ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

August 5, 2024

Kenisha Hoard, Administrator
Millcreek Of Arkansas
P.O. Box 727
Fordyce, AR 71742

Dear Ms. Hoard:

On July 25, 2024 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 Intermediate Care Facilities for Individuals with Intellectual Disabilities 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 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 call your Reviewer.

Sincerely,

Jeff Rosenbaum

DPSQA/Office of Long Term Care
Survey & Certification Section

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cc: DRA
DDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G011	A. BUILDING _____ B. WING _____	07/25/2024

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W 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. The findings on this statement of deficiencies demonstrate non-compliance with the requirements of 42 CFR, Part 483, subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a well-maintained homelike environment. The findings are: 1. During environmental rounds at Oak Creek House on 07/23/2024 from 7:32 AM through 7:49 AM, the following concerns were identified: a. The first door to the left down the long hall had a crack with an indention on the upper right-hand side of the door on the second panel down from the top.	W 104		

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

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W 104	Continued From page 1 b. The wall behind and to the right of the toilet in bathroom #2 had yellow staining along the trim at the base of the wall. c. Bathroom #1 had a toilet observed with wet yellow fluid on the base around the bolt, and yellow staining over the floor trim, to the right and behind the toilet. d. Room #8, on the room side of the door, the upper right-hand panel, second from the top was cracked and indented. e. Room #4, on the hall side of the door, the middle-left panel had cracking, 12 inches in diameter, with cracks coming off of the main crack. f. A towel was observed behind the dryer on the floor. g. The lower door handle on the black refrigerator in the kitchen was broken on the bottom. 2. Environmental rounds at the Boys Ranch on 07/23/2024 from 8:43 AM through 8:51 AM revealed the following concerns: a. Room #5's bathroom door had a 4 inch crack on the upper right-hand side of the inside of the door. The shower in the room had a crack in the wall next to the shower, head high and 3 inches long. b. There was a piece of clothing behind the dryer on the floor. c. Bathroom #1 had paint peeled off the wall next	W 104		

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to the toilet in several places with the largest area 8 inches long by 4 inches wide. On the wall to the left of the sink, paint had been peeled from the wall board from an area 3 feet by 12 inches.

d. On 07/24/2024 at 10:29 AM, the Chief Operating Officer (CEO) stated that the doors had been replaced.

3. During observations in the Main Kitchen on 07/24/2024 from 1:03 PM, through 1:30 PM, the following concerns were identified:

a. In the entry hall and main eating area there were 14 cracked or broken 18 inches by 18 inch tiles.

b. A ceiling tile over the serving area next to the air vent had brown staining and what looked like new wet brown stain. It was raining outside.

4. During environmental rounds at Haley house on 07/23/2024 from 9:24 AM, through 10:15 AM, the following concerns were identified:

A. On the boys' hallway, 5 out of 6 fluorescent light covers had debris and bugs visible in the covers. The fluorescent light covers, in the dining area, kitchen, and girls' hallways, had varying degrees of debris including bugs and flies visible in the covers.

B. In the backyard, in the corner closest to the Administration building were 5 used tires in a pile by the privacy fence with grass and weeds growing up and around the tires.

C. On the back corner of the roof, closest to the Administration building, a light fixture with 2 light reflectors/shades was in disrepair with one lamp

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W 104	Continued From page 3 holder and reflector hanging only by wires. 5. On 07/24/2024, a "document" of the open maintenance requests was supplied by the facility Chief Executive Officer (CEO) and reviewed, which revealed an open maintenance request for item A that had been submitted on 07/24/2024 at 7:59 AM per the CEO. There were no open maintenance requests for items B and C per document. No maintenance policy was provided. Items A through C were discussed with the CEO.	W 104		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were administered without errors for 1 (Client #7) case mix sample. The findings are: Client #7's "Physician's Orders" dated 03/05/2024 were reviewed and read in part, "Miralax 17 gm [grams] PO [by mouth] BID [twice a day] for constipation." a. On 07/23/2024 at 8:04 AM, during observation of the medication administration, Licensed Practical Nurse (LPN) #1 poured the medication out into the cap at about the halfway point and stated that was 17 grams. b. The inside of the medication lid had a white inner cap that had a raised arrow indicator	W 369		

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W 369	Continued From page 4 pointing to the upper lip of the white cap, and "17 gm [grams]" next to the arrow. c. Licensed Practical Nurse (LPN) #1 was asked to observe the medication lid and the arrow indicator for the 17 gram dose. LPN #1 stated, "I see, it should have been to the top." d. A "Medication Management" policy with a revised date of 12/2023 received from the Chief Executive Officer (CEO) on 07/24/2024 at 10:29 AM. The policy was reviewed and read in part, "Preparing and Dispensing..., Medications are dispensed by the designated pharmacy upon receiving a written, telephone, or verbal order from an approved prescriber as listed on the authorized list of prescribers..., the pharmacy dispenses the medications and delivers them to the nurse on duty..."	W 369		
W 390	DRUG LABELING CFR(s): 483.460(m)(2)(i) The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to remove medication that was beyond the expiration date in 1 of 1 medication room. The findings are: On 07/28/2024 at 12:25 PM, in Willow Creek House, in the medication cabinet, where the over-the-counter medications were kept, the following item was found: A bottle of artificial tears with an expiration date of 03/2024. Licensed Practical Nurse (LPN) #1 confirmed the expiration	W 390		

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W 390	Continued From page 5 date and threw away the bottle. When asked who was responsible for checking medications expiration dates, LPN #1 reported the nurses were responsible for checking their assigned houses and throwing expired medications away. On 07/24/2024 at 10:29 AM, review of a facility "policy" titled, "Medication Management," in part specified, "...Medication Disposal" Medications that have been discontinued, expired, damaged and/or contaminated are removed from individual patient/resident bins and/or stock medication supply and stored in a separate cabinet of the medication room. These non-controlled substances are disposed of a minimum of one time per month by placing into a separate container..."	W 390		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food items were stored properly, sealed, labeled, and dated to maintain freshness and palatability to minimize the potential for food borne illness; hair covering was worn at all times in the kitchen; and expired foods were promptly removed from stock, dented cans were discarded; the ice machine was maintained in a clean manner and equipment used to cut medication in half was cleaned between clients (Clients #2, #8, and #9). The findings are:	W 454		

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Haley House:

On 07/23/2024 beginning at 7:20 AM, the morning meal preparation and subsequent serving of the meal was observed. House Staff #1 and Life Skills Teacher (LST) #1 were transferring food from large serving dishes supplied by the main kitchen into smaller serving dishes via serving utensils and placing serving dishes on individual tables for client consumption. House Staff #1 and LST #1's hair was braided, neither of the staff members were wearing hairnets. A client worker who had a long ponytail, was not wearing a hairnet was setting the table, carrying glasses of liquid and carrying food items to the other clients' tables.

On 07/23/2024 at 8:23 AM, Life Skills Teacher (LST) #1 verified that hairnets are supposed to be worn when working in the kitchen during meals and that hairnets were available in the office for use by staff and clients. LST #1 confirmed that she had not worn a hairnet, "...today, it slipped my mind...". At 8:28 AM, House Staff #1 verbally confirmed that hairnets are supposed to be worn while serving meals and stated, "...but I forgot today..."

On 07/23/2024, during a tour of the kitchen and pantry at Haley House that began at 8:45 AM, the following observations were made in the pantry:

-A 6-pound 11 ounce can of cheese sauce had a dent approximately 2.5 inches long by 1 inch wide and ½ inch from the top seal.

-A 16 ounce can of vanilla frosting with best use by date of "Jun [June] 26, 24 [2024]"; 2 cans of

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lemon frosting with a best use by date of "Jun 16, 2024"; and 2 cans of cookie flavor frosting with a best use date by of "Jun 16, 2024."

-A 56-ounce container of powder coffee creamer with an opened date of "10-1-22 [10/01/2024]" with a best use by date of "Jul [July] 16, 2024."

-A small glass container containing a white granular substance with no content label or date, 1/5 full.

-A 32-ounce jar of strawberry jam, 1/2 full, with an open date of "2-14-24 [02/14/2024]" with label directions containing, "Refrigerate after opening."

-A 15-ounce jar of sandwich spread, 3/4 full, with an expiration date of "20 Dec [December] 2023", and an opened date of "6-23-23 [06/23/2023]." The manufacturer label directions contained the statement, "Refrigerate after opening."

Life Skills Teacher (LST) #1 was present during the above kitchen tour and verbally confirmed the food contained in the dented cans would be used as well as the other food in the pantry would for client consumption, and the findings noted above were confirmed. LST #1 began to throw away the outdated items and the items that required refrigeration after opening from the pantry. When asked who was responsible for checking the pantry for expired items and how often the pantry was checked, LST #1 stated, "I am ...every week."

On 7/23/2024 at 10:19 AM Life Skills Teacher (LST) #1 accompanied the Surveyor to the outside storage shed where the ice machine was located, upon request, LST #1 opened the lid and

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used a white paper towel to wipe the inside of the ice machine at the top of the lid opening. A medium amount of brown residue was noted on the paper towel after the procedure. When the Surveyor asked how often the ice machine was cleaned, LST #1 reported "once a week ...I cleaned it last Wednesday."

A facility "policy" titled, "Infection Control", with a reviewed/revised date of 2023 was received and reviewed on 07/24/2024 at 12:23 PM, and specified in part, "To prevent the transmission of infection in the dining area through education of staff and residents to good personal hygiene and proper dining area habits...b. Personal Hygiene: Personnel should also be aware of the necessity of wearing clean clothes daily as well as hairnets/gloves."

The "Nutrition Services", "policies" with a reviewed/revised: 09/2019 date was received and reviewed on 7/24/2024 at 10:29 AM, and read in part, "...POLICY: Receiving Food and Supplies PURPOSE: To prevent food spoilage and product breakdown during the handing and storage of all items...4. b. Do not accept but return to the supplier, any item that is...2. Indented, rusty, damaged cans ...6. All perishable products are to be dated. All stock must be rotated with each new order received..., ...POLICY: Sanitation Standards: Equipment/Physical Plant ...3. Temperatures of all refrigerators and freezers must be checked and recorded daily. POLICY: Cleaning Schedules...DAILY ...I. Ice Scoop/Bucket, J. Ice machine-wipe down and around door and outside; POLICY: Equipment Temperature Log on Daily Journal PURPOSE: In order to insure that refrigerator and freezers are in proper working order and to assist in the

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prevention of food borne illness, refrigerator/freezer temperatures will be recorded twice per day in dietary. PROCEDURE: Refrigerator/Freezer: Our refrigerators/freezers have been identified name of cottage and correspond with the equipment temperature log. Each refrigerator/freezer contains a working thermometer..."

Review of the "Patient Information Sheet" noted Client #2 had diagnoses including unspecified intellectual disabilities, reactive attachment disorder of childhood, and posttraumatic stress disorder.

Review of the "physician orders" dated 07/19/2024, read in part, " ...Tenex 1 mg [milligram]...tab [tablet]...@ [at] 8AM [8:00 AM] and 1/2 tab at 12 N [12:00 noon]..."

Review of the "Patient Information Sheet" noted, Client #8 had diagnoses including mild intellectual disability, disruptive mood dysregulation disorder, reactive attachment disorder, attention deficit hyperactivity disorder, and separation anxiety disorder.

Review of the "Medication Administration Record" dated 06/21/2024 read in part, "...Clonidine 0.1mg [milligram] 1/2 tab [tablet]...Q [every] 8AM [8:00 AM] and 12N [12:00 Noon] 2 tabs Q HS [hour of sleep] for impulse..."

Review of the "Patient Information Sheet" noted, Client #9 had diagnoses including mild intellectual disabilities, conduct disorder and attention deficit hyperactivity disorder.

Review of the "Medication Administration Record"

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dated 05/17/2024, read in part, "...Clonidine 0.1 mg [milligram]...1/2 tab [8:00 AM] and 12N [12:00 Noon] ...Haldol 10 mg...1/2 tab at [8:00 AM] and 12N [12:00 Noon]..."

On 07/23/2024 at 11:50 AM, the Surveyor observed Licensed Practical Nurse (LPN) #1 during the noon medication pass at Willow Creek House. At 12:01 PM, LPN #1 obtained Client #8's Clonidine 0.1mg (milligram) tablet from the prescription bottle and used a pill cutter that was on the counter to cut the tablet in half. LPN #1 put 1/2 of the tablet into a medicine cup and transferred the other 1/2 back to the prescription bottle. The 1/2 tablet in the medicine cup was then administered to Client #8. LPN #1 put the pill cutter back on the cabinet without cleaning it.

On 07/23/2024 at 12:10 PM, Licensed Practical Nurse (LPN) #1 obtained Client #2's Tenex 1mg tablet from the prescription bottle and used the pill cutter that was on the counter to cut the tablet in half. Licensed Practical Nurse (LPN) #1 put 1/2 of the tablet into a medicine cup and transferred the other 1/2 back to the prescription bottle. The 1/2 tablet in the medicine cup was then administered to Client #2. LPN #1 put the pill cutter back on the cabinet without cleaning it before or after use.

On 07/23/2024 at 12:23 PM, Licensed Practical Nurse (LPN) #1 obtained Client #9's Clonidine 0.1 mg (milligram) tablet from the prescription bottle and used the same pill cutter to cut Client #9's tablet in half that was on the counter that had been used for cutting Client #2 and Client #8's medication. LPN #1 put 1/2 of the tablet into a medicine cup and transferred the other 1/2 back to the prescription bottle. LPN #1 repeated the

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process with Client #9's Haloperidol 10mg tablet cutting the 10 mg tablet in half. The two 1/2 tablets in the medicine cup were then administered to Client #9. LPN #1 put the pill cutter back on the cabinet without cleaning it before or after use.

On 07/23/2024, during an interview at 12:30 PM, Licensed Practical Nurse (LPN) #1 confirmed that the same pill cutter was used for all three clients and that clients do not have individual pill cutters. When asked, LPN #1 confirmed that the pill cutter was not cleaned between clients and reported that it is cleaned weekly. LPN #1 showed a monitoring log posted on the wall for the cleaning schedule of equipment that included "Pill Cutter" with dates of "07/02/24, 07/10/24 and 7/16/24".

On 07/25/2024 at 9:45 AM, during an interview the Assistant Director of Nursing (ADON) stated to the Surveyor that pill cutters should be cleaned "after each use and PRN [as needed]" The Surveyor asked if the pill cutter should be cleaned between each client, the ADON replied, "Yes."

On 07/24/2024 at 10:29 the Chief Executive Officer provided a facility policy titled, "Medication management" with a revised date of 12/2023, that specified in part, Section "Infection Control in Medication Administration ...The nurse will transfer the medication from the closed container it is stored in (blister pack or bottle) to the inside of the medication cup without contaminating the medication. The medication will be considered contaminated if it comes in contact with any surface other than the inside of the closed container it is stored in or the inside of the medication cup it will be administered from."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G011	A. BUILDING _____ B. WING _____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	1828 INDUSTRIAL DRIVE FORDYCE, AR 71742

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W 454	Continued From page 12 During observations in the main kitchen on 07/24/2024 from 1:03 PM through 1:30 PM, the following concerns were identified: a. The milk box contained 26 pints of expired 2% milk dated, "Jul [July] 23", the milk box did not contain a thermometer. Cook #1 looked through the case, moving crates of milk to verify there was no thermometer, none was found. Cook #1 retrieved a thermometer and placed it in the milk box. Cook #1 was asked if the milk box should have a thermometer in it. Cook #1 stated yes it should have a thermometer.	W 454		

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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

January 28, 2025

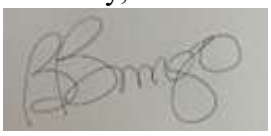
Kenisha Hoard, Administrator
Millcreek Of Arkansas
P.O. Box 727
Fordyce, AR 71742

Dear Ms. Hoard:

Based on the approval of the Plan of Correction for the Recertification survey conducted on July 25, 2024, your facility was found to be in substantial compliance with program requirements. Your certification remains in effect unless terminated due to non-compliance with program requirements or voluntary withdrawal from the program.

If you have any questions, please contact your reviewer: **Breanna Marengo at 501-320-6280 or email to breanna.marengo@dhs.arkansas.gov.**

Sincerely,



for Jeff Rosenbaum
DPSQA/Office of Long Term Care
Survey and Certification Section

bbm

APOC 08/23/24
TF

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

PRINTED: 08/05/2024
FORM APPROVED
OMB NO. 0938-0391

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W 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. The findings on this statement of deficiencies demonstrate non-compliance with the requirements of 42 CFR, Part 483, subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a well-maintained homelike environment. The findings are: 1. During environmental rounds at Oak Creek House on 07/23/2024 from 7:32 AM through 7:49 AM, the following concerns were identified: a. The first door to the left down the long hall had a crack with an indention on the upper right-hand side of the door on the second panel down from the top.	W 104	Step 1 Corrective Action On 7/23/2024, upon notification of deficient practice, the Administrator and Milieu Coordinator made observations at Oak Creek, Boys Ranch, and Haley House to ensure a well-maintained homelike environment. Any deficiencies were immediately corrected and no other deficiencies were noted. Oak Creek All damaged or broken doors were replaced on 7/24/2024 (1a.1d,1e). Areas noted were cleaned on 7/23/2024 (1b,1c). Towel was removed from behind the dryer on 7/23/2024 (1f). Refrigerator door handle was repaired on 7/24/2024 (1g).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kenisha Heard, LNHA | TITLE: Program Director | (X6) DATE: 8.14.2024

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.

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W 104	Continued From page 1 b. The wall behind and to the right of the toilet in bathroom #2 had yellow staining along the trim at the base of the wall. c. Bathroom #1 had a toilet observed with wet yellow fluid on the base around the bolt, and yellow staining over the floor trim, to the right and behind the toilet. d. Room #8, on the room side of the door, the upper right-hand panel, second from the top was cracked and indented. e. Room #4, on the hall side of the door, the middle-left panel had cracking, 12 inches in diameter, with cracks coming off of the main crack. f. A towel was observed behind the dryer on the floor. g. The lower door handle on the black refrigerator in the kitchen was broken on the bottom. 2. Environmental rounds at the Boys Ranch on 07/23/2024 from 8:43 AM through 8:51 AM revealed the following concerns: a. Room #5's bathroom door had a 4 inch crack on the upper right-hand side of the inside of the door. The shower in the room had a crack in the wall next to the shower, head high and 3 inches long. b. There was a piece of clothing behind the dryer on the floor. c. Bathroom #1 had paint peeled off the wall next	W 104	Boys Ranch Bathroom door was replaced on 7/24/2024 (2a). Clothing behind dryer was removed on 7/23/2024 (2b). Bathroom was repainted on 7/24/2024 (2c). Haley House Hallway light fixtures were cleaned on 7/23/2024 (4a). Tires were removed and discarded on 7/23/2024 (4b). Outside light fixture will be repaired or replaced by 8/24/2024 (4c). Main Kitchen 14 cracked/broken tiles were removed on 7/24/2024 (3a). A capital expenditure request was approved on 8/12/2024 to have the floor replaced in the main kitchen. The flooring will be replaced by 8/24/2024 (3a). Roof leak was repaired and ceiling tiles were replaced on 7/24/2024 (3b). Step 2 Identification of other with a potential to be affected by deficient practice On 7/24/2024, the Administrator identified 61 clients through census review that had the potential to be affected by deficient practice.	

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W 104	Continued From page 2 to the toilet in several places with the largest area 8 inches long by 4 inches wide. On the wall to the left of the sink, paint had been peeled from the wall board from an area 3 feet by 12 inches. d. On 07/24/2024 at 10:29 AM, the Chief Operating Officer (CEO) stated that the doors had been replaced. 3. During observations in the Main Kitchen on 07/24/2024 from 1:03 PM, through 1:30 PM, the following concerns were identified: a. In the entry hall and main eating area there were 14 cracked or broken 18 inches by 18 inch tiles. b. A ceiling tile over the serving area next to the air vent had brown staining and what looked like new wet brown stain. It was raining outside. 4. During environmental rounds at Haley house on 07/23/2024 from 9:24 AM, through 10:15 AM, the following concerns were identified: A. On the boys' hallway, 5 out of 6 fluorescent light covers had debris and bugs visible in the covers. The fluorescent light covers, in the dining area, kitchen, and girls' hallways, had varying degrees of debris including bugs and flies visible in the covers. B. In the backyard, in the corner closest to the Administration building were 5 used tires in a pile by the privacy fence with grass and weeds growing up and around the tires. C. On the back corner of the roof, closest to the Administration building, a light fixture with 2 light reflectors/shades was in disrepair with one lamp	W 104	Step 3 Ensure deficient practice does not recur Milieu Coordinator and Director of Nutrition Services will in-service staff on identifying and addressing concerns that affect the environment of care by 8/24/2024. Step 4 Monitoring The Administrator/Designee will monitor cottages and main kitchen weekly to ensure a well-maintained homelike environment. Any negative findings will be corrected and Administrator will be notified. Completion date 8/24/2024	

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W 104	Continued From page 3 holder and reflector hanging only by wires. 5. On 07/24/2024, a "document" of the open maintenance requests was supplied by the facility Chief Executive Officer (CEO) and reviewed, which revealed an open maintenance request for item A that had been submitted on 07/24/2024 at 7:59 AM per the CEO. There were no open maintenance requests for items B and C per document. No maintenance policy was provided. Items A through C were discussed with the CEO.	W 104		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medications were administered without errors for 1 (Client #7) case mix sample. The findings are: Client #7's "Physician's Orders" dated 03/05/2024 were reviewed and read in part, "Miralax 17 gm [grams] PO [by mouth] BID [twice a day] for constipation." a. On 07/23/2024 at 8:04 AM, during observation of the medication administration, Licensed Practical Nurse (LPN) #1 poured the medication out into the cap at about the halfway point and stated that was 17 grams. b. The inside of the medication lid had a white inner cap that had a raised arrow indicator	W 369	Step 1 Corrective Action On 7/23/2024, upon notification of deficient practice, ADON assessed client #7 for any adverse side effects cause by incorrect dosage. No negative findings were noted. Step 2 Identification of others with the potential to be affected by deficient practice On 7/23/2024, through record review, the Administrator identified four clients that had the potential to be affected by deficient practice. Step 3 Ensure deficient practice does not recur On 7/23/2024, ADON in-serviced LPN #1 to ensure medications are being administered without errors.	

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W 369	Continued From page 4 pointing to the upper lip of the white cap, and "17 gm [grams]" next to the arrow. c. Licensed Practical Nurse (LPN) #1 was asked to observe the medication lid and the arrow indicator for the 17 gram dose. LPN #1 stated, "I see, it should have been to the top." d. A "Medication Management" policy with a revised date of 12/2023 received from the Chief Executive Officer (CEO) on 07/24/2024 at 10:29 AM. The policy was reviewed and read in part, "Preparing and Dispensing..., Medications are dispensed by the designated pharmacy upon receiving a written, telephone, or verbal order from an approved prescriber as listed on the authorized list of prescribers..., the pharmacy dispenses the medications and delivers them to the nurse on duty..."	W 369	Step 4 Monitoring ADON/Designee will monitor medication pass weekly to ensure Miralax is being administered per physician orders. Any negative findings will be immediately corrected and Administrator will be notified. Completion date 8/24/2024	
W 390	DRUG LABELING CFR(s): 483.460(m)(2)(i) The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed to remove medication that was beyond the expiration date in 1 of 1 medication room. The findings are: On 07/28/2024 at 12:25 PM, in Willow Creek House, in the medication cabinet, where the over-the-counter medications were kept, the following item was found: A bottle of artificial tears with an expiration date of 03/2024. Licensed Practical Nurse (LPN) #1 confirmed the expiration	W 390	Step 1 Corrective Action On 7/24/2024, upon notification of deficient practice, LPN #1 discarded expired eye drops. No other findings were identified. Step 2 Identification of others with the potential to be affected by deficient practice. On 7/24/2024, Administrator identified 15 clients through census review, that had the potential to be affected by deficient practice.	

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W 390	Continued From page 5 date and threw away the bottle. When asked who was responsible for checking medications expiration dates, LPN #1 reported the nurses were responsible for checking their assigned houses and throwing expired medications away. On 07/24/2024 at 10:29 AM, review of a facility "policy" titled, "Medication Management," in part specified, "...Medication Disposal" Medications that have been discontinued, expired, damaged and/or contaminated are removed from individual patient/resident bins and/or stock medication supply and stored in a separate cabinet of the medication room. These non-controlled substances are disposed of a minimum of one time per month by placing into a separate container..."	W 390	Step 3 Ensure deficient practice does not recur On 7/24/2024, ADON in-serviced nursing staff to check expiration dates of OTC medications and dispose of any out-dated medications monthly. Any negative findings will be corrected and Administrator will be notified. Step 4 Monitoring ADON/Designee will monitor OTC medication stock monthly to ensure medication that is beyond the expiration date is removed from med room. Completion date 8/24/2024	
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food items were stored properly, sealed, labeled, and dated to maintain freshness and palatability to minimize the potential for food borne illness; hair covering was worn at all times in the kitchen; and expired foods were promptly removed from stock, dented cans were discarded; the ice machine was maintained in a clean manner and equipment used to cut medication in half was cleaned between clients (Clients #2, #8, and #9). The findings are:	W 454		

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W 454	Continued From page 6 Haley House: On 07/23/2024 beginning at 7:20 AM, the morning meal preparation and subsequent serving of the meal was observed. House Staff #1 and Life Skills Teacher (LST) #1 were transferring food from large serving dishes supplied by the main kitchen into smaller serving dishes via serving utensils and placing serving dishes on individual tables for client consumption. House Staff #1 and LST #1's hair was braided, neither of the staff members were wearing hairnets. A client worker who had a long ponytail, was not wearing a hairnet was setting the table, carrying glasses of liquid and carrying food items to the other clients' tables. On 07/23/2024 at 8:23 AM, Life Skills Teacher (LST) #1 verified that hairnets are supposed to be worn when working in the kitchen during meals and that hairnets were available in the office for use by staff and clients. LST #1 confirmed that she had not worn a hairnet, "...today, it slipped my mind...". At 8:28 AM, House Staff #1 verbally confirmed that hairnets are supposed to be worn while serving meals and stated, "...but I forgot today..." On 07/23/2024, during a tour of the kitchen and pantry at Haley House that began at 8:45 AM, the following observations were made in the pantry: -A 6-pound 11 ounce can of cheese sauce had a dent approximately 2.5 inches long by 1 inch wide and ½ inch from the top seal. -A 16 ounce can of vanilla frosting with best use by date of "Jun [June] 26, 24 [2024]"; 2 cans of	W 454	Step 1 Corrective Action On 7/23/2024, upon notification of deficient practice, Haley House Unit Coordinator supplied Life Skills Teacher #1 with hairnets in which she donned. Unit Coordinator discarded dented can of cheese sauce, all expired food items, and all food items that were not properly labeled or refrigerated after opening. Unit Coordinator also cleaned inside lid of ice machine. No other negative findings were identified. On 7/23/2024, upon notification of deficient practice, ADON assessed client #8, #2, and #9 for adverse side effects from using the same pill cutter without cleaning it before/after use. No negative findings were identified. On 7/24/2024, Dietary Manager removed all 26 pints of expired milk and checked to make sure a thermometer was placed inside milk box. No other negative findings were identified. Step 2 Identification of others that had the potential to be affected by deficient practice. On 7/24/2024, through census review, the Administrator identified 15 clients that had the potential to be affected by deficient practice.	

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W 454	Continued From page 7 lemon frosting with a best use by date of "Jun 16, 2024"; and 2 cans of cookie flavor frosting with a best use date by of "Jun 16, 2024." -A 56-ounce container of powder coffee creamer with an opened date of "10-1-22 [10/01/2024]" with a best use by date of "Jul [July] 16, 2024." -A small glass container containing a white granular substance with no content label or date, 1/5 full. -A 32-ounce jar of strawberry jam, 1/2 full, with an open date of "2-14-24 [02/14/2024]" with label directions containing, "Refrigerate after opening." -A 15-ounce jar of sandwich spread, 3/4 full, with an expiration date of "20 Dec [December] 2023", and an opened date of "6-23-23 [06/23/2023]." The manufacturer label directions contained the statement, "Refrigerate after opening." Life Skills Teacher (LST) #1 was present during the above kitchen tour and verbally confirmed the food contained in the dented cans would be used as well as the other food in the pantry would for client consumption, and the findings noted above were confirmed. LST #1 began to throw away the outdated items and the items that required refrigeration after opening from the pantry. When asked who was responsible for checking the pantry for expired items and how often the pantry was checked, LST #1 stated, "I am ...every week." On 7/23/2024 at 10:19 AM Life Skills Teacher (LST) #1 accompanied the Surveyor to the outside storage shed where the ice machine was located, upon request, LST #1 opened the lid and	W 454	Step 3 Ensure deficient practice does not recur On 7/24/2024, Unit Coordinator in-serviced Haley House staff to wear hairnets when handling food, check canned foods for dents upon receipt, checking food expiration dates, labeling and dating food items properly, cleaning the ice machine, and to follow manufacturer labels regarding food storage after opening. On 7/24/2024, Dietary Manager in-serviced dietary staff to check milk expiration dates after vendor services and ensure a thermometer is placed in milk box. On 7/24/2024, ADON in-serviced nursing staff on cleaning pill cutter between each client. ADON also contacted pharmacy in order to ensure pills are cut prior to being delivered to facility. Step 4 Monitoring The Administrator/Designee will monitor Haley House, Main Kitchen, and med pass weekly to ensure food items are stored properly, sealed, labeled, and dated to maintain freshness and palatability to minimize the potential for food borne illness; hair coverings are worn at all times in the kitchen; and expired foods are promptly removed from stock, dented cans are discarded; the ice machine is	

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W 454	Continued From page 8 used a white paper towel to wipe the inside of the ice machine at the top of the lid opening. A medium amount of brown residue was noted on the paper towel after the procedure. When the Surveyor asked how often the ice machine was cleaned, LST #1 reported "once a week ...I cleaned it last Wednesday." A facility "policy" titled, "Infection Control", with a reviewed/revised date of 2023 was received and reviewed on 07/24/2024 at 12:23 PM, and specified in part, "To prevent the transmission of infection in the dining area through education of staff and residents to good personal hygiene and proper dining area habits...b. Personal Hygiene: Personnel should also be aware of the necessity of wearing clean clothes daily as well as hairnets/gloves." The "Nutrition Services", "policies" with a reviewed/revised: 09/2019 date was received and reviewed on 7/24/2024 at 10:29 AM, and read in part, "...POLICY: Receiving Food and Supplies PURPOSE: To prevent food spoilage and product breakdown during the handing and storage of all items...4. b. Do not accept but return to the supplier, any item that is...2. Indented, rusty, damaged cans ...6. All perishable products are to be dated. All stock must be rotated with each new order received..., ...POLICY: Sanitation Standards: Equipment/Physical Plant ...3. Temperatures of all refrigerators and freezers must be checked and recorded daily. POLICY: Cleaning Schedules...DAILY ...I. Ice Scoop/Bucket, J. Ice machine-wipe down and around door and outside; POLICY: Equipment Temperature Log on Daily Journal PURPOSE: In order to insure that refrigerator and freezers are in proper working order and to assist in the	W 454	maintained in a clean manner and equipment used to cut medication in half is cleaned between clients. Any negative findings will be corrected and Administrator will be notified. Completion date 8/24/2024	

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(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
W 454	Continued From page 9 prevention of food borne illness, refrigerator/freezer temperatures will be recorded twice per day in dietary. PROCEDURE: Refrigerator/Freezer: Our refrigerators/freezers have been identified name of cottage and correspond with the equipment temperature log. Each refrigerator/freezer contains a working thermometer..." Review of the "Patient Information Sheet" noted Client #2 had diagnoses including unspecified intellectual disabilities, reactive attachment disorder of childhood, and posttraumatic stress disorder. Review of the "physician orders" dated 07/19/2024, read in part, " ...Tenex 1 mg [milligram]...tab [tablet]...@ [at] 8AM [8:00 AM] and 1/2 tab at 12 N [12:00 noon]..." Review of the "Patient Information Sheet" noted, Client #8 had diagnoses including mild intellectual disability, disruptive mood dysregulation disorder, reactive attachment disorder, attention deficit hyperactivity disorder, and separation anxiety disorder. Review of the "Medication Administration Record" dated 06/21/2024 read in part, "...Clonidine 0.1mg [milligram] 1/2 tab [tablet]...Q [every] 8AM [8:00 AM] and 12N [12:00 Noon] 2 tabs Q HS [hour of sleep] for impulse..." Review of the "Patient Information Sheet" noted, Client #9 had diagnoses including mild intellectual disabilities, conduct disorder and attention deficit hyperactivity disorder. Review of the "Medication Administration Record"	W 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G011	A. BUILDING _____ B. WING _____	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	1828 INDUSTRIAL DRIVE FORDYCE, AR 71742

(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
W 454	Continued From page 10 dated 05/17/2024, read in part, "...Clonidine 0.1 mg [milligram]...1/2 tab [8:00 AM] and 12N [12:00 Noon] ...Haldol 10 mg...1/2 tab at [8:00 AM] and 12N [12:00 Noon]..." On 07/23/2024 at 11:50 AM, the Surveyor observed Licensed Practical Nurse (LPN) #1 during the noon medication pass at Willow Creek House. At 12:01 PM, LPN #1 obtained Client #8's Clonidine 0.1mg (milligram) tablet from the prescription bottle and used a pill cutter that was on the counter to cut the tablet in half. LPN #1 put 1/2 of the tablet into a medicine cup and transferred the other 1/2 back to the prescription bottle. The 1/2 tablet in the medicine cup was then administered to Client #8. LPN #1 put the pill cutter back on the cabinet without cleaning it. On 07/23/2024 at 12:10 PM, Licensed Practical Nurse (LPN) #1 obtained Client #2's Tenex 1mg tablet from the prescription bottle and used the pill cutter that was on the counter to cut the tablet in half. Licensed Practical Nurse (LPN) #1 put 1/2 of the tablet into a medicine cup and transferred the other 1/2 back to the prescription bottle. The 1/2 tablet in the medicine cup was then administered to Client #2. LPN #1 put the pill cutter back on the cabinet without cleaning it before or after use. On 07/23/2024 at 12:23 PM, Licensed Practical Nurse (LPN) #1 obtained Client #9's Clonidine 0.1 mg (milligram) tablet from the prescription bottle and used the same pill cutter to cut Client #9's tablet in half that was on the counter that had been used for cutting Client #2 and Client #8's medication. LPN #1 put 1/2 of the tablet into a medicine cup and transferred the other 1/2 back to the prescription bottle. LPN #1 repeated the	W 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G011	A. BUILDING _____ B. WING _____	07/25/2024

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W 454	Continued From page 11 process with Client #9's Haloperidol 10mg tablet cutting the 10 mg tablet in half. The two 1/2 tablets in the medicine cup were then administered to Client #9. LPN #1 put the pill cutter back on the cabinet without cleaning it before or after use. On 07/23/2024, during an interview at 12:30 PM, Licensed Practical Nurse (LPN) #1 confirmed that the same pill cutter was used for all three clients and that clients do not have individual pill cutters. When asked, LPN #1 confirmed that the pill cutter was not cleaned between clients and reported that it is cleaned weekly. LPN #1 showed a monitoring log posted on the wall for the cleaning schedule of equipment that included "Pill Cutter" with dates of "07/02/24, 07/10/24 and 7/16/24". On 07/25/2024 at 9:45 AM, during an interview the Assistant Director of Nursing (ADON) stated to the Surveyor that pill cutters should be cleaned "after each use and PRN [as needed]" The Surveyor asked if the pill cutter should be cleaned between each client, the ADON replied, "Yes." On 07/24/2024 at 10:29 the Chief Executive Officer provided a facility policy titled, "Medication management" with a revised date of 12/2023, that specified in part, Section "Infection Control in Medication Administration ...The nurse will transfer the medication from the closed container it is stored in (blister pack or bottle) to the inside of the medication cup without contaminating the medication. The medication will be considered contaminated if it comes in contact with any surface other than the inside of the closed container it is stored in or the inside of the medication cup it will be administered from."	W 454		

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W 454	Continued From page 12 During observations in the main kitchen on 07/24/2024 from 1:03 PM through 1:30 PM, the following concerns were identified: a. The milk box contained 26 pints of expired 2% milk dated, "Jul [July] 23", the milk box did not contain a thermometer. Cook #1 looked through the case, moving crates of milk to verify there was no thermometer, none was found. Cook #1 retrieved a thermometer and placed it in the milk box. Cook #1 was asked if the milk box should have a thermometer in it. Cook #1 stated yes it should have a thermometer.	W 454		