



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

January 4, 2024

Craig Gammon, Administrator United Methodist Childrens Home 2002 S Fillmore St Little Rock, AR 72214-4848

Dear Mr. Gammon:

On December 21, 2023 a Recertification 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, Reviewer OLTC, Survey & Certification Section PO Box 8059, Slot S404 Little Rock, AR 72201-4608 (501) **320-6235** 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 <u>ADH.HFS@Arkansas.gov</u>

If you have any questions, please contact your Reviewer.

Sincerely,

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DPSQA/Office of Long Term Care Survey & Certification Section

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cc:

DRA

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	D. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		04L106	B. WING			12/	21/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
	IETHODIST CHILDRENS	НОМЕ			2002 S FILLMORE ST			
				L	LITTLE ROCK, AR 72214			
(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 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
N 000	Initial Comments		N	000				
N 127	is an official, legal door remain unchanged ex- correction, correction space. Any discrepan- citation(s) will be repo- Office (RO) for referra- Inspector General (O information is inadver provider/supplier, the should be notified imm A validation survey wi 12/18/2023 through 1 The facility was not in Subpart G - Condition Psychiatric Residentia PROTECTION OF RI CFR(s): 483.356(a)(2 An order for restraint written as a standing basis. This ELEMENT is no Based on record revi- failed to ensure a phy restraint was received The findings were: Client #5 had diagnos Dysregulation Disorda	IG) for possible fraud. If tently changed by the State Survey Agency (SA) mediately. as conducted from 2/21/2023. a compliance with §483, as of Participation for al Treatment Center. ESIDENTS b) or seclusion must not be order or on an as-needed of the met as evidenced by: iew and interview, the facility visician's order for a physical d for 1 (Client #5) of 1 client. ses of Disruptive Mood er, Attention Deficit r (ADHD) and Child Physical	N	127				
		SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE	

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

(X6) DATE

PRINTED: 01/04/2024

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.

	S FOR MEDICARE &			E CONSTRUCTION		O. 0938-03	
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED	
		04L106	B. WING		12	2/21/2023	
IAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	θE		
JNITED M	IETHODIST CHILDRENS	вноме	2002 S FILLMORE ST LITTLE ROCK, AR 72214				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
N 127	Continued From pag	e 1	N 127	7			
	A Nursing Progress r	note dated 10/31/23 revealed					
	Client #5 was placed						
		[4:38 PM]" The Seclusion Dated 10/31/2023 at 04:38					
		#5 was placed in a restraint.					
	During record review	, no physician orders were					
	found for physical res						
	On 12/21/2023 at 1:1	15 PM, the Surveyor					
		ian orders for the restraint on					
	On 12/21/2023 at 1:5	53 PM, the Nurse Manager					
	-	ot a physician's order for the					
		or asked the Nurse Manager ed to be orders for any type					
		se Manager stated, "Yes."					
	A policy provided by						
		AM revealed, "Subject: se of Personal or Chemical					
		on" with an effective date of					
		nted, "Section J Orders: 1.					
	-	usion procedure must be					
	-	pursuant to an order from the					
		who is primarily responsible of the resident served6.					
		but no longer than one hour					
		restraint or seclusion, a					
		otifies and obtains an order					
		nd, 2. Writes the time/date,					
	order and who received and seclusion form	/ed the order on the restraint "					
N 142			N 142				
11 172	SECLUSION			-			
	CFR(s): 483.358(c)						

Facility ID: 3005

If continuation sheet Page 2 of 6

						IO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		04L106	B. WING		1	2/21/2023	
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
	IETHODIST CHILDRENS	НОМЕ		2002 S FILLMORE ST LITTLE ROCK, AR 72214			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
N 142	A physician or other I permitted by the state restraint or seclusion restrictive emergency most likely to be effe- emergency safety sit with staff. This ELEMENT is no Based on record rev failed to ensure an of chemical restraints w time for 3 (Clients #1 findings are: 1. Client #1 had diag Dysregulation Disord Disorder, Schizophre Deficit Hyperactivity I Disorder and Child N a. The Seclusion and 11/13/2023 revealed "11/13/2023 o2:05 PI The personal restrain minutes. A chemical on "11/13/2023 02:05 progress note "Zypre [intramuscularly] and documented as giver b. The Seclusion and 11/07/2023 revealed "11/07/2023 revealed "11/07/2023 revealed "11/07/2023 revealed	icensed practitioner e and the facility to order must order the least / safety intervention that is ctive in resolving the uation based on consultation of met as evidenced by: iew and interview, the facility rder for physical and rere not received at the same , #2 and #5) clients. The nosis of Disruptive Mood er, Reactive Attachment mia Spectrum, Attention Disorder, Autism Spectrum eglect. I Restraint Order form dated date and time order received M" for the personal restraint. th had a duration of "4" restraint order was received 5 PM" Medication per nursing xa 5 mg [milligrams] IM Benadryl 50 mg IM" were	N 142				

Facility ID: 3005

If continuation sheet Page 3 of 6

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/04/2024 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		04L106	B. WING			12/	21/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UNITED M	IETHODIST CHILDRENS	НОМЕ			2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
N 142	and Benadryl 50 mg x c. The Seclusion and 10/10/2023 revealed of received, "10/10/2023 restraint. A chemical r on "10/10/2023 01:50 nursing progress note Benadryl 25 mg x 1 w d. The Seclusion and 10/09/2023 was reviet time order received "1 the personal restraint. a duration of "7" minu order was received or Medication given per "Zyprexa 5 mg IM and given. e. The Seclusion and 10/03/2023 was reviet time order received "1 the personal restraint. a duration of "1" minu order was received or Medication given per "Zyprexa 5 mg IM and given. f. The Seclusion and I 10/02/2023 was reviet time order received "1 the personal restraint. a duration of "1" minu order was received or Medication given per "Zyprexa 5 mg IM and given.	k [times] 1 was given. Restraint Order form dated date and time order 3 01:50 PM" for the personal restraint order was received PM" Medication given per a "Zydis 5 mg x 1 and vas given. Restraint Order form dated wed and revealed date and 10/09/2023 09:22 AM" for . The personal restraint had tes. A chemical restraint n "10/09/2023 09:22 AM" nursing progress note d Benadryl 50 mg IM was Restraint Order form dated wed and revealed date and 10/03/2023 09:00 AM" for . The personal restraint had tes. A chemical restraint n "10/03/2023 09:00 AM" for . The personal restraint had tes. A chemical restraint n "10/03/2023 09:00 AM" nursing progress note d Benadryl 50 mg IM was Restraint Order form dated wed and revealed date and 10/02/2023 04:00 PM" for . The personal restraint had tes. A chemical restrain	N	142			

If continuation sheet Page 4 of 6

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		04L106	B. WING			12/	21/2023
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNITED N	IETHODIST CHILDRENS	НОМЕ			002 S FILLMORE ST ITTLE ROCK, AR 72214		
(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 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 142	g. The Seclusion and 9/27/2023 was review time order received "S personal restraint. Th duration of "9" minute was received on "9/2". Medication given per "Zyprexa 5 mg and B h. On 12/19/2023 at 7 Manager was asked to chemical restraint phy She confirmed that the personal restraint and received at the same 2. Client #2 had diagr Disorder, Disruptive In Disorder, Borderline I History of Physical At a. The Seclusion and 10/11/2023 revealed "10/11/2023 revealed of "10/11/2023 at 05:22 restraint. A chemical on "10/11/2023 at 05:22 restraint. A chemical on "10/11/2023 revealed of "3. Client #5 had diagr Dysregulation Disorder psychological and ses a. The Seclusion and 09/28/2023 revealed received, "09/28/2023 personal restraint. A or received on "09/28/2023 per nursing progress	Restraint Order form dated ved and revealed date and 0/27/2023 09:10 AM" for the e personal restraint had a ves. A chemical restraint order 7/2023 09:10 AM" nursing progress note enadryl 50 mg was given. 11:45 AM, the Nurse to review the physical and visician's orders for Client #1. e above listed orders for d a chemical restraint were time. nosis of Reactive Attachment mpulse Control, Bipolar ntellectual Functioning and buse and Neglect. Restraint Order form dated date and time order received PM" for the personal restraint order was received 22 PM" Medication per e "Zyprexa 5 mg IM and vere documented as given. noses of Disruptive Mood er, Child physical, xual abuse. Restraint Order form dated date and time order	N	142			

Facility ID: 3005

If continuation sheet Page 5 of 6

PRINTED: 01/04/2024

	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/04/2024 M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		04L106	B. WING	·		12	/21/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	IETHODIST CHILDRENS	HOME			2002 S FILLMORE ST LITTLE ROCK, AR 72214		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
N 142	Continued From page	• 5	N	142	2		
	12/18/2023 at 11:35 A Procedures for the us Restraints & Seclusio "June 2000" Section I of personal restraint r justification. The ratio address and identify t interventions that wer restrictive intervention de-escalation. time-ou teaching. allowing the feelings, decrease sti removing other reside restraint or seclusion and continued pursua attending physician w for the ongoing care of As soon as possible, after the initiation of ru licensed nurse. 1. No from the physician an	e attempted and failed. Less a would include verbal ut. prompts, preventive e resident to verbalize muli in the environment by ents J. Orders: 1. Any procedure must be used unt to an order from the tho is primarily responsible of the resident served 6. but no longer than one hour estraint or seclusion, a tifies and obtains an order d, 2. Writes the time/date, ed the order on the restraint					

If continuation sheet Page 6 of 6





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

January 25, 2024

Craig Gammon, Administrator United Methodist Childrens Home 2002 S Fillmore St Little Rock, AR 72214-4848

Dear Mr.. Gammon:

On December 21, 2023, we conducted a Recertification 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 January 16, 2024.

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,

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Theresa Forrest, Reviewer DPSQA/Office of Long Term Care Survey & Certification Section

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		ID HUMAN SERVICES		I	NTED: 01/04/2024 FORM APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION (X3)	B NO. 0938-0391 DATE SURVEY COMPLETED
		04L106	B. WING		12/21/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UNITED M	IETHODIST CHILDRENS	HOME		2002 S FILLMORE ST LITTLE ROCK, AR 72214	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments		N 000		1
N 127	is an official, legal door remain unchanged ex- correction, correction space. Any discrepar- citation(s) will be repor- Office (RO) for referra- Inspector General (O information is inadver provider/supplier, the should be notified imm A validation survey w 12/18/2023 through 1 The facility was not in Subpart G - Condition Psychiatric Residentia PROTECTION OF RI CFR(s): 483.356(a)(2 An order for restraint written as a standing basis. This ELEMENT is no Based on record revi- failed to ensure a phy restraint was received The findings were: Client #5 had diagnos Dysregulation Disord	IG) for possible fraud. If tently changed by the State Survey Agency (SA) mediately. as conducted from 2/21/2023. a compliance with §483, as of Participation for al Treatment Center. ESIDENTS) or seclusion must not be order or on an as-needed at met as evidenced by: ew and interview, the facility resician's order for a physical d for 1 (Client #5) of 1 client. ess of Disruptive Mood er, Attention Deficit r (ADHD) and Child Physical	N 127	Corrective Action: The policy and procedure in place already require orders to be obtained for any restraint. Upon being notified of the deficiency in this area additional monitoring steps were put in place to insure that he policy is followed. All clients could potentiall be effected by this issue so all clients have been included in the corrective response. All cases were reviewed and no additional negating findings were identified. The Nurse Manager responsible for checking that orders are obtained for all restraints and seclusions and now checks these twice weekly for complian The residential treatment center (RTC) prog- has now enlisted the assistance of the health information management (HIM) department, monitor the completion of seclusion and rest documentation (S&R's) and physician orders as well, and the results of these audits are reported to administration. The Nurse Manag- now reports on the accuracy of S&Rs includid completed orders, at the bi-monthly Department Head Meetings. The Nurse Manag- reports (CIR's) and data collected by the RT Office Manager. Person Responsible: RTC Nurse Manager with the assistance of the HIM department in conducting audits of order accuracy and completion.	tive is 1-16-24 ce. ram to raint ger ng ager t C
LABORATORY	 DIRECTOR'S OR PROVIDER/\$	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	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.

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING		1	2/21/2023	
AME OF PI	ROVIDER OR SUPPLIER	•	s	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
INITED M		S HOME		002 S FILLMORE ST ITTLE ROCK, AR 72214			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE		(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETIO	
N 127	Continued From pag	je 1	N 127				
		note dated 10/31/23 revealed					
	and Restraint Form	[4:38 PM]" The Seclusion Dated 10/31/2023 at 04:38 #5 was placed in a restraint.					
	During record reviev	v, no physician orders were					
	found for physical re						
		15 PM, the Surveyor cian orders for the restraint on urse Manager.					
	reported there was r restraint. The Surve if there were suppos	53 PM, the Nurse Manager not a physician's order for the yor asked the Nurse Manager ed to be orders for any type se Manager stated, "Yes."					
	A policy provided by 12/18/2023 at 11:35 Procedures for the u Restraints & Seclusi "June 2000" docume	the Administrator on AM revealed, "Subject: ise of Personal or Chemical on" with an effective date of ented, "Section J Orders: 1. usion procedure must be					
	used and continued attending physician for the ongoing care As soon as possible after the initiation of licensed nurse. 1. N	pursuant to an order from the who is primarily responsible of the resident served6. , but no longer than one hour restraint or seclusion, a otifies and obtains an order					
	order and who recei and seclusion form.						
N 142	ORDERS FOR USE SECLUSION CFR(s): 483.358(c)	OF RESTRAINT OR	N 142				

Facility ID: 3005

If continuation sheet Page 2 of 6

PRINTED: 01/04/2024 FORM APPROVED

	S FOR MEDICARE &					0.0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMF	LETED	
		04L106	B. WING		12/	21/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	IETHODIST CHILDRENS	НОМЕ		2002 S FILLMORE ST LITTLE ROCK, AR 72214			
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
N 142	A physician or other I permitted by the state restraint or seclusion restrictive emergency most likely to be effect	icensed practitioner e and the facility to order must order the least v safety intervention that is	N 14	2 Corrective Action: Upon notification of the deficiency nurses	s were educated to		
	Based on record rev failed to ensure an or chemical restraints w time for 3 (Clients #1, findings are: 1. Client #1 had diage Dysregulation Disord Disorder, Schizophre Deficit Hyperactivity ID Disorder and Child N a. The Seclusion and 11/13/2023 revealed "11/13/2023 o2:05 PN The personal restrain minutes. A chemical for on "11/13/2023 02:05 progress note "Zypre [intramuscularly] and documented as given b. The Seclusion and 11/07/2023 revealed "11/07/2023 revealed "11/07/2023 o9:57 AN The personal restrain minute. A chemical restrain minute. A chemical restrain	ere not received at the same , #2 and #5) clients. The hosis of Disruptive Mood er, Reactive Attachment nia Spectrum, Attention Disorder, Autism Spectrum eglect. Restraint Order form dated date and time order received A" for the personal restraint. t had a duration of "4" restraint order was received b PM" Medication per nursing xa 5 mg [milligrams] IM Benadryl 50 mg IM" were		ensure that no simultaneous orders for p chemical restraints are obtained. This de potentially impact all clients, so all currer reviewed and no additional negative find Nursing staff are required to indicate that measures have been attempted and faile supporting documentation specified on th Restraint Form. The less restrictive meas are not limited to verbal de-escalation, pr self-time-out, removing other residents fr decrease stimuli, preventative teaching, r resident to verbalize feelings. The Nurse Manager is now responsible f the orders for physical and chemical rest been received simultaneously. The Nurs reports on the accuracy of orders for resi regard to the timing requirements in bi-m Head Meetings. Education and training of also included in on the job orientation tra discussed within in-service trainings per Person Responsible: RTC Nurse Manager	hysical and ficiency could it client cases were ings were identified. t less restrictive ed within the ne Seclusion and sures include, but ompts for a om the area to and allowing the for monitoring that raints have not se Manager also rraints and with onthly Department on this issue is now aining and taining to orders.	1-16-24	

If continuation sheet Page 3 of 6

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/04/2024 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		04L106	B. WING			12/	21/2023
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UNITED M	IETHODIST CHILDRENS	НОМЕ			002 S FILLMORE ST ITTLE ROCK, AR 72214		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 142	and Benadryl 50 mg x c. The Seclusion and 10/10/2023 revealed of received, "10/10/2023 restraint. A chemical r on "10/10/2023 01:50 nursing progress note Benadryl 25 mg x 1 w d. The Seclusion and 10/09/2023 was reviet time order received "1 the personal restraint. a duration of "7" minu order was received or Medication given per "Zyprexa 5 mg IM and given. e. The Seclusion and 10/03/2023 was reviet time order received "1 the personal restraint. a duration of "1" minu order was received or Medication given per "Zyprexa 5 mg IM and given. f. The Seclusion and I 10/02/2023 was reviet time order received "1 the personal restraint. a duration of "1" minu order was received or Medication given per "Zyprexa 5 mg IM and given.	k [times] 1 was given. Restraint Order form dated date and time order 3 01:50 PM" for the personal restraint order was received PM" Medication given per a "Zydis 5 mg x 1 and vas given. Restraint Order form dated wed and revealed date and 10/09/2023 09:22 AM" for . The personal restraint had tes. A chemical restraint n "10/09/2023 09:22 AM" nursing progress note d Benadryl 50 mg IM was Restraint Order form dated wed and revealed date and 10/03/2023 09:00 AM" for . The personal restraint had tes. A chemical restraint n "10/03/2023 09:00 AM" for . The personal restraint had tes. A chemical restraint n "10/03/2023 09:00 AM" nursing progress note d Benadryl 50 mg IM was Restraint Order form dated wed and revealed date and 10/02/2023 04:00 PM" for . The personal restraint had tes. A chemical restrain	N	142			

If continuation sheet Page 4 of 6

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	
		04L106	B. WING			12/	21/2023
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
	IETHODIST CHILDRENS	НОМЕ			002 S FILLMORE ST ITTLE ROCK, AR 72214		
(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 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
N 142	g. The Seclusion and 9/27/2023 was review time order received "S personal restraint. Th duration of "9" minute was received on "9/2". Medication given per "Zyprexa 5 mg and B h. On 12/19/2023 at 7 Manager was asked to chemical restraint phy She confirmed that the personal restraint and received at the same 2. Client #2 had diagr Disorder, Disruptive In Disorder, Borderline I History of Physical At a. The Seclusion and 10/11/2023 revealed "10/11/2023 revealed of "10/11/2023 at 05:22 restraint. A chemical on "10/11/2023 at 05:22 restraint. A chemical on "10/11/2023 revealed of "3. Client #5 had diagr Dysregulation Disorder psychological and ses a. The Seclusion and 09/28/2023 revealed received, "09/28/2023 personal restraint. A or received on "09/28/2023 per nursing progress	Restraint Order form dated ved and revealed date and 0/27/2023 09:10 AM" for the e personal restraint had a ves. A chemical restraint order 7/2023 09:10 AM" nursing progress note enadryl 50 mg was given. 11:45 AM, the Nurse to review the physical and visician's orders for Client #1. e above listed orders for d a chemical restraint were time. nosis of Reactive Attachment mpulse Control, Bipolar ntellectual Functioning and buse and Neglect. Restraint Order form dated date and time order received PM" for the personal restraint order was received 22 PM" Medication per e "Zyprexa 5 mg IM and vere documented as given. noses of Disruptive Mood er, Child physical, xual abuse. Restraint Order form dated date and time order	N	142			

Facility ID: 3005

If continuation sheet Page 5 of 6

PRINTED: 01/04/2024

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/04/2024 MAPPROVED D. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		04L106	B. WING			12/21/2023		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
	IETHODIST CHILDRENS	НОМЕ			002 S FILLMORE ST .ITTLE ROCK, AR 72214			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
N 142	Continued From page	5	N	142				
	12/18/2023 at 11:35 A Procedures for the us Restraints & Seclusio "June 2000" Section I of personal restraint r justification. The ratio address and identify t interventions that wer restrictive intervention de-escalation. time-ou teaching. allowing the feelings, decrease sti removing other reside restraint or seclusion and continued pursua attending physician w for the ongoing care of As soon as possible, after the initiation of ru licensed nurse. 1. No from the physician an	e attempted and failed. Less a would include verbal ut. prompts, preventive e resident to verbalize muli in the environment by ents J. Orders: 1. Any procedure must be used ant to an order from the tho is primarily responsible of the resident served 6. but no longer than one hour estraint or seclusion, a tifies and obtains an order d, 2. Writes the time/date, ed the order on the restraint						

If continuation sheet Page 6 of 6





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

March 4, 2024

Craig Gammon, Administrator United Methodist Childrens Home 2002 S Fillmore St Little Rock, AR 72214-4848

Dear Mr.. Gammon:

During the Revisit survey conducted on February 21, 2024, your facility was found to be in compliance with program requirements. Please email the signed CMS 2567 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,

Lenda Whate, RN

DPSQA/Office of Long Term Care Survey and Certification Section

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SIATEMAN OF CRETCHORS (M) REVURBENSUMPLEX COLUMETER CONSTRUCTION (M) COMPLETER (M) COMPLETER <th colspan="5"></th> <th>FORM APPROVE OMB NO. 0938-03</th> <th></th>						FORM APPROVE OMB NO. 0938-03		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING COMMETTED NAE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE R UNITED METHODIST CHILDRENS HOME STREET ADDRESS, CITY, STATE, 2P CODE COMMETTED PRETX SUMMAY STATELENT OF DEFICIENCES STREET ADDRESS, CITY, STATE, 2P CODE COMMETTED PRETX SUMMAY STATELENT OF DEFICIENCES ITTLE ROCK, AR 72214 COMMETTED PRETX REQUILIDENCY INCLINENTING INFORMATION ID PRETX COMMETTED YM000 Initial Comments (N 000) Initial Comments (N 000) Note: The CMS-2567 (Slatement of Deficiencies) is an official, legal document, All information must remain unchange decept for entering the plan of correction, correction, dates, and the signature space. Any discrepting the plan of correction, correction dates, and the signature space. Any discrepting the plan of correction, correction dates, and the signature space. Any discrepting the plan of correction, correction dates, and the signature space. Any discrepting the plan of correction, correction for Psychiatric Residential Treatment Center. (N 000)								
Out of PROVIDER OR SUPPLIER Difference						COMPLETED		
UNITED METHODIST CHILDRENS HOME 2002 S FILLINDRE ST LITTLE ROCK, AR 72214 PREFIX TAG SIMMARY STATEMENT OF DEFICIENCIES (ROUNDERS FLANOF CORRECTION (ROUNDERS FLANOF (ROUNDERS FLANOF CORRECTI			04L106	B. WING				
UNITED METHODIST CHILDRENS HOME LITTLE ROCK, AR 72214 (p4) ID TWETTX ISJUMARY STATEMENT OF DEFICIENCIES ISJUM REVISION WIST BEREPOED BY FULL RESULATORY OR LSC DENTIFYING IMPORTATION) IPERT TWE IPERVISION CONSIGNATION OF DEFICIENCIES ISJUM REVISION WIST BEREPOED BY FULL RESULATORY OR LSC DENTIFYING IMPORTANTION) IPERT TWE IPERVISION CONSIGNED AND DE CROSS-REFERENCE ON OF A MARGOPRATE DEFICIENCY Optimized CROSS-REFERENCE ON OF A MARGOPRATE DEFICIENCY Optimized CROSS-REFERENCE DEFICIENCY	NAME OF PI	ROVIDER OR SUPPLIER		STE	REET ADDRESS, CITY, STATE, ZIP CODE			
PREFIX TXG CEACH OBFICIENCY MUST BE PRECEDED BY FULL RECULTORY OR LSC IDENTIFYING INFORMATION) PREFX TXG CEACH OBFICITIES ACTION SHOULD BE DEFICIENCY) CEACH OBFICITIES ACTION SHOULD BE DEFICIENCY) (N 000) Initial Comments (N 000) 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 (RO) for poschiatric Residential Treatment Center. The facility was in compliance with \$483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center. Image: Compliance with \$483, Subpart G - Conditions of Participation for Psychiatric	UNITED METHODIST CHILDRENS HOME							
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 referal 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. The facility was in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	ON SHOULD BE COMPLETION HE APPROPRIATE DATE		
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 (OG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The facility was in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.	{N 000}	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)		{N 000}				
G - Conditions of Participation for Psychiatric Residential Treatment Center.								
		G - Conditions of Par	ticipation for Psychiatric					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE				2E	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.

PRINTED: 03/04/2024

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