April 12, 2023

Youth Home, Incorporated
Attn: Beverly Foti, Chief Regulatory Officer
beverly.foti@youthhome.org
20400 Colonel Glen Road
Little Rock, Arkansas 72210

The Division of Provider Services and Quality Assurance of the Arkansas Department of Human Services has contracted with Arkansas Foundation for Medical Care (AFMC) to perform Inspections of Care (IOC) for Inpatient Psychiatric for Under 21. The Medicaid Manual for Inpatient Psychiatric Services for Under Age 21 was used in the completion of this report.

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

Youth Home, Incorporated
Provider ID#: [redacted]
Onsite Inspection Date: April 6, 2023

A summary of the inspection and deficiencies noted are outlined below. The provider must submit a Corrective Action Plan (CAP) designed to correct any deficiency notes in the written report of the IOC. Accordingly, you must complete and submit to AFMC a Corrective Action Plan for each deficiency noted. The Corrective Action Plan must state with the specificity the:

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

The CAP must be completed within 30 calendar days of the date of the email notice of the IOC report at the link provided.

The contractor (AFMC) will:

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

Please see § 160 of the Medicaid Manual for an explanation of your rights to administrative reconsideration and appeal. Additionally, the imposition of this Corrective Action Plan does not prevent the Department of Human Services from prescribing additional remedial actions as may be necessary.

Inspection of Care Summary

Facility Tour:

Upon arrival at the facility, AFMC staff was promptly greeted at the entrance by a Youth Home, Incorporated staff member. AFMC was immediately taken to a conference room where they were met by the Unit Manager. AFMC staff was given the completed and signed consent form listing approval for access to the AFMC portal.

A tour of the facility was completed with the Unit Manager. Several staff members were observed interacting calmly with clients throughout the facility. All clients were in class at the school building. Staff were able to answer questions regarding the facility. There were four dormitories that were toured along with the school building, cafeteria, gymnasium, and outside grounds. The following is a list of environmental observations found during the facility tour.

- Sturgis House had trash scattered throughout the dormitory. Otherwise, there were no concerns noted.
- Chestnut House had trash scattered throughout the dormitory. Otherwise, there were no concerns noted.
- Rose House was clean and well organized. The Carpet in dormitory had recently been replaced with new vinyl flooring two months ago when AFMC was on site. New vinyl flooring was noted to be separating from the subfloor and "bubbling" throughout the building. In the day room the floor has separated to the point the door was hard to open as the vinyl flooring was blocking the door. This was noted as a trip hazard. Facility staff had called the company that had installed the flooring before AFMC staff left.
- Mabee House was clean and well organized. No concerns noted.
- School was in session. The school building was noted to be extremely clean, and classrooms were very well organized. AFMC staff noted one classroom had a staff member that was sitting in the back of the class eating food from an outside restaurant. This was pointed out to the Unit Manager who reported it to the supervisor. The Unit Manager stated they do not allow staff to eat outside food in front of the clients as this can trigger behaviors in the clients since they are not allowed to have food in the classroom or from outside restaurants. No other issues noted during the tour of this building.
- Cafeteria was noted to be extremely clean. No concerns noted.
- Gymnasium was noted to be a very large space and was clean and well organized.
- The outside grounds were noted to be clean and well-manicured. AFMC staff did observe two large trash cans behind the Rose House that had been knocked over with trash and food items scattered across the grounds. This appeared to be from wild animals knocking over the cans.

Facility Review-Policies and Procedures:

Upon review of the site's policies and procedures, the following deficiencies were noted:

Regulation	Deficiency Statement	Reviewer Notes
Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376	HR records did not indicate training in the use of nonphysical intervention skills, such as de-escalation on an annual basis.	The provider lacked evidence that all direct care staff are trained in the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations on an annual basis.
Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376	HR records did not indicate that all direct care personnel have ongoing education, training, and demonstrated knowledge of techniques to identify	The provider lacked evidence that all direct care personnel have ongoing education, training, and demonstrated knowledge of techniques to identify

	staff and resident behaviors that may trigger an emergency safety situation semi-annually.	staff and resident behaviors, events and environmental factors that may trigger emergency safety situations
Medicaid IP Sec. 2; CFR 42 482.130, 483.376	There is no documentation in the HR records that all direct care personnel are trained in facility's Restraint and Seclusion policy.	The provider lacked evidence that all direct care personnel are trained, as well as demonstrate competency, in facility's Restraint and Seclusion policy and appropriate procedures to be used in Restraint and Seclusion interventions.

Personnel Records- Licenses, Certifications, Training:

There was a total of 29 personnel records requested, seven (26%) professional staff and 22 (26%) paraprofessional staff. During the review of the personnel records, the following deficiencies were noted:

Personnel Record Number	Rule	Credential Validated	Outcome	Reviewer Notes
SR013583	Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376	Restraint and Seclusion Training (CPI)	Failed	The last completed annual training was completed on 10/06/2021 and the six-month refresher was last completed on 04/20/2022.

Clinical Summary

As a part of the Quality of Care survey of the IOC, an active Fee for Service (FFS) Medicaid client list was requested, client and/or guardian interviews were conducted, and a clinical record review was completed. There was no active FFS Medicaid clients. The following is a summary of findings and noted deficiencies.

Client/Guardian Interviews:

No active FFS Medicaid clients currently admitted at the time of IOC. Therefore, no client interviews were conducted.

Clinical Record Review Deficiencies:

No active FFS Medicaid clients currently admitted at the time of IOC. Therefore, no clinical records reviewed.

Program Activity/Service Milieu Observation:

During the facility tour, staff and clients were observed in the classroom setting. Staff were calmly interacting and engaged with clients.

Medication Pass:

No active FFS Medicaid clients received medications during medication pass. Due to the observation of non-Medicaid clients not being complaint with the HIPAA minimal necessary rule, no medication pass was observed. AFMC RN visited with the medication nurse who was able to show AFMC RN the facility policies and procedures regarding medication administration, narcotic count/reconciliation/handling, and medication discrepancies. The tour of the medication room was completed with the medication nurse. An open vial of TB skin test was observed in medication refrigerator in nurse's station that was not labeled with date of opening and with nurse's initials.

Corrective Action Plan:

The CAP must be completed within 30 calendar days of the date of the email notice of the IOC report available for review. The IOC Report and Request for Corrective Action can be accessed through the link to AccessPoint, provided via email.

**For more details on the individual related deficiencies, please log into the portal.*

Respectfully,

AFMC Inspection Team
InspectionTeam@afmc.org

1020 W. 4TH ST., SUITE 300
LITTLE ROCK, AR 72201 • afmc.org

- Close Window
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CAP-0007025

Corrective Action Plan Details

CAP Number	CAP-0007025	**Provider Response Due**	
Inspection	DPSQA-0007025	**AFMC Response Due**	
Status	Approved	**Due Date Override**	
Cancellation Reason			
Date Requested	4/18/2023		

CAP Approval Process

Submitted Date	5/10/2023	**Submitted By**	Beverly Foti
CAP Returned Date/Time			
Approved Date	5/16/2023	**Approved By**	Ladeana Bell

Request for Reconsideration

Recon Submitted Date		**Recon Submitted By**	
Recon Reviewed Date/Time		**Recon Reviewed By**	
Revised Report Sent		**Recon Review Results**	

Notes

Provider Overdue ☐

AFMC Overdue ☐

CAP Response Notes

For this CAP:
Of the 5 deficiency areas submitted:
5 plan(s) have been approved as submitted
0 were rejected and will need changes

Outcome: This CAP was Approved.

Overall Feedback:
Thank you for your response.

Timeliness Notes

Next Step: Your CAP has been accepted by AFMC. AFMC recommends you download a copy of your accepted CAP for your records by selecting the Printable View button in the top right-hand corner.

Followup

Require Followup ☐

Followup Date

System Information

Created By	Shelley Ruth, 4/18/2023 3:11 PM	**Last Modified By**	Ladeana Bell, 5/16/2023 8:53 AM

Deficiency Areas

Med Pass/Administration

Origin	**Survey**
Regulation	
Instances	**1**
Corrective Action	**Director of Nursing has secured stickers to place on each box of medication when vials are delivered from the pharmacy with Date Opened and Date Expired listed as a prompt. Training was provided to all nursing staff at the April 18, 2023 Nursing Meeting on proper use of the stickers.**
Person Responsible	**Kara Brooks, Director of Nursing**
Completion Date	**4/18/2023**

Restraint and Seclusion Training (CPI) - IP Acute

Origin	**Credential Validation**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Instances	**1**
Corrective Action	**Training Director discovered that our online training system was kicking team members out of the training plan if their profile was reactivated during a current CPI certification period. This occurred for the one team member who was not current; he left our employ on 6/22 and returned 8/22. The reminder for his annual and semi-annual training was missed. Once the error was discovered, our Training Director found a workaround for those re-hires with current certification periods. It should not occur again.**
Person Responsible	**Livvey Rurup, Training Director**
Completion Date	**4/19/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	**Training Director discovered that our online training system was kicking team members out of the training plan if their profile was reactivated during a current CPI certification period. This occurred for the one team member who was not current; he left our employ on 6/22 and returned 8/22. The reminder for his annual and semi-annual training was missed. Once the error was discovered, our Training Director found a workaround for those re-hires with current certification periods. It should not occur again.**
Person Responsible	**Livvey Rurup, Training Director**
Completion Date	**4/19/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Instances	**1**
Corrective Action	**Training Director discovered that our online training system was kicking team members out of the training plan if their profile was reactivated during a current CPI certification period. This occurred for the one team member who was not current; he left our employ on 6/22 and returned 8/22. The reminder for his annual and semi-annual training was missed. Once the error was discovered, our Training Director found a workaround for those re-hires with current certification periods.**
Person Responsible	**Livvey Rurup, Training Director**
Completion Date	**4/19/2023**

Inspection Elements

Origin	**Survey**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Instances	**1**

Corrective Action	**Training Director discovered that our online training system was kicking team members out of the training plan if their profile was reactivated during a current CPI certification period. This occurred for the one team member who was not current; he left our employ on 6/22 and returned 8/22. The reminder for his annual training was missed. Once the error was discovered, our Training Director found a workaround for those re-hires with current certification periods.**
Person Responsible	**Livvey Rurup, Training Director**
Completion Date	**4/19/2023**

Deficiencies

DEF-0076260

Status	**Accepted**
Related To	**SURVEY-0006311**
Regulation	
Deficiency Statement	**Multi-dose vial facility policy was not followed.**
Service Details	**Multi-dose vial of TB skin test was found opened but not labeled with the date opened and the initials of the nurse who opened vial in the medication room refrigerator of the nurses station in the administration building.**

DEF-0076348

Status	**Accepted**
Related To	**SR013583**
Regulation	**Medicaid IP Sec. 2: 221.804; 42 CFR 482.130, 483.376**
Deficiency Statement	**Failed Validation**
Service Details	**Expired: The last completed annual training was completed on 10/06/2021 and the six month refresher was last completed on 04/20/2022.**

DEF-0076349

Status	**Accepted**
Related To	**SURVEY-0006310**
Regulation	**Medicaid IP Sec. 2; CFR 42 482.130, 483.376**
Deficiency Statement	**There is no documentation in the HR records that all direct care personnel are trained in facility's Restraint and Seclusion policy.**
Service Details	**The provider lacked evidence that all direct care personnel are trained, as well as demonstrate competency, in facility's Restraint and Seclusion policy and appropriate procedures to be used in Restraint and Seclusion interventions.**

DEF-0076350

Status	**Accepted**
Related To	**SURVEY-0006310**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Deficiency Statement	**HR records did not indicate that all direct care personnel have ongoing education, training, and demonstrated knowledge of techniques to identify staff and resident behaviors that may trigger an emergency safety situation semi-annually.**
Service Details	**The provider lacked evidence that all direct care personnel have ongoing education, training, and demonstrated knowledge of techniques to identify staff and resident behaviors, events and environmental factors that may trigger emergency safety situations on a semi-annual basis.**

DEF-0076351

Status	**Accepted**
Related To	**SURVEY-0006310**
Regulation	**Medicaid IP Sec. 2: 221.804; CFR 42 482.130, 483.376**
Deficiency Statement	**HR records did not indicate training in the use of nonphysical intervention skills, such as de-escalation on an annual basis.**
Service Details	**The provider lacked evidence that all direct care staff are trained in the use of nonphysical intervention skills, such as de-escalation, mediation conflict resolution, active listening, and verbal and observational methods, to prevent emergency safety situations on an annual basis.**

CAP History

5/16/2023 8:53 AM

User	**Ladeana Bell**
Action	**Changed Next Step:. Changed Record Type from Submitted to Completed. Changed CAP Response Notes. Changed Approved Date to 5/16/2023. Changed Approved By to Ladeana Bell. Changed Status from Submitted to Approved.**

5/10/2023 11:22 AM

User	**Beverly Foti**
Action	**Changed Submitted Date to 5/10/2023. Changed Submitted By to Beverly Foti. Changed Next Step:. Changed Record Type from Requested to Submitted. Changed Status from Requested to Submitted.**

4/18/2023 3:13 PM

User	**Shelley Ruth**
Action	**Changed Next Step:. Changed Record Type from New to Requested. Changed Date Requested to 4/18/2023. Changed Status from New to Requested.**

4/18/2023 3:11 PM

User	**Shelley Ruth**
Action	**Created.**

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