



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 HUMANSERVICES.ARKANSAS.GOV

September 8, 2020

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

Dear Mr. Stadter:

On August 28, 2020, a Complaint Investigation survey was conducted at your facility by the Office of Long Term Care to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid (Title XIX) Program. This survey found that your facility had deficiencies requiring correction/substantial correction prior to a revisit as specified in the attached CMS-2567.

Plan of Correction

A POC must be submitted within 10 calendar days of you receipt of the Statement of Deficiencies. Failure to submit a POC may result in termination. Include a completion date for each deficieny cited.

Amanda M Smith, RN Supervisor
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
Telephone (501) 320-3963; Fax (501) 682-6159
or email to amanda.m.smith@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 plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.

e. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. Your facility is ultimately accountable for its own compliance. The plan of correction will serve as the facility's allegation of compliance. Unless otherwise stated on the PoC, the last completion date will be the date of alleged compliance.

Informal Dispute Resolution

In accordance with 42 CFR § 488.331, you have one opportunity to question deficiencies through an informal dispute resolution (IDR) process. To obtain an IDR, you must send your written request to Health Facility Services, Arkansas Department of Health within ten (10) calendar days from receipt of the Statement of Deficiencies. The request must state the specific deficiencies the facility wishes to challenge. The request should also state whether the facility wants the IDR to be performed by a telephone conference call, record review, or a face-to-face meeting.

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

Please submit your request to:

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

If you have any questions, please call Amanda M Smith at 501-320-3963.

Sincerely,

RN Supervisor

DPSQA/Office of Long Term Care Survey & Certification Section

randa mosmill

ams

cc:

DRA

PRINTED: 09/08/2020 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			CONSTRUCTION	ĺv i se en i	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER FOR YOUTH AND FAMI	LIES INC		6	TREET ADDRESS, CITY, STATE 501 W 12TH STREET ITTLE ROCK, AR 72225	, ZIP CODE		
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N 207	Complaint #AR00025 or in part, with these f FACILITY REPORTIN CFR(s): 483.374(b)		N N	207				
	to both the State Med	rt each serious occurrence icaid agency and, unless w, the State designated acy system. that must be reported						
	section §483.352 of the aresident's suick (1) Staff must report involving a resident to agency and the State Advocacy system by the section of the section o	de attempt. any serious occurrence both the State Medicaid designated Protection and	-			- a	······································	e en la region
L ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	1	•	TITLE			(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BÜILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		04L101	B. WING _		08	C 3/28/2020	
	ROVIDER OR SUPPLIER FOR YOUTH AND FAMI	LIES INC	,	STREET ADDRESS, CITY, STATE, ZIP COI 6501 W 12TH STREET LITTLE ROCK, AR 72225		+411	
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	(Quality Assurance) F documented, "Clien property destruction a during the first day of process of unscrewin attempted to verbally Client #1 became ago the staff person in the place the client in an Intervention]. Client # resisting. Staff report that her arm was hurt Client #1 sat on the g	nt of Human Services) QA Report Form, dated 8/24/20, t #1 been engaging in and attempted to incite a riot school. She was in the g a screw on the desk. Staff de-escalate the situation. gressive toward staff, hitting a face. Staff attempted to ESI [Emergency Safety 41 was pulling back and as Client #1 began to say ing, staff went hands off. round. Nursing was notified a sent to [Hospital]. It was a was broken. "					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	COMPI		
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N 207	b. On 8/28/20 at 3:02 was asked, "Was a S	e 2 2 p.m., the Program Director erious Occurrence Report of Long Term Care]?" She	N 2	207			

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, PO Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D C 20503

Provider/Supplier Number		Provider/Supplier Name						
04L101		CENTERS FOR YO	UTH	AND FAMILIES INC				
Type of Survey (select all that apply)	A B C D	Complaint Investigation Dumping Investigation Federal Monitoring Follow-up Visit Other	E F G H	Initial Certification Inspection of Care Validation Life Safety Code	I J K L	Recertification Sanctions/Hearing State License CHOW		
Extent of Survey (select all that apply)								

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. 30283	08/28/2020	08/28/2020	0.50	0.00	4.25	0.00	3.50	2.75
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Total SA Supervisory Review Hours	0.25	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?.... $\,N_0\,$

FORM CMS-670 (12-91) EventID: UV9I11 Facility ID: 3000 Page





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 HUMANSERVICES.ARKANSAS.GOV

September 21, 2020

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

Dear Ms. Dawson:

On August 28, 2020, we conducted a Complaint Investigation survey at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and have approved your plan of correction and presume that you will achieve substantial correction by September 25, 2020.

We will be conducting a revisit of your facility to verify that substantial correction has been achieved and maintained.

If you have any questions, please contact your reviewer at (501) 320-3963.

Sincerely,

Amanda M Smith, RN Supervisor DPSQA/Office of Long Term Care Survey & Certification Section

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/08/2020 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	INSTRUCTION	(X3) DATE SURVEY COMPLETED C
		04L101	B. WING	·	08/28/2020
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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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL'		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	Complaint #AR00028 or in part, with these for in part, with these failed to ensure a Seri was submitted for 1 (Collents who sustained physical restraint. The collent #1 was admidiagnoses of Disruptive Disorder and Attention Disorder. a. A DHS (Departmer (Quality Assurance) R documented, "Client property destruction a during the first day of process of unscrewing attempted to verbally collent #1 became agg the staff person in the place the client in an E Intervention]. Client # resisting. Staff reports that her arm was hurtle Client #1 sat on the great staff part in the great staff and the great staf	ew and interview, the facility ous Occurrence Report Client #1) of 1 sampled a fractured arm during a refindings are: etted on 7/17/20 and had be Mood Dysregulation and Endicit Hyperactivity at of Human Services) QA report Form, dated 8/24/20, #1 been engaging in a latempted to incite a riot school. She was in the pascrew on the desk. Staff de-escalate the situation. The staff attempted to incite a ressive toward staff, hitting face. Staff attempted to			1. Centers has updated its Agency Decision Matrix check for reporting to include the Sta Medicaid agency and Disabili Rights of Arkansas to be notifi within mandated time frames. 2. The responsibility for reporting to one individual in risk management minimize reporting error. 3. Centers leadership will be notified immediately of a "serioccurrence" to ensure the reporting checklist is executed 4. Updates to the matrix, reporting checklist is executed 4. Updates to the matrix, reporting checklist is executed 5. Quality Assurance Committed 6. Quality Assurance Committed 7. Quality Assurance Committed 8. Quality Assurance Committed 9. Quality Ass	ate ity fied . orting t to ious d. orting rship	9.16.20 9.16.20 9.16.20 9.25.20 Monthly there- after.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CENTERS	FOR YOUTH AND FAMIL	LIES INC		6501 W 12TH STREET LITTLE ROCK, AR 72225		
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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 HUMANSERVICES.ARKANSAS.GOV

October 28, 2020

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

Dear Ms. Dawson:

During the Complaint Investigation follow-Up/revisit survey conducted on October 26, 2020, your facility was found to be in compliance with program requirements. Your certification remains in effect unless terminated due to non-compliance with program requirements or voluntary withdrawal from the program. A CMS 2567 is enclosed, indicating your facility's compliance status. Please sign and date the 2567 and fax to Amanda M Smith at (501) 682-6159 or email to amanda.m.smith@dhs.arkansas.gov @dhs.arkansas.gov as soon as possible. If you are signed up with the Electronic POC (E-POC) you must submit all information through the EPOC system.

Please refer to the Medicare/Medicaid Certification and Transmittal (CMS Form 1539) for your period of certification.

If you have any questions please contact your reviewer at 501-320-3963.

Sincerely,

RN Supervisor

DPSQA/Office of Long Term Care Survey and Certification Section

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PRINTED: 01/05/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CENTERS FOR YOUTH AND FAMILIES INC (Y4) ID SUMMARY STATEMENT OF DEFICENCIES (EACH DEFICE ENCY MIST BE PRECEDED BY FULL TAG (EACH DEFICENCY MIST BE PRECEDED BY FULL TAG (EACH DEFICENCY MIST BE PRECEDED BY FULL TAG (EACH OCRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) (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 (RC) 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 October 26, 2020 for all deficiencies cited on August 28, 2020. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance was found. The facility is in compliance with all regulations surveyed.		OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	1 1	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY
NAME OF PROVIDER OR SUPPLIER CENTERS FOR YOUTH AND FAMILIES INC (X4) ID PREFIX TAG (X4) ID PREFIX REGULATORY OR LSC IDENT FY NG INFORMATION) [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 October 26, 2020 for all deficiencies cited on August 28, 2020. All deficiencies cited on August 28, 2020. All deficiencies cited on August 28, 2020. All deficiencies county of the provider of th			04L101	B. WING _			l	
PREFIX TAG REGULATORY OR LSC IDENT FY NG INFORMATION) 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 October 26, 2020 for all deficiencies cited on August 28, 2020. All deficiencies have been corrected, and no new noncompliance was found. The facility is in			LIES INC	,	6501 W 12TH STREET	E, ZIP CODE		
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LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Facility ID: 3000

(X6) DATE

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, PO 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 Nam	e			
04L101		CENTERS FOR YO	UTH	AND FAMILIES INC		
Type of Survey (select all that apply) A D	A B C D	Complaint Investigation Dumping Investigation Federal Monitoring Follow-up Visit Other	E F G H	Initial Certification Inspection of Care Validation Life Safety Code	I J K L	Recertification Sanctions/Hearing State License CHOW
Extent of Survey (select all that apply)	B E C P	outine/Standard Survey (all provide xtended Survey (HHA or Long Tern artial Extended Survey (HHA) Other Survey		. /		

SURVEY TEAM AND WORKLOAD DATA

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

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30283	10/26/2020	10/26/2020	0.50	0.00	3.75	0.00	2.50	1.25
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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?.... $\,N_0\,$

FORM CMS-670 (12-91) EventID: UV9I12 Facility ID: 3000 Page