



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

October 20, 2023

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

Dear Mr. Hill:

On October 11, 2023 a Complaint Investigation 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.

Theresa Forrest, LPN, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
(501) 3206235
email to Theresa.Forrest@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 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 ADH.HFS@Arkansas.gov

If you have any questions, please contact your Reviewer.

Sincerely,

DPSQA/Office of Long Term Care Survey & Certification Section

Lenola Whate, RN

tf

cc: DRA

PRINTED: 10/20/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	04L112		B. WING _	B. WING			C 10/11/2023	
	ROVIDER OR SUPPLIER MILY HEALTH AND FITN	ESS CENTER FOR CHILDRE		STREET ADDR 815 E ST LOU HAMBURG,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
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N 128	is an official, legal doremain unchanged excorrection, correction space. Any discrepancitation(s) will be reported office (RO) for referrations pector General (Oinformation is inadver provider/supplier, the should be notified immall or in part, with definition 1932.	cument. All information must acept for entering the plan of dates, and the signature cy in the original deficiency orted to the Dallas Regional al to the Office of the IG) for possible fraud. If tently changed by the State Survey Agency (SA) mediately. 33 was not in compliance, ciencies cited at N128 and compliance with §483, as of Participation for al Treatment Center.	N.	28				
	This ELEMENT is no Based on record revifailed to ensure a phy implemented without findings are: Review of the Restrait 9/15/2023 for Client #	injury for Client #1. The						
	harm to self or others Client #1 in a physica	A telephone order to place I hold up to one hour for owards staff was initiated at						

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04L112		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	TNESS CENTER FOR CHILDRE		STREET ADDRESS, CITY, STATE, ZIP CO 815 E ST LOUIS HAMBURG, AR 71646			
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N 132	Behavior Managen Interventions repor 8:10 PM Client #1 the face on the cheraised area to the I On 10/9/23 at 2:45 Director of Educati restraint incident on the visible on the face DON stated, "The little to bite. There a scratch. There wis face." The Surveyoprior to the restrain knowledge." On 10/10/23 at 2:1 Client #1 about the He stated, "I got slittle with the visible vis	d at 7:19 PM. d Nurse) Assessment for ment and/or Emergency Safety to dated 9/15/2023 showed at had bruising to the left side of sek area, a cut on his lip and a left side of temple area. p.m., the Surveyor with the on watched the video of the n 9/15/23. The restraint was ideo due to being in the client's 2 a.m., the Surveyor asked the (DON) how Client #1 got the and the cut on his lip. The ip looked like he might have was blood from his ear, it was as a bruise in the crease of his or asked if he had these injuries to the DON stated, "Not to my 7 p.m., the Surveyor asked restraint incident on 9/15/23. Immed. He pushed me and the bed." RESIDENTS	N 1				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER DELTA FAMILY HEALTH AND FITNESS CENTER FOR CHILDRE				STREET ADDRESS, CITY, STATE, ZIP COD 815 E ST LOUIS HAMBURG, AR 71646		10/11/2020		
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N 132	(including any histor abuse). This ELEMENT is r Based on observati interview, the facility	ge 2 ge 2 ge and personal history y of physical or sexual not met as evidenced by: on, record review and failed to ensure a physical in a safe manner for Client	N	32				
	9/15/23 showed Clir physical aggression obtained for a physic	raint Order Form dated at #2 behavior escalated to and a telephone order was cal hold up to 1 hour with a m. and ending at 2:58 p.m.						
	Director of Educatio 9/15/23 incident with showed Behavior Cowho was sitting at a physical contact bet Client #2 occurred, tootact, a desk fell of Coach #2 and Clien Behavior Coach #2 #2 in a physical hold	o.m., the Surveyor with the n watched the video of the n the restraint. The video oach #2 talking with Client #2 desk in a classroom; then ween Behavior Coach #2 and then the two had physical over, and then Behavior t #2 both fell to the ground. was then seen placing Client I. The Director of Education been a little less aggressive.						
	Behavior Coach #3 with Client #2 on 9/1 itself was just awful. over on her way dow							
	Client #2 about the	p.m., the Surveyor asked restraint incident on 9/15/23. e touched me like he was						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) C	(X3) DATE SURVEY COMPLETED		
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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	I	10/11/2023	
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N 132	going to pull me out of wouldn't go. He was y him to quit touching n	of the classroom, but I yanking on my arm. I told ne or I was going to hit him. I when he slammed me into	N 1	32			





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

October 30, 2023

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

Dear Mr. Hill:

On October 11, 2023, we conducted a Complaint Investigation 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 October 27, 2023.

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: Theresa Forrest at 501-320-6235 or email to Theresa.Forrest@dhs.arkansas.gov.

Sincerely,

Theresa Forrest, Reviewer

David E. Miller for

DPSQA/Office of Long Term Care

Survey & Certification Section

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APOC 10/30/2027

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

DM

PRINTED: 10/20/2023 FORM APPROVED OMB NO. 0938-0391

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DELTA FA	MILY HEALTH AND FITN	IESS CENTER FOR CHILDRE		815 E ST LOUIS	40			
				HAMBURG, AR 716	46			
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	is an official, legal do remain unchanged ex correction, correction space. Any discrepar citation(s) will be repr Office (RO) for referral Inspector General (O information is inadventaged.	IG) for possible fraud. If rtently changed by the State Survey Agency (SA)						
	all or in part, with def N132.	333 was not in compliance, iciencies cited at N128 and						
N 128	Subpart G - Condition Psychiatric Residenti PROTECTION OF R CFR(s): 483.356(a)(3 Restraint or seclusion	al Treatment Center. ESIDENTS	N 1	Instructor/Dept of Education Di service to all sta Techniques to u	ne Program Director an rector provided training aff outlining proper CPI use to prevent harm or	and in-		
	This ELEMENT is not Based on record rev failed to ensure a phy implemented without findings are: Review of the Restra 9/15/2023 for Client # to hit staff with a closharm to self or others Client #1 in a physical	ot met as evidenced by: iew and interview, the facility /sical restraint was injury for Client #1. The		team approach, indicate need for interventions us CPI Instructor/E review camera restraint holds proper findings. If any inappropriate or proper cause, the notified by the resuspension of s	aining included emphas circumstances that wo rephysical hold as well sed to prevent physical pept. of Education Directootage for a minimum per week and document restraint hold is found a restraint is initiated the licensing unit will be next day as well as tempt at a red and decisive discipletermined.	ould as hold. ctor will of 3 t to be without porary in-		
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	ROVIDER OR SUPPLIER MILY HEALTH AND FITN	ESS CENTER FOR CHILDRE		8-	TREET ADDRESS, CITY, STATE, ZIP CODE 15 E ST LOUIS AMBURG, AR 71646		
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N 128	Behavior Managemer Interventions report d 8:10 PM Client #1 had the face on the cheek raised area to the left On 10/9/23 at 2:45 p.i Director of Education restraint incident on 9	t 7:19 PM. Nurse) Assessment for and/or Emergency Safety ated 9/15/2023 showed ated bruising to the left side of area, a cut on his lip and a	N	128	cont'd from page 1 The documentation of these footage revishall be kept by DFC and provided to the Licensing Specialist by the last day of emonth until licensing unit determines desis corrected and goal of 100% complianmet for 4 consecutive months.	e ach ficiency	10/27/2023
	On 10/10/23 at 9:22 a Director of Nursing (D bruising to the face ar DON stated, "The lip I tried to bite. There was a scratch. There was face." The Surveyor a	i.m., the Surveyor asked the ON) how Client #1 got the od the cut on his lip. The cooked like he might have solved from his ear, it was a bruise in the crease of his sked if he had these injuries the DON stated, "Not to my					
N 132	Client #1 about the re He stated, "I got slam threw me up on the be PROTECTION OF RE CFR(s): 483.356(b) Emergency safety inte safety intervention mu manner that is safe, p appropriate to the sev	ervention. An emergency list be performed in a roportionate, and erity of the behavior, and bogical and developmental	N	132	On 9.20.2023 the Program Director and Instructor/Dept of Education Director provided training a service to all staff outlining proper CPI Techniques to use to prevent harm or in client. The training included emphasis o approach, circumstances that would ind need for physical hold as well as interve used to prevent physical hold. CPI Instructor/Dept. of Education Director	ijury to n team icate entions	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
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	(including any histo abuse). This ELEMENT is a Based on observatinterview, the facility hold was performed #2. The findings are A review of the Ress 9/15/23 showed Clir physical aggression obtained for a physistart time of 2:40 p.1 On 10/9/23 at 2:45 p. Director of Educatio 9/15/23 incident with showed Behavior Cowho was sitting at a physical contact beto Client #2 occurred, to contact, a desk fell of Coach #2 and Client #2 in a physical hold said "He could have On 10/10/23 at 2:05 Behavior Coach #3 awith Client #2 on 9/1 itself was just awfullover on her way downeds.	n; and personal history ry of physical or sexual not met as evidenced by: ion, record review and y failed to ensure a physical in a safe manner for Client e: traint Order Form dated nt #2 behavior escalated to and a telephone order was cal hold up to 1 hour with a m. and ending at 2:58 p.m. o.m., the Surveyor with the n watched the video of the n the restraint. The video cach #2 talking with Client #2 desk in a classroom; then ween Behavior Coach #2 and then the two had physical over, and then Behavior t #2 both fell to the ground. was then seen placing Client I. The Director of Education been a little less aggressive. p.m., the Surveyor asked about the restraint incident 5/23. She stated, "The hold Her face hit the desk. It fell yn."	N 132		ent to be without porary in- blinary eviews he each	10/27/2023
	Client #2 about the r	p.m., the Surveyor asked estraint incident on 9/15/23. touched me like he was				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04L112		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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N 132	going to pull me out o wouldn't go. He was y him to quit touching m	f the classroom, but I ranking on my arm. I told ne or I was going to hit him. I rhen he slammed me into	N	132				





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

December 13, 2023

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

Dear Mr. Hill:

During the Revisit survey conducted on December 13, 2023, your facility was found to be in compliance with program requirements. **Please email the signed CMS 2567 to:**Theresa.Forrest@dhs.arkansas.gov.

If you have any questions, please contact your reviewer: Theresa Forrest at 501-320-6235 or email to Theresa.Forrest@dhs.arkansas.gov.

Sincerely,

DPSQA/Office of Long Term Care Survey and Certification Section

Lenola Whate, RN

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PRINTED: 12/13/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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