



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,

Administrative Services Manager

DPSQA/Office of Long Term Care
Survey & Certification Section

sgb

cc: DRA

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

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		04L107	B. WING _			10/	27/ 2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 20400 COLONEL GLENN ROAD LITTLE ROCK, AR 72210	Ē	10//	2772021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
N 000	is an official, legal doremain unchanged excorrection, correction space. Any discrepancitation(s) will be reported (RO) for referral Inspector General (Oinformation is inadver	IG) for possible fraud. If tently changed by the State Survey Agency (SA)	N O				
N 122	or in part, with deficie N0189, and N0214. The facility was not in Subpart G - Conditio Psychiatric Residentia	ı compliance with §483, ns of Participation for al Treatment Center	N 1	32			
N 132	safety intervention manner that is safe, pappropriate to the set the resident's chronol age; size; gender; phasychiatric condition; (including any history abuse).	ervention. An emergency ust be performed in a proportionate, and verity of the behavior, and logical and developmental lysical, medical, and and personal history	N 1	32 			(V6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L107	B. WING		C 10/27/2021
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N 132	Continued From pa	ge 1	N 13	2	
	Based on observatinterview, the facility restraint was performanner for 1 (Clien clients. The finding Client #1 was admit diagnoses Unspecific Related Disorder and Disorder. a. A Session Information documented, "Everage [Client #1] dropped accused one of his started to yell at this angry. Staff told the would go to their robut [Client #1] kept cursing when talking asked to go to his reflected up leaving chairs, and then stated the state of	not met as evidenced by: ion, record review and y failed to ensure a personal med in a safe and appropriate t #1) of 1 (Client #1) sampled s are: Itted on 4/15/21 and had fied Trauma and Stressor and Unspecified Anxiety Ination report dated 10/24/21 ents Leading to Incident: his snack on the ground and peers of laughing at him. He is peer and was upset and em to stop arguing or they soms. The other peer stopped talking and was arguing and g to staff. [Client #1] was soom and replied "make me". g the room, kicked the milieu arted pulling down some sons that had been placed se. He then went into the e door behind him" Report) Narrative dated ed, "Time: 03:30 [3:30] PM; sonal Restraint; Intervention ervation Narrative: While staff estraint pt [patient] began ember and head-butting			
	When staff was able	aming and trying to bite staff. e to take him to the back area n room is he bit two different			

	С
	10/27/2021
I	10/21/2021
RECTION SHOULD BE PPROPRIATE	(X5) COMPLETION DATE

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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		04L107	B. WING			10/27/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE		
YOUTH H	OME INC			20400 COLONEL GLENN ROAD			
	J2			LITTLE ROCK, AR 72210			
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N 132	The Unit Manager was happened?" He stat their feet off the groun #3] should have had hold and then if need used her body to help Unit Manager was as you saw on the video "No, they had his feet	is asked, "What should have ed, "You don't want to lift and. [QBHP #1] and [QBPH him in the medium or high ed [QBHP #2] could have o move him forward." The ked, "Would you say what was correct?" He stated, toff the floor."		132			
	seclusion, all staff inv safety intervention, and and administrative state debriefing session that review and discussion 483.370(b)(1) The enthat required the inter	at includes, at a minimum, a n of - nergency safety situation					
	Based on record revifailed to ensure a star after the use of a rest sampled clients. The Client #1 was admitted diagnoses Unspecified Related Disorder and Disorder.	ed on 4/15/21 and had ed Trauma and Stressor					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			20400 COLO	RESS, CITY, STATE, ZIP CODE INEL GLENN ROAD CK, AR 72210	1 10,	2172021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 189	Status: Personal Res Patient Status: Locke PM; Patient Status: Locked PM; Patien	ncident Report] B PM; Patient Status: Time: 3:08 PM; Patient traint End; Time 3:09 PM; d Seclusion; Time: 3:24 ocked Seclusion End" Ition report dated 10/24/21 Debriefing; Date Staff leted: 10/24/21; Time Staff leted: 3:15 PM" Itied the Staff Debriefing was less before the locked 30 p.m., the Records was asked, "The IR If [Client #1] was in locked, the time documented led was 3:24 p.m. The staff let the time of the staff fo p.m., nine minutes before lended. Can you explain hat's what time they notified it 3:15 p.m." The Records was asked, "The debriefing logether and talking over, did lated, "Well it says they were le Records Compliance They can't participate in the lent is still going on, correct?" The Records Compliance According to didn't hold the debriefing logoty: She stated, "No, Intation it didn't end until	N 1				
N 214	EDUCATION AND TR	RAINING	N 2	14			

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION PUILDING			(X3) DATE SURVEY COMPLETED		
		04L107	B. WING			1	C 27/2021
NAME OF PR	ROVIDER OR SUPPLIER			204	REET ADDRESS, CITY, STATE, ZIP CODE 400 COLONEL GLENN ROAD TTLE ROCK, AR 72210	1 10/	2//2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 214	CFR(s): 483.376(a) The facility must requeducation, training, a of - This STANDARD is a Based on observation interview, the facility retrained in the appropersonal restraint for clients who were subapplication of a personal restraint for clients who were subapplication of a personal restraint for clients who were subapplication of a personal restraint for client #1 was admitted diagnoses Unspecified Related Disorder and Disorder. a. A Session Informated documented, " Ever [Client #1] dropped haccused one of his postarted to yell at this pangry. Staff told ther would go to their room but [Client #1] kept tacursing when talking asked to go to his room the ended up leaving chairs, and then start Halloween decoration	ire staff to have ongoing and demonstrated knowledge hot met as evidenced by: n, record review and failed to ensure staff were opriate application of a 1 (Client #1) of 1 sampled fect to the inappropriate onal restraint. The findings and restraint. The findings and to staff and to stop arguing at him. He oper and was upset and in to stop arguing or they ms. The other peer stopped alking and was arguing and to staff. [Client #1] was of mand replied "make me". The room, kicked the milieu end pulling down some ins that had been placed in the room into the	N:	214			
	10/24/21 documented	eport) Narrative dated d, "Time: 03:30 [3:30] PM; nal Restraint; Intervention					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE (X7) MULTIP		' '	(X3) DATE SURVEY COMPLETED		
		04L107	B. WING _			C 10/27/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 20400 COLONEL GLENN ROAD LITTLE ROCK, AR 72210	'	10/21/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
N 214	was performing a rescratching a staff m them. He was screwhen staff was able where the seclusion staff members twice Patient Status: Persc. On 10/27/21 at 10 restraint was review as follows: At 3:04:53 [p.m.] the the home, kicked a the room and went. The client came out into the kitchen, and Behavioral Health Fithe client into the kitchen with his and the client's feet was joined by QBHI and QBPH #3 had the behind their necks a client's legs. The clithree staff members released by QBPH and the arms and client's legs and the milieu door to the set of the control of of th	ervation Narrative: While staff estraint pt [patient] began ember and head-butting aming and trying to bite staff. The to take him to the back area in room is he bit two different eeachTime: 3:08 PM; conal Restraint End" 10:11 a.m., the video of the red and the observations were red and the observations were red client in the milieu area of chair, threw an item across back into the recreation room, went dishut the door. Qualified Provider (QBHP) #1 followed then. QBHP #1 came out of arms around Client #1's waist were off the floor. QBHP #1 P #2 and QBPH #3. QBPH #1 P #2 and QBPH #3. QBPH #1 P #2 and QBPH #3 was holding the ent was in the air between the structure. The client's feet were #2. QBPH #1 had the client QBPH #3 picked up the eclient was carried through the	N 2	14		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L107	B. WING			C 0/27/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 20400 COLONEL GLENN ROAD LITTLE ROCK, AR 72210		3/21/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 214	stated, "No." The Un "When [QBHP #1], [Owere observed carryithrough the milieu towas that a proper CP The Unit Manager wahappened?" He stattheir feet off the grouf #3] should have had hold and then if need used her body to help Unit Manager was as you saw on the video "No, they had his fee" e. On 10/27/21, at 1" was asked, "Have yo to restraints?" He statworked since then but the phone yesterday The Unit Manager was retraining with other seed who picked him under the phone yesterday. The Unit Manager was asked, to be retrained on CF Monday. He may wow Manager was asked, incident?" He stated. 12:59 p.m. the Unit Many reason why you con [QBHP #1] or staff after the stated of the control of the phone yesterday.	a proper CPI hold? He it Manager was asked, 2BHP #2] and [QBHP #3] ng [Client #1] in the air and wards the seclusion room, I hold?" He stated, "No." as asked, "What should have ed, "You don't want to lift and. [QBHP #2] and [QBHP him in the medium or high ed [QBHP #2] could have o move him forward." The ked, "Would you say what was correct?" He stated,	N 21				





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 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,

DPSQA/Office of Long Term Care

Saudie Bisciston Administrative Services Manager

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	1 042.107		STREET ADDRESS, CITY, STATE, ZIP CODE 20400 COLONEL GLENN ROAD LITTLE ROCK, AR 72210	10/27/2021	
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N 000	Initial Comments		N C	! 000 :		
	is an official, legal dor remain unchanged ex correction, correction space. Any discrepant citation(s) will be repo Office (RO) for referrat Inspector General (Officemation is inadver	IG) for possible fraud. If tently changed by the State Survey Agency (SA)	:			
	Complaint #AR00027 or in part, with deficie N0189, and N0214.	557 was substantiated, all ncies cited at N0132,				
N 132	The facility was not in Subpart G - Condition Psychiatric Residentia PROTECTION OF RECFR(s): 483.356(b)	al Treatment Center	N 1	32		
	safety intervention mu manner that is safe, p appropriate to the sev	roportionate, and erity of the behavior, and ogical and developmental vsical, medical, and and personal history				
ABORATORY I	DIRECTOR'S OR PROVIDER'S	UPPLIER REPRESENTATIVE'S SIGNATURE		C, E. D.	(X6) DATE	

Any deficiency statement energy 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IUCY11

Facility ID: 3006

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

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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YOUTH H	OME INC			LITTLE ROCK, AR 72210	
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N 132	Continued From page This ELEMENT is no	e 1 t met as evidenced by:	N 13	A training video was developed to d holds and examples of inappropriate are CPI trained will be required to c video by 11/24/21.	holds. All staff who
	restraint was perform manner for 1 (Client # clients. The findings Client #1 was admitte	ailed to ensure a personal ed in a safe and appropriate f1) of 1 (Client #1) sampled are: d on 4/15/21 and had d Trauma and Stressor		A report will be run in Relias, our or to assure the training is completed. The ongoing review of all incidents Unit Managers will be reported to the Officer on a monthly basis and quart Improvement Committee.	and retraining by the ne Chief Clinical
	documented, "Even [Client #1] dropped hi accused one of his pe started to yell at this pangry. Staff told them would go to their room but [Client #1] kept ta cursing when talking taked to go to his room the ended up leaving chairs, and then started Halloween decoration throughout the house kitchen and shut the complete the co	s that had been placed He then went into the door behind him" port) Narrative dated , "Time: 03:30 [3:30] PM; nal Restraint; Intervention ation Narrative: While staff raint pt [patient] began			11/24/21

where the seclusion room is he bit two different

CENIER	S FUR MEDICARE &	MEDICAID SEKVICES				ONIB NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L107	B. WING		·	C 10/27/2021	
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 10/2//2021	
					COLONEL GLENN ROAD		
YOUTH H	OME INC				LE ROCK, AR 72210		
				LITT			
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N 132	Continued From page	∌ 2	N.	132			
	staff members twice		•••				
	Patient Status: Perso						
	c. On 10/27/21 at 10:	11 a.m., the video of the					
		d and the observations were					
	ALO 0 4 70 F 3 II.	alternation above an effect of the second					
		client in the milieu area of					
		nair, threw an item across ack into the recreation room.		-			
		of the recreation room, went					
		shut the door. Qualified		:			
	·	ovider (QBHP) #1 followed					
		hen. QBHP #1 came out of		-			
		ms around Client #1's waist					
	and the client's feet w	ere off the floor. QBHP #1					
	was joined by QBHP	#2 and QBPH #3. QBPH #1					
		e client's arms wrapped					
		d QBPH #2 was holding the					
	_	nt was in the air between the					
	three staff members.						
	•	2. QBPH #1 had the client					
		BPH #3 picked up the					
	milieu door to the sec	lient was carried through the					
	milieu door to the sec	idsion foom.					
	d On 10/27/21 at 2:4	1 p.m., the Unit Manager					
		each CPI [Crisis Prevention		:			
		e stated, "Yes." The Unit					
		"How long have you taught					
	CPI?" He stated, "Ab	out three or four years."		-			
	The Unit Manager wa	s asked, "When [QBHP #1]		:			
		and carried him out of the				***************************************	
		a proper CPI hold?" He					
	stated, "No." The Uni						
		BPH #2] and [QBPH #3]					
	•	ng [Client #1] in the air and					
	-	/ards the seclusion room,					
	was that a proper CPI	hold?" He stated, "No."					

CENIER	S FUN MEDICARE &	MEDICAID SEKVICES			OIME NO. 0930-0381
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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		04L107	B. WING _		10/27/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
YOUTH HO	OME INC			20400 COLONEL GLENN ROAD	
				LITTLE ROCK, AR 72210	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
N 132	Continued From page	a 2	, 81.4	· ·	
IN 132.	Continued From page		N 1	132	:
		as asked, "What should have ted, "You don't want to lift			
		nd. [QBHP #1] and [QBPH			
		him in the medium or high			
	hold and then if neede	ed [QBHP #2] could have		:	
		o move him forward." The			
	•	ked, "Would you say what			
		was correct?" He stated,		•	
N 189	"No, they had his feet POST INTERVENTION		N 1	189 The proper use of the post interv	antion dehriefing
IN 1US	CFR(s): 483.370(b)	N DEDRIEFINGS	IV i	is described in a PowerPoint pre	•
	01 / 1(0). 101.11 1(0)				
	Within 24 hours after	the use of restraint or		included in the training video for	
		volved in the emergency		It was presented to the Clinical T	•
		nd appropriate supervisory		Meeting on 11/3/21. All other st	taff must complete
	and administrative sta	aff, must conduct a at includes, at a minimum, a		this training by 11/24/21.	
	review and discussion			A report will be run in Relias, ou	ur online training forum
	TOTIOTI GITG GIGGGGG.	101		to assure the training is complete	-
	483.370(b)(1) The em	nergency safety situation		a regular basis and sent out to all	•
	that required the inter-	_		—·	-
	•	cipitating factors that led up		As incidents are reviewed by the	-
	to the intervention;			debriefing will be a part of the re	
				these reviews will be reported to	
				Officer on a monthly basis, and o	
	This ELEMENT is no	ot met as evidenced by:		Performance Improvement Com-	mittee.
		iew and interview the facility			
		ff debriefing was conducted			11/24/21
		raint for 1 (Client #1) of 1			:
	sampled clients. The	tindings are.			
	Client #1 was admitted	d on 4/15/21 and had			
	diagnoses Unspecified	d Trauma and Stressor		:	
	Related Disorder and	Unspecified Anxiety		:	
	Disorder.				
	a. A Session Informat	ition report dated 10/24/21			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
				С	
		04L107	B. WING	***************************************	10/27/2021
NAME OF P	ROVIDER OR SUPPLIER		S1	REET ADDRESS, CITY, STATE, ZIP CODE	
VOLITH H	OME INC		20	400 COLONEL GLENN ROAD	
YOUTH HOME INC			LI	TTLE ROCK, AR 72210	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
N 189	Continued From page	. 4	N 189		
,	documented, "IR [In		. 11 105		
	NarrativeTime: 3:03	· -			
		ime: 3:08 PM; Patient			
		traint End;Time 3:09 PM;	:		
		d Seclusion:Time: 3:24			
		ocked Seclusion End"			
	b. A Session Information	tion report dated 10/24/21			
		Debriefing; Date Staff			
	Debriefing was compl	eted: 10/24/21; Time Staff			
	Debriefing was compl	eted: 3:15 PM"			
		ted 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 v	was asked, "The IR			
		[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 aske		ogether and talking over, did			
		ated, "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				:	
		over?" She stated, "No,			
		tation it didn't end until			
	3:32."				
N 214	EDUCATION AND TR	AINING	N 214		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/02/2021 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
		(1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		94L107	B. WING		C 10/27/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
YOUTH HOME INC			20400 COLONEL GLENN ROAD LITTLE ROCK, AR 72210		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE COMPLETION THE APPROPRIATE DATE
N 214	education, training, and of - This STANDARD is in Based on observation interview, the facility for retrained in the appropersonal restraint for clients who were subjapplication of a personare: Client #1 was admitted diagnoses Unspecifie Related Disorder and Disorder. a. A Session Informated documented, " Even [Client #1] dropped his accused one of his pestarted to yell at this pangry. Staff told them would go to their room but [Client #1] kept tall cursing when talking the asked to go to his room the ended up leaving the chairs, and then started Halloween decoration.	ire staff to have ongoing and demonstrated knowledge not met as evidenced by: In, record review and ailed to ensure staff were priate application of a 1 (Client #1) of 1 sampled ect to the inappropriate and restraint. The findings Indicate the inappropriate and restraint. The findings Indicate the inappropriate and stressor unspecified Anxiety Inspecified Anxiety Inspect Anxiety Inspecified Anxiety Inspect Anxiety Ins	N	the Unit Managers for app Any time something inapp for retraining purposes wil involved. This review beg review and retraining will Officer on a monthly basis this will be presented to th Improvement Committee. In addition, an update to o 1405 was approved on 11/ for all staff if they observe	

10/24/21 documented, "...Time: 03:30 [3:30] PM; Patient Status: Personal Restraint; Intervention

OUT TO TO TO TO TO THE POST OF			7) 7 001(577) 107(01)	ONE NO. 0930-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED			
		04L107	B. WING		C 10/27/2021	
NAME OF P	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	IOULD BE COMPLETION	
N 214	Continued From page	e 6	N 2	14		
	Description or Obserwas performing a resscratching a staff me them. He was screat When staff was able where the seclusion of	vation Narrative: While staff traint pt [patient] began mber and head-butting ming and trying to bite staff. to take him to the back area room is he bit two different eachTime: 3:08 PM;	,			
	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					
	the client into the kitc the kitchen with his a and the client's feet w	ovider (QBHP) #1 followed hen. QBHP #1 came out of the street of the floor. QBHP #1 #2 and QBPH #3. QBPH #1				
	and QBPH #3 had the behind their necks an client's legs. The clien three staff members.	e client's arms wrapped and QBPH #2 was holding the not was in the air between the The client's feet were 2. QBPH #1 had the client				
	under the arms and C	QBPH #3 picked up the client was carried through the				
	was asked, "Do you to and Intervention]?" H Manager was asked, CPI?" He stated, "Ab The Unit Manager was	41 p.m., the Unit Manager each CPI [Crisis Prevention le stated, "Yes." The Unit "How long have you taught out three or four years." as asked, "When [QBHP #1] and carried him out of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			С			
		04L107	B. WNG		10/27/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	
YOUTH HOME INC				20400	COLONEL GLENN ROAD	
rou in n	JANE INC			LITTL	E ROCK, AR 72210	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
N 214	Continued From page	. 7	N.	214:		1
	· •	a proper CPI hold? He	14.	2 1 7		
		t Manager was asked,				
		BHP #2] and [QBHP #3]				
		ng [Client #1] in the air and				
	= -	vards the seclusion room,				
	_	hold?" He stated, "No."				1
	The Unit Manager wa	s asked, "What should have				
		ed, "You don't want to lift				
		d. [QBHP #2] and [QBHP				
		nim in the medium or high				
		ed [QBHP #2] could have				
		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 sta	ted, "[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					
						Ì
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."					
	v					





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,

DPSQA/Office of Long Term Care

Saudie Biscifton Administrative Services Manager

Survey and Certification Section

sgb

PRINTED: 12/02/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED	
		04L107	04L107 B. WING			R-C 11/30/2021	
NAME OF PROVIDER OR SUPPLIER YOUTH HOME INC				STREET ADDRESS, CITY, STATE, ZIP 20400 COLONEL GLENN ROAD LITTLE ROCK, AR 72210	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{N 000}	is an official, legal doc remain unchanged ex correction, correction space. Any discrepan citation(s) will be repo Office (RO) for referra Inspector General (Ol information is inadver provider/supplier, the should be notified imm	G) for possible fraud. If tently changed by the State Survey Agency (SA) nediately. ed on November 30, 2021 ed on October 27, 2021. All n corrected, and no new bund. The facility is in	{N 0	00)			

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.