ARKANSAS DEPARTMENT OF HUMAN SERVICES

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 1, 2021

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

Dear Mr. Kuchinski:

On October 28, 2021 a Validation 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.

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.

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:

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, please call Sandra Broughton, Program Administrator at 501-320-6182.

Sincerely,

Sandra Broughton
Administrative Services Manager

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
	04L101	A. BUILDING _____ B. WING _____	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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
E 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The findings on this statement of deficiencies demonstrate non-compliance with §483.73 - Emergency Preparedness Requirements for Psychiatric Residential Treatment Facilities.	E 000		
E 004	Develop EP Plan, Review and Update Annually CFR(s): 441.184(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency	E 004		

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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E 004	Continued From page 1 preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive emergency preparedness (EP) plan was reviewed and updated at least annually and operationalized to prepare for resident and staff safety in the event of a potential emergency or disaster situations for 1 of 1 facility. This failed practice had the	E 004		

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E 004	Continued From page 2	E 004		

potential to affect all 49 residents who resided in the facility, according to the Resident Census Report provided by the Clinical Director on 10/25/21. The findings are:

1. The facility's current Emergency Operations Plan was reviewed on 10/27/21 at 11:00 a.m. and did not address the following items:

a. The facility Emergency Plan did not have a geographic plan of hazards in the facilities region.

b. The facility Emergency Plan did not have an updated patient population list.

c. The facility Emergency Plan had no procedure for tracking patients and staff.

d. The facility Emergency Plan had no policy and procedure to address sheltering in place.

e. The facility Emergency Plan had no policy and procedure to address medical professionals and volunteers.

f. The facility Emergency Plan did not address the waiver procedure when declared by the Secretary.

g. The facility Emergency Plan did not address an alternate means of communication, and there was no communication plan documented.

h. The facility Emergency Plan did not have updated resident contact information.

i. The facility Emergency Plan did not address the facility occupancy needs.

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E 004	Continued From page 3 j. The facility Emergency Plan did not have an updated patient list. k. The facility Emergency Plan did not address or document the training and testing of the Emergency Plan for the staff knowledge. l. The facility Emergency Plan did not address or document the subsistence needs for staff and patients. m. The facility Emergency Plan did not address or document procedures for tracking of staff and patients. n. The facility Emergency Plan did not address the means the facility would use to release patient information of general condition and location of clients. o. The facility Emergency Plan did not provide documentation of annual table top, and full scale exercises. 2. On 10/27/21 at 11:09 a.m., the Assistant Clinical Director was asked, "Do you have any documentation for your emergency preparedness other than your policy and procedure?" She stated, "We do not have any documentation other than our fire, bomb threat, lock down and severe weather."	E 004		
N 000	Initial Comments A 5 year valadation survey was conducted from10/25/21 through 10/28/21. The facility was in compliance with §483, Subpart	N 000		

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N 000	Continued From page 4 G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000		

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November 29, 2021

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

Dear Mr. Kuchinski:

On October 28, 2021, we conducted a Validation 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 December 3, 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,

Sandra Broughton
Administrative Services Manager

DPSQA/Office of Long Term Care
Survey & Certification Section

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December 16, 2021

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

Dear Mr. Kuchinski:

During the Revisit survey conducted on December 15, 2021, your facility was found to be in compliance with program requirements. **Please email the signed CMS 2567 Sandra.Broughton@dhs.arkansas.gov.**

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

Sincerely,

Sandra Broughton
Administrative Services Manager

DPSQA/Office of Long Term Care
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