September 20, 2024

Arkansas Foundation for Medical Care (AFMC) performs Inspections of Care (IOC) reviews of the Behavioral Health Agencies for the Division of Provider Services and Quality Assurance with the Arkansas Department of Humans Services. The Arkansas Department of Human Services Division of Behavioral Health Services Licensure Standards 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

An incident occurred at the following service site that prompted an order for an additional review. Upon review of the policies relevant to the incident, the findings are noted below:

Habilitation Center, LLC
1810 Industrial Drive
Fordyce, AR
Onsite Inspection Date: September 16, 2024
Onsite Inspection Time: 9:05 AM

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

Inspection of Care Summary

Health and Safety-Policy Review

This additionally ordered inspection was triggered by a complaint against Habilitation Center, LLC. Based on the nature of the incident, the following were requested for review:

- Policies
    - Infection Control Policies and Plan
    - Illness Screening Policy *(This was found in the facility's Infection Control Plan.)*
    - Vital Signs Policy *(This was found in the facility's Chapter 17 – Physical Health Services.)*
    - Policy and Procedure regarding when to obtain outside medical care for client *(This was found in the facility's Chapter 18 – Referral Services.)*
    - Policy and/or Procedure regarding notifying parent or guardian when client is ill *(No policy or procedure provided.)*
    - Client Home Visit/Home Pass Policy
    - Policy regarding when to cancel a home visit/pass *(COO stated there is no written policy or procedure for this. They rely on the case manager or the nursing staff to notify parents or guardian when client is ill.)*
- Client file of the alleged victim

Observation:

Upon arrival at the facility, AFMC staff were promptly greeted at the entrance by a Habilitation Center, LLC receptionist in the main lobby. AFMC staff signed the visitor log. AFMC staff were immediately taken to a conference room where they were met by the Chief Operations Officer and the Director of Risk Management. AFMC staff was given the completed and signed consent form listing approval for access to the AFMC portal. 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 Chief Operations Officer and the Director of Risk Management. Areas toured included multiple units and houses on the upper and lower campus, nurses station including the medication room, cafeteria, gymnasium, several outdoor courtyards, and school building that houses the educational classrooms. The facility environment was extremely clean, well-organized, and appeared to be in good repair. Therapeutic group activities and classes were in session. There were no immediate issues noted during the facility tour. Staff were able to answer questions regarding the facility.

There were two units, Eagle Hall and Kangaroo Hall, in the main building on the upper campus that were both on quarantine precautions until September 18, 2024. Both units had 2 clients each that had tested positive for COVID-19. Eagle Hall had 17 clients quarantined and Kangaroo Hall had 12 clients quarantined. AFMC staff toured both units with facility staff and were required to wear surgical masks while on the unit. Outside both units there are masks at the central nurses' station was an area where the mask was available as well as an area where to dispose of the mask and hand sanitizer was available for use. All clients remain in the unit for all educational classes, activities, and meals except for some outdoor activities so clients can get exercise and fresh air. When these units are outside, they are the only unit in the area.

Staff and clients were observed throughout the facility in the classroom setting in the school unit and in organized group activities throughout the campus. Clients were engaged in schoolwork and activities. Two staff members were noted to be on their phone in two separate classrooms. Otherwise, staff were calmly interacting with clients and providing a therapeutic environment that was conducive for learning and treatment therapies.

AFMC staff reviewed the final document request form with the Chief Operations Officer at the completion of the on-site Inspection of Care and the provider signed the acknowledgement of manual requirements that were not made available in the provider's policy and procedures. AFMC staff explained that these findings were preliminary and there was still an off-site portion to be completed.

Personnel Records – Licenses, Certifications, Training:

Based on the nature of the incident there were no personnel records reviewed.

Clinical 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:

Rule Found Deficient	Specific Rule Violation(s)	Record	Reviewer Notes
RR0035815	IP Psych 217.000	There is no documentation of a Social Evaluation conducted by professional staff or the evaluation was not conducted within 60 hours of admission.	The client was admitted to the facility on 2024 at The social evaluation was completed on 024 at which is 9.5 hours passed the 60 hours after admission requirement.
RR0035815	IP Psych 217.000	There is no documentation of a Medical Evaluation conducted by a physician and/or the evaluation was not conducted within 60 hours of admission.	The client was admitted to the facility on 2024 at The medical evaluation was completed on 2024 at which is 6.25 hours passed the 60 hours after admission requirement.

Summary of Findings and Resolution:

Below is a summary of findings from the policy and procedure review:

- Infection Control Policy/Plan reviewed.
  - Page 4: Patient-Related Measures
    - All patients shall receive, within twenty-four hours of admission, a complete physical examination, which shall include appropriate laboratory tests and a chest x-ray if ordered by the admitting physician.
    - Any patient with suspected infections or communicable diseases will be examined by the physician and orders for acute care or proper isolation will be obtained.
    - All patients will receive education on Infection Control
  - Page 11: IV. Visiting Regulations
    - Visiting with residents in isolation shall be limited to the immediate staff working with that resident. They shall be instructed by nursing staff on isolation rules.
  - Page 11: V. Suspected Infections
    - Residents suspected of having acquired infections shall be reported to the medical staff immediately and the appropriate precautions instituted promptly according to isolation policy.
  - Infection Control Plan includes an Antibiotic Stewardship Program. According to the "Suggested antibiotic Protocols for Conditions" on page 25, the antibiotic that this client was placed on is not a recommended antibiotic for [redacted] Antibiotics listed for [redacted] include [redacted] orally twice daily for five days, [redacted] orally three times daily for seven days, and [redacted] orally twice daily for seven days. [redacted] is listed for community acquired [redacted] s a weight-based dosage orally for seven days and for acute [redacted] as a weight based dosage orally for ten days. *The client was placed on [redacted] orally for five days.*
- Chapter 17 – Physical Health Services
  - Page 9 Vital Signs
    - All patients/residents have vital signs taken upon admission, routinely, as ordered by the physician, or as indicated based on nursing assessment. Any specific order for vital signs is followed per doctor's orders. Nurses take vital signs after any change in the patient's/resident's condition. Examples include but are not limited to: change in mental status, any respiratory problems, and change in color.
- Chapter 18 – Referral Services
  - This policy details each type of referral including medical specialists and emergency services.
    - Page 4 Medical Specialists: Patients/Residents requiring medical services, i.e., endocrinology, ophthalmology, dermatology, gynecology, may be referred to Arkansas Children's Hospital unless otherwise specified. Patients/Residents requiring specialized medical services receive such services upon the written and signed order of a physician. Prior to or at the time of the patient's/resident's referral from Millcreek, all pertinent medical and psychiatric information is provided to the medical specialist. Upon completion of the service, a written report shall be provided by the specialist for incorporation in the patient's/resident's clinical record.
    - Page 4 Emergency Services: Emergency Services are provided through the Dallas County Medical Center.
- Therapeutic Passes/Visitation Policy states the following:
  - Visitation and passes are encouraged with all patients. The purpose of therapeutic passes is to interact with family members and to work on specific goals. Passes allow the parents, patients, staff, and physician an opportunity to assess changes that have been made or to identify problem areas that need further work. The parents' feedback to the staff at the end of a pass is essential for making therapeutic passes an effective part of the treatment program. Whether a patient receives a pass depends upon a number of factors and the decision is made by the Treatment Team. The Treatment Team determines the specific dates and time of departure and return to the Unit. Instructions for pass medications are explained by the nurse to the parents/guardians and patient

prior to leaving on pass. When deemed appropriate, body checks are completed upon returning. While on a home pass or visit, the communication from guardians regarding the patients' interactions, etc., will be documented in the patient's chart. Personal items may be checked by staff upon admission and upon return from a pass as deemed necessary.

Below in a synopsis of events for the alleged victim:

- Client admitted to Habilitation Center, LLC on [redacted] 2024, at [redacted]
- Client was placed in Flamingo Hall in the main building on the upper campus. Flamingo Hall was placed on quarantine from August 23, 2024, until September 6, 2024, for respiratory illness.
- The following significant events were documented in the nursing staff notes of the client's clinical record:
  - On [redacted] 2024, at [redacted] on the admission assessment the client's temperature was documented as 97.2°F and there were no signs or symptoms of cough, congestion, or sore throat noted in the initial assessment.
  - On August 15, 2024, at 7:45 a.m. the nursing staff documented the client complained of feeling "warm" and of a sore throat. The nurse documented the client's temperature was 97.8°F and throat had some redness. [redacted] given orally and [redacted] given orally. There was no follow-up documentation noted.
  - On August 21, 2024, at 11:50 a.m. the client presented to the nurses' station with complaints of chills, stomachache, sore throat, and cough. The nursing staff documented client's throat had redness and irritation. The client's temperature was documented as 101°F. The client was tested for both strep throat and COVID-19 and both tests were negative. The client was given [redacted] orally, [redacted] orally, and [redacted] orally. There was no follow-up documentation or temperature checks noted.
  - On August 22-23, 2024, there was no nursing documentation of any previously documented signs and symptoms of illness or temperature checks.
  - On August 24, 2024, at 7:45 a.m. the nursing staff documented the client complained of headache of 5/10 on pain scale and cough. The client was given [redacted] orally and [redacted] orally. No temperature check was documented.
  - On August 24, 2024, 9:30 a.m. the nursing staff documented follow-up with client who had no further complaints of headache or cough.
  - On August 24, 2024, at 7:40 p.m. the nursing staff documented the client complained of cough, fever, congestion. Temperature was 103.6°F. The client was given [redacted] orally and [redacted] orally.
  - On August 24, 2024, at 9:00 p.m. the nursing staff documented reassessment of client's condition as a decrease in client's temperature and cough. Actual temperature not documented at this time.
  - On August 25, 2024, at 12:52 a.m. the nursing staff documented the client complained of cough and fever. Temperature was 99.4°F. The client was given [redacted] orally and [redacted] orally.
  - On August 25, 2024, at 2:20 a.m. the nursing staff documented reassessment of client's condition as a decrease in temperature and cough. Actual temperature not documented at this time.
  - On August 25, 2024, at 5:45 p.m. the nursing staff documented client's temperature as 102.8°F. The client was given [redacted] orally.
  - On August 26, 2024, at 2:18 a.m. the nursing staff documented the client complained of coughing and headache. Client's temperature was 99.5°F. The client was given [redacted] orally and [redacted] orally.
  - On August 26, 2024, at 7:30 a.m. the nursing staff documented the client complained of sore throat. The client's temperature was 98.4°F. The client was given [redacted] orally.

- On August 26, 2024, at 1:40 p.m. the nursing staff documented given. No other documentation regarding client's symptoms or requests noted in chart.
- On August 26, 2024, at 7:05 p.m. the nursing staff documented client's temperature 100.3°F. The client was given orally.
- On August 27, 2024, at 1:10 a.m. the nursing staff documented the client complained of cough and congestion. The client's temperature was 98.2°F. The client was given orally and an allergy tablet (name, dosage, and route of medication not documented).
- On August 27, 2024, at 7:30 a.m. the nursing staff documented that the client was to be transported to for mono spot test and a complete blood count (CBC) to be done due to oral illness and elevated temperature. *(No test results were submitted for clinical review nor was there any documentation in the nursing staff notes regarding the client being transported or returning to facility.)*
- On August 27, 2024, at 7:40 a.m. the nursing staff documented the client's temperature was 100.8°F and the client requested throat spray for irritated throat. The client was given orally and orally.
- On August 27, 2024, at 12:54 p.m. the nursing staff documented the client's temperature was 99.6°F. The client was given orally.
- On August 27, 2024, at 7:36 p.m. the nursing staff documented the client complained of cough, congestion, headache, and sore throat. The client's temperature was 100.1°F. The client was given orally and orally.
- On August 28, 2024, at 12:58 a.m. the nursing staff documented the client complained of cough and congestion. The client's temperature was 98.5°F. The client was given orally.
- On August 28, 2024, at 7:15 a.m. the nursing staff documented the client complained of cough and was given orally.
- On August 28, 2024, at 10:30 a.m. the nursing staff documented the client was transported to for a chest x-ray due to cough and fever. *(No results or documentation was submitted regarding chest x-ray.)*
- On August 29, 2024, at 7:00 a.m. the nursing staff documented the client complained of sore throat and was given orally.
- On August 30, 2024, at 7:00 a.m. the nursing staff documented the client complained of sore throat and was given orally.
- On August 31, 2024, at 7:15 a.m. the nursing staff documented the client's speech as being "hoarse" and that client requested throat spray. *(No documentation in nursing staff notes of throat spray being given to client. No medication administration records uploaded for review to verify requested treatment given to client.)*
- On September 1, 2024, at 8:05 a.m. the nursing staff documented the client requested throat spray and was given orally.
- On September 2, 2024, at 9:30 a.m. the nursing staff documented the client returned from an on campus pass with family. The parents of the client brought the client cough drops, tea, and Kleenex. Items were kept at the nurses' station.
- On September 3, 2024, at 7:45 a.m. the nursing staff documented the client was noted to have a cough. Client refused and requested The client's temperature was 99.8°F. The client was given orally.
- On September 3, 2024, at 2:18 p.m. the nursing staff documented receiving an order from the physician for orally to be taken daily every morning for

The nursing staff also documented attempting to contact client's mother to get consent to administer antibiotic but there was no answer, so nurse left voicemail. No other attempts to contact mother on this date were documented.

- On September 4, 2024, at 7:00 a.m. the nursing staff documented that the client was given the first dose of [redacted] orally.
- On September 5, 2024, at 7:00 a.m. the nursing staff documented that the client was still taking the antibiotics.
- On September 6, 2024, at 7:00 a.m. the nursing staff documented that the client was still taking the antibiotics.
- On September 7, 2024, at 7:35 a.m. the nursing staff documented that the client was still taking the antibiotics.
- On September 9, 2024, at 7:45 a.m. the nursing staff documented that the client complained that throat was "a little sore" and [redacted] was given. Also, the nursing staff documented the antibiotic regimen was completed the day before which would have been September 8, 2024.
- On September 13, 2024, at 8:40 a.m. the nursing staff documented the client left the facility for a 72-hour home pass.
- On September 16, 2024, at 2:05 p.m. the nursing staff documented the client had returned to facility from 72-hour pass. While on home pass with family, the client's mother took client to be seen by a physician before bringing client back to facility and received a prescription for [redacted] The nursing staff documented they would contact mother for clarification of order.

- No other documentation was submitted for review after September 16, 2024, at 2:04 p.m. due to AFMC conducted Inspection of Care on this date.
- No physician orders, physician notes, or medication administration records were submitted for review for this client. Unable to determine if the nursing staff remained in contact with the physician regarding the health of the client.
- The Chief Operating Officer attached a letter date September 17, 2024, to the client's clinical record that stated the following:
  - The client was scheduled for a pass on September 2, 2024. However, due to the client's illness, the pass was canceled, but this information was not relayed to the family. When the family arrived on campus, it was decided to allow the visit, modifying it to an on-campus pass due to the quarantine. Upon their arrival, the parents were informed that the visit could proceed, but quarantine precautions needed to be followed. They were given the option of an outdoor visit or using a meeting room, with masks required for the duration of the visit.

Respectfully,

Inspection of Care Team
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