ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

December 6, 2023

David Napier, Administrator
Youth Home Inc
20400 Colonel Glenn Road
Little Rock, AR 72210-5323

Dear Mr. Napier:

On November 28, 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 your receipt of the Statement of Deficiencies. Failure to submit a POC may result in termination. Include a completion date for each deficiency 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 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 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,

Lynda White, RN

DPSQA/Office of Long Term Care
Survey & Certification Section

tf

cc: DRA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L107	A. BUILDING _____ B. WING _____	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUTH HOME INC	20400 COLONEL GLENN ROAD LITTLE ROCK, AR 72210

(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 #AR00031282 was not in compliance, all or in part, with deficiencies written at N132 and N172. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.	N 000		
N 132	PROTECTION OF RESIDENTS CFR(s): 483.356(b) Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse). This ELEMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a restraint was conducted in a safe and appropriate manner to	N 132		

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

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N 132	Continued From page 1	N 132		

prevent potential injury for 1 (Client #1).

The findings are:

1. Client #1, had diagnoses of "Reactive Attachment Disorder and Disruptive Mood Dysregulation Disorder.

a. An Incident Report, provided by the Record Compliance Officer, on 10/25/2023, listed the complaint as "Personal Restraints, Locked Seclusion, Aggressiveness to Staff and Peers, Injury to Staff, Threat to Safety, and Property Destruction." Also described Resident being rude, hid in closet, refused medications, flipped over furniture, personal restraint, placed in seclusion, broke peers cup, exposed sharp plastic edges, spiting, scratching staff, after banging her head on walls and front window of seclusion room. RN (Registered Nurse) assessment noted after the incident. Resident reported small abrasion on her palm side next to her thumb from the restraint, petechiae around her eyes and cheeks that were not observed on 10/25/2023. A hotline report was made. The resident was ordered for further evaluation at ER (Emergency Room) on 10/26/2023 for petechia rash, on her face and headache, knee pain with a diagnosis of concussion. Resident was placed on activity limit for three (3) days.

b. An interview with Chief Clinical Officer on 11/27/2023 at 1:30 PM, stated that QBHP (Qualified Behavioral Health Provider) #1 had been let go because, "Video footage showed [QBHP #1] had initiated a one-person restraint, jerking patient and had shoved her into seclusion. Without ensuring that the room was free of hazards or other occupants."

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N 132	Continued From page 2	N 132		

c. Physician Orders dated 10/25/2023, at 8:06 PM, read in part, "...Place in locked seclusion for up to 60 minutes until calm and cooperative and no longer a threat to safety."

d. On 11/27/2023, at 1:35 PM, a telephone interview was conducted with RN #1. She stated, "The resident refused her medication, by slamming her door, and had stepped away for three minutes. Upon returning, she heard resident screaming and being escorted to the seclusion room by [QBHP #1]." In response to the question, "What did you observe?" RN #1 stated, "Resident had picked up a water bottle, left by another resident, and was banging it on the glass, banging her head on the floor. There were three, [QBHP #1], [QBHP #2], and [QBHP #3] holding her on the floor. I got a pillow for her head and then she agreed to stop and went to the comfort room, refused treatment. The resident went to the hospital the next day."

e. During a lap top video review on 11/27/2023 at 1:50 PM with the Unit Manager #1, he stated that Client #1 on 10/25/2023 at 8:05 PM, had walked into the day room, and knocked over two chairs. "[QHBP #1] aggressively took the resident to the seclusion room, locked the door as [QHBP #2] escorted another resident out of the open seclusion room leaving the plastic empty water bottle. Then from 8:06 PM to 8:10 PM, the resident continued to loudly scream and break the plastic bottle into small pieces, hitting it on the walls, camera, and the front window of the room as well as banging her head on walls. At 8:10 PM, [QHBP #1] with two other employees came into the room, subdued the resident by holding arms and legs. [RN #1] began to remove shards of the

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N 132	Continued From page 3	N 132		

plastic water bottle." In response to the question "What was wrong with the restraints?" Unit Manager #1 stated "He snatched her up, not the CPI [Crisis Prevention Institute] hold we use, grabbed her and spun her around."

f. On 11/27/2023 at 2:30 PM, QBHP #2 stated, "I entered the dayroom after Client #1 had been taken into the seclusion room by [QHBP #1]." In response to the question, "What did you observe?" QBHP #2 stated, "She was banging a plastic bottle on the window door. I stayed at the door, until they came back to subdue her. Another resident had been in the open seclusion room sleeping and I had moved her out." In response to the question, "Did you see her banging her head?" QBHP #2 replied, "I did not."

g. On 11/27/2023 at 2:45 PM, QBHP #3 stated that Client #1 had not been compliant. In response to the question, "Why was [Client #1] not compliant?" QBHP #3 stated, "She was yelling, screaming, and throwing chairs. My partner, [QBHP #1], grabbed her. I did not get up as I was eating dinner. [QBHP #1] took her to the seclusion room and called me to take his place. [Client #1] was kicking, screaming, scratching, drew blood from my hand from scratches, and banging her head. [RN #1] brought a pillow. She deescalated to a calm state. We released her to a calm state, she was assessed by the nurse." In response to the question, did you see a broken water bottle?" QHBP #3 did not recall the water bottle.

h. At 11/27/2023 at 3:15 PM, Client #1 arrived accompanied by her counselor. In response to the question, "Can you tell me what happened before going to the hospital on 10/26/2023?"

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N 132	Continued From page 4 Client #1 stated, "I had left the comfort room (10/25/2023), after having had locked myself in my room closet so I could breathe. I went to the Dayroom and started knocking down chairs. [QHBP #1] grabbed me by my hoodie and took me to seclusion. I pinched him because he was hurting me. I cut my right hand. Another girl was sleeping, and I got her water bottle. Rather not be in seclusion so I banged my head and got a concussion. Banged my head on the walls and floor. The concussion feels like bolts tightening. I went to the hospital the next day." In response to the question, "Why did you go to the hospital the next day?" Client #1 stated, "Needed doctor's approval before I could go." i. During a second laptop viewing of the incident on 10/25/2023 at 8:07 PM, on 11/28/2023 with Unit Manager #2. He stated "The video of the seclusion began at 8:06 PM, shows [QHBP #1], taking [Client #1] into the locked seclusion room, and the previous resident is moved out by [QHBP #2], leaving the water bottle on the floor. The resident is banging the water bottle on the glass, camera, and the wall as well as her banging her head. They should have held her, moved the broken plastic out of the seclusion room. They usually talk them down before they lock the resident in, making sure other residents were not in the room and free of plastic bottles and debris." In addition, he said, "[QHBP #1], took her to the ground, CPI does not take residents to the floor. It is not a proper technique."	N 132		
N 172	MONITORING DURING AND AFTER SECLUSION CFR(s): 483.364(b)(2) [A room used for seclusion must] Be free of	N 172		

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N 172	Continued From page 5	N 172		

potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

This ELEMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure a resident was protected from physical harm while being placed in a locked seclusion room (Client #1).

The findings are:

1. Client #1, had diagnoses of "Reactive Attachment Disorder and Disruptive Mood Dysregulation Disorder.

a. An Incident Report, provided by the Record Compliance Officer, on 10/25/2023, listed the complaint as "Personal Restraints, Locked Seclusion, Aggressiveness to Staff and Peers, Injury to Staff, Threat to Safety, and Property Destruction." Also described Resident being rude, hid in closet, refused medications, flipped over furniture, personal restraint, placed in seclusion, broke peers cup, exposed sharp plastic edges, spiting, scratching staff, after banging her head on walls and front window of seclusion room. RN (Registered Nurse) assessment noted after the incident. Resident reported small abrasion on her palm side next to her thumb from the restraint, petechiae around her eyes and cheeks that were not observed on 10/25/2023. A hotline report was made. The resident was ordered for further evaluation at ER (Emergency Room) on 10/26/2023 for petechia rash, on her face and headache, knee pain with a diagnosis of concussion. Resident was placed on activity limit for three (3) days.

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N 172	Continued From page 6	N 172		

b. An interview with Chief Clinical Officer on 11/27/2023 at 1:30 PM, stated that QBHP (Qualified Behavioral Health Provider) #1 had been let go because, "Video footage showed [QBHP #1] had initiated a one-person restraint, jerking patient and had shoved her into seclusion. Without ensuring that the room was free of hazards or other occupants."

c. On 11/27/2023, at 1:35 PM, On 11/27/2023, at 1:35 PM, a telephone interview was conducted with RN #1. She stated, "The resident refused her medication, by slamming her door, and had stepped away for three minutes. Upon returning, she heard resident screaming and being escorted to the seclusion room by [QBHP #1]." In response to the question, "What did you observe?" RN #1 stated, "Resident had picked up a water bottle, left by another resident, and was banging it on the glass, banging her head on the floor. There were three, [QBHP #1], [QBHP #2], and [QBHP #3] holding her on the floor. I got a pillow for her head and then she agreed to stop and went to the comfort room, refused treatment. The resident went to the hospital the next day."

d. During a lap top video review on 11/27/2023 at 1:50 PM with the Unit Manager #1, he stated that Client #1 on 10/25/2023 at 8:05 PM, had walked into the day room, and knocked over two chairs. "[QHBP #1] aggressively took the resident to the seclusion room, locked the door as [QHBP #2] escorted another resident out of the open seclusion room leaving the plastic empty water bottle. Then from 8:06 PM to 8:10 PM, the resident continued to loudly scream and break the plastic bottle into small pieces, hitting it on the walls, camera, and the front window of the room as well as banging her head on walls. At 8:10 PM,

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N 172	Continued From page 7	N 172		

[QHBP #1] with two other employees came into the room, subdued the resident by holding arms and legs. [RN #1] began to remove shards of the plastic water bottle." In response to the question "What was wrong with the restraints?" Unit Manager #1 stated "He snatched her up, not the CPI [Crisis Prevention Institute] hold we use, grabbed her and spun her around."

e. On 11/27/2023 at 2:30 PM, QBHP #2 stated, "I entered the dayroom after Client #1 had been taken into the seclusion room by [QHBP #1]." In response to the question, "What did you observe?" QBHP #2 stated, "She was banging a plastic bottle on the window door. I stayed at the door, until they came back to subdue her. Another resident had been in the open seclusion room sleeping and I had moved her out." In response to the question, "Did you see her banging her head?" QBHP #2 replied, "I did not."

f. At 11/27/2023 at 3:15 PM, Client #1 arrived accompanied by her counselor. In response to the question, "Can you tell me what happened before going to the hospital on 10/26/2023?" Client #1 stated, "I had left the comfort room (10/25/2023), after having had locked myself in my room closet so I could breathe. I went to the Dayroom and started knocking down chairs. [QHBP #1] grabbed me by my hoodie and took me to seclusion. I pinched him because he was hurting me. I cut my right hand. Another girl was sleeping, and I got her water bottle. Rather not be in seclusion so I banged my head and got a concussion. Banged my head on the walls and floor. The concussion feels like bolts tightening. I went to the hospital the next day." In response to the question, "Why did you go to the hospital the next day?" Client #1 stated, "Needed doctor's

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N 172	Continued From page 8 approval before I could go." g. During a second lap top viewing of the incident on 10/25/2023 at 8:07 PM, on 11/28/2023 with Unit Manager #2. He stated "The video of the seclusion began at 8:06 PM, shows [QHBP #1], taking [Client #1] into the locked seclusion room, and the previous resident is moved out by [QHBP #2], leaving the water bottle on the floor. The resident is banging the water bottle on the glass, camera, and the wall as well as her banging her head. They should have held her, moved the broken plastic out of the seclusion room. They usually talk them down before they lock the resident in, making sure other residents were not in the room and free of plastic bottles and debris." In addition, he said, "[QHBP #1], took her to the ground, CPI does not take residents to the floor. It is not a proper technique." h. The Policy "Use of Seclusion-Intensive Residential" (Reviewed 07/24/2023), read in part, "...Seclusion is utilized to protect the patient from injuring self or others... It is not used as punishment or for the convenience of team members. Seclusion is used only for emergency situations when less restrictive interventions have not been successful... VIII. Seclusion is not used in a manner that causes undue physical discomfort, harm or pain to the patient..."	N 172		

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

January 3, 2024

David Napier, Administrator
Youth Home Inc
20400 Colonel Glenn Road
Little Rock, AR 72210-5323

Dear Mr. Napier:

On November 28, 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 December 14, 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
DPSQA/Office of Long Term Care
Survey & Certification Section

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N 000	Initial Comments	N 000		

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Complaint #AR00031282 was not in compliance, all or in part, with deficiencies written at N132 and N172.

The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center.

N 132	PROTECTION OF RESIDENTS CFR(s): 483.356(b)	N 132	

Emergency safety intervention. An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).

This ELEMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure a restraint was conducted in a safe and appropriate manner to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Beverly Foti
TITLE: Chief Regulatory Officer
(X6) DATE: 12/14/2023

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 132	Continued From page 1 prevent potential injury for 1 (Client #1). The findings are: 1. Client #1, had diagnoses of "Reactive Attachment Disorder and Disruptive Mood Dysregulation Disorder. a. An Incident Report, provided by the Record Compliance Officer, on 10/25/2023, listed the complaint as "Personal Restraints, Locked Seclusion, Aggressiveness to Staff and Peers, Injury to Staff, Threat to Safety, and Property Destruction." Also described Resident being rude, hid in closet, refused medications, flipped over furniture, personal restraint, placed in seclusion, broke peers cup, exposed sharp plastic edges, spiting, scratching staff, after banging her head on walls and front window of seclusion room. RN (Registered Nurse) assessment noted after the incident. Resident reported small abrasion on her palm side next to her thumb from the restraint, petechiae around her eyes and cheeks that were not observed on 10/25/2023. A hotline report was made. The resident was ordered for further evaluation at ER (Emergency Room) on 10/26/2023 for petechia rash, on her face and headache, knee pain with a diagnosis of concussion. Resident was placed on activity limit for three (3) days. b. An interview with Chief Clinical Officer on 11/27/2023 at 1:30 PM, stated that QBHP (Qualified Behavioral Health Provider) #1 had been let go because, "Video footage showed [QBHP #1] had initiated a one-person restraint, jerking patient and had shoved her into seclusion. Without ensuring that the room was free of hazards or other occupants."	N 132	Youth Home upgraded our camera system in July 2020 which covers most common areas of our campus. This enables us to have clear quality pictures and audio of incidents that makes review of incidents more meaningful and more efficient. Video footage of each restraint/seclusion incident is reviewed as quickly as possible by the Unit Manager, usually within 24 hours, and by Jan. 1, 2024 this will occur on weekends also. Each video reviewed is documented with details of the scenario and kept in a Video Review Log. When anything is noted that is either questionable or inappropriate, the Chief Clinical Officer is notified. Action taken either leads to retraining for the team member(s) involved, a hotline call, and/or disciplinary action up to and including termination. In the case of this incident, the team member involved in the inappropriate hold received disciplinary action of dismissal. All other team members who were part of the incident received retraining from their Unit Manager, Anthony White, regarding appropriate holds in Crisis Prevention Institute training on 10/26/23. They also received disciplinary action in the form of a written personnel action. The incident was reported to the Child Abuse Hotline on the date of review. On 10/25/23, the date of the incident for Resident # 1, she was assessed by nurse	12/14/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L107	A. BUILDING _____ B. WING _____	C 11/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 132	Continued From page 2 c. Physician Orders dated 10/25/2023, at 8:06 PM, read in part, "...Place in locked seclusion for up to 60 minutes until calm and cooperative and no longer a threat to safety." d. On 11/27/2023, at 1:35 PM, a telephone interview was conducted with RN #1. She stated, "The resident refused her medication, by slamming her door, and had stepped away for three minutes. Upon returning, she heard resident screaming and being escorted to the seclusion room by [QBHP #1]." In response to the question, "What did you observe?" RN #1 stated, "Resident had picked up a water bottle, left by another resident, and was banging it on the glass, banging her head on the floor. There were three, [QBHP #1], [QBHP #2], and [QBHP #3] holding her on the floor. I got a pillow for her head and then she agreed to stop and went to the comfort room, refused treatment. The resident went to the hospital the next day." e. During a lap top video review on 11/27/2023 at 1:50 PM with the Unit Manager #1, he stated that Client #1 on 10/25/2023 at 8:05 PM, had walked into the day room, and knocked over two chairs. "[QHBP #1] aggressively took the resident to the seclusion room, locked the door as [QHBP #2] escorted another resident out of the open seclusion room leaving the plastic empty water bottle. Then from 8:06 PM to 8:10 PM, the resident continued to loudly scream and break the plastic bottle into small pieces, hitting it on the walls, camera, and the front window of the room as well as banging her head on walls. At 8:10 PM, [QHBP #1] with two other employees came into the room, subdued the resident by holding arms and legs. [RN #1] began to remove shards of the	N 132	Ebony Galmore, R.N. at 8:28 p.m . as part of her face-to-face assessment after the incident. We consider that any other resident of our facility has the potential to be affected by the findings; therefore, on the date of the incident, that included 39 other residents. We will continue to monitor each incident of seclusion/ restraint that occurs in our facility. The monitoring is completed by video review of all incidents by the Unit Manager assigned to the area the incident occurs in with documentation of details via a Video Review Log. The Chief Clinical Officer reviews on a weekly basis and reports results from the log at each Performance Improvement Committee meeting on a quarterly basis. Members of that committee include our Chief Medical Officer, all the Executive Team, Director of Nursing, all other departments within the facility. In addition, beginning January 1, 2024 Youth Home is embarking on a concerted effort to decrease our number of restraints and seclusions. We will begin using a checklist to assist with predicting violent behavior which has been effective in other settings similar to ours. It is a checklist that is completed on each patient for each shift that helps predict their level of escalation. It is communicated to each shift coming on to help them be prepared to work best with each patient. The number of seclusions and restraints prior to beginning the tool will be compared	

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N 132	Continued From page 3	N 132	to the number after beginning use each month with these results reported to the Performance Improvement Committee by the Chief Clinical Officer on a quarterly basis.	

plastic water bottle." In response to the question "What was wrong with the restraints?" Unit Manager #1 stated "He snatched her up, not the CPI [Crisis Prevention Institute] hold we use, grabbed her and spun her around."

f. On 11/27/2023 at 2:30 PM, QBHP #2 stated, "I entered the dayroom after Client #1 had been taken into the seclusion room by [QHBP #1]." In response to the question, "What did you observe?" QBHP #2 stated, "She was banging a plastic bottle on the window door. I stayed at the door, until they came back to subdue her. Another resident had been in the open seclusion room sleeping and I had moved her out." In response to the question, "Did you see her banging her head?" QBHP #2 replied, "I did not."

g. On 11/27/2023 at 2:45 PM, QBHP #3 stated that Client #1 had not been compliant. In response to the question, "Why was [Client #1] not compliant?" QBHP #3 stated, "She was yelling, screaming, and throwing chairs. My partner, [QBHP #1], grabbed her. I did not get up as I was eating dinner. [QBHP #1] took her to the seclusion room and called me to take his place. [Client #1] was kicking, screaming, scratching, drew blood from my hand from scratches, and banging her head. [RN #1] brought a pillow. She deescalated to a calm state. We released her to a calm state, she was assessed by the nurse." In response to the question, did you see a broken water bottle?" QHBP #3 did not recall the water bottle.

h. At 11/27/2023 at 3:15 PM, Client #1 arrived accompanied by her counselor. In response to the question, "Can you tell me what happened before going to the hospital on 10/26/2023?"

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N 132	Continued From page 4 Client #1 stated, "I had left the comfort room (10/25/2023), after having had locked myself in my room closet so I could breathe. I went to the Dayroom and started knocking down chairs. [QHBP #1] grabbed me by my hoodie and took me to seclusion. I pinched him because he was hurting me. I cut my right hand. Another girl was sleeping, and I got her water bottle. Rather not be in seclusion so I banged my head and got a concussion. Banged my head on the walls and floor. The concussion feels like bolts tightening. I went to the hospital the next day." In response to the question, "Why did you go to the hospital the next day?" Client #1 stated, "Needed doctor's approval before I could go." i. During a second laptop viewing of the incident on 10/25/2023 at 8:07 PM, on 11/28/2023 with Unit Manager #2. He stated "The video of the seclusion began at 8:06 PM, shows [QHBP #1], taking [Client #1] into the locked seclusion room, and the previous resident is moved out by [QHBP #2], leaving the water bottle on the floor. The resident is banging the water bottle on the glass, camera, and the wall as well as her banging her head. They should have held her, moved the broken plastic out of the seclusion room. They usually talk them down before they lock the resident in, making sure other residents were not in the room and free of plastic bottles and debris." In addition, he said, "[QHBP #1], took her to the ground, CPI does not take residents to the floor. It is not a proper technique."	N 132		
N 172	MONITORING DURING AND AFTER SECLUSION CFR(s): 483.364(b)(2) [A room used for seclusion must] Be free of	N 172		

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N 172	Continued From page 5 potentially hazardous conditions such as unprotected light fixtures and electrical outlets. This ELEMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was protected from physical harm while being placed in a locked seclusion room (Client #1). The findings are: 1. Client #1, had diagnoses of "Reactive Attachment Disorder and Disruptive Mood Dysregulation Disorder. a. An Incident Report, provided by the Record Compliance Officer, on 10/25/2023, listed the complaint as "Personal Restraints, Locked Seclusion, Aggressiveness to Staff and Peers, Injury to Staff, Threat to Safety, and Property Destruction." Also described Resident being rude, hid in closet, refused medications, flipped over furniture, personal restraint, placed in seclusion, broke peers cup, exposed sharp plastic edges, spiting, scratching staff, after banging her head on walls and front window of seclusion room. RN (Registered Nurse) assessment noted after the incident. Resident reported small abrasion on her palm side next to her thumb from the restraint, petechiae around her eyes and cheeks that were not observed on 10/25/2023. A hotline report was made. The resident was ordered for further evaluation at ER (Emergency Room) on 10/26/2023 for petechia rash, on her face and headache, knee pain with a diagnosis of concussion. Resident was placed on activity limit for three (3) days.	N 172	Retraining on the proper use of seclusion was provided by the Unit Manager, Anthony White, on 10/26/23 for all staff involved in the incident quickly after review of the video. This retraining included a reminder discussion of the need to intervene when an inappropriate interaction is observed. All direct care staff were assigned a training module on seclusion in our online learning system on 12/7/23 to be completed by 12/14/23. At the time of report, all team members except 18 had completed this training. Any who have not completed the training module will be required to complete it prior to being in ratio on their next scheduled shift. Failure to do so will result in disciplinary action. Youth Home will monitor each incident of seclusion that occurs at our facility. The monitoring is completed by video review of all incidents by the Unit Manager assigned to the area where the incident occurs with documentation of details via a Video Review Log. The Chief Clinical Officer reviews on a weekly basis and reports results from the log at each Performance Improvement Committee meeting on a quarterly basis.	12/28/23

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N 172	Continued From page 6	N 172		

b. An interview with Chief Clinical Officer on 11/27/2023 at 1:30 PM, stated that QBHP (Qualified Behavioral Health Provider) #1 had been let go because, "Video footage showed [QBHP #1] had initiated a one-person restraint, jerking patient and had shoved her into seclusion. Without ensuring that the room was free of hazards or other occupants."

c. On 11/27/2023, at 1:35 PM, On 11/27/2023, at 1:35 PM, a telephone interview was conducted with RN #1. She stated, "The resident refused her medication, by slamming her door, and had stepped away for three minutes. Upon returning, she heard resident screaming and being escorted to the seclusion room by [QBHP #1]." In response to the question, "What did you observe?" RN #1 stated, "Resident had picked up a water bottle, left by another resident, and was banging it on the glass, banging her head on the floor. There were three, [QBHP #1], [QBHP #2], and [QBHP #3] holding her on the floor. I got a pillow for her head and then she agreed to stop and went to the comfort room, refused treatment. The resident went to the hospital the next day."

d. During a lap top video review on 11/27/2023 at 1:50 PM with the Unit Manager #1, he stated that Client #1 on 10/25/2023 at 8:05 PM, had walked into the day room, and knocked over two chairs. "[QHBP #1] aggressively took the resident to the seclusion room, locked the door as [QHBP #2] escorted another resident out of the open seclusion room leaving the plastic empty water bottle. Then from 8:06 PM to 8:10 PM, the resident continued to loudly scream and break the plastic bottle into small pieces, hitting it on the walls, camera, and the front window of the room as well as banging her head on walls. At 8:10 PM,

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N 172	Continued From page 7	N 172		

[QHBP #1] with two other employees came into the room, subdued the resident by holding arms and legs. [RN #1] began to remove shards of the plastic water bottle." In response to the question "What was wrong with the restraints?" Unit Manager #1 stated "He snatched her up, not the CPI [Crisis Prevention Institute] hold we use, grabbed her and spun her around."

e. On 11/27/2023 at 2:30 PM, QBHP #2 stated, "I entered the dayroom after Client #1 had been taken into the seclusion room by [QHBP #1]." In response to the question, "What did you observe?" QBHP #2 stated, "She was banging a plastic bottle on the window door. I stayed at the door, until they came back to subdue her. Another resident had been in the open seclusion room sleeping and I had moved her out." In response to the question, "Did you see her banging her head?" QBHP #2 replied, "I did not."

f. At 11/27/2023 at 3:15 PM, Client #1 arrived accompanied by her counselor. In response to the question, "Can you tell me what happened before going to the hospital on 10/26/2023?" Client #1 stated, "I had left the comfort room (10/25/2023), after having had locked myself in my room closet so I could breathe. I went to the Dayroom and started knocking down chairs. [QHBP #1] grabbed me by my hoodie and took me to seclusion. I pinched him because he was hurting me. I cut my right hand. Another girl was sleeping, and I got her water bottle. Rather not be in seclusion so I banged my head and got a concussion. Banged my head on the walls and floor. The concussion feels like bolts tightening. I went to the hospital the next day." In response to the question, "Why did you go to the hospital the next day?" Client #1 stated, "Needed doctor's

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N 172	Continued From page 8	N 172		

approval before I could go."

g. During a second lap top viewing of the incident on 10/25/2023 at 8:07 PM, on 11/28/2023 with Unit Manager #2. He stated "The video of the seclusion began at 8:06 PM, shows [QHBP #1], taking [Client #1] into the locked seclusion room, and the previous resident is moved out by [QHBP #2], leaving the water bottle on the floor. The resident is banging the water bottle on the glass, camera, and the wall as well as her banging her head. They should have held her, moved the broken plastic out of the seclusion room. They usually talk them down before they lock the resident in, making sure other residents were not in the room and free of plastic bottles and debris." In addition, he said, "[QHBP #1], took her to the ground, CPI does not take residents to the floor. It is not a proper technique."

h. The Policy "Use of Seclusion-Intensive Residential" (Reviewed 07/24/2023), read in part, "...Seclusion is utilized to protect the patient from injuring self or others... It is not used as punishment or for the convenience of team members. Seclusion is used only for emergency situations when less restrictive interventions have not been successful... VIII. Seclusion is not used in a manner that causes undue physical discomfort, harm or pain to the patient..."

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

March 4, 2024

David Napier, Administrator
Youth Home Inc
20400 Colonel Glenn Road
Little Rock, AR 72210-5323

Dear Mr. Napier:

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,

Lynda White, RN

DPSQA/Office of Long Term Care
Survey and Certification Section

tf

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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 February 21, 2024, for all deficiencies cited on November 28, 2023. 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.