ARKANSAS DEPARTMENT OF HUMAN SERVICES
Division of Provider Services and Quality Assurance

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August 13, 2024

United Methodist Children's Home
2002 S Fillmore St
Little Rock, AR 72204-4909

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

Observations and any deficiencies noted are listed below for the inspection conducted at the following service site on the following date:

United Methodist Children's Home
Provider Medicaid ID: [redacted]
Onsite Inspection Date: August 08, 2024
Onsite Inspection Time: 8:49 AM

A summary of the policies reviewed, and finds are noted below:

Inspection of Care Summary

Health and Safety-Policy Review

This additionally ordered inspection was triggered by a complaint against United Methodist Children's Home. Based on the nature of the incident, the following were requested for review:

- Policies
- Staffing Schedules and Daily Census from July 1, 2024, until date of IOC
- Personnel Records
- Client file of the alleged victim

Health and Safety Deficiencies:

Upon review of the site's policies, procedures, and certification requirement, no deficiencies were noted.

Observations:

Upon arrival at the facility, AFMC staff was promptly greeted at the entrance by a United Methodist Children's Home receptionist in the main lobby. AFMC was immediately taken to a conference room where they were met by the Compliance Director and the Corporate Compliance Specialist. AFMC staff received the completed and signed consent form listing approval for access to the AFMC portal prior to arrival to the site visit. Facility staff were given the Document Request Form, and AFMC staff discussed the requirements for the Inspection of Care.

A tour of the facility was completed with the Corporate Compliance Specialist and the Nurse Manager. Areas toured included the boys' and the girls' units including the dayrooms and clients' rooms, the seclusion rooms, medication room, cafeteria, gymnasium, and outdoor courtyard. The facility environment was extremely clean, well-organized, and appeared to be in good repair. Therapeutic group activities were in session on both units. Staff were able to answer questions regarding the facility.

Upon entering the girl's unit, AFMC staff noted one female adolescent client sitting quietly at a table drawing. AFMC noted the only visible staff member present on the unit at this time was a housekeeper. AFMC staff asked the Nurse Manager who was giving the tour if it was facility policy for clients to be left in the care of housekeeping. The Nurse Manager did ask the housekeeper where the staff responsible for the client was located, and the housekeeper stated the Behavioral Instructor (BI) was in the bathroom. The Nurse Manager stayed with the client until the BI returned. Upon personnel file review it was noted that the housekeeping staff was not properly trained to supervise clients. They did not have current CPR nor restraint and seclusion training.

While visiting with the facility nurse in the medication room, AFMC staff observed the alleged victim come to the window of the medication room inquiring about getting treatment for a wound on their foot. Staff nurse excused herself from the conversation to take care of the wound. AFMC staff observed the alleged victim take flip flops off and lay across the furniture. No dressing was noted on the wound of their right foot.

Additional Health and Safety Policy Review:

Based on the nature of the incident, the following additional policies were requested for review:

- Incident Reporting Policy
- Critical Incident Logbook
- Skin and Wound Assessment Policy
- Nurse On-Call Policy
- Vital Signs Policy – Per facility staff, there is no policy regarding frequency of vital signs.
- Staffing Policy
- BI Job Description
- Nurse Job Description

Personnel Records – Licenses, Certifications, Training:

There was a total of nine professional personnel records reviewed. There were no deficiencies noted during the personnel record review.

Clinical Record Review Deficiencies:

AFMC was provided with the alleged victim's file for review.

The provider uploaded records which were then reviewed for compliance with licensure standards. Based on the review of clinical components of licensure requirements, the following deficiencies were noted:

Record Number	Rule	Deficiency Statement	Reviewer Notes
RR0035188	IP Psych 221.702	Restraint or seclusion intervention was used as a means of coercion, discipline, convenience or retaliation.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.702, 221.703, 221.704	Physician order was not specific to the acute incident requiring the use of restraints or seclusion.	Multiple incidents of restraint and seclusion have been utilized on this client since [redacted]24 admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.703	A face-to-face assessment of the physical and psychological well-being of the resident was not completed within 1 hour of the initiation of the emergency safety intervention by a physician or other licensed practitioner.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.

Record Number	Rule	Deficiency Statement	Reviewer Notes
RR0035188	IP Psych 221.703	The order for restraint or seclusion does not include the date and time the order was obtained.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.703	The start and stop times of the emergency safety intervention were not documented.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.703	The name(s) of the staff involved in the emergency safety intervention were not documented.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.703	The documentation of the intervention was not completed by the end of the staff's shift.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.703	The intervention was not conducted within the time limitations for the client's specific age.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.703	The order for the emergency safety intervention does not include the length of time for which the physician or other licensed practitioner permitted by the State and the facility to order restraint or seclusion authorized its use.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.704	The date and time the team physician was consulted was not documented in the resident's record.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.707	There is no documentation of the facility notifying the resident's parent(s) or legal guardian(s) as soon as possible after a serious occurrence.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.709	There is no documentation of a face-to-face post intervention debriefing within 24 hours after the use of restraint or seclusion with staff involved and the Client.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.
RR0035188	IP Psych 221.709	There is no documentation of a post intervention debriefing within 24 hours after the use of restraint or seclusion with all staff involved.	Upon review of the restraint and seclusion log, numerous incidents of restraint and seclusion have been utilized on this client since admission. No restraint or seclusion documentation submitted for review.

Summary of Findings and Resolution:

Below in a synopsis of events for the alleged victim:

- Client admitted to United Methodist Children's Home on [redacted] 2024.
- On July 18, 2024, the client became upset after staff took their papers and began kicking doors in the hallway. The client broke through the magnetic locking doors on hallway and attempted to break through the magnetic locking doors into the boy's unit. When the client kicked the door, the client's toe got stuck in the magnetic lock and client pulled foot away, injuring the fifth digit of right foot. Initially the client refused assessment and walked around foyer of unit dripping blood and smearing blood onto walls and floor. Once the client became compliant with assessment, the wound was assessed and cleaned by nurse and reported to the APRN who ordered the client to be transferred to [redacted] for further evaluation and treatment via EMS. Client returned approximately 6.5 hours later after receiving [redacted] studies revealing a [redacted] Client was placed on [redacted] for wound. The client also was given an [redacted] to wear to protect wound from further injury. Once the client returned to the facility, the client was aggressive toward staff and tried attacking staff members. Staff had to call the on-call nurse in to facility (licensed nurses are on-call and not in-house from 10:00p.m. until 6:00a.m. each night) to assist with client behaviors. The client removed the orthopedic boot and refused to wear it.
- Documentation daily after the client returned from the emergency department stated that the client was non-compliant with the wound care and refused treatment numerous times. The client would remove the dressing from the wound and refused to wear shoes throughout the facility. Staff documented numerous times daily of encouraging the client to put flip flops on. Staff also documented daily that the wound was cleaned and redressed due to the client removing dressing and that the client was dragging foot across the floor, carpet, and furniture after removing dressing, and pulling scab off until wound would bleed.
- On July 31, 2024, the RN Nurse Manager assessed the client's wound to the right fifth toe. In the assessment, the nurse manager stated that the wound appeared to be worse and had dehisced at wound edges with greenish-yellow exudate present in wound with some areas of dark discoloration/black appearing tissue without odor. Tip of right fifth toe appeared red and inflamed. The APRN was called and updated with wound pictures sent. APRN instructed nursing staff to send the client to [redacted] for further evaluation and treatment. The client stayed at [redacted] for wound care and [redacted] and returned to the facility on [redacted] 2024. Upon returning to facility the wound had steri-strips applied and covered with dressing. The client continued to remove the dressing numerous times daily and continued to pick at the wound.
- On August 7, 2024, staff documented the client's right fifth toe appeared dirty with pieces of hair noted in the wound. There was dried up yellow tinted discharge and the wound had discolored, darkened areas suggestive of dead tissue/necrosis observed. The nurse cleansed the wound, removed debris as much as possible, applied multiple steri-strips firmly, and covered the toe with two bandages. Nursing continued to document the client's noncompliance with leaving the dressing on, picking at wound, and not wearing appropriate shoes.

Below are findings based on review of the critical incident reports:

- Upon review of the critical incident report logbook, AFMC staff noted that there were missing times, missing details, and follow-up was not documented.
- Critical incident reports were reviewed for the alleged victim during the timeframe of received complaint. Below is a summary of reviewed incident reports and outcomes:
    - On July 16, 2024, at 8:15 p.m. per the critical incident report, the client got upset after staff would not allow client to take books to their room. The client began yelling and screaming and becoming aggressive as staff put the client's books back in the coping skills closet. The client pushed staff while he was walking out the door. A staff member backhanded the client hitting the client in the face. Other staff intervened, removing the client from the dayroom. The client continued to be aggressive toward staff and staff had to hold the client away from the staff member who had the client's books. The client continued to hit and punch at staff and hit the staff member holding the books in the face injuring their nose. The client grabbed their books and kicked their way through the doors of the unit. The client received a chemical restraint. The client was assessed by the nurse and was found to have no markings or bruises.

- On July 18, 2024, at 6:15 p.m. per the critical incident report, the client asked to be excused during dinner. The client entered the hallway and crossed over into the dayroom grabbing their book. The staff told the client that they couldn't have their book until dinner was over. The client got upset and refused to respond to the staff, yelling profanities at the staff. The client was kicking at the magnetic lock door and was able to get to the elevator area. The client heard the elevator coming and kicked the elevator door. The client then started kicking at the magnetic locked door to enter the foyer area. While kicking at the door the client cut "pinky toe" on right foot. The nurse was informed of the incident and the ambulance was called.
- On July 22, 2024, at approximately 6:45 p.m. per the critical incident report, the client got off task because they couldn't find their books. The client began to dump out Legos, markers, color pencils, etc. The client began making verbal threats to attack the staff and throwing objects at staff. The client threw dominos causing them to break. The client then began to make threats of cutting with the broken dominos. The client refused to pick up the spilled items and pushed through staff and began kicking at the door. The client was able to be redirected to sit down and calm down.
- On July 31, 2024, at 1:08 p.m. per the critical incident report, the client was in the cafeteria and the client was trying to step on another client's heel, hitting his "pinky toe" on the edge of the table. The nurse was notified and put peroxide and a band-aid wrap on the client's toe.
- On August 4, 2024, time not documented per the critical incident report the client got upset because he couldn't play the video game. The client went into a "tantrum" screaming. The client was observed picking at toe and trying to twist skin off making it bleed.

- AFMC staff spoke with one of the direct care nurses regarding the above incidents. The nursing staff member was able to verbalize much more details about the above incidents. Nursing documentation also provided much more detail regarding the client's behaviors as well as detailed wound assessment and follow-up care including the client having to be transferred to [redacted] for continued care on [redacted] 2024, and [redacted] 2024. AFMC staff spoke with the nurse manager and the BI supervisor who both relayed that the critical incident reports are only completed by the BI. When asked if an incident occurs that isn't witnessed by a BI but instead a licensed nurse who fills out the incident report, and the nurse manager and BI supervisor both stated the BI will still fill out the critical incident report. When asked if any training was given to staff on how to fill out a critical incident report, the supervisory staff stated no. AFMC staff did speak with the Corporate Compliance Officer regarding the lack of important details such as wound assessments, missing times, and no follow-up.
- AFMC staff noted the Critical Incident Report Policy implies that a witness to the incident will fill out report. The policy states the narrative section will contain a detailed description of the incident and the use of presumptive descriptors (*i.e. patient was aggressive*) will not be used. The Policy also states that the staff will complete the follow-up section and what information must be included.

Below are other related findings based on requested policies:

- AFMC staff requested daily staffing per shift and client census from July 1, 2024, until August 8, 2024. Facility staff were unable to provide adequate documentation of staffing for each shift and what the census was each shift to determine if staffing was appropriate based on facility's staffing policy.
- AFMC staff requested a copy of the On-Call Nurse Policy for review. The facility does not staff an in-house licensed nurse after 10:00 p.m. until 6:00 a.m. The on-call nurse is required to be available by phone and must respond to the facility within 30 minutes of receiving a phone call if needed. The on-site staff will contact the on-call nurse regarding any medical concerns, restraints, or need for physician input on client behaviors. Once having received a call, the nurse is required to advise on-site unlicensed staff on medical issues and if needed respond to the hospital to assess or provide care for the client(s).
- AFMC staff requested a copy of the Vital Signs Policy. Routine vital signs to include temperature, heart rate, respiratory rate, blood pressure, and pain scale is a way to assess for infection and psychotropic medication reactions. The facility does not have a policy stating the frequency of how often or when it should be appropriate for vital signs to be taken. AFMC staff visited with the facility nurse who stated vital signs are taken upon admission and once weekly. Facility nurse also stated the staff try to take all weekly vital signs on Mondays but sometimes they get missed or the client refuses, so they will continue daily to try to obtain vital signs, but there is no written standard.

Respectfully,

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