ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of Provider Services and Quality Assurance

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October 8, 2019

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Deficiencies were noted during the Inpatient Psych U21 Inspection of Care (IOC) conducted at the following service site on the following dates:

Perimeter Behavioral of the Ozarks
September 18, 2019

These deficiencies are outlined below. Section 241.600 of the Inpatient Psych Medicaid Manual states: "The provider must submit a Corrective Action Plan designed to correct any deficiency noted in the written report of the IOC." Accordingly, you must complete and submit to AFMC a Corrective Action Plan for each deficiency noted. The Corrective Action Plan must state with specificity the:

(a) Corrective action to be taken;
(b) Person(s) responsible for implementing and maintaining the corrective action; and
(c) Completion date or anticipated completion date for each corrective action.

The CAP must be completed within 30 calendar days of the date of the email notice of the IOC report. Please complete the attached Corrective Action Plan document and submit it via email to Inspectionteam@afmc.org.

The contractor (AFMC) will:

(a) Review the Corrective Action Plan;
(b) Determine whether the Corrective Action Plan is sufficient to credibly assure future compliance; and
(c) Forward the Corrective Action Plan to the Division of Provider Services and Quality Assurance (DPSQA).

Please see § 160 of the Medicaid Manual for an explanation of your rights to administrative reconsideration and appeal.

Inspection of Care Summary of Findings:

Facility Tour and General Observations:
As a part of the IOC process, a facility tour and review were completed. There were no deficiencies noted during the tour of the facility.

Client/Family Interviews:

Eighteen client interviews were conducted onsite at Perimeter Behavioral of the Ozarks. One client refused to talk with AFMC staff. Due to information received during a client interview there was one report made to the Child Abuse Hotline. The CEO was notified of the Child Abuse Hotline call. Concerns presented during the interviews are noted below.

Based on interviews conducted the following were observed:

- One client stated "I have no idea why I am here"
- Three clients could not verbalize any of the treatment/therapy they are receiving.
- Four clients stated they are not actively participating in treatment.
- Five clients stated they are not following their treatment plan. One client said "I have been here three months and I have not seen a therapist once"
- Seven clients stated they are not making progress and one client stated, "I am getting worse".
- Three clients were unaware of what medications they are taking.
- Seven clients stated they were not informed of their client rights.
- Nine clients stated they were not informed of the facility's seclusion and restraint policy.
- Seven clients stated they were not satisfied with their treatment and one client was undecided. One client said, "they are very short staffed…they are not here for our needs".
- Five clients stated they are unsure of how to file a complaint.
- Seven clients stated they did not feel safe and/or respected at this facility. Clients said "staff wont let me in the restroom when I'm about to pee my pants & they just sitting there playing cards", "staff is disrespectful and gets an attitude if you ask them things…staff antagonizes us", "staff is mean and disrespectful", "staff disrespectful at times…always yelling at the kids", "residents make me feel unsafe because they yell and fight", {name redacted} her emotions to work…when she have a headache she gives us clients consequences", and "some staff is on phone…too busy with themselves and not caring about us kids"

Medication Pass Observation:

Medication pass was observed on 9/18/2019. Perimeter Behavioral Health RN had signed a medication out prior to giving it. RN stated, "I didn't know you were coming and had done this before I knew you were coming". Medication Administration Record is not to be signed prior to medication has been given or refused. Talked with Director of Nursing about signing medications out prior to administration on 1 of 2 medications given. She stated she had already addressed the issue prior to us making her aware. Director of Nursing stated that administering RN was a new RN and was educated on not signing medications given prior to administration. He did go back and verify that the med was signed out of the Medication Administration Record after giving it and that is when he realized he had already signed it out. He followed all protocol listed in policy and was able to verbally go through everything on checklist that was not viewed at medication pass. Medication room was clean and organized, he knew his patients well, and medication cart was clean and organized.

Employee Record Review:

25% of direct care employee and 25% of non-direct care employee records were reviewed. Out of 9 employee records one record did not have a child and adult maltreatment. One record did not have seclusion/restraint training. Two records did not have a CPR certification. All records had a completed background check. All had annual nonphysical intervention trainings. All licenses were up to date.

Chart Review Deficiencies:

Record Review Number:	Regulation(s):	Comments:
11883	217.00	Medical Evaluation did not include diagnosis or summary of present medical findings
12037	217.00 218.200	Medical Evaluation did not include mental and physical functional capacity Individual Plan of Care did not include a description of the functional level of the Client
13136	217.00	Medical Evaluation did not include a summary of present medical findings
13334	204.100	Progress notes did not include the relationship of the services to the treatment regimen described in the plan of care
14529	217.00	Medical Evaluation does not include diagnosis or summary of current medical condition
14792	204.100	Progress notes did not document the specific service provided
15024	218.100 218.200	Individual Plan of Care not developed in consultation with the recipient and his or her parent(s), legal guardian(s)- record noted patient refused and two attempts were made to contact family but no documented contact Individual Plan of Care did not include a description of the functional level of the Client
15083	204.100 217.00	Progress note did not document setting in which services provided Medical Evaluation does not include a diagnosis or summary of current medical findings
15241	217.00	Medical Evaluation does not include a diagnosis or summary of current medical findings
15346	204.100	Progress notes did not include relationship of services provided to the regimen included in the treatment plan
15653	217.00 218.100	Medical Evaluation does not include diagnosis or summary of current medical findings No Individual Plan of care in the record
15676	217.00	Medical Evaluation does not include diagnosis or summary of current medical findings

General chart review observations:

- 47% of charts had incomplete medical evaluations, missing diagnosis, current medical findings, or mental and physical capacity.
- 26% of charts are missing documentation of services being provided, the setting in which the services were provided, or how the services relate to the treatment plan.
- 21% of records reviewed were missing treatment plans or treatment plans did not include functional capacity of child or did not document completion in consultation with the parent and/or legal guardian.

Corrective Action Plan:

The CAP must be completed within 30 calendar days of the date of the email notice of the IOC report. Please complete the attached Corrective Action Plan document and submit it via email to Inspectionteam@afmc.org.

Respectfully,

InspectionTeam@afmc.org

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