Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059
P: 501.320.6182
F: 501.682.6159

September 23, 2021

David Napier, Administrator
Youth Home Inc
20400 Colonel Glenn Road
Little Rock, AR 72210-5323

Dear Mr. Napier:

On September 14, 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,

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
	04L107	A. BUILDING ______ B. WING ______	09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUTH HOME INC	20400 COLONEL GLENN ROAD LITTLE ROCK, AR 72210

(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 facility was in compliance with Emergency Preparedness of Psychiatric Residential Treatment Center.	E 000		
N 000	Initial Comments A Validation survey was conducted from 9/8/2021 through 9/14/2021. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000		
N 209	FACILITY REPORTING CFR(s): 483.374(b)(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State designated Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be	N 209		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 209	Continued From page 1	N 209		

maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

This ELEMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure the Office of Long Term Care was notified of a serious occurrence for 1 of 1 (Client #8) sampled client who had an injury requiring out of facility medical care. The findings are:

1. Client #8 had diagnoses of Post traumatic stress disorder, Attention deficit hyperactivity disorder combined type, and Disruptive mood dysregulation disorder,

a. On 9/9/2021 at 8:50 a.m., 12:35 p.m., and 3:35 p.m., Resident #8 was wearing a cast on his right lower arm and hand.

b. An Incident Report dated 8/19/2021 documented, "Clients were playing basketball. Client became frustrated with another peer and began punching him in the face... [Client # 8] came into the nurse's office with an injured right hand after punching his peer in the head at the gym... sent to [hospital] to receive and x-ray... returned from ER [emergency room], Stoic, walked into milieu with no issues. Per report from [hospital] ER Right small finger metacarpal fracture."

2. A list was provided by the facility on 9/13/2021 of serious injuries faxed to the Office of Long Term Care for the past year. There were no reports concerning Client #8 on the list.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L107	A. BUILDING ______ B. WING ______	**09/14/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUTH HOME INC	**20400 COLONEL GLENN ROAD** **LITTLE ROCK, AR 72210**

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N 209	Continued From page 2 3. On 9/13/2021 at 2:30 p.m., the Director of Records Compliance stated that the Office of Long Term Care was not notified of the incident to Client #8 on 8/19/2021. She stated that the incident happened after hours and that nursing sends it out when the incident occurs after hours. She stated that it was a new nurse that sent it out. 4. A form titled Office of Long Term Care Serious Incidents Serious Incident Reporting documented, "If the following occurs: ...Serious Injuries-significant impairment of the physical condition of the resident as determined by qualified medical personnel... Records Compliance during business hours & [and] Nursing staff after hours/weekends shall fax the incident report to the following: Office of Long Term Care."	N 209		

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
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P: 501.320.6182
F: 501.682.6159

September 30, 2021

David Napier, Administrator
Youth Home Inc
20400 Colonel Glenn Road
Little Rock, AR 72210-5323

Dear Mr. Napier:

On September 14, 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 October 14, 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

Approved 9/30/2021 SGB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L107	A. BUILDING ______ B. WING ______	09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 000	Initial Comments A Validation survey was conducted from 9/8/2021 through 9/14/2021. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center	N 000		
N 209	FACILITY REPORTING CFR(s): 483.374(b)(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State designated Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be	N 209	1. Director of Nursing developed a short training module for all nursing staff that is available on our electronic learning system. This module outlines the steps necessary for reporting serious incidents to all compliance and regulatory bodies including the Office of Long-Term Care. All nursing staff must complete this module by 10/14/21.	10/14/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	C.E.O.	9-30-2021

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 209	Continued From page 1 maintained in the resident's record, as well as in the incident and accident report logs kept by the facility. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the Office of Long Term Care was notified of a serious occurrence for 1 of 1 (Client #8) sampled client who had an injury requiring out of facility medical care. The findings are: 1. Client #8 had diagnoses of Post traumatic stress disorder, Attention deficit hyperactivity disorder combined type, and Disruptive mood dysregulation disorder, a. On 9/9/2021 at 8:50 a.m., 12:35 p.m., and 3:35 p.m., Resident #8 was wearing a cast on his right lower arm and hand. b. An Incident Report dated 8/19/2021 documented, "Clients were playing basketball. Client became frustrated with another peer and began punching him in the face... [Client # 8] came into the nurse's office with an injured right hand after punching his peer in the head at the gym... sent to [hospital] to receive and x-ray... returned from ER [emergency room], Stoic, walked into milieu with no issues. Per report from [hospital] ER Right small finger metacarpal fracture." 2. A list was provided by the facility on 9/13/2021 of serious injuries faxed to the Office of Long Term Care for the past year. There were no reports concerning Client #8 on the list.	N 209	2. An update to our Incident Report Policy, # 413 was approved on 9/27/21 in our Executive and Manager's Meeting and distributed to all Youth Home employees on 9/28/21. The up-date includes the instructions for sending incident reports to all regulatory agencies/ bodies. 3. The instruction sheets for responding to a serious incident were posted on our Staff Portal so that they can be easily accessed by any staff member who needs it. In addition, the instruction sheets are kept in a binder placed in each residential house for reference; these are updated by the Records Compliance team as necessary. Completed on 9/24/21. 4. The Records Compliance Coordinator checks daily for incidents that have occurred and must be sent out to regulatory agencies. If she is unsure whether an incident has been sent by nursing staff in the evening or weekend, she will go ahead and send the incident report to the appropriate agencies. This process began immediately after the survey. 5. The list of serious incidents that have been sent to the Office of Long-Term Care will be checked against the list the department supervisor runs on a monthly basis for all incidents. The results of the comparison will be reported through the facility Performance Improvement Committee. Completed initially on 10/10/21 and monthly thereafter.	9/28/21 9/24/21 9/15/21 10/10/21

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Division of Provider Services
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P.O. Box 8059, Slot S404
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October 15, 2021

David Napier, Administrator
Youth Home Inc
20400 Colonel Glenn Road
Little Rock, AR 72210-5323

Dear Mr. Napier:

During the Revisit survey conducted on October 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,

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
	04L107	A. BUILDING ______ B. WING ______	R 10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUTH HOME INC	**20400 COLONEL GLENN ROAD LITTLE ROCK, AR 72210**

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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
04L107	YOUTH HOME INC

Type of Survey (select all that apply)

I				

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)

A				

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	09/08/2021	09/14/2021	0.50	0.00	23.50	0.00	11.50	1.00
2.	09/08/2021	09/14/2021	0.50	0.00	23.50	0.00	10.50	1.00
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14.								

Total SA Supervisory Review Hours..... 1.00

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
04L107	YOUTH HOME INC

Type of Survey (select all that apply)

I	D			

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)

A				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
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SURVEY TEAM AND WORKLOAD DATA

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1. (6), (b) (	10/15/2021	10/15/2021	0.50	0.00	2.50	0.00	2.00	1.00
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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**