ARKANSAS DEPARTMENT OF HUMAN SERVICES

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 Deficienicies. 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 10th 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L112	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELTA FAMILY HEALTH AND FITNESS CENTER FOR CHILDRE	815 E ST LOUIS HAMBURG, AR 71646

(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 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 # AR00027919 was unsubstantiated.	N 000		
N 120	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center COVID-19 Vaccination of Facility Staff CFR(s): 441.151(c)(1)-(3)(i)-(x) § 441.151 General requirements. (c) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.	N 120		

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.

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N 120	Continued From page 1 (1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (c)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the center setting and who do not have any direct contact with residents and other staff specified in paragraph (c)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (c)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or	N 120		

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N 120	Continued From page 2 its residents; (iii) A process for ensuring that the facility follows nationally recognized infection prevention and control guidelines intended to mitigate the transmission and spread of COVID-19, and which must include the implementation of additional precautions for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (c)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive	N 120		

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N 120	Continued From page 3 and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (c)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to meet the requirements for Condition of Participation at N120, as evidenced by failure to ensure a policy and procedure related to the vaccination of staff, appropriate interventions were in place to mitigate the spread of COVID-19, and only 53 percent of staff were vaccinated. The findings are:	N 120		

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N 120	Continued From page 4 1. The facility failed to meet the requirements for the Condition of Participation at N120, as evidenced by the failure to implement policy and procedures related to the vaccination of staff and appropriate interventions were in place to mitigate the spread of COVID-19. 2. On 3/10/22, at 11:15 a.m., the following policy was received from the Administrator: "QA [Quality Assurance] Reporting re [regarding]: COVID-19 Safe Practices; QA Meeting April 28th, 2020; In response to the COVID-19 global crisis, and by mandate set forth by the [Official's office], [Facility] implemented safe practices to ensure all staff and clients remain safe and secure from exposure based on the recommendations of the [Governing Body]. Interventions: 1. Mandatory temperature reading/symptom check prior to building entry by staff and clients. 2 [Two] week daily temperature/symptoms check monitoring on all new admits. 2. Implementation of Client Screening Tool Formatted to intake coordinator packet... 3. Restriction of entry into facility for delivery of parcels etc. All deliveries are taking place outside and [Facility] staff retrieves supplies. 4. Stocking of enough N95 masks for employees in the event that we experience a positive COVID 19 in house. 5. Staff permitted to wear PPE [Personal Protective Equipment] at his/her own discretion to minimize any anxieties regarding possible exposure. 6. Administrative contact with state officials as well as participation in conference calls conducted by [Governing Body]. 7. Implementation/continuation of telehealth visits for medical provider [Physician] as well as family e-visits when appropriate/warranted. 8. COVID-19 and Physician Hotline access posted for staff..."	N 120		

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N 120	Continued From page 5 a. The policy did not address vaccination of staff that regularly work with clients in the facility or to ensure staff who were not fully vaccinated, or who have been granted an exemption or accommodation as authorized by law, or who have a temporary delay, adhere to additional precautions that are intended to mitigate the spread of COVID-19. 3. On 3/10/22, at 8:46 a.m., no staff were observed wearing masks. The Administrator stated, "The majority of our staff have not been vaccinated." The Administrator was asked, "Do you have any medical or religious exemptions?" He stated, "No." According to a list received from the DON (Director of Nursing) on 3/10/22, at 8:50 a.m., the facility had 45 staff members of which 24 staff had been listed as vaccinated. 4. On 3/10/22, at 1:30 p.m., the Administrator was asked, "Is this the only COVID policy you have?" He stated, "Yes." The Administrator was asked, Are any of you staff being tested?" He stated, "No." The Administrator was asked, "Is anybody who is unvaccinated wearing appropriate PPE for example, N95 masks?" He stated, "No."	N 120		
N 156	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.	N 156		

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N 156	Continued From page 6 This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Physician's order for a physical restraint was signed by the physician for 1 of 1 (Client #1) who was physically restrained. The findings are: Client #1 was admitted on 1/13/22 and had diagnoses Depression and Anxiety. a. A facility Restraint Order Form dated 2/15/22 documented, "...MD [Medical Doctor] Order: Place in physical hold for up to 1 hour for physical aggression. Time Initiated: 1700 [5:00 p.m.], Time Ended: 1710 [5:10 p.m.]..." On 3/10/22 there was no Physician signature on the restraint order, twenty-three days after the physical restraint had been initiated. b. On 3/10/22 at 10:50 a.m., the Director of Nursing was asked, "Do you have a signed Physician's order for the restraint?" She stated, "No. He was informed, but we have no signed Physician's order."	N 156		

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& 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,

Sandra Broughton
Administrative Services Manager

DPSQA/Office of Long Term Care
Survey & Certification Section

sgb

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

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

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 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 # AR00027919 was unsubstantiated.	N 000		
N 120	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center COVID-19 Vaccination of Facility Staff CFR(s): 441.151(c)(1)-(3)(i)-(x) § 441.151 General requirements. (c) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.	N 120	Policy IC35/ Employee Health COVID CONTROL PLAN was developed, approved by leadership committee and implemented 3.17.2022 in compliance with N-0120 CMS guidelines for Covid-19 Health Care Staff Vaccination. All company employees will be inserviced on policy IC35 beginning 3.17.2022 through 3.31.2022. All company employees will be expected to comply with policy IC35 or hereby be subjected to company IC35 contingency plan regarding failure to comply. Assistant Administrator, Program Director and Director of Nursing will be responsible for ensuring all company employees receive inservice. The HR Director developed a data base on 3.17.2022 to track vaccintation status of facility staff. The Human Resource Director will report to Administratorand Director of Nursing/Infection Control Director weekly to update on current employee compliance with IC35. POC for N120 will be completed by 4.8.2022.	

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

Administrator 3/18/22 — 3/18/22

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N 120	Continued From page 2 its residents; (iii) A process for ensuring that the facility follows nationally recognized infection prevention and control guidelines intended to mitigate the transmission and spread of COVID-19, and which must include the implementation of additional precautions for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (c)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive	N 120		

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N 120	Continued From page 3 and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: (ii) A process for ensuring that all staff specified in paragraph (c)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to meet the requirements for Condition of Participation at N120, as evidenced by failure to ensure a policy and procedure related to the vaccination of staff, appropriate interventions were in place to mitigate the spread of COVID-19, and only 53 percent of staff were vaccinated. The findings are:	N 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L112	A. BUILDING _____ B. WING _____	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 120	Continued From page 4 1. The facility failed to meet the requirements for the Condition of Participation at N120, as evidenced by the failure to implement policy and procedures related to the vaccination of staff and appropriate interventions were in place to mitigate the spread of COVID-19. 2. On 3/10/22, at 11:15 a.m., the following policy was received from the Administrator: "QA [Quality Assurance] Reporting re [regarding]: COVID-19 Safe Practices; QA Meeting April 28th, 2020; In response to the COVID-19 global crisis, and by mandate set forth by the [Official's office], [Facility] implemented safe practices to ensure all staff and clients remain safe and secure from exposure based on the recommendations of the [Governing Body]. Interventions: 1. Mandatory temperature reading/symptom check prior to building entry by staff and clients. 2 [Two] week daily temperature/symptoms check monitoring on all new admits. 2. Implementation of Client Screening Tool Formatted to intake coordinator packet... 3. Restriction of entry into facility for delivery of parcels etc. All deliveries are taking place outside and [Facility] staff retrieves supplies. 4. Stocking of enough N95 masks for employees in the event that we experience a positive COVID 19 in house. 5. Staff permitted to wear PPE [Personal Protective Equipment] at his/her own discretion to minimize any anxieties regarding possible exposure. 6. Administrative contact with state officials as well as participation in conference calls conducted by [Governing Body]. 7. Implementation/continuation of telehealth visits for medical provider [Physician] as well as family e-visits when appropriate/warranted. 8. COVID-19 and Physician Hotline access posted for staff..."	N 120		

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N 120	Continued From page 5 a. The policy did not address vaccination of staff that regularly work with clients in the facility or to ensure staff who were not fully vaccinated, or who have been granted an exemption or accommodation as authorized by law, or who have a temporary delay, adhere to additional precautions that are intended to mitigate the spread of COVID-19. 3. On 3/10/22, at 8:46 a.m., no staff were observed wearing masks. The Administrator stated, "The majority of our staff have not been vaccinated." The Administrator was asked, "Do you have any medical or religious exemptions?" He stated, "No." According to a list received from the DON (Director of Nursing) on 3/10/22, at 8:50 a.m., the facility had 45 staff members of which 24 staff had been listed as vaccinated. 4. On 3/10/22, at 1:30 p.m., the Administrator was asked, "Is this the only COVID policy you have?" He stated, "Yes." The Administrator was asked, Are any of you staff being tested?" He stated, "No." The Administrator was asked, "Is anybody who is unvaccinated wearing appropriate PPE for example, N95 masks?" He stated, "No."	N 120		
N 156	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.	N 156	The attending physician was inserviced by the assistant administrator on 3.17.2022 regarding CMS guidelines and DFC Policy PC 11 that require physician signature as soon as possible after a restraint or seclusion order. The Docusign program was purchased 3.17.2022 and activated to expedite physician signature as soon as possible as permitted by the state of AR.	

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N 156	Continued From page 6 This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Physician's order for a physical restraint was signed by the physician for 1 of 1 (Client #1) who was physically restrained. The findings are: Client #1 was admitted on 1/13/22 and had diagnoses Depression and Anxiety. a. A facility Restraint Order Form dated 2/15/22 documented, "...MD [Medical Doctor] Order: Place in physical hold for up to 1 hour for physical aggression. Time Initiated: 1700 [5:00 p.m.], Time Ended: 1710 [5:10 p.m.]..." On 3/10/22 there was no Physician signature on the restraint order, twenty-three days after the physical restraint had been initiated. b. On 3/10/22 at 10:50 a.m., the Director of Nursing was asked, "Do you have a signed Physician's order for the restraint?" She stated, "No. He was informed, but we have no signed Physician's order."	N 156	The assistant administrator inserviced the attending physician of Docusign application and activated physician Docusign account on 3.17.2022. The Director of Nursing will inservice all nursing staff regarding CMS guidelines and DFC policy PC 11 for obtaining physician signature as soon as possible after a restraint or seclusion order and use of Docusign application by 3.25.2022. The attending nurse will review each seclusion and restraint to ensure the physician signature is attained as soon as possible prior to forwarding to the DIrector of Nursing for compliance review. POC for N156 will be completed by 4.8.2022.	

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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,

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 April 19, 2022 for all deficiencies cited on March 10, 2022. 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.