



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

March 15, 2022

Dean Hill, Administrator Delta Family Health And Fitness Center For Children 815 E St Louis Hamburg, AR 71646

#### IMPORTANT NOTICE – PLEASE READ CAREFULLY

Dear Mr. Hill:

On March 10, 2022 the Office of Long Term Care conducted a Complaint survey to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid program. This survey found that your facility was not in compliance with conditions of participation. The facility failed to meet the Condition of Participation for Use of Restraint and Seclusion. Specifically, the facility was not in compliance with the following requirements:

#### N0120 - COVID 19 Vaccination of Facility Staff

The CMS 2567 "Statement of Deficiencies and Plan of Correction" with all deficiencies identified during the complaint survey on March 10, 2022 is enclosed.

#### Remedies

Based on the deficiencies cited, we are recommending to the State Medicaid Agency (SMA) the immediate imposition of the following remedies:

Termination of the provider agreement effective June 8, 2022 if substantial compliance is not achieved by that date.

#### **Plan of Correction**

A Plan of Correction (PoC) must be submitted witin ten (10) calendar days of receipt of the Statement of Deficiencies. It is imperative that an acceptable plan of correction be received by this office by March 25, 2022 to ensure a revisit can be conducted within 45 calendar days of the survey. Termination will take place on June 8, 2022 if compliance is not achieved.

A revisit will be authorized after an acceptable PoC is received. The PoC must be emailed to:

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 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 a 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 deficiency 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 or the requirement for timely submission of an acceptable plan of correction. 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 10<sup>th</sup> Street, Suite 400 Little Rock, AR 72204 Phone: 501-661-2201 Fax: 501-661-2165 ADH.HFS@Arkansas.gov

#### **Appeal Rights**

To appeal a sanction regarding licensure and certification, you or your legal counsel must make a written request to:

# Director Arkansas Department of Human Services P.O. Box 1437, Slot 210 Little Rock, AR 72203-1437

Pursuant to Appendix A of the Long Term Care Provider Manual, the Chairman must receive the request within sixty (60) days of receipt of this letter. The request must state the basis for the appeal with supporting documentation attached.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

If you have any questions, please contact your Reviewer.

Sincerely,

Administrative Services Manager
DPSQA/Office of Long Term Care

Survey & Certification Section

sgb

cc: DRA

PRINTED: 03/15/2022 FORM APPROVED OMB NO. 0938-0391

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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.

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	the Condition of Partitevidenced by the failing procedures related to appropriate intervention the spread of COVID  2. On 3/10/22, at 11: was received from the Assurance] Reporting Safe Practices; QA Moresponse to the COV mandate set forth by [Facility] implemented	tre to implement policy and the vaccination of staff and ons were in place to mitigate 19.  15 a.m., the following policy Administrator: "QA [Quality ore [regarding]: COVID-19 leeting April 28th, 2020; In ID-19 global crisis, and by				
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N 156	that regularly work wi ensure staff who were have been granted ar accommodation as at have a temporary del precautions that are it spread of COVID-19.  3. On 3/10/22, at 8:4 observed wearing mastated, "The majority vaccinated." The Adryou have any medica He stated, "No." Accepted the DON (Director of a.m., the facility had 4:24 staff had been listed.  4. On 3/10/22, at 1:3 was asked, "Is this thinave?" He stated, "Yasked, Are any of you stated, "No." The Adanybody who is unvaried processed. "Seculusion CFR(s): 483.358(j)  The physician or other permitted by the stated restraint or seclusion	authorized by law, or who ay, adhere to additional intended to mitigate the 6 a.m., no staff were asks. The Administrator of our staff have not been ministrator was asked, "Do I or religious exemptions?" ording to a list received from Nursing) on 3/10/22, at 8:50 45 staff members of which ed as vaccinated.  10 p.m., the Administrator was a staff being tested?" He Iministrator was asked, "Is ccinated wearing appropriate 5 masks?" He stated, "No."	N 1	56		

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

March 21, 2022

Dean Hill, Administrator Delta Family Health And Fitness Center For Childre 815 E St Louis Hamburg, AR 71646

Dear Mr. Hill:

On March 10, 2022, 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 April 8, 2022.

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 Biseighten Administrative Services Manager

Survey & Certification Section

sgb

PRINTED: 03/15/2022 FORM APPROVED OMB NO. 0938-0391

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N 000	is an official, legal d remain unchanged of correction, correction space. Any discrepa- citation(s) will be reported from the control of the control information is inadver provider/supplier, the should be notified in	67 (Statement of Deficiencies) ocument. All information must except for entering the plan of a dates, and the signature ancy in the original deficiency ported to the Dallas Regional real to the Office of the OIG) for possible fraud. If ertently changed by the estate Survey Agency (SA) nmediately.	N 000		
N 120	Subpart G - Condit Psychiatric Residen COVID-19 Vaccinat CFR(s): 441.151(c) § 441.151 General (c) COVID-19 Vaccinated facility must develop procedures to ensurvaccinated for COV section, staff are contained to the completion of a primary vaccination completion of a primary is defined a single-dose vaccination.	requirements. cination of facility staff. The county and implement policies and re that all staff are fully ID-19. For purposes of this considered fully vaccinated if it for more since they completed con series for COVID-19. The contract and the administration of the county accinated in the county accination series for done in the administration of the county accination.	N 12	Policy IC35/ Employee Health COVID CO PLAN was developed, approved by leade committee and implemented 3.17.2022 in compliance with N-0120 CMS guideline Covid-19 Health Care Staff Vaccination. All company employees will be inserviced IC35 beginning 3.17.2022 through 3.31.20 company employees will be expected to with policy IC35 or hereby be subjected to IC35 contingency plan regarding failure to Assistant Administrator, Program Director Director of Nursing will be responsible for all company employees receive inservice. Director developed a data base on 3.17.2 vaccintation status of facility staff. The Hur Resource Director will report to Administra Director of Nursing/Infection Control Directo update on current employee complianc POC for N120 will be completed by 4.8.20	rship s for on policy 1022. All omply company comply. and ensuring The HR 1022 to track nan itorand tor weekly e with IC35.

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.

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

Event ID: RT6D11

Facility ID: 3009

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  OF MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
N 120	Continued From pag	e 4	N 120			
	the Condition of Parl evidenced by the fail procedures related to appropriate intervent the spread of COVID 2. On 3/10/22, at 11 was received from the Assurance Reporting Safe Practices; QA I response to the COV mandate set forth by [Facility] implements staff and clients remexposure based on [Governing Body]. It temperature reading building entry by stadily temperature/sy all new admits. 2. It Screening Tool Formpacket 3. Restricted elivery of parcels of place outside and [Facility o	dure to implement policy and to the vaccination of staff and tions were in place to mitigate 0-19.  15 a.m., the following policy me Administrator: "QA [Quality of re [regarding]: COVID-19 Meeting April 28th, 2020; In VID-19 global crisis, and by the [Official's office], and safe practices to ensure all ain safe and secure from the recommendations of the interventions: 1. Mandatory dysymptom check prior to off and clients. 2 [Two] week the motion of Client matted to intake coordinator on of entry into facility for eact. All deliveries are taking facility] staff retrieves and of enough N95 masks for the vent that we experience a fin house. 5. Staff permitted to into minimize any anxieties exposure. 6. Administrative efficials as well as participation conducted by [Governing intation/continuation of medical provider [Physician]				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDIN	IPLE CONSTRUCTION IG	COMPL	(X3) DATE SURVEY COMPLETED C	
		04L112	B. WING_		1	10/2022	
NAME OF PROVIDER OR SUPPLIER  DELTA FAMILY HEALTH AND FITNESS CENTER FOR CHILDRE				STREET ADDRESS, CITY, STATE, ZIP CO 815 E ST LOUIS HAMBURG, AR 71646	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
N 120	that regularly work ensure staff who whave been granted accommodation a have a temporary precautions that a spread of COVID-  3. On 3/10/22, at observed wearing stated, "The majo vaccinated." The you have any medited the pool of the DON (Director a.m., the facility have and the stated, "No." At the DON (Director a.m., the facility have?" He stated asked, "Is thi have?" He stated asked, Are any of stated, "No." The anybody who is upper for example, ORDERS FOR USECLUSION CFR(s): 483.358(  The physician or permitted by the stream of the stated of the stream of the stated o	not address vaccination of staff is with clients in the facility or to were not fully vaccinated, or who dan exemption or as authorized by law, or who delay, adhere to additional re intended to mitigate the 19.  8:46 a.m., no staff were masks. The Administrator rity of our staff have not been Administrator was asked, "Do dical or religious exemptions?" According to a list received from of Nursing) on 3/10/22, at 8:50 ad 45 staff members of which listed as vaccinated.  1:30 p.m., the Administrator she only COVID policy you staff being tested?" He administrator was asked, "Is nvaccinated wearing appropriate N95 masks?" He stated, "No." SE OF RESTRAINT OR		The attending physiciar by the assistant admini 3.17.2022 regarding CN and DFC Policy PC 11 physician signature as after a restraint or seclistic program purchased 3.17.2022 a to expedite physician s	strator on  MS guidelines that require soon as possible usion order. was nd activated ignature as soon		
Anglement of the charge of the	•			as possible as permitte AR.	a by the state of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  IG	СОМР	(X3) DATE SURVEY COMPLETED C	
		04L112	B. WING_		03/	10/2022	
NAME OF PROVIDER OR SUPPLIER  DELTA FAMILY HEALTH AND FITNESS CENTER FOR CHILDRE			STREET ADDRESS, CITY, STATE, ZIP CODE  815 E ST LOUIS  HAMBURG, AR 71646				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	VIDER'S PLAN OF CORRECTION (X5) CORRECTIVE ACTION SHOULD BE COMPLET EFFERENCED TO THE APPROPRIATE DATE DEFICIENCY)		
N 156	This ELEMENT is not Based on record reversal failed to ensure a Phrestraint was signed (Client #1) who was findings are:  Client #1 was admitted diagnoses Depression.  A facility Restrain documented, "MD Place in physical hol aggression. Time In Time Ended: 1710 [5] there was no Physici order, twenty-three corestraint had been in b. On 3/10/22 at 10: Nursing was asked, Physician's order for	of met as evidenced by: view and interview, the facility ysician's order for a physical by the physician for 1 of 1 physically restrained. The  ed on 1/13/22 and had on and Anxiety.  t Order Form dated 2/15/22 [Medical Doctor] Order: d for up to 1 hour for physical itiated: 1700 [5:00 p.m.], 5:10 p.m.]" On 3/10/22 ian signature on the restraint days after the physical	N 1	The assistant administ the attending physicia application and activa Docusign account on The Director of Nursii all nursing staff regar guidelines and DFC p 11 for obtaining physias soon as possible a or seclusion order an Docusign application The attending nurse weach seclusion and rethe physician signatu soon as possible priothe Director of Nursir review.  POC for N156 will be 4.8.2022.	an of Docusign ated physician 3.17.2022.  In the service of the se		





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

April 20, 2022

Dean Hill, Administrator Delta Family Health And Fitness Center For Childre 815 E St Louis Hamburg, AR 71646

Dear Mr. Hill:

During the Revisit survey conducted on April 19, 2022, 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: 04/20/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		04L112	B. WING			R-C <b>04/19/2022</b>	
NAME OF PROVIDER OR SUPPLIER  DELTA FAMILY HEALTH AND FITNESS CENTER FOR CHILDRE				STREET ADDRESS, CITY, STATE, ZIP COI 815 E ST LOUIS HAMBURG, AR 71646	DE	1 04/	13/2022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{N 000}	is an official, legal do remain unchanged excorrection, correction space. Any discreparcitation(s) will be reported (RO) for referral Inspector General (Oinformation is inadverprovider/supplier, the should be notified improvider of the should be notified improvider.  A revisit was conduct deficiencies cited on deficiencies have been noncompliance was from the should be notified in the should be notified i	IG) for possible fraud. If tently changed by the State Survey Agency (SA) mediately.  ed on April 19, 2022 for all March 10, 2022. All en corrected, and no new ound. The facility is in	{N 0				(Ve) PATE

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

E (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.