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 2, 2021

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

Dear Mr. Napier:

On October 27, 2021 a Complaint 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
	04L107	A. BUILDING _____ B. WING _____	C 10/27/2021

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 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. Complaint #AR00027557 was substantiated, all or in part, with deficiencies cited at N0132, N0189, and N0214.	N 000		
N 132	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center PROTECTION OF RESIDENTS 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).	N 132		

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

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N 132	Continued From page 1	N 132		

This ELEMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure a personal restraint was performed in a safe and appropriate manner for 1 (Client #1) of 1 (Client #1) sampled clients. The findings are:

Client #1 was admitted on 4/15/21 and had diagnoses Unspecified Trauma and Stressor Related Disorder and Unspecified Anxiety Disorder.

a. A Session Information report dated 10/24/21 documented, "...Events Leading to Incident: [Client #1] dropped his snack on the ground and accused one of his peers of laughing at him. He started to yell at this peer and was upset and angry. Staff told them to stop arguing or they would go to their rooms. The other peer stopped but [Client #1] kept talking and was arguing and cursing when talking to staff. [Client #1] was asked to go to his room and replied "make me". He ended up leaving the room, kicked the milieu chairs, and then started pulling down some Halloween decorations that had been placed throughout the house. He then went into the kitchen and shut the door behind him..."

b. An IR (Incident Report) Narrative dated 10/24/21 documented, "...Time: 03:30 [3:30] PM; Patient Status: Personal Restraint; Intervention Description or Observation Narrative: While staff was performing a restraint pt [patient] began scratching a staff member and head-butting them. He was screaming and trying to bite staff. When staff was able to take him to the back area where the seclusion room is he bit two different

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N 132	Continued From page 2	N 132		

staff members twice each...Time: 3:08 PM; Patient Status: Personal Restraint End..."

c. On 10/27/21 at 10:11 a.m., the video of the restraint was reviewed and the observations were as follows:

At 3:04:53 [p.m.] the client in the milieu area of the home, kicked a chair, threw an item across the room and went back into the recreation room. The client came out of the recreation room, went into the kitchen, and shut the door. Qualified Behavioral Health Provider (QBHP) #1 followed the client into the kitchen. QBHP #1 came out of the kitchen with his arms around Client #1's waist and the client's feet were off the floor. QBHP #1 was joined by QBHP #2 and QBPH #3. QBPH #1 and QBPH #3 had the client's arms wrapped behind their necks and QBPH #2 was holding the client's legs. The client was in the air between the three staff members. The client's feet were released by QBPH #2. QBPH #1 had the client under the arms and QBPH #3 picked up the client's legs and the client was carried through the milieu door to the seclusion room.

d. On 10/27/21 at 2:41 p.m., the Unit Manager was asked, "Do you teach CPI [Crisis Prevention and Intervention]?" He stated, "Yes." The Unit Manager was asked, "How long have you taught CPI?" He stated, "About three or four years." The Unit Manager was asked, "When [QBHP #1] picked up [Client #1] and carried him out of the kitchen area was that a proper CPI hold?" He stated, "No." The Unit Manager was asked, "When [QBHP #1], [QBPH #2] and [QBPH #3] were observed carrying [Client #1] in the air and through the milieu towards the seclusion room, was that a proper CPI hold?" He stated, "No."

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N 132	Continued From page 3 The Unit Manager was asked, "What should have happened?" He stated, "You don't want to lift their feet off the ground. [QBHP #1] and [QBPH #3] should have had him in the medium or high hold and then if needed [QBHP #2] could have used her body to help move him forward." The Unit Manager was asked, "Would you say what you saw on the video was correct?" He stated, "No, they had his feet off the floor."	N 132		
N 189	POST INTERVENTION DEBRIEFINGS 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 record review and interview the facility failed to ensure a staff debriefing was conducted after the use of a restraint for 1 (Client #1) of 1 sampled clients. The findings are: Client #1 was admitted on 4/15/21 and had diagnoses Unspecified Trauma and Stressor Related Disorder and Unspecified Anxiety Disorder. a. A Session Information report dated 10/24/21	N 189		

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N 189	Continued From page 4 documented, "...IR [Incident Report] Narrative...Time: 3:03 PM; Patient Status: Personal Restraint...Time: 3:08 PM; Patient Status: Personal Restraint End;...Time 3:09 PM; Patient Status: Locked Seclusion;...Time: 3:24 PM; Patient Status: Locked Seclusion End..." b. A Session Information report dated 10/24/21 documented, "...Staff Debriefing; Date Staff Debriefing was completed: 10/24/21; Time Staff Debriefing was completed: 3:15 PM..." Documentation indicated the Staff Debriefing was completed nine minutes before the locked seclusion ended. c. On 10/27/21, at 3:30 p.m., the Records Compliance Director was asked, "The IR narrative documented [Client #1] was in locked seclusion at 3:09 p.m., the time documented locked seclusion ended was 3:24 p.m. The staff debriefing documented the time of the staff debriefing was at 3:15 p.m., nine minutes before the locked seclusion ended. Can you explain this?" She stated, "That's what time they notified the therapist on call at 3:15 p.m." The Records Compliance Director was asked, "The debriefing is everybody getting together and talking over, did that happen?" She stated, "Well it says they were in the debriefing." The Records Compliance Director was asked, "They can't participate in the debriefing if the incident is still going on, correct?" She stated, "Correct." The Records Compliance Director was asked, "According to documentation, they didn't hold the debriefing after the restraint was over?" She stated, "No, according to documentation it didn't end until 3:32."	N 189		
N 214	EDUCATION AND TRAINING	N 214		

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N 214	Continued From page 5 CFR(s): 483.376(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of - This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff were retrained in the appropriate application of a personal restraint for 1 (Client #1) of 1 sampled clients who were subject to the inappropriate application of a personal restraint. The findings are: Client #1 was admitted on 4/15/21 and had diagnoses Unspecified Trauma and Stressor Related Disorder and Unspecified Anxiety Disorder. a. A Session Information report, dated 10/24/21, documented, "...Events Leading to Incident: [Client #1] dropped his snack on the ground and accused one of his peers of laughing at him. He started to yell at this peer and was upset and angry. Staff told them to stop arguing or they would go to their rooms. The other peer stopped but [Client #1] kept talking and was arguing and cursing when talking to staff. [Client #1] was asked to go to his room and replied "make me". He ended up leaving the room, kicked the milieu chairs, and then started pulling down some Halloween decorations that had been placed throughout the house. He then went into the kitchen and shut the door behind him..." b. An IR (Incident Report) Narrative dated 10/24/21 documented, "...Time: 03:30 [3:30] PM; Patient Status: Personal Restraint; Intervention	N 214		

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N 214	Continued From page 6	N 214		

Description or Observation Narrative: While staff was performing a restraint pt [patient] began scratching a staff member and head-butting them. He was screaming and trying to bite staff. When staff was able to take him to the back area where the seclusion room is he bit two different staff members twice each...Time: 3:08 PM; Patient Status: Personal Restraint End..."

c. On 10/27/21 at 10:11 a.m., the video of the restraint was reviewed and the observations were as follows:

At 3:04:53 [p.m.] the client in the milieu area of the home, kicked a chair, threw an item across the room and went back into the recreation room. The client came out of the recreation room, went into the kitchen, and shut the door. Qualified Behavioral Health Provider (QBHP) #1 followed the client into the kitchen. QBHP #1 came out of the kitchen with his arms around Client #1's waist and the client's feet were off the floor. QBHP #1 was joined by QBHP #2 and QBPH #3. QBPH #1 and QBPH #3 had the client's arms wrapped behind their necks and QBPH #2 was holding the client's legs. The client was in the air between the three staff members. The client's feet were released by QBPH #2. QBPH #1 had the client under the arms and QBPH #3 picked up the client's legs and the client was carried through the milieu door to the seclusion room.

d. On 10/27/21, at 2:41 p.m., the Unit Manager was asked, "Do you teach CPI [Crisis Prevention and Intervention]?" He stated, "Yes." The Unit Manager was asked, "How long have you taught CPI?" He stated, "About three or four years." The Unit Manager was asked, "When [QBHP #1] picked up [Client #1] and carried him out of the

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e. On 10/27/21, at 11:02 a.m., the Unit Manager was asked, "Have you done any retraining related to restraints?" He stated, "[QBHP #1] hasn't worked since then but I have spoken to him on the phone yesterday the twenty-fifth at 3:26 p.m." The Unit Manger was asked, "Have you done any retraining with other staff?" He stated, "[QBHP #2] won't be here until Friday. [QBHP #1] was the one who picked him up off the ground." The Unit Manager was asked, "When is [QBHP #1] going to be retrained on CPI?" He stated, "Possibly Monday. He may work on Sunday." The Unit Manager was asked, "He hasn't worked since the incident?" He stated, "He worked yesterday." At 12:59 p.m. the Unit Manager was asked, "Is there any reason why you didn't immediately retrain [QBHP #1] or staff after this incident?" He stated, "Well I called an talked to [QBHP #1] and we will start retraining."

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November 12, 2021

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

Dear Mr. Napier:

On October 27, 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 November 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,

Sandra Broughton
Administrative Services Manager

DPSQA/Office of Long Term Care
Survey & Certification Section

sgb

Approved POC 11/12/2021 SGB

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

PRINTED: 11/02/2021
FORM APPROVED
OMB NO. 0938-0391

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N 132	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center PROTECTION OF RESIDENTS 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).	N 132		

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C.E.O. 11-11-2021

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 132	Continued From page 1 This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a personal restraint was performed in a safe and appropriate manner for 1 (Client #1) of 1 (Client #1) sampled clients. The findings are: Client #1 was admitted on 4/15/21 and had diagnoses Unspecified Trauma and Stressor Related Disorder and Unspecified Anxiety Disorder. a. A Session Information report dated 10/24/21 documented, "...Events Leading to Incident: [Client #1] dropped his snack on the ground and accused one of his peers of laughing at him. He started to yell at this peer and was upset and angry. Staff told them to stop arguing or they would go to their rooms. The other peer stopped but [Client #1] kept talking and was arguing and cursing when talking to staff. [Client #1] was asked to go to his room and replied "make me". He ended up leaving the room, kicked the milieu chairs, and then started pulling down some Halloween decorations that had been placed throughout the house. He then went into the kitchen and shut the door behind him..." b. An IR (Incident Report) Narrative dated 10/24/21 documented, "...Time: 03:30 [3:30] PM; Patient Status: Personal Restraint; Intervention Description or Observation Narrative: While staff was performing a restraint pt [patient] began scratching a staff member and head-butting them. He was screaming and trying to bite staff. When staff was able to take him to the back area where the seclusion room is he bit two different	N 132	A training video was developed to demonstrate appropriate holds and examples of inappropriate holds. All staff who are CPI trained will be required to complete this training video by 11/24/21. A report will be run in Relias, our online training modules to assure the training is completed. The ongoing review of all incidents and retraining by the Unit Managers will be reported to the Chief Clinical Officer on a monthly basis and quarterly to the Performance Improvement Committee.	11/24/21

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staff members twice each...Time: 3:08 PM; Patient Status: Personal Restraint End..."

c. On 10/27/21 at 10:11 a.m., the video of the restraint was reviewed and the observations were as follows:

At 3:04:53 [p.m.] the client in the milieu area of the home, kicked a chair, threw an item across the room and went back into the recreation room. The client came out of the recreation room, went into the kitchen, and shut the door. Qualified Behavioral Health Provider (QBHP) #1 followed the client into the kitchen. QBHP #1 came out of the kitchen with his arms around Client #1's waist and the client's feet were off the floor. QBHP #1 was joined by QBHP #2 and QBPH #3. QBPH #1 and QBPH #3 had the client's arms wrapped behind their necks and QBPH #2 was holding the client's legs. The client was in the air between the three staff members. The client's feet were released by QBPH #2. QBPH #1 had the client under the arms and QBPH #3 picked up the client's legs and the client was carried through the milieu door to the seclusion room.

d. On 10/27/21 at 2:41 p.m., the Unit Manager was asked, "Do you teach CPI [Crisis Prevention and Intervention]?" He stated, "Yes." The Unit Manager was asked, "How long have you taught CPI?" He stated, "About three or four years." The Unit Manager was asked, "When [QBHP #1] picked up [Client #1] and carried him out of the kitchen area was that a proper CPI hold?" He stated, "No." The Unit Manager was asked, "When [QBHP #1], [QBPH #2] and [QBPH #3] were observed carrying [Client #1] in the air and through the milieu towards the seclusion room, was that a proper CPI hold?" He stated, "No."

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 _____	C 10/27/2021

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
N 132	Continued From page 3 The Unit Manager was asked, "What should have happened?" He stated, "You don't want to lift their feet off the ground. [QBHP #1] and [QBPH #3] should have had him in the medium or high hold and then if needed [QBHP #2] could have used her body to help move him forward." The Unit Manager was asked, "Would you say what you saw on the video was correct?" He stated, "No, they had his feet off the floor."	N 132		
N 189	POST INTERVENTION DEBRIEFINGS 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 record review and interview the facility failed to ensure a staff debriefing was conducted after the use of a restraint for 1 (Client #1) of 1 sampled clients. The findings are: Client #1 was admitted on 4/15/21 and had diagnoses Unspecified Trauma and Stressor Related Disorder and Unspecified Anxiety Disorder. a. A Session Information report dated 10/24/21	N 189	The proper use of the post intervention debriefing is described in a PowerPoint presentation that is included in the training video for all CPI trained staff. It was presented to the Clinical Therapists in the Clinical Meeting on 11/3/21. All other staff must complete this training by 11/24/21. A report will be run in Relias, our online training forum, to assure the training is completed. Reports are run on a regular basis and sent out to all managers. As incidents are reviewed by the Unit Managers, the debriefing will be a part of the review. The results of these reviews will be reported to the Chief Clinical Officer on a monthly basis, and quarterly through the Performance Improvement Committee.	11/24/21

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N 189	Continued From page 4	N 189		

documented, "...IR [Incident Report] Narrative...Time: 3:03 PM; Patient Status: Personal Restraint...Time: 3:08 PM; Patient Status: Personal Restraint End;...Time 3:09 PM; Patient Status: Locked Seclusion;...Time: 3:24 PM; Patient Status: Locked Seclusion End..."

b. A Session Information report dated 10/24/21 documented, "...Staff Debriefing; Date Staff Debriefing was completed: 10/24/21; Time Staff Debriefing was completed: 3:15 PM..." Documentation indicated the Staff Debriefing was completed nine minutes before the locked seclusion ended.

c. On 10/27/21, at 3:30 p.m., the Records Compliance Director was asked, "The IR narrative documented [Client #1] was in locked seclusion at 3:09 p.m., the time documented locked seclusion ended was 3:24 p.m. The staff debriefing documented the time of the staff debriefing was at 3:15 p.m., nine minutes before the locked seclusion ended. Can you explain this?" She stated, "That's what time they notified the therapist on call at 3:15 p.m." The Records Compliance Director was asked, "The debriefing is everybody getting together and talking over, did that happen?" She stated, "Well it says they were in the debriefing." The Records Compliance Director was asked, "They can't participate in the debriefing if the incident is still going on, correct?" She stated, "Correct." The Records Compliance Director was asked, "According to documentation, they didn't hold the debriefing after the restraint was over?" She stated, "No, according to documentation it didn't end until 3:32."

N 214 EDUCATION AND TRAINING N 214

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 214	Continued From page 5 CFR(s): 483.376(a) The facility must require staff to have ongoing education, training, and demonstrated knowledge of - This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff were retrained in the appropriate application of a personal restraint for 1 (Client #1) of 1 sampled clients who were subject to the inappropriate application of a personal restraint. The findings are: Client #1 was admitted on 4/15/21 and had diagnoses Unspecified Trauma and Stressor Related Disorder and Unspecified Anxiety Disorder. a. A Session Information report, dated 10/24/21, documented, "...Events Leading to Incident: [Client #1] dropped his snack on the ground and accused one of his peers of laughing at him. He started to yell at this peer and was upset and angry. Staff told them to stop arguing or they would go to their rooms. The other peer stopped but [Client #1] kept talking and was arguing and cursing when talking to staff. [Client #1] was asked to go to his room and replied "make me". He ended up leaving the room, kicked the milieu chairs, and then started pulling down some Halloween decorations that had been placed throughout the house. He then went into the kitchen and shut the door behind him..." b. An IR (Incident Report) Narrative dated 10/24/21 documented, "...Time: 03:30 [3:30] PM; Patient Status: Personal Restraint; Intervention	N 214	All emergency safety interventions will be reviewed by the Unit Managers for appropriate use of CPI techniques. Any time something inappropriate is viewed, a short video for retraining purposes will be completed with the staff involved. This review began on 11/8/21. The results of the review and retraining will be reported to the Chief Clinical Officer on a monthly basis; this will be presented to the quarterly Performance Improvement Committee. In addition, an update to our Ethical Standards Policy # 1405 was approved on 11/8/21 that added duty to intervene for all staff if they observe misconduct, or inappropriate behavior from another staff member during an interaction with a patient. 11/8/21

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	04L107	A. BUILDING _____ B. WING _____	C 10/27/2021

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N 214	Continued From page 6	N 214		

Description or Observation Narrative: While staff was performing a restraint pt [patient] began scratching a staff member and head-butting them. He was screaming and trying to bite staff. When staff was able to take him to the back area where the seclusion room is he bit two different staff members twice each...Time: 3:08 PM; Patient Status: Personal Restraint End..."

c. On 10/27/21 at 10:11 a.m., the video of the restraint was reviewed and the observations were as follows:

At 3:04:53 [p.m.] the client in the milieu area of the home, kicked a chair, threw an item across the room and went back into the recreation room. The client came out of the recreation room, went into the kitchen, and shut the door. Qualified Behavioral Health Provider (QBHP) #1 followed the client into the kitchen. QBHP #1 came out of the kitchen with his arms around Client #1's waist and the client's feet were off the floor. QBHP #1 was joined by QBHP #2 and QBPH #3. QBPH #1 and QBPH #3 had the client's arms wrapped behind their necks and QBPH #2 was holding the client's legs. The client was in the air between the three staff members. The client's feet were released by QBPH #2. QBPH #1 had the client under the arms and QBPH #3 picked up the client's legs and the client was carried through the milieu door to the seclusion room.

d. On 10/27/21, at 2:41 p.m., the Unit Manager was asked, "Do you teach CPI [Crisis Prevention and Intervention]?" He stated, "Yes." The Unit Manager was asked, "How long have you taught CPI?" He stated, "About three or four years." The Unit Manager was asked, "When [QBHP #1] picked up [Client #1] and carried him out of the

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N 214	Continued From page 7	N 214		

kitchen area was that a proper CPI hold? He stated, "No." The Unit Manager was asked, "When [QBHP #1], [QBHP #2] and [QBHP #3] were observed carrying [Client #1] in the air and through the milieu towards the seclusion room, was that a proper CPI hold?" He stated, "No." The Unit Manager was asked, "What should have happened?" He stated, "You don't want to lift their feet off the ground. [QBHP #2] and [QBHP #3] should have had him in the medium or high hold and then if needed [QBHP #2] could have used her body to help move him forward." The Unit Manager was asked, "Would you say what you saw on the video was correct?" He stated, "No, they had his feet off the floor."

e. On 10/27/21, at 11:02 a.m., the Unit Manager was asked, "Have you done any retraining related to restraints?" He stated, "[QBHP #1] hasn't worked since then but I have spoken to him on the phone yesterday the twenty-fifth at 3:26 p.m." The Unit Manger was asked, "Have you done any retraining with other staff?" He stated, "[QBHP #2] won't be here until Friday. [QBHP #1] was the one who picked him up off the ground." The Unit Manager was asked, "When is [QBHP #1] going to be retrained on CPI?" He stated, "Possibly Monday. He may work on Sunday." The Unit Manager was asked, "He hasn't worked since the incident?" He stated, "He worked yesterday." At 12:59 p.m. the Unit Manager was asked, "Is there any reason why you didn't immediately retrain [QBHP #1] or staff after this incident?" He stated, "Well I called an talked to [QBHP #1] and we will start retraining."

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

December 2, 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 November 30, 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
Survey and Certification Section

sgb

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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 30, 2021 for all deficiencies cited on October 27, 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.