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

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UPDATED: December 4, 2024
November 25, 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 71742-7110
Onsite Inspection Date: November 20, 2024
Onsite Inspection Time: 8:56 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
  - Restraint Policy
  - Restraint Log for October 2024 and November 2024
  - Incident Reporting Policy
  - Critical Incident Reporting Policy
  - Incident Report and any surrounding documentation regarding this complaint *Facility provided the following documentation:*
    - Incident Report dated October 25, 2024
    - Arkansas Mandated Reporter Form
    - Employee Disciplinary Action Report
    - 521 Visit Compliance Report
- Client file of the alleged victim
- Employee File Review

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. AFMC staff were 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.

Personnel Records – Licenses, Certifications, Training:

Based on the nature of the incident, personnel records were reviewed. There were no deficiencies noted.

Upon the review of the alleged offenders personnel record, the following was noted:

- 08/05/24- initial staff hire date
- 10/25/24- alleged incident
- 10/31/24- attended annual training of Therapeutic Crisis Intervention System (TCI)
- 11/05/24- termination of offender

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, there were no deficiencies noted.

Summary of Findings and Resolution:

Below is a summary of observations from the chart review of the alleged victim:

- Client was admitted to Habilitation Center LLC on [redacted]2024, at 2:50 p.m. and was still a client in the facility on the date of the additionally ordered Inspection of Care.
- Client had multiple episodes documented in the nursing notes and staff observation notes detailing the client's behaviors that included the following:
    - Self-harming behaviors including biting self and banging head on wall
    - Non-compliance with structured activities and classroom work
    - Yelling/screaming at staff, teachers, and peers
    - Hitting staff and peers
    - Provoking/agitating other clients in an attempt to fight
    - Running away from staff and threatening to elope
    - Threats of killing self
    - Use of inappropriate language toward peers and staff
    - Use of sexually inappropriate gestures and statements to staff
    - Injuring self when banging head on wall and threatening to blame staff for injuries to "get them fired"
- On September 24, 2024, October 5, 2024, and November 12, 2024, the client was placed on unit restrictions due to continuous disruptive behaviors.
- On September 24, 2024, from 12:42 p.m. until 12:52 p.m. the client was placed in a physical hold due to biting self and hitting other peers. Restraint documentation was reviewed, and all elements of required documentation were met.
- On October 23, 2024, at 1:00 p.m. there was documentation by a Behavioral Health Assistant on the daily observation sheet that stated the client was provoking peers and was aggressive. Clients were separated. The client ran inside the unit banging head on hallway doors. The client was removed from the area by staff and noted to have a scratch on finger on right hand. The client stated they were going to say staff did it. Staff had to do a safety protocol and escorted the client from the door due to self-harming behavior.
- On October 25, 2024, at 7:55 p.m. there was documentation by a Behavioral Health Assistant on the daily observation sheet that stated the client asked a Staff Member A 'why they were so mean and mad.' Staff Member A told client they are 'a provoker and messy.' Staff Member A and client continued to argue, and Staff Member B told the client to go color in another spot to calm down. Staff Member A then called client "gay lil boy" and client called staff a 'bitch'. Staff Member A then 'jacked patient up by shirt against the wall'. The client and Staff Member A started getting physically aggressive. Staff Member B told Staff Member A to "stop and chillout and go get a breather." The nursing staff documentation did not document the incident.

- On November 12, 2024, at 11:45 a.m. there was documentation by a Behavioral Health Assistant on the daily observation sheet that stated the client was non-compliant and ran away from staff toward the highway. The client was escorted back to the unit. The client stated they were going to lie and said all the staff had hit the client. The client punched themselves in the forehead. At 12:00 p.m. the client ran out of the assigned area again and was escorted back to the unit. The client began screaming "they are hurting me." The client stated that they would keep doing it to "get staff in trouble."
- On November 17, 2024, at 5:17 p.m. there was documentation by a Behavioral Health Assistant on the daily observation sheet that stated the client was choking themselves and attempted to run away from staff. Staff redirected client. At 5:32 p.m. staff asked the client to use coping mechanisms. The client took a marker from a peer and bit the end of the marker off and swallowed it. The staff reported this to the nurse. At 5:32 p.m. Behavioral Health Tech documented that the client "made a false allegation against a staff member" about a staff member inappropriately touching the client and upsetting the other clients with the allegation. The client was confronted with the allegation in front of the other clients and the client stated, "I lied, she didn't. I just wanted to get someone fired."
- No other documentation for this client was submitted for review after November 20, 2024, due to AFMC conducting Inspection of Care on this date.

Policy and Procedure Review:

There were no deficiencies noted during the review. The following is a summary of observations from the request documents and policy and procedure review:

- Restraint and Seclusion Policy
  - Facility does not utilize seclusion but does utilize physical holds and chemical restraints.
  - Noteworthy statements from Restraint and Seclusion Policy:
    - Millcreek uses the Therapeutic Crisis Intervention System (TCI) developed by Cornell University. TCI is a crisis prevention and intervention model for residential childcare facilities.
    - The PRTF Individualized Behavioral Contingencies policy provided includes staff training requirements for staff involved in restraints. The policy states *"all direct care staff, staff involved in the use of restraint, and those authorized to initiate restraint, will receive initial and ongoing training. Millcreek Leadership will conduct this training during the initial orientation, annually, and at any other time deemed necessary." "Staff members must demonstrate competency in both a written and physical skills test for TCI. All TCI trained employees must attend a semi-annual TCI refresher training which last for four hours. This refresher training is conducted every six months from the date of original training."*
- October 2024 Restraint Log observations:
  - There were 54 incidents of restraints documented for the entire month of October.
    - 48 out of 54 incidents of physical holds only
    - 6 out of 54 incidents had both a physical hold and chemical restraint
  - There were 32 incidents involving restraints that were not able to be reviewed on the security camera system due to restraints occurring where there was no camera coverage or due to technical difficulties with camera system.
- November 2024 Restraint Log observations:
  - There were 50 incidents of restraints documented from November 1, 2024, through November 19, 2024.
    - 36 out of 50 incidents of physical holds only
    - 14 out of 50 incidents had both a physical hold and chemical restraint
  - No reviews of any restraints for November have been completed at the time of IOC.
- Review of the Incident Report observations:
  - Incident occurred on October 25, 2024, at 7:51 p.m.
  - The incident was reported by the alleged victim's guardian after the alleged victim disclosed the information to the guardian via telephone call.

    - The facility was notified via email on November 4, 2024, of the incident. The email was sent to the facility on the evening of November 3, 2024. The incident report does not disclose who sent the email.
    - The incident report includes initial corrective actions including:
        - External reporting to the Arkansas Department of Human Services through the Mandated Reporting Portal.
        - Coordination with local law enforcement by proactively contacting the Dallas County Sheriff's Office. According to the incident report the facility expressed their intent to fully cooperate with any investigations or procedures initiated by external authorities.
        - An internal investigation process to ensure all necessary steps are being taken to address the incident.
- Employee Disciplinary Report observations:
    - Employee was counselled regarding unsatisfactory job performance and patient abuse and neglect: improper Therapeutic Crisis Intervention.
    - Employee was terminated on November 5, 2024.
- Arkansas Mandated Reporter Form observations:
    - Per the Chief Operations Officer the incident was not accepted.
- 521 Visit Compliance Form observations:
    - Regulation Number 100.109.1.g and 100.110.9.c found out of compliance.

Respectfully,

Inspection of Care Team
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