM; Procedure: Seclusion..." There was no documentation of this Emergency Safety Intervention in the client's record.

b. An Incident Report Form dated 7/1/21 documented, "Client and his peer were in the hallway being noncompliant continuously kicking doors, threatening other peers, upon separation client became aggressive and swung at staff causing the client to be placed in restraint..." There was no documentation of this Emergency Safety Intervention in the client's record.

3. Client #12 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, and Attention-Deficit/Hyperactivity Disorder.

a. An Incident Report Form dated 2/13/21 documented, "Client was observed attacking peers two separate times this evening. He also displayed noncompliant bx [behaviors] by kicking unit doors and instigating peers... Client received a chemical restraint due to behavior..." There was no documentation of this Emergency Safety

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N 149	Continued From page 92 Intervention in the client's record. b. A Seclusion or Restraint Order dated 2/19/21 documented, "...Order Type: Chemical Restraint..." There was no documentation of this Emergency Safety Intervention in the client's record. c. An Incident Report Form dated 3/8/21 documented, "...Type of Incident: Disturbance, Property Damage..." A Seclusion or Restraint Order dated 3/8/21 at 8:00 PM documented, "...Chemical Restraint..." There was no documentation of the Emergency Safety Intervention in the client's record. d. A Nursing Progress Note dated 4/11/21 at 2:35 PM documented, "...RN [Registered Nurse] face to face assessment 4-11-21 at 2:35 pm. [Client #12] is alert, oriented x [times] 3. Full ROM [Range of Motion]. No injury noted. Personal restraint due to property damage..." There was no documentation of the Emergency Safety Intervention in the client's record. e. An Incident Report Form dated 4/22/21 documented, "...Client was placed in seclusion and given a chemical restraint..." A Seclusion or Restraint Order dated 4/22/21 at 7:30 AM documented, "...Chemical Restraint..." There was no documentation of the Emergency Safety Intervention in the client's record. f. A Seclusion or Restraint Order dated 4/22/21 at 11:53 AM documented, "...Seclusion..." There was no documentation of the Emergency Safety Intervention in the client's record.	N 149		

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4. Client #4 had diagnoses of Disruptive Mood Dysregulation Disorder and Posttraumatic Stress Disorder.

a. A Seclusion or Restraint Order was dated 3/16/21.

An Incident Report Form dated 3/16/21 documented, "...5) Designation of Incident... Client to Staff... 7) Clear, Concise Narrative Description... Client began to show aggressive behavior by pushing staff, threatening and strongly shoving. Client then was trying to elope by kicking doors around the unit. He was then placed in a restraint and seclusion room..."

There was no Seclusion and Restraint Form or Nurses' Progress Note in the client record addressing the restraint and / or seclusion.

5. Client #5 had diagnoses of Severe Major Depressive Disorder and Oppositional Defiant Disorder.

a. Physician's Orders dated 4/4/21 documented, "...Zyprexa 5 mg [milligrams] IM [intramuscular] Benadryl 50 mg IM Now. May place in seclusion. Physically aggressive..."

A Seclusion and Restraint Form 1 dated 4/4/21 documented, "...Seclusion and Restraint..." There were no observations documented on the form to be maintained in the client record.

6. Client #7 had diagnoses of Disruptive Mood Dysregulation Disorder, Autism Spectrum Disorder and Unspecified Schizophrenia Spectrum.

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a. A handwritten Incident Report Form dated 2/28/21 documented, "...Injury Client... bruise on right shoulder... Disturbance... Client to Staff... 7) Clear, concise narrative description... Client was asked to raise his hand and ask for permission before getting out of this seat without permission... Client then became verbally and physically aggressive toward staff by close hand swinging and hitting staff on the arm. Client was then placed in a basket hold..."

There was no Seclusion and Restraint Form or Nurses' Progress Note in the client record addressing the restraint and / or seclusion.

b. A handwritten Incident Report Form dated 3/12/21 documented, "...Disturbance... Client-to-Client, Client-to-Staff... 7) Clear, concise narrative description... Client threw a ball at another peer, they got into a physical altercation. Once the client was in the hallway he began to throw chairs at doors..."

On 8/10/21 at 3:22 p.m., the video of the 3/12/21 incident was reviewed with the Administrator. Client #7 was placed in a physical hold prior to staff removing him to the hallway.

There was no Seclusion and Restraint Form or Nurses' Progress Note in the client record addressing the restraint and or seclusion.

c. A handwritten Report to Quality Assurance dated 3/18/21 documented, "...Description of Incident [Client] was instructed to give the pen he was using to draw with to his peer so they could be scribe during family conference. [Client] then got very upset, cursed staff and his peer as well. [Client] then threw pen at his peer and hit him

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with it... [Client] was then grabbed from behind by the peer he hit with the pen and cursed out... Once [Client] was pulled away from client he started to attack staff... and he was placed in 2 man control position..."

There was no Seclusion and Restraint Form or a Nurses' Progress Note in the client record addressing the restraint and or seclusion.

On 8/3/21 at 2:52 p.m., the Administrator stated, "This incident [3/18/21] didn't get properly documented. I knew it happened, so I pulled the information for you, but the nurses didn't document it in the record."

7. 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. A Seclusion and Restraint Log dated 4/6/21 at 12:30 PM and provided by the Administrator on 8/2/21 at 12:17 PM documented a chemical restraint for Client #1. No documentation of this ESI was located in the client's record.

b. Incident Report Packets received from Consultant #1 on 8/4/21 at 12:08 PM, documented the following ESIs for Client #1, which were not documented in the client's EMR or paper medical record:

1.) An Incident Report Packet dated 3/24/21 by Behavioral Interventionist (BI) #4 documented, "... [Client #1] walked over to peer and began hitting peer several times over her head. Client

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continued her behavior after staff intervened. Client threw staff phone on the floor and while staff attempted a restraint client hit and grabbed at staff until being place in a restraint."

2.) An Incident Report Packet dated 4/11/21 by BI #4 documented, "...client became verbally aggressive with staff. Client bit staff in the face and pulled staff by her hair. Client was placed in a restraint and received a chemical due to her aggressive behavior."

3.) An Incident Report Form dated 4/27/21 by BI #2 documented, "...[Client #1] stated she was going to attack staff. [Client #1] waited on staff to walk by and attempted to swing. [Client #1] was placed in a physical restraint and given a chemical."

4.) An Incident Report Form dated 4/29/21 by LBI #2 documented, "...then started charging toward staff to help her friend and was placed in CPI [Crisis Prevention Institute personal restraint] and began trying to self-harm while being defiant combative and off task".

5.) An Incident Report dated 6/8/21 by Life Behavior Instructor (LBI) #1 documented, "...When staff attempted to stop [Client #1] from self-harm, [Client #1] attacked staff. [Client #1] was placed in a physical restraint and given a chemical when negative behavior did not stop. [Client #1] then calmed down..."

6.) An Incident Report dated 6/17/21 by BI #1 documented, "Client was aloud [sic] to go to room. Once client entered room she began to self-harm. When staff intervened, client began to argue and threating [sic] staff and tried to push

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staff out of the way to close the door. Client was placed in a restain [sic] due to continue behavior. Client received a chemical and calmed down and became compliant."

c. On 08/04/21 at 12:08 PM, Consultant #1 was asked if the above Incident Report Forms and related documentation were kept in the client's record also. She stated, "No, these are kept in a separate binder."

8. Client #2 had diagnoses of Major Depressive Disorder with Psychotic Features, Oppositional Defiant Disorder, and Other Circumstances Related to Child Neglect Personal History.

A Seclusion and Restraint Log provided by the Administrator on 8/02/21 at 12:17 PM documented Client #2 had an ESI involving administration of a chemical restraint on 6/15/21 at 4:05 PM. No documentation of this ESI was found under the Seclusion and Restraint section in the EMR.

9. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit / Hyperactivity Disorder.

a. A Restraint and Seclusion Log entry dated 6/15/21 documented the client received a chemical restraint at 2:27 PM. There was no documentation of this ESI in the Seclusion and Restraint Section of the EMR or the Nursing Progress Notes.

b. A Restraint and Seclusion Log entry dated 7/12/21 documented the client received a chemical restraint at 3:49 PM. This ESI was not documented in the Seclusion and Restraint List in

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N 149	Continued From page 98 the client's EMR. 10. The Seclusion and Restraint documentation section of the Electronic Medical Record (EMR) had areas for documentation of Emergency Safety Interventions (ESIs), including the time the Emergency Safety Intervention is initiated, type of ESI, end time of the ESI, criteria for release, behavior demonstrated, less restrictive interventions attempted, criteria for the ESI, and assessment at time of removal. It also contained the sections for documenting any injuries, behavior information, observation log for all types of ESIs, post intervention debriefing for client and staff, and documentation of Face to Face assessments post intervention. On 8/12/21 at 11:37 AM, the Administrator was asked, "Should the restraint and seclusion documentation be done on the Electronic Medical Record under the Seclusion and Restraint Section?" He stated, "Yes, that should be the official documentation, and those should be the official orders with the e-signatures."	N 149		
N 155	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(i) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all Emergency Safety Interventions (ESIs) were documented on a cumulative log to enable tracking of the interventions used and the outcomes for 12 (Clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10,	N 155	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing staff. Nursing staff in both units have been provided with the correct cumulative restraint and seclusion log to be used in tracking emergency procedures. These forms containing all needed information will be completed after each emergency procedure. The forms will be audited weekly by the Nurse Manager and in that person absence by the RTC Director or MCH administrator. The results of the audits will be reported to the RTC Director and MCH Administrator.	9-15-21

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#11, and #12) of 12 sampled clients who had ESIs performed. The findings are:

1. 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. Individual Seclusion and Restraint Log sheets dated from 1/11/21 to 7/22/21 were received from the Administrator on 8/2/2021 at 12:17 PM. The Administrator stated, "This is the log for female clients. I know it is not all together on one log sheet, we are working on that. Some people have the wrong form in the facility. I know it should be all together and not on separate sheets of paper." The individual log sheets documented ESIs for Client #1 on 7/22/21, 7/21/21, 6/15/21, 5/10/21, 4/12/21, 4/11/21, 4/6/21, 03/2/21, and 1/19/21.

b. Individual Behavioral Intervention Log sheets documented Client #1 also had ESIs on 6/17/21, 6/14/21, 6/12/21, 6/8/21, 4/29/21, 4/27/21, 4/4/21, 3/24/21, 3/19/21, 3/15/21, and 2/10/21, which were not documented on the individual Seclusion and Restraint Log sheets provided by the Administrator.

2. Client #2 had diagnoses of Major Depressive Disorder with Psychotic Features, Oppositional Defiant Disorder, and Other Circumstances Related to Child Neglect Personal History.

a. Individual Seclusion and Restraint Log sheets dated from 1/11/21 to 7/22/21 documented ESIs for Client #2 on 6/15/21, 6/7/21, 06/6/21, 5/30/21, 4/29/21, 4/28/21, 4/27/21, 4/26/21, and 4/12/21.

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b. Physician Orders in the Electronic Medical Record documented Client #2 also had ESIs performed on 6/17/21, 4/14/21, and 4/6/21, which were not reflected on the Seclusion and Restraint Logs.

3. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit/Hyperactivity Disorder.

a. On 8/02/21 at 12:17 PM, a Seclusion and Restraint Log was received from the Administrator, who stated, "This is the log for male clients; you can see it is all together, pretty much by month."

b. Individual Behavioral Intervention Log sheets dated 6/22/21, 6/12/21, 5/22/21, 5/19/21/ 5/18/21, 5/17/21, 5/12/21, and 5/8/21 documented ESIs for Client #3 which were not documented on the Seclusion and Restraint Log.

4. Client #4 had diagnoses of Disruptive Mood Dysregulation Disorder and Posttraumatic Stress Disorder.

a. A Seclusion or Restraint Order was dated 3/16/2021.

b. A Seclusion or Restraint Order was dated 3/21/2021.

c. A Seclusion or Restraint Order was dated 4/30/2021 at 7:26 p.m.

d. These entries were not documented on the Seclusion and Restraint Log.

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N 155	Continued From page 101 5. Client #5 had diagnoses of Severe Major Depressive Disorder and Oppositional Defiant Disorder. a. A Seclusion and Restraint Form 1 was dated 4/4/2021. b. This entry was not documented on the Seclusion and Restraint Log. 6. Client #6 had diagnoses of Disruptive Mood Dysregulation Disorder and Epilepsy. a. A Seclusion and Restraint Form 1 was dated 1/26/2021. b. A Seclusion and Restraint Form 1 was dated 1/28/2021. c. A Seclusion and Restraint Form 1 was dated 2/6/2021. d. These entries were not documented on the Seclusion and Restraint Log. 7. Client #7 had diagnoses of Disruptive Mood Dysregulation Disorder, Autism Spectrum Disorder and Unspecified Schizophrenia Spectrum. a. An Incident Report Form was dated 2/28/2021. b. An Incident Report Form was dated 3/12/2021. c. A Report to Quality Assurance was dated 3/18/2021. d. These entries were not documented on the Seclusion and Restraint Log.	N 155		

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8. Client #8 had a diagnosis of Major Depressive Disorder.

Seclusion and Restraint Forms 1 documented the client had Emergency Safety Interventions documented for 5/15/21, 6/8/21, and 6/24/21, which were not listed on the facility Seclusion and Restraint Log.

9. Client #9 had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder.

Seclusion and Restraint Forms 1 documented the client had ESIs performed on 4/28/21, 4/30/21, 5/5/21, 5/18/21, 5/20/21, 5/25/21, 6/11/216, 6/12/21, 6/14/21, 7/1/21 and 7/8/21, which were not listed on the facility's Seclusion and Restraint Log.

10. Client #10 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Unspecified Disruptive, Impulse-Control and Conduct Disorder, Attention-Deficit/ Hyperactivity Disorder and Anxiety Disorder.

Seclusion and Restraint Forms 1 documented the client had ESIs performed on 4/19/21, 4/27/21, and 4/28/21 which were not listed on the facility's Seclusion and Restraint Log.

11. Client #11 had a diagnosis of Disruptive Mood Dysregulation Disorder.

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N 155	Continued From page 103 Seclusion and Restraint Forms 1 documented the client had ESIs performed on 4/3/21, 4/4/21, 4/27/21, and 4/28/21, which were not listed on the facility's Seclusion and Restraint Log. 12. Client #12 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, and Attention-Deficit/Hyperactivity Disorder. Seclusion and Restraint Forms 1 documented the client had ESIs performed on 2/12/21, 2/13/21, 2/19/21, 4/3/21, 4/4/21, 4/11/21, 4/15/21, 4/22/21, 4/27/21, 4/28/21, 5/3/21, and 5/5/21, which were not listed on the facility's Seclusion and Restraint Log. 13. On 8/2/21 at 2:12 PM, the Administrator was asked, "Are the Seclusion and Restraint Logs cumulative?" He stated, "No, but we have been working on that since we have been made aware we should have been keeping a log. You can see we have done that for the males." He was asked, "When did the facility start working on making cumulative logs?" The Administrator stated, "It's been in the last month or two, since it was brought to our attention."	N 155		
N 170	MONITORING DURING AND AFTER SECLUSION CFR(s): 483.364(a) Clinical staff, trained in the use of emergency safety interventions, must be Physically present in or immediately outside the seclusion room, continually assessing, monitoring, and evaluating the physical and psychological well-being of the resident in seclusion. Video monitoring does not	N 170	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing and direct care staff who might perform a restraint or seclusion. All identified staff will complete an in-service training provided by the MCH administrator on proper techniques and requirements of monitoring a client during a seclusion. This will include direct eyes-on monitoring as well as the appropriate response and requirement for discontinuation of a seclusion when a client has become calm and no longer posing a safety risk. The in-service will be at various times but will be completed by 9-15-21. Continued on next page...	9-15-21

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N 170	Continued From page 104 meet this requirement. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff provided continuous visual monitoring while clients were in the seclusion rooms to assure the physical and psychological well-being of the client for 3 (Clients #4, #9 and #11) of 3 sampled clients who had been placed in seclusion. The findings are: 1. Client #4 had diagnoses of Disruptive Mood Dysregulation Disorder and Posttraumatic Stress Disorder. a. A Seclusion and Restraint Form dated 6/15/21 documented, "...Behavior Demonstrated - physically aggressive with staff, kicking doors attempting to elope... 1. Observation beginning time: 11:15 a.m. Procedure: ...Transport... Client Behavior... Hurting self, combative... Ending Time: 11:16 a.m. 2. Observation beginning time: 11:17 a.m. Procedure: ...Seclusion... Other (location) seclusion room... Client Behavior: threatening, combative, cursing. Staff Response: ...observation/no change... Ending Time: 12:17 p.m. 3. Observation beginning time: 11:22 a.m. Procedure: ...Chemical Restraint... Other (location) seclusion room... Client Behavior: combative... Staff Response: ...Observation/No Change... Ending Time: 11:23 a.m..." b. On 8/11/21 at 4:30 p.m., the video of the incident on 6/15/21 involving Client #4 was reviewed with the Administrator. At 11:16 a.m. on the video, Client #4 was transported to the seclusion room by 2 male staff. At 11:17 a.m., Client #4 was kicking the door of the seclusion room. At 11:19 a.m., Client #4 was standing at	N 170	Continued from previous page... Additionally all seclusions will be reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements. This will be effective as of 9-15-21 but has already been put in place.	

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the door when staff entered the seclusion room and administered an injection. The Administrator was asked, "Should simultaneous chemical restraint and seclusion be used?" and he stated, "No, should not do both." At 11:45 a.m., Client #4 was lying on the floor. At 11:56 a.m., there was no staff at the window of the seclusion room. The Administrator confirmed there was no staff monitoring the seclusion room and was asked, should monitoring of the seclusion rooms be continuous? He stated "Yes." The Administrator was asked, "What is the criteria to come out?" He stated, "Calm, not threatening." When asked, "Is the client calm?" The Administrator stated, "Yes, he's calm, should come out." The client was released at 12:18 p.m.

c. On 8/13/21 at 10:14 a.m., the Nurse Manager stated, "The clients are supposed to be observed the whole time in there."

2. Client #9 had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder.

A Seclusion and Restraint Form dated 4/28/21 documented, "Restraint and Seclusion; Date and Time Initiated: 4/28/2021 2:58 p.m. Date and Time Ended: 4/28/21 3:50 p.m... Behavior demonstrated to justify use of procedure: During transition from the dayroom to classroom client ran out of the boys' unit classroom exit doors with three peers. Staff called for assistance... Seclusion and Restraint Observation Log 2...1. Observation Beginning Time: 02:58 PM; Procedure: Chemical Restraint; Location: Day

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N 170	Continued From page 106 Area / Hall... Client Behavior: Threatening... Ending Time: 2:59 PM. 2. Observation, Beginning Time: 3:05 PM; Procedure: Seclusion; Location: Seclusion Room...Client Behavior: Sitting...Ending Time: 3:50 PM..." An Incident Report Form dated 4/28/21 at 2:00 p.m. documented, "...Behavioral Intervention Observation Log; Time: 2:58; Procedure: 4 (Chemical)... Client Behavior: 8 (Threatening)... Time: 2:59; Procedure: 4... Client Behavior: 8; Time: 3:05; Procedure: 3 (Seclusion); Location: 3 (Seclusion Room)... Client Behavior: 7 (Sitting)... Time: 3:20; Procedure: 3; Location: 3... Client Behavior: 7... Time 3:35; Procedure: 3; Location: 3... Client Behavior: 7... Time: 3:50; Procedure: 3; Location: 3... Client Behavior: 7..." The client was released from the seclusion room at 3:50 p.m. Documentation indicated the client was sitting, with no documented aggressive behaviors, for 45 minutes before being released. 3. Client #11 was admitted on 3/5/21 and had a diagnosis of Disruptive Mood Dysregulation Disorder. a. A Seclusion and Restraint Form dated 4/28/21 documented, "Time and Date Initiated: 04/28/2021 2:53 PM; Time and Date Ended: 04/28/2021 2:54 P.M. ... During Transition from the boys' day room to the classroom, client ran out of the boys' unit classroom exit door with three peers... Procedure: Chemical Restraint..." b. On 8/13/21, at 9:50 a.m., the video of the incident on 4/28/21 was observed with the Corporate Compliance Director. At 2:52 PM, Client #9 and #11 walked from Hallway 2 into the elevator vestibule with 3 staff members. At 2:55 PM both clients turned around, facing the wall,	N 170		

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N 170	Continued From page 107 placed their hands up on the wall and an injection was administered by the nurse to both clients. At 2:54 PM, both clients and staff entered the elevator, exited the elevator, and walked to and around the circular bench in the foyer. At 2:58 PM, both clients were kicking the unit doors. At 2:59 PM, both clients went into the elevator vestibule with staff. At 3:01 PM, Client #9 exited the vestibule and walked into the unit. At 3:03 PM, Client #11 exited the vestibule and walked into the unit. Client #9 was sitting on a chair in the foyer, then got up and walked into the vestibule and was talking to staff. The client exited the vestibule into the foyer, then into the seclusion room at 3:05 PM. At 3:06 PM, staff walks away from seclusion room and no staff are seen monitoring the client. At 3:05 PM, Client #11 walked into the seclusion room, and staff were walking around in the unit. No staff were visually monitoring the seclusion room. At 3:08 PM, the video stopped, and there were no staff observed monitoring the seclusion rooms from 3:05 PM through 3:08 PM when the video ended. 4. Client #2 had diagnoses of Major Depressive Disorder with Psychotic Features, Oppositional Defiant Disorder, and Other Circumstances Related to Child Neglect Personal History. An entry dated 4/28/21 at 8:11 AM in the Electronic Medical Record (EMR) Observation Log by Registered Nurse (RN) #4 documented Client #2 was in seclusion and then received a chemical restraint, with the client combative and sitting. One minute later at 8:12 AM, RN #4 documented the client was calm and sitting. The Observation Log documented the client was calm and still in seclusion at 8:21 AM. No other	N 170		

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N 170	Continued From page 108 observation notes were documented until 9:06 AM. At that time, RN #4 documented Client #2 was calm and was released from seclusion. 5. The facility Seclusion & (and) Restraint policy, received from the Administrator on 8/2/21 at 12:36 PM, documented, "...Monitoring of Residents: 1. Clinical staff training in the use of emergency safety intervention must include that Direct Care Staff (Behavior Instructors) are: 1. physically present (if seclusion, right outside the door looking in), 2. continually assessing and monitoring the physical and psychological well-being of the resident..."	N 170		
N 188	POST INTERVENTION DEBRIEFINGS CFR(s): 483.370(a) Within 24 hours after the use of the restraint or seclusion, staff involved in an emergency safety intervention and the resident must have a face-to-face discussion. This discussion must include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the wellbeing of the resident. Other staff and the resident's parent(s) or legal guardian(s) may participate in the discussion when it is deemed appropriate by the facility. The facility must conduct such discussion in a language that is understood by the resident and by the resident's parent(s) or legal guardian(s). The discussion must provide both the resident and staff the opportunity to discuss the circumstances resulting in the use of restraint or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint or seclusion.	N 188	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing and direct care staff who might perform a restraint or seclusion. All identified staff will complete an in-service training on proper procedure for conducting a client debriefing. This will include who must be present, what to do if a staff member must be excused, and the goals of the process. Time frames required for completion will also be covered. Debriefing documentation will be reviewed by the program supervisors and compliance reported to the RTC Director and the MCH Administrator. This in-service will be completed by 9-12-21	9-15-21

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This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure all staff who participated in Emergency Safety Intervention (ESI) were present during the client debriefing to provide the client and staff with an opportunity to analyze the events surrounding the ESI and determine if any changes in the clients' treatment plans were needed for 7 (Clients #1, #3, #4, #6, #9, #10, and #12) of 12 sampled clients who had ESIs performed. The findings are:

1. Client #9 had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder.

a. A Seclusion and Restraint Form dated 4/21/21 documented, "...Client became noncompliant in the foyer area with CNA [Certified Nursing Assistant] staff. Client started kicking doors... Procedure: Chemical Restraint... Staff in Attendance: [Registered Nurse (RN) #7], [Behavioral Interventionist (BI) #8], [RN #2]..." The Incident Report dated 4/21/21 documented, "...Roles... & [and] Names of Others Involved... [BI #8], [Life Behavior Instructor (LBI) #1]... Staff Debriefing... Staff Members present: [BI #8], [BI #12]". There were no other names of those who attended listed on the Client Debriefing.

b. A Seclusion and Restraint Form dated 4/28/21 documented, "...During transition from the dayroom to classroom client ran out of the boys unit classroom exit doors with three peers... Procedure: Chemical Restraint... Seclusion... Staff in Attendance: Consultant #2, [LBI #2], [BI #6]". An Incident Report dated 4/28/21 documented, "...Roles... & Names of Others

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N 188	Continued From page 110 Involved... [BI #13]... Staff Debriefing... Staff Members present... [Consultant #2], [BI #6], [RN #2]". There were no other names of those who attended listed on the Client Debriefing. c. An Incident Report dated 4/30/21 documented, "...Roles... & Names of Ohers Involved... [Consultant #1], [BI #14], [Consultant #2]... Client jumped into a physical altercation hitting a peer and placing a peer in a choke hold.... Client received a chemical restraint... Staff Debriefing... Debriefing conducted by: [Consultant #2]; Staff members present: [Consultant #2], [Consultant #1], [RN #2]..." There were no other names of those who attended listed on the Client Debriefing. d. An Incident Report dated 6/12/21 documented, "...Roles...& Names of Others Involved... [BI #8], [BI #11]... Client became noncompliant while in the foyer area and started kicking the doors. Client kicked out several doors and aggressively tried to kick out exit door... Client was placed in a physical restraint and ordered seclusion... Staff Debriefing... Staff Members Present: [BI #8], [BI #17], [Consultant #1]. Name any staff who participated in the intervention and were excused from the debriefing... N/A [Not applicable]..." There were no other names of those who attended listed on the Client Debriefing. e. A Seclusion and Restraint Form dated 6/21/21 documented, "...Aggressive with staff and kicking open unit doors attempting to elope... Procedure: Chemical Restraint..." The Incident Report dated 6/21/21 documented, "...Roles...& Names of Others Involved... [BI #3], [Consultant #2]... Staff Debriefing... Staff Members Present: [Mental Health Therapist (MHT) #1], [BI #3]..." There	N 188		

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were no other names of those who attended listed on the Client Debriefing.

f. An Incident Report dated 6/24/21 documented, "...Roles... & Names of Others Involved: [BI #3], [LBI #1], [BI #18]...Ct [Client] was attempting to destroy property, jumping on furniture... was placed in a physical restraint... Staff Debriefing... [LBI #1], [Nurse #1], [BI #3]..." There were no other names of those who attended listed on the Client Debriefing.

g. An Incident Report Form dated 7/1/21 documented, "...Roles... & Names of Others Involved... [BI #7], [Consultant #2], [Consultant #1]... Client Debriefing... Debriefing Conducted By: [BI #7], Staff Members present: [BI #7], [BI #13]; Name any staff who participated in the intervention and were excused from the debriefing: No..." There were no other names of those who attended listed on the Client Debriefing.

2. Client #10 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Unspecified Disruptive, Impulse-Control and Conduct Disorder, Attention-Deficit/ Hyperactivity Disorder and Anxiety Disorder.

A Seclusion and Restraint Form dated 4/28/21 documented, "...During transition from the boys' day room to the classroom the client ran out of the boys' unit classroom exit door with three peers... Procedure: Chemical Restraint..." The Incident Report dated 4/28/21 documented, "...Roles... & Names of Others Involved: [BI #13]... Staff Debriefing... Staff Members present: [Consultant #2], [BI #6], [RN #2]..." There were

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no other names of those who attended listed on the Client Debriefing.

3. Client #12 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, and Attention-Deficit/Hyperactivity Disorder.

a. An Incident Report dated 2/13/21 documented, "Roles... & Names of Others Involved: [BI #11], [BI #12], [Nurse #2]; Client was observed attacking peers two separate times this evening. He also displayed noncompliance by kicking unit doors and instigating peers... received a chemical due to behavior... Staff Debriefing... Staff members present: [Consultant #2], [BI #1], Nurse Manager... Name any staff who participated in the intervention and were excused from the debriefing...None..." There were no other names of those who attended listed on the Client Debriefing.

b. An Incident Report dated 4/22/21 documented, "...Roles... & Names of Others Involved: [RN #2], [BI #7]... Client was woke up for hygiene and upon finishing client would not follow instructions to stay seated, client began to get upset and non-compliant... was placed in seclusion and given a chemical... Staff Debriefing... Staff Members present: [BI #7], [BI #8]... Name any staff who participated in the intervention and were excused from the debriefing...N/A..." There were no other names of those who attended listed on the Client Debriefing.

4. Client #4 had diagnoses of Disruptive Mood

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Dysregulation Disorder and Posttraumatic Stress Disorder.

a. An Incident Report dated 4/30/21 documented, "...6) Roles... & Names of others involved... [LBI #1], [BI #4], [BI #6] and [BI #8]... 7) Clear, concise narrative description... client was in the gym with peers when he and a peer got into a physical altercation. Client became extremely aggressive and was placed in a physical restraint..."

b. The Post-Intervention Debriefing form dated 4/30/21 documented, "...Staff Debriefing ... 4/30/21 (not timed) Staff Members present: [BI #8]..." There were no other staff names listed on the Client Debriefing.

5. Client #6 had diagnoses of Disruptive Mood Dysregulation Disorder and Epilepsy.

a. An Incident Report Form dated 1/26/21 documented, "...Disturbance... Client-to-Staff...6) Roles... & Names of others involved... [LBI #1], [BI #7] and [BI #9]..."

The Post-Intervention Debriefing form dated 1/26/21 documented, "...Staff Debriefing... 1/26/21 12:43 p.m. Staff Members present: [LBI #1] and [BI #7]... Name any staff who participated in the intervention and were excused from the debriefing because his/her presence would jeopardize the well-being of the client: N/A [not applicable]..." There were no other staff names listed on the Client Debriefing.

b. An Incident Report Form Dated 2/8/21 documented, "...Disturbance... Self-Inflicted... 6) Roles & Names of others involved... [BI #7] and [Consultant #2]..."

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The Post-Intervention Debriefing form dated 2/8/21 documented, "Client Debriefing... 2/8/21 Debriefing conducted by [BI #7]. Staff Members present: [blank]. Name any staff who participated in the intervention and were excused from the debriefing because his/her presence would jeopardize the well-being of the client: [blank]..." There were no other names listed on the Client Debriefing.

6. 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.

The Seclusion and Restraint form dated 6/12/21 at 9:25 p.m. documented, "Client was physically and verbally aggressive towards staff and attempting to self-harm... [Licensed Practical Nurse (LPN) #1], [BI #8], and [BI #11] checked for contraband..." The client debriefing documented only BI #11 as participating.

7. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder and Unspecified Attention Deficit / Hyperactivity Disorder.

The Seclusion and Restraint form dated 5/12/21 at 10:02 a.m. documented, "...kicking unit doors, self-harming, physically aggressive with staff..." RN #2 was documented as participating in the ESI for Client #3 but was not listed as participating in the Client Debriefing.

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Corrective action begins on next page...

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N 189	Continued From page 115 CFR(s): 483.370(b) Within 24 hours after the use of restraint or seclusion, all staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, must conduct a debriefing session that includes, at a minimum, a review and discussion of - 483.370(b)(1) The emergency safety situation that required the intervention, including discussion of the precipitating factors that led up to the intervention; This ELEMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure all staff who participated in Emergency Safety Intervention (ESI) were present during the staff debriefing to provide the staff with an opportunity to analyze the events surrounding the ESI and determine if any changes in the clients' treatment plans were needed for 6 (Clients #1, #4, #6, #9, #10, and #12) of 12 (Clients #1 through #12) sampled clients who had ESIs performed. The findings are: 1. Client #9 had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder. a. A Seclusion and Restraint Form dated 4/21/21 documented, "...Client became noncompliant in the foyer area with CNA [Certified Nursing Assistant] staff. Client started kicking doors... Procedure: Chemical Restraint... Staff in	N 189	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing and direct care staff who might perform a restraint or seclusion. All identified staff will complete an in-service training provided by the Program Consultants and or the Administrator, on proper procedure for conducting a staff debriefing. This will include who must be present, what to do if a staff member must be excused, and the goals of the process. Time frames required for completion will also be covered, including order of client and staff debriefing meetings. Debriefing documentation will be reviewed by the program supervisors and compliance reported to the RTC Director and the MCH Administrator. This in-service will be at various times to include all shifts but will be completed by 9-15-21	9-15-21

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N 189	Continued From page 116 Attendance: [Registered Nurse (RN) #7], [Behavioral Interventionist (BI) #8], [RN #2]..." The Incident Report dated 4/21/21 documented, "...Roles... & [and] Names of Others Involved... [BI #8], [Life Behavior Instructor (LBI) #1]... Staff Debriefing... Staff Members present: [BI #8], [BI #12]". There were no other names listed of staff who attended the Staff Debriefing. b. A Seclusion and Restraint Form dated 4/28/21 documented, "...During transition from the dayroom to classroom client ran out of the boys unit classroom exit doors with three peers... Procedure: Chemical Restraint... Seclusion... Staff in Attendance: Consultant #2, [LBI #2], [BI #6]". An Incident Report dated 4/28/21 documented, "...Roles... & Names of Others Involved... [BI #13]... Staff Debriefing... Staff Members present... [Consultant #2], [BI #6], [RN #2]". There were no other names listed of staff who attended the Staff Debriefing. c. An Incident Report dated 4/30/21 documented, "...Roles... & Names of Ohers Involved... [Consultant #1], [BI #14], [Consultant #2]... Client jumped into a physical altercation hitting a peer and placing a peer in a choke hold.... Client received a chemical restraint... Staff Debriefing... Debriefing conducted by: [Consultant #2]; Staff members present: [Consultant #2], [Consultant #1], [RN #2]..." There were no other names listed of staff who attended the Staff Debriefing. d. An Incident Report dated 6/11/21 documented, "...Roles... & Names of Others Involved... [BI #7], [BI #2], [Consultant #2]... He refused to come in the building once in the building he was instructed to take shoes off while in laundry area he ripped the cabinet off the hinges... Client was given a	N 189		

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chemical restraint... Staff Debriefing... Staff Members present: [BI #15], [Consultant #2], [Nurse Manager], [BI #7]..." There were no other names listed of staff who attended the Staff Debriefing.

e. An Incident Report dated 6/12/21 documented, "...Roles...& Names of Others Involved... [BI #8], [BI #11]... Client became noncompliant while in the foyer area and started kicking the doors. Client kicked out several doors and aggressively tried to kick out exit door... Client was placed in a physical restraint and ordered seclusion... Staff Debriefing... Staff Members Present: [BI #8], [BI #17], [Consultant #1]. Name any staff who participated in the intervention and were excused from the debriefing... N/A [Not applicable]..." There were no other names listed of staff who attended the Staff Debriefing.

f. A Seclusion and Restraint Form dated 6/21/21 documented, "...Aggressive with staff and kicking open unit doors attempting to elope... Procedure: Chemical Restraint..." The Incident Report dated 6/21/21 documented, "...Roles...& Names of Others Involved... [BI #3], [Consultant #2]... Staff Debriefing... Staff Members Present: [Mental Health Therapist (MHT) #1], [BI #3]..." There were no other names listed of staff who attended the Staff Debriefing.

g. An Incident Report dated 6/24/21 documented, "...Roles... & Names of Others Involved: [BI #3], [LBI #1], [BI #18]...Ct [Client] was attempting to destroy property, jumping on furniture... was placed in a physical restraint... Staff Debriefing... [LBI #1], [Nurse #1], [BI #3]..." There were no other names listed of staff who attended the Staff Debriefing.

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	04L106	A. BUILDING ______ B. WING ______	C 08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 189		N 189		

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h. An Incident Report dated 7/27/21 documented, "Roles...& Names of Others Involved: [Consultant #2], [LBI #1], [BI #6]... Ct peer was upset after receiving correctives for not following instructions after staff prompted him to have a seat while being up without permission... Ct started kicking every door and kicking the glass to the cafeteria window... ct was given a chemical... Staff Debriefing... Staff Members present: [Consultant #2], [RN #2]..." There were no other names listed of staff who attended the Staff Debriefing.

2. Client #10 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, Unspecified Disruptive, Impulse-Control and Conduct Disorder, Attention-Deficit/ Hyperactivity Disorder and Anxiety Disorder.

A Seclusion and Restraint Form dated 4/28/21 documented, "...During transition from the boys' day room to the classroom the client ran out of the boys' unit classroom exit door with three peers... Procedure: Chemical Restraint..." The Incident Report dated 4/28/21 documented, "...Roles... & Names of Others Involved: [BI #13]... Staff Debriefing... Staff Members present: [Consultant #2], [BI #6], [RN #2]..." There were no other names listed of staff who attended the Staff Debriefing.

3. Client #12 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, and Attention-Deficit/Hyperactivity Disorder.

a. An Incident Report dated 2/13/21 documented,

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"Roles... & Names of Others Involved: [BI #11], [BI #12], [Nurse #2]; Client was observed attacking peers two separate times this evening. He also displayed noncompliance by kicking unit doors and instigating peers... received a chemical due to behavior... Staff Debriefing... Staff members present: [Consultant #2], [BI #1], Nurse Manager..." There were no other names listed of staff who attended the Staff Debriefing.

b. An Incident Report dated 4/22/21 documented, "...Roles... & Names of Others Involved: [RN #2], [BI #7]... Client was woke up for hygiene and upon finishing client would not follow instructions to stay seated, client began to get upset and non-compliant... was placed in seclusion and given a chemical... Staff Debriefing... Staff Members present: [BI #7], [BI #8]..." There were no other names listed of staff who attended the Staff Debriefing.

4. Client #4 had diagnoses of Disruptive Mood Dysregulation Disorder and Posttraumatic Stress Disorder.

a. An Incident Report dated 4/30/21 documented, "...6) Roles... & Names of others involved... [LBI #1], [BI #4], [BI #6] and [BI #8]... 7) Clear, concise narrative description... client was in the gym with peers when he and a peer got into a physical altercation. Client became extremely aggressive and was placed in a physical restraint..."

b. The Post-Intervention Debriefing form dated 4/30/21 documented, "...Staff Debriefing ... 4/30/21 (not timed) Staff Members present: [BI #8]..." There were no other staff names listed on

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N 189	Continued From page 120	N 189		

the Staff Debriefing.

5. Client #6 had diagnoses of Disruptive Mood Dysregulation Disorder and Epilepsy.

a. An Incident Report Form dated 1/26/21 documented, "...Disturbance... Client-to-Staff...6) Roles... & Names of others involved... [LBI #1], [BI #7] and [BI #9]..."

The Post-Intervention Debriefing form dated 1/26/21 documented, "...Staff Debriefing... 1/26/21 12:43 p.m. Staff Members present: [LBI #1] and [BI #7]..." There were no other staff names listed on the Staff Debriefing.

b. An Incident Report Form dated 2/6/21 documented, "...Injury... [Client] self-harmed hitting walls, doors and floors... Disturbance... Client-to-Client, Client-to-Staff, Self-inflicted... 6) Roles... & Names of others involved... [BI #10] and [BI #9]..."

The Post-Intervention Debriefing form dated 2/6/21 documented, "...Staff Debriefing... 2/6/21 (not timed) Staff Members present: [BI #9]..." There were no other staff names listed on the Staff Debriefing.

6. 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.

The Seclusion and Restraint form dated 6/12/21 at 9:25 p.m. documented, "Client was physically and verbally aggressive towards staff and

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N 189	Continued From page 121 attempting to self-harm... [Licensed Practical Nurse (LPN) #1], [BI #8], and [BI #11] checked for contraband... Staff Debriefing... Conducted by [BI #11]..." The section designated for documentation of staff members who were present for the staff debriefing did not include LPN #1's name.	N 189		
N 202	MEDICAL TREATMENT FOR INJURIES CFR(s): 483.372(c) Staff involved in an emergency safety intervention that results in an injury to a resident or staff must meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff involved in an Emergency Safety Intervention (ESI) that resulted in client injuries met with supervisory staff to evaluate the circumstances that caused the injuries and developed and implemented a plan to prevent further potential injuries for 1 (Client and #9) 3 (Clients #5, #7 and #9) sampled clients who received an injury during a personal restraint. The findings are: Client #9 had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder, and Attention-Deficit/Hyperactivity Disorder. a. A Seclusion and Restraint Form dated 7/27/21 documented, "Date and Time Initiated: 7/27/2021 1:23 PM; Date and Time Ended: 7/27/2021 1:33 PM... Behavior demonstrated to justify use of	N 202	This deficiency has the potential to impact all clients so the following actions will be completed and pertain to all nursing and direct care staff who might perform a restraint or seclusion. All restraints and seclusions are now being reviewed by the MCH Administrator, the RTC Director or a designee and documented as to compliance with procedural and policy requirements. As part of this review process needed feedback or other actions are noted. This is then passed on to the supervisor who meets with the staff involved to evaluate the circumstances and discuss needed actions. The staff involved then sign and acknowledgment of this meeting and information. This will be effective as of 9-12-21.	9-15-21

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N 202	Continued From page 122	N 202		

procedure: Physically aggressive with staff, kicking doors / windows, attempting to elope... Assessment (Upon removal from procedure - time): 7/27/2021 2:00 PM... Physical Status Assessment: bruising on chin, swelling on cheek and bleeding from his nose...1. Observation: Beginning Time: 1:23 PM; Procedure: Personal Restraint: Other (Location): hallway... Client Behavior: Cursing Threatening... 2. Observation: Beginning Time: 1:24 PM; Procedure: Chemical Restraint..."

b. A Nursing Progress Note dated 7/27/21 at 3:00 PM documented, "...Client and peer were kicking on any door they could, kicking windows, trying to break out and elope. Staff was able to keep client and peer from making it out of the building, but client became very physically aggressive with staff, punching them, pushing them, being verbally aggressive. This nurse notified the DR [Doctor] and order was received to give client a chemical restraint by IM [intramuscular injection). After client tried to swing on staff with a closed fist, client was put in restraint for 10 min [minutes] due to still being aggressive... He was noted to have a little bruising on his chin and cheek was slightly swollen and nose bled slightly..."

c. On 8/12/21 at 3:41 PM, the Surveyor and Administrator reviewed the surveillance video for the 7/27/21 incidents involving Client #9, with the following findings:

At 1:18:36, the client kicked through a door and swung at staff.

At 1:19:23, the client kicked a door and walked down the hallway with four staff following him, pacing with his head down, kicking doors.

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N 202	Continued From page 123 At 1:23:56, three staff grabbed the client, and the staff and client fell to the floor. The client was struggling and was released from the restraint at 1:30:42. The client then was placed in a sitting position on the floor at the end of the hallway. The Administrator stated, "...when they went to the floor, they should have released him." d. On 8/13/21, at 9:05 a.m., Registered Nurse (RN) #2 was asked, "How did [Client #9] get injured during a restraint on 7/27?" She stated, "He's a very aggressive, big child. He was attacking staff, and staff had to put him in a restraint, and he was taken to the floor and he got bruising. I could see the blood on the floor. It was coming from his nose. When he allowed me to assess him, I saw it was coming from his nose. It wasn't really flowing, it was just some; it was a little swollen, but he was able to move his nose back and forth. He had a nickel-sized abrasion on his chin. His right cheek was a little swollen." The RN was asked, "Have you had any retraining related to restraints after this?" She stated, "No." e. On 8/13/21 at 10:20 a.m., the Nurse Manager was asked, "Have you or staff had any retraining on CPI [Crisis Prevention Intervention] facility wide?" She stated, "Not that I recall."	N 202		
N 207	FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported	N 207	As nurses are the staff charged with determining (with the consultation of other medical staff) the seriousness of any injury and assessing risk from suicide gestures or ideations, the nursing staff will be responsible for this reporting. This will be either directly by completing the incident report or by documented communication with the program consultant (supervisor) who will then complete the report and submit it within the required time frame. All serious occurrence reports will be sent to the State Medicaid Agency(Office of Long-Term Care) and Disability Rights Arkansas. Continued on next page....	9-15-21

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N 207	Continued From page 124 include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include - the name of the resident involved in the serious occurrence, - a description of the occurrence and, - the name, street address, and telephone number of the facility. 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 c/o [complains of] finger, nose and lip pain. Will	N 207	Continued from previous page... Nursing reporting will be monitored by the Nurse Manager, and all incident reports are reviewed by the MCH administrator. To be assured that the requirements are clearly understood, this information will be included in an in-service review provided by the MCH Administrator that all nurses will complete no later than 9-15-21.	

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N 207	Continued From page 125 administer Tylenol or IBU [ibuprofen] and give ice pack and continue to monitor." b. A Radiology Interpretation Report dated 7/23/21 documented results of an X-ray of Client #1's right index finger as, "...Impression: Acute index finger P3 [third phalanx or bone of the finger] fracture". c. On 8/13/21 at 10:48 a.m., the Corporate Compliance Director was asked, "How was [Client #1's] finger broken?" She stated, "I'm not sure, but I will find that information for you." d. On 08/13/21 at 11:25 AM, the Administrator was asked, "Was a serious occurrence report made and sent to the proper authorities regarding [Client #1's] broken finger?" He stated, "What happened was, she was hurt during a fight. That evening, the nurse didn't think the finger was broken... she [Client #1] went to the nurse the next day and complained about the finger. She was sent for X-rays, and we found out it was broken. The nurse didn't report this to the person doing the incident report, so a serious occurrence report was not done, and so it wasn't reported to you, DHS [Department of Human Services]". The Administrator was asked, "Has it been reported now?" He stated, "They are working on it; the report isn't done yet, but I can get that to you when it is done."	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

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

Sincerely,

DPSQA/Office of Long Term Care
Survey & Certification Section

sgb

cc: DRA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{N 000}	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A revisit survey was conducted from 09/28/2021 to 09/30/2021. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	{N 000}		
{N 135}	PROTECTION OF RESIDENTS CFR(s): 483.356(c)(3) [At admission, the facility must] obtain an acknowledgment, in writing, from the resident, or in the case of a minor, from the parent(s) or legal guardian(s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency safety situation. Staff must file this acknowledgment in the resident's record; and This ELEMENT is not met as evidenced by:	{N 135}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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Based on record review and interview, the facility failed to ensure an Authorization/ Consent /Release document for use of Emergency Safety Interventions (ESIs) was signed by the client's parents/legal guardian at the time of admission for 4 (Clients 1, 2, 4, and 5) sampled clients who were admitted to the facility. The findings are:

1. Client #2 was admitted to the facility on 09/19/2021 and had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia spectrum and Other Psychotic Disorder, Tourette's Disorder, Unspecified Attention-Deficit/Hyperactivity disorder, and Unspecified Feeding or Eating Disorder.

a. On 09/28/2021 at 11:30 a.m., Client #2's medical records were reviewed for Authorization/ Consent/ Release for the use of ESIs, signed by her parents/legal guardian. No consent was found.

b. On 09/28/21 at 2:21 p.m., the Administrator stated, "I forgot to tell you that with the new kids, we are putting their restraint/seclusion consents in the document library on the EMRs [Electronic Medical Records]." He was told, "No consent was found on the EMR for [Client #2]", and was asked, "Would it be anywhere else?" He looked at Client #2's EMR at this time, then stated, "That one in fact is unfortunately missing. I have no idea what happened to [Client #2], why it isn't there. You picked the one that isn't there. It was the weekend, but that is no excuse because they got the same training everyone else did, we should have it."

2. Client #1 was admitted to the facility on 10/29/2020, and diagnoses of Major Depressive

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UNITED METHODIST CHILDRENS HOME	**2002 S FILLMORE ST** **LITTLE ROCK, AR 72214**

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{N 135}	Continued From page 2 Disorder, Oppositional Defiant Disorder, and Posttraumatic Stress Disorder. 3. Client #4 was admitted to the facility on 04/16/2021, and had diagnoses of Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Posttraumatic Stress Disorder and Attention-Deficit/Hyperactivity Disorder. 4. Client #5 was admitted to the facility on 06/03/2021, and had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Schizophrenia Spectrum and Other Psychotic Disorder, and Unspecified Attention-Deficit/Hyperactivity Disorder. 5. According to a list received from the Administrator on 09/29/2021 at 10:22 a.m., the parents or guardians of Clients #1, 4, and 5, had been sent the facility Seclusion, Restraint, and Time-Out Policy on 09/09/21 but had not responded. The Administrator stated, "This is a log of who did not have a consent on their chart when we reviewed them, after you came in last time and that we have sent them a request for consent. What we are doing is mailing them 2 copies of the policy on restraint and seclusion for their review, one for them to keep, and one for them to sign and return to us for those who did not have consents on their charts. As you can see, we have about 5 who have responded and returned the signature sheets, but a number who haven't. We are planning on sending out another request or calling them to get it done." He was asked, "So, you still have several clients without parental or guardian consents on their charts, should they have one?" He answered, "Yes." He was asked, "Have you followed up with the parents or guardians since they were initially sent	{N 135}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING _____ B. WING _____	R-C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{N 135}	Continued From page 3 out?" The Administrator replied, "Not yet. We wanted to give them time to respond, but we are going to start following up. One even had an incorrect address and was returned to us non-deliverable so we have to figure that out."	{N 135}		
{N 149}	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(h) Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following: This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an Emergency Safety Intervention (ESI) was documented and in the client's record to assure an accurate and complete record of the events leading up to, during, and after the intervention for 1 of (Client #1) sampled client who had ESI. The findings are: Client #1 was admitted to the facility on 10/29/2020, and had diagnoses of Major Depressive Disorder, Oppositional Defiant Disorder, and Posttraumatic Stress Disorder. a. The facility Seclusion and Restraint Log was received from the Administrator on 09/28/2021 at 10:44 a.m. It documented Client #1 was in a personal (physical) restraint from 4:07 to 4:08 p.m., and from 4:08 to 4:09 p.m. It also	{N 149}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING ______ B. WING ______	R-C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{N 149}	Continued From page 4	{N 149}		

documented Client #1 received a chemical restraint of Zyprexa/Zydis 10 mg (milligrams) and Benadryl 100 mg po (by mouth) on 09/24/21 at 4:23 p.m.

b. A verbal order dated 09/24/2021 at 4:00 p.m. received by Registered Nurse (RN) #1 documented, "Zyprexa 10 mg po x [times] 1 and Benadryl 100 mg po x 1." RN #1 wrote a second order at the same time to "Transfer to Acute Care [Local Psychiatric Hospital] due to self harming, suicidal thoughts and wrapping clothes around her neck and stating she wants to kill herself."

c. A Physician Order dated 09/24/2021 at 4:07 p.m. by RN #2 documented, "Personal Restraint Team Control -Not to Exceed One Hour. Duration of Order in minutes 1."

d. A Physician Order dated 09/24/2021 at 4:23 p.m. by RN #2 documented a Chemical Restraint PO.

e. On 09/28/2021 at 11:40 a.m., there was no documentation of a Seclusion and Restraint in the Client #1's medical record for a personal/physical restraint on 09/24/21.

d. On 09/28/2021 at 11:40 a.m., the Seclusion and Restraint documentation for Client #1 was completed by RN #1 for the chemical restraint administered on 9/24/2021 at 4:23 p.m. There was no documentation behaviors demonstrated, less restrictive interventions attempted, observation during restraint, client and staff debriefing (all staff documented as present for the restraint were documented as present for the debriefings with the exception of the nurse who did not document himself as being present),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING ______ B. WING ______	R-C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{N 149}	Continued From page 5	{N 149}		

notification of the guardian.

e. On 09/29/21 at 2:55 p.m., a review of the facility video at the time documented on the log for the physical and chemical restraints of Client #1 on 09/24/2021 was done with the Administrator present. He stated, "You will see she has her shirt off, this is because she tried to hurt herself by tying it around her neck, so they had to take it away from her, that's why she is only in her bra." At 4:07 p.m. on the video, two staff members [Behavioral Interventionalist (BI) #2 and BI #3 are seen in the hallway facing the camera, Client #1 can not be seen well because she is standing underneath the camera. BI #2 and #3 walk towards her location and appear to place Client #1 in a hold. Client#1 is seen dropping to the floor and staff does not place her back in hold while she is on the floor. At 4:08:29, Client #1 is seen spitting at BI #1, heading towards her and hitting the wall next to her. At 4:08: 51, Client #1 is placed back into a hold by BIs #2 and #3. BI #4 enters camera view while the client is in hold. The client then drops to the floor again and is released from restraint. Client #1 walks back and stands under the camera, and the documented chemical restraint at 4:23 p.m. is not seen on the video. Client was seen again on video at 4:37 p.m. entering the foyer accompanied by BI #3.

f. On 09/30/21 at 11:10 a.m., the Administrator was asked, "Was there any documentation of the personal restraints on the log for [Client #1]? I didn't find any on the chart." He stated, "If you say there wasn't any, then, it wasn't done. There was an order though. [RN #1] is new here, and he is still learning the documentation, he may have just missed it." The Administrator was next asked,

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{N 149}	Continued From page 6 "About that order, it was only written for a duration of 1 minute. Should it have been written that way? Wasn't the restraint twice for a total of 2 minutes?" He stated, "No, the restraint was two minutes wasn't it. I assume that was a typo. She was in and out of restraints." He was next asked, "Is the staff still just asking the physician for orders for the time the nurse is told the client is in restraint?" He answered, "They shouldn't be, it should be for one hour." He was also asked, "Was the nurse in the debriefings? He wasn't listed." The Administrator replied, "He did the report." The Surveyor stated, "But he didn't list himself or excuse himself." The Administrator stated, "I can follow up on that, he probably forgot to put himself."	{N 149}		
{N 207}	FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious occurrence. The report must include - the name of the resident involved in the serious occurrence,	{N 207}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING ______ B. WING ______	R-C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	**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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{N 207}	Continued From page 7	{N 207}		

- a description of the occurrence and,
- the name, street address, and telephone number of the facility.

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 #3) of 6 sampled clients. The findings are:

Client #3 was admitted to the facility on 01/31/2021, and had diagnoses of Major Depressive Disorder, (Recurrent episode, Severe), Oppositional Defiant Disorder, and Reactive Attachment Disorder.

a. On 09/28/2021 at 9:50 a.m., the Administrator was asked, "Have there been any serious occurrences or deaths in the facility since the last survey?" He stated, "No deaths. No serious occurrences. Maybe one, where an X-ray was done. I will check."

b. On 09/28 at 10:44 a.m., the Administrator stated, "We did have one serious occurrence, a serious occurrence of a sprained ankle with an X-ray. On the 6th [September 6, 2021], [Client #3] was hopping around, jumped up and down, and hurt her ankle. An X-ray was done after the nurse was notified. They said they faxed it into everyone, but they [Behavioral Interventionalist #1] don't have a fax confirmation, our machine doesn't always print one. For whatever reason they didn't get one."

The Incident Report Form from Behavioral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING ______ B. WING ______	R-C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	**2002 S FILLMORE ST LITTLE ROCK, AR 72214**

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{N 207}	Continued From page 8	{N 207}		

Interventionalist (BI) #1 documented, "... Date and Time of Incident 9/6/2021 at 12:39 p.m... [Client #3] was observed being excited after coming from water play. Client was in line to transition from the foyer to the day room. As client was in line client was jumping up and down and as client landed, she landed on her right foot twisting her ankle. Client was crying and in pain. Nurse assessed the ankle and offered client some pain medication to help with the pain. Client received an X-ray around 2:00 p.m."

c. On 09/28 at 11:02 a.m., an Incident Report Form was received from the Administrator, and he stated, "This is the serious occurrence form for your office, and attached is the facility report form, the one hand-written. We are looking for something to show it was faxed to your office. The problem is, even the fax numbers you gave us the last time you were here don't work when we have tried them. I had talked to [staff at the Office of Long-Term Care], and she said we could start emailing them in. I guess we will have to figure out a better way. He was then asked, "When did you talk to [staff at the Office of Long -Term Care]?" He stated, "Oh, maybe about a week or so ago." He was then asked, "Do you have proof of that, e-mailing the report?" He stated, "Let me keep checking."

d. On 09/28 at 11:19 a.m., a document named "Communication Management Report" was received from the Administrator. He stated, "This is the fax log, and these two numbers are the Disability Rights number and the Office of Long Term Care Number. This is showing the report was faxed, but there is still a problem I admit, that even though the incident happened on the 6th, it wasn't faxed until the 8th. That was because the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING ______ B. WING ______	R-C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	2002 S FILLMORE ST LITTLE ROCK, AR 72214

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{N 207}	Continued From page 9 person who was supposed to fax it, didn't think it was a serious occurrence because the X-ray didn't show a fracture. I had to tell her that didn't matter, fracture or not, because [Client #3] still had to go out for an X-ray." e. On 9/29/21 at 2:37 p.m. the Administrator was asked, after he was given the fax log to review, "Has the serious occurrence from 9/6 actually been sent to the Office of Long Term Care? Does the 'NG' on the transmitted fax log mean it didn't go through? Because the Disability Rights Number says 'OK'?" The Administrator stated, "The staff tried to send it, sometimes our fax prints confirmations and sometimes it doesn't. I know they tried several times, they told me, but the numbers don't work, even the new numbers you gave us last time. We have contacted [staff at the Office of Long Term Care], and we plan on going to e-mailing them to your office. I don't know if the NG stands for No Good, but I will follow up on this. It looks like it didn't send." He was also asked, "Have you e-mailed the report since I first entered for the review and asked about it?" He stated, "I'm not sure, but I don't that know it has been sent. Someone is working on it." f. A copy of an e-mail sent 09/29 at 5:33 p.m. to [Program Manager at the Office of Long Term Care] was received from the Administrator on 09/30/21 at 8:56 a.m.. It stated, "It was discovered that the attached report [Serious Occurrence Report for Client #3] had not been transmitted when the fax attempt was made on 9-8-21. I tried several times at both of the numbers we have and on two different machines. It would not go through. I am sending it now as this was only discovered not to have gone through today."	{N 207}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING ______ B. WING ______	R-C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	2002 S FILLMORE ST LITTLE ROCK, AR 72214

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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
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
Survey and Certification Section

sgb

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L106	A. BUILDING ______ B. WING ______	R-C **11/03/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED METHODIST CHILDRENS HOME	**2002 S FILLMORE ST** **LITTLE ROCK, AR 72214**

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{N 000}	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A revisit was conducted on November 3, 2021 for all deficiencies cited on September 30, 2021. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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

FORM APPROVED

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				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
M Other
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
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.								

Total SA Supervisory Review Hours..... 5.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 1.00

Total RO Clerical/Data Entry Hours..... 0.00

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

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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Provider/Supplier Number	Provider/Supplier Name
04L106	UNITED METHODIST CHILDRENS HOME

Type of Survey (select all that apply)

A	D			

A	Complaint Investigation	E	Initial Certification	I	Recertification
B	Dumping Investigation	F	Inspection of Care	J	Sanctions/Hearing
C	Federal Monitoring	G	Validation	K	State License
D	Follow-up Visit	H	Life Safety Code	L	CHOW
M	Other				

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1.)(6), (b) (7	09/28/2021	09/30/2021	1.00	0.00	19.00	0.00	4.00	7.50
2.								
3.								
4.								
5.								
6.								
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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?.... **No**

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

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Provider/Supplier Number	Provider/Supplier Name
04L106	UNITED METHODIST CHILDRENS HOME

Type of Survey (select all that apply)

A	D			

A Complaint Investigation
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I Recertification
J Sanctions/Hearing
K State License
L CHOW

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
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.)(6), (b) (7	11/03/2021	11/03/2021	0.50	0.00	6.25	0.00	0.50	0.00
2.	11/03/2021	11/03/2021	0.50	0.00	6.25	0.00	0.50	1.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.25

Total RO Clerical/Data Entry Hours..... 0.00

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