Appendix II: Exhibits

Warehouses of Neglect: How Taxpayers Are Funding Systemic Abuse in Youth Residential Treatment Facilities

A Senate Committee on Finance Staff Report

June 12, 2024

20180304 Piney Ridge CAP for Program Review IOC [Redacted]

OKLAHOMA
Health Care Authority

Serving Oklahomans through SoonerCare

Kevin Corbett | Chief Executive Officer

J. Kevin Stitt | Governor

Post-CAP Reassessment Review Findings

3/19/2021

[redacted] Director PI/RM
Piney Ridge Treatment Center
[redacted]
Fayetteville AR [redacted]

RE: Psychiatric Residential Treatment Program(s [redacted]

Dear Ms. [redacted]

On 3/18/2021, the Oklahoma Health Care Authority's (OHCA) Service Quality Review (SQR) team completed a desktop post-Corrective Action Plan (CAP) review of your facility. This letter is to inform you of the review findings and any steps you will need to ensure compliance with regulations and your OHCA contract.

This CAP follow-up consisted of reviewing all submitted documentation including clinical record documents for four (4) SoonerCare members to determine compliance status in three (3) areas identified as needing correction in your most recent review. The following is an overview of these findings.

Overall, great improvement was noted in several areas during this review. Therefore, we plan to end the continuing, frequent post-CAP reassessment reviews you have been undergoing. However, please keep in mind that any issues identified as not fully meeting requirements in this review will be audited during your next annual SQR with the expectation of improved compliance.

Finding 1: Individual Plan(s) of Care (IPCs) – Partial Compliance, Needs Improvement

Collaboration with the guardian was not documented in four (4) of the IPCs reviewed, and on multiple plans the signature page section asking if the guardian participated in plan development was checked "no." Three (3) charts contained a page not included with the plan of care that indicated the IPC signature page was mailed to the guardian. These were counted as having documentation of collaboration for this review, but in the future this may not be accepted as mailing just the signature page with no other communication

occurring does not give the guardian an opportunity to review the plan of care or participate in the care planning process. Be aware that OHCA expects good faith efforts (such as one calls on d days &/or times) to a guardian for IPC review and these efforts must be documented. It is recommended that this documentation be included with the relevant IPC.

Finding 2: Active Treatment – In Compliance

Significant improvement was noted in this area. In all, shortages of active treatment hours were noted in only four (4) of the fourteen (14) weeks of treatment reviewed. Of these, only one (1) was missing a note for the service completely. The remaining instances were due to documentation errors and are discussed below

Finding 3: Active Treatment Documentation – Partial Compliance, Needs Improvement

Many areas of active treatment documentation showed marked improvement compared to previous reviews. No duplicate notes were identified, and many activity therapy notes included insightful, individualized observations about the resident's pa cipation and learning process during the groups. Additional there were fewer instances of elective service notes missing required elements; although there were eight (8) elective service notes that were missing a start &/or stop time enough other services were provided and appropriately documented that this did not result in any shortages of required treatment. Documentation issues which did create a shortage of active treatment hours included two (2) family therapy notes in the same chart that indicated the sessions lasted only five (5) minutes each, and one (1) instance of overlapping service times for individual and family therapy which caused a shortage of 30 minutes individual therapy. The content of the family therapy notes with start/stop times documenting five (5) minute sessions seemed to indicate a longer session was likely provided, so these were treated as a documentation e ror rather than missing active treatment hours.

Additional Areas Of Note

In addition to the issues related above, the following additional areas were noted as being significant during this post-CAP review:

Multiple group rehab notes were observed to have inappropriate additions and/or corrections to them. This was found in all charts reviewed to a greater or lesser extent. In some cases, information was documented on the same note in what appeared to be two (2) noticeably different handwriting styles & ink. In others, lines were drawn

through parts of the note and different information documented, also often in what appeared to be a different handwriting style and ink. These notes were counted toward active treat nt hou for this review ut m y not be allowed in future reviews. Corrections and additions to medical record documentation must indicate who made the change, by ***legible*** signature or initials, and the date the changes were made. Failure to follow these guidelines in the future may result in recoupment.
2. Overall therapy notes were very thorough and provided excellent evidence of ongoing treatment and residents' progress through the therapy process. Additionally, several individual & family therapy and collateral notes documented active and ongoing efforts to create a thorough discharge plan including safety planning with guardians and referrals to appropriate outpatient supports.

We appreciate your continuous efforts at quality improvement for our members and hope to see continued improvement in the future.

Respectfully,

LPC Digitally signed by LPC
Date: 2021.03.19 09:08:50 -05'00'

LPC
Behavio lth Specialist
Service Quality Review - Behavioral Health Operations
Oklahoma Health Care Authority

Oklahoma C OK 05
Phone: ~ Fax:
Email: hca.

20180409 Piney Ridge AR Beacon CAP [Redacted]

Appendix 2

PRTC
PINEY RIDGE TREATMENT CENTER

5-8-18

Beacon Health Options
[redacted]

RE: Corrective Action Plan for Inpatient Inspection of Care 4-9-18—4-12-18

Dear Beacon Health Options:

Please find attached the Corrective Action Plan that has been developed for the Inpatient Inspection of Care IOC that occurred 4-9-18—4-12-18. Please let me know if you need any additional information or if any follow up is necessary.

Sincerely,
[redacted]
CEO

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April 26, 2018

[redacted]
Piney Ridge Treatment Center
[redacted]
Fayetteville, AR [redacted]

Provider Number: [redacted]

Beacon Health Options noted one or more deficiencies during the Inpatient Inspection of Care (IOC) conducted at the following service site on the following dates:

Piney Ridge Treatment Center
April 9, 2018 to April 12, 2018

Section 241.600 of the Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual states: "The facility is required to submit a Corrective Action Plan designed to rectify any area of deficiency noted in the written report of the inspection of care." Accordingly, you must complete and submit to Beacon Health Options a Corrective Action Plan for each deficiency noted.

The Corrective Action Plan must state with specificity the:

(a) Corrective action to be taken;
(b) Person(s) responsible for implementing and maintaining the corrective action; and
(c) Completion date or anticipated completion date for each corrective action.

Within 14 calendar days of the date of the written IOC report you must submit a completed Corrective Action Plan to [redacted] The contractor will:

(a) Review the Corrective Action Plan;
(b) Determine whether the Corrective Action Plan is sufficient to credibly assure future compliance; and
(c) Forward the Corrective Action Plan to the Division of Medical Services.

Please see § 161 of the Arkansas Medicaid Manual for an explanation of your rights to administrative reconsideration and appeal.

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Piney Ridge Treatment Center
[redacted]
Fayetteville, AR [redacted]

April 9, 2018 to April 12, 2018

**** CLINICAL RECORD REVIEW ****

Element 7: Admission Evaluation
Three beneficiary records did not document a Social Evaluation conducted within 60 hours of admission by professional staff.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 217.000

Corrective Action: Members of the clinical department were provided with information detailing this deficiency from the 2018 audit.

It was and will be further discussed with members of the team that the Social Evaluation must be conducted and turned into the Medical Records department within 60 hours of a resident being admitted to Piney Ridge Treatment Center.

The Director of Clinical Services also developed an admissions check list for members of the clinical staff that includes the Social Evaluation being completed and turned in within 60 hours. Each check list will be turned into the Clinical Director for review.

All members of the clinical department will be advised of these recommendations and will review the checklist and admissions requirements on 5/18/2018, 5/25/2018, and 6/1/2018.

Identify Person Responsible: [redacted] M.S., LPC, Director of Clinical Services

Completion Date: 6/1/2018

Element 18: Individual Plan of Care
Two beneficiary records did not document an Individual Plan of Care developed by the facility-based team (physician and MHP).

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 218.000

Corrective Action: Members of the clinical department were provided with information detailing this deficiency from the 2018 audit.

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It was and will be further discussed with members of the team that the physical document showing the development of the Individual Plan of Care is due to Medical Records the day the Individual Plan of Care is developed with the treatment team.

Documentation of the development of the Individual Plan of Care for all beneficiaries will continue to be monitored through monthly chart audits by the clinical department and reported to the Performance Improvement Committee and the Committee of the Whole. Results of these monthly audits will be disseminated to the responsible parties for correction.

All members of the clinical department will be advised of these recommendations and will review the checklist and admissions requirements on 5/18/2018, 5/25/2018, and 6/1/2018.

Identify Person Responsible: [redacted] M.S., LPC, Director of Clinical Services

Completion Date: 6/1/2018

Element 20: Individual Plan of Care
Five beneficiary records did not document an Individual Plan of Care developed in consultation with the recipient and his or her parent(s), legal guardian(s), or others in whose care he or she will be released after discharge.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 218.100

Corrective Action: Members of the clinical department were provided with information detailing this deficiency from the 2018 audit.

It is an ongoing discussion with members of the clinical team that obtaining the signature of the parent or guardian verifying that the Individual Plan of Care was developed in consultation with the recipient and his/her parent/guardian remains a priority within the process of formulating the Individual Plan of Care. Additionally, members of the clinical team continue to be advised to clearly review the Initial Plan of Care in the first Family Therapy session for residents and to include obtained feedback/consultation from the family/guardian and for this feedback from the guardians to be included in the clinical progress note for the family therapy session.

A part time clinical case manager has been added to the clinical team. Tracking guardian involvement in the formulation of the Individual Plan of Care will be a specific job duty assigned to the new role.

Guardians have the expectation of their involvement in the formulation / updates of the Individual Plan of Care reviewed with them at the time of admission. Guardians sign an information sheet declaring their understanding of their required documented involvement in formulating the Individual Plan of Care and expressing their willingness to provide said documentation.

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All members of the clinical department will be advised of these recommendations on 5/18/2018, 5/25/2018, and 6/1/2018. Documentation of evidence of family/guardian consultation in the development of the Individual Plan of Care for all beneficiaries will continued to be monitored through monthly chart audits by the clinical department and reported to the Performance Improvement Committee and the Committee of the Whole. Results of these monthly audits will be disseminated to the responsible parties for correction.

Identify Person Responsible: [redacted] M.S., LPC, Director of Clinical Services

Completion Date: 6/1/2018

Element 43: Seclusion and Restraint
One beneficiary record did not document the intervention documentation completed by the end of the staff's shift.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 221.703

Corrective Action: The DON and/or Nursing Assistant will review all ESI documentation and physician orders for ESI's the next business day following the day the ESI occurred for presence and completion of ESI documentation.

All nursing staff will be re-educated on the ESI policy at the next nurses meeting on 5/10/18 which details the requirement for documentation for all ESI's

Documentation for Emergency Safety Interventions: All seclusions, chemical restraints, and physical restraints will be documented by a qualified Registered Nurse in the resident's medical record and will reflect justification, implementation, and outcome of procedure (to include behavior at the time of release) and shall address the failure of least restrictive interventions. Documentation must be completed by the end of the shift on which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends.

Identify Person Responsible: [redacted] Director of Nursing

Completion Date: 5/11/2018

Element 45: Therapeutic Leave
One beneficiary record did not document a therapeutic leave evaluation providing support to the plan of care objectives and goals.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 222.110

Corrective Action: Members of the clinical department were provided with information detailing this deficiency from the 2018 audit.

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The requirement that direct care staff have the resident's guardian complete a Therapeutic Pass Results Form when retrieving residents upon return from therapeutic pass will be added to the all staff Safety Huddle.

All completed Therapeutic Pass forms will be returned to the Primary Therapist(s) after passes are completed. Any Pass Results Form that was not adequately completed at the time the resident was returned from the Therapeutic Pass will be completed by the Primary Therapist by contacting the guardian / participants in the therapeutic pass. All members of the clinical department will be advised of these recommendations on 5/18/2018, 5/25/2018, and 6/1/2018.

Documentation of completed Therapeutic Pass Results forms will be monitored through monthly chart audits. Results of these monthly audits will be disseminated to the responsible parties for correction.

Identify Person Responsible: [redacted] M.S., LPC, Director of Clinical Services

Completion Date: 6/1/2018

Element 46: Therapeutic Leave
One beneficiary record did not document staff contact with beneficiary and person(s) responsible for the beneficiary for therapeutic leave in excess of 72 consecutive hours.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 222.110

Corrective Action: The Therapeutic Pass form has been revised to prompt documenting contact with beneficiary and person responsible for the beneficiary for therapeutic leave in excess of 72 hours.

All nursing staff will be re-educated on documenting contact with residents and person(s) responsible for the beneficiary/residents for therapeutic leave in excess of 72 consecutive hours and educated on the revision of the Therapeutic Pass form. This education will occur at the next Nurses meeting on 5/10/18.

Identify Person Responsible: [redacted] DON

Completion Date: 5/11/2018

Element 47: Therapeutic Leave
Two beneficiary records did not document progress notes that provide statements that track the beneficiary's actions and reactions and clearly reveal the beneficiary's achievements or regressions while on therapeutic leave.

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Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 222.110

Corrective Action: Members of the clinical department were provided with information detailing this deficiency from the 2018 audit.

The requirement that the Primary Therapist must clearly document the beneficiary's overall response including their actions and reactions and achievements or regressions following all therapeutic leaves will be reviewed with all members of the clinical department on 5/18/2018, 5/25/2018, and 6/1/2018.

Identify Person Responsible: [redacted] M.S., LPC, Director of Clinical Services

Completion Date: 6/1/2018

**** FACILITY REVIEW ****

Question 11: Non Physical Intervention

Inpatient provider does not have documentation in HR records that all direct care personnel are trained, as well as demonstrate competency within required time frames*, in use of nonphysical intervention skills to prevent emergency safety situations (i.e., Handle with Care, CPI, SAMA, etc.).

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 221.804, 42 CFR, 482.13**, 483.376***

Corrective Action: Human Resource Manager will monitor expiration dates of CPI certification and inform supervisor at least a month in advance of upcoming expiration dates of CPI certification. Human Resource Manager will follow up with supervisors, on a weekly schedule, to ensure compliance prior to the CPI certification expiration date. There will be scheduled CPI trainings monthly. Employees will be required to sign up for the training they will attend for the month.

Identify Person Responsible: [redacted] Human Resource Manager

Completion Date: 5/4/2018

Question 12: CPR

Inpatient provider does not have documentation in HR records that all direct care personnel are currently certified in cardiopulmonary resuscitation.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 221.804, 42 CFR, 482.13**, 483.376***

Corrective Action: Human Resource Manager will monitor expiration dates of CPR certification and inform supervisor at least a month in advance of upcoming expiration dates of CPR certification. Human

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Resource Manager will follow up with supervisors, on a weekly schedule, to ensure compliance prior to the CPR certification expiration date. There will be scheduled CPR trainings monthly. Employees will be required to sign up for the training they will attend for the month.

Identify Person Responsible: [redacted] Human Resource Manager

Completion Date: 5/4/2018

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(NOTE: If you have additional documentation to refute a deficiency identified in your Inspection of Care or Desk Review Report, please request a reconsideration. You have thirty (30) calendar days from the date of this notice to request reconsideration, in writing, by fax using the IOC Deficiency Review Fax Coversheet or email to [redacted] Please include all additional information that you believe supports the refuted deficiency. The timeframe for the requirement for a Corrective Action Plan is suspended until the determination of the reconsideration.)

Beneficiary and Provider Right to Appeal This Decision
Pursuant to ACT 1758 of 2005, both the beneficiary and the provider have the right to appeal this decision. If either party is not satisfied with the decision on your case, the beneficiary may request a fair hearing from the Office of Appeals and Hearings or the provider may request a fair hearing from the Arkansas Department of Health. If both the provider and beneficiary are requesting a hearing, these will also go to the Arkansas Department of Health. You may use the enclosed Notice of Appeal Form to request an appeal. Please enclose a copy this Notice of Action with your appeal. Failure to provide a copy of this Notice of Action will result in your appeal being delayed.

How and When to Appeal

Beneficiary:
The Office of Appeals and Hearings must receive a written hearing request within thirty (30) calendar days of the date on this letter. Send your request to Office of Appeals and Hearings, PO Box 1437, Slot N401, Little Rock, AR 72203-1437.

Provider or Provider/Beneficiary:
The Arkansas Department of Health must receive a written hearing request within thirty (30) calendar days of the date on this letter. Send your request to Arkansas Department of Health, Attn: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.

Continuation of Services Pending Appeal (Beneficiary only)
If you are already receiving services and the department's decision was to reduce or eliminate those services, you may postpone the reduction or elimination of services until the appeal is decided by sending your appeal request in time to be received by the Office of Appeals and Hearings or Arkansas Department of Health within ten (10) calendar days from the date of this letter. However, if you do that and you lose or abandon the appeal, you will be responsible for the cost of all services that are not approved in Section I (above). The Department will take action against you to recover those costs.

If you send your written hearing request in time to be received by the Office of Appeals and Hearings or Arkansas Department of Health within ten (10) calendar days from the date on this letter, we will not reduce or eliminate your services unless you tell us that you do not want to postpone the reduction or elimination of services pending the appeal.

Your Right to Representation
If you request a Hearing, you have the right to appear in person and to be represented by a lawyer or other person you select. If you wish to have a lawyer you may ask the local County Office to help you identify one. If free legal services are available where you live, you may ask your County Office for their address and phone number.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
NOTICE OF APPEAL

I want to appeal the attached decision. I understand that the Arkansas Department of Health must receive this notice within thirty (30) calendar days of the date of the attached decision.

Type of Appeal: ____Provider Appeal

I have attached a copy of the Inspection of Care report pertaining to _____.
(Site for Inspection of Care)

The date of the Inspection of Care report was _____.

Please list Chart numbers and elements requested for this appeal.

_____

_____ _____
Provider Name Provider's Medicaid ID Number

_____ _____
Provider Site Provider Site Address

_____ _____
Provider Representative Telephone Number

For Provider appeal please send your request to:

Arkansas Department of Health
4815 West Markham Street Slot 31
Little Rock, AR 72205

20180409 Piney Ridge AR Beacon Report [Redacted]

Appendix 3

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Inspection of Care Report

Provider Name		IOC Dates
Piney Ridge Treatment Center		April 9, 10, 11, and 12, 2018
Service Site Address	**Site Provider Number**	**Report Mail Date**
[redacted] Fayetteville, Arkansas [redacted]	[redacted]	April 26, 2018

Purpose of the Review

The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) has contracted with Beacon Health Options to perform on-site inspections of care (IOC) of inpatient psychiatric services for under age 21 provided by Inpatient providers. The [clinical] reviews are conducted by licensed mental health professionals and are based on applicable federal and state laws, rules and professionally recognized standards of care.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Regulation 241.00

The on-site inspections of care of Inpatient Psychiatric Services for Under 21 providers are intended to:

A. Promote Inpatient Psychiatric Services for Under 21 that are provided in compliance with federal and state laws, rules and professionally recognized standards of care;
B. Identify and clearly define areas of deficiency where the provision of services is not in compliance with federal and state laws, rules and professionally recognized standards of care;
C. Require provider facilities to develop and implement appropriate corrective action plans to remediate all deficiencies identified;
D. Provide accountability that corrective action plans are implemented and
E. Determine the effectiveness of implemented corrective action plans.

For further information on General Conditions and Record Keeping, see Sections 142.100 and 142.300(A) of the RSPMI Provider Manual.

Below are the results of the Inpatient Inspection of Care for the facility:

Program Review

1. This facility was accredited in 2016 by The Joint Commission; the accreditation is valid through 2019. This facility is currently licensed by the appropriate State agency. (Arkansas Medicaid Inpatient Psychiatric Manual Regulations 202.100 and 202.200)
2. The provider does have written policies and procedures available for review. (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 241.200)
3. The services available in the facility are adequate to meet the health needs of each recipient and promote beneficiaries' maximum physical, mental, and psychosocial functioning. (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.610)

4. The facility has a facility-based Certification of Need (CON) Team in place whose membership meets state and federal requirements. (Arkansas Medicaid Inpatient Psychiatric Manual Regulations 215.100, 215.200, 215.210, and 215.220 and 42 CFR Sections 441.153 and 441.156)
5. There is a written Utilization Review (UR) Plan and a Committee to perform UR functions that meets all federal requirements for utilization control. (Arkansas Medicaid Inpatient Psychiatric Manual Regulations 221.000 thru 221.550 and 42 CFR Sections 456.201 thru 456.245)
6. The facility has current Restraint and Seclusion policies which comply with Medicaid, state, and federal regulations and provide for beneficiaries' safety. (Arkansas Medicaid Inpatient Psychiatric Manual Regulations 221.700 thru 221.710 and 42 CFR Sections 441.151, 482.13, and 483.350 thru 483.376)
7. For PRT Facilities only: The facility has submitted to Arkansas Medicaid a Letter of Attestation that the facility is in compliance with CMS regulations regarding use of Restraint and Seclusion. (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.801 and 42 CFR Section 483.374)
8. The facility has complied with Medicaid, state, and federal reporting requirements of death, serious injury, or attempted suicide. (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.803 and 42 CFR Sections 482.13 and 483.374)
9. The facility has a training program in place offering training on the facility's Restraints and Seclusion policy, and training on the appropriate procedures to be used in Restraints and Seclusion, including a repertoire of approaches that can be used to de-escalate beneficiaries. (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.804 and 42 CFR Sections 482.13 and 483.376)

Personnel Record Review

The staff providing services at the service site consisted of one hundred thirty-three (133) direct care personnel. Personnel records for seventeen of thirty (56%) Physician, RN, and Mental Health Professional direct care staff were reviewed and personnel records for fifty-three of one hundred three (51%) Non-Professional Mental Health and LPN staff were reviewed.

Mental Health Professional, RN, APN, and Physician Personnel Records:

Seven Mental Health Professional (MHP), seven RN, and three Physician personnel records were reviewed. The following deficiencies were found:

11. One Mental Health Professional *(#29)* personnel record did not document training and demonstrated competency within required time frames in nonphysical intervention skills to prevent emergency safety situations (i.e., Handle with Care, CPI, SAMA, etc.). *[Note: MHP has been on FMLA since November 2017.]* (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.804 and 42 CFR Sections 482.13 and 483.376)

Non-Professional Mental Health, LPN, and Other Direct Care Staff Personnel Records:

Forty-nine Non-Professional Mental Health and four LPN personnel records were reviewed. The following deficiencies were found:

11. Two Non-Professional Mental Health *(#67 and #105*) personnel records did not document training and demonstrated competency within required time frames in nonphysical intervention skills to prevent emergency safety situations (i.e., Handle with Care, CPI, SAMA, etc.). (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.804 and 42 CFR Sections 482.13 and 483.376)

12. Four Non-Professional Mental Health (*# 71, 96, 117, and 125*) personnel records did not document current certification in CPR. *[Note: One Non-Professional Mental Health staff (#117) has been on leave since March 2018.]* (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.804 and 42 CFR Sections 482.13 and 483.376)

The following observations were made in the review of personnel records:

- One Non-Professional Mental Health *(#104)* personnel record had a Criminal Background Finding: Disposition Date: 11/04/13; Charge: Forgery; Type: Felony; Disposition: Deferred.

Staff Interviews

Fifteen direct care staff members were interviewed (12% of 41). There were multiple concerns expressed by the staff during the interviews:

Some of the staff expressed concerns about the safety of both the beneficiaries and the staff due to the aggressiveness of some of the beneficiaries at Piney Ridge. One staff stated, "There are a couple of beneficiaries that are not appropriate for treatment here". Another staff reported that the "walkies" (wireless communication) do not always work properly.

Three staff expressed concerns about conducting a restraint intervention. One staff reported being worried about bending the beneficiary's elbow too far back. Another staff reported that a CPI restraint requires two staff, but there are only three staff on duty, leaving only one person to monitor the other beneficiaries. It was noted by one staff that when he was first hired, the ratios of staff to beneficiaries was low, but that had improved. One staff stated that "restraints can be confusing" and would like more training on how to perform a restraint when a beneficiary is moving within the restraint. One staff reported that questionable restraints are being utilized, such as staff grabbing the beneficiary by the arm and then walking them back, usually outside and beyond the camera range. This concern has been reported to the supervisor and to the Director of Nursing, but does not feel anything is done about this because it is not on the camera.

One staff member expressed a concern that new staff are being manipulated by the beneficiaries. The staff member stated that staff are spending time in the doorways to beneficiaries' rooms, especially new staff; this is after lights out around 10:30 p.m. The staff suggested that supervisors should walk the halls around this time in the evening. These concerns have been reported to the supervisor and addressed in their staff meetings, but continue to be an issue.

One staff expressed concerns about staff not treating the beneficiaries with dignity. They reported that some of the behavior techs antagonize the beneficiaries. An example given was, when staff were trying to de-escalate a beneficiary, a tech walks by and makes an "antagonistic" remark to the beneficiary. Staff did report that yelling has decreased and that the staff that did not treat the beneficiaries with dignity had been terminated.

The interviews did not raise any other questions or concerns.

Beneficiary Interviews

Forty-three beneficiaries (100% of 43) were interviewed. Results of the interviews are as follows:

Beneficiary Understanding of the Reason for Admission and of the Treatment Received

- 40 of 43 beneficiaries (93%) were able to report the reason they had been admitted.
- 3 of 43 beneficiaries (7%) were not able to report the reason they had been admitted.

- 35 of 43 beneficiaries (81%) could report, in a general way, some of the Goals and Objectives they were working on in treatment. (*Beneficiary Comments included the following: "Some yes and some no.")*
- 8 of 43 beneficiaries (19%) could not report, in a general way, some of the Goals and Objectives they were working on in treatment. (*Beneficiary Comments included the following: Does "not fully" understand his treatment plan; "Not at the moment, because of me not accepting anything they are saying."; "No, not really")*

- 33 of 43 beneficiaries (77%) reported the treatment interventions they were receiving as being helpful in addressing their target psychiatric symptoms. (*Beneficiary Comments included the following: "Extremely"; "Kind of; more yes"; "Yeah, but the kids are bullies.")*
- 10 of 43 beneficiaries (23%) reported the treatment interventions they were receiving not to be helpful in addressing their target psychiatric symptoms.
  Beneficiary Comments included the following:
  - *"It's helping me get better, but it is also making me more depressed"*
  - *"They are helping me but it is not working" … "Because it is taking me a long time to reach level 3. I don't understand the treatment. I understand what I am supposed to do, but I don't know how to do it."*
  - *"I feel that I can't prepare for the real world if I can't be in the real world"*
  - *"I never did anything wrong; since I was framed, I don't really have to do anything here"*
  - *"Not so far"*

- 35 of 43 beneficiaries (81%) could explain what the help was that they were receiving.
- 8 of 43 beneficiaries (19%) could not explain what the help was that they were receiving. (*Beneficiary Comments included the following: "I have no idea")*

Beneficiary Knowledge of Medications Used in Their Treatment

- 2 of 43 beneficiaries (5%) were not taking any psychotropic medications.

- 23 of 41 beneficiaries (56%) taking psychotropic medications were able to name at least 50% of their psychotropic medications.
- 18 of 41 beneficiaries (44%) taking psychotropic medications were not able to name at least 50% of their psychotropic medications.

- 24 of 41 beneficiaries (59%) taking psychotropic medications could state the reason they took at least 50% of their psychotropic medications.
- 17 of 41 beneficiaries (41%) taking psychotropic medications could not state the reason for taking at least 50% of their psychotropic medications.

Beneficiary's Sense of Being Treated with Respect by Staff

- 32 of 43 beneficiaries (74%) reported that staff members treat them with respect.
  Beneficiary Comments included the following:
  - *"Half and half"*
  - "*The staff treat me very well"*
  - *"Most of the time"*
  - "*Some of them*"
  - "*Sometimes, the most disrespectful thing they do is group punishment. They say stuff like 'at least I can go home at the end of the day'"*
- 11 of 43 beneficiaries (26%) reported that staff members do not treat them with respect.
  Beneficiary Comments included the following:
  - *"The staff are always yelling at the kids and they wait a long time to break up fights. It doesn't get dealt with."*
  - *"The staff keep saying they don't have to listen to us, that we can't do anything to them because I'm a child. They antagonize me."*
  - *"Not always; it depends on who the staff is"*
  - *"The staff treat me badly"* [Note: Beneficiary did not provide any specific information regarding what was meant by this.]

- 29 of 43 beneficiaries (68%) reported staff treat peers with respect.
  Beneficiary Comments included the following:
  - *"Really it depends on how they act. Most staff have to bribe the good kids to be good."*
  - *"Half and half"*
  - *"Most of the time"*
  - *"Sometimes"*
- 13 of 43 beneficiaries (30%) reported staff members do not treat peers with respect.
  Beneficiary Comments included the following:
  - *"Some of the first shift staff try to trigger the kids. The staff pick favorites a lot."*
  - "*Not really, no. Some kids eat out of the trash can and staff treat those particular kids disrespectfully. Staff wonder why kids keep trading food, but they don't feed us much."*
  - *"There is favoritism and double standards. A lot of the staff seem biased towards the biracial kids."*
- 1 of 43 beneficiaries (2%) did not respond regarding staff members treating peers with respect.

Beneficiary's Sense of Personal Safety

- 23 of 43 beneficiaries (53%) reported feeling safe at the facility.
  Beneficiary Comments included the following:
  - *"Sometimes, like it depends. There are times when I don't."* [Note: Beneficiary said he worries about people touching him when he is asleep and worries about people fighting.]
  - *"Yes, other than the kids being riled up and fighting. They are usually in fights."*
  - *"Yes, a little bit. There are some kids I'm worried about."*
- 20 of 43 beneficiaries (47%) reported not feeling safe at the facility.
  Beneficiary Comments included the following:
  - *"Yes and no, more no. The reason I don't feel safe here is because they never clean the unit until the State gets here. They have ants because some kids throw food on the floor"*
  - *"The kids fight a lot"*
  - *"Yes and no. That's a hard question because of the peers and I get the feeling staff really don't care."*
  - *"Not all the time because staff are biased and a peer is picking on me."*
  - *"'Cause of the negative peers - that's the only reason"*

- *"I don't feel safe at all because everybody's out to get you here. All the children…if they don't like you, they will beat you up for no reason. They fight in here a lot."*
- *"My peers seem out to get me sometimes"*
- *Likes how the staff tells residents to stay out of other people's business. Some residents "like to get caught up in it."*
- *"No, because I was abused as a child and am surrounded by people who have victims."*
- *"Just everybody fighting and all the restraints…. I almost got my arm broken and almost got my toe broken."* [Note: No incident report was found that supported this comment.]
- *"I was attacked twice by a resident and got a carton of milk thrown at me, so I don't feel safe here. I just don't like it here. I really don't."*
- *"Every time a resident gets in trouble they just write it up and don't do anything. Staff doesn't watch the ones that are on one-to-one and it isn't fair to get a group punishment."*
- *"Sometimes I feel like I am going to get punched or get into a fight."*

[Note: Beneficiary reports of peer-to-peer aggression (fighting) were discussed with Piney Ridge administrative staff during the course of the Inspection of Care and again during the Exit Interview.]

<u>Beneficiary Perception of Safety during Staff Implementation of Restraint/Seclusion</u>

- 35 of 43 beneficiaries (81%) believed that the staff members try not to harm beneficiaries during the performance of a personal restraint.
  Beneficiary Comments included the following:
  - *"When they restrain people, they do it way too aggressively"*
  - *"Yes, but it depends on the staff"*
  - *"Sometimes. When the resident does something to them, I can tell the staff gets a little aggressive towards them."*
  - *Sometimes, but fights make her feel unsafe*
  - *"Yes, but sometimes staff is more aggressive than they need to be"*
  - *"More yes than no"*
  - *"Yes and no. To the kids who act up a lot they say 'Well if someone comes after you, I am going to be slow to move.'"*
- 8 of 43 beneficiaries (19%) believed that some staff members either don't care whether a beneficiary is injured during a personal restraint or intentionally try to harm the beneficiary.
  Beneficiary Comments included the following: "I've seen staff slam kids into walls when they put them in a restraint." [Note: Beneficiary did not provide names and said that this had not been seen recently.]

<u>Beneficiary Knowledge and Perception of Grievance Procedure</u>

- 36 of 43 beneficiaries (84%) reported knowing how to file a grievance at the facility.
- 7 of 43 beneficiaries (16%) reported not knowing how to file a grievance at the facility. (*Beneficiary Comments included the following: "Not really")*

- 18 of 43 beneficiaries (42%) believe that the grievance process works/is effective. (*Beneficiary Comments included the following: "Yes, it would work, but would take time."*
- 24 of 43 beneficiaries (56%) believe that the grievance process does not work.
  Beneficiary Comments included the following:
  - *"Staff tend to get away with things they don't think are seen. Some staff say inappropriate things to kids or when they don't think kids are listening"*
  - *"Not really. It really depends on what it is about. If it is on the staff, it won't help. If it is on a kid, it might work sometimes."*
  - *"In some matters, no"*

  - *"I've already tried"*
  - *"Well, staff 'sags' sometimes"*
  - *"I get really bored. I don't have anything to do. The only fun I get to do is when I go to my therapist. I would like more therapy."*
  - *"No; I've done it at two other facilities and it didn't do anything"*
- 1 of 43 beneficiaries (2%) was unable to respond regarding the effectiveness of the facility's grievance process.

<u>General Beneficiary Comments included the following:</u>

- *"I've slept on a cot since I've been here"* [note: approximately one month]. *"It is actually really comfortable."* [Note: The reason that the beneficiary has been sleeping on a cot is due to bed bugs in beneficiary bed.]

- *"We've seen all sorts of bugs crawling around on our unit like earwigs, ants, and, sometimes, spiders. We've had bed bugs twice in my room since we've been here and we might still have them."*
- *"Also, some of the boys are slobs and will just drop their apple cores and staff gets on to them, but we have ants and we have bed bugs. They have called the exterminators twice but we still have them."*
- *"The cleanliness is nasty as heck; the bathrooms need to be kept cleaner and the walls."*
- *"Some boys piss outside"*

- *"I don't get fed enough. I'm always hungry."*
- *"The food is bad"; "Sometimes the food we have here makes my stomach hurt"*
- *"Their food is fake"; "They give us carbonated water and call it Sprite"; dislikes the food*

- *"I need a stricter therapist"*
- *"The staff like to restrain people sometimes for no reason"*
- *"The staff are petty and rude"*
- *"Are they allowed to do group punishment? Cause if one person messes up they take it out on the whole unit."*
- *"I just don't like the group punishments we get, and some residents get babied"; staff show "favorites"*
- *Dislikes that they take away personal items: "They take away things we use for coping skills. We are not allowed to have more than one book in our room. Can you imagine that?"*
- *"The coping skills I'm used to using they don't allow here like music, Rubik's cube, video games…"*
- *Dislikes "the rules"*
- *Dislikes "Just the way they run things. It's too chaotic."*

- *"We need another girl's unit. A younger girls' unit and an older girls' unit."*
- *"Just how small it is here and how big the kids are. When you are small, you get picked on more."*
- *"The residents took my clothes. I only have two pairs of pants and one shirt."*

- *Dislikes that they can't go out when they want and feels "cooped up" all the time*
- *"They keep me here and away from my mom"*
- *"They only give us 10 minutes on phone calls. I don't get to talk to my mom long enough."*
- *"The way everybody likes to fight."*
- *Dislikes "no phones!"*

- *Dislikes that they can't have fidget cubes or spinners*
- *"They need more basketball goals and new nets"*

- *"Can you put that they should have a variety of toys here like Legos and action figures?"*
- *"I don't like that we can't draw on walls; they should put up big chalkboards so we can draw"*
- *"I feel like we should be able to be more open about our sexuality, express ourselves the way we need to."*

- *"My therapist is helping me"*
- *"I like my therapist and some of the staff"*
- *"I like the help I'm getting and I like my therapist. She helps me a whole lot."*
- *Likes "my therapist and my teacher"*
- *"It (therapy) has helped me with more than sexual stuff. It's helped me with responsibility and anger."*
- *"They're open to process with you."*
- *"The staff try a lot, they work hard. They never give up on us."*
- *"It is helping me a little. I like my therapist. My therapist is amazing."*
- *Likes "Some of the girls I meet and some of the staff – a lot of the staff honestly."*
- *"Definitely like the therapist. They need to do a survey so they can match them up better with the therapist because some kids get babied and some therapists are more blunt with kids who don't need that."*

- *"I like that it is getting me more interactive with other people"*
- *"Some of the peers try and process with you. Some of them even give you coping skills, like things to write or to look at."*

- *"I like the outside time and Honors Room and most of the staff"*
- *Likes that he is not stuck in a cell and can walk around all day*
- *Likes "the outside time, recreation activities"*
- *Likes "the isolation"*
- *Likes "how they let us have a bunch of extra free time outside, and how they are trying to help us"*

- *"I love the food! The food is delicious"*
- *"I like the food"*
- *"Every now and then the food messes with me, but other than that it is all good"*

Beneficiary Family Interviews

The parents/guardians of five beneficiaries (12% of 43) were interviewed. Results of the interviews are as follows:

- 5 of 5 parents/guardians (100%) reported knowing why their child had been admitted to this facility.

- 5 of 5 parents/guardians (100%) reported being kept informed of any changes in medication. (*Parent/Guardian Comments included the following: "They call us about every little thing; we just talked to them this morning.")*

- 5 of 5 parents/guardians (100%) reported that they and their child have been treated with respect by staff at the facility. (*Parent/Guardian Comments included the following: "Most of the time")*

- 4 of 5 parents/guardians (80%) reported that they understood and felt comfortable and satisfied with the frequency with which they can call and visit their child.
- 1 of 5 parents/guardians (20%) reported that they did not understand and did not feel comfortable and satisfied with the frequency with which they can call and visit their child. (*Parent/Guardian Comments included the following: "No, because I can't call him at all")*

- 5 of 5 parents/guardians (100%) reported being involved in the treatment of their child at this facility. (*Parent/Guardian Comments included the following: "We have gotten a detailed treatment plan and all that"; "They have been wonderful")*

- 3 of 5 parents/guardians (60%) reported that their child's symptoms and problems have decreased since coming to this facility. (*Parent/Guardian Comments included the following: "Yes, ma'am, extremely")*
- 1 of 5 parents/guardians (20%) reported that their child's symptoms and problems have not decreased since coming to this facility. (*Parent/Guardian Comments included the following: "Not yet")*
- 1 of 5 parents/guardians (20%) was unable to respond if their child's symptoms and problems have decreased since coming to this facility.
  Parent/Guardian Comments included the following:
  - *"Not yet, but [*beneficiary*] is a hard nut to crack. Her issues are really extensive and she has only been there a month"*
  - *"I think it has, but he has an anger issue. I don't think he is taking his medication. They need to make sure he is swallowing it."*

- 5 of 5 parents/guardians (100%) reported having been informed about the restraint and seclusion policy at the time of admission.

- 4 of 5 parents/guardians (80%) reported knowing how to lodge a complaint with the facility if they had concerns. (*Parent/Guardian Comments included the following: "I believe so")*
- 1 of 5 parents/guardians (20%) reported not knowing how to lodge a complaint with the facility if they had concerns. (*Parent/Guardian Comments included the following: "No, but if I have a problem, I just call up there and talk to the front desk and they put me through to the right person")*

Inspection/Observation of Milieu

For the purpose of this IOC, the following areas were inspected:

- *East Unit/Males: Beneficiary Bedrooms and Bathrooms #301 and #306*
- *North Unit/Males: Beneficiary Bedrooms and Bathrooms #201 and #203*
- *West Unit/Males: Beneficiary Bedrooms and Bathrooms #101 and #102; Seclusion Room*
- *South Unit/Female: Beneficiary Bedrooms and Bathrooms #404 and #405*
- *Nursing Station*
- *Cafeteria*
- *Classroom #2 and Women's Bathroom*
- *Multi-Room*

Safety Concerns:

- East Unit/Males: Bedroom #301: The window is boarded up. [*Note: The facility stated it takes six weeks to obtain a new window and that this is the fourth week. It is noted that this concern was identified in the Program Review On-Site Visit on March 4, 2018; the provider is submitting a Corrective Action Plan to address this concern.*]

- North Unit/Males: Bedroom #201: The room was closed and not available for inspection. [*Note: The facility stated the room was closed due to its being treated for bed bugs. It is noted that the issue of bed bugs was identified in the Program Review On-Site Visit on March 4, 2018; the provider is submitting a Corrective Action Plan and monthly reports to address this concern.*]

- West Unit/Males:
  - Bathroom #101: Trim around the bathroom floor was missing
  - Bedroom #102: Wood on the bunk bed was split, exposing a sharp edge
  - Bathroom #102: What appeared to be mold and mildew were observed on the floor and on the ceiling above the shower [*Note: It is noted that the concern about mold in this bathroom was identified in the Program Review On-Site Visit on March 4, 2018; the provider is submitting a Corrective Action Plan to address this concern.*]
  - Seclusion Room: The window and mirrors were scratched [*Note: It is noted that this concern was identified in the Program Review On-Site Visit on March 4, 2018; the provider is submitting a Corrective Action Plan to address this concern.*]

- Male Units: Males are housed with four and six to each bedroom. [*Note: It is noted that this concern was identified in the Program Review On-Site Visit on March 4, 2018 and will be addressed by Child Care Licensing.*]

- Classroom: Women's Bathroom: The toilet was tied down with metal wire, with sharp wire exposed. [*Note: The facility addressed this safety concern on 04/12/18, the day after the IOC team identified the issue.*]

Observations: Cameras:

- *There are cameras in common areas of the facility (hallways, dayrooms, and cafeteria). The facility has the ability to monitor the unit in real time from management staff computers. The cameras can record and hold video for 14 days.*

Service Implementation (Observation of Services)

Group Therapy on the South Unit with eleven adolescent girls was observed. The group was led by a Mental Health Professional (MHP) and two other staff members were also in the room. The group began with the group members confronting each other about rules and rule-breaking. They were accepting of feedback from their peers and several admitted to breaking the rules. The group then began discussing loss and how to cope with loss. The MHP pointed out that this group has experienced a great deal of loss. The beneficiaries were engaged and did significant therapeutic work on the topic of loss. There were no behavioral issues observed during the group.

Clinical Record Review

At the time of the IOC, a total of 43 beneficiaries with active Arkansas Medicaid were enrolled for Inpatient Psychiatric services. All 43 charts were selected and reviewed.

The following summarizes the outcome of the Clinical Record Review:

Admission Evaluation

Element 7. Three beneficiary records did not document a Social Evaluation conducted within 60 hours of admission by professional staff in accordance with section 217.000 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Record	Finding	Service	Regulations	Comments
[redacted]	7	Social Evaluation	217.000	Due 03/08/18; no Social Evaluation found in record
[redacted]	7	Social Evaluation	217.000	Due 03/17/18; no Social Evaluation found in record
[redacted]	7	Social Evaluation	217.000	Due 03/25/18; no Social Evaluation found in record

Individual Plan of Care

Element 18. Two beneficiary records did not document an Individual Plan of Care developed by the facility-based team (physician and MHP) in accordance with sections 218.100 and 215.220 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Element 20. Five beneficiary records did not document the Individual Plan of Care was developed in consultation with the recipient and his or her parent(s), legal guardian(s), or others in whose care he or she will be released after discharge in accordance with section 218.100 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Record	Finding	Date	Service	Regulations	Comments
[redacted]	20	05/24/17	Individual Plan Of Care	218.100	Parent/guardian consultation not documented until 07/15/17
[redacted]	20	05/22/17	Individual Plan Of Care	218.100	Parent/guardian consultation not documented until 09/20/17
[redacted]	20	06/02/17	Individual Plan Of Care	218.100	No parent/guardian consultation documented
[redacted]	20	11/30/17	Individual Plan Of Care	218.100	No parent/guardian consultation documented
[redacted]	20	03/14/18	Individual Plan Of Care	218.100	No parent/guardian consultation documented
[redacted]	18		Individual Plan Of Care	218.000	No Plan of Care found in record; due 03/28/18
[redacted]	18		Individual Plan Of Care	218.000	No Plan of Care found in record; due 04/05/18

Seclusion and Restraint

Element 43. One beneficiary record did not document that the intervention was completed by the end of the staff's shift in accordance with section 221.703 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Record	Finding	Date	Service	Regulations	Comments
[redacted]	43	03/05/18	Seclusion and Restraint Documentation	221.703	No documentation of restraint intervention; nursing note documents that resident was in verbal altercation with a peer and that "Staff quickly intervened and pulled the peer and this resident apart." [*See Clinical Observations below*]

Therapeutic Leave

Element 45. One beneficiary record did not document a therapeutic leave evaluation which provided support to the plan of care objectives and goals in accordance with section 222.110 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Element 46. One beneficiary record did not document staff contact with beneficiary and person(s) responsible for the beneficiary for therapeutic leave in excess of 72 consecutive hours in accordance with section 222.110 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Element 47. Two beneficiary records did not document statements that track the beneficiary's actions and reactions and clearly reveal the beneficiary's achievements or regressions while on therapeutic leave in accordance with section 222.110 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Record	Finding	Date	Service	Regulations	Comments
[redacted]	47	03/30/18 03/15/18	Therapeutic Leave	222.110	No documentation by staff of beneficiary's achievement or regression while on pass
[redacted]	47	03/02/18	Therapeutic Leave	222.110	No documentation by staff of beneficiary's achievement or regression while on pass
[redacted]	45	03/16/18	Therapeutic Leave	222.110	Therapeutic Leave evaluation form does not provide support to Plan of Care objectives and goals
[redacted]	46	03/20/18	Therapeutic Leave	222.110	No documentation of staff contact with beneficiary or guardian after 72 hours

Clinical Observations

Record	Observation
[redacted]	Documentation that beneficiary was on pass from 03/20/18 until 03/25/18; however, Daily Rehabilitation progress note dated 03/24/18 documented that beneficiary was in Goals group from 7:30 PM to 8:00 PM.
[redacted]	Documentation in record states that staff are utilizing "voluntary escorts" as responses to beneficiary aggressive behaviors; however, the documentation states that the staff are laying hands on the beneficiaries, which would indicate that the intervention was a restraint. Example: Nursing note dated 03/05/18 nursing note documents that resident was in verbal altercation with a peer and that "Staff quickly intervened and pulled the peer and this resident apart". The documentation was also confusing in that one document stated that the beneficiary was seeing a doctor for injuries in reference to an elopement, but other documentation state that it was due to an aggressive incident with a peer.

Findings in Beneficiary Interviews, Follow-Up to Beneficiary Interviews, and Clinical Record Reviews and Child Abuse Hotline Reports:

The following were identified during the Inspection of Care, either by the Beacon Physician during the beneficiary interviews or by the Beacon Reviewers conducting the clinical records review. Both of these findings were reported to the Arkansas Child Abuse Hotline.

Record 24: (1) The beneficiary reported the following during the Beacon Physician interview on April 10, 2018: On Sunday, April 8, 2018, [*beneficiary name redacted*] reports he was eating in the cafeteria and had traded a food item for a carton of soy milk. Beneficiaries are not allowed to trade food, so he had the soy milk in his lap below the table surface. [*Staff name redacted*] was standing at a distance and directed the beneficiary to "come over here". [*Beneficiary name redacted*] replied "I'm not going over there" so [*staff name redacted*] walked over to the beneficiary, grabbed him by the shoulders, and "yanked me off my chair". Since the tables have attached stools without backs, the beneficiary fell to the ground, hitting his head and his right elbow. He reports his elbow hurt and when he extended it, it made a "clicking sound". He was examined by the nurses, who arranged for him to see the PCP on 04/11/18. During the course of the interview, the beneficiary demonstrated that he is not able to fully extend his elbow and reports pain and a popping sensation with attempted extension. He was placed on "no sports" until cleared/treated.

Beacon reviewed the facility's video regarding this reported incident with facility staff. A report was made by the Beacon physician to the Arkansas Child Abuse Hotline and has been reported to the Arkansas Division of Child Care and Early Childhood Education Placement and Residential Licensing. The facility suspended the staff member effective 04/10/18. [*Note: The facility terminated the staff member effective 04/19/18.*]

(2) In addition, on Sunday April 8, 2018, [*beneficiary name redacted*] reports he was on his unit when a peer, [*peer name redacted*], started hitting him with a "rat tail" (a rolled-up towel which is snapped at someone). The beneficiary was hit on both shoulders, which caused red welts. During the beneficiary interview, the beneficiary pulled up the sleeves of his t-shirt, revealing multiple bruises on his deltoids. The beneficiary stated a staff member saw the incident, but just "sat and watched" and did not try to intervene or stop the peer.

Beacon reviewed the facility's video regarding this reported incident with facility staff. The review of the video indicated that two other staff members were intervening in the incident. A report was made by the Beacon physician to the Arkansas Child Abuse Hotline.

Evidence of CAP Implementation

Evidence was provided of CAP implementation for following identified Elements with deficiencies from the accepted CAP for the IOC conducted April 3 to April 6, 2017:

- Element #1 [PCP Referral]
- Element #20 [Plan of Care (involvement of beneficiary/guardian in development)]
- Element #40 [Seclusion/Restraint (parent/guardian notification within 24 hours)]
- Element #41 [Seclusion/Restraint (debriefing with beneficiary and staff involved)]
- Element #42 [Seclusion/Restraint (debriefing with all staff involved)]
- Element #43 [Seclusion/Restraint (all documentation completed by end of shift)]
- Question #11 Non Physical Intervention
- Question #12 CPR

Partial evidence was provided of CAP implementation for following identified Element with deficiencies from the accepted CAP: Element #54 Medical Necessity. The CAP stated the director of UR and clinical services and the director of admissions will meet weekly to plan and review pending discharges. No evidence of these meetings or reviews was provided.

Exit Interview – Minutes – April 12, 2018 Start Time: 02:04 p.m.	
Participants	
Beacon Health Options Reviewers:	**Provider:**
[redacted] LCSW; [redacted] MD; [redacted] LCSW; [redacted] LMSW; and [redacted] MHPP	[redacted]

I. Introduction

- Beacon Health Options thanked the staff at Piney Ridge Treatment Center for assisting throughout the process.
- Beacon identified the areas that would be reviewed during the Exit Interview (facility tour, service observation, personnel record review, staff interviews, clinical record review, beneficiary interviews, family interviews, and decertifications).
- Beacon let Piney Ridge staff know they can expect their final Inspection of Care (IOC) Report in two weeks and then will have two weeks from the date of the report to respond with a Corrective Action Plan. The provider also has 30 days from the date of the report to request a reconsideration of any deficiencies identified in the report.
- Beacon stated that the results reported during this exit interview are preliminary.

II. Service Observation

- Group Therapy on the South Unit with eleven adolescent girls was observed. The group was led by a Mental Health Professional (MHP) and two other staff members were also in the room. The group began with the group members confronting each other about rules and rule-breaking. The group then began discussing loss and how to cope with loss. The MHP pointed out that this group has experienced a great deal of loss. The beneficiaries were engaged and did significant therapeutic work on the topic of loss.

III. Facility Tour

A. Beacon reported on the safety issues that were identified in the facility tour. Beacon explained that a full review of identified issues would be included in the IOC Report. Beacon asked the Piney Ridge staff if there were any questions regarding the facility tour and there were none.

IV. Personnel Record Review/Staff Interviews

A. Beacon reported 70 personnel records were reviewed. Beacon reported the following deficiencies: four personnel records did not document current CPR certification and three personnel records did not document current CPI certification.

B. Beacon reported that 15 staff members were interviewed. Staff expressed concerns about the restraint and seclusion training and would like more specific training; there was also a concern that appropriate CPI restraint interventions are not being utilized. Staff reported that some of the behavior tech staff are antagonistic towards the beneficiaries. Staff expressed concerns about the safety of the beneficiaries and the staff due to the aggressiveness of some of the beneficiaries. It was stated that concerns are expressed to supervisors and it has not made a difference with some of the different situations.

C. Beacon asked if there were any questions regarding the personnel records review or staff interviews. No questions were raised.

V. Clinical Records Review

A. Beacon stated that they would review the tool by element and give the estimated number of deficiencies per element. Beacon asked Piney Ridge staff to ask any questions throughout the review as needed.

B. Beacon identified the following as estimated number of deficiencies for the following elements:

- Element #7 - Social Evaluation in record within timeframes - 4
- Element #18 - Plan of Care (developed with MD and MHP) - 2
- Element #20 - Plan of Care (involvement of beneficiary/guardian in development) - 3
- Element #43 - Seclusion/Restraint (all documentation completed by end of shift) - 1
- Element #45 - Therapeutic Leave (documented in plan of care objectives and goals) – 1
- Element #46 - Therapeutic Leave (documentation of staff in contact with beneficiary and guardian when leave exceeds 72 hours) - 1
- Element #47 - Therapeutic Leave (documentation that describes beneficiary's achievements or regressions while on leave) - 1
- Clinical Observation: Staff that observe a restraint intervention also need to be in the debriefing.

C. Beacon asked if there were any questions about the clinical records review. No questions were raised.

VI. Beneficiary Interviews

A. Beacon reported that 43 beneficiaries were interviewed. The beneficiaries expressed that they do not like group punishments. They stated that they do not like not being able to have a fidget cube and that there is a general lack of things to do on the unit. They expressed that they do not like the uncleanliness of others and that some of the beneficiaries will throw food, such as apple cores, on the floor. The beneficiaries reported that there are earwigs, bed bugs, and, especially, ants. They stated that some staff are picking favorites. They expressed that they do not feel safe, due to the aggressiveness of peers. The safety issue was also discussed with the provider during the IOC.

B. Beacon asked if there were any questions about the interviews. No questions were raised.

VII. Beneficiary Family Interviews

A. Beacon reported that five family members of beneficiaries were interviewed. One of the family members expressed the concern that their child was "cheeking" his medicine. One family member said that they did not like that they could not call in to their child and did not like the allowed length of the conversation.

B. Beacon asked if there were any questions about the interviews. No questions were raised.

VIII. Decertifications / Arkansas Child Abuse Hotline Reports

A. Beacon reported there were no decertifications. However, the authorizations for [redacted] ends on 04/25/18 and for [redacted] ends on 04/23/18; the beneficiaries should be ready for discharge on those dates.

B. Beacon did report that the beneficiary for [redacted] needs to become more involved.

C. Beacon reminded the provider that they have the right to request a reconsideration/appeal.

D. Beacon reported that two reports were made to the Arkansas Child Abuse Hotline based upon reports by beneficiaries during the Beacon physician interviews and follow-up reviews of records.

E. Beacon asked if there were any questions about the interviews or decertifications. No questions were raised.

IX. Conclusion

A. Beacon reported that on-site and webinar training is available for providers. Beacon informed the provider that, if the provider would like to schedule a training or if the provider has any questions about the IOC Report, please contact [redacted] Project Director.

B. Beacon asked to whom the provider would like the IOC Satisfaction Survey to be e-mailed; the provider designated [redacted]

The Exit Interview was then concluded.

20180525 Millcreek CMS 2567 report N Tags POC [Redacted]

Appendix 4

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. [redacted]

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BLDG. _____ B. WING _____	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A Complaint Survey was conducted on 5/24/18 to 5/25/18. Complaint [redacted] was substantiated (all or in part) with deficiencies cited at N100, N128, N145, and N167.	N 000	Step #1 Corrective Action: On, 05/24/18, upon notification of deficient practice, the DON/Designee observed/checked all restraints within the last 30 days to ensure the following: A. physical restraints are safely implemented B. apply restraint(s) according to facility policy utilizing Therapeutic Crisis Intervention C. monitor and assess during and after the physical restraint for resident #1 No additional negative findings were found. Step #2 Identification of others with the potential of being affected: On, 05/24/18, DON/Designee through review of the restraint log immediately identified 58 residents who had the potential to be affected from the deficient practice by reviewing all restraints within the last 30 days to determine that a face to face assessment was completed by an RN (Registered Nurse) within 1 hour of all restraints Training for involved nursing staff was started on 5/24/18 by the Residential Services Director/Designee observed/checked to ensure the following: A. physical restraints are safely implemented B. apply restraint(s) according to facility policy utilizing Therapeutic Crisis Intervention C. monitor and assess during and after the physical restraint to determine if those residents were affected. Any negative findings were corrected immediately.	6/24/2018
N 100	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Complaint [redacted] was substantiated (all or in part) in these findings.	N 100		

LABORATORY DI[redacted]ATURE TITLE CEO (X6) DATE 6/26/18

Any deficiency s[redacted]ch 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BLDG. _____ B. WING _____	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

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N 100	Continued From page 1 Based on record review and interview, the facility failed to meet the requirements for the Condition of Participation of Restraints and Seclusion, as evidenced by the facility's failure to ensure physical restraints were safely implemented to prevent potential injuries, failure to apply the restraint according to facility policy utilizing Therapeutic Crisis Intervention, and failure to monitor and assess during and after the physical restraint for 1 (Resident #1) of 5 (Residents #1 - #5) case mix residents who had physical restraints implemented. This failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury, or death to Resident #1, who was injured during implementation of physical restraints on 5/17/18. The Administrator was notified of the Immediate Jeopardy on 5/25/18 at 12:30 p.m. The findings are: 1.The facility failed to ensure physical restraints were applied appropriately and safely implemented to prevent injuries for 1 (Resident #1) of 5 (Residents #1 - #5) who were involved with physical restraints. This failed practice resulted in immediate jeopardy, which caused or could have caused serious harm, injury, or death to 1 (Resident #1) who was involved in physical restraint that resulted in injury. Refer to N128. 2.On 5/25/18 at 3:45 p.m., the Immediate Jeopardy was removed when the facility implemented the following Plan of Removal: a. Identification: The total number of residents at risk is 162. b. Assessments:	N 100	Step #3 To ensure deficient practice does not recur: On 05/24/18, the Residential Services Director/Designee in-serviced All involved and non-involved staff to ensure the following: A. physical restraints are safely implemented B. apply restraint(s) according to facility policy utilizing Therapeutic Crisis Intervention C. monitor and assess during and after the physical restraint Step #4 Monitoring: Director of Staff Development or Residential Services Director/Designee will monitor to ensure the following: A. physical restraints are safely implemented B. apply restraint(s) according to facility policy utilizing Therapeutic Crisis Intervention C. monitor and assess during and after the physical restraint by observation and documenting on the restraint log and restraint packets, for all occurrences weekly for 8 weeks or until compliance is verified by OLTC. Any negative findings will be corrected immediately and Administrator/Designee notified. Step #5 QA: DON/Designee will present all findings to the monthly QA committee for further review and recommendations.	6/24/18

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N 100	Continued From page 2 1.On 5/25/18 at 1:41 p.m. all applicable departments head met to discuss failed practices that resulted in the finding of immediate jeopardy. 2.On 5/25/18 at 2:00 p.m. a plan was developed to immediately remove the risk to individuals and immediately implement corrective measures preventing repeated jeopardy situations. 3.On 5/25/18 at 2:30 p.m. the DON (Director of Nursing) reviewed all restraints within the last 30 days to determine that a face to face assessment was completed by an RN (Registered Nurse) within 1 hour of all restraints. No other deficiencies were noted. 4.On 5/18/18 the offender was placed on administrative leave pending results of the final investigation. c. Training Training of direct care staff and supervisors involved with the incident was initiated by the Residential Services Director on 5/24/18 at 5:30 p.m. upon notification of the deficient practices. All staff involved with the reported incident were in-serviced on mandated reporting, reporting to supervisors, zero tolerance for abuse, and maintaining safety of all of the clients at all times. Training for all non-involved direct care staff, supervisors, and all new employees was initiated by the Residential Services Director on 5/25/28 at 7:00 a.m. All staff will be in-serviced at the beginning of each shift and prior to entering the units and having contact with any clients.	N 100		6/24/18

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N 100	Continued From page 3 Training of nursing staff involved with the incident was initiated on 5/25/18 at 6:15 p.m. by the Residential Services Director regarding mandated reporting, reporting to supervisors, zero tolerance for abuse, and maintaining safety of all clients at all times. Training for all non-involved nurses and all new employees began on 5/25/18 at 7:00 a.m. All nurses will be in-serviced at the beginning of each shift and prior to entering the units and having contact with any clients. d. Monitoring Restraints will be reviewed on an ongoing basis for proper practices by the Director of Staff Development or the Residential Services Director through video if available. A column was added to the restraint log on 5/25/18 at 3:00 p.m. to indicate if the incident was reviewed by camera. An indicator box for camera review will be added to the restraint packet by 5/22/18. Direct care staff will be monitored on an ongoing basis for proper use of TCI (Therapeutic Crisis Intervention) through review of documentation and observation by supervisors or the Residential Services Director. Any improper practices will immediately be reported to supervisory personnel and the staff involved will be retrained before being allowed to return to work. Nursing Staff will be monitored on an ongoing basis through documentation and observation rounds by the Director of Nursing. Any improper practices will immediately be reported to supervisory personnel and the involved nurse or nurses will be retrained before being allowed to	N 100		6/24/18

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N 100	Continued From page 4 return to work. e. Documentation All in-service sheets and documentation will be kept with the Director of Staff Development.	N 100		6/24/18
N 128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Complaint [redacted] was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure physical restraints were properly applied and safely implemented to prevent injuries for 1 (Resident #1) of 5 (Residents #1 - #5) sampled residents who were involved with physical restraints. This failed practice resulted in immediate jeopardy, which caused or could have caused serious harm, injury, or death to 1 (Resident #1) who was involved in physical restraint that resulted in injury. The Administrator was notified of the Immediate Jeopardy on 5/25/18 at 12:30 p.m. The findings are: 1. Resident #1 had diagnoses of Disruptive Mood Dysregulation Disorder, Posttraumatic Stress Disorder, Other Specified Depressive Disorders, Problems related to Other Legal Circumstances, Other Specific Problems Related to Primary Group, Complex Seizures, Type II Diabetes, Seasonal Allergies, and Victim of physical and emotional abuse.	N 128	**Plan of removal will be incorporated into the facility's plan of correction** Step #1 Corrective Action: On, 05/24/18, upon notification of deficient practice, the DON/Designee observed/checked all restraints within 30 days to ensure physical restraints are properly applied and safely implemented to prevent injuries for resident #1. No additional negative findings were found. Step #2 Identification of others with the potential of being affected: On, 05/24/18, DON/Designee through review of the restraint log immediately identified 58 residents who had the potential to be affected from the deficient practice by reviewing all restraints within the last 30 days to determine that a face to face assessment was completed by an RN (Registered Nurse) within 1 hour of all restraints. Training for involved nursing staff was started on 5/24/18 by the Residential Services Director/Designee observed/checked to ensure physical restraints are properly applied and safely implemented to prevent injuries to determine if those residents were affected. Any negative findings were corrected immediately.	

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N 128	Continued From page 5 a. An Emergency Safety Intervention and Debriefing form documented the date and time placed in restraint was 5/17/18 at 7:30 p.m. "Patient's Behavior:... Pt [patient] became aggressive toward staff and was asked several times to return to unit. Pt. refused & [and] continued to be aggressive towards staff, hitting, spitting & pushing on staff... Pt. was placed in physical restraint for safety... Assessment Date 051818 [5/18/18] Assessment Time 1055 [10:55 a.m.] Total Duration of Restraint: 20 minutes Physical Well-being: Injury Before restraint: Scratches to Rt [right] of nose bruise [below] lt [left] eye. Injury during restraint: Scratch from Rt nare to below Rt eye - 4 scratches rt hand between thumb & finger 2 - 2" [inch] scratches 1 ½ [inch] scratch left side back neck - scratch back of rt hand. First Aid Applied... TAO [triple antibiotic ointment] applied..." This assessment documentation was completed by Registered Nurse (RN) #2. Nurses Notes dated 5/18/18 at 10:55 a.m., completed by RN #2, documented, "...Rt eye with bruise under eye..." b. A policy titled "Therapeutic Crisis Intervention" obtained from the Staff Development Coordinator on 5/24/18 at 11:09 a.m. documented "Physical Holds: Team Restraint - Supine Restraint... a. With a signal from the team leader, the team works simultaneously to perform trained TCI (Therapeutic Crisis Intervention) procedures including the following: 1. Obtaining a hold - Team simultaneously approach the patient from opposite sides and grasp the patient's arms above the wrist with their outside hands. 2. Yoke - Both staff slide their inside arms under the	N 128	Step #3 To ensure deficient practice does not recur: On 05/24/18, the Residential Services Director/Designee in-serviced all involved and non-involved staff to ensure physical restraints are properly applied and safely implemented to prevent injuries Step #4 Monitoring: Director of Staff Development or Residential Services Director/Designee will monitor to ensure physical restraints are properly applied and safely implemented to prevent injuries by observation and documenting on the restraint log and restraint packets, for all occurrences weekly for 8 weeks or until compliance is verified by OLTC. Any negative findings will be corrected immediately and Administrator/Designee notified. Step #5 QA: DON/Designee will present all findings to the monthly QA committee for further review and recommendations.	6/24/18

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N 128	Continued From page 6 patient's armpits and gently brings the patient's arms across the plane of their bodies, securing the young person's arms against their chest. 3. Take Down - Both staff take one step forward with their outside legs and kneel on the floor on their inside knees. This action brings the patient down backwards. The staff break the patient's fall by letting their knees make contact with the floor first and bringing the patient down beside them. 4. Secure the arms - Team leader and assistant secure the patient's arms by placing the arms on floor and holding slightly above wrist with outside arms and place hand on shoulders. Have patient's palms down on floor, do not force arms into that position. 5. Secure legs - Third staff gets on the floor and wrap patient's legs by extending their inside arm over the patient's legs to protect face and placing his outside arm under the patient's legs above the knees to secure the legs wrap arms around the patient's leg "circling the legs" above the knees. 6. A physical hold should not be used without the approval of a nurse or supervisor except in extreme case, when the safety of the patients or others is at risk." c. On 5/24/18 at 5:45 p.m., the camera footage in Zebra Hall dated 5/17/18 at 7:30 p.m. was reviewed with the Residential Services Director (RSD). The footage showed several non-case mix residents went outside of the building and had to be escorted back into the building. Direct Care Staff #2 had Resident #1 against the wall adjacent to the medication room and Direct Care Staff #2's left forearm was positioned against the resident's neck and upper chest area, pinning Resident #1 against the wall. The RSD was asked, "Did you see the left forearm in the neck and upper chest area holding [Resident #1] against the wall?" The RSD stated, "Yes". The	N 128		6/24/18

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N 128	Continued From page 7 RSD was asked, "Would you call that abuse?" He stated, "Yes". d. On 5/24/18 at 6:05 p.m., Direct Care Staff #1 was asked, "What did you see on 5/17/18 when [Resident #1] was out of control before she was restrained?" Direct Care Staff #1 replied, "I was looking at her [Direct Care Staff #2], and she had [Resident #1] pinned up against the wall." Direct Care Staff #1 was asked if pinning a resident up against the wall was a proper restraint and stated, "No". Direct Care Staff #1 was asked, "Did you report it to anybody?" The staff responded, "No, because the supervisor came right out the door." Direct Care Staff #1 was asked, "Do you think you should have reported this incident that you saw?" The staff responded, "Yes". Direct Care Staff #1 was asked, "Do you think pinning [Resident #1] against the wall was a type of abuse?" The staff responded, "In a way, yes it was." e. On 5/24/18 at 6:19 p.m. Licensed Practical Nurse (LPN) #1 was asked, "What did you see when you came out of the medication room?" The LPN stated, "I did see [Resident #1] up against the wall... I did see everything". The LPN was asked, "Were there any injuries?" LPN #1 stated, "Scratch left side of her neck, left forearm, right side of her nose right after the struggle... I believe she got them during the struggle... the blood was fresh." f. On 5/25/18 at 11:29 a.m., Direct Care Staff #3 was asked, "What restraint technique are you taught at [this facility]?" The staff replied, "Therapeutic Crisis Intervention". The Direct Care Staff was asked, "Are you taught to put your forearm across the neck and chest area to hold a	N 128		6/24/18

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N 128	Continued From page 8 resident against the wall until more help arrives?" Direct Care Staff #3 stated, "No". g. On 5/25/18 at 11:56 a.m., the Director of Nursing was asked why LPN #1 did not notify anyone and stated, "I don't know. I can't answer that. Personally, I would have made a phone call... It [potential abuse] was missed on multiple levels." 2. A policy titled "Guidelines for Patient/Resident Rights Violations Alleged Abuse/Neglect/Exploitation/Serious Occurrence" obtained from the Administrator at 4:30 p.m., on 5/24/18 documented, "Any person that is a witness to or has knowledge of suspected abuse, neglect, exploitation, serious occurrence or other patient/resident rights violations is required to report the incident immediately to his/her supervisor or the designated shift supervisor". On 5/24/18 at 3:00 p.m., the Residential Services Director (RSD) was asked, "What are staff trained about abuse and neglect and reporting incidents of suspected abuse or neglect?" The Residential Services Director stated, "They are mandated reporters and should immediately report to their supervisor on duty at the time." The RSD was asked, "Did they report [Resident #1] was pinned against the wall before being put into a physical restraint?" The RSD stated, "No ma'am." The RSD was asked, "Should they have reported this incident immediately?" The RSD stated, "Yes." On 5/25/18 at 11:45 a.m., the staffing sheets for 5/17/18 documented that Direct Care Staff #2 worked the 2nd and 3rd shift in a different female cottage. The physical restraint occurred on	N 128		6/24/18

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N 128	Continued From page 9 5/17/18 at 7:30 p.m., and the alleged offender did not leave the campus until approximately 7:00 a.m. on 5/18/18. Direct Care Staff #2 was not placed on Administrative Leave until 5/18/18. 3. On 5/25/18 at 3:45 p.m., the Immediate Jeopardy was removed when the facility implemented the following Plan of Removal: a. Identification: The total number of residents at risk is 162. b. Assessments: 1.On 5/25/18 at 1:41 p.m. all applicable departments head met to discuss failed practices that resulted in the finding of immediate jeopardy. 2.On 5/25/18 at 2:00 p.m. a plan was developed to immediately remove the risk to individuals and immediately implement corrective measures preventing repeated jeopardy situations. 3.On 5/25/18 at 2:30 p.m. the DON (Director of Nursing) reviewed all restraints within the last 30 days to determine that a face to face assessment was completed by an RN (Registered Nurse) within 1 hour of all restraints. No other deficiencies were noted. 4.On 5/18/18 the offender was placed on administrative leave pending results of the final investigation. c. Training Training of direct care staff and supervisors involved with the incident was initiated by the Residential Services Director on 5/24/18 at 5:30	N 128		6/24/18

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N 128	Continued From page 10 p.m. upon notification of the deficient practices. All staff involved with the reported incident were in-serviced on mandated reporting, reporting to supervisors, zero tolerance for abuse, and maintaining safety of all of the clients at all times. Training for all non-involved direct care staff, supervisors, and all new employees was initiated by the Residential Services Director on 5/25/28 at 7:00 a.m. All staff will be in-serviced at the beginning of each shift and prior to entering the units and having contact with any clients. Training of nursing staff involved with the incident was initiated on 5/25/18 at 6:15 p.m. by the Residential Services Director regarding mandated reporting, reporting to supervisors, zero tolerance for abuse, and maintaining safety of all clients at all times. Training for all non-involved nurses and all new employees began on 5/25/18 at 7:00 a.m. All nurses will be in-serviced at the beginning of each shift and prior to entering the units and having contact with any clients. d. Monitoring Restraints will be reviewed on an ongoing basis for proper practices by the Director of Staff Development or the Residential Services Director through video if available. A column was added to the restraint log on 5/25/18 at 3:00 p.m. to indicate if the incident was reviewed by camera. An indicator box for camera review will be added to the restraint packet by 5/22/18. Direct care staff will be monitored on an ongoing basis for proper use of TCI (Therapeutic Crisis	N 128		6/24/18

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MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

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N 128	Continued From page 11 Intervention) through review of documentation and observation by supervisors or the Residential Services Director. Any improper practices will immediately be reported to supervisory personnel and the staff involved will be retrained before being allowed to return to work. Nursing Staff will be monitored on an ongoing basis through documentation and observation rounds by the Director of Nursing. Any improper practices will immediately be reported to supervisory personnel and the involved nurse or nurses will be retrained before being allowed to return to work. e. Documentation All in-service sheets and documentation will be kept with the Director of Staff Development.	N 128		
N 145	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(f) Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to- (1) The resident's physical and psychological status; (2) The resident's behavior;	N 145	Step #1 Corrective Action: On, 05/24/18, upon notification of deficient practice, the DON/Designee observed/checked all restraints within the last 30 days to ensure physician or other licensed practitioner conducts a face-to-face assessment of the physical and psychosocial wellbeing within one hour of initiation of an emergency safety intervention to determine the need for further medical or psychological treatment for resident #1. No additional negative findings were found.	6/24/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BLDG. _____ B. WING _____	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 145	Continued From page 12 (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention. This ELEMENT is not met as evidenced by: Complaint [redacted] was substantiated (all or in part) in these findings. Based on interview and record review, the facility failed to ensure a physician or other licensed practitioner conducted a face-to-face assessment of the physical and psychosocial wellbeing within one hour of initiation of an emergency safety intervention to determine the need for further medical or psychological treatment for 1 (Resident #1) of 5 (Residents #1 - #5) sampled residents who were involved in physical restraints. The findings are: Resident #1 had diagnosis of Disruptive Mood Dysregulation Disorder, Posttraumatic Stress Disorder, Other Specified Depressive Disorders, Problems related to Other Legal Circumstances, Other Specific Problems Related to Primary Group, Complex Seizures, Type II Diabetes, Seasonal Allergies, and Victim of physical and emotional abuse. a. An Emergency Safety Intervention and Debriefing form documented the date and time placed in restraint was 5/17/18 at 7:30 p.m. "Patients Behavior:... Pt [patient] became aggressive toward staff and was asked several times to return to unit. Pt. refused & [and] continued to be aggressive towards staff, hitting, spitting & pushing on staff... Pt. was placed in physical restraint for safety... Assessment Date	N 145	Step #2 Identification of others with the potential of being affected: On, 05/24/18, DON/Designee through review of the restraint log immediately identified 58 residents who had the potential to be affected from the deficient practice by observing/checking all restraints within the last 30 days to ensure physician or other licensed practitioner conducts a face-to-face assessment of the physical and psychosocial wellbeing within one hour of initiation of an emergency safety intervention to determine if those residents were affected. Any negative findings were corrected immediately. Step #3 To ensure deficient practice does not recur: On 05/24/18, the Residential Service Director/Designee in-serviced all involved and non-involved staff to ensure physician or other licensed practitioner conducts a face-to-face assessment of the physical and psychosocial wellbeing within one hour of initiation of an emergency safety intervention Step #4 Monitoring: Director of Staff Development or Residential Services Director/Designee will monitor to ensure physician or other licensed practitioner conducts a face-to-face assessment of the physical and psychosocial wellbeing within one hour of initiation of an emergency safety intervention by observation and documenting on the restraint log and restraint packets, for all occurrences weekly for 8 weeks or until compliance is verified by OLTC. Any negative findings will be corrected immediately and Administrator/Designee notified. Step #5 QA: DON/Designee will present all findings to the monthly QA committee for further review and recommendations.	6/24/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BLDG. _____ B. WING _____	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 145	Continued From page 13 051818 [5/18/18] Assessment Time 1055 [10:55 a.m.] Total Duration of Restraint: 20 minutes Physical Well-being: Injury Before restraint: Scratches to Rt [right] of nose bruise [below] lt [left] eye. Injury during restraint: Scratch from Rt nare to below Rt eye - 4 scratches rt hand between thumb & finger 2 - 2" [inch] scratches 1 1/2 [inch] scratch left side back neck - scratch back of rt hand. First Aid Applied... TAO [triple antibiotic ointment] applied..." This assessment documentation was completed by Registered Nurse (RN) #2, over 14 hours after the restraint was implemented. There was no documentation an assessment by an RN was conducted within one hour of the initiation of the restraint. 1) Nurses Notes dated 5/18/18 at 10:55 a.m. completed by RN #2 documented, "...Rt eye with bruise under eye..." 2) On 5/24/18 at 2:54 p.m., the Director of Nursing (DON) was asked, "Tell me about the nursing staffing on the evening of 5/17/18?" The DON stated, "We try to have an RN [Registered Nurse] on each shift. There was not one that night. If not one, they should have called me. I was made aware the next day. I feel like it's an error in communication." The DON was asked; "Who normally does the assessment after a restraint?" The DON stated, "An RN should do an assessment within an hour [of the restraint]. [RN #2] did the assessment the next day." b. On 5/24/18 at 5:45 p.m., the camera footage in Zebra Hall dated 5/17/18 at 7:30 p.m. was reviewed with the Residential Services Director (RSD). The footage showed several non-case mix residents went outside of the building and had to be escorted back into the building. Direct	N 145		6/24/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BLDG. _____ B. WING _____	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 145	Continued From page 14 Care Staff #2 had Resident #1 against the wall adjacent to the medication room and Direct Care Staff #2's left forearm was in the neck and upper chest area holding Resident #1 against the wall. The RSD was asked, "Did you see the left forearm in the neck and upper chest area holding [Resident #1] against the wall?" The RSD stated, "Yes". The RSD was asked, "Would you call that abuse?" He stated, "Yes". c. On 5/24/18 at 6:19 p.m. Licensed Practical Nurse (LPN) #1 was asked, "What did you see when you came out of the medication room?" The LPN stated, "I did see her [Resident #1] up against the wall. I did see everything." The LPN was asked, "Were there any injuries?" LPN #1 stated, "Scratch left side of her neck, left forearm, right side of her nose right after the struggle. I believe she got them during the struggle... the blood was fresh." The LPN was asked "Why didn't you notify the Registered Nurse (RN)?" The LPN did not answer. d. On 5/25/18 at 11:56 a.m., the Director of Nursing was asked, "Why do you think the nurse [LPN #1] didn't think notifying an RN was an issue?" The DON replied, "I don't know. I can't answer that."	N 145		
N 167	MONITORING DURING AND AFTER RESTRAINT CFR(s): 483.362(c) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the restraint is removed.	N 167	Step #1 Corrective Action: On, 05/24/18, upon notification of deficient practice, the DON/Designee observed/checked all restraints within 30 days to ensure physician or licensed practitioner conducts an assessment immediately after an emergency safety intervention to determine the wellbeing for resident #1. No additional negative findings were found.	6/24/18

PRINTED: 06/08/2018
FORM APPROVED
OMB NO. [redacted]

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BLDG. _____ B. WING _____	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 167	Continued From page 15 This ELEMENT is not met as evidenced by: Complaint [redacted] was substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure a physician or licensed practitioner conducted an assessment immediately after an emergency safety intervention to determine the wellbeing of 1 (Resident #1) of 5 (Residents #1- #5) sampled residents who were involved in a physical restraint. The findings are: Resident #1 had diagnosis of Disruptive Mood Dysregulation Disorder, Posttraumatic Stress Disorder, Other Specified Depressive Disorders, Problems related to Other Legal Circumstances, Other Specific Problems Related to Primary Group, Complex Seizures, Type II Diabetes, Seasonal Allergies, and Victim of physical and emotional abuse. a. An Emergency Safety Intervention and Debriefing form documented the date and time placed in restraint was 5/17/18 at 7:30 p.m. "Patients Behavior:... Pt [patient] became aggressive toward staff and was asked several times to return to unit. Pt. refused & [and] continued to be aggressive towards staff, hitting, spitting & pushing on staff... Pt. was placed in physical restraint for safety... Assessment Date 051818 [5/18/18] Assessment Time 1055 [10:55 a.m.] Total Duration of Restraint: 20 minutes Physical Well-being: Injury Before restraint: Scratches to Rt [right] of nose bruise [below] lt [left] eye. Injury during restraint: Scratch from Rt nare to below Rt eye -4 scratches rt hand	N 167	Step #2 Identification of others with the potential of being affected: On, 05/24/18, DON/Designee through review of the restraint log immediately identified 58 residents who had the potential to be affected from the deficient practice by observing/checking all restraints within the last 30 days to ensure physician or licensed practitioner conducts an assessment immediately after an emergency safety intervention to determine the wellbeing to determine if those residents were affected. Any negative findings were corrected immediately. Step #3 To ensure deficient practice does not recur: On 05/24/18, the Residential Service Director/Designee in-serviced All nurses to ensure physician or licensed practitioner conducts an assessment immediately after an emergency safety intervention to determine the wellbeing Step #4 Monitoring: DON/designee will monitor to ensure physician or licensed practitioner conducts an assessment immediately after an emergency safety intervention to determine the wellbeing by observation and documenting on restraint log, for all restraint occurrences weekly for 8 weeks or until compliance is verified by OLTC. Any negative findings will be corrected immediately and Administrator/Designee notified. Step #5 QA: DON/Designee will present all findings to the monthly QA committee for further review and recommendations.	6/24/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BLDG. _____ B. WING _____	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 167	Continued From page 16 between thumb & finger 2 - 2" [inch] scratches 1 1/2 [inch] scratch left side back neck - scratch back of rt hand. First Aid Applied... TAO [triple antibiotic ointment] applied..." This assessment documentation was completed by Registered Nurse (RN) #2. Nurses Notes dated 5/18/18 at 10:55 a.m. completed by RN #2 documented, "...Rt eye with bruise under eye..." b. On 5/24/18 at 2:54 p.m., the Director of Nursing (DON) was asked, "Tell me about the nursing staffing on the evening of 5/17/18?" The DON stated, "We try to have an RN [Registered Nurse] on each shift. There was not one that night. If not one, they should have called me. I was made aware the next day. I feel like it's an error in communication." The DON was asked, "Who normally does the assessment after a restraint?" The DON stated, "An RN should do an assessment within an hour [of the restraint]. [RN #2] did the assessment the next day." c. On 5/24/18 at 6:19 p.m. Licensed Practical Nurse (LPN) #1 was asked, "What did you see when you came out of the medication room?" The LPN stated, "I did see her [Resident #1] up against the wall. I did see everything." The LPN was asked, "Were there any injuries?" LPN #1 stated, "Scratch left side of her neck, left forearm, right side of her nose right after the struggle. I believe she got them during the struggle... the blood was fresh." LPN #1 was asked "Was there an RN there to do a post restraint assessment?" The LPN stated, "No." The LPN was asked, "Was there supposed to be an RN there?" LPN #1 stated, "I think they are supposed to have one." The LPN was asked, "Why didn't you notify	N 167		6/24/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BLDG. _____ B. WING _____	C 05/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 167	Continued From page 17 the RN?" The LPN did not answer. d. On 5/25/18 at 11:56 a.m., the Director of Nursing was asked, "Why do you think the nurse [LPN #1] didn't think notifying an RN was an issue?" The DON replied, "I don't know. I can't answer that." A document provided by the Residential Services Director on 5/24/18 at 2:50 p.m. titled "[Facility] Shift Supervisor Report PRTF [Psychiatric Residential Treatment Facility]" documented, "Registered Nurse on call/on duty: [Director of Nursing]."	N 167		6/24/18

20180629 Millcreek 2567 w POC 071119 [Redacted]

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

PRINTED: 07/11/2019
FORM APPROVED
OMB NO [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center Complaint [redacted] was substantiated, all or in part, with a deficiency cited at N0128.	N 000		
N 128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Complaint [redacted] was substantiated, all or in part, with these findings: Based on observation, record review and interview, the facility failed to ensure a client that was placed in a physical restraint did not sustain an injury for 1 of 1 (Resident #1) sampled client who was physically restrained. The findings are: Client #1 was admitted on 6/24/19 and had	N 128		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 128	Continued From page 1	N 128		

diagnoses Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation; Disinhibited Attachment Disorder of Childhood; and Conduct Disorders.

a. A Social History Prior to Admission to MOA [Millcreek of Arkansas] updated 6/21/19 documented, "...He is having escalating verbal and physical aggression. During the past week, the patient has attacked multiple staff members and his therapist. He threatened to kill the nurse practitioner on the day of admission. He was placed in a hold due to escalating aggression. He attacked his therapist and mother on the day of admission in the office..."

b. OLTC (Office of Long Term Care) Incident And Accident Report, dated 6/25/19 at 8:40 p.m., documented, "...Location: [Home] Hallway: On 6/25/19 [Resident #1] was provoking peers and being non-compliant to staff directives. [Resident #1] was directed multiple times to stop. [Resident #1] then became physically aggressive towards staff by punching/kicking and throwing his shoes directly at staff. Staff separated from [Resident #1]. [Resident #1] continued to be aggressive and target staff. Nurse and supervisor notified. [Resident #1] was placed in a physical restraint for safety of self and others. During the physical restraint patient continued to display strong aggression and resistance by lifting his upper body off the floor. [Resident #1] also refused to comply to any directives given by the nurse and supervisor. Nursing Evaluation: Per [LPN (Licensed Practical Nurse) #1]: bruising and redness to right shoulder petechiae to right leg and redness to right leg. ROM [Range-of-motion] to right shoulder. Sent to [Hospital] for evaluation. [Staff #1] was located on right

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 128	Continued From page 2 shoulder where patient was badly bruised." c. Nurse's Note, dated 6/25/19 at 4:46 p.m., documented, "Pt [patient] may be placed in a physical restraint not to exceed 20 minutes d/t [due to] physical aggression towards staff and refusing to calm. While in physical restraint pt refused to calm and tried to remove self from restraint and attempting to bite staff. Pt was able to calm on own and was released at 1656 [4:56 p.m.] When nurse walked into hall, pt was already in supine 3 man tci [Therapeutic Crisis Intervention] hold. After pt was released bruising and redness were noted to R [right] shoulder, petechiae noted to R [right] leg and redness noted to R leg. Pt rates pain 10/10 [ten of ten] and has no ROM [range-of-motion] to R [right] shoulder and refuses to move it. Full ROM noted to all other extremities. Pt declines ice pack and declines pain meds [medications] @ [at] this time. (1719) [5:19 p.m.] pt being sent to ER [emergency room] for evaluation of pain to R shoulder..." d. On 6/28/19 at 2:14 p.m., RN (Registered Nurse) #1 and LPN #1 were asked, "Can you tell me what happened when [Resident #1] was restrained?" [LPN #1] stated, "They called a code green and when we got down there he was already in the three man restraint." [RN #1] stated, "We could hear him hollering, let me up, let me up, I'll be good. Then I bent down and said you need to calm down and count to ten. Then he started to try to count to ten and started to bite one of them and I told him don't bite, don't bite." RN #1 and LPN #1 were asked, "Was he fighting?" LPN #1 stated, "He was trying to come up with his body and his legs were coming out of the restraint, so just kinda wiggle wormed." RN	N 128		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 128	Continued From page 3 #1 and LPN #1 were asked, "Is bruising normal during a restraint?" LPN #1 stated, "You can get some bruising right there in the crease [indicating crease between the junction of the upper arm and shoulder], that is pretty normal, but not to that extent." Both RN #1 and LPN #1] stated, "Not to that extent." RN #[and LPN #1 were asked, "Was it caused by undo pressure on his shoulder?" LPN #1 stated, "Yeah, I never seen a restraint look like that." e. On 6/28/19 at 2:24 p.m., Resident #1 was asked, "Can you tell me what happened when you were restrained?" Resident #1 stated, "Do you want to see my bruises?" Resident #1 had on shorts and he pointed out a penny size, fading, light brown bruise on the upper right thigh. Resident #1 moved the neck of his t-shirt down exposing the right shoulder where a fading brown, green and yellow bruise, approximately 3 inches in width and 4 to 5 inches in length was observed. The Surveyor stated, "That's a pretty good bruise." Resident #5 stated, "Yeah, that's where they were holding me down. They kept pushing harder and harder, then the nurse told me to count to ten and they pushed down harder. I tried to bite them." Resident #1 was asked, "Were you trying to get out of the restraint?" He stated, "Yeah, when they were pushing down so hard, it was hurting."	N 128		

20180717 Resource IN DCS Licensing Survey Report [Redacted]

Indiana Department of Child Services
Central Office Residential Licensing Unit

RESIDENTIAL LICENSING: EXIT REPORT AND NARRATIVE

LICENSING STUDY: Annual **ARRIVED:** 7/17/18 **DEPARTED:** 7/20/2018

LICENSING PERIOD: 8/3/17 - 8/2/21 **TIME:** 9:00 AM **TIME:** 4:00 PM

FACILITY NAME: RTC Resource - Hope, Unity, Reach and Inspire

FACILITY ADDRESS: [redacted]

CITY: Indianapolis **STATE:** IN **ZIP CODE:** [redacted] **COUNTY:** [redacted]

TYPE OF FACILITY: ☐ CCI ☐ GH ☐ LTC ☐ ESC ☒ PSF ☐ LCPA

FACILITY ADMINISTRATOR: [redacted] **TITLE:** CEO

EMAIL: [redacted] **PHONE:** [redacted]

FACILITY REPRESENTATIVE: [redacted] **TITLE:** CEO

LICENSE # [redacted]

RECOMMENDATION:
☒ A ☐ I ☐ P ☐ R
☐ D ☐ S ☐ N/A

Key Code: A) approved; I) initial license recommended; P) probation; R) revoke; D) deny initial license; S) suspend license; N/A) not applicable

Capacity: 39
Age: 11-21
Gender: both

Current Census: 28
Average Annual Census: 31

A. ADMINISTRATION: ☒ changes; ☒ organizational structure; ☐ board; ☐ finances; ☐ application; ☒ policies and procedures; ☒ staff records; ☒ children's records

B. PROGRAM: ☐ changes; ☐ admission; ☒ treatment program; ☒ recreation; ☒ education; ☒ discipline; ☒ daily life; ☐ discharge; ☒ observation of children (a.m., p.m.)

LCPA Only: ☐ adoption placements; ☐ foster care placements; ☐ foster care training; ☐ home studies; ☐ post placement reports

C. STAFF: ☐ changes; ☒ schedule; ☒ supervision; ☒ qualifications; ☒ training; ☐ volunteers; ☐ administrative; ☒ professional; ☐ child care

D. BUILDING/GROUNDS: ☒ toured units: ☐ changes; ☒ children's rooms; ☒ bath/toilet facilities; ☐ kitchen; ☒ living space; ☐ staff quarters; ☐ isolation room; ☐ confinement room; ☒ maintenance; ☐ safety; ☐ CCS inspection ☐ SFM; ☐ plans; ☒ office space

1. **STATE BUILDING COMMISSION PLANS** (initial licensure): n/a
2. **STATE DEPARTMENT OF HEALTH PLANS** (initial licensure): n/a
3. **DEPARTMENT OF HOMELAND SECURITY-FIRE AND BUILDING SAFETY:** 4/26/18
4. **SANITATION/CHILD CARE: 5/30/18**
5. **HEALTH CARE PROGRAM:** 7/26/17 - 9/30/21
6. **NUTRITION/FOOD SERVICE PROGRAM: 8/1/17 - 9/30/21**

WAIVERS OR VARIANCES: Resource private secure license has been approved for a waiver for 2-11-47 (a) which states - employees shall complete a separate application for employment prior to working in a private secure facility.

FORMAL COMPLAINTS:

Narrative continued on page 2

Indiana Department of Child Services
Central Office Residential Licensing Unit

RESIDENTIAL LICENSING – EXIT REPORT AND NARRATIVE (page 2)

NON-COMPLIANCE WITH IAC SECTION: ☐ LCPA ☐ 2-9 ☐ 2-10 ☒ 2-11 ☐ 2-12 ☐ 2-13

I. POSITIVES:

Staff were professional and helpful.
All files were made readily available and were very well organized.
The units were clean All bedrooms were well maintained.
Staff files contained 30 day, 60 day and 90 day reviews after hire.
Probation youth had IYAS in their files.

II. AREAS OF NON-COMPLIANCE:

Personnel Records:
No non-compliances

Children's Records:
465 IAC 2-11-46 Child's Records
(a)(3) File for ME missing address and marital status of mother.
(a)(6) File for DM missing religious information.
(a) 12 File for MM missing court order or document ordering placement.
(a)(13) File for MM missing Case Plan.
465 IAC 2-11-66 Treatment Plans
(f) Files for FS, DW, TL, MW and MM missing documentation of parent involvement in Treatment Plan development.
(h)(2) Files for RS, DM and DW missing Treatment Plan goals, staff assignments, time schedules and steps in: Daily Living Activities.
(h)(3) File for DM missing Treatment Plan goal, staff assignments, time schedules and steps in: Specialized Recreation.

II. REMINDERS AND/OR RECOMMENDATIONS:

The bathrooms on Hope and Unity need some minor repairs; Hope bathroom had gap in the floor between the tile and a shower stall which would allow water to flow under the floor, toilet closets had holes in walls and there was no toilet paper for use. The bathroom on Unity was missing glass in a window, the opening was covered with plywood, there was also a gap between the tile and a shower stall which would allow for water to run under the floor.

Agency should be requesting Case Plans on a regular basis until the Case Plan is received and filed in the client file. If mulitiple requests are unsuccessful in obtaining the Case Plan the agency should request assistance from the FCM supervisor.

Documentation of contact with the child's parent/guardian, family case manager or probation officer, where input to the treatment plan is solicited, should be included in the treatment plan or additional documentation attached to monthly reports. Notation on the treatment plan signature pages and/or Family Input Addendum, with the date in which the treatment plan was mailed to the child's parent/guardian, family case manager or probation officer should be documented as applicable.

DCS Central Office has final approval of review.

SATISFACTORY REVIEW: Yes ☒ No ☐ N/A ☐	**PLAN OF CORRECTION DUE BY:**	**FOLLOW UP CONSULTATION BY:**
The signatures note that the entire exit report and narrative was discussed upon completion of this review and that any other areas of concerns or questions have been addressed unless otherwise stated.		
DATE: 7/18/18	**LICENSING CONSULTANT:** [redacted]	
DATE: 7/18/18	**FACILITY REPRESENTATIVE:** [redacted]	
DATE SUBMITTED FOR REVIEW:		
DATE:	**SUPERVISOR REVIEW/APPROVAL:**	

20180823 Millcreek Beacon POC [Redacted]

Appendix 7

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August 23, 2018

[redacted]
Millcreek of Arkansas
[redacted]
Fordyce, AR [redacted]

Provider Number: [redacted]

Beacon Health Options noted one or more deficiencies during the Inpatient Inspection of Care (IOC) conducted at the following service site on the following dates:

Millcreek of Arkansas
July 23, 24, 26, 30, and 31, 2018

Section 241.600 of the Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual states: "The facility is required to submit a Corrective Action Plan designed to rectify any area of deficiency noted in the written report of the inspection of care." Accordingly, you must complete and submit to Beacon Health Options a Corrective Action Plan for each deficiency noted.

The Corrective Action Plan must state with specificity the:

(a) Corrective action to be taken;
(b) Person(s) responsible for implementing and maintaining the corrective action; and
(c) Completion date or anticipated completion date for each corrective action.

Within 14 calendar days of the date of the written IOC report you must submit a completed Corrective Action Plan to [redacted] The contractor will:

(a) Review the Corrective Action Plan;
(b) Determine whether the Corrective Action Plan is sufficient to credibly assure future compliance; and
(c) Forward the Corrective Action Plan to the Division of Medical Services.

Please see § 161 of the Arkansas Medicaid Manual for an explanation of your rights to administrative reconsideration and appeal.

Email Copy: [redacted]

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Millcreek of Arkansas
[redacted]
Fordyce, AR [redacted]

July 23, 24, 26, 30, and 31, 2018

**** CLINICAL RECORD REVIEW ****

Element 1: PCP
Two beneficiary records did not document of a PCP referral, for beneficiaries under age 21, for inpatient psychiatric services made prior to the provision of services or there is a retroactive PCP referral covering the service and received no more than 45 calendar days after the date of the service (or the date of Medicaid authorization).

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 211.000, 213.000, 213.100

Corrective Action Admissions nurse will be re-educated on ensuring that a PCP referral is received no more than 45 calendar days after the date of service and a renewal is completed prior to the expiration of previous referral or every six months (whichever is first) on each patient. The Director of Nursing, or designee, will complete an audit indicator monthly on all new admissions along with a PCP referral log to ensure that these are received within designated time frame. The results of the audit will be reported to the PI committee on a monthly basis.

Identify Person Responsible [redacted] LPN Admissions Nurse, [redacted] Director of Admissions, and [redacted] RN Director of Nursing

Completion Date 09/23/18

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Element 11: Admission Evaluation
Six beneficiary records did not document a Medical Evaluation conducted by a physician within 60 hours of admission.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 217.000

Corrective Action The medical staff will be re-educated on the completion of medical evaluations within the required time frame. An indicator has been updated and the results will be reported to the performance improvement committee monthly.

Identify Person Responsible [redacted] RN, Director of Nursing

Completion Date 09/23/18

Element 20: Individual Plan of Care
One beneficiary record did not document an Individual Plan of Care developed in consultation with the recipient and his or her parent(s), legal guardian(s), or others in whose care he or she will be released after discharge.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 218.100

Corrective Action A mandatory training on the process of completing the resident's Individual Plan of Care will be held to educate on the inclusion of parent and/or guardian involvement in treatment planning. The Clinical Director, or designee, will audit 10% of active charts per month to ensure that documentation of involvement is being completed and report to the PI committee monthly.

Identify Person Responsible [redacted] LCSW, Clinical Director

Completion Date 09/23/18

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Element 26: Individual Plan of Care
Four beneficiary records did not document an Individual Plan of Care including discharge plans and, at an appropriate time, post-discharge plans, and also include the coordination of inpatient services with partial discharge plans and related community services to ensure continuity of care in the recipient's family, school and community upon discharge.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 218.200

Corrective Action A mandatory training for therapists and case managers will be held to educate on transferring the information from the Discharge Planning Form (DPF) to the Master Treatment Plan (MTP). The DPF will be updated and submitted monthly with the updated MTP. The Clinical Director, or designee, will audit 10% of active charts monthly for compliance with discharge planning and report to the PI Committee monthly.

Identify Person Responsible [redacted] LCSW, Clinical Director _

Completion Date 09/23/18

Element 38: Seclusion and Restraint
One beneficiary record did not document a face-to-face assessment within one hour of initiation of the intervention.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 221.703

Corrective Action All nursing staff will be re-educated in a mandatory training to ensure face to face assessment occurs within one hour of initiation with the resident involved in the restraint. An indicator has been updated and the results will be reported to the performance improvement committee monthly.

Identify Person Responsible [redacted] RN, Director of Nursing

Completion Date 09/23/18

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Element 41: Seclusion and Restraint
Four beneficiary records did not document a face to face post intervention debriefing within 24 hours after the use of restraint or seclusion with staff involved and beneficiary.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 221.709

Corrective Action All supervisory staff will be re-educated in a mandatory training to ensure face to face debriefings occur within 24 hours with the resident involved in the restraint and debriefings are signed by everybody involved. An indicator has been updated and the results will be reported to the performance improvement committee monthly.

Identify Person Responsible [redacted] RN, DON and [redacted] Dir. Of Res Services

Completion Date 09/23/18

Element 42: Seclusion and Restraint
Three beneficiary records did not document a post intervention debriefing within 24 hours after the use of restraint or seclusion with all staff involved including appropriate supervisory and administrative staff.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 221.709

Corrective Action All nursing and admin staff will be re-educated in a mandatory training to ensure face to face debriefings occur within 24 hours of the restraint and debriefings are signed by everybody involved. An indicator has been updated and the results will be reported to the performance improvement committee monthly.

Identify Person Responsible [redacted] DON and [redacted] Dir. Of Res Services

Completion Date 9/23/18

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Element 47: Therapeutic Leave
Six beneficiary records did not document progress notes that provide statements that track the beneficiary's actions and reactions and clearly reveal the beneficiary's achievements or regressions while on therapeutic leave.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Manual Section 222.110

Corrective Action A mandatory training will be held with nursing, transportation, case managers, and therapists to educate on the required fields on the Therapeutic Leave Evaluation (TLE) form where feedback from the parent(s) and/or guardian (s) is required. The Clinical Director, or designee, will audit 10% of current charts monthly and report to PI monthly.

Identify Person Responsible [redacted] LCSW, Clinical Director

Completion Date 9/23/18

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(NOTE: If you have additional documentation to refute a deficiency identified in your Inspection of Care or Desk Review Report, please request a reconsideration. You have thirty (30) calendar days from the date of this notice to request reconsideration, in writing, by fax using the IOC Deficiency Review Fax Coversheet or email [redacted] Please include all additional information that you believe supports the refuted deficiency. The timeframe for the requirement for a Corrective Action Plan is suspended until the determination of the reconsideration.)

Beneficiary and Provider Right to Appeal This Decision
Pursuant to ACT 1758 of 2005, both the beneficiary and the provider have the right to appeal this decision. If either party is not satisfied with the decision on your case, the beneficiary may request a fair hearing from the Office of Appeals and Hearings or the provider may request a fair hearing from the Arkansas Department of Health. If both the provider and beneficiary are requesting a hearing, these will also go to the Arkansas Department of Health. You may use the enclosed Notice of Appeal Form to request an appeal. Please enclose a copy this Notice of Action with your appeal. Failure to provide a copy of this Notice of Action will result in your appeal being delayed.

How and When to Appeal

Beneficiary:
The Office of Appeals and Hearings must receive a written hearing request within thirty (30) calendar days of the date on this letter. Send your request to Office of Appeals and Hearings, PO Box 1437, Slot N401, Little Rock, AR 72203-1437.

Provider or Provider/Beneficiary:
The Arkansas Department of Health must receive a written hearing request within thirty (30) calendar days of the date on this letter. Send your request to Arkansas Department of Health, Attn: Medicaid Provider Appeals Office, 4815 West Markham Street, Slot 31, Little Rock, AR 72205.

Continuation of Services Pending Appeal (Beneficiary only)
If you are already receiving services and the department's decision was to reduce or eliminate those services, you may postpone the reduction or elimination of services until the appeal is decided by sending your appeal request in time to be received by the Office of Appeals and Hearings or Arkansas Department of Health within ten (10) calendar days from the date of this letter. However, if you do that and you lose or abandon the appeal, you will be responsible for the cost of all services that are not approved in Section I (above). The Department will take action against you to recover those costs.

If you send your written hearing request in time to be received by the Office of Appeals and Hearings or Arkansas Department of Health within ten (10) calendar days from the date on this letter, we will not reduce or eliminate your services unless you tell us that you do not want to postpone the reduction or elimination of services pending the appeal.

Your Right to Representation
If you request a Hearing, you have the right to appear in person and to be represented by a lawyer or other person you select. If you wish to have a lawyer you may ask the local County Office to help you identify one. If free legal services are available where you live, you may ask your County Office for their address and phone number.

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ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
NOTICE OF APPEAL

I want to appeal the attached decision. I understand that the Arkansas Department of Health must receive this notice within thirty (30) calendar days of the date of the attached decision.

Type of Appeal: ____Provider Appeal

I have attached a copy of the Inspection of Care report pertaining to _____.
(Site for Inspection of Care)

The date of the Inspection of Care report was _____.

Please list Chart numbers and elements requested for this appeal.

_____

[redacted]
Provider Name

[redacted]
Provider's Medicaid ID Number

Millcreek of Arkansas
Provider Site

[redacted] Forrest. AR [redacted]
Provider Site Address

[redacted]
Provider Representative

[redacted]
Telephone Number

For Provider appeal please send your request to:

Arkansas Department of Health
4815 West Markham Street Slot 31
Little Rock, AR 72205

20180904 Piney Ridge AR Beacon Report [Redacted]

Appendix 8

beacon health options

On-Site Visit / Desk Review Report

Provider Name		Review Dates
Piney Ridge Treatment Center		September 4, 5, 6, 7, 10, and 11, 2018
Service Site Address	**Site Provider Number**	**Report Mail Date**
[redacted] Fayetteville, AR [redacted]	[redacted]	October 5, 2018
Desk Review – Beacon Reviewers		
[redacted], LCSW; [redacted]		

Purpose of the Review

The Division of Medical Services (DMS) of the Arkansas Department of Human Services (DHS) has contracted with Beacon Health Options to perform on-site inspections of care (IOC) of inpatient psychiatric services for under age 21 provided by Inpatient providers. The [clinical] reviews are conducted by licensed mental health professionals and are based on applicable federal and state laws, rules and professionally recognized standards of care.

Arkansas Inpatient Psychiatric Services for Under 21 Medicaid Regulation 241.000

The on-site inspections of care of Inpatient Psychiatric Services for Under 21 providers are intended to:

A. Promote Inpatient Psychiatric Services for Under 21 that are provided in compliance with federal and state laws, rules and professionally recognized standards of care;
B. Identify and clearly define areas of deficiency where the provision of services is not in compliance with federal and state laws, rules and professionally recognized standards of care;
C. Require provider facilities to develop and implement appropriate corrective action plans to remediate all deficiencies identified;
D. Provide accountability that corrective action plans are implemented and
E. Determine the effectiveness of implemented corrective action plans.

For further information on General Conditions and Record Keeping, see Sections 142.100 and 142.300(A) of the Arkansas Inpatient Psychiatric Services for Under 21 Provider Manual.

Below are the results of the Inpatient On-Site Visit / Desk Review for this facility.

Program Review

1. This facility was accredited in 2016 by The Joint Commission; the accreditation is valid through 2019. This facility is currently licensed by the appropriate State agency. (Arkansas Medicaid Inpatient Psychiatric Manual Regulations 202.100 and 202.200)
2. The provider does have written policies and procedures available for review. (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 241.200)

3. The services available in the facility are adequate to meet the health needs of each recipient and promote beneficiaries' maximum physical, mental, and psychosocial functioning. (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.610)
4. The facility has a facility-based Certification of Need (CON) Team in place whose membership meets state and federal requirements. (Arkansas Medicaid Inpatient Psychiatric Manual Regulations 215.100, 215.200, 215.210, and 215.220 and 42 CFR Sections 441.153 and 441.156)
5. There is a written Utilization Review (UR) Plan and a Committee to perform UR functions that meets all federal requirements for utilization control. (Arkansas Medicaid Inpatient Psychiatric Manual Regulations 221.000 thru 221.550 and 42 CFR Sections 456.201 thru 456.245)
6. The facility has current Restraint and Seclusion policies which comply with Medicaid, state, and federal regulations and provide for beneficiaries' safety. (Arkansas Medicaid Inpatient Psychiatric Manual Regulations 221.700 thru 221.710 and 42 CFR Sections 441.151, 482.13, and 483.350 thru 483.376)
7. For PRT Facilities only: The facility has submitted to Arkansas Medicaid a Letter of Attestation that the facility is in compliance with CMS regulations regarding use of Restraint and Seclusion. (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.801 and 42 CFR Section 483.374)
8. The facility has complied with Medicaid, state, and federal reporting requirements of death, serious injury, or attempted suicide. (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.803 and 42 CFR Sections 482.13 and 483.374)
9. The facility has a training program in place offering training on the facility's Restraints and Seclusion policy, and training on the appropriate procedures to be used in Restraints and Seclusion, including a repertoire of approaches that can be used to de-escalate beneficiaries. (Arkansas Medicaid Inpatient Psychiatric Manual Regulation 221.804 and 42 CFR Sections 482.13 and 483.376)

Personnel Record Review

The staff currently providing services at the facility consisted of one hundred eighteen (118) direct care personnel. Personnel records for thirteen of 118 (11%) direct care staff were reviewed.

Personnel Records Reviewed:
Two Mental Health Professional (MHP), two RN, one Physician, seven Non-Professional Mental Health, and one LPN personnel records were reviewed.

No deficiencies were found.

Staff Interviews

Thirteen direct care staff members were interviewed (11% of 118). One staff expressed concerns at times about how certain staff treat the beneficiaries, but feels the management handles these concerns promptly. One staff expressed that they feel the Safety training does not teach what to do when the beneficiary is fighting back in the restraint. Another staff stated that, if there are multiple beneficiaries arguing, the staff are unable to utilize CPI. No other concerns were raised in the staff interviews.

Beneficiary Interviews

Twenty beneficiaries (40% of 49 beneficiaries) were interviewed. Results of the interviews are as follows:

Beneficiary Understanding of the Reason for Admission and of the Treatment Received

- 18 of 20 beneficiaries interviewed (90%) were able to report the reason they had been admitted.
- 2 of 20 beneficiaries interviewed (10%) were not able to report the reason they had been admitted.

- 15 of 20 beneficiaries interviewed (75%) could report, in a general way, some of the Goals and Objectives they were working on in treatment.
- 5 of 20 beneficiaries interviewed (25%) could not report, in a general way, some of the Goals and Objectives they were working on in treatment.

- 18 of 20 beneficiaries interviewed (90%) reported the treatment interventions they were receiving as being helpful in addressing their target psychiatric symptoms.
- 2 of 20 beneficiaries interviewed (10%) reported the treatment interventions they were receiving as not being helpful in addressing their target psychiatric symptoms.

- 19 of 20 beneficiaries interviewed (95%) could explain what the help was that they were receiving.
- 1 of 20 beneficiaries interviewed (5%) could not explain what the help was that they were receiving.

Beneficiary Knowledge of Medications Used in Their Treatment

- 12 of 20 beneficiaries interviewed (60%) taking psychotropic medications were able to name at least 50% of their psychotropic medications.
- 8 of 20 beneficiaries interviewed (40%) taking psychotropic medications were not able to name at least 50% of their psychotropic medications.

- 16 of 20 beneficiaries interviewed (80%) taking psychotropic medications could state the reason they took at least 50% of their psychotropic medications.
- 4 of 20 beneficiaries interviewed (20%) taking psychotropic medications could not state the reason they took at least 50% of their psychotropic medications.

Beneficiary Perception of Being Treated with Respect by Staff Members

- 17 of 20 beneficiaries interviewed (85%) reported that staff members treat them with respect.
- 3 of 20 beneficiaries interviewed (15%) reported that staff members do not treat them with respect.
  Beneficiary Comments included the following:
  - [Staff name reacted] *makes fun of me. Calls me a baby for sucking my thumb, also* [staff name redacted] *calls me gay*
  - *Most do not. They are mean to me - like they don't give us free time sometimes.*

- 19 of 20 beneficiaries interviewed (95%) reported staff members treat peers with respect.
- 1 of 20 beneficiaries interviewed (5%) reported staff members do not treat peers with respect.
  Beneficiary Comments included the following:
  - *They talk about the kids out in the hall. Make fun of them. Don't know their names. Some staff plays favorites especially* [staff name redacted]. *She argues with kids and plays favorites.*

Beneficiary Perception of Personal Safety at the Facility

- 17 of 20 beneficiaries interviewed (85%) reported feeling safe at the facility.
- 3 of 20 beneficiaries interviewed (15%) reported not feeling safe at the facility.
  Beneficiary Comments included the following:
  - *Not always. I worry about getting shots and a peer hit me in the eye.*
  - *Lots of fighting - girls fight a lot – I worry about the safety of the younger kids*

Beneficiary Perception of Safety during Staff Members' Implementation of Restraint/Seclusion

- 17 of 20 beneficiaries interviewed (85%) believed that the staff members try not to harm beneficiaries during the performance of a personal restraint.
- 3 of 20 beneficiaries interviewed (15%) believed that some staff members either do not care whether a beneficiary is injured during a personal restraint or intentionally try to harm the beneficiary.
  Beneficiary Comments included the following:
  - *Some hold you harder than others*
  - [Staff name redacted] *was rough with me, but I did not have marks on me.*

Beneficiary Knowledge and Perception of Grievance Procedure

- 18 of 20 beneficiaries interviewed (90%) reported knowing how to file a grievance at the facility.
- 2 of 20 beneficiaries interviewed (10%) reported not knowing how to file a grievance at the facility.

- 17 of 20 beneficiaries interviewed (85%) believed that the grievance process works/is effective.
- 3 of 20 beneficiaries interviewed (15%) believed that the grievance process does not work.
  Beneficiary Comments included the following:
  - *Have turned in one or two and had no feedback*
  - *Filed one and got no feedback*
  - *I have written some and it does not work. They read it but it doesn't work.*
  - *Only check box once a month and that is not often enough*

General Beneficiary Comments regarding what they like about the facility:

- *They help people*
- *I like my therapist*
- *Opportunities and freedom. Doesn't feel like a prison, good food*
- *RT* [recreation therapy] *and free time, group therapy and individual therapy*
- *Helps with trauma*
- *Helps with coping with anger and getting through hard times*

General Beneficiary Comments regarding what they do not like about the facility:

- *Staff calling me names*
- *Food portions are too small*
- *Unit stinks*
- *I don't like the peers fighting*
- *Dislike how they treat me, they pick favorites*
- *Some staff act like they don't care*
- *Doesn't help with anger, and self-harm*
- *Some residents; they need to move on that are not making progress and disturbing others*
- *I don't like how the little kids are on my unit.*
- *Staff curses - sometimes they curse at residents like say "you aren't getting shit".* [Staff name redacted] *curses to other staff when talking to them.*
- *Yelling and fighting; staff yells too*

Beneficiary Family Interviews

The parents/guardians of three beneficiaries (6% of 49) were interviewed. Results of the interviews are as follows:

- 3 of 3 parents/guardians interviewed (100%) reported knowing why their child had been admitted to this facility.

- 3 of 3 parents/guardians interviewed (100%) reported being involved in the treatment of their child at this facility.
- 3 of 3 parents/guardians interviewed (100%) reported being kept informed of any changes in medication.
- 3 of 3 parents/guardians interviewed (100%) reported that they and their child have been treated with respect by staff at the facility.
- 3 of 3 parents/guardians interviewed (100%) reported that their child's symptoms and problems have decreased since coming to this facility.
- 3 of 3 parents/guardians interviewed (100%) reported having been informed about the restraint and seclusion policy at the time of admission.
- 3 of 3 parents/guardians interviewed (100%) reported knowing how to lodge a complaint with the facility if they had concerns.

- 2 of 3 parents/guardians interviewed (67%) reported that they understood and felt comfortable and satisfied with the frequency with which they can call and visit their child.
- 1 of 3 parents/guardians interviewed (33%) reported that they did not understand or feel comfortable and satisfied with the frequency with which they can call and visit their child.

Follow-Up to Beneficiary Interviews

Beneficiaries were interviewed by a Beacon Reviewer conducting an On-Site Visit for a Desk Review at Piney Ridge Treatment Center performed by Beacon Health Options of Arkansas for the Arkansas Medicaid Program. During the interviews, beneficiaries referenced staff behaviors that raised concerns. The Beacon Reviewer conducting the beneficiary interviews met with the Piney Ridge Clinical Director and the Director of PI/RM on September 5, 2018 prior to leaving the facility. The concerns addressed were two beneficiary reports of provider staff members "making fun" of the beneficiaries, including the specific report of staff calling the beneficiaries "gay". The staff member names that were identified by the beneficiaries in the interviews were given to the Piney Directors in the discussion. There was no response from the provider regarding how they would respond to the identified concerns.

<u>Facility Tour/Observation of Milieu</u>

For the purpose of this On-Site Visit, the following areas were inspected:

- *East Unit Males: Beneficiary Bedroom #301; Seclusion Room*
- *North Unit Males: Beneficiary Bedroom #201*
- *West Unit Males: Beneficiary Bedrooms and Bathrooms #101 and #102; Seclusion Room*
- *Classroom: Women's Bathroom*

The following Safety Concerns were identified:

- East Unit Males: Bedroom #301: There was no film over the outside window that was replaced (making the interior of the room visible from the outside). The other double-paned window on the outside was broken, but there was a temporary shield covering the broken window (until the new window is installed).

Service Implementation (Observation of Services)

Group Therapy on the South Unit with eleven adolescent girls was observed. The group was led by a Mental Health Professional (MHP) and one other staff member was also in the room. The group held a mock court, deciding if a beneficiary should move to level two. The witnesses gave testimony on how much progress they saw from the beneficiary on trial. The staff members in the room were called as witnesses also. There was a judge and lawyers along with a court reporter and jury. The group members were very involved and appeared to be practicing coping skills, giving feedback to each other, and gaining insight.

Clinical Record Review

At the time of the IOC, a total of 49 beneficiaries with active Arkansas Medicaid were enrolled for Inpatient Psychiatric services. Twenty records were selected and reviewed.

The following summarizes the outcome of the Clinical Record Review:

PCP Referral

Element 2. One beneficiary record did not document a PCP referral renewal prior to the expiration of previous referral or every six months (whichever is first) in accordance with section 213.300 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Record	Element	Date	Service	Regulations	Comments
[redacted]	2	08/20/18	PCP Referral Renewal	213.300	PCP renewal due 08/14/18

Plan of Care Review

Element 31. Two beneficiary records did not document a plan of care review which recommended changes in the plan as indicated by the recipient's overall adjustment as an inpatient in accordance with section 218.300 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Record	Element	Date	Service	Regulations	Comments
[redacted]	31	08/29/18	Plan of Care Review	218.300	Target completion dates for objectives were either not documented or were not updated (and, therefore, expired)
[redacted]	31	08/09/18	Plan of Care Review	218.300	Target completion dates for objectives not updated; no revision of goals established on Plan of Care dated 02/22/18 when no or minimal progress has been documented

Seclusion and Restraint

Element 40. Two beneficiary records did not document the parent/guardian was notified of the intervention within 24 hours after the occurrence in accordance with section 221.707 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Element 42. One beneficiary record did not document a post intervention debriefing within 24 hours after the use of restraint or seclusion with all staff involved including appropriate supervisory and administrative staff in accordance with section 221.709 of the Arkansas Medicaid Inpatient Psychiatric Manual.

Record	Finding	Date	Service	Regulations	Comments
[redacted]	40	08/03/18 08/28/18	Seclusion and Restraint Documentation	221.707	Only one attempt to reach guardian with voice message left documented
[redacted]	42	08/15/18	Seclusion and Restraint Documentation	221.709	All staff involved in intervention not present for staff debriefing
[redacted]	40	08/31/18	Seclusion and Restraint Documentation	221.707	Only one attempt to reach guardian (within 24 hours) with voice message left documented

Clinical Observations

Note: In multiple records there was documentation of beneficiaries involved in some form of physical interaction or altercation. In those records, the staff responses were identified as "separating" the beneficiaries. There was no documentation as to how the "separation" occurred and whether a physical intervention by staff was required. If a physical intervention was required, it was not documented as such and there was no documentation of a physical restraint related to these "separations".

[redacted]	Resident Precaution Form dated 07/04/18 documents "Pt. hit peer after telling him to stop poking him with pencil. Staff separated residents." No documentation of a restraint. Nursing note dated 08/03/18 @1302 documents "Peer became aggressive and attacked resident. Residents were separated by staff." No documentation of a restraint.
[redacted]	Nursing note dated 07/25/18 @1925 documents beneficiary was "separated" from a peer. No documentation of restraint.
[redacted]	Resident Precaution Form dated 07/04/18 documents "assault on peer. Staff separated." No documentation of restraint. Resident Precaution Form dated 08/11/18 documents staff separated beneficiary from peer when they were hitting each other. No documentation of restraint. Nursing note dated 07/25/18 @0735 documents beneficiary was in a fight with another peer and "Staff immediately separated residents and escorted them back to the unit." No documentation of restraint. Nursing note dated 08/14/18 @1400 documents beneficiary and another resident were separated by staff while fighting. No documentation of restraint.
[redacted]	Nursing note dated 08/21/18 @0950 documents beneficiary was hit by a peer and "residents were separated by staff immediately." No documentation of restraint.
[redacted]	Nursing note dated 08/29/18 @1920 documents beneficiary and another peer were separated while involved in fighting each other. No documentation of restraint.
[redacted]	Nursing note dated 09/01/18 @2000 documents "Peer charged at him and they started fighting, staff intervened and got them separated." No documentation of restraint.

Evidence of CAP Implementation

Evidence was provided of CAP implementation on all identified Elements containing deficiencies from the accepted CAP for the Inspection of Care conducted April 9, 10, 11, and 12, 2018 for the following Elements:

- Element #7 - Social Evaluation in record within timeframes
- Element #18 - Plan of Care (developed with MD and MHP)
- Element #19 - Plan of Care (developed within 14 days after admission)
- Element #43 - Seclusion/Restraint (all documentation completed by end of shift)
- Element #45 - Therapeutic Leave (documented in plan of care objectives and goals)
- Element #46 - Therapeutic Leave (documentation of staff in contact with beneficiary and guardian when leave exceeds 72 hours)
- Element #47 - Therapeutic Leave (documentation that describes beneficiary's achievements or regressions while on leave)

- Question #11 - Non-Physical and Physical Intervention Skills Certification (HR records)
- Question #12 - CPR Certification (HR records)

20181025 Millcreek CMS 2567 ANNUAL ICF POC 2018 (corrected) [Redacted]

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	[redacted]	A. BUILDING _____ B. WING _____	10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

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E 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 facility was in compliance with §483.475 - Emergency Preparedness Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities.	E 000		
W 000	INITIAL COMMENTS The findings on this statement of deficiencies demonstrate non-compliance with the requirements of the 42 CFR, Part 483, subpart I for the Intermediate Care Facilities for Individuals with Intellectual Disabilities. A full survey was conducted 10/22/18 to 10/25/18.	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.	W 104		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure a safe, comfortable and home-like environment was provided in 2 (Oak Creek and Willow Creek homes) of 3 (Oak Creek, Willow Creek, and the Boys Ranch) client homes, as evidenced by failure to maintain door frames, walls and corners in good repair, kitchen cabinets and a wall in dining area were clean, shower walls and floors were free from mold and cracks, coverings on all furniture was in good repair, windows had proper coverings and a light fixture was in good repair in the Oak Creek home; failure to ensure furniture was in good repair, laundry room pipes were free of drips / leaks, a refrigerator was not dripping on floor, the shower floor was in clean condition, windows, paint, and kitchen cabinets were kept clean, and walls were in good repair in the Willow Creek home.The findings are: On 10/22/18 at 4:30 p.m., the following observations were made in the Oak Creek House: a. Bedroom #1, the door frame, outside the room and inside the room, joints separated at the top, left corner on the outside of the room and top left on the inside of the room. Paint missing in multiple areas of the door frame. On the left side of the bedroom when entering, 2 windows, with no curtains, only the lower half frosted. The light cover was cracked and missing a large irregular area. b. Bedroom #3, as you enter the bedroom, the wall with the headboard and clothing shelf, had multiple areas with paint missing. The door knob	W 104		

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W 104	Continued From page 2 was loose and above the door knob approximately 3-4", an irregular area approximately 1x1", missing. An area on the corner of the wall adjacent to the closet by the bedroom door, half way up, was missing plaster and paint, approximately 6-8" and 1 inch on each side of the corner. long. Just above the baseboard on the same wall, an area approximately 4-5" area missing plaster and paint. On the same wall just above the baseboard nearer the door, the dry wall in indented inward, with the wood showing. Inside door frame, on the left side midway up approximately 3x6" green color area missing paint. c. In the dining room, to the right, in the corner, multiple, different sized areas of missing paint and the wall by the kitchen door had multiple areas of debris on the wall. d. In the living room, the door going outside, had a large area of paint missing, as well as the wall , leading to the door was missing paint. 2 couches had tears and rips on backs and seats. 1st, starting right to left the far right, middle of the back had an approximately 2x6" tear, lower down approximately 4" rip. The seat, midway, underneath had a large tear. The next seat to the left had a 1-2" rip, and to the far left approximately 4-5" irregular area missing. Next back approximately 4-6" rip. 2nd couch, approximately mid back approximately 12" rip. The next seat, midway, underneath large torn area. Last back to the left approximately 8-10" rip. Multiple areas on the walls missing paint. e. The laundry room, in between the washer and dryer, near floor, area on the wall, dry wall in disrepair.	W 104		

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W 104	Continued From page 3 f. In the kitchen a cabinet door below the sink had a dark substance on it. 6 lower cabinet doors by the stove had various areas that had debris on them. The refrigerator had a towel under the door and the outside of it had discoloration and debris all over it. A storage room door in the kitchen coming from the dining area had paint missing and had gray debris on the door, corner next to the door knob missing plaster and paint. The small sink had a dripping faucet. g. In the hallway, the heat and air return vent had gray debris. h. In bathroom #1, 3 tiles in front of the blue cabinets, had multiple cracks. 1 tile at the corner of the bathroom cabinet, had a crack from corner to corner. The shower stall had a crack from bottom to near the shower handle. The shower had a black substance in the bottom seams around the entire shower stall, and starting up the side seams. A part of a baseboard was missing on the right side of the sink cabinet under the toilet paper container, the next tile up was cracked multiple times. i. In bathroom #2, above the sink a large area with paint missing and black discoloration, and peeling paint. There were multiple cracks in the floor tile. There was black debris inside and outside of the shower, and around the handicap support bar. A dry wadded up wash cloth in the storage/ soap area. Between the wall and the commode was black debris and white debris. Black substance in the corner seam. On 10/23/18 at 7:45 am. the following observations were made at Willow Creek Cottage:	W 104		

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W 104	Continued From page 4 a. Area behind washer and dryer with PVC pipe had wet dirty towel underneath pipe b. Three cushion couch on right side of living room (against window area) with holes in middle cushion c. Carpet in living room dirty and with multiple stains. d. Three cushion couch on left side of living room (against window area) with torn cushions and left end of couch broken and tilting. e. Chair in living room (to left side of doorway leading to right back of house) with multiple rips. f. Hole in wall near baseboard (to left of cabinet) in walkway from living room to dining room g. Cabinet in walkway from living room to dining room where bread and placemats were stored was dusty and dirty. h. Splatter from garbage can on cabinet and walls underneath cabinet in walkway from living room to dining room i. Refrigerator in kitchen with damp towel stuffed under bottom front on floor. j. Kitchen cabinets fronts dirty. k. Shower in bathroom of bedroom 3 with dark substance on floor of shower and staining from water dripping down wall from faucet. l. Faded areas/splatters on walls of bathroom off	W 104		

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W 104	Continued From page 5 bedroom 3. m. Walls throughout cottage with dirty paint. o. Windows dirty throughout house. p. Floor in dining room with dark stains. q. On 10/23/18 at 9:47 a.m. the administrator was interviewed. He was asked: When was the last time you were in Willow Creek Cottage? He stated, "I was actually there on Friday, I went through the cottage to see what repairs needed to be done, and a list was made. We have a plan to repair and remodel in all the cottages and are working on it." He was then asked; Who is responsible for making sure the cottage is kept clean, things are dusted, and windows are clean? He answered, "That would be the unit coordinator." He was finally asked: When was the carpet replaced or cleaned last? He stated, "I am not sure when it was last replaced, that is one of the things we are planning on in the remodel, it was cleaned about 6 months ago."	W 104		
W 109	COMPLIANCE W FEDERAL, STATE & LOCAL LAWS CFR(s): 483.410(b) The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to sanitation. This STANDARD is not met as evidenced by: Based on observation, record review, and	W 109		

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W 109	Continued From page 6 interview, the facility failed to ensure the kitchen, dining, and associated areas were maintained in sanitary condition consistent with state requirements and standards of kitchen sanitation, as evidenced by failure to ensure kitchen and dining areas were clean, temperatures of refrigerators, freezers and dishwasher water were regularly monitored, opened bags of bulk foods were stored in a closed container, dirty cleaning equipment was stored out of the food service area, and trash was contained within the dumpster for 1 of 1 facility. The findings are: 1. Temperature logs for October 2018 for the refrigerator "milkbox", provided by the Dietary Manager, documented no temperatures from 10/1 through 10/7 and 10/14 through 10/21. Temperatures in the pantry "milkbox", walk in cooler and walk in freezer were not recorded on 10/14, 10/17, and 10/19-10/22. 2. A temperature log for October 2018 for the dishwasher documented no temperatures from 10/1/18 - 10/7/18 and 10/14/18-10/21/18. 3. On 10/24/18 at approximately 11:00 a.m., the following observations were made: a. Two dented cans were stored on pantry shelf with a tag on the shelf that documented, "use first." b. A fan with a heavy build-up of dust and an oily substance was positioned where it would blow directly over the food preparation area in the kitchen. c. Open bulk bags of salt, flour and corn meal were stored in a bin on the floor with no lid in	W 109		

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W 109	Continued From page 7 place. d. The bottom shelf of the steam table where food service pans were being stored had a build-up of sticky debris. e. Dirty cleaning supplies, including a mop bucket with dirty brown water, mops, a broom with a large wad of hair hanging off of it, and cleaning rags, were stored in a food service area to the left of the beverage service area, and to the right of the condiment service area in the dining room. f. All door thresholds had dark brown build-up into the corners of the base boards g. Four air vents in the dining area had a dark brown build-up. h. Base boards of the periphery of the dining room had excessive brown build-up extending approximately ½ inch from the base board i. A fluorescent light in a small anteroom adjacent to the South door had a build-up of a black substance covering approximately 50% of the 2 foot by 4 foot cover. The egress door was half covered by a brownish substance. j. Multiple pieces of trash were scattered on the ground around the dumpster, including large shards of pointed glass. 2. On 10/24/18 at 11:30 a.m., the Dietary Manager was asked how staff would know not to use dented cans that were on a pantry shelf with other cans. She stated, "Oh, should I put them somewhere else?" She was asked why the bin with the bulk cornmeal, flour and salt was not	W 109		

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W 109	Continued From page 8 covered. She stated "The lid broke." When asked why the temperature logs for the refrigerators/freezers and dishwasher were not completed, she stated, "The person who normally checks them was on vacation." When asked if there was a process for checking these things when a staff member was off, she stated, "The cooks should check them, but obviously it wasn't done. 3. The Provider Manual, ICF/MR [ICF/IID], 15 Bed or Less Long Term Care Facilities RULES AND REGULATIONS, OFFICE OF LONG TERM CARE, documented, "411.1 ...Exposed floor surfaces and floor coverings shall promote mobility in areas used by clients and shall promote maintenance of sanitary conditions... 725.2 Floors shall be cleaned after each meal... 725.7 ...Storage cabinets shall be kept clean... 729.1 The facility must provide a sanitary environment to avoid sources and transmission of infections... 478 Garbage must be kept in approved containers with tight-fitting covers. The containers must be thoroughly cleaned before reuse. Garbage or rubbish and trash shall be disposed of by incineration, burial, sanitary fill, or other approved methods. Garbage areas shall be kept clean and in a state of good repair..."	W 109		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure clients were given a choice as to	W 247		

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W 247	Continued From page 9 their beverage preference during a meal to provide the client with the opportunity to make choices for 1 (Client #10) of 5 (Clients #3, #6, #7, #9 and #10) sampled clients who lived in Oak Creek House. The findings are: Client #10 had diagnoses of Mild Intellectual Disability, Major Depressive Disorder and Recurrent Episode, with Psychotic Features. On 10/23/18 at 5:10 p.m., clients were served an evening meal consisting of mozzarella sticks, tossed salad with dressing, spiral fries, apples, chocolate milk and water. At 5:35 p.m., Client #10 stated, "I don't like chocolate milk, I want white milk." He was asked by the surveyor, "Can't you choose to have white milk?" He stated, "No." a. At 5:40 p.m., Developmental Trainer #1 was asked, "Can clients have white milk for supper?" She stated, "No, they get white milk for breakfast and chocolate for supper." b. At 5:50 p.m., the refrigerator was checked; it contained white and chocolate milk. c. On 10/25/18 at 10:22 a.m., the Chief Executive Officer (CEO) was asked, "Do staff get training on client choices concerning food and drink?" He stated, "Yes, they do."	W 247		
W 261	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3) The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in	W 261		

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W 261	Continued From page 10 contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Speciality Constituted Committee was trained related to the rights of the clients, as to what constitutes a restriction of a right and the difference between punishment and training in order to protect the rights of the clients who resided in 1 of 1 facility. The findings are: 1. Human Rights Committee Meeting Minutes (Specially Constituted Committee) dated from 01-05-2018 through 10/20/2018 only addressed Psychotropic medications for clients. There was no indication of any restraints, behavior programs or other rights restrictions being addressed in the minutes. There was no indication in the minutes of training of the Human Rights Committee (Specially Constituted Committee) on the rights of the clients, what constituted a restriction of a right and the difference between punishment and training. 2. On 10/24/18 at 3:45 p.m., the Administrator documented, "We haven't inserviced them on that, but if we need to, we will".	W 261		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.	W 262		

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W 262	Continued From page 11	W 262		

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the Specially Constituted Committee reviewed and approved an Aversive Behaviorial Technique (restraint) to protect the rights of 1 (Client 9) of 1 client who was involved in more than 1 restraint. The findings are:

Client #9 had diagnoses of Mild Intellectual Disability, Other Persistent Mood (Affective) Disorders, Reactive Attachment Disorder, Attention Deficit Hyperactiity Disorder, Combined Presentation, and Problems related to Primary Support Group.

a. The Individual Program Plan (IPP) review for Client #9 on 10/24/18 at 2:45 p.m. documented Client #9 was involved in a physical and chemical restraint on 4/17/18 and on 3/29/18.

b. The Human Rights Committee Meeting Minutes (Specially Constituted Committee) dated from 01-05-2018 through 10/20/2018 only addressed Psychotropic medications for clients; there was no indication of any restraints, behavior programs or other rights restrictions being addressed in the minutes.

c. The facility's policy, Chapter 25 - ICF-IID [Intermediate Care Facility for Individuals with Intellectual Disability] "Behavioral Management", presented by the Director of Risk Management and Performance Improvement on 10/25/18 at 11:15 a.m., documented, "The resident and legal guardians are afforded full disclosure regarding the expected benefits and possible risks associated with aversive techniques. An aversive

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(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 262	Continued From page 12 technique is defined as any procedure, which is designed to suppress a specific behavior by using direct programmatic decelerators and presenting some degree of intrusiveness. Techniques generally considered aversive include, but are not limited to: TCI [Therapeutic Crisis Intervention] physical holds... Approved treatment is administered following documentation that less restrictive interventions failed and written informed consent is yielded. Consent is in effect for twelve (12) months from the date signed and may be revoked... Approved treatment is administered following documentation that less restrictive interventions failed and written in formed consent is yielded. Consent is in effect for twelve (12) months from the date signed...Consent Procedures:...3. "Once written informed consents gained, the Behavior Program or approach may be implemented. In the ICF-IDD, a presentation and approval by the Human Rights Committee is required before implementing... Review of Special Treatments... 1. In ICF-IID, uses of special treatments are reviewed quarterly or more often if indicated by the Program Team, Behavior Management, and Human Rights Committee..."	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that a signed consent was	W 263		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(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 263	Continued From page 13 obtained prior to the utilization of physical hold, as required by policy and procedure, to protect client rights for 1 (Client #9) of 1 sampled client who was involved in a physical hold. The findings are: Client #9 had diagnoses of Mild Intellectual Disability, Other Persistent Mood (Affective) Disorders, Reactive Attachment Disorder, Attention Deficit Hyperactiity Disorder, Combined Presentation, and Problems related to Primary Support Group. a. The Induvidual Program Plan (IPP) review on 10/24/18 at 2:45 p.m. documented Client #9 was involved in a physical and chemical restraint on 4/17/18 and on 3/29/18. b. A signed consent dated 6/29/2016 and signed by the client's guardian documented, "Restraint is to be used only as a therapeutic measure or to prevent a patient from causing physical or mental harm to himself or others and shall not be used for punishment or for the convenience of the staff". c. On 10/25/18 at 2:25 p.m., Staff #4 was asked, "When you showed the surveyor the consent for the restraint signed by the guardian iin 2016, has there been a consent signed for restraints since that time?" The employee stated, "No, we get the consent signed at admission, and the only annual consents we require are for medications". d. The facility's policy, Chapter 25 - ICF-IID [Intermediate Care Facility for Individuals with Intellectual Disability], "Behaviorial Management", presented by the Director of Risk Management and Performance Improvement on 10/25/18 at 11:15 a.m., documented, "The resident and legal	W 263		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(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 263	Continued From page 14 guardians are afforded full disclosure regarding the expected benefits and possible risks associated with aversive techniques. An aversive technique is defined as any procedure, which is designed to suppress a specific behavior by using direct pogrammatic decelerators and presenting some degree of intrusiveness. Techniques generally considered aversive include, but are not limited to: TCI (Therapeutic Crisis Intervention) physical holds. Approved treatment is administered following documentation that less restrictive interventions failed and written informed consent is yelded. Consent is in effect for twelve (12) months from the date signed and may be revoked."	W 263		
W 295	PHYSICAL RESTRAINTS CFR(s): 483.450(d)(1)(i) The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written informed consent for restraints was obtained annually, that restraint use was included in the Individual Program Plan (Master Treatment Plan) and restraints were reviewed by the Human Rights Committee as per facility policy for 1 (Client #9) of 10 (Clients #1 through #10) sampled clients reviewed for restraints. The findings are: Client #9 had diagnoses of Mild Intellectual Disability, Other Persistent Mood (Affective)	W 295		

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	[redacted]	A. BUILDING _____ B. WING _____	10/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(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 295	Continued From page 15 Disorders, Reactive Attachment Disorder, Attention Deficit Hyperactivity Disorder, Combined Presentation, and Problems related to Primary Support Group. a. A signed consent dated 6/29/2016 and signed by the client's guardian documented, "Restraint is to be used only as a therapeutic measure or to prevent a patient from causing physical or mental harm to himself or others and shall not be used for punishment or for the convenience of the staff". b. As of 10/25/18, the current IPP documentation did not specify the use of restraints, did not specify the type of client behavior to be managed, did not document what less restrictive behavioral approaches were to be attempted or what to do if approaches were unsuccessful, did not document the type of restraint to be used, and did not address the replacement behavior being taught to the client to reduce the need for future restraints.	W 295		

Appendix 9.

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	[redacted]	A. BUILDING **01** B. WING _____	**10/25/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

(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
E 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.	E 000		
K 000	The facility was in compliance with §483.475 - Emergency Preparedness Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities. INITIAL COMMENTS The facility is in compliance with Title 42, Code of Federal Regulations §483.70 (z), life safety from fire.	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

20181218 Millcreek ICF CMS 2567 POC [Redacted]

Appendix 10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	R 12/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

(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 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 the 42 CFR, Part 483, subpart I for the 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 and interview, the facility failed to ensure a safe, comfortable and home-like environment was provided in 2 (Oak Creek and Willow Creek) of 3 (Oak Creek, Willow creek, and Boys Ranch) homes, as evidenced by failure to maintain door frames, walls and corners in good repair, kitchen cabinets, storage cabinets/shelves and walls were clean, windows in bedrooms had proper coverings and were	{W 104}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	[redacted]	A. BUILDING _____ B. WING _____	R 12/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

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{W 104}	Continued From page 1	{W 104}		

clean, a closet door was properly attached, and a rocking chair was in good repair. The findings are:

1. On 12/17/18 at 1:30 p.m., the following observations were made in the Oak Creek House:

a. In Bedroom #1 there was paint missing in multiple areas of the door frame. There were 2 windows on the left side of the bedroom that did not have curtains and only the lower half of the windows was frosted.

b. In the dining room in the corner to the right, multiple, different sized areas were missing paint, and the wall by the kitchen door had multiple areas of stains and debris stuck to the wall.

c. In the living room, the door to the outside and the wall was missing paint.

d. In the laundry room, the dry wall between the washer and dryer, near the floor, was in disrepair.

e. In the kitchen a cabinet door below the sink had a dark substance on it. Six lower cabinet doors by the stove had various areas that had debris on them. A storage room door in the kitchen coming from the dining area had paint missing, the corner next to the door knob was missing plaster and paint.

2. On 12/17/18 at 2:15 p.m. the following observations were made at Willow Creek Home:

a. Across the hall from the laundry room was a

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	[redacted]	A. BUILDING _____ B. WING _____	R 12/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

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{W 104}	Continued From page 2 closet door that was out of its track and sitting on the floor leaning against the wall. b. A hole in the wall, near the baseboard, to the left of the cabinet in the walkway between the living room and the dining area, had paper stuffed into it, with the hole and paper covered with clear tape. c. The cabinet in the walkway, between the living room and the dining area, had dust and debris on the shelf holding a plant and red decorative container. The plant and container were dusty. d. On the cabinet in the walkway between the living room and dining area were splatters of unknown substances from the garbage. There was a black substance on the wall and base board behind the garbage can. e. In bedroom #3 were stains and splatters of unknown substances on the walls of the bathroom. f. The walls throughout the home were dirty. g. The windows throughout the house were dirty and there were dead insects and other debris between the screen and window in the kitchen area. h. A rocking chair outside the front door had a broken runner on the right side. 3. On 12/17/18 at 3:45 p.m., the CEO (Chief Operating Officer) was shown pictures of the environment in Willow Creek house. He was asked about the hole in the wall near the cabinet in the walkway between the living room and	{W 104}		

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	[redacted]	A. BUILDING _____ B. WING _____	R 12/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{W 104}	Continued From page 3 dining area. He stated, "I can't believe someone did that, I'll get it taken care of." He was asked regarding the dust and debris on the cabinet in walkway, he stated, "I know that was dusted, that has to be new dust since Thanksgiving, because I know it was cleaned then." He was asked regarding the splatter on the cabinet from the garbage can, he stated "I will make sure it is completely clean." The CEO was then asked if the black substance on the base board behind the same garbage can (under the cabinet) was mold. He answered, "I don't think so but we will check into it." He was asked regarding paint in the bathroom off of bedroom 3 and he stated, "All that splatter is fading from bleach. We already have plans in place to paint the bathroom white." He was asked about the windows being dirty and he stated, "I know they were cleaned inside and out. Maybe they just don't look clean because they are Plexiglas, but while we are doing everything else, we will clean them again too." The CEO was informed of the closet door being off track and sitting on the floor propped on a wall where it could fall on a client. He stated, "That is an easy fix, but no one had reported it, maintenance will take care of it." He was shown the picture of the broken rocking chair and the CEO stated, "No one had reported that either, but we will take care of it."	{W 104}		
{W 109}	COMPLIANCE W FEDERAL, STATE & LOCAL LAWS CFR(s): 483.410(b) The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to sanitation.	{W 109}		

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{W 109}	Continued From page 4	{W 109}		

This STANDARD is not met as evidenced by:
Based on observation and record review, the facility failed to ensure the kitchen, dining, and associated areas were maintained in a sanitary condition as evidenced by failure to ensure ceiling vents and fans, shelves, and ceiling lights were clean, and trash was contained in the dumpsters and the dumpsters had lids for 1 of 1 facility. The findings are:

1. On 12/17/18 at 1:15 p.m., the following observations were made in the main kitchen, dining and associated areas:

a. A fan had a buildup of dust and was blowing directly on the steam table area.

b. The bottom shelf of the steam table, where food service pans were being stored, was sticky to touch and had an approximately 1 by 1.5 centimeter area where a purple jelly-like substance was spilled.

c. Most of the ceiling vents (throughout the facility including screened vents and tiered vents) were covered in a dirty and dusty dark-brown substance.

The Dietary Consultant was asked, "Does that fan (blowing on the steam table) appear clean?" She stated, "No." She was asked, "Are the air vents clean?" She stated, "You can see where maintenance cleaned the one by the exit door and the light. Maintenance said the others weren't dirty, they just needed to be painted." She was then asked, "Do you think they are clean?" She

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{W 109}	Continued From page 5	{W 109}		

stated, "I can't really say, but maintenance says they just need to be painted." The Dietary Consultant was asked to wipe one vent with a rag on top of a broom. Some of the dark, dusty substance fell of the vent and a large amount remained on the rag. The Consultant was asked, "Do you think they are clean?" She replied, "No, definitely not." She was asked, "How many of the vents need to be cleaned?" She stated, "Almost all of them in the building."

d. Ceiling light fixtures contained debris on inside of the coverings.

The Dietary Consultant was asked, "Are the light fixtures in the ceiling clean?" She stated, "No, it looks like most of them need to be cleaned also."

e. Trash was scattered in a wide radius around the two dumpsters. The dumpster on the left side was missing 1 of 2 lids, the dumpster on the right side had no lid.

The Dietary Consultant was asked, "Should trash be scattered around the dumpster area like this?" She answered, "No." She was asked, "Is it a pest risk?" She stated, "Yes." She was asked, "Do the dumpsters have lids?" She replied, "Just that half lid on the one." She was asked, "Should they have lids?" She stated yes. She was asked, "Is not having lids a pest risk also?" She stated, "Definitely for raccoons and other animals."

2. The Provider Manual, ICF/MR [ICF/IID], 15 Bed or More Long Term Care Facilities RULES AND REGULATIONS, OFFICE OF LONG TERM CARE, documented, "312.1 All rooms and every part of the building (exterior and interior) shall be kept clean, orderly,, and free of offensive odors...

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

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{W 109}	Continued From page 6 312.6 Buildings and grounds shall be kept free from refuse and litter... 312.13 Garbage must be kept in substantial containers with tight fitting covers..."	{W 109}		

20190331 Village OQPS [Redacted]

Organization Response for Incident # [redacted]

General Information

Incident Number: [redacted]

Incident Date: 03/31/2019

Organization ID: [redacted]

Organization Name: Village Behavioral Health

Organization Street Address: [redacted]

Organization City/State/Zip Addr: Louisville, TN [redacted]

Programs: Behavioral Health Care Accreditation Program

Incident Sites

Site Name	Address
Village Behavioral Health	[redacted] Louisville, TN [redacted]

Did you contact Complainant?

Complaint Summary:

Please respond to the concerns in the below:

Time period: on or around March 6, 2019.

-Concerns regarding inconsistent application/interpretation of the visitation policy and whether there is a 30 day wait time for visitations.

-Visitation meeting rooms are in the basement level and are filthy. Dust is thick under the microwave oven and on chairs. The carpet and walls are dirty with separation from the trim on the wall and portions of carpet verses no carpet on the floor was noted. This room was an area where staff came in and out of to clock in/out.

-Cabins have 11 boys and have no running water. Boys use a port-a-potty at night and have some type of cooler to wash their hands/brush their teeth. They go to a bath house to take showers.

-One night, a patient tried to jump off the room to commit suicide and there was only 1 counselor in the

Organization Response for Incident # [redacted]

cabin. Two counselors are supposed to be in the cabin at night.

-Delay in administering medications that were prescribed/necessary for patient.

[redacted]

Address the Specific allegation(s) and provide an analysis and review of related systems and processes:

[redacted]

Systems Improvements and/or Follow-up Actions:

[redacted]

Measurement/sustainability of compliance to related standards:

[redacted]

[redacted]

20190604 Millcreek Alaska HSS Referral Hold Letter [Redacted]

THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health and Social Services

Division of Behavioral Health
Anchorage Office

3601 C Street, Suite 878
Anchorage, Alaska 99503-5923
Main: 907.269.3600
Fax: 907.269.3623

June 4, 2019

[redacted] CEO
Millcreek Behavioral Health
[redacted]
Fordyce, AR [redacted]
Fax: (870) 352-2433

SENT VIA CERTIFIED MAIL:

RE: Extended Admissions Hold

Dear Mr: [redacted]

The State of Alaska, Department of Health and Social Services, Division of Behavioral Health (DBH) is working diligently with the Leadership of the Millcreek Psychiatric Residential Treatment Facility (PRTF) on ensuring compliance with Code of Federal Regulations (CFR) for Centers for Medicare & Medicaid Services (CMS) and the State of Alaska Regulations. DBH staff conducted an integrated site reviews of Millcreek PRTF and provided ongoing technical assistance with an explanation of CMS regulations since April 7, 2016.

The annual review conducted by DBH in March 3-8, 2018 had identified concerns regarding use of restraints at the facility and warranted a Plan of Improvement (POI) to correct identified deficiencies. An unannounced visit of Millcreek PRTF on February 4, 2019 conducted by [redacted] DBH, Medicaid Section Manager, [redacted] DBH, Psychiatric Nurse IV, and [redacted] OCS, Psychiatric Nurse IV, South & West Regions, had identified that use of restraints remain problematic. As a result of the review, Millcreek PRTF was placed on admissions holds to the facility for 90 days effective February 19, 2019 and had 6 corrective actions items that must be addressed by the end of 90 days admissions hold.

As of today, reviewed Personal Restraint events continues to be out of compliance with 42 C.F.R. 483.350 - 483.376, adopted by reference in 7 AAC 160.900, governing the use of restraint and seclusion. Additionally, items number 1, 2, 3 and 6 of POI has not been fully addressed by the facility.

Due to Millcreek's non-compliance with CMS Regulations (42 CFR 483.350 -376; 42 CFR 456.609-610; 42 CFR 441.155), and the State of Alaska Regulations (7AAC 140.400 - 7 AAC 140.415; Behavioral Health Inpatient Psychiatric Review Provider Manual) **the Division will not approve any admissions to the facility until further notice effective immediately.**

You should be fully aware that failure to comply with this sanction may result in further actions including, but not limited to, withholding Medicaid payments, suspension, or termination from the Medicaid Program.

Appeal Rights

Pursuant to 7 AAC 105.280, you may request an appeal and a formal hearing to contest the Department's decision to not approve admissions to Desert Hills until Desert Hill is in a full compliance with the State of Alaska Regulations (7AAC 140.400 - 7 AAC 140.415; Behavioral Health Inpatient Psychiatric Review Provider Manual) and CMS Regulations (42 CFR 483.350 -376; 42 CFR 456.609-610; 42 CFR 441.155).

Your request for appeal must:

1. Be in writing.
2. Be submitted no later than 30 days after the date of this notice.
3. A written request that specifies the basis upon which the decision is challenged and includes any supporting documentation; and a copy of this notice.
4. Be submitted to:

Department of Health and Social Services
Division of Behavioral Health
Attn: [redacted] Medicaid Program Specialist V
Medicaid Services Section &Tribal Program Manager
[redacted]
Anchorage, AK [redacted]

A decision on appeal will be the final administrative decision. The department will notify the provider of the provider's right to appeal to the superior court under the Alaska Rules of Appellate Procedure.

If you have any questions, please contact [redacted] at [redacted] or [redacted]

The Division look forward to a continued partnership with your agency to ensure fulfillment of Federal and State of Alaska Regulations.

Sincerely,

[redacted]

for [redacted]
Medicaid Program Specialist V
Medicaid Services Section &Tribal Program Manager

PRINTED: 10/07/2019
FORM APPROVED
OMB NO. [redacted]

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(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 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A complaint survey was conducted from 9/25-9/27/19. Complaint [redacted] was substantiated, all or in part, with no deficiency cited. 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 156	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4) The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.	W 156	Step #1 Corrective Action: On 9/27/2019, upon notification of deficient practice, the Program Director checked to assure the DHS-762 was completed and sent to the Office of Long Term Care to ensure notification of final report was sent for Client #1. No additional negative findings were found.	10/18/2019

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 10/07/2019
FORM APPROVED
OMB NO. [redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 156	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and record review, the facility failed to ensure the results of investigations into allegations of abuse were reported to the Office of Long Term Care (OLTC) within five working days for 1 of (Clients #1) sample client who had an allegation of abuse. The findings are: Client #1 was diagnosed with Mild Intellectual Disability, Disruptive Mood Dysregulation Disorder, Generalized Anxiety Disorder, and Unspecified Psychosis. a. On 9/17/19 at 4:36 p.m., an email from a DHHS (Department of Health and Human Services, DCFS (Department of Child and Family Services) supervisor was sent to the facility Risk Manager. The subject was "Foster child reports that was called into the hotline." The email documented, "AV [alleged victim] is 12y0 [year old] foster child [Client #1]. AO [Alleged Offender] is Unknown 1 [Facility Staff]. AV was seen on 9/10/19 with human bites on her right arm (wrist & shoulder). It also appeared someone had slapped/hit the av's face on the right side. AV's right ear and right side of face were swollen like she had been hit with an object. AV said there were two girls in the cottage that had hit her. . . AV was spoken with again on yesterday (9/16/19) and asked about her face. AV shut down and wouldn't tell anything. . . Millcreek staff was asked if they were aware of the injuries on the av. Staff said yes, they were aware and if they had not documented about what happened to the av they would be in trouble... b. On 9/17/19, after the facility received the above	W 156	Step #2 Identification of other with the potential of being affected: On 9/27/2019, the Program Director through record review immediately identified 4 residents who had the potential to be affected from the deficient practice. Client #1 final investigative report was submitted to the Office of Long Term care on 9/28/2019. Each of the allegation were evaluated to ensure results of investigations into allegations of abuse are reported to the Office of Long Term Care (OLTC) within five working days to determine if those residents were affected. No other negative findings were found. Step #3 To ensure deficient practice does not recur: On 9/27/2019 through 9/30/2019 to ensure all administrative and direct care staff were in-serviced by the Program Director and direct supervisors related to the federal regulations regarding reporting of incidents as outlined by State Law, specifically of the initial report by 11:00 am the following day of the incident and the final investigation reporting by the 5th day business day. All incident reports will be immediately forwarded to the milieu coordinator who will in turn notify the Program Director of the incident. Administration will be informed and an investigation will immediately ensue. Appropriate in-service education will be instituted. Witness statements will be	10/18/2019 10/18/2019

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

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	[redacted]	A. BUILDING _____ B. WING _____	C 09/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

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W 156	Continued From page 2 allegations of abuse for Client #1, the facility transmitted an initial report to the Office of Long-Term Care on the same day with investigation pending. c. On 9/26/19 at 10:33 a.m., the Program Director was asked if the five-day investigation report required by law had been submitted to the Office of Long-Term Care. He stated, "The five-day report was due yesterday and it has not been submitted yet. It is supposed to be submitted today." d. On 9/26/19 at 4:48 p.m., the Risk Manager showed the investigation report to the Surveyor and was asked, "Has this been transmitted to the office yet?" He stated, "Not yet, I'm waiting for [Administrator] to sign off on it."	W 156	collected and other items related to a thorough investigation by the Risk Management Department. The findings of the investigation will be reported to the Administrator on the evening of the 4th day following the incident. All of the above evidence will be evaluated and forwarded to the Office of Long Term Care by the morning of the 5th day. Step 4 Monitoring: The Program Director will monitor to ensure all allegations of abuse are reported to the Office of Long Term care by the 5th business day by record review and observation and will be documented on a form developed for reporting to the Performance Improvement Committee. The allegation reports will be monitored daily and with each occurrence for 8 weeks or until compliance is verified by the OLTC. Any negative findings will be corrected immediately and the Administrator will be notified.	10/18/2019

EXIT CONFERENCE
ATTENDEE SIGNATURES

Date: 10/23/19

Provider #: [redacted] Facility Name: Mill creek of Arkansas

Facility City: Fordyce

Name:	Functional Title:
[redacted]	RN/QAC
	RN/QAPI
	MC/PS
	RN, Program Director

Medicare census:_____ Medicaid census:_____

PRINTED: 07/11/2019
FORM APPROVED
OMB NO. [redacted]

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	[redacted]	A. BUILDING _____ B. WING _____	C 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center Complaint [redacted] was substantiated, all or in part, with a deficiency cited at N0128.	N 000	Step #1 Corrective Action: On, 6/28/19, upon notification of deficient practice, the Administrator checked to ensure all staff and nurses had been in-serviced to ensure physical restraints are safely implemented and no injury or potential injuries had occurred with resident #1. No additional negative findings were found. Step #2 Others Identified All residents were deemed to be potentially at risk if a failed practice occurred in the future. Step #3 Corrective Measures All direct care staff were in-serviced between 6/28/19 and 6/31/19 by their direct supervisors related to the proper techniques to be utilized during an emergency safety intervention to ensure the safety of the resident.	
N 128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Complaint [redacted] was substantiated, all or in part, with these findings: Based on observation, record review and interview, the facility failed to ensure a client that was placed in a physical restraint did not sustain an injury for 1 of 1 (Resident #1) sampled client who was physically restrained. The findings are: Client #1 was admitted on 6/24/19 and had	N 128	The nursing staff were in-serviced between 6/28/19 and 6/31/19 by the DON and ADON on the assessment and follow-up for a complaint made as a result of an emergency safety intervention. Nurses were also re-in-serviced on the policy was mandating all clients who complain of joint pain, long bone pain, any laceration, any bruising, injury to the head, or other significant complaint of pain, will be taken immediately to the physician's office or to the local emergency room, if after hours, for evaluation by medical personnel and notify Administrator/ Designee.	

LABORATOR[redacted] RE TITLE (X6) DATE

CEO 7/23/19

Any deficie[redacted]e 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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	[redacted]	A. BUILDING _____ B. WING _____	C 06/28/2019

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MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

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N 128	Continued From page 1 diagnoses Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation; Disinhibited Attachment Disorder of Childhood; and Conduct Disorders. a. A Social History Prior to Admission to MOA [Millcreek of Arkansas] updated 6/21/19 documented, "...He is having escalating verbal and physical aggression. During the past week, the patient has attacked multiple staff members and his therapist. He threatened to kill the nurse practitioner on the day of admission. He was placed in a hold due to escalating aggression. He attacked his therapist and mother on the day of admission in the office..." b. OLTC (Office of Long Term Care) Incident And Accident Report, dated 6/25/19 at 8:40 p.m., documented, "...Location: [Home] Hallway: On 6/25/19 [Resident #1] was provoking peers and being non-compliant to staff directives. [Resident #1] was directed multiple times to stop. [Resident #1] then became physically aggressive towards staff by punching/kicking and throwing his shoes directly at staff. Staff separated from [Resident #1]. [Resident #1] continued to be aggressive and target staff. Nurse and supervisor notified. [Resident #1] was placed in a physical restraint for safety of self and others. During the physical restraint patient continued to display strong aggression and resistance by lifting his upper body off the floor. [Resident #1] also refused to comply to any directives given by the nurse and supervisor. Nursing Evaluation: Per [LPN (Licensed Practical Nurse) #1]: bruising and redness to right shoulder petechiae to right leg and redness to right leg. ROM [Range-of-motion] to right shoulder. Sent to [Hospital] for evaluation. [Staff #1] was located on right	N 128	Staff placed on Administrative leave will be in-serviced and retrained prior to returning to work upon completion of all external investigations. Step #4 Monitoring Trainer or administrative team will monitor to ensure Emergency Safety Intervention (ESI) did not result in an injury by observation and documenting on video if available or witness interviews, daily for any restraints for 8 weeks or until compliance is verified by OLTC. Any negative findings will be corrected.	7/22/19

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

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N 128	Continued From page 2 shoulder where patient was badly bruised." c. Nurse's Note, dated 6/25/19 at 4:46 p.m., documented, "Pt [patient] may be placed in a physical restraint not to exceed 20 minutes d/t [due to] physical aggression towards staff and refusing to calm. While in physical restraint pt refused to calm and tried to remove self from restraint and attempting to bite staff. Pt was able to calm on own and was released at 1656 [4:56 p.m.] When nurse walked into hall, pt was already in supine 3 man tci [Therapeutic Crisis Intervention] hold. After pt was released bruising and redness were noted to R [right] shoulder, petechiae noted to R [right] leg and redness noted to R leg. Pt rates pain 10/10 [ten of ten] and has no ROM [range-of-motion] to R [right] shoulder and refuses to move it. Full ROM noted to all other extremities. Pt declines ice pack and declines pain meds [medications] @ [at] this time. (1719) [5:19 p.m.] pt being sent to ER [emergency room] for evaluation of pain to R shoulder..." d. On 6/28/19 at 2:14 p.m., RN (Registered Nurse) #1 and LPN #1 were asked, "Can you tell me what happened when [Resident #1] was restrained?" [LPN #1] stated, "They called a code green and when we got down there he was already in the three man restraint." [RN #1] stated, "We could hear him hollering, let me up, let me up, I'll be good. Then I bent down and said you need to calm down and count to ten. Then he started to try to count to ten and started to bite one of them and I told him don't bite, don't bite." RN #1 and LPN #1 were asked, "Was he fighting?" LPN #1 stated, "He was trying to come up with his body and his legs were coming out of the restraint, so just kinda wiggle wormed." RN	N 128		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

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N 128	Continued From page 3 #1 and LPN #1 were asked, "Is bruising normal during a restraint?" LPN #1 stated, "You can get some bruising right there in the crease [indicating crease between the junction of the upper arm and shoulder], that is pretty normal, but not to that extent." Both RN #1 and LPN #1] stated, "Not to that extent." RN #[and LPN #1 were asked, "Was it caused by undo pressure on his shoulder?" LPN #1 stated, "Yeah, I never seen a restraint look like that." e. On 6/28/19 at 2:24 p.m., Resident #1 was asked, "Can you tell me what happened when you were restrained?" Resident #1 stated, "Do you want to see my bruises?" Resident #1 had on shorts and he pointed out a penny size, fading, light brown bruise on the upper right thigh. Resident #1 moved the neck of his t-shirt down exposing the right shoulder where a fading brown, green and yellow bruise, approximately 3 inches in width and 4 to 5 inches in length was observed. The Surveyor stated, "That's a pretty good bruise." Resident #5 stated, "Yeah, that's where they were holding me down. They kept pushing harder and harder, then the nurse told me to count to ten and they pushed down harder. I tried to bite them." Resident #1 was asked, "Were you trying to get out of the restraint?" He stated, "Yeah, when they were pushing down so hard, it was hurting."	N 128		

DisabilityRights ARKANSAS

[redacted] Executive Director

April 5, 2019

[redacted] Chief Executive Officer
Millcreek Behavioral Health
[redacted]
Fordyce, Arkansas [redacted]

RE: Millcreek Monitoring Report

Dear Mr [redacted]

Disability Rights Arkansas (DRA) is the designated protection and advocacy agency for the State of Arkansas. As part of our federal mandate, we monitor various facilities that provide services to people with disabilities.

I am writing on behalf of DRA to bring to your attention our concerns regarding observations during our recent monitoring. Our concerns are two-fold: patient accessibility to numerous environmental hazards, and inadequate service provision.

Environmental Hazards

DRA visited this facility on March 21st 2019, March 28th 2019, and April 1st 2019 as part of our on-going monitoring of the psychiatric residential treatment facilities around the state. During these visits, we spoke with multiple youth residing in Flamingo hall. These youth spoke of self-harming using objects found in their residential hall. On March 28th 2019, staff observed these same objects freely accessible to the youth in Flamingo Hall; these represent unsafe and inadequate living conditions for youth with histories of self-injurious behavior. Staff spoke with the evening shift supervisor (who accompanied staff) about concerns. On April 1st 2019, staff monitored Flamingo Hall again. The same hazards that were noted on March 28th 2019 remained present. These concerns were shared immediately with Mr. [redacted], the PRTF program director.

Our findings are as followings:

- **Broken hygiene bins.** Multiple youth spoke of self-harming using broken plastic from their hygiene bins. The use of this plastic to self-harm or attempt to self-harm has been documented by Millcreek staff. As this is a known hazard, then

the presence of the broken hygiene bins is concerning. It is recommended that all plastic bins be examined and replaced immediately if broken in any way. If a replaced bin is subsequently broken, staff should immediately replace it.

- **Showers.** The laminate walls of the 2nd and 3rd shower stalls (from left) are cracked. The 2nd stall is of greatest concern because it is severely cracked and very sharp. One youth specifically stated she had used the 2nd stall to self-harm. When Mr. [redacted] was informed, he said that work orders had been submitted for both stalls. In the meantime he said that staff were watching patients shower while in the broken stalls. This is an inadequate stopgap solution as it represents a gross violation of patient privacy and creates potential for other abuse. It is recommended that these work orders be rushed for immediate address. It is recommended that the 2nd and 3rd stalls not be used at all until the safety concerns can be addressed.

- **Cushioned Couches.** The state of the cushioned couch in Day Room 1 is unacceptable. The cushions have been torn and frame of the couch is exposed. One youth spoke about using the spring of the couch to self-harm. This attempt is documented by Millcreek staff, yet the couch remains accessible to patients. We did not observe exposed or accessible springs in the couch cushion; however, if there are springs in the couch, they are an obvious self-harm hazard. The exposed and accessible foam in the cushion is likely to be hazardous upon ingestion. It is recommended that all cushioned furniture be removed or repaired.

- **Bathroom Mirror.** The top corner of the mirror is still bent to a hazardous angle. This hazard was reported to you by DRA staff on March 21st 2019. Whether this has been addressed and occurred again, or has not been addressed at all, the result is the same. If the mirror is weakened so that it cannot be kept from being re-bent, it is recommended the entire mirror be replaced.

DRA staff expressed concerns regarding environmental hazards in a letter addressed January 30th 2019. In this letter (RE: [redacted] DRA staff recommended "Regular environmental rounds should be conducted to spot potential hazards and identify suicide hazards requiring abatement." [redacted] Risk Analyst for Millcreek Behavioral Health, responded to this specific concern on February 20th 2019, stating "Rounds have been started and are completed on a random daily basis." The continued existence of environmental hazards is worrying. Please reply with how this will be corrected in the future.

Inadequate Service Provision

On March 21st 2019 DRA spoke via staff translator with the (then) 9 youths in Office of Refugee Resettlement (ORR) custody. DRA spoke with youth in ORR custody via staff translator again on March 28th 2019 and April 1st 2019. As these youth speak little to no English, we find that Millcreek Behavioral Health cannot provide adequate care or services to these children. On April 1st 2019, Mr. [redacted] stated that the youth have

access to a staff translator 40 hours per week. Further inquiry revealed that a staff translator is only available during the day shift for school hours. Google Translate is not an effective means of communication. One youth, [redacted] is linguistically isolated, unable to adequately speak to staff or her peers after school hours. She expressed frustration and anxiety at this isolation. Her linguistic anxiety has led to frequent bouts of emotional distress as documented by Millcreek staff as well as self-injurious behavior. The lack of precise communication presents an evident danger to all Spanish-speaking youth as they have no dependable and immediate means to communicate if in emotional crisis. As these youth were placed with Millcreek because of their mental health needs, these large gaps in staff translator availability is neglectful. Furthermore, it is problematic to conduct therapy or other mental services via staff translator; the patient would be unlikely to disclose potential abuse or other issues perpetrated by the staff translator. Youth have also shared with us that they don't like using Stratus Audio Inc. as it feels like talking with a stranger. DRA recognizes and commends Millcreek Behavioral Health for its on-going attempts to hire additional Spanish-speaking staff. However, DRA strongly recommends that all children under ORR custody be moved to a placement with the existing resources to accommodate Spanish speaking children as soon as possible.

DRA urges Millcreek Behavioral Health to take immediate action to address the concerns raised in this letter and requests a written response.

[redacted]
[redacted] Advocate

CC: [redacted]
Office of Long Term Care
Mail Slot [redacted]
P.O. Box [redacted]
Little Rock AR 72203-8059

CC: Office of Refugee Resettlement
Administration for Children and Families
Mary E. Switzer Building
330 C Street, SW
Room 5123
Washington, DC 20201-0001

Disability Rights ARKANSAS

[redacted] Executive Director

January 30, 2019

[redacted]
Chief Executive Officer
Millcreek
[redacted]
Fordyce, AR [redacted]

RE: [redacted]

Dear: Mr. [redacted]

Disability Rights Arkansas (DRA) is the designated Protection and Advocacy agency for the State of Arkansas. As part of our federal mandate, we monitor various facilities that provide services to people with disabilities.

DRA was notified of an incident about a client of Millcreek [redacted] who refused to consent to an evening strip search. In response, four female staff members restrained her. During the restraint, one of the staff members put her hand inside [redacted] bra, touched her breasts and visually examined her chest area. Before releasing [redacted] from this restraint, staff forced her to agree to a search of her vaginal cavity. DRA investigated the incident. As part of our investigation, DRA interviewed the client, reviewed incident reports and nursing notes and her Crisis Management Plan. DRA also discussed the case with [redacted] Director of Risk Management, and [redacted] LCSW.

After investigating this incident, DRA has concerns about several issues found during the investigation. These issues include the use of restraint, strip searches, cavity searches and staff negligence. They also include [redacted] lack of therapy and prevention of self-harm.

DRA spoke with [redacted] LCSW, on December 14, 2018, concerning the restraint. She stated that [redacted] was asked to submit to a search, which she refused. [redacted] then hit a staff person so she was restrained. [redacted] denies that she became aggressive. I was unable find documentation supporting that she hit a staff person. One nursing note dated November 30, 2018 states that [redacted] refused to follow directions, referring to the restraint on November 26, 2018.

I also inquired about the strip searches. Ms. [redacted] stated that [redacted] safety plan addressed the imposed strip searches. DRA understands that [redacted] self-harms and will use various objects to do so. The safety plan states that "staff will check [redacted] for contraband when leaving school or other activities where she could have access to items that she could harm self or others." It doesn't state that there will be a strip or cavity search of any kind.

Ms. [redacted] stated that the searches were completed in a respectful manner, where the bra would be removed while the underwear was still on, and vice versa, so she was not naked. [redacted] stated the evening strip searches were conducted while she was made to squat in the shower, naked.

There were reportedly two cavity searches completed; Ms. [redacted] confirmed this. Only one cavity search is documented in the nursing notes dated October 20, 2018. While interviewing [redacted] she stated that during one cavity search on or about November 30, 2018, the nurse was present but the supervisor, [redacted] completed the actual cavity search; there is no documentation to dispute this. The documentation for the strip searches is sparse and there is no documentation sheet for the cavity searches.

Nursing documentation shows tha[redacted] was continually accessing items used to self-harm even though she was a 1:1 staff ratio most of the time. She was able to take batteries from a clock and a remote control and swallow them, she put glass in her vagina and had elastic placed around her neck on three occasions in a suicide attempt. When I met with [redacted] on December 21, 2018, she was wearing boots with buttons the size of a quarter that she could have removed and swallowed. She also had an elastic hair band tied around her wrist. The cottage where she lives had cotton balls glued to the walls on a mural, there were ink pens lying about, peeling paint in her bedroom, remote controls on a table and various items she could have accessed to ingest.

[redacted] also still had access to items to cut her arms. There were numerous new scars over her old scars. When I inquired about how staff was not aware of the new cuts, I was told they were not checking for them. I asked if there was a body mark sheet to document her self-injuries and I was told there was not. My concern is that if they were doing strip searches, they would surely see her arms and realize that she was accessing items to cut herself. There's no mention of her cutting her arms in the nurses notes, which leads me to question if staff is providing real 1:1 supervision. They were not able to keep her from self-harming and [redacted] told me herself that they did not watch her closely. Since Millcreek admitted [redacted] to the program, her guardians would expressly assume that the patient would be protected from harm, including self-harm.

After reviewing the dates therapy was offered to [redacted] I am concerned that she is not being offered enough therapeutic services. [redacted] was offered individual therapy a total of five times from October 12, 2018, to November 30, 2018.

She refused three out of those five sessions offered. My record review was completed on December 21, 2018 and no sessions had been offered in December. She did, however, attend group sessions thirteen times. [redacted] is supposed to receive individual therapy at least one time per week.

Recommendations

Based on our investigation of this incident, DRA recommends the following:

1) The Crisis Management Plan should clearly state what kind of searches will be performed.
2) Cavity searches should be performed by medical personnel only.
3) There should be a specific form to complete after searches to identify what kind of search (cavity or strip search) took place, and who performed it.
4) Staff should be adequately manned, orientated, and trained about suicide prevention, communication and self-harm.
5) Millcreek should re-examine unit designs and environment for suicidal youth.
6) Regular environment rounds should be conducted to spot potential hazards and identify suicide hazards requiring abatement.

At this time we are closing our investigation. We hope that Millcreek will continue to monitor staff-patient interactions to ensure that this was a one-time incident and not a systemic problem within the facility.

Sincerely,

[redacted] Advocate

Enclosures

[redacted]

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services and Quality Assurance
Office of Long Term Care
http://humanservices.arkansas.gov/dms/Pages/oltcHome.aspx
[redacted] Little Rock, AR 72203-8059
Fax: [redacted]

CERTIFIED MAIL # [redacted]

January 23, 2019

[redacted] Administrator
Millcreek Of Arkansas
[redacted]
Fordyce, AR [redacted]

Dear Mr. [redacted]

During the revisit conducted on January 21, 2019, your facility was found to be in compliance with program requirements. Your certification remains in effect unless terminated due to non-compliance with program requirements or voluntary withdrawal from the program. **A CMS 2567 is enclosed, indicating your facility's compliance status. Please sign and date the 2567 and fax to** [redacted] **at** [redacted] **as soon as possible.**

Please refer to the Medicare/Medicaid Certification and Transmittal (CMS Form 1539) for your period of certification.

If you have any questions please contact your reviewer at [redacted]

Sincerely,

[redacted]
[redacted] DHS Program Administrator
Office of Long Term Care
Survey and Certification Section

sgb

cc: file

PRINTED: 01/22/2019
FORM APPROVED
OMB NO. [redacted]

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	R 01/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(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 000}	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A revisit was conducted on January 21, 2019 for all deficiencies cited on December 18, 2018. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{W 000}		

[redacted] NATURE | TITLE CEO | (X6) DATE 1/23/19

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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Arkansas Department of Human Services
Office of Long Term Care
[redacted]
Little Rock, AR 72203-8059
Phone: [redacted]
Fax: [redacted]
http://humanservices.arkansas.gov/dms/Pages/oltcHome.aspx

To:	[redacted] Administrator	**Fax:**	[redacted]
From:	[redacted] DHS Program Administrator	**Date:**	1/[illegible]/19
Re:	Compliance CMS 2567 and Letter – Millcreek of Arkansas ICF/IID	**Pages** (including cover sheet):	3

Comments:

Please sign page 1 of the revisit survey and fax back to me as soon as you can.

Thank You

"Prohibition of Disclosure: This information has been disclosed to you from records that are confidential. You are prohibited from using the information for other than the stated purpose; from disclosing it to any other party without the specific written consent of the person to whom it pertains; and are required to destroy the information after the stated need has been fulfilled, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose."

CONFIDENTIAL

20191011 Piney Ridge OLTC POC RESPONSE ATTACHMENTS

PRTC
PINEY RIDGE TREATMENT CENTER

November 4, 2019

[redacted] Reviewer
OLTC, Survey & Certification Section
[redacted]
Little Rock, AR [redacted]

RE: Plan of Correction

Dear Ms. [redacted]
Piney Ridge Treatment Center has received the request for a Plan of Correction in relation to the October 11, 2019 Compliant Survey. In addition to this letter, you will find the requested Plan of Correction and supporting documentation that is being provided as part of the Plan of Correction. If you need additional information or have any questions, please do not hesitate to contact me.

Sincerely

[redacted]
[redacted] RN
Director of Nursing
Piney Ridge Treatment Center

PRTC
PINEY RIDGE TREATMENT CENTER

NURSING DEPARTMENT IN-SERVICE AGENDA

DATE OF IN-SERVICE: 10/16/2019 **TIME: 07:30**

TOPICS COVERED:

- **EMERGENCY SAFETY INTERVENTIONS**
  - Residents cannot have more than one Emergency Safety Intervention (ESI) at one time. Ex.: A resident cannot be given a chemical restraint and secluded simultaneously.
  - ESI Documentation must reflect the MD ordering the physical restraint, the seclusion, and the chemical restraint. Each intervention should be a separate call to the physician and documentation should reflect each individual call time.

[redacted] FAYETTEVILLE, AR [redacted] • TEL [redacted] • FAX [redacted]

Nurse 10/16/19 @ 0730 sign in

[redacted]

Topics :1) Cannot have more than one Emergency Safety Intervention at one time, example: A resident cannot be given a chemical restraint and secluded.
2) On ESI documents, the MD ordering physical restraint, seclusion, chemical restraint should be called 3 times for 3 interventions documentation should reflect that time
Nurses not present, educated on above topics individually [redacted]

COMPETENCY RN RESTRAINT/SECLUSION "FACE TO FACE EVALUATION"

EMPLOYEE: _____ **VIEWED TRAINING RECORDING ON DATE:** _____

Circle all that apply (refer to the Seclusion/Restraint Physician Assessment/Progress Note as needed)

1. In the absence of a physician or his designee, a trained RN may now perform a restraint/seclusion "face to face" evaluation within 1 hour.
   a. True
   b. False
2. The purpose of performing a face to face evaluation within 1 hour is to assure:
   a. Restraint/Seclusion was used for the appropriate reason.
   b. The patient is physically safe.
   c. Least restrictive measures are being used.
3. The only criterion for use of a restraint or seclusion is that the patient is a danger to themselves or others.
   a. True
   b. False
4. Staff members do <u>not</u> need to use their empathetic communication skills to attempt to deescalate the situation before using Restraint/Seclusion.
   a. True
   b. False
5. When must the patient be released from Restraint/Seclusion?
   a. When the patient is calm and verbalizes willingness to maintain safety.
   b. Demonstrates the ability to maintain safety (e.g. tolerates progressive release of restraints, willingness to stay in open seclusion room for specified time or other agreed appropriate behavior).
   c. Positive response to medications resulting in the patient's ability to maintain safety.
   d. When the staff members feel that he has learned his lesson.
6. Pertinent Mental Status Findings include:
   a. Orientation
   b. Responsiveness
   c. Mood
   d. Affect
7. Physical Evaluation includes
   a. Patient is able to breathe freely with skin color that is pink and chest movement that is unrestricted.
   b. All extremities are pink and no pressure is being placed on the joints.
   c. Patient has complaints of pain or discomfort or injury.
8. The assessment is documented on the *Seclusion/Restraint Physician Assessment/Progress Note* form found in the Restraint/Seclusion Packet.
   a. True
   b. False
9. The "face to face" assessment is shared with the patient's physician or designee and a verbal order is received to continue or discontinue the restraint and is documented on the physician's signature line.
   a. True
   b. False
10. Restraint and seclusion cannot be used simultaneously.
    a. True
    b. False

Employee Signature _____ Date _____

PRTC PINEY RIDGE TREATMENT CENTER | RVGH RIDGEVIEW GROUP HOME

CHARGE NURSE COMPETENCY CHECKLIST

EMPLOYEE: _____ **DATE OF HIRE:** _____

	COMPETENCIES	INITIALS	DATE
	Admission Process		
1.	Obtains admission order.		
2.	Interview resident, complete and document Nursing Assessment.		
3.	Reconcile Medications.		
4.	Document admission in the Progress Note.		
5.	Search resident belongings.		
6.	Inventory personal belongings.		
7.	Complete lab or schedule lab draw.		
8.	Chart vitals.		
9.	Complete consults for Dietary Assessment, etc.		
	Discharge Process		
1.	Complete and document Discharge Physical.		
2.	Complete #3 on the Aftercare Plan.		
3.	Reconcile Medications.		
4.	Obtain MD order for discharge.		
5.	Nurse or Therapist: Visit with family to complete Aftercare Plan.		
6.	Write Discharge Note in Progress Record.		
	Understand Role in ESI (Seclusion, Restraint, Chemical Restraint)		
1.	Understands ESI Policy and Procedures.		
2.	Physician Order (time limited).		
3.	Documents least restrictive interventions or measures taken, the behavioral assessment, and on-going observation.		
4.	If ordered, performs one (1) hour face to face assessment, has completed face to face assessment training.		
5.	Face to Face Competency Completed.		
6.	Understands seclusions and restraints cannot be used simultaneously.		
	Physicians' Order Process		
1.	Able to obtain, review, and verify verbal orders.		
2.	Able to obtain, review, and verify telephone orders.		
3.	Completes transcription of physician orders.		
4.	Demonstrates ability to sign and note orders.		
5.	Demonstrates ability to review chart and perform a chart check.		

	COMPETENCIES	INITIALS	DATE
	Demonstrates and Completes Documentation		
1.	Nursing documentation/assessments are completed within time frames.		
2.	Psychiatric problems or potential psychiatric problems are identified and appropriately handled.		
3.	Nursing assessment checklist completed daily.		
4.	Nursing progress documentation.		
5.	Errors in charting.		
6.	Legal signature.		
7.	Continuation from page to page.		
8.	Date and time.		
9.	Charting objectivity.		
10.	Black ink.		
11.	Military time.		
	Understands Medication Administration Procedures		
1.	Medication Administration Record (MAR).		
2.	Medication teaching.		
3.	Narcotic count procedure.		
4.	Monitor for adverse drug reactions.		
5.	Medication Consent Procedure.		
6.	TB Skin Test.		
7.	Scheduled Medication times.		
8.	Medication pass (including mouth check).		
9.	Medication Room key responsibility.		
	Understands Medication Ordering Procedures		
1.	Medication Ordering Process.		
2.	Cycle Fill (When to order and how).		
3.	Ordering Pharmacy Medical Records (MARs Monthly).		
4.	Ordering Narcotics		
5.	Checking in medications with pharmacy representative.		
	Understands Infection Control Procedure		
1.	Universal Precautions.		
2.	Blood Borne Pathogen Exposure Plan.		
3.	Hand-Washing Technique.		
4.	Infection Report Form.		
	Understands Laboratory Procedures		
1.	Lab Ordering Process.		
2.	Lab Refrigerator.		
	Understands Pass Procedure		
1.	Pass Order.		
2.	Procedure for obtaining pass medications.		
3.	Safety Plan.		
4.	Search Upon Return from Pass.		

	COMPETENCIES	INITIALS	DATE
	Identifies Emergency Phone Numbers		
1.	911.		
2.	ER Department.		
3.	Fire Department.		
4.	Police Department.		
5.	After Hours Emergency Contacts.		
6.	Poison Control.		
	Demonstrates Correct Use of:		
1.	Thermometer.		
2.	Blood Pressure Cuff.		
3.	Stethoscope.		
4.	Copier/Fax Machine.		
	Unit Training		
1.	Unit Schedules.		
2.	Program Rules.		
3.	Behavior Modification Program.		
4.	Meal Administration and Standards.		
5.	Charting Procedures for Staff.		
6.	Time Out Procedure.		
7.	Phone Call Procedure.		
8.	Search Policy.		
9.	Report Book.		
10.	Contraband.		

Staff will receive additional education and training if they are unsatisfactory in any of the above areas.

Comments: _____

_____

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Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

PRTC PINEY RIDGE TREATMENT CENTER | RVGH RIDGEVIEW GROUP HOME

MEDICATION NURSE COMPETENCY CHECKLIST

EMPLOYEE: _____ **DATE OF HIRE:** _____

	COMPETENCIES	INITIALS	DATE
	Admission Process		
1.	Obtain vitals		
2.	Urine Drug Screen		
3.	Transcribe Medication Orders to MAR		
4.	Order Medications from Pharmacy		
5.	Administer TB Skin Test		
	Discharge Process		
1.	Provide a ten (10) day supply of medications		
2.	Provide prescription from MD for a thirty (30) day supply of medications.		
	Understand Role in ESI (Seclusion, Restraint, Chemical Restraint)		
1.	Understands ESI Policy and Procedures.		
2.	Understands Role During ESI Events.		
3.	Understands seclusions and restraints cannot be used simultaneously.		
	Physicians' Order Process		
1.	Able to obtain, review, and verify verbal orders.		
2.	Able to obtain, review, and verify telephone orders.		
3.	Completes transcription of physician orders.		
4.	Demonstrates ability to sign and note orders.		
	Demonstrates and Completes Documentation		
1.	Nursing progress documentation.		
2.	Errors in charting.		
3.	Legal signature.		
4.	Continuation from page to page.		
5.	Date and time.		
6.	Charting objectivity.		
7.	Black ink.		
8.	Military time.		
	Understands Medication Administration Procedures		
1.	Medication Administration Record (MAR).		
2.	Medication teaching.		
3.	Narcotic count procedure.		
4.	Monitor for adverse drug reactions.		
5.	Medication Consent Procedure.		
6.	TB Skin Test.		
7.	Injections		
8.	Scheduled Medication times.		
9.	Medication pass (including mouth check).		
10.	Medication Room key responsibility.		

	COMPETENCIES	INITIALS	DATE
	Understands Medication Ordering Procedures		
1.	Medication Ordering Process.		
2.	Cycle Fill (When to order and how).		
3.	Ordering Pharmacy Medical Records (MARs Monthly).		
4.	Ordering Narcotics		
5.	Checking in medications with pharmacy representative.		
	Understands Infection Control Procedure		
1.	Universal Precautions.		
2.	Blood Borne Pathogen Exposure Plan.		
3.	Hand-Washing Technique.		
4.	Infection Report Form.		
	Understands Laboratory Procedures		
1.	Lab Ordering Process.		
2.	Lab Refrigerator.		
	Understands Pass Procedure		
1.	Pass Order.		
2.	Procedure for obtaining pass medications.		
3.	Safety Plan.		
4.	Search Upon Return from Pass.		
	COMPETENCIES	INITIALS	DATE
	Identifies Emergency Phone Numbers		
1.	911.		
2.	ER Department.		
3.	Fire Department.		
4.	Police Department.		
5.	After Hours Emergency Contacts.		
6.	Poison Control.		
	Demonstrates Correct Use of:		
1.	Thermometer.		
2.	Blood Pressure Cuff.		
3.	Stethoscope.		
4.	Copier/Fax Machine.		
	Unit Training		
1.	Unit Schedules.		
2.	Program Rules.		
3.	Behavior Modification Program.		
4.	Meal Administration and Standards.		
5.	Charting Procedures for Staff.		
6.	Time Out Procedure.		
7.	Phone Call Procedure.		
8.	Search Policy.		
9.	Report Book.		
10.	Contraband.		

Staff will receive additional education and training if they are unsatisfactory in any of the above areas.

Comments: _____

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

PINEY RIDGE TREATMENT CENTER

POLICY:	Emergency Safety Interventions	**POLICY #:**	5C-01
DEPARTMENT:	Nursing	**SECTION:**	Behavior Management
EFFECTIVE DATE:	04/2009	**REVISION DATE:**	06/24/2009, 01/07/2010, 03/2011, 09/2011, 10/2011, 11/2011, 05/2012, 09/2012, 04/2013, 10/2013, 03/2014, 08/2014, 08/2018, 11/2019
ADMINISTRATOR/APPROVED BY	[redacted]	**TITLE:**	DON

I. **PURPOSE:**
To provide guidelines for implementing the therapeutic use of restraint and seclusion.

II. **POLICY:**
It shall be the policy of Piney Ridge Center that each resident has the right to be free from physical restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation. Physical restraints and seclusions shall be utilized in a way that is humanitarian and caring and used in a way in which the resident's rights, dignity, well-being, and safety are assured. The use of physical restraint and seclusion shall always be implemented utilizing the least restrictive measures to prevent a resident from injuring self or others in an emergency safety situation. Any use of physical restraint and or seclusion requires clinical justification by a clinically qualified Registered Nurse (RN) and must have a physician's order. The order must be obtained at time of initiation of emergency safety intervention or immediately after not to exceed 60 minutes. Physical restraint or seclusion must not result in harm or injury to the resident and must be used only in the following situations:

A. To ensure the safety of the resident or others during an emergency safety situation. An emergency safety situation means unanticipated resident behavior that places the resident or others at a serious threat of violence or injury if no intervention occurs and it calls for an emergency safety intervention as defined by this policy.

B. Until the emergency safety situation has ceased and the resident's safety and the safety of others can be insured, even if a physical restraint or seclusion order has not expired.

C. The physical restraint and seclusion procedures are only authorized according to procedures as set forth in this policy. <u>The term restraint does not include briefly holding without undue force of a resident in order to comfort him or her, or holding a resident's hand to safely escort a resident from one area to another</u>. **Mechanical restraints are prohibited for use at Piney Ridge Center in accordance with state, federal, and other regulatory standards**. All direct care staff are trained in Crisis Prevention Institute techniques and will follow the procedures outlined in their manual and training. Staff members who are not currently certified shall not be allowed to participate in restraint procedures.

D. Restraints and seclusions shall not be administered simultaneously.

III. **DEFINITIONS:**

A. Chemical Restraint: The administration of a one-time psychotropic medication only by the order of a staff physician or approved physician extender to act as an adjunct to any previously prescribed treatment. Chemical restraint is a crisis intervention used to resolve an emergency safety situation to contain severe, out of control behavior, exacerbation of psychosis which is likely to cause harm to the resident, other residents, or staff. Such medications are to be prescribed by the physician or approved physician extender in the lowest possible doses necessary to reduce anxiety and/or agitation exhibited by the resident. The intended goals shall not be to induce unconsciousness, shall not be used as a punitive measure, and shall not be used as a convenience for staff. It shall be utilized when, by the assessment of the Physician and the RN, the use of physical force could be potentially more traumatic to the resident. The intended goal should be to prevent injury to the resident or other residents or staff and to allow the resident the ability to process more appropriate ways to meet his or her specific needs.

B. Emergency Safety Situation: An unanticipated resident behavior that places the resident or others in serious threat of violence or injury if no intervention occurs and that calls for an emergency safety intervention.

C. Emergency Safety Intervention: The use of a physical restraint, chemical restraint, or seclusion as an immediate response to an emergency safety situation.

D. Physical Restraint: The application of physical external force (not to include mechanical restraint) on the resident to limit mobility. It shall be used for a period of time as brief as possible and in such a manner that reduces the chance of physical harm as much as possible. Physical restraint shall not restrict respiratory movements or other vital functions. A physician's order is required for physical restraints. Physical restraint is a crisis intervention used to resolve an emergency safety situation to contain severe, out of control behavior, which is likely to cause harm to the resident, other residents, or staff.
   1. Time Limitation: One (1) hour for residents under the age of nine (9); two (2) hours for residents ages nine (9) to seventeen (17); and four (4) hours for residents ages eighteen (18) to twenty-one (21).

E. Seclusion: The involuntary confinement of a resident alone in a room or an area from which the resident is physically prevented from leaving. The sole purpose for seclusion is to prevent physical harm to the resident, other residents, and/or staff.
   1. Time Limitations: Same as physical restraint time limitation.

F. Serious Injury: Any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

G. Clinically Qualified Registered Nurse: A registered nurse is determined to be clinically qualified when they have been trained in the use of Emergency Safety Interventions, Crisis Prevention Institute techniques, and Face-to-Face Evaluations.

IV. **PROCEDURE**:

A. Physical Restraint and Seclusion Justification: Prior to the use of seclusion, chemical restraint, or physical restraint a clinical assessment is conducted by the physician, approved physician extender,

or clinically qualified RN trained in the use of emergency safety interventions. Alternative approaches, such as verbal redirection, separation from stimulus, processing with another staff member, and encouraging movement to a quieter environment should be tried first.

1. The only justification for use of seclusion or physical restraint in an emergency safety situation is to prevent injury to:
   a. Self
   b. Other residents
   c. Others

B. Physical Restraint and Seclusion Orders:

1. A written order from the physician is required for the use of a physical restraint, chemical restraint, or seclusion. If the physician is not in the facility to order the use of restraint, seclusion, or chemical restraint, the Registered Nurse provides an emergency assessment, obtains the physician's verbal order at the time of the emergency safety intervention is initiated by staff. The physician's verbal order must be followed with the physician's signature verifying the verbal order. The physician must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based upon consultation with staff. Restraints and seclusions shall not be administered simultaneously.
2. The order shall be dated, timed, symptom specific, and time limited to no longer than the duration of the emergency safety situation.
3. A face-to-face emergency assessment of the physical and psychological well-being of the resident is conducted by the ordering provider or delegated by order to a clinically qualified Registered Nurse within one hour of the beginning of an incident.
4. A second call to the physician will be made within one (1) hour of the face to face assessment to give the resident's status.
5. Any order for seclusion, physical restraint, or chemical restraint must be dated, timed, behaviorally specific, and time limited (e.g. 02-15-01, 18:00, seclude now for up to sixty (60) minutes to prevent harm to self or others). PRN orders for seclusion or restraint are not permitted. When the resident has regained control, he or she will be removed from seclusion or physical restraint by the nurse. The staff involved will meet in a debriefing to discuss the event and offer feedback to one another before the end of the shift concerning events that took place and identify possible alternate methods which could be used to change behaviors. The resident shall be included in part of this debriefing session with staff.
6. All less restrictive interventions utilized to prevent the use of seclusion, physical restraint, or chemical restraint will be documented such as:
   a. Emphasis on self-control.
   b. Appropriate venting of anger with a staff member.
   c. Discussion of problem in a one-on-one meeting with staff.
   d. Separation from person contributing and/or feeding into the aggression or escalating behavior.
   e. Emphasis on responsibility for one's own choices.
7. The face-to-face assessment and the physical restraint, chemical restraint, or seclusion order must be documented in the resident's medical record by staff involved in the emergency safety intervention before the end of the shift. This includes, but is not limited to:
   a. The resident's physical and psychological status.
   b. The resident's behavior.

c. The appropriateness of the intervention measures.
d. Any complications resulting from the intervention.

8. The ordering physician must sign the verbal order as soon as possible.

C. Implementation of Order:

1. The implementation of the order for seclusion, physical restraint, or chemical restraint will only be carried out under the direct supervision of an RN who is privileged for this procedure. The use of seclusion and restraint shall not be done simultaneously. Such privileging is valid upon completion of training in the proper use of seclusion, restraint, or chemical restraint, Crisis Prevention Institute techniques. Staff members who are not currently certified in Crisis Prevention Institute techniques shall not be allowed to participate in the emergency safety intervention.
2. Clinical staff trained in the use of emergency safety interventions, Crisis Prevention Institute techniques, must be physically present to continually assess and monitor the resident in the physical restraint or seclusion. If the emergency safety situation continues near the time limits of the order, an RN must immediately contact the ordering physician in order to receive further instructions. A new order must be received following the RN emergency re-assessment before physical restraint or seclusion is continued.
3. A physician or Registered Nurse will perform a face to face assessment within one (1) hour following physical restraint, chemical restraint, or seclusion.

D. Seclusion and Restraint Parent and/or Legal Guardian Notification:

1. Piney Ridge Center must notify the parent(s) and/or legal guardian(s) whenever a resident is physically restrained, chemically restrained, or secluded as soon as possible after the initiation of the intervention. If the guardian is not notified by the start of the next day, a letter will be sent to the guardian, a copy placed in the medical record, and documented in the restraint packet. Documentation of such notification occurs in the resident's medical record and must include the date and time the parent(s) and/or legal guardian(s) were notified.

E. Notification of Registered Nurse to Clinical Director and Medical Director:

1. The Registered Nurse must notify the Medical Director and Clinical Director if there are two (2) or more occurrences of seclusion or physical restraint within a twelve (12) hour period to evaluate the emergency safety situations and take actions as deemed necessary.

F. Documentation for Emergency Safety Interventions:

1. All seclusions, chemical restraints, and physical restraints will be documented by a qualified Registered Nurse in the resident's medical record and will reflect justification, implementation, and outcome of procedure (to include behavior at the time of release) and shall address the failure of least restrictive interventions. Documentation must be completed by the end of the shift on which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include the following:
   a. Each order for physical restraint, chemical restraint, or seclusion as previously outlined in the policy.
   b. Time and results of the emergency safety intervention when it actually began and ended.
   c. Time and results of the pre-assessment required as described earlier.

d. The emergency safety situations that required the resident to be physically restrained, chemically restrained, or secluded.
e. The name of staff involved in the emergency safety intervention.

2. Each occurrence of physical restraint, chemical restraint, and seclusion will be documented by the Registered Nurse in the resident's medical record (Emergency Safety Intervention Justification Form) and will include antecedents, less restrictive interventions, crisis intervention techniques, clinical justification, implementation, and outcome of procedure.
3. The Emergency Safety Intervention Justification Form will be completed by the Registered Nurse following the situation.
4. The Observation Flow Sheet on the reverse of the justification form must have an entry by the Registered Nurse at least every fifteen (15) minutes; the observation of the resident must be constant.

G. Physical Restraint and Seclusion Debriefing:

1. Staff involved in the emergency safety intervention as well as an appropriate supervisory staff and/or administrative team member and the resident both participate in a face-to-face discussion within twenty-four (24) hours of the emergency safety intervention. This discussion may also include other staff and the resident's parent(s) and/or legal guardian(s) when it is deemed appropriate. The discussion must be in a language that is understood by all parties. The discussion will include:
   a. The circumstances that resulted in the use of physical restraint or seclusion.
   b. Alternative techniques that might have prevented the use of the intervention of physical restraint or seclusion.
   c. Procedures, if any, that staff are to implement to prevent any recurrence of the use of physical restraint; and the outcome of the intervention, including any injuries that may have resulted from the use of physical restraint or seclusion.
   d. The resident will complete a debriefing form and it will be placed in the resident's chart behind the Emergency Safety Intervention Justification form. This will be conducted within twenty-four (24) hours. A separate debriefing of staff involved will be held. The Director of Nursing and the Medical Director or designee conduct a daily review of each occurrence.

2. Serious Injury Occurrence: If a staff member or resident receives a serious injury during an emergency safety intervention, the staff involved will debrief with the supervisor. A body assessment completed, identifying any injuries to staff or resident that occurred during the time of the emergency safety intervention. Identification of the cause of the injury and a description of the injury will be documented on the body assessment form included in the Emergency Safety Intervention Justification form. This form is to be filed in the resident's medical record following the ESI Justification form. During the debriefing, staff involved will determine what can be done to prevent such injuries during the ESI in the future. The staff involved may receive 1:1 retraining from the certified Crisis Prevention Institute techniques instructor to prevent potential injuries in the future. All serious injuries will be reported to the Office of Long Term Care and Disability Rights Center by the close of business the next day.

H. Seclusion Guidelines:

1. When a resident is placed in seclusion, the resident is searched to assure there are no objects on his or her person other than necessary clothing. All jewelry, belts, and other potentially harmful objects will be removed. More than one staff member must be present during the search.

2. When a resident is in the seclusion room he or she must be under Constant 1:1 observation of clinical staff trained in the use of emergency safety interventions (Crisis Prevention Institute techniques trained).
3. Be observant of the resident's general condition. Report anything unusual to the Charge Nurse.
4. If the resident has to use the bathroom, he or she must be supervised by one staff that is the same gender as the resident.
5. Any verbal communication with the resident should be reassuring and supportive. Assess readiness to process and report to the Charge Nurse.
6. Seclusion will not be used in a manner that causes physical discomfort, harm, or pain to the resident.

I. Physical Restraint and Seclusion Evaluation and Performance Improvement Activities:
1. The Director of Nursing or designee will review each use of chemical restraint, physical restraint, and/or seclusion daily and will investigate unusual or unwarranted patterns.
2. As part of the Committee of the Whole meetings, the Safety, Risk Management, and Infection Control Committee will review the use of physical restraint and seclusion each month to assess ways in which to create a social and cultural environment which limits physical restraint and seclusion use to clinically appropriate and adequately justified situations.
3. As part of the Committee of the Whole meetings, the Performance Improvement Committee shall assign Interdisciplinary Work Groups to address any trends and/or patterns of use and work towards elimination of seclusion and physical restraint.

J. Admission Notification for Emergency Safety Intervention:
1. Piney Ridge Treatment Center will inform both the incoming resident and, in the case of a minor, the resident's parent (s) or legal guardian (s) of the facility's policy regarding the use of restraint or seclusion during an emergency safety situation that may occur while the resident is in the program.
2. Facility will communicate its restraint and seclusion policy in a language that the resident, or his or her parent (s) or legal guardian (s) understands (including American Sign Language, if appropriate) and when necessary, the facility must provide interpreters or translators.
3. Facility will obtain an acknowledgement, in writing, from the resident, or in the case of a minor, from the parent (s) or legal guardian (s) that he or she has been informed of the facility's policy on the use of restraint or seclusion during an emergency situation safety situation. Staff to file this acknowledgement in the resident's record and provide a copy of the facility policy to the resident and in the case of a minor, to the resident's parent (s) or guardian (s).
4. Family or guardian (s) of resident and resident to be provided contact information for child Abuse hotline phone 1-800-482-5964. Children's advocacy centers, 124 West Capitol Ave, suite 865, Little Rock, AR, 72201 phone 501-615-8633. Arkansas Department of Human Services, Donaghey Plaza, P.O. Box 1437, Little Rock, AR, 72203, phone 501-682—1001.

PRTC
PINEY RIDGE TREATMENT CENTER

SERIOUS OCCURRENCE MONITORING

DATE: _____ **# OF SERIOUS OCCURRENCES:** _____

RESIDENTS WITH SERIOUS OCCURRENCES: _____

_____

Indicators	Yes	No	N/A	Comment
1. NOTIFICATION MADE TO STATE MEDICAID AGENCY				
2. NOTIFICATION MADE TO STATE DESIGNATED PROTECTION AND ADVOCACY SYSTEM				
3. COPY OF NOTIFICATION REPORTS PLACED IN RESIDENT'S CHART				
4. COPY OF NOTIFICATION REPORT PLACED IN THE INCIDENT/ACCIDENT LOG				

Comments: _____

_____

_____

_____

Reviewed By: _____ **Date:** _____ **Time:** _____

[redacted] FAYETTEVILLE, AR [redacted] • TEL [redacted] • FAX [redacted]

PRTC
PINEY RIDGE TREATMENT CENTER

AFFIX RESIDENT LABEL HERE

SECLUSION AND RESTRAINT WORKSHEET

Privileged and Confidential for PI/QI Purposes Only

MR# _____ **Resident Name:** _____ **Nurse on Duty:** _____

ESI Date: _____ **ESI Time:** _____ **Order Time:** _____

Measure: ESI Documentation
Benchmark: 100%
Sample: 100% (30 ESI Forms reviewed monthly)
Data Sources: ESI Paperwork (seclusion, restraint, chemical restraint)

Indicators	Yes	No	N/A	Comment
1. The ESI Form documents the resident's date, time of ESI, and release from restraint or seclusion.				
2. The ESI Form documents the ordering physician and date and time order received.				
3. The ESI form documents one hour face to face completed within one hour of initiation of the ESI.				
4. The ESI Form documents Resident Debriefing within 24 hours of ESI.				
5. The ESI Form documents Staff Debriefing within 24 hours of the ESI and completed after Resident Debriefing.				
6. Guardian Notified of ESI.				
7. ESI Forms, after completion, are reviewed and signed by the Director of Nursing.				
8. The ESI Form documents supervisor or administrator review.				
9. The ESI Order is signed, dated, and timed ASAP.				
10. Seclusion and Restraint did not occur simultaneously.				

Comments: _____

_____

_____

_____

Reviewed By: _____ **Date:** _____ **Time:** _____

20191011 Piney Ridge OLTC POC RESPONSE-REVISED SIGNED [Redacted]

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

PRINTED: 10/23/2019
FORM APPROVED
OMB NO. [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] FAYETTEVILLE, AR [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A Complaint investigation was conducted from 10/8/19 through 10/11/19. Complaint # [redacted] was substantiated, all or in part, with deficiencies cited at N0131 and N0209.	N 000	N131 PROTECTION OF RESIDENTS Step #1 Corrective Action: On, 10/23/2019, upon notification of deficient practice, the DON observed/ checked (to verify no restraint or seclusion moving forward was administered simultaneously) to ensure chemical restraint and Seclusion is not used simultaneously to assure the safety of resident #1, #2, #3, #4, #6, #7, #8, #9, and #10. No additional negative findings were found. Step #2 Identification of others with the potential of being affected: On, 10/23/19, DON through Emergency safety intervention log and immediately identified 18 residents in the last 90 days who had the potential to be affected from the deficient practice by (Don reviewed each emergency safety intervention listed with chemical restraint and seclusion used simultaneously) DON observed/ checked to ensure chemical restraint and seclusion is not used simultaneously in future to determine if those residents were affected. Any negative findings were corrected immediately.	11/06/19
N 131	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center PROTECTION OF RESIDENTS CFR(s): 483.356(a)(4) Restraint and seclusion must not be used simultaneously. This ELEMENT is not met as evidenced by: Complaint [redacted], was substantiated, all or in part, in these findings. Based on record review and interviews, the	N 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] | TITLE: Director of Nursing | (X6) DATE: 11/06/19

Any defi[redacted]notes 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 131	Continued From page 1 facility failed to ensure a chemical restraint and seclusion were not used simultaneously used to assure the safety of 9 of 9 (Resident #1, #2, #3, #4, #6, #7, #8, #9, and #10) case mix residents who were chemically restrained while in seclusion. The findings are: 1. Resident #1 had diagnoses of Disruptive Mood Dysregulation Disorder, Posttraumatic Stress Disorder, Attention Deficit Hyperactivity Disorder and Reactive Attachment Disorder. a. Emergency Safety Intervention Justification Progress Note had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint. "Restraint ...Date and Time Actually Placed in Restraint Date: 9/10/19 Time: 1225 [12:25 p.m.] Date & [and] Time Removed from Restraint Date: 9/10/19 Time: 1236 [12:36 p.m. Date & Time Restraint Order Received form MD [Medical Doctor] Date: 9/10/19 Time: 1225 [12:25 p.m.] ... Resident Behavior... Aggression toward staff, hitting, kicking, punching ... Seclusion ...Date and Time Actually Placed in Seclusion Date: 9/10/19 Time: 1236 [12:36 p.m.] Date & Time Removed from Restraint Date: 9/10/19 Time: 1300 [1:00 p.m.] Date & Time Restraint Order Received form MD Date: 9/10/19 Time: 1225 [12:25 p.m.] Resident Behavior... Secluded related to aggression for safety, until calm as evidenced by screaming, cussing, kicking staff and banging on quite room windows. Chemical Restraint Date & Time Restraint Order Received form MD Date: 9/10/19 Time: 1225 [12:25 p.m.] Date &Time Nurse Actually	N 131	Step #3 To ensure deficient practice does not recur: On 10/16/2019, 11/06/2019, the DON/ Designee in-serviced nurses to ensure chemical restraint and seclusion is not used simultaneously. The Emergency Safety Intervention policy was also updated to ensure no seclusion or restraint is administered simultaneously. If nurse not present he or she has been or will be in-serviced prior to working next shift. The nursing department competency checklists were also updated to ensure competency monitoring. Step #4 Monitoring: DON and administrative assistant to the DON will monitor to ensure chemical restraint and Seclusion is not used simultaneously by observation and documenting on emergency safety intervention checklist, each business day weekly for 8 weeks or until compliance is verified by OLTC. Any negative findings will be corrected immediately and DON notified. Completion Date: 11/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

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N 131	Continued From page 2 Administered Chemical Restraint Date: 9/10/19 Time: 1235 [12:35 p.m.] b. Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint. "Restraint ...Date and Time Actually Placed in Restraint Date: 9/15/19 Time: 1400 [2:00 p.m.] Date & Time Removed from Restraint Date: 9/15/19 Time: 1420 [2:20 p.m.] Date & Time Restraint Order Received form MD Date: 9/15/19 Time: 1415 [2:15 p.m.]... Resident Behavior...Resident started punching staff as they were redirecting and trying to guide resident from the fence outside. Restrained for safety. Seclusion... Date and Time Actually Placed in Seclusion Date: 9/15/19 Time: 1420 [2:20 p.m.] Date & Time Removed from Seclusion Date: 9/15/19 Time: 1425 [2:25 p.m.] Date & Time Restraint Order Received form MD Date: 9/15/19 Time: 1415 [2:15 p.m.]. Resident Behavior...While in restraint resident was jerking his body around in attempt to throw staff off balance. Resident bit staff and attempted to kick staff. Secluded for safety. Chemical Restraint... Date & Time Restraint Order Received form MD Date: 9/15/19 Time: 1415 [2:25 p.m.]. Date &Time Nurse Actually Administered Chemical Restraint Date: 9/15/19 Time: 1420 [2:20 pm.] Medication administered: Zyprexa/Benadryl Dosage: 10 mg [Zyprexa]/50 mg [Benadryl] Route: IM ... Resident Behavior... While in seclusion resident behavior continued to escalate. Resident screaming, slams head against wall, kicks seclusion room door multiple	N 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 131	Continued From page 3 times, punches wall. Chemical restraint administered for safety. The progress note was signed by the physician on 9/16/19. 2. Resident #4 had diagnoses of Major Depressive Disorder, Oppositional Defiant Disorder, Autism Spectrum, and Child Neglect. a. Emergency Safety Intervention Justification Progress Note had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint. "Restraint ...Date and Time Actually Placed in Restraint Date: 9/6/19 Time: 1240 [12:40 p.m.] Date & Time Removed from Restraint Date: 9/10/19 Time: 1245 [12:45 p.m.] Date & Time Restraint Order Received form MD Date: 9/6/19 Time: 1248 ...Resident Behavior ... Resident flipping filing cabinets, rolling in the carpet and tried to call 911 on teacher's phone, kicking staff when they redirected resident. Seclusion...Date and Time Actually Placed in Seclusion Date: 9/6/19 Time: 1245. Date & Time Removed from Restraint Date: 9/10/19 Time: 1300 [1:00 p.m.] Date & Time Restraint Order Received form MD Date: 9/10/19 Time: 1248. Resident Behavior...While in restraint resident continued to try and trip staff and spit on staff calling her a whore, slammed body into staff. Chemical Restraint...Date & Time Restraint Order Received form MD Date: 9/6/19 Time: 1248. Date &Time Nurse Actually Administered Chemical Restraint Date: 9/6/19 Time: 1252	N 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

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N 131	Continued From page 4	N 131		

[12:52 p.m.]. Medication administered: Thorazine/Benadryl Dosage 100 mg/100 mg Route: IM ... Resident Behavior... Resident continued to throw objects at staff and threaten staff...

The progress note was signed by the physician on 9/6/19 at 3:00 p.m.

3. Resident #6 had diagnoses of Unspecified Trauma and Stressor related Disorder, Borderline Intellectual Functioning, and Physical Abuse.

a. Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint.

"Restraint ...Date and Time Actually Placed in Restraint Date: 9/15/19 Time: 1546 (3:46 p.m.) Date & Time Removed from Restraint Date: 9/15/19 Time: 1555 [3:55 p.m.] Date & Time Restraint Order Received form MD Date: 9/15/10 Time: 1546... Resident Behavior... Resident was throwing cups on the unit which upset one of his peer to where resident tried to fight the peer but staff intervene and got hit by resident.

Seclusion...Date and Time Actually Placed in Seclusion Date: 9/15/19 Time: 1555
Date & Time Removed from Seclusion Date: 9/15/19 Time: 1625 [4:25 p.m.]
Date & Time Seclusion Order Received form MD Date: 9/15/19 Time: 1546...
Resident Behavior...While in restraint resident was shoving his body against staff trying to break the restraint.

Chemical Restraint ... Date & Time Restraint

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 131	Continued From page 5 Order Received form MD Date: 9/15/19 Time: 1546 Date &Time Nurse Actually Administered Chemical Restraint Date: 9/15/19 Time: 1550 [3:50 p.m.] Medication Administered; Thorazine/Benadryl Dosage 50 mg/50 mg Route: IM ...Resident Behavior...While in time out room resident started banging his head into the wall over and over, refusing to regain control of his behavior ..." The progress note was signed by the physician on 9/20/19. b. Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint. "Restraint ...Date and Time Actually Placed in Restraint Date: 9/19/19 Time: 1920 [7:20 p.m.] Date & Time Removed from Restraint Date: 9/19/19 Time: 1928 [7:28 p.m.] Date & Time Restraint Order Received form MD Date: 9/15/10 Time: 1925 [7:25 p.m.] ... Resident Behavior... Resident was in dayroom, horseplaying with peers. They were both antagonizing each other then both became very aggressive. Resident continued trying to fight peer and they had to be separated. Resident was restrained for his safety and others as he keep kicking peer. Seclusion...Date and Time Actually Placed in Seclusion Date: 9/19/19 Time: 1928 Date & Time Removed from Seclusion Date: 9/19/19 Time: 1945 [7:45 p.m.] Date & Time Restraint Order Received form MD Date: 9/19/19 Time: 1925 ... Resident Behavior... While resident was being restrained, he continue hitting and fighting,	N 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 131	Continued From page 6 kicking staff and banging his head in the wall Secluded for his safety. Chemical Restraint...Date & Time Restraint Order Received form MD Date: 9/19/19 Time: 1925 Date & Time Nurse Actually Administered Chemical Restraint Date: 9/15/19 Time: 1927 [7:27 p.m.] Medication Administered" Zyprexa/Benadryl Dosage: 10mg/50 mg Route: IM ... Resident Behavior...While resident was still being restrained, he continued kicking, hitting staff and banging his head into the wall. An order to give IM received from MD (Medical Doctor) on call ..." c. Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint. "Restraint ...Date and Time Actually Placed in Restraint Date: 9/21/19 Time: 2351 [11:51 p.m.] Date & Time Removed from Restraint Date: 9/22/19 Time: 0005 [12:05 a.m.] Date & Time Restraint Order Received form MD Date: 2/21/19 Time: 2356 [11:56 p.m.]... Resident Behavior...Resident in room screaming, climbing on bed and repeatedly finding items to harm self with. Resident became aggressive and began to attack any staff that tried to process or intervene. Seclusion ...Date and Time Actually Placed in Seclusion Date: 9/22/19 Time: 0005 Date & Time Removed from Seclusion Date: 9/22/19 Time: 0023 [12:23 a.m.] Date & Time Seclusion Order Received form MD Date: 9/21/19 Time: 2356. Resident Behavior...Resident beating own head, screaming trying to tie clothing around own neck,	N 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 131	Continued From page 7	N 131		

took all object resident could harm self with and allowed to calm in seclusion.

Chemical Restraint...Date & Time Chemical Restraint Order Received form MD Date: 9/21/19 Time: 2356 Date &Time Nurse Actually Administered Chemical Restraint Date: 9/22/19 Time: 0001 [12:01 a.m.] Medication Administered: Thorazine/Benadryl Dosage: 100mg/100 mg Route: IM ...Resident Behavior... Resident began to hit and kick staff spitting and scratching at staff when they blocked his blows, kicking in restraint repeatedly. Bashing his own head on walls and floors ..."

This progress note was signed by the physician on 9/22/19 at 10:00 a.m.

4. Resident #7 had diagnoses of Unspecified Trauma and Stressor Related Disorder, Non-parental Child Sexual Abuse.

Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint.

Restraint [#1] "...Date and Time Actually Placed in Restraint Date: 9/18/19 Time: 0820 [8:20 a.m.] Date & Time Removed from Restraint Date: 9/18/19 Time: 0823 [8:23 a.m.] Date & Time Restraint Order Received form MD Date: 9/18/19 Time: 0825 [8:25 a.m.] ... Resident Behavior... #1. Resident pounding fist and kicking windows and doors of nursing station. Refused verbal redirect."

Restraint [#2] "...Date and Time Actually Placed in Restraint Date: 9/18/19 Time: 0900 [9:00 a.m.] Date & Time Removed from Restraint Date:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 131	Continued From page 8 9/18/19 Time: 0907 [9:07 a.m.] Date & Time Restraint Order Received form MD Date: 9/18/19 Time: 0903 [9:03 a.m.]... Resident Behavior...#2. Resident attacked peers and staff, punching, hitting and kicking. Seclusion...Date and Time Actually Placed in Seclusion Date: 9/18/19 Time: 0907 Date & Time Removed from Seclusion Date: 9/18/19 Time: 0937 [9:37 a.m.] Date & Time Seclusion Order Received form MD Date: 9/18/19 Time: 0903 ... Resident Behavior...Resident continued to push and pull against staff. Resident was secluded for safety following chemical restraint. Chemical Restraint...Date & Time Restraint Order Received form MD Date: 9/18/19 Time: 0905 [9:05 a.m.] Date &Time Nurse Actually Administered Chemical Restraint Date: 9/18/19 Time: 0903 Medication Administered: Zyprexa/Benadryl Dosage: 10 [mg]/50 [mg] Route: IM Resident Behavior... Resident unable to calm Attacked staff and peers when he re-escalated. Refused direction ..." This progress note was signed by the physician on 9/18/19 at 10:00 a.m. 5. Resident #8 had diagnoses of Posttraumatic Stress Disorder, Chronic. Unspecified Disruptive, Impulse Control, Conduct Disorder and Attention Deficit Hyperactivity Disorder. a. Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint.	N 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 131	Continued From page 9	N 131		

"Restraint ...Date and Time Actually Placed in Restraint Date: 9/28/19 Time: 1740 [5:40 p.m.] Date & Time Removed from Restraint Date: 9/28/19 Time: 1746 [5:46 p.m.] Date & Time Restraint Order Received form MD Date: 9/28/19 Time: 1745 [5:45 p.m.]... Resident Behavior... Resident was on the unit aggressively chasing one of his peers on the unit, attempting to choke this peer as staff tried to intervene and redirect resident to stop. He would cuss at the staff and continue on chasing peer threatening to choke his peer, he slapped staff and kicked peer. Restrained for safety.

Seclusion ...Date and Time Actually Placed in Seclusion Date: 9/28/19 Time: 1746 Date & Time Removed from Seclusion Date: 9/28/19 Time: 1800 [6:00 p.m.]...
Date & Time Seclusion Order Received form MD Date: 9/28/19 Time: 1745...
Resident Behavior...When in restraint, resident started to cuss and kick the two staff that had him in CPI [Crisis Prevention Intervention] restraint then started to slam himself into staff refusing to stop. Secluded for safety.

Chemical Restraint...Date & Time Chemical Restraint Order Received form MD Date: 9/28/19 Time: 1745 Date &Time Nurse Actually Administered Chemical Restraint Date: 9/28/19 Time: 1750 [5:50 p.m.] Medication Administered: Benadryl/Zyprexa Dosage: 50 mg/10mg Route IM/IM Resident Behavior...Continued to cuss and kick the two staff that had him in a restraint refusing to regain control over his emotions and body..."

This progress note was signed by the physician on 9/28/19 at 7:00 p.m.

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	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 131	Continued From page 10 b. Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint. "Restraint ...Date and Time Actually Placed in Restraint Date: 10/6/19 Time: 0809 [8:09 a.m.]Date & Time Removed from Restraint Date: 10/6/19 Time: 0813 [8:13 a.m.]Date & Time Restraint Order Received form MD Date: 10/6/19 Time: 0810 [8:10 a.m.]... Resident Behavior...Resident in bedroom, Physical aggression toward peer and staff members. Resident attempted to punch peer. Staff stepped between the residents. Resident proceeded to punch a nurse and two staff members. Restrained for safety. Seclusion...Date and Time Actually Placed in Seclusion Date: 10/6/19 Time: 0813 Date & Time Removed from Seclusion Date: 10/6/19 Time: 0840 [8:40 a.m.] Date & Time Seclusion Order Received form MD Date:10/6/19 Time: 0810... Resident Behavior... Continued physical aggression while restrained. Resident was kicking a staff member. Resident was kicking the doors. Secluded for safety. Chemical Restraint...Date & Time Restraint Order Received form MD Date: 10/6/19 Time: 0810 Date &Time Nurse Actually Administered Chemical Restraint Date: 10/6/19 Time: 0812 [8:12 a.m.] Medication Administered: Zyprexa 10 [mg]/Benadryl 50 [mg] Dosage: 10/50 Route: IM ...Resident Behavior...Continued aggression towards staff. Resident kicking the quite room door. Banging on the windows. Medicine given for safety."	N 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

(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
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6. Resident #2 had diagnoses of Disruptive Mood Dysregulation Disorder, Other Specified Trauma and Stressor Related Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation; Child Sexual Abuse, Confirmed, Subsequent Encounter; academic or Educational Problem; and Encounter for Mental Health Services for Perpetrator of Non-parental Child sexual Abuse.

Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint.

"Restraint ... "Date & Time Actually Placed in a Restraint Date: 9/21/19 Time: 1917 [7:17 p.m.] Date & Time Removed from Restraint Date: 9/21/19 Time:1925 [7:25 p.m.] Date & Time Restraint Order Received from MD Date: 9/21/19 Time 1918 [7:18 p.m.]. . . Fist fighting c [with] a peer on the unit repeatedly, going back to threaten and fight, punch over and over again.

Seclusion ... Date & Time Actually Placed in Seclusion Date 9/21/19 Time: 1925 Date & Time removed from Seclusion Date: 9/21/19 Time: 1940 [7:40 p.m.] Date & Time Seclusion Order Received from MD Date: 9/21/19 Time: 1918.

Chemical Restraint ... Date & Time Chemical Restraint Order Received from MD Date: 9/21/19 Time: 1923 [7:23 p.m.] Date & Time Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 131	Continued From page 12 Actually Administered Chemical Restraint Date: 9/21/19 Time: 1924 [7:24 p.m.] Medication Administered: Thorazine/Benadryl Dosage: 100 mg/100 [mg] Route: IM ... Resident Behavior ... [Resident] fighting with staff in restraint, shoving, kicking, biting and scratching in restraint ..." This progress note was signed by the physician on 9/22/19 at 10:00 a.m. 7. Resident #3 had diagnoses of Disruptive Mood Dysregulation Disorder; Posttraumatic Stress Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation; Child Sexual Abuse, Suspected, Subsequent Encounter; and Child Neglect, Confirmed, Subsequent Encounter. Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint. "Restraint ... Date & Time Actually Placed in Restraint Date: 9/22/19 Time 1110 [11:10 a.m.] Date & Time Removed from Restraint Date: 9/22/19 1119 [11:19 a.m.] Date & Time Restraint Order Received from MD Date: 9/22/19 Time:1109 [11:09 a.m.]. . .R [Resident] took a pen from one of his staff and started hitting staff over and over as he was being redirected to give up the pen. R then threaten to stab staff with the pen. R was restrained for safety. Seclusion Date & Time Actually Placed in Seclusion Date 9/22/19 1120 [11:20 a.m.] Date & Time Removed from Seclusion 9/22/19 1145 [11:45 a.m.] Date & Time Seclusion Order Received from MD 9/22/19 1109 Resident Behavior ...While in a restraint R started kicking	N 131		

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	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 131	Continued From page 13 staff and one nurse over and over threatening to kill them refusing to regain control of behavior. Chemical Restraint Date & Time Chemical Restraint Order Received from MD Date: 9/22/19 Time: 1120 Date & Time Nurse Actually Administered Chemical Restraint Date: 9/22/19 Time: 1119 [11:19 a.m.] Medication Administered: Zyprexa 10 [mg]/Benadryl Dosage 10/50 [mg] Route: IM ... Resident Behavior Continued to kick staff and nurse while threatening to kill staff not regaining control of emotions and behavior." 8. Resident #9 had diagnoses of Autism Spectrum Disorder; Unspecified Trauma and Stressor Related Disorder; Encounter for Mental Health Services for Perpetrator of Non-parental Child Sexual Abuse; Child Sexual Abuse, Confirmed, Subsequent Encounter; and Child Physical Abuse, Confirmed, Subsequent Encounter. Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint. "Restraint ... Date & Time Actually Placed in Restraint Date:9/29/19 Time: 1210 pm [12:10 p.m.] Date & Time Removed from Restraint Date: 9/29/19 Time: [unable to determine] Date & Time Restraint Ordered from MD 9/29/19 1216 pm [12:16 p.m.] ... Resident Behavior... R was upset with a peer because he felt that a peer poop his free time ball. So R threw his ball in his peers face which caused peer to try fight R but staff intervene and removed peer but R started punching staff in the face while trying to get to peer ...	N 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 131	Continued From page 14 Seclusion ... Date 9/29/19 Time 1221 [12:21 p.m.] Date and Time Removed from Seclusion 9/29/19 1250 [12:50 p.m.]. Date and Time seclusion Order Received from MD Date: 9/29/19 Time: 1216 ... Resident Behavior ...R was continuing to be aggressive with staff and yelling cussing and kicking at the time out room door ... Chemical Restraint ... Date & Time Chemical Restraint Order Received from MD Date: 9/29/19 Time 1216 Date & Time Nurse Actually Administered Chemical Restraint Date 9/29/19 Time 1221 [12:21 p.m.] Medication Administered: Zyprexa/ Benadryl Dosage: 10mg/50 mg Route IM/IM ... Resident Behavior ... Kicking door in time out room while cussing and threatening his peers. Refusing to regain control even as staff was trying to process him down." 9. Resident #10 had diagnoses of Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder, Combined Presentation; Child Physical Abuse, Confirmed, Initial Encounter; Child Sexual Abuse, Suspected, Subsequent Encounter; and Intellectual Disability. Mild. Emergency Safety Intervention Justification Progress Note (had an X in the box next to Restraint, next to Seclusion and next to Chemical Restraint. "Restraint ... Date & Time Actually Placed in Restraint Date: 9/22/19 Time: 1740 [5:40 p.m.] Date & Time Removed from Restraint Date: 9/22/19 Time: 1743 [5:43 p.m.] Date & Time Restraint Order Received from MD Date: 9/22/19 Time: 1735 [5:35 p.m.] ... Resident Behavior ...	N 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 131	Continued From page 15	N 131		

Resident tried busted through west unit trying to get to outside, then went to seclusion room and turned to staff. Threatening et [and] positioning to stab them with a pencil. Resident placed in 2 person standing restraint after continued beating on door et window ...

Seclusion ... Date & Time Actually Placed in Seclusion Date 9/22/19 Time #1 1730 [5:30 p.m.] /#2 1743 [5:43 p.m.]. Date & Time Removed from Seclusion 9/22/19 Time #1 1740 [5:40 p.m.] / #2 1810 [6:10 p.m.]. Date and Time Seclusion Order Received from MD Date: 9/22/19 Time: 1735 ... Resident Behavior ... Resident broke into laundry room several times. Angry. Posturing staff. Tried to bust out west outside door but then walked into seclusion room. Slammed door and started hitting window [with] fist. door then locked. #2 Resecluded following Thorazine 50 et Benadryl 100 mg IM for Dyscontrol for safety until calm.

Chemical Restraint ... Date & Time Chemical Restraint Order Received from MD 9/22/19 1735 Date & Time Nurse Actually Administered Chemical Restraint Date 9/22/19 Time: 1743 [5:43 p.m.] Medication Administered: Thorazine/ Benadryl Dosage: 50/100 [mg] Route: IM ... Resident Behavior ...Continued aggression hitting et kicking seclusion room door et window. Threatening staff. Posturing."

10. On 10/11/19 at 9:03 a.m., the Director of Nursing was asked, "What is your criteria for the use of a physical restraint, seclusion and chemical restraint?" She stated, "Imminent harm to self and others. I will just read you from the policy." She was asked, "Should a chemical restraint and seclusion be used simultaneously?" She stated, "No, they should not be used

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 131	Continued From page 16 simultaneously." N 209 FACILITY REPORTING CFR(s): 483.374(b)(3) Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State designated Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility. This ELEMENT is not met as evidenced by: Complaint [redacted], was substantiated, all or in part, in these findings. Based on record review and interview, the facility failed to ensure a serious occurrence report was maintained in the clinical record for easy reference for 2 of 2 (Residents #11 and #12) of case mix residents who had a serious occurrence report. The findings are: 1. A Serious Injury Reporting Form documented, "8/9/19 - Resident [Resident #11] ... was outside playing with 10 other residents and two staff were monitoring them one resident ran to one fence and started climbing it. [Resident #11] then ran to another fence and climbed it. Staff requested [Resident #11] come down immediately and he turned around and started sliding down the fence to come down. [Resident #11's] left arm started to connect or catch on the fence link. He then jumped down, he was knocked to the ground when jumping and landed on his left arm. He	N 131 N 209	N209 FACILITY REPORTING Step #1 Corrective Action: On, 10/23/2019, upon notification of deficient practice, the DON observed/ checked (made copies of the notification and documentation of serious occurrence and placed in the client's clinical record) to ensure serious occurrence report is maintained in the clinical record for easy reference for residents #11 and #12. No additional negative findings were found. Step #2 Identification of others with the potential of being affected: On, 10/23/2019, the DON through looking at serious occurrence binder for the past 90 days immediately identified 3 residents who had the potential to be affected from the deficient practice by (the charts of these 3 residents were checked to verify each notification and documentation was currently placed in the chart) Administrative assistant to the DON observed/checked to ensure serious occurrence report was maintained in the clinical record for easy reference to determine if those residents were affected. Any negative findings were corrected immediately.	11/06/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] FAYETTEVILLE, AR [redacted]

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N 209	Continued From page 17 reported immediate pain. Nurses came to him and helped him inside where he was immediately seen by his PCP [Primary Care Physician] who was at the facility seeing routine patients. PCP MD [Medical Doctor] ordered 911 to be called as [Resident #11's] pain was extreme. [Resident #11] was brought via ambulance to [hospital] and treated for left elbow injury with effusion - an early fracture. Splint applied, order for Tylenol of Motrin for pain and appointment made for orthopedic MD for X-rays and cast." The form documented the Office of Long Term Care (OLTC) and Disability Rights of Arkansas (DRA) were notified by fax on 8/12/19 at 9:24 a.m. 2. A Serious Injury Reporting Form documented, "9/10/19 - Resident [Resident #12] ...was playing outside during recreational time. Resident climbed part way up a fence and caught right hand on the top of fence. Resident came down and went to nurse's station immediately. Right and left hands washed thoroughly with soap and water. 1 x [by] 1/8 inch laceration present, gauze dressing applied for pressure. MD orders [Resident #12] to be taken to [hospital] for evaluation. 2 sutures placed on right hand that will be removed 9/20/19. Primary care physician follows up 9/11/19, orders over the counter triple antibiotic ointment." The form documented OLTC and DRA were notified by fax on 9/12/19 at 10:57 a.m. 3. On 10/11/19 at 9:03 a.m., the Director of Nursing was asked if there was documentation in the resident's chart that notifications were made to the appropriate agencies. The Director of Nursing stated, "No. I just keep the fax and documentation in a file."	N 209	Step #3 To ensure deficient practice does not recur: On 11/06/2019, the DON in-serviced nursing staff present and will in-service any nurse unable to attend prior to their next shift to work to ensure serious occurrence report is maintained in the clinical record for easy reference. Step #4 Monitoring: Administrative assistant to DON will monitor to ensure serious occurrence report is maintained in the clinical record for easy reference by observation and documenting on serious occurrence checklist, each business day for 8 weeks or until compliance is verified by OLTC. Any negative findings will be corrected immediately and DON notified. Completion Date: 11/06/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 209	Continued From page 18 4. The Policy: Emergency Safety Interventions provided by the Director of Nursing on 10/10/19 at 9:11 a.m. documented, "Serious Injury Occurrence . . .This form is to be filed in the resident's medical record following the ESI (Emergency Safety Intervention) Justification form."	N 209		

20191126 Piney Ridge AR DHS CAP Agreement signed [Redacted]

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care and Early Childhood Education

P.O. Box 1437, Slot S140 · Little Rock, AR 72203-1437
501-682-8590 · Fax: 501-683-6060 · TDD: 501-682-1550

Corrective Action Agreement

Date: November 26, 2019
Agency: Piney Ridge Treatment Center
License Number: [redacted]

This document constitutes a formal Corrective Action Agreement between Piney Ridge Treatment Center and The Division of Child Care and Early Childhood Education, Placement and Residential Licensing Unit. This Corrective Action Agreement will be in effect for a period of six months from the date of signing by both parties. This agreement may be extended beyond the date if the agency experiences any serious non-compliance during the corrective action period.

The purpose of this agreement is to gain and maintain a high degree of compliance with licensing requirements. The following non-compliance areas have been cited during the past six months.

Minimum Licensing Standards (Residential): Section 1005 – Behavior Management

- **1005.1 – Behavior Management: "The agency shall have a written discipline policy that is consistently followed".**
- **1005.2 – Behavior Management: "Discipline shall be directed toward teaching the child acceptable behavior and self-control".**
- **1005.3 – Behavior Management: "Discipline shall be appropriate to the child's age, development, and history".**
- **1005.4h – Behavior Management: "The following actions shall not be used, including as discipline: "Physical injury or threat of bodily harm".**

Piney Ridge Treatment Center has agreed to implement the following:

- Staff will not use physical discipline as a means of correcting a child's behavior.
- The facility shall abide by all the Behavior Management requirements as listed in Section 1005 of The Minimum Licensing Requirements for Sexual Rehabilitative Programs.
- Staff will participate in an overview of Trauma Informed Care and Conscious Discipline. These trainings will be provided by The Division of Childcare and Early Childhood Education (DCCECE).

This document is intended to clarify any outstanding issues and to reduce the risk of misunderstanding or miscommunication. During the probationary provisional time frame, frequent unannounced monitoring visits will be made to assure compliance.

Please be advised that any serious non-compliance cited during this corrective action period may result in a recommendation for adverse action on the license. Any serious violation of this corrective action plan will result in a recommendation for adverse action on the license.

Please do not hesitate to contact the Division of Child Care and Early Childhood Education, Placement and Residential Licensing Unit, if you have any questions or concerns regarding ongoing compliance with this agreement or any licensing requirement.

The signature of the licensee constitutes full acceptance of the provisions of this agreement.

[redacted] CEO 12.4.19
Owner/Director Date

[redacted] 12-4-19
Licensing Specialist Date

[redacted] 12-4-19
Licensing Supervisor Date

20191126 Piney Ridge Licensing CAP Recommendations Letter [Redacted]

November 26, 2019

Piney Ridge Treatment Center

Psychiatric Residential Treatment Facility/Sexual Rehabilitative Program

[redacted]

Fayetteville, AR [redacted]

Dear Provider,

After a records review for year 2019, it has been determined by the Management of the Placement and Residential Licensing Unit that Piney Ridge Treatment Center could benefit from a Corrective Action Plan. The identified concerns regarding the Piney Ridge Treatment Center are the results of how the direct care staff at your facility responded to incidents involving youth at the facility. Section 1005 Behavior Management – Sexual Rehabilitative Programs – Minimum Licensing Standards were cited. Listed below are the standards that have been cited with a True licensing complaint.

Compliance Notice dated 8/20/19: (Discussed a previous incident that occurred on 3/23/19)

1005.3/4 "Discipline shall be appropriate to the child's age, development, and history. The following shall not be used as a form of discipline"; "h. physical injury or threat of bodily harm."

The licensing Complaint was found "True".

No additional corrective action was required. The involved staff is no longer employed by the agency.

Nature of Complaint: The report alleges that on 3/23/19 a child had a towel and was snapping it at other residents. Staff (1) obtained the towel and was snapping it back at him to illustrate what not to do and the towel contacted his hand.

- **Interim Corrective Action:** Staff was suspended pending the outcome of the investigation.
- **Findings: True Licensing Complaint**. Staff did violate the agency policy. Cited 1005.2 "Discipline shall be directed toward teaching the child acceptable behavior and self-control." Unsubstantiated maltreatment report.
- **Corrective Action:** The staff member's last date of employment was 4/4/19.

Compliance Notice dated 7/22/19: Cited 1005.1 – The agency shall have a written discipline policy that is consistently followed. The licensing complaint was founded as "true". The incident occurred on 4/1/19. No additional corrective action was indicated. The involved staff member is no longer employed with the agency.

Nature of Complaint: The report alleges that on 4/1/19, the child reported that staff threw him across the timeout room. This allegedly occurred when the child was being transported to the seclusion room.

- **Interim Corrective Action:** The staff member was terminated for violating agency policy.
- **Findings:** "True" Licensing Complaint. Cited 1005.1
- **Corrective Action:** Staff was terminated for violating agency policy.

Compliance Notice dated 8/20/19: The incident occurred on 4/12/19. Cited 1005.1 – "The agency shall have a written discipline policy that is consistently followed." "True" licensing complaint. No additional corrective action was indicated. The involved staff is no longer employed with the agency.

Nature of Complaint: The report alleges that on 4/12/19, child (1) reported that Staff (1) slammed him against the fence several times. Staff (1) reported having to restrain the child (1) outside. Child (1) had a lump/abrasion above his right temple and a scratch on the back of his right arm.

- **Interim Corrective Action**: N/A – Staff (1) was terminated from PRTC based on policy infraction.
- **Findings** – Unsubstantiated maltreatment. "True" Licensing Complaint/Staff was terminated for violating agency policy. 1005.1 "The agency shall have a written discipline policy that is consistently followed".
- **Corrective Action** – N/A

As a part of the Corrective Action Plan (CAP), the Placement and Residential Licensing Unit (PRLU), would like to offer Piney Ridge Treatment Center access to Trauma Informed Care training and Conscious Discipline training at **no cost** to your facility. It is our goal to ensure the safety and well-being of all youth that are placed in facilities that have experienced trauma in their lives.

Sincerely,

[redacted]

Program Manager

Placement and Residential Licensing Unit

700 Main St.

Little Rock, AR 72203

[redacted]

20200514 Little Creek_5142020_extension-JC-final report [Redacted]

Appendix 17.

Preliminary Accreditation Report

Habilitation Centers, LLC

[redacted]

Fordyce, AR [redacted]

Organization Identification Number: [redacted]

Unannounced Extension Event New Service: 5/14/2021 - 5/14/2021

Program Surveyed

Behavioral Health Care and Human Services

Preliminary Report: Posted 5/14/2021

The Joint Commission
Table of Contents

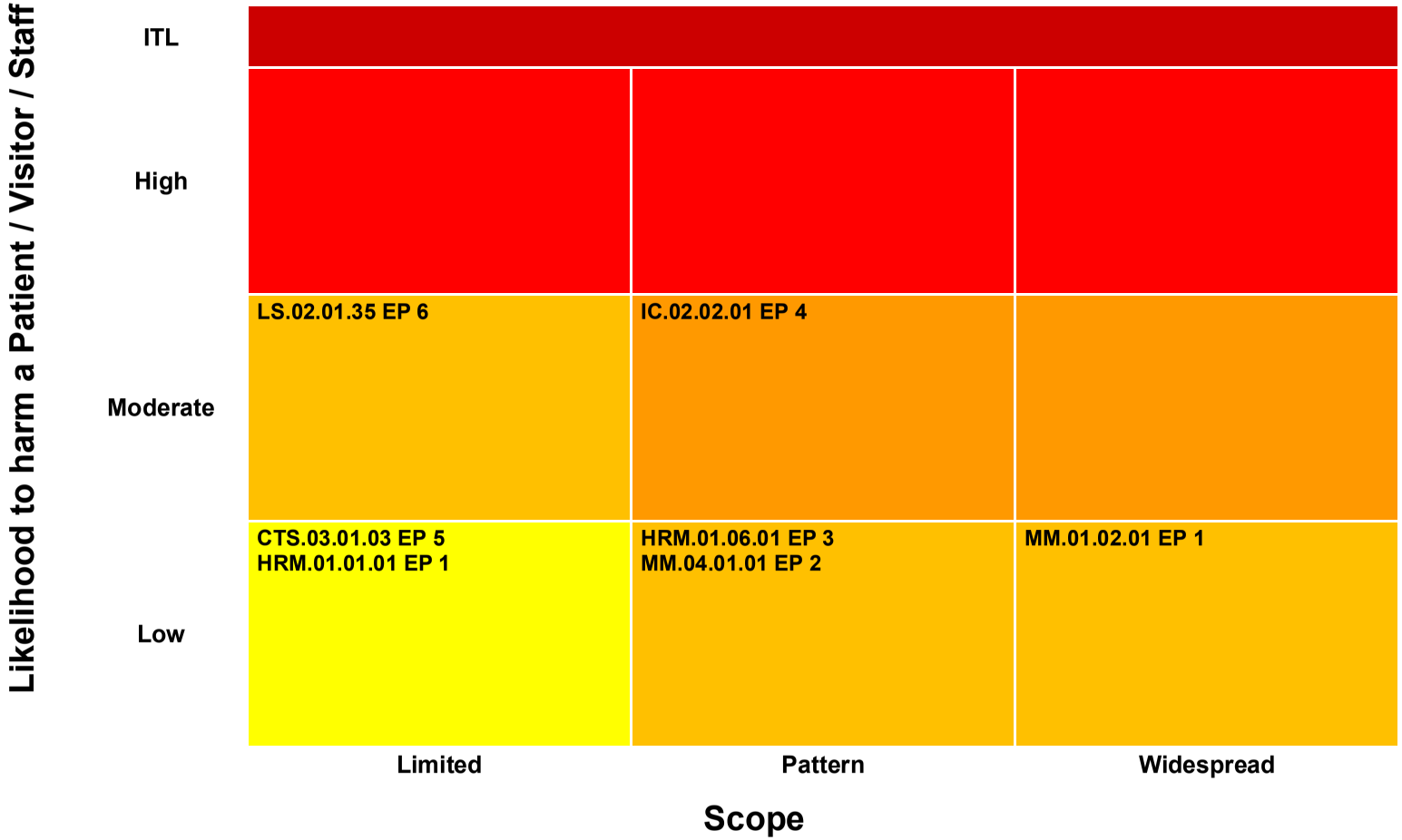
The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	05/14/2021 - 05/14/2021	Requirements for Improvement	Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.	Your official report will contain specific follow-up instructions regarding your survey findings.

Appendix 17.

The Joint Commission
SAFER™ Matrix

Program: Behavioral Health Care and Human Services



Appendix 17.

The Joint Commission
Requirements for Improvement

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.03.01.03	5	Low Limited	Reasons for deferring a goal, or the objectives leading toward or related to a goal, are documented.	1). Observed in Record Review at Habilitation Centers, LLC [redacted] Fordyce, AR) site.In one record reviewed medical concerns identified on the assessments had not been included or deferred on the treatment plan. These included acne, plantar fasciitis, Osgood-Schlatter Disease, vitamin D deficiency, nocturnal enuresis and bulimia. This was confirmed by the Clinical Director.
HRM.01.01.01	1	Low Limited	Each position has a written job description that identifies the following: - The minimum qualifications of the position - The competencies of the position, which include the minimum skills, knowledge, and experience required for the position - The duties and responsibilities of the position Note: A written contract may replace a job description. (For more information on contracted services, refer to Standard LD.04.03.09.)	1). Observed in HR File Review at Habilitation Centers, LLC [redacted] Fordyce, AR) site.The job description had been missing from the HR file of a Behavioral Health Tech. This was confirmed by the HR Director.
HRM.01.06.01	3	Low Pattern	The organization conducts an initial assessment of staff competence. This assessment is documented.	1). Observed in Competency Session at Habilitation Centers, LLC [redacted], Fordyce, AR) site.In two of four HR files reviewed the initial assessment of staff competence had been missing from the HR file. This was confirmed by the HR Director.
IC.02.02.01	4	Moderate Pattern	The organization implements infection prevention and control activities when doing the following: Storing medical supplies and devices.	1). Observed in Infection Control System Tracer at Habilitation Centers, LLC ([redacted] Fordyce, AR) site.In discussions with nursing staff, urine specimens had been stored in the same refrigerator as nasal swab testing kits. This was corrected during the survey; a second refrigerator was placed in the nursing area.
LS.02.01.35	6	Moderate Limited	There are 18 inches or more of open space maintained below the sprinkler to the top of storage. Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3)	1). Observed in Building Tour at Habilitation Centers, LLC [redacted] Fordyce, AR) site.The distance between the top of the dry food storage shelves and the sprinkler head had been less than 18 inches. Kitchen staff measured the distance and found it to be 12 inches. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Increase surveillance (EP-8)

Appendix 17.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
MM.01.02.01	1	Low Widespread	The organization develops a list of look-alike/sound-alike medications it stores, dispenses, or administers. Note 1: One source of look-alike/sound-alike medication name pairs is the Institute for Safe Medication Practices (https://www.ismp.org/recommendations/confused-drug-names-list). Note 2: This element of performance is also applicable to sample medications.	1). Observed in Medication Management Tracer at Habilitation Centers, LLC [redacted] Fordyce, AR) site.Although the organization had the Institute for Safe Medication Practices (ISMP), it had not developed a list of look-alike sound-alike based on the medication commonly administered. This was confirmed by medical staff.
MM.04.01.01	2	Low Pattern	For organizations that prescribe medications: The organization follows a written policy that defines the following: - The minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and medication frequency - When indication for use is required on a medication order - Precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear	1). Observed in Medication Management Tracer at Habilitation Centers, LLC [redacted] ordyce, AR) site.The physician's standing order indicated Acetaminophen and Ibuprofen could be used for pain. The order did not provide instruction on how a choice was determined. The Director of Nursing indicated medical staff, not the physician, typically made the decision on which medication to use.

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
CTS.03.01.03	5	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	Reasons for deferring a goal, or the objectives leading toward or related to a goal, are documented.
HRM.01.01.01	1	The organization develops written job descriptions.	Each position has a written job description that identifies the following: - The minimum qualifications of the position - The competencies of the position, which include the minimum skills, knowledge, and experience required for the position - The duties and responsibilities of the position Note: A written contract may replace a job description. (For more information on contracted services, refer to Standard LD.04.03.09.)
HRM.01.06.01	3	Staff are competent to perform their job duties and responsibilities.	The organization conducts an initial assessment of staff competence. This assessment is documented.
IC.02.02.01	4	The organization reduces the risk of infections associated with medical supplies and devices. Note: This standard applies only to organizations that use medical supplies and devices.	The organization implements infection prevention and control activities when doing the following: Storing medical supplies and devices.
LS.02.01.35	6	The organization provides and maintains systems for extinguishing fires. Note: This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.	There are 18 inches or more of open space maintained below the sprinkler to the top of storage. Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3)
MM.01.02.01	1	The organization addresses the safe use of look-alike/sound-alike medications.	The organization develops a list of look-alike/sound-alike medications it stores, dispenses, or administers. Note 1: One source of look-alike/sound-alike medication name pairs is the Institute for Safe Medication Practices (https://www.ismp.org/recommendations/confused-drug-names-list). Note 2: This element of performance is also applicable to sample medications.
MM.04.01.01	2	Medication orders are clear and accurate. Note: This standard is applicable only to organizations that prescribe medications. The elements of performance in this standard do not apply to prescriptions written by a prescriber who is not affiliated with the	For organizations that prescribe medications: The organization follows a written policy that defines the following: - The minimum required elements of a complete medication order, which must include medication name, medication dose, medication route, and

The Joint Commission

Standard	EP	Standard Text	EP Text
		organization.	medication frequency - When indication for use is required on a medication order - Precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

20200806 Piney Ridge AR DHS CAP Agreement signed [Redacted]

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Child Care & Early Childhood Education
P.O. Box 1437, Slot S140, Little Rock, AR 72203-1437
P: 501.682.8590 F: 501.683.6060 TDD: 501.682.1550

Corrective Action Agreement

To: [redacted]

Date: August 6th, 2020
Agency: Piney Ridge Treatment Center
License Number: [redacted]

This document constitutes a formal Corrective Action Agreement between Piney Ridge Treatment Center and the DHS Division of Child Care and Early Childhood Education, Placement and Residential Licensing Unit. This Corrective Action Agreement will be in effect for a period of six months from the date of signing by both parties. This agreement may be extended beyond the date if the agency experiences any serious non-compliance during the corrective action period.

The purpose of this agreement is to gain and maintain a high degree of compliance with licensing requirements. The following non-compliance areas have been cited during the past six months.

Minimum Licensing Standards (Residential): Section 905 – Behavior Management & Section: 912 Bathrooms

- **905.4d. – The following actions shall not be used, including as discipline:**
  - **Derogatory comments about the child, the child's family, race, or gender.**
- **912.6 – There shall be an adequate supply of soap, towels, and tissue.**

Piney Ridge Treatment Center has agreed to implement the following:

- Staff will not use racially/culturally inappropriate language with residents or other staff.
- Piney Ridge Treatment Center has provided staff with Cultural Competence training and will detail how the training received will be implemented.
- For the month of August, the offending staff will meet with the ADON or DON weekly and discuss how training is being implemented on the unit and what has been learned in training providing examples. For the month of September, the offending staff will meet

with the ADON or DON twice that month and discuss how training is being implemented on the unit and what has been learned in training providing examples. For the month of October, offending staff will meet with the ADON or DON once that month to discuss how what has been learned in training is being implemented on the unit.

- The ADON and/or DON will have the responsibility of monitoring the offending staff during assigned shifts. The ADON and/or DON will intervene, correct and report any behavior that goes against the licensing standards identified in Section 905 – Behavior Management of the Minimum Licensing Standards.

- Although there was an adequate supply of soap, towels and tissue viewed in the supply area, the items were not readily accessible for some residents that did not have any in their rooms. The plan for providing soap, and paper towels for all residents includes installing smoked clear paper towel dispensers that will give a visible way to see if this is a contraband location as well as the fill level of the supply of tri-fold paper towels. The facility has requested approval to order 36 of these dispensers from Grainger. Once ordered, these have a lead time of approximately 3 weeks. The estimated completion date for this is 8-31-2020. There may be supply issues from the company. In the meantime, different paper towels will be used in the rooms with a completion date of 8-7-2020. In addition, in the bedrooms during am and pm hygiene, residents have towels available for use. Each resident's room will have a fire resistant lightweight flexible molded plastic waste basket with a brown breathable paper bag for disposing of the paper towels and the expected time frame to have all of these in bedrooms is 8-7-2020. Manual operation soap dispensers will be installed in all resident restrooms by 8-31-2020. This will prevent access to batteries or mechanical parts and provide a soap/body wash product within the shower and bathroom areas for all resident rooms. There may be supply issues from the company. The estimated completion date for this is 8-31-2020. Bathrooms currently have hand pump soaps on the counters. The facility is currently sourcing, and it is estimated that they will pilot 2 different steel covers for these dispensers to add another level of protection from tampering and provide for the safety of the residents by 8-31-2020 dependent on supply issues.

- The facility shall abide by all the Behavior Management requirements as listed in the Minimum Licensing Standards Section 900 Psychiatric Residential Treatment Facilities 905 - Behavior Management.

- The facility shall abide by all Bathroom requirements as listed in the Minimum Licensing Standards Section 900 Psychiatric Residential Treatment Facilities 912 – Bathrooms.

This document is intended to clarify any outstanding issues and to reduce the risk of misunderstanding or miscommunication. During the probationary provisional time frame, frequent unannounced monitoring visits will be made to assure compliance.

Please be advised that any serious non-compliance cited during this corrective action period may result in a recommendation for adverse action on the license. Any serious

violation of this corrective action plan will result in a recommendation for adverse action on the license.

Please do not hesitate to contact the Division of Child Care and Early Childhood Education, Placement and Residential Licensing Unit, if you have any questions or concerns regarding ongoing compliance with this agreement or any licensing requirement.

The signature of the licensee constitutes full acceptance of the provisions of this agreement.

[redacted] RN LICED 08/06/00

Owner/Director Date

Licensing Specialist Date

Licensing Supervisor Date

20201002 Piney Ridge OLTC POC RESPONSE Final [Redacted]

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

PRINTED: 10/16/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center Complaint # [redacted] was substantiated with deficiencies cited at N100, N126, and N144.	N 000	N100 and N126 Findings: Failure to ensure a chemical restraint was not administered without documenting the attempt to allow a client to calm down or the use of less restrictive interventions. Corrective Action and Education: The Director of Nursing and Director of Residential Training and Development [redacted] provided training on the Restraint and Seclusion Policy and Milieu Management and documentation requirements to all direct care staff which included:	
N 100	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Complaint # [redacted] was substantiated all or in part with these findings: Based on record review and interview, the facility failed to meet the requirements of the Condition of Participation for Protection of Residents, as evidenced by the facility's failure to meet the regulatory requirements at N126. The facility	N 100	• Ensuring staff attempt to allow a client to calm down and offer less restrictive interventions to clients prior to administering a chemical restraint. • Staff documenting all attempts of allowing a client to calm down and the use of less restrictive interventions in the medical record. Responsible Individual: Director of Nursing, CEO	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 10/16/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 100	Continued From page 1 failed to ensure a chemical restraint was not administered without documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint for 10 (Client #1, #3, #4, #5, #6, #7, #8, #9, #11 and #13) sampled residents who were involved in chemical restraints. This failed practice had the potential to affect 93 facility clients as documented on a list provided by the Medical Records Director on 9/27/20 at 9:37 p.m. The findings are: The facility failed to ensure a chemical restraint was not administered without documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint for 10 (Client #1, #3, #4, #5, #6, #7, #8, #9, #11 and #13) sampled clients.	N 100	Auditing and Monitoring: The Director of Nursing and designated staff complete random audits of 30 inpatient records monthly, using the Seclusion and Restraint Audit Tool to verify: • Staff attempt to allow a client to calm down prior to administering a chemical restraint • Staff attempt to offer less restrictive interventions prior to administering a chemical restraint. • Staff documents all attempts which allow a client to calm down and the use of less restrictive interventions • The Director of Nursing, and Nurse Supervisors are responsible for addressing any compliance concerns directly with the indicated employee. • The Director of Nursing aggregates, analyzes and reports all results from these chart audits monthly, along with a plan of correction for any indicator scoring below 90%, to the Quality Council. • The Risk/PI Director reports data results along with a plan of correction for any indicator scoring below 90% monthly to the Performance Improvement Committee.	
N 126	PROTECTION OF RESIDENTS CFR(s): 483.356 (a)(1) Each resident has the right to be free from restraint or seclusion, of any form, used as a means of coercion, discipline, convenience, or retaliation. This ELEMENT is not met as evidenced by: Complaint # [redacted] was substantiated all or in part with these findings: Based on record review and interview, the facility failed to ensure a chemical restraint was not administered without documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the	N 126		

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	[redacted]	A. BUILDING _____ B. WING _____	C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 126	Continued From page 2 administration of a chemical restraint for 10 (Client #1, #3, #4, #5, #6, #7, #8, #9, #11 and #13) of 13 sampled clients. This failed practice had the potential to affect 93 facility clients as documented on a list provided by the Medical Records Director on 9/27/20 at 9:37 p.m. The findings are: 1. Client #4 was admitted on 5/26/20 and had diagnoses Posttraumatic Stress Disorder. A Master Treatment Plan Review dated 9/1/20 documented, "..What are some things that make it more difficult for the resident when they are already upset? Yelling, loud noise, not having personal space. Are there particular triggers that will cause the resident to escalate? Date Identified: 5/27/2020 Loud Noise, Not having personal space...If resident becomes upset or is in danger of hurting self or someone else, what interventions have been effective? Date Identified: 5/27/2020 Voluntary Timeout in Quite Room, Sitting by the Nurse's Station, Talking to Another Resident, Talking with Male Staff, Writing in Journal, Deep Breathing/Relaxation, Other: Shuffling Cards, Watching TV (television), Talking with Female Staff, Calling a Friend, Drawing, Listening to Music..." a. An Emergency Safety Intervention Justification Progress Note dated 9/12/20 documented, "Date & (and) Time Actually Placed in Restraint Date: 9/12/2020 Time: 0833 (8:33 a.m.), Date & Time Removed From Restraint: Date 9/12/2020 Time: 0835 (8:35 a.m.), Date & Time Restraint Order Received from MD (Medical Doctor) Date: 9/12/2020 Time: 0830 (8:30 a.m.), Type of Restraint Used: Standing 2 person, Resident Behavior: Please give detailed justification for	N 126	• The Director of Nursing aggregates, analyzes and reports all results from these chart audits monthly, along with a plan of correction for any indicator scoring below 90%, to the PI Committee. • The Risk/PI Director reports data results along with a plan of correction for any indicator scoring below 90% monthly to the Performance Improvement Committee.	

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restraint: R (Resident) agitated over breakfast began demanding different food. She then began throwing food/drinks at Nursing shoving staff, & verbally threating. R escorted to timeout room....Date & Time Chemical Restraint Order Received from MD Date: 9/12/2020 Time 0832 (8:32 a.m.), Date & Time Nurse Actually Administered Chemical Restraint Date: 9/12/2020 Time: 0835 (8:35 a.m.), Medication Administered: Thorazine/Benadryl Dosage: 100mg (milligrams)/100mg, Route: IM (Intermuscular)...Resident Behavior: Please give detailed justification for Chemical Restraint: R cont (continued) to be combative during escort-R given IM chemical restraint per MD order for safety...Resident Behavior at Time of Release: R calmer...Restraint and Seclusion Monitoring...Time AM/PM 0835, Observation/Behavior Code 15 [Exit Criterion met, no longer a danger, Care Code 4 [Chemical Restraint], 10 [released containment]..."

An Emergency Safety Intervention Physician's Orders dated 9/12/20 at 8:30 a.m., documented, "Restrain resident for up to 30 minutes for cont. (continued) bx (behavior) dyscontrol, As evidenced by throwing food/milk, shoving staff, verbally threatening...9/12/2020 Time: 0832 (8:32 a.m.), Give Resident Thorazine 100/Benadryl 100mg X (times) one dose now for increased behavioral Dyscontrol. As evidenced by cont. (continued) combative bx (behavior)..."

A Nursing Progress Note dated 9/12/20 at 8:33 a.m., documented, "The resident became angry because she got a hot tray for breakfast instead of a cold tray for breakfast. The resident was told that a staff member could get her a cold tray for breakfast but it would take about ten minutes for

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shift change. The resident poured her Silk milk and peers milk into the nurse's station through the opening into the window, The resident also threw food through the opening. The resident began to yell and threaten nurses and staff members. The resident began to throw objects across the dayroom. A staff member went to process with the resident but the refused and pushed the staff member. The resident continued to be aggressive towards staff members. The resident was restrained for safety per [Doctor] order at 0833 (8:33 a.m.) The resident continued aggression towards staff members while restrained. The resident was given a chemical restraint per Dr's (Doctor's) order for dyscontrol at 0835 (8:35 a.m.) The resident was released from the restraint at 0835...."

An order for the physical restraint was documented at 8:30 a.m., an order for a chemical restraint was documented obtained at 8:32 a.m., two minutes after the order for the physical restraint. Documentation indicated the client was placed in the physical restraint at 8:33 a.m., one minute after receiving the order for the chemical restraint and the chemical restraint was administered at 8:35 a.m., two minutes after being placed in the physical restraint. The order for the chemical restraint was received before the client was placed in a physical restraint. The Restraint and Seclusion Monitoring sheet documented under the Observation/Behavior Code, that Exit Criterion was met and was no longer a danger at the time the chemical restraint was administered. There was no documentation interventions for de-escalation listed on the client's Master Treatment Plan Review had been attempted before being placed in the physical

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restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint.

b. An Emergency Safety Intervention Justification Progress Note dated 9/19/20 documented, "...Date & (and) Time Placed in Restraint Date 9/19/2020 Time: 0910 (9:10 a.m.), Date & Time Removed from Restraint Date 9/19/2020 Time: 0915 (9:15 a.m.), Date & Time Order Restraint Order Received from MD (Doctor) Date: 9/19/2020 Time: 0906 (9:06 a.m.), Type of Restraint Standing 2 person, Resident Behavior: Please give justification for restraint: Resident was part of residents attacking staff, started to punch, kick, hit and [word illegible] staff, was restrained for safety...Date & Time Chemical Restraint Order Received from MD Date: 09/19/2020 Time: 0908 (9:08 a.m.), Date & Time Nurse Actually Administered Chemical Restraint Date: 9/19/2020 Time: 0915 (9:15 a.m.), Medication Administered: Thorazine/Benadryl, Dosage: 100/100 Route: IM (Intermuscular)...Resident Behavior: Please give detailed justification for Chemical Restraint Continue aggressiveness with staff, kicking, pushing staff and threatening...Resident Behavior at Time of Release: Calm...Restraint & Seclusion Monitoring...Time AM/PM 0915, Observation/Behavior Code Calm/Quiet/Willing to talk..."

An Emergency Safety Intervention Physician's Order dated 9/19/20, documented an order for a physical restraint was given at 9:06 a.m., and an order for Thorazine/Benadryl was documented as received at 9:08 a.m., two minutes after the order

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N 126	Continued From page 6 for the physical restraint was received. A Nursing Progress Note dated 9/19/20 at 9:10 a.m., documented, "Resident was on the unit with other residents, started going after staff, screaming at staff, punching, kicking, hitting and pushing several staff members. Resident was restraint for safety as per Dr's (Doctor's) orders and PRN (as needed) Thorazine/Benadry 100 mg (milligrams) administered IM (intermuscular) as per Dr's orders..." Documentation indicated the order for the chemical restraint was received two minutes before the client was placed in a physical restraint and the client was calm/quiet/willing to talk at the time the chemical restraint was administered. There was no documentation interventions for de-escalation listed on the client's Master Treatment Plan Review had been attempted before being placed in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint. c. An Emergency Safety Intervention Justification Progress Note dated 9/19/20 at 5:00 p.m., documented, "...Date & (and) Time Actually Placed in Restraint Date: 9/19/2020 Time: 1700 (5:00 p.m.), Date & Time Removed from Restraint Date: 9/19/2020 Time 1712 (5:12 p.m.), Date & Time Restraint Order Received from MD (Doctor) 9/19/2020 Time 1703 (5:03 p.m.), Type of Restraint Used Standing 2 person, Resident Behavior: Please give detailed justification for restraint Physical aggression towards staff and property R (Resident) pushed staff, punched	N 126		

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staff, R attempt to set off the fire sprinkler, R continued the aggression toward staff, R continued aggression, R restrained for safety...Date & Time Chemical Restraint Order Received from MD Date: 9/19/2020 Time: 1705 (5:05 p.m.), Date & Time Nurse Actually Administered Chemical Restraint Date: 9/19/2020 Time: 1712 (5:12 p.m.), Medication Administered: Zypexa Dosage: 20 mg (milligrams) Route: IM (intermuscular), Resident Behavior: Please give detailed justification for Chemical Restraint Continued physical aggression towards staff while restrained. R kicked a nurse. R kicked a door. R given a chemical for safety...Resident Behavior at Time of Release: Calm...Restraint & Seclusion Monitoring...Time AM/PM 1712, Observation/Behavior Code 14 [Calm/Quiet/Willing to talk] 15 [Exit Criterion met, no longer a danger]..."

An Emergency Safety Intervention Physician's Orders dated 9/19/20, documented, "Time: 1703, Restrain resident for up to 30 minutes for physical aggression...Date: 9/19/2020 Time: 1705 (5:05 p.m.) Give Resident Zyprexa 20 mg (milligrams) x (times) one dose now for increased behavioral Dyscontrol..." An order for a chemical restraint was received two minutes after an order for a physical restraint was received. A chemical restraint was documented as administered at 5:12 p.m.

Documentation indicated the client was calm/quiet/willing to talk at the time of the administration of the chemical restraint and release from the physical restraint. There was no documentation interventions for de-escalation listed on the client's Master Treatment Plan Review had been attempted before being placed

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in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint.

d. An Emergency Safety Intervention Justification Progress Note dated 9/27/20, documented, "...Date & (and) Time Actually Placed in Restraint Date: 9/27/2020 Time: 1250 (12:50 p.m.), Date & Time Removed from Restraint Date: 9/27/2020 Time: 1254 (12:54 p.m.) Date & Time Restraint Order Received from DM (Doctor) 9/27/2020 Type of Restraint Standing 2 person Resident Behavior: Please give detailed justification for restraint: Physical aggression towards staff members and property R (Resident) was kicking the door and threatening nearby staff R threw a cup of water into nurse's station onto computer. R pushed staff. R restrained for safety...Date & Time Chemical Restraint Order Received from MD Date: 9/27/2020 Time: 1252 (12:52 p.m.) Date & Time Nurse Actually Administered Chemical Restraint Date: 9/27/2020 Time: 1254 (12:54 p.m.) Medication Administered: Thorazine/Benadryl, Dosage 100/100, Route: IM (Intermuscular)...Resident Behavior: Please give detailed justification for Chemical Restraint Continued physical aggression towards staff member R (Resident) kicked staff and grabbed at staff members. R threatening staff members. R continued dyscontrol. Chemical given for safety...Resident Behavior at Time of Release: Calm..."

An Emergency Safety Intervention Physician's Orders, dated 9/27/20, documented, "Time:1250 (12:50 p.m.) Restrain resident for up to 30

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minutes for physical aggression As evidenced by pushing staff, throwing water into the nurse's station...Time: 1252 (12:52 p.m.) Give Resident Thorazine/Benadryl x (times) one dose now for increase behavioral Dyscontrol...." An order for a chemical restraint was received two minutes after an order for a physical restraint was received. The chemical restraint was administered at 12:54 p.m.

A Nursing Progress Note dated 9/27/20 at 12:50 p.m. documented, "...The resident was restrained for safety when she pushed staff members. The resident was restrained for safety per [Doctor] order at 1250 (12:50 p.m.)...The resident was given a chemical restraint for dyscontrol per [Doctor] order at 1254 (12:54 p.m.). The resident was released from the restraint a 1254 (12:54 p.m.)..."

Documentation indicated the client was calm at the time of release and administration of the chemical restraint. There was no documentation interventions for de-escalation listed on the client's Master Treatment Plan Review had been attempted before being placed in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint.

2. Client #5 was admitted on 3/23/20 and had diagnoses Unspecified Trauma and Stressor Related Disorder and Other Specified Disruptive, Impulse Control Related Disorder.

A Master Treatment Plan Review dated 9/1/20 documented, "...Triggers contributing to

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escalation: Being touched, not having personal space, What are some things that make it more difficult for the resident when they are already upset? Being touched, not having personal space. Are there particular triggers that will cause the resident to escalate? Date Identified: 3/24/2020 Being Touched, Loud Noise, Not Having Personal Space, Yelling. If resident becomes upset or is in danger of hurting self or someone else, what interventions have been effective? Date Identified: 3/24/2020 Sitting by the Nurse's Station, Talking to Another Resident, Writing in a journal, Lying Down with Cold Face Cloth, Other: Reading, Art, Calling a Friend, Listening to Music. Preference in the event this would be necessary: Date Identified: 3/24/2020 Other: Talking to someone..."

a. An Emergency Safety Intervention Justification Progress Note dated 9/13/20 documented, "...Date & (and) Time Actually Placed in Restraint Date: 9/13/2020 Time: 1335 (1:35 p.m.), Date & Time Removed from Restraint Date: 9/13/2020 Time: 1338 (1:38 p.m.) Date & Time Restraint Order Received from MD (Doctor) Date: 9/13/2020 Time: 1334 (1:34 p.m.), Type of Restraint Used Standing 2 person, Resident Behavior: Please give detailed justification for restraint While in dayroom R (Resident) became upset & began busting through unit door. When staff stood between door & R, R began hitting & shoves staff. Restrained for safety...Date & Time Chemical Restraint Order Received from MD Date: 9/13/2020 Time: 1336 (1:36 p.m.), Date & Time Nurse Actually Administered Chemical Restraint Date: 9/13/2020 Time: 1338 (1:38 p.m.), Medication Administered: Thorazine Dosage: 50 mg (milligrams) Route: IM (Intermuscular)...Resident Behavior at Time of

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Release: Calm...Restraint & Seclusion Monitoring...Time AM/PM 1338 (1:38 p.m.) Observation/Behavior Code 11 [quiet] 15 [Exit Criterion met, no longer a threat..."

An Emergency Safety Intervention Physician's Order dated 9/13/20 documented, "..Time: 1334 (1:34 p.m.) Restrain resident for up to 30 minutes for assaultive bx (behavior)/property destruction...Time: 1336 (1:36 p.m.) Give Resident Thorazine 50 mg x one dose now for increased behavioral Dyscontrol..." An order for a chemical restraint was received two minutes after the order for a physical restraint was received. The chemical restraint was administered three minutes after the client was placed in a physical restraint.

Nursing Progress Note, dated 9/13/20 at 1:35 p.m., documented, "...Restrained for safety per MD order at 1335 (1:35 p.m.). During restraint, resident shoved and hit staff despite all attempts to de-escalate by staff and nurse. MD notified and resident given Thorazine 50 mg (milligrams) IM (intermuscular) X (times) one dose now r/t (related to) behavioral dyscontrol at 1338 (1:38 p.m.). Resident released from restraint and continued to monitor..."

Documentation indicated the client was quiet and exit criterion was met at the time the chemical restraint was administered and client was released. There was no documentation interventions for de-escalation listed on the client's Master Treatment Plan Review had been attempted before being placed in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or

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the use of less restrictive interventions before the administration of a chemical restraint.

3. Client #8 was admitted on 6/29/20 and had diagnoses Disruptive Mood Dysregulation Disorder and Attention Deficit Hyperactivity Disorder, Combined Presentation.

A Master Treatment Plan Review dated 9/2/20 documented, "...Are there particular Triggers that will cause the resident to escalate? Date Identified: 6/29/2020 Being Touched, Particular Time of Day, Loud Noise, Having Control/Input, Not Having Personal Space, Yelling. Describe: When being touched and doesn't want to be, he asks the person to not touch him, but will become irritated if they don't listen; "More agitated in the afternoon";...tries to get away from everybody when he doesn't have personal space...If resident becomes upset or is in danger of hurting self or someone else, what interventions have been effective? Date Identified: 6/29/20 Voluntary Timeout in Quit Room, Talking to Another Resident, Talking with Male Staff, Writing in Journal, Deep Breathing/Relaxation, Watching TV (Television), Pacing Halls, Talking with Female Staff, Calling a Friend, Drawing..."

a. An Emergency Safety Intervention Justification Progress Note dated 9/15/20, documented, "Date & (and) Time Actually Placed in Restraint Date: 9/15/2020 Time: 2115 (9:15 p.m.), Date & Time Removed from Restraint Date: 9/15/2020 Time 2121 (9:21 p.m.), Date & Time Restraint Order Received from MD (Doctor) Date: 9/15/2020 Time: 2116 (9:16 p.m.), Type of Restraint Used Standing 2 person, Resident Behavior: Please give detailed justification for the restraint R (Resident) eloped out west unit exit door into the

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	[redacted]	A. BUILDING _____ B. WING _____	C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR**[redacted]

(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
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garden area and became physically aggressive c (with) staff upon verbal request to return to unit. Restrained for safety...Date & Time Chemical Restraint Order Received from MD Date: 9/15/2020 Time: 2120 (9:20 p.m.), Date & Time Nurse Actually Administered Chemical Restraint Date 9/15/2020 Time: 2121 (9:21 p.m.)...Resident Behavior at Time of Release: Calm/In Control...Restraint & Seclusion Monitoring...Time AM/PM 2121 (9:21 p.m.), Observation/Behavior Code 15 [Exit Criterion met, no longer a danger]..."

An Emergency Safety Intervention Physician's Orders dated 9/15/20 documented, "Time 2116 (9:16 p.m.), Restrain resident for up to 30 minutes for eloping/aggression to staff...Time: 2120 (9:21 p.m.) Give Resident Zyprexa10/Benadryl 100 x (times) one dose now for increased behavioral Dyscontrol..."

A Nursing Progress Note dated 9/15/20 at 9:15 p.m., documented, "...When staff followed resident and verbally redirected resident to come inside, resident became physically aggressive with staff and restrained for Safety per MD order at 2115 (9:15 p.m.)...MD notified and resident given Zypexa 10 mg (milligram)/Benadryl 100mg IM (Intermuscular) X (times) 1 dose now r/t (related to) behavioral dyscontrol at 2121 (9:21 p.m.). Resident released from restraint and monitoring by staff continued..." An order for a chemical restraint was received at 9:20 p.m., four minutes after an order for a physical restraint was received. The chemical restraint was administered 6 minutes after the physical restraint was initiated.

Documentation indicated the client was calm, and

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	[redacted]	A. BUILDING _____ B. WING _____	C 10/02/2020

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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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exit criterion met, no longer a danger at the time of the administration of the chemical restraint. There was no documentation interventions for de-escalation, listed on the client's Master Treatment Plan Review, had been attempted before being placed in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint.

b. An Emergency Safety Intervention Justification Progress Note dated 9/20/20 documented, "...Date & (and) Time Actually Placed In Restraint Date: 9/20/2020 Time: 0842 (8:42 a.m.), Date & Time Removed from Restraint Date 9/20/2020 Time: 0845 (8:45 a.m.), Date & Time Restraint Order Received from MD (Doctor), Type of Restraint Used Standing 2 person, Resident Behavior. Please give detailed justification for restraint: At breakfast, R (Resident) broke out of cafeteria exit door, climbed on to the awnings, and refused to come down. R walked on awning to area where he removed himself & ran for the gate in an attempt to elope. R began hitting & shoving staff when staff blocked R from gate. Restrained for safety...Date & Time Chemical Restraint Order Received from MD Date: 9/20/2020 Time: 0840 (8:40 a.m.), Date & Time Nurse Actually Administered Chemical Restraint Date: 9/20/2020 Time: 0845, Medication Administered Thorazine/Benadryl Dosage: 100 mg (milligrams)/100 mg Route IM (Intermuscular)...Resident Behavior at Time of Release: Calm, Restraint & Seclusion Monitoring...Time AM/PM 0845 (8:45 a.m.), Observation/Behavior Code 15 [Exit Criterion met, no longer a danger]..."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 126	Continued From page 15 An Emergency Safety Intervention Physician's Order dated 9/20/20 documented, "Time: 0836 (8:36 a.m.), Restrain Resident for up to 30 minutes for Assualtive bx (behavior) As evidenced by Physical aggression toward staff, hitting and shoving...Time: 0842 (8:42 a.m.) Give Resident Thorazine 100/Benadryl 100 x (times) one dose now for increased behavioral Dyscontrol..." Nursing Progress Note, dated 9/20/20 at 8:45 a.m., documented, "...Restrained for safety per MD (Doctor) order at 0842 (8:42 a.m.). During restraint, resident continued to display physical aggression...MD notified and resident given Thorazine 100 mg (milligrams)/Benadryl/100 mg IM (Intermuscular) now r/t (related to) behavioral dyscontrol per MD (Doctor) order at 0845 (8:45 a.m.). Released from containment..." An order for a chemical restraint was received at 8:42 a.m., six minutes after an order for a physical restraint was received. However, the physical restraint was not inititiated until 8:42 a.m., the same time the chemical restraint order was received. The chemical restraint was administered three minutes after the physical restraint was initiated. At the time of the administration of the chemical restraint, documentation indicated the client was calm, exit criterion had been met, was no longer a danger. There was no documentation interventions for de-escalation, listed on the client's Master Treatment Plan Review, had been attempted before being placed in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or	N 126		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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the use of less restrictive interventions before the administration of a chemical restraint.

c. An Emergency Safety Justification Progress Note dated 9/23/20 documented, "...Date & (and) Time Actually Placed in Restraint Date: 9/23/2020 Time: 1255 (12:55 p.m.), Date & Time Removed from Restraint Date: 9/23/2020 Time: 1258 (12:58 p.m.) Date & Time Restraint Order Received from MD (Doctor) Date 9/23/2020 Time: 1254 (12:54 p.m.), Type of Restraint Used Standing 2 person, Resident Behavior: Please give detailed justification for restraint: During transition, R (Resident) stepped out of line and ran towards the fence in area C. When staff attempted to block R, the R began hitting at/pushing staff. Restrained for safety...Date & Time Chemical Restraint Order Received from MD Date: 9/23/2020 Time: 1256 (12:56 p.m.), Date & Time Nurse Actually Administered Chemical Restraint Date: 9/23/2020 Time: 1258 (12:58 p.m.), Medication Administered: Zyprexa/Benadryl Dosage: 10 mg(milligrams)/100 mg, Route: IM (Intermuscular)...Resident Behavior at Time of Release: Calm...Restraint & Seclusion Monitoring:...Time AM/PM 1258 (12:58 p.m.), Observation/Behavior Code 15 [Exit Criterion met, no longer a danger]..."

An Emergency Safety Intervention Physician's Orders dated 9/23/20 documented, "Time: 1254 (12:54 p.m.), Restrain resident for up to 30 minutes for assualtive bx (behavior), As evidenced by R (Resident) running away from staff in an attempt to elope/became physically aggressive c (with) staff...Date: 9/23/2020 Time: 1256 (12:56 p.m.), Give Resident Zyprexa 10/Benadryl 100 x (time) one dose now for increased behavioral Dyscontrol..."

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N 126	Continued From page 17 A Nursing Progress Note dated 9/23/20 at 12:55 p.m., documented, "...Restrained for safety per MD order at 1255 (12:55 p.m.)...new order obtained at 1258 (12:58 p.m.) to give resident Zyprexa 10 mg (milligrams)/Benadryl 100 mg IM (Intermuscular) X (times) 1 dose now r/t (related to) behavioral dyscontrol..." An order for a chemical restraint was received two minutes after an order for a physical restraint was received, however the physical restraint was not initiated until two minutes before the chemical restraint was administered. Documentation on the Emergency Safety Intervention Justification Progress Note indicated the client was calm, exit criterion met, no longer a danger at the time the chemical restraint was administered. There was no documentation interventions for de-escalation, listed on the client's Master Treatment Plan Review, had been attempted before being placed in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint. 4. Client #9 was admitted on 8/11/20 and had diagnoses Disruptive Mood Dysregulation Disorder, Unspecified Trauma and Stressor-Related Disorder, and Other Personal History of Psychological Trauma. The Master Treatment Plan Review dated 9/3/20 documented, "...What are some things that make it more difficult for the resident when they are already upset? Talking to her. Give her time to breathe and will calm down on her own...If	N 126		

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resident becomes upset or is in danger of hurting self or someone else, what interventions have been effective? Date Identified: 8/12/2020, Writing in Journal, Deep Breathing/Relaxation, Watching TV (television), Calling a Friend, Exercise, Drawing, Listening to Music..."

a. An Emergency Safety Intervention Justification Progress Note dated 9/19/20 documented, "...Date & (and) Time Actually Placed in Restraint Date: 9/19/2020 Time: 0920 (9:20 a.m.), Date & Time Removed from Restraint Date: 9/19/2020 Time: 0925 (9:25 a.m.), Date & Time Restraint Order Received from MD (Doctor) Date: 9/19/2020 Time: 0918 (9:18 a.m.), Type of Restraint Used Standing 2 person, Resident Behavior: Please give detailed justification for restraint Physical aggression towards staff members and property R (Resident) push staff, threatened staff, R attempted to set off fire sprinklers, R hit staff members, R restrained for safety...Date & Time Chemical Restraint Order Received from MD Date: 9/19/2020 Time: 0922 (9:22 a.m.), Date & Time Nurse Actually Administered Chemical Restraint: Date: 9/19/2020 Time: 0925 (9:25 a.m.), Medication Administered: Thorazine/Benadryl, Dosage: 50/50, Route: IM (Intermuscular)...Resident Behavior at Time of Release: Calm..."

An Emergency Safety Intervention Physician's Orders dated 9/19/20 documented, "...Time: 0918 (9:18 a.m.), Restrain resident for up to 30 minutes for physical aggression towards staff nurses, hitting and pushing staff nurses...Time: 0922 (9:22 a.m.) Give Resident Thorazine/Benadryl x (times) one dose now for increased behavioral Dyscontrol..." An order for a chemical restraint was received four minutes after

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 126	Continued From page 19 an order for a physical restraint was received. The chemical restraint was administered five minutes after the client was physically restrained. Documentation on the Emergency Safety Intervention Justification Progress Note indicated the client was calm at the time the chemical restraint was administered. There was no documentation interventions for de-escalation listed on the client's Master Treatment Plan Review had been attempted before being placed in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint. 5. Client #1 was admitted on 8/13/20 and had diagnoses Unspecified Trauma and Stressor Related Disorder. A Master Treatment Plan dated 8/26/20 documented, "...What are things that make it more difficult for the resident when they are already upset? Someone getting close to them, touching them or yelling. Are there particular triggers that will cause the resident to escalate? Date Identified: 8/14/13: Being touched, People in uniform, Loud Noise, Having Control/Input, Not having personal space, Yelling,...If resident becomes upset or is in danger of hurting self or someone else, what interventions have been effective? Date Identified: 8/14/20, Voluntary Timeout in Quite Room, Writing in Journal, Drawing, Listening to Music. Preference in the event this would become necessary: Date Identified: 8/14/13, Open Door Separation from Community Milieu..."	N 126		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 126	Continued From page 20 a. An Emergency Safety Justification Progress Note dated 9/11/20 documented, "...Date & (and) Time Actually Placed in Restraint Date: 09/11/2020 Time: 1425 (2:25 p.m.), Date & Time Removed from Restraint Date 09/11/2020 Time: 1430 (2:30 p.m.), Date & Time Restraint Order Received from MD (Doctor) Date 09/11/2020 Time: 1422 (2:22 p.m.), Type of Restraint Used Standing 2 person, Resident Behavior: Please give detailed justification for restraint: Resident was very aggressive with peer and staff pushing, hitting, punching staff, was restrained for safety...Date & Time Chemical Restraint Order Received from MD Date 09/11/2020 Time: 1427 (2:27 p.m.), Date & Time Nurse Actually Administered Chemical Restraint Date: 09/11/2020 Time: 1430 (2:30 p.m.), Medication Administered: Thorazine/Benadryl, Dosage: 100 mg (milligrams)/50 mg, Route: IM (intermuscular)...Resident Behavior at Time of Release: Calm...Restraint & Seclusion Monitoring...Time AM/PM 1430 (2:30 p.m.), Observation/Behavior Code: 14 [Calm/Quiet/Willing to talk]..." An Emergency Safety Intervention Physician's Orders dated 9/11/20 documented, "...Time: 1422 (2:22 p.m.), Restrain resident for up to 30 minutes for being aggressive with staff and peers. As evidenced by stepping on peer, pushing running into doors being aggressive with staff..." A Physician's Order Sheet, dated 9/11/20 at 2:20 p.m., documented, "...Thorazine 100 mg Benadryl 50 mg IM Aggressive Behavior..." An order for a chemical restraint was received two minutes after the initiation of the physical restraint and was administered five minutes after the initiation of the physical restraint.	N 126		

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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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N 126	Continued From page 21 Documentation indicated the client was calm, quiet, willing to talk at the time the chemical restraint was administered. There was no documentation interventions for de-escalation listed on the client's Master Treatment Plan Review had been attempted before being placed in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint. b. An Emergency Safety Intervention Justification Progress Note dated 9/18/20 documented, "...Date & (and) Time Actually Placed in Restraint Date: 9/18/2020 Time: 2104 (9:04 p.m.), Date & Time Removed from Restraint Date: 9/18/2020 Time: 2107 (9:07 p.m.), Date & Time restraint Order Received from MD Date: 9/18/2020 Time: 2103 (9:03 p.m.), Type of Restraint Used Standing 2 person, Resident Behavior: Please give detailed justification for restraint: After repeatedly threatening elopement and physical harm to peers, R (Resident) attempted to attack a staff member...Date & Time Chemical Restraint Order Received from MD (Doctor) Date: 9/18/2020 Time: 2106 (9:06 p.m.), Date & Time Nurse Actually Administered Chemical Restraint Date: 9/18/2020 Time: 2107 (9:07 p.m.), Medication Administered: Zyprexa/Benadryl, Dosage: 10 mg (milligrams)/100 mg, Route IM (Intermuscular)...Resident Behavior at Time of Release: Calm...Restraint & Seclusion Monitoring:...Time AM/PM: 2107 (9:07 p.m.) Observation/Behavior Code 15 [Exit Criterion met, no longer a danger...Face to Face Assessment With RN (Registered Nurse) One	N 126		

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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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Hour From Initiation Of ESI (Emergency Safety Intervention) Event...2. Describe the resident reaction to the intervention and the resident's behavior: R (Resident) accepted shots, almost laughing-bragging about it..."

An Emergency Safety Intervention Physician's Orders dated 9/18/20 documented, "..Time: 2103 (9:03 p.m.), Restrain resident for up to 30 minutes for assaultive bx (behavior), As evidenced by attempting to attack staff...Time: 2106 (9:06 p.m.) Give Resident Zyprexa 10/Benadryl 100 x (times) one dose now for increased behavioral Dyscontrol..." An order for a chemical restraint was received 3 minutes after the order for a physical restraint was received. A chemical restraint was administered three minutes after the initiation of a physical restraint.

Documentation on the Emergency Safety Justification Progress Note indicated the client was calm, exit criterion met, no longer a danger, accepted the shot and was "almost laughing-bragging about it" at the time of the administration of the chemical restraint. There was no documentation interventions for de-escalation listed on the client's Master Treatment Plan Review had been attempted before being placed in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint.

c. An Emergency Safety Intervention Justification Progress Note dated 9/19/20 documented, "Date & (and) Time Actually Placed in Restraint Date: 9/19/2020 Time: 0908 (9:08 a.m.), Date & Time

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

PRINTED: 10/16/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR**[redacted]

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Removed from Restraint Date: 9/19/2020 Time: 0910 (9:10 a.m.), Date & Time Restraint Order Received from MD (Doctor) Date: 9/19/2020 Time: 0900 (9:00 a.m.). Type of Restraint Used Standing 2 person, Resident Behavior: Please give detailed justification for restraint: Physical aggression towards staff members and property. R (Resident) pushing staff, punching staff, kicking staff, threatening staff. Continued aggression towards staff and property. R restrained for safety...Date & Time Chemical Restraint Order Received from MD (Doctor) Date: 9/19/2020 Time: 0905 (9:05 a.m.), Date & Time Nurse Actually Administered Chemical Restraint Date 9/19/2020 Time: 0910 (9:10 a.m.), Medication Administered: Thorazine/Benadryl Dosage: 100/100...Resident Behavior at Time of Release: Calm..."

An Emergency Safety Intervention Physician's Orders dated 9/19/20 documented, "...Time 0900 (9:00 a.m.) Restrain resident for up to 30 minutes for physical aggression...Time: 0905 (9:05 a.m.), Give Resident Thorazine 100 mg (milligrams) Benadryl 100 mg x (times) one dose now for increased behavioral Dyscontrol..." An order for a chemical restraint was received five minutes after an order for a physical restraint. The client was placed in the physical restraint three minutes after the order for the physical restraint was received and the chemical restraint was administered two minutes after the physical restraint was initiated.

There was no documentation interventions for de-escalation listed on the client's Master Treatment Plan Review had been attempted before being placed in the physical restraint or before a chemical restraint was administered. There was no documentation of the attempt to

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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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allow time for the client to calm or the use of less restrictive interventions before the administration of a chemical restraint.
6. Client #6 had diagnoses of Posttraumatic Stress Disorder, unspecified, Disruptive Mood Dysregulation, Combined Type, and Attention Deficit Hyperactivity Disorder, Combined Type.

The Master Treatment Plan Review documented,"If resident becomes upset or is in danger of hurting self or someone else, what interventions have been effective." Voluntary Timeout in Quiet Room, Pacing the Halls, and exercise where the interventions marked.

a. An Emergency Safety Intervention Justification form documented,"Date and (&) Time Actually Placed in Restraint Date: 9/13/2020 Time: 1617 Date &Time Removed from Restraint Date: 9/13/2020 Time: 1620 Date & Time Restraint Order Received from Medical Doctor (MD) Date: 9/13/2020 Time 1615... Date & Time Chemical Restraint Order Received from MD Date 9/13/2020 Time 1618 Date & Time Nurse Actually Administered Chemical Restraint Date: 9/13/2020 Time 1618 Date & Time Nurse Actually Administered Chemical Restraint Date: 9/13/2020 Time: 1620 Medication Administered: Zyprexa/ Benadryl Dosage: 10 milligrams (mg)/ 100 mg Route Intramuscular (IM)... Resident behavior at time of release: Calm... 1620 Observation/ Behavior Code 15." The form documented the corresponding behavior of 15 documented in the Observation/ Behavior Code at 1620, the same time the form documented the chemical restraint given, as,"Exit Criterion met, no longer a danger." There was only one minute documented between the time the resident was placed in a restraint and the time an order was obtained for a chemical

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 126	Continued From page 25 restraint. An Emergency Safety Intervention Physician's Order's form documented, "Date: 9/13/2020 Time 1615 Restrain resident for up to 30 minutes for assaultive behavior (bx). As evidenced by Resident (R) attempting to attack peer/ trying to bust through unit door/ physical aggression with (c) staff upon restraints. Release when calm... Date 9/13/2020 Time 1618 Give resident Zyprexa 10 / Benadryl 100 X one dose now for increased behavioral dyscontrol." There was only 3 minutes documented between the time the order for the restraint was obtained and the time the order for the chemical restraint was obtained. A Nursing Progress Note documented," 9/13/2020 1617 While on the unit, a peer became upset with this resident and kicked the resident's free time tote because the resident had allegedly "flicked a hornet" at this resident. Peer was taken to a different unit and this resident began busting through unit doors to get to the peer. When nurse stood in front of the unit door and attempted to redirect, the resident became physically aggressive with the nurse and restrained for safety per Medical Doctor (MD) order at 1617. During restraint, resident continued to shove and kick staff to get to the peer and refused all attempts to de-escalate by staff and nurses. MD notified and resident given Zyprexa 10 mg/Benadryl 100 mg IM X 1 dose now r/t behavioral dyscontrol per MD order at 1620." b. An Emergency Safety Intervention Justification Progress Note documented,"Date & Time Actually Placed in Restraint Date: 9/27/2020 Time: 1856 Date & Time Removed from Restraint Date: 9/27/2020 Time: 1904 Date & Time Restraint	N 126		

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	[redacted]	A. BUILDING _____ B. WING _____	C 10/02/2020

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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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Order Received from MD Date: 9/27/2020 Time: 1857... Date & Time Chemical Restraint Order Received from MD Date: 9/27/2020 Time: 1858 Date & Time Nurse Actually Administered Chemical Restraint Date: 9/27/2020 Time 1904 Medication Administered: 10 mg Zyprexa/ 100 mg bendryl Dosage: 10 mg/10 mg Route IM... Resident Behavior at time of Release: calm/ cooperative." There were only 2 minutes documented from the time the resident was placed in a restraint and the time an order was obtained for a chemical restraint.

An Emergency Safety Intervention Physician's Orders documented,"Date 9/27/2020 Time 1857 Restrain resident for up to 30 minutes for aggression/ property destruction / self harm as evidenced by assaulting staff, destroying bed, endangering peers ... Date 9/27/2020 1858 Give Resident 10 mg Zyprexa IM / 100 mg Benadryl IM X one dose now for increased behavioral Dyscontrol." There was only one minute documented between the time of the order for the restraint and the order for the chemical restraint.

A Nursing Progress Note documented," 9/27/2020 1840 Resident and peers in dayroom with staff. Resident began to verbally antagonize peers... Resident charged at staff and was restrained for safety at that time. MD order received at 1857. Resident escorted to quiet room to remove him from area with peers. Resident appeared to headbutt staff, kick staff scream and break free from restraint. Order for 10 mg Zyprexa IMX1 now and Benadryl 100 mg now received from on call MD ay 1858. Administered at 1904 per order."

7. Client #3 had diagnoses of Disruptive Mood

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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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Dysregulation Disorder, Unspecified Trauma and Stressor Related Disorder, and Unspecified Anxiety Disorder.

The Master Treatment Plan Review documented,"If resident becomes upset or is in danger of hurting self or someone else, what interventions have been effective?" Voluntary timeout in quiet room, sitting by nurse's station, talking to another resident, talking with male staff, writing in journal, deep breathing/ relaxation, lying down with cold face cloth, wrapping in a blanket, watching TV, pacing the halls, exercise, drawing, and listening to music were interventions checked on the form.

a. An Emergency Safety Intervention Justification Progress Note documented,"Date & Time Actually Placed in Restraint Date: 9/13/2020 Time: #1 0803 #2 0854 Date & Time Removed from Restraint Date 9/13/2020 Time: #1 0806 #2 0856 Date & Time Restraint Order Received from MD Date: 9/13/2020 Time: #1 0805 #2 0853 ... Date & Time Actually Placed in Seclusion Date: 9/13/2020 Time: 0806 Date & Time Actually Placed in Seclusion Date: 9/13/2020 Time: 0827 Date & Time Seclusion Order Received from MD Date: 9/13/2020 Time: 0807... Date & Time Chemical Restraint Order Received from MD Date: 9/13/2020 Time: 0853 Date & Time Nurse Actually Administered Chemical Restraint Date: 9/13/2020 Time: 0856... Resident Behavior at Time of Release: Calm... 0856 Observation/ Behavior Code 14, 15." The form documented the corresponding behavior at 0856, the same time the form documented the chemical restraint was given, of 14 as "Calm/Quiet/Willing to talk and 15 as "Exit Criterion met, no longer a danger." The same time was documented when the resident

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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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was placed in a restraint for Time #2 and the time an order was obtained for a chemical restraint.

An Emergency Safety Intervention Physician Orders for documented,"Date 9/13/2020 Time 0853 Give Resident Zyprexa/ Benadryl X one dose now for increased behavioral Dyscontrol." There was no order observed on the form for a second restraint.

A Nursing Progress Note documented,"9/13/2020 0803 The resident was in the cafeteria and walked over to a peer and pushed him to the ground. The resident slapped the peer across the neck and attempted to kick the peer. Staff members stepped between the residents. The resident refused attempts to redirect behavior. The resident continued to be aggressive towards the peer. The resident was restrained for safety per [Doctor] order at 0803. The resident continued aggression towards staff members. The resident was placed in seclusion at 0806 per Dr's order. The resident became calm and was released from seclusion at 0827. At 0850, the resident again be escalated and aggressive towards staff members. The resident climbed onto chairs in the dayroom and refused to come down. When staff members approached the resident, he slapped, kicked and hit the staff members. After numerous attempts to redirect the resident's behavior, the resident continued to try to hit and kick staff members. The resident was restrained for safety per Dr.'s order at 0853. The resident became aggressive towards staff members while restrained. The resident refused attempts to calm down. The resident was given a chemical restraint per Dr.'s order at 0856 for continued dyscontrol. The resident was given Zyprexa 10 mg and Benadryl 50 mg via

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intramuscular injection. The resident was released from the restraint at 0856."

b. An Emergency Safety Intervention Justification Progress Note documented,"Date & Time Actually Placed in Restraint 9/20/2020 Time 1130 Date & Time Removed from Restraint 9/20/2020 at 1134 Date & Time Restraint Order Received from MD 9/20/2020 Time: 1130. . .Date & Time Chemical Restraint Order Received from MD Date: 9/20/2020 Time 1131 Date & Time Nurse Actually Administered Chemical Restraint 9/20/2020 1134 Medication Administered: Zyprexa/ Benadryl Dosage 10 mg/ 50 mg Route IM...Resident Behavior at Time of Release: R calm...Observation/ Behavioral Code 1134 12." The form documented the corresponding behavior at 1134, the same time the form documented the chemical restraint was given, of 12 as "Sad/Crying." There was only one minute documented between the time the client was placed in a restraint and the time an order was obtained for a chemical restraint.

An Emergency Safety Intervention Physician's Orders form documented,"Date 9/20/2020 Time 1130 Restrain resident for up to 30 minutes for continued (cont) bx dyscontrol ... Date 9/20/2020 Time 1131 Give Resident Zyprexa 10 mg/ Benadryl 50 mg X one dose now for increased behavioral Dyscontrol." There was only one minute documented between the time for the order for the restraint and the order for the chemical restraint.

c. An Emergency Safety Intervention Justification Progress Note documented,"Date & Time Actually Placed in Restraint 9/23/2020 Time 1845 Date & Time Removed from Restraint Date 9/23/2020

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PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

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Time 1848 Date & Time Restraint Order Received from MD 9/23/2020 Time: 1844. ... Date & Time Chemical Restraint Order Received from MD Date: 9/23/2020 Time 1846 Date & Time Nurse Actually Administered Chemical Restraint 9/23/2020 1848 Medication Administered: Zyprexa/ Benadryl Dosge: 10 mg/ 100 mg Route IM...Resident Behavior at Time of Release: Calm...Observation/ Behavior Code 1848 15." The form documented the corresponding behavior at 1848, the same time the form documented the chemical restraint was given, of 15 as "Exit Criterion met, no longer a danger." There was only one minute documented between the time the client was placed in a restraint and the time an order was obtained for a chemical restraint.

An Emergency Safety Intervention Physician's Orders form documented,"Date 9/23/2020 1844 Restrain resident for up to 30 minutes for up to 30 minutes... Date 9/23/1010 1846 Give Resident Zyprexa/ Benadryl 100 X one dose now for increased behavioral control." There was only 2 minutes documented between the time the order for the restraint and the order for the chemical restraint.

A Nursing Progress Note documented," 9/23/2020 1845 This resident began to climb the walls in the dayroom, sitting in the water fountain, and walking on the chairs during hygiene time. Resident then came out of the dayroom and poured an entire bottle of soap on the carpet. When the staff intervened and attempted to take the bottle of soap from resident, the resident then began slapping and punching staff. Resident then ran in to a peer's room and went went under a peer's bed. Staff intervened and resident then

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began slapping, punching, and kicking at staff when redirecting resident out from under the peer's bed. Restrained for safety per MD order at 1845. Resident continued to shove, fight, and kick staff during the restraint and refused all staff attempts to de-escalate. MD notified and new order obtained to give resident Zyprexa 10 mg/ Benadryl 100 mg IM X1 dose now related to (r/t) behavioral dyscontrol at 1848."

8. Client #7 had diagnoses of Disruptive Mood Desegregation Disorder, Other Specific Trauma and Stressor Disorder (complex trauma, sexualized behaviors), and Attention-Deficit/Hyperactivity Disorder,Unspecified.

The Master Treatment Plan documented,"If resident becomes upset or is in danger of hurting self or someone else, what interventions have been effective?" Sitting by the Nurse's Station, Talking to Another Resident, Deep Breathing/ Relaxation, Calling a friend, and Listening to Music were the interventions checked on the form.

a. An Emergency Safety Intervention Justification Progress Note documented,"Date & Time Actually Placed in Restraint 9/14/2020 Time:1645 Date & Time Removed from Restraint Date: 9/14/2020 Time: 1648 Date & Time Restraint Order Received from MD Date 9/14/2020 1643... Date & Time Chemical Restraint Order Received from MD 9/14/2020 Time 1645 Date & Time Nurse Actually Administered Chemical Restraint Date: 9/14/2020 Time 1648 Medication Administered: Ypres/ Beady Dosage: 10/100 Route IBM...Resident Behavior at Time of Release: Calm...1648 Observation/Behavior Code 14, 15."

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The form documented the corresponding behavior at 1648, the same time the form documented the chemical restraint was given, of 14 as "Calm/Quiet/Willing to talk" and of 15 as "Exit Criterion met, no longer a danger." The same time was documented when the resident was placed in a restraint and the time an order was obtained for a chemical restraint.

An Emergency Safety Intervention Physician's Orders form documented,"Date: 9/14/2020 Time: 1643 Restrain resident for up to 30 minutes for assault box/ property destruction. . .Date: 9/14/2020 1645 Give Resident Ypres 10 mg/ Beady 100 mg X one dose now for increased behavioral Dyscontrol." There was only 2 minutes from the time of the order for a restraint and the order for a chemical restraint.

A Nursing Progress Note documented,"9/14/2020 1645 Resident in annex building with staff. Resident became upset with a peer and began pushing and shoving against staff to get to the peer. Staff attempted to stand in between resident and peer. Resident then began to pull apart the wall and pull wires and an exit sign down. Resident restrained for safety and continued to fight staff AEB hitting and kicking staff. Resident unable to de-escalate and 10 mg Zyprexa IM X 1 now and 100 mg Benadryl IM X 1 now ordered by the physician and administered at 1648 for behavioral dyscontrol."

b. An Emergency Safety Intervention Progress Note documented,"Date & Time Actually Placed in Restraint Date:9/19/2020 Time 0826 Date & Time Removed from Restraint Date: 9/19/2020 Time 0830 Date & Time Order Received from MD Date: 9/19/2020 Time: 0810. . .Date & Time

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Chemical Restraint Order Received from MD Date 9/19/2020 Time 0817 Date & Time Nurse Actually Administered Chemical Restraint Date: 9/19/2020 Time: 0830 Medication Administered: Thorazine/ Benadryl Dosage: 50mg/100 mg Route: IM...Resident Behavior at Time of Release: R calm... 0830 Observation/ Behavior Code 15." The form documented the corresponding behavior at 0830, the same time the form documented the chemical restraint was given, of 15 as "Exit Criterion met, no longer a danger."

An Emergency Safety Intervention Physician's Orders form documented,"Date 9/19/2020 Time: 0810 Restrain resident for up to 30 minutes for cont. unsafe bx... Date 9/19.2020 0817 Give resident Thorazine 50 mg/ Benadryl 100 mg X one dose now for increased behavioral Dyscontrol." There was only 7 minutes from the time the restraint was ordered until the time the chemical restraint was ordered.

9. Client #11 had a diagnosis of Unspecified Trauma and Stressor Related Disorder.

The Master Treatment Plan Review documented,"If resident becomes upset or is in danger of hurting self or someone else, what interventions have been effective?" Talking to Another Resident, Talking with Male Staff, Pacing the Halls, Talking with Female Staff, Calling a Friend, Exercise, Drawing, and Listening to Music were the interventions checked on the form.

a. An Emergency Safety Intervention Justification Progress Note documented,"Date & Time Actually Placed in Restraint Date: 9/20/2020 Time: 1100 Date & Time Removed from Restraint Date:

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9/20/2020 Time: 1102 Date & Time Restraint Order Received from MD 9/20/2020 Time: 1058...Date & Time Chemical Restraint Order Received from MD Date: 9/20/2020 Time: 1101 Date & Time Nurse Actually Administered Chemical Restraint Date:9/20/2020 Time 11:02 Medication Administered: Thorazine/ Benadryl Dosage: 100 mg/ 100 mg...Resident Behavior at Time of Release: Calm...1102 Observation/ Behavior Code 14, 15." The form documented the corresponding behavior at 1102, the same time the form documented the chemical restraint was given,of 14 as"Calm/ Quiet/ willing to talk" and of 15 as "Exit Criterion met, no longer a danger." There was only 1 minute between the time it was documented that the client was placed in the restraint and the time an order for a chemical restraint was obtained.

An Emergency Safety Intervention Physician's Orders form documented,"Date: 9/20/2020 Time: 1058 Restrain resident for up to 30 minutes for property damage/ physical aggression... Date: 9/20/2020 Time: 1101 Give Resident Thorazine 100/ Benadryl 100 X one dose now for increased behavioral Dyscontrol." There was only 3 minutes documented from the time the order for a restraint was obtained and the order for a chemical restraint was obtained.

A Nursing Progress Note documented,"9/20/1010 1100... Resident then began busting through the unit doors and refused all redirects by staff. Restrained for safety per MD order at 1100. During restraint, resident continued to escalate and began shoving staff. Resident refused to de-escalate despite all staff attempts. MD notified and resident given Thorazine 100 mg/ Benadryl 100 mg IM X 1 dose now r/t behavioral dyscontrol

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N 126	Continued From page 35 per MD order at 1102." 10. Client #13 had diagnoses of Unspecified Trauma and Stressor Related Disorder and Intellectual Disability, Mild. The Master Treatment Plan Review documented, "If resident becomes upset or is in danger of hurting self or someone else, what interventions have been effective?" Talking to Another Resident, Lying Down with Cold Face Cloth, Calling a friend, and Other: chew gum, play cards, playing video games were interventions checked on the form. a. An Emergency Safety Intervention Justification Progress Note documented, Date & Time Actually Placed in Restraint "Date: 9/3/2020 Time: 1815 Date & Time Removed from Restraint Date: 9/3/2020 Time: 1820 Date & Time Restraint Order Received from MD Date: 9/3/2020 Time: 1813 ... Date & Time Chemical Restraint Order Received from MD Date: 9/3/2020 Time 1818 Date & Time Nurse Actually Administered Chemical Restraint Date 9/3/2020 Time: 1820 Medication Administered: Zyprexa/ Benadryl Dosage: 10 mg/ 50 mg Route: IM...Resident Behavior at Time of Release: Calm and getting tired... 1820 Observation/ Behavior Code 11, 14, 15." The form documented the corresponding behavior at 1820, the same time the form documented the chemical restraint was given, of 11 as Quiet, of 14 as"Calm/ Quiet/ willing to talk" and of 15 as "Exit Criterion met, no longer a danger." There was only 5 minutes between the time it was documented that the restraint the client was placed in the restraint and the time an order for a chemical restraint was obtained.	N 126		

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An Emergency Safety Intervention Physicians Orders form documented, "Date: 9/3/2020 Time 1813 Restrain resident for up to 30 minutes for property damage... Date: 9/3/2020 Time 1818 Give Resident Zyprexa 10 mg/ Benadryl 50 mg X one dose now for increased behavioral Dyscontrol." There was only five minutes documented between the time the restraint order was obtained and the time the order for the chemical restraint was obtained.

11. On 10/1/20 at 11:02 a.m., Licensed Clinical Social Worker #1 was asked, when a client has escalation in behavior, what should the staff do? She stated, "Remove clients from situation, try to isolate the Kido who is acting up, have the staff process with the Kido, which includes things like what do you need at this moment, offer to see if therapist is available. If not find a staff they feel conformable, connected with to help with that processing." The Social Worker was asked, when should a restraint be used? She stated, "A restraint should never be used except in a dire emergency, as a last resort and used for the child's safety." The Social Worker was asked, is this a physical restraint? She stated, "Yes, we should never put our hands on anybody unless they are a danger to theirselves, someone else and then that should be announced such as telling them, you need to calm down example, hey Kido if you can't get you to calm, we are going to have to come and help you calm down." What happens after you have to restrain them? She stated, "I would continue to have a dialogue with them, such as if they say 'let me go, let me go', then I would say alright if I let you go will you calm down? If the Kido could not calm nursing should get involved then nursing would assess the next step whether it's seclusion or chemical

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	[redacted]	A. BUILDING _____ B. WING _____	C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY RIDGE TREATMENT CENTER, INC	[redacted] **FAYETTEVILLE, AR** [redacted]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 126	Continued From page 37	N 126		

restraint." The Social Worker was asked, when should a chemical restraint be used? She stated, "I'm with the thought process of it shouldn't. That should be the last, last, last resort."

12. On 10/1/20 at 11:28 a.m., Therapist #1 was asked, when should a chemical restraint be used? She stated, "Imminent danger to the child or other people, that should be used as a last resort." Therapist #1, a Mental Health Professional was asked, should a chemical restraint be given within three minutes of the client being physically restrained? She stated, "Absolutely not, at the very short end five minutes. I would definitely say that is too soon, because three minutes doesn't give them time to reset and begin to calm down...We have CPI (Crisis Prevention Intervention) training that is being done, but it is heavy on restraints and I do not feel like they are heavy on de-escalation."

13. On 10/6/20 at 9:38 a.m., the DON (Director of Nursing) was asked, when the Doctor signs a restraint order how is that done? She stated, "They come in once a week and some come in three times a week, it just depends. They don't come in immediately." The DON was asked do they, the Doctors, see the kids when they sign the order? She stated, "They are seeing them telemed mostly." The DON was asked, how do they determine who is seen? She stated, "If the nurses do a consult, like if someone gets hurt they are seen. If they are just restrained and not necessarily hurt they don't necessarily see those kids or if they are [State] kids they don't see those kids." The DON was asked, when do they regularly see the kids? She stated, "When they are doing Master Treatment Plan review. All the kids have MTPRs (Master Treatment Plan

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N 126	Continued From page 38	N 126		

Reviews). When it's time for them to have MTPRs they go over all the restraints, any infractions, activities, medications to see if there are any adjustments that need to be done. The Doctor, therapist, nurse and the children come in to the meeting, it's all over telemed right now. They sit in front of the computer, the doctor asks how are you doing, how do you fee about your meds (medications), is there anything we need to change." The DON was asked, how often are they done? She stated, "[State] is every twenty-one days and every other state is twenty-eight days." The DON was asked, they are done about once a month? She stated, "Yes." The DON was asked, if the child is having frequent chemical restraints, they address that about once a month? She stated, "Yes."

14. The facility Policy on Emergency Safety Intervention, received from the Medical Records Director on 9/28/20 at 10:05 a.m., documented, "...1. Purpose: To provide Guidelines for implementing the therapeutic use of restraint and seclusion...III. Definitions: A. Chemical Restraint: The administration of a one-time psychotropic medication only by the order of a staff physician or approved physician extender to act as an adjunct to any previously prescribed treatment. Chemical restraint is a crisis intervention used to resolve an emergency safety situation to contain severe out of control behavior, exacerbation of psychosis which is likely to cause harm to the resident, or other residents, or staff. Such medications are to be prescribed by the physician or approved physician extender in the lowest possible doses necessary to reduce anxiety and/or agitation exhibited by the resident. The intended goal shall not be to induce unconsciousness, shall not be used as a punitive

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measure, and shall not be used as a convenience for staff. It shall be utilized when, by the assessment of the Physician and the RN (Registered Nurse), the use of physical force could be potentially more traumatic to the resident. The intended goal should be to prevent injury to the resident or other residents or staff and to allow the resident the ability to process more appropriate ways to meet his or her specific needs...IV. Procedure: A. Physical Restraint and Seclusion Justification: Prior to the use of seclusion, chemical restraint, or physical restraint a clinical assessment is conducted by the physician, approved physician extender, or clinical qualified RN (Registered Nurse) trained in the use of emergency safety interventions. Alternative approaches, such as verbal redirection, separation from stimulus, processing with another staff member, and encouraging movement to a quieter environment should be tried first...B. Physical Restraint and Seclusion Orders:...6. All less restrictive interventions utilized to prevent the use of seclusion, physical restraint, or chemical restraint will be documented such as: a. emphasis of self-control. b. Appropriate venting of anger with a staff member. c. Discussion of problem in a one-on-one meeting with staff. d. Separation from person contributing and/or feeding into the aggression or escalating behavior. e. Emphasis on responsibility for one's own choices...E. Notification of Registered Nurse to Clinical Director and Medical Director: 1. The Registered Nurse must notify the Medical Director and Clinical Director if there are two (2) or more occurrences of seclusion or physical restraint within a (12) hour period to evaluate the emergency safety situations and take actions as deemed necessary...I. Physical Restraint and Seclusion Evaluation and Performance

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N 126	Continued From page 40 Improvement Activities: 1. The Director of Nursing or designee will review each use of chemical restraint, physical restraint, and/or seclusion daily and will investigate unusual or unwarranted patterns. 2. As part of the Committee of the Whole meetings, the Safety, Risk Management, and Infection Control Committee will review the use of physical restraint and seclusion each month to assess ways in which to create a social and cultural environment which limits physical restraint and seclusion use to clinically appropriate and adequately justified situations. 3. As part of the Committee of the Whole meetings, the Performance Improvement Committee shall assign Interdisciplinary Work Groups to address any trends and/or patterns of use and work towards elimination of seclusion and physical restraint...."			
N 144	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(e) Each order for restraint or seclusion must: (1) Be limited to no longer than the duration of the emergency safety situation; and (2) Under no circumstances exceed 4 hours for residents ages 18 to 21; 2 hours for residents ages 9 to 17; or 1 hour for residents under age 9. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was an active order for use of restraint and/or seclusion procedure for one (Client #3) of 13 sampled residents (Resident 1 - 13) who were restrained or secluded. The findings are:	N 126 N 144	N144 Findings: Failure to ensure there is an active order for use of seclusion and/ or restraint. Corrective Action and Education: The Director of Nursing and Nurse Supervisors provided training on the Emergency Safety Interventions Policy and documentation requirements related to active orders for seclusion and/or restraint to all Registered Nurses which included: • Ensuring a clinically qualified Registered Nurse/Licensed Practical Nurse obtains an order from a physician for all episodes of seclusion and/or restraint at the time of initiation of an emergency safety intervention or immediately after, not to exceed 60 minutes. • Ensuring RNs/LPN immediately contact the ordering physician in order to receive further instructions if an emergency safety situation continues near the time limits of the order.	

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

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FORM APPROVED
OMB NO. 0938-0391

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N 144	Continued From page 41 1. Client #3 had diagnoses of Disruptive Mood Dysregulation Disorder, Unspecified Trauma and Stressor Related Disorder, and Unspecified Anxiety Disorder. a. A Nursing Progress Note documented,"9/13/2020 0803 The resident was in the cafeteria and walked over to a peer and pushed him to the ground. The resident slapped the peer across the neck and attempted to kick the peer. Staff members stepped between the residents. The resident refused attempts to redirect behavior. The resident continued to be aggressive towards the peer. The resident was restrained for safety per [Doctor] order at 0803. The resident continued aggression towards staff members. The resident was placed in seclusion at 0806 per Dr's order. The resident became calm and was released from seclusion at 0827. At 0850, the resident again be escalated and aggressive towards staff members. The resident climbed onto chairs in the dayroom and refused to come down. When staff members approached the resident, he slapped, kicked and hit the staff members. After numerous attempts to redirect the resident's behavior, the resident continued to try to hit and kick staff members. The resident was restrained for safety per Dr.'s order at 0853." b. An Emergency Safety Intervention Justification Progress Note documented,"Date & Time Actually Placed in Restraint Date: 9/13/2020 Time: #1 0803 #2 0854 Date & Time Removed from Restraint Date 9/13/2020 Time: #1 0806 #2 0856 Date & Time Restraint Order Received from MD Date: 9/13/2020 Time: #1 0805 #2 0853 . . . Date & Time Actually Placed in Seclusion Date: 9/13/2020 Time: 0806 Date & Time Actually	N 144	Responsible Individual: Director of Nursing, Director of Residential Training and Development Auditing and Monitoring: The Director of Nursing, Nurse Supervisors and designated staff complete random audits of 30 inpatient records monthly, using the Seclusion and Restraint Audit Tool to verify: • Every event of seclusion and/ or restraint contains an active order. • The Director of Nursing or designated individual aggregates, analyzes and reports all results from these chart audits and Leadership Rounds monthly, along with a plan of correction for any indicator scoring below 90%, to the Quality Council. • The Risk/PI Director reports QAPI data results along with a plan of correction for any indicator scoring below 90% monthly to the Medical Executive Committee	

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N 144	Continued From page 42 Placed in Seclusion Date: 9/13/2020 Time: 0827 Date & Time Seclusion Order Received from MD Date: 9/13/2020 Time: 0807..." c. An Emergency Safety Intervention Physicians Orders form dated 9/13/20 documented, "Date: 9/13/20 Time: 0805 Restrain resident for up to 30 minutes for physical aggression..." This physician order expired at 0835. A new physician order was not obtained for the restraint use at 0854. d. On 9/28/20, during clinical record review, there was no documentation of a Physician's Order for a second restraint for 9/13/20. e. On 9/30/20 at 1:35 p.m., the Risk Manager was asked, is there a separate order for the physical and chemical restraint that occurred on 9/13/20 at 8:53 a.m. for Client #3, and she stated, "No."	N 144		

20210318 Piney Ridge OHCA CAP Review Findings [Redacted]

OKLAHOMA
Health Care Authority

Serving Oklahomans
through SoonerCare

Kevin Corbett | Chief Executive Officer

J. Kevin Stitt | Governor

Post-CAP Reassessment Review Findings

3/19/2021

[redacted] Director PI/RM
Piney Ridge Treatment Center
[redacted]
Fayetteville AR [redacted]

RE: Psychiatric Residential Treatment Program(s) 200131960C

Dear Ms. Adams,

On 3/18/2021, the Oklahoma Health Care Authority's (OHCA) Service Quality Review (SQR) team completed a desktop post-Corrective Action Plan (CAP) review of your facility. This letter is to inform you of the review findings and any steps you will need to ensure compliance with regulations and your OHCA contract.

This CAP follow-up consisted of reviewing all submitted documentation including clinical record documents for four (4) SoonerCare members to determine compliance status in three (3) areas identified as needing correction in your most recent review. The following is an overview of these findings.

Overall, great improvement was noted in several areas during this review. Therefore, we plan to end the continuing, frequent post-CAP reassessment reviews you have been undergoing. However, please keep in mind that any issues identified as not fully meeting requirements in this review will be audited during your next annual SQR with the expectation of improved compliance.

Finding 1: Individual Plan(s) of Care (IPCs) – Partial Compliance, Needs Improvement

Collaboration with the guardian was not documented in four (4) of the IPCs reviewed, and on multiple plans the signature page section asking if the guardian participated in plan development was checked "no." Three (3) charts contained a page not included with the plan of care that indicated the IPC signature page was mailed to the guardian. These were counted as having documentation of collaboration for this review, but in the future this may not be accepted as mailing just the signature page with no other communication

occurring does not give the guardian an opportunity to review the plan of care or participate in the care planning process. Be aware that OHCA expects good faith efforts (such as phone calls on different days &/or times) to reach a guardian for IPC review, and these efforts must be documented. It is recommended that this documentation be included with the relevant IPC.

Finding 2: Active Treatment – In Compliance

Significant improvement was noted in this area. In all, shortages of active treatment hours were noted in only four (4) of the fourteen (14) weeks of treatment reviewed. Of these, only one (1) was missing a note for the service completely. The remaining instances were due to documentation errors and are discussed below.

Finding 3: Active Treatment Documentation – Partial Compliance, Needs Improvement

Many areas of active treatment documentation showed marked improvement compared to previous reviews. No duplicate notes were identified, and many activity therapy notes included insightful, individualized observations about the resident's participation and learning process during the groups. Additionally, there were fewer instances of elective service notes missing required elements; although there were eight (8) elective service notes that were missing a start &/or stop time enough other services were provided and appropriately documented that this did not result in any shortages of required treatment. Documentation issues which did create a shortage of active treatment hours included two (2) family therapy notes in the same chart that indicated the sessions lasted only five (5) minutes each, and one (1) instance of overlapping service times for individual and family therapy which caused a shortage of 30 minutes individual therapy. The content of the family therapy notes with start/stop times documenting five (5) minute sessions seemed to indicate a longer session was likely provided, so these were treated as a documentation error rather than missing active treatment hours.

Additional Areas Of Note

In addition to the issues related above, the following additional areas were noted as being significant during this post-CAP review:

1. Multiple group rehab notes were observed to have inappropriate additions and/or corrections to them. This was found in all charts reviewed to a greater or lesser extent. In some cases, information was documented on the same note in what appeared to be two (2) noticeably different handwriting styles & ink. In others, lines were drawn

through parts of the note and different information documented, also often in what appeared to be a different handwriting style and ink. These notes were counted toward active treatment hours for this review but may not be allowed in future reviews. Corrections and additions to medical record documentation must indicate who made the change, by ***legible*** signature or initials, and the date the changes were made. Failure to follow these guidelines in the future may result in recoupment.
2. Overall therapy notes were very thorough and provided excellent evidence of ongoing treatment and residents' progress through the therapy process. Additionally, several individual & family therapy and collateral notes documented active and ongoing efforts to create a thorough discharge plan including safety planning with guardians and referrals to appropriate outpatient supports.

We appreciate your continuous efforts at quality improvement for our members and hope to see continued improvement in the future.

Respectfully,

[redacted], LPC Digitally signed by [redacted], LPC
Date: 2021.03.19 09:08:50 -05'00'

[redacted], LPC
Behavioral Health Specialist
Service Quality Review - Behavioral Health Operations
Oklahoma Health Care Authority
[redacted].
Oklahoma City, OK 73105
Phone: [redacted] ~ Fax: [redacted]
Email: [redacted]@okhca.org

20210401 MillcreekofArkansas CMS-OLTC-final report [Redacted]

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

PRINTED: 04/13/2021
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

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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. A Focused Fundamental survey was conducted from March 29, 2021 through April 1, 2021.	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 and interview the facility failed to ensure walls were repaired and new paint added, paneling and trim were repaired, sinks were cleaned and free of dark substances, sheetrock was replastered and free from gouges, air/heating vents were repaired and exits sign were secured in 1 (Oak Creek) residence; Failed to ensure missing cabinets in the dining room were replaced, cabinet doors were hung correctly, and bottom cabinet shelves were in good repair, a used grease container was empty and in good repair, a plexiglass was mounted correctly and was free of tape, window sills were	W 104		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 repaired and painted, dining room walls and doors were painted, the base boards were intact, edging on cabinets were replaced, linoleum was replaced, heating vents were cleaned, the refrigerator was repaired to stop leakage and a hole behind a pipe in the kitchen was repaired and foam pipe sealant was applied correctly in 1 (Boys Ranch) residence. Failed to ensure chairs and couches were free from cracks, tears and holes in the seat cushions, backyard equipment was repaired and or removed from premises, multiple floor tiles throughout the residence were free of discoloration or replaced, air vents were free from dust and dirt and shower walls were clean and free form black discoloration in 1 (Willow Creek) residence and; Failed to ensure mattresses were in good condition or replaced and vent covering were secured to maintain a comfortable, safe environment for 1 (Haley House) residence. The findings are: 1. On 3/30/2021 at 11:25 a.m., in the Oak Creek residence, the following was observed: a. There was a shelf located in the living room with multiple areas of paint missing. b. At 11:37 a.m., there was an approximately 18-inch-long and 1-inch wide piece of paneling that had pulled away from the wall. This area was in the living room, next to the above shelf. c. At 11:44 a.m., in the bathroom located to the right of the entrance door to the living room, there was a dark unknown substance on the bathroom sink counter.	W 104		

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W 104	Continued From page 2 d. At 11:48 a.m., a section of corner trim was damaged and had some of the trim missing in the hall to the right of the entrance door to the living room. The area missing was approximately 18 inches long by 1/4 inch wide. e. At 11:55 a.m., in bedroom #3, there was a gouge in the sheetrock by the bed. This gouged area measured approximately 18 inches by 3 inches. f. At 12:00 p.m., the air return vent next to the dining room was damaged and bent. g. At 12:05 p.m., the heating vent in the floor of the kitchen was bent down into the duct work. h. At 12:15 p.m., in the bathroom near room #8, there was a dark substance on the back wall of the shower. It measures approximately 6 inches by 1/4 inch. There were also multiple areas with dark substance on the wall above the shower stall. i. At 12:20 p.m., the exit sign between room #4 and the living room was loose. One corner of the sign was hanging approximately 1 1/2 inches down from the ceiling and a screw was exposed on that corner. j. At 12:50 a.m., the countertop in the kitchen near the refrigerator had 2 visible broken tiles. One tile measured 6 inches by 4 inches and the second tile measured approximately 6 inches on the side and 3 inches on the top of the counter and had a missing tile piece in this area. 2. On 3/30/21 at 10:24 a.m., in the Boys Ranch house, the following was observed.	W 104		

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MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

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W 104	Continued From page 3 a. One of six doors on a cabinet, outside of the kitchen in the dining room, was missing, and coats were stuffed into the open cabinet. The Dietary Manager was asked, how long has the door been off? She stated, "A long time. It used to be a soda fountain that sat here, but now it's gone, and it's turned into a lost and found storage cabinet." b. At 10:43 a.m., a black cooking oil bin was located outside in the back of the cafeteria. There was a buildup of a black greasy substance on the top of the bin and a black greasy substance was running from the bin into a field behind it. (pictures were taken at this time). On 3/31/21 at 4:31 p.m., the Administrator was asked, "When has the bin been emptied, is it still being used?" He stated, "I don't know." The Administrator was asked, "Should it be emptied?" He stated, "Those things are through a contract, so I don't know if it's being used and it's leaking. Then it needs to be removed and the dirt excavated, and new dirt brought in. You can't leave the grease out there. It's not going to go away." c. At 11:23 a.m., a Plexiglas window located in the living area had tape across the bottom and approximately 8 inches up the right side. The window had been screwed into the frame. Behavioral Health Assistant (BHA) #7 was asked, "Why is this taped?" She stated, "The edging came off and they put tape to keep the wind, cold out. The BHA was asked, "How long has that tape been there?" She stated, "They put it up there when it snowed to keep the snow out." The windowsill had areas of missing paint exposing the wood. (Pictures were taken at this time).	W 104		

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	[redacted]	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

(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 104	Continued From page 4 d. The dining room walls, from the floor to approximately halfway up the walls, and the base boards had areas of missing and chipped paint. The swing door separating the kitchen and the dining room had areas of missing paint. (Pictures were taken at this time). e. At the entrance to the dining room the linoleum was missing and an area approximately one foot in diameter, in front of the cabinets in the kitchen, was missing. (Pictures were taken at this time) f. The edging around the bar, to the right of the entrance to the kitchen, had edging missing, exposing the wood. (Pictures were taken at this time). g. The heating vent in the dining room had a build-up of dust and a black substance. (Pictures were taken at this time). h. On 3/31/21 at 7:55 a.m., a towel was on the bottom shelf inside the refrigerator. Cook #1 was asked, "Why is that towel across the bottom of the shelf?" She stated, "Because it leaks, sometimes it leaks in the back and runs to the front and we have to put a towel on the side to keep it from running out in the floor." The cook was asked, "How long has it been doing that?" She stated, "It started last year." The Cook was asked, "Have you told anyone?" She stated, "Yes, and I imagine she did a maintenance request on it." There was a brown discoloration on the bottom shelf of the refrigerator. The Cook stated, "That's the reason the bottom is rusted, because it is leaking." (Pictures were taken at this time).	W 104		

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W 104	Continued From page 5 i. The bottom of the cabinet on the end, near the storage area, which contained the pots and pans was discolored with a black substance and had a strong moldy, stale smell. Cook #1 stated, "That's where the pipe was leaking. The maintenance fixed the pipe, but that was left." The Cook was asked, "How long ago was that?" She stated, "Ten months." (Pictures were taken at this time). j. There was a piece of linoleum, triangle shaped, coming loose from the left top side of the cabinet. k. A black pipe, which came down from the ceiling, through the top cabinets on the left side of the sink, had a hole behind it in the wall that had aluminum foil stuffed into the hole. The bottom edge of the pipe, which ran through the back of the countertop, had a foam sealant around the bottom which ran down onto the cabinet. (Pictures were taken at this time). l. The front of the dishwasher had a buildup of an unknown brown substance. 3. On 3/30/21 at 8:03 a.m., the following observations were made in the Willow Creek residence. a. A chair outside the medication room had multiple cracks in the back and seat cushions. (Picture was taken). A vent and light fixture in the bathroom by the medication room had dirt and or dust on them. (Picture was taken). b. At 10:12 a.m., equipment in the backyard area was in disrepair. This equipment included an old ramp, within 25 feet of a basketball court used by	W 104		

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the clients, with railing leaning and in pieces, and ramp itself with multiple areas missing, torn up, and pieces hanging from bottom of the ramp. (Pictures were taken). A piece of outdoor equipment with a slide, rope climb and other attachments with rotten boards and screws sticking out. (Pictures taken). A wooden swing, within 10 feet of a swing used by the clients, had holes in the metal frame which holds the swing, and multiple boards missing in the swing itself resulting in large holes in the seat of the swing. (Pictures were taken). Two wooden structures resembling pieces of a train, had black discoloration, board pieces missing from the decorative wheels resulting in rough surfaces and rusty screws sticking out. (Pictures were taken). None of the equipment was marked as "keep off," "unsafe", or blocked off in any way to prevent clients from getting on them. The back of the house to the right of the gate and close to the air conditioner unit had an approximately 5-foot patch of black appearing substance and moss on the lower bricks and concrete. (Pictures were taken).

c. On 3/30/21 at 10:12 a.m., Unit Coordinator #2 was asked, "How do you keep the clients away from the equipment in the backyard that is falling apart?" She stated, "They don't go over there. They mainly go to the basketball court and the swings, but they don't go over there. That stuff came from a different unit, Boys Ranch. It was falling apart 5 years ago when I was over there, and then they just moved it over here."

d. On 3/31/21 at 7:06 a.m., in a couch by the single window in the living room area, there were holes and tears present in all 3 seat cushions. (Picture was taken). A chair next to this couch,

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against the wall, had cracks in the seat cushion. There was a couch by the TV, that had holes and a large circular indention in the left seat cushion. (Picture were taken).

e. At 9:51 a.m., Multiple floor tiles present in the dining room had gray discoloration (pictures taken). In the hallway past the dining room, the vent covering of the air filter was dirty and dusty. (Picture taken). Down the same hallway, the first bedroom to the right had gray discoloration of floor tiles inside the doorway. There were patches of thick dried on black substance in front of the closet door area. (Pictures were taken). Floor tiles were dirty and discolored inside door of back (last bedroom) down same hallway (picture taken). Large areas of black colored substance were present on the walls above the shower in the bathroom attached to the back bedroom. (Pictures were taken).

4. On 03/30/21 at 3:46 p.m., the following observations were made in the Haley House:

a. In bedroom #7, a bed, under the window, had a large, circular appearing indention in the middle of the mattress. (Picture taken). Bedroom #8 had 2 beds appearing to have indentions, running down the mid-center of the mattresses. (Pictures taken).

b. On 3/30/21 at 3:56 p.m., a vent cover in the sitting room was hanging from the ceiling by the screw in one end. (Picture taken).

c. On 4/1/2021 at 9:08 a.m., Unit Coordinator #1 (UC #1) was asked, "Have there been any complaints or concerns by the clients or staff about the condition of any of the mattresses in

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W 104	Continued From page 8 this house?" She stated, "I know some of them need to be replaced, are in pretty bad shape. I was just going to place a purchase order for them." She was then asked, "Do any of them have tears or holes in them to your knowledge?" She answered, "Not to my knowledge, the staff checks them every week when the linen is changed, and they would tell me if there were any holes or tears. It is just the general state of the mattresses." She was asked if she would accompany the surveyor to all the client bedrooms in Haley House to identify mattresses needing replacement. In bedroom 8, which belongs to 2 female clients, she was asked, "Do these 2 mattresses need replacing?" She stated, "Yes, and I know there are some in the boy's rooms that do too." In bedroom #7 (also a female client bedroom), while looking at the bed under the window UC #1 was asked, "Should this bed have the large crater appearing dip in the middle of the mattress? Should it be replaced?" She stated, "No, that shouldn't be there, it needs to be replaced." In each of the bedrooms belonging to male clients, the UC was asked to identify mattresses needing replacement. UC #1 identified mattresses in bedroom #1 (2 mattresses), bedroom #3 (2 mattress), bedroom #4 (1 mattresses), bedroom #5 (1 mattress). After the UC identified 9 mattresses needing replacement, she stated, "I will place a purchase order after you show the list to [Administrator]." d. On 4/1/21 at 3:15 pm, while being shown the pictures of the environment at Willow Creek, the Administrator was asked, "How do you ensure the clients stay off of the unsafe equipment in the back yard of Willow Creek?" He answered, "They know it is off limits."	W 104		

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W 159	Continued From page 9	W 159		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Qualified Intellectual Disability Professional (QIDP) documented observations based on client needs to ensure the clients' active treatment program was current for 3 (Client #1, #2, and #6) case mix clients. The findings are: 1. Client #6 had diagnoses of Mild Intellectual Disabilities, Disruptive Mood Dysregulation Disorder Combined Presentation, Hypothyroidism and Enuresis. a. On 3/31/2021 the client's chart was reviewed. The most recent QIDP observation documented in the client's chart was dated 10/6/2020. b. On 3/31/2021 at 10:45 a.m. the Administrator was asked if there were any documentation of QIDP observations more recent than 10/6/2020. At 10:55 a.m., more documentation was provided with a date of 10/26/20. c. As of 4/1/21 at 4:00 p.m., there was no more information provided by the facility of more recent QIDP documentation. 2. Client #2 had diagnoses of Mild Intellectual Disabilities, Disruptive Mood Dysregulation Disorder, Posttraumatic Stress Disorder, and Attention Deficit Hyperactivity Disorder Combined Presentation.	W 159		

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W 159	Continued From page 10 a. On 3/31/2021 the client's chart was reviewed. The most recent QIDP observation documented in the client's chart was dated 10/7/2020. b. On 3/31/2021 at 3:20 p.m., the Administrator was asked if there was any documentation of QIDP observations more recent than 10/7/2020. c. As of 4/1/2021 at 4:00 p.m., there was no more information provided by the facility of more recent QIDP observations/documentation. 3. Client #1 had a diagnosis of Moderate Intellectual Disabilities. a. On 4/1/2021 the client's chart was reviewed. The most recent QIDP observation documented in the client's chart was dated 10/6/2020. b. On 3/31/2021 at 3:20 p.m., the Administrator was asked if there was any documentation of QIDP observations more recent than 10/6/2020. The Administrator stated, "We don't have them."	W 159		
W 341	NURSING SERVICES CFR(s): 483.460(c)(5)(ii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to control of communicable diseases and infections, including the instruction of other personnel imethods of infection control. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff had temperatures taken and	W 341		

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were screened for COVID prior to working in 2 residences and failed to ensure staff wore mask to prevent the potential spread of the COVID-19 virus. The findings are:

1. On 03/30/2021 at 8:35 a.m., Behavior Health Associate (BHA) #2 was asked, "Were you screened for COVID this morning before starting work?" She answered, "I did screening on the main campus." She was asked, "Do you go to the office before coming to work?" She stated, "Yes, we go to the main office and get screened."

2. On 03/30/21 at 9:25 a.m., the Administrator was asked, "Where are staff screened in the office in the morning before starting their shift in the houses?" The Administrator stated, "They are screened at their houses before they can go in and be with the clients. I wouldn't expect the staff from Boys Ranch to come all the way in here, so they do it in the houses." He was asked, "Staff aren't screened here in the office in the early morning?" He stated, "No."

3. On 03/30/2021 at 9:40 a.m., BHA #3 was asked, "Where are you screened for COVID before you come in the house?" She answered, "We are not really, we were at one time." She was asked, "How long has it been since you were screened, or your temperature taken?" She stated, "Not for months maybe." She was asked, "Do you have a temperature documented for this morning?" She answered, "No it wasn't taken." She was asked, "Is there any paperwork showing recent screening in the house?" She looked in a folder with screening forms, showed that all were blank, and then stated, "No."

4. On 03/30/2021 at 9:44 a.m., Unit Coordinator

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(UC) #2, was asked, "Who should take temperatures before the staff come in the residence?" She answered, "We normally have the nurse, or I check, but my thermometer isn't working, so I'm going to get another one."

5. On 03/30/2021 at 10:34 a.m., UC #1 was asked, "How were you screened for COVID this morning?" She stated, "I took my temperature, we have to take our own. I got here at 9, my temperature was 97.4 and I wrote it here on this sheet [Sheet titled "Employee Pre-work disease prevention clearance worksheet dated 3/30/21]." UC #1 was then asked, "Who else is working in the house today?" She identified the staff members, including Behavior Health Associate (BHA) #1. She was then asked, "Why is there no temperature or screening by her name?" She answered, "It should be on here. I get here at 9 and I try to check. She is in the classroom, not here right now."

6. On 03/30/2021 at 11:20 a.m., BHA #1 was asked, "What time did you get to the house and start working this morning?" She replied, "7:05." She was asked, "How were you screened for COVID this morning before entering the residence?" She stated, "You mean like my temperature? We can either go to the nurse or we can take it ourselves. I prefer to go to the nurse." She was asked, "Did you get your temperature taken this morning?" After thinking about it, she then stated, "No, I guess I didn't. We were busy this morning." She was asked, "Should you have been screened and had your temperature taken before starting work according to policy?" She answered, "Yes."

7. A document from the facility infection control

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W 341	Continued From page 13 policy and procedure manual titled, "Prevention Strategies for Transmission of the Coronavirus in Healthcare Settings", was received from the Administrator on 04/01/2021 at 3:30 pm., documented, " ...Utilize a screening tool to assure an adequate screen is performed to enter the facility." 8. A document received from the Administrator on 04/01/2021 at 3:30 pm, titled "Happy Holidays from Infection Control and Employee Health" included: "Continue to take your temperature before reporting to work." 9. On 3/30/2021 at 12:08 p.m., during the lunch meal, Developmental Trainer (DT) #1 walked through the dining room, talking to clients who were at the dining room tables, coming within 2 feet of the clients and was not wearing a mask. The DT was asked, "What have they told you about wearing masks around the clients?" He stated, "We don't have to have them on when eating, but if we are around them, we have to have them on." The DT was asked, "I saw you walking around and talking to the clients in the dining room, "Should you have had the mask on while walking through there talking to the clients?" He stated, "Probably should have, yes." 10. On 3/30/2021 at 12:13 p.m., during the lunch meal, Behavioral Tech (BT) #1 who did not have a mask on, was sitting at the dining room table between two clients who were eating. The two clients were approximately 2 feet away from her on each side. The BT was asked, "What have they told you about wearing masks?" She stated, "You are always supposed to have them on at all times."	W 341		

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W 341	Continued From page 14 11. On 3/30/2021 at 2:10 p.m., Teacher #1 was in class, at her desk without a mask on from 2:10 p.m. to 2:52 p.m. Two clients went up to the teacher's desk, within 3 feet of the teacher during this time. Teacher #1 was asked why she was not wearing a mask. The teacher stated, "My mouth was sore, and the mask was tight on me." 12. On 3/30/2021 at 5:35 p.m., two Behavioral Health Associates (BHA) were eating supper at the table with 3 clients without social distancing. BHA #5 was sitting on the side of the table. 1 client was sitting across the table from BHA #5, approximately 2 feet away. Another client was sitting at the end of the table, approximately 2 feet away. BHA #6 was sitting on the other end of the table. A client was sitting on the side of the table to her left side, approximately 2 feet away. 13. On 3/30/2021 at 5:50 p.m. and 5:55 p.m., BHA #6 and BH #5 were asked if they usually ate with the clients. They both responded "Yes." 14. A facility memorandum note provided by the Administrator on 4/1/2021 at 3:30 p.m., documented, "Happy Holidays from Infection Control and Employee Health . . . you will be required to wear your mask at all times."	W 341		
W 371	DRUG ADMINISTRATION CFR(s): 483.460(k)(4) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.	W 371		

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W 371	Continued From page 15 This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the active treatment medication objective was conducted to increase potential in meeting individual objectives for 4 sampled clients (Clients #1, #5, #7 and #8) who were observed on medication pass. The findings are: 1. Client #7 had diagnoses of Intellectual Disability Mild and Disruptive Mood Dysregulation Disorder. a. On 3/30/2021 at 12:15 p.m., Licensed Practical Nurse (LPN) #2 administered medication (meds) to the client. The LPN did not ask the client any questions or give the client any information/teaching related to his medication during this time. b. The Medication (Med) Teaching - March 2021 sheet in the medication room documented, "[Client #1] will state shape of meds without assistance." 2. Client #8 had diagnoses of Intellectual Disability: Mild, Unspecified Mood Disorder, and Other Conduct Disorders. a. On 3/30/2021 at 12:25 p.m., LPN #2 administered the client medication. The LPN did not ask the client any questions or give the client any information/teaching related to his medication during this time. b The Med Teaching - March 2021 sheet in the medication room documented, "[Client #8] will give times meds taken without assistance."	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

(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 371	Continued From page 16 3. Client #1 had a diagnosis of Intellectual Disability: Moderate. a. On 3/30/2021 at 7:40 p.m., LPN #3 administered the client medication. The LPN did not ask the client any questions or give the client any information/teaching related to his medication during this time. b. The Med Teaching - March 2021 sheet in the medication room documented, "[Client #1] state name without assistance." 4. On 3/31/2021 at 8:25 a.m., LPN #2 was asked about the objectives for medication teaching and why she did not do any teaching related to the objectives for Client #7 and Client #8 during the medication pass on 3/30/2021. The LPN stated the objectives were on a sheet that was posted on the inside of the door to the medication closet. LPN #2 also stated that she did most of her teaching in the mornings. 5. Client #5 had diagnoses of Moderate Intellectual Development Disorder, and Disruptive Mood Dysregulation Disorder (a mental disorder with frequent temper outbursts). a. On 03/31/2021 at 9:00 a.m., LPN #1 administered medication to Client #5 in the Haley House. Client #5 was calm, cooperative, and alert. She was handed a cup of medication and a cup of water with laxative when she came to the nurse's station window. The client did not participate in the medication process in any other way and stated nothing about her medications. The nurse did not provide any teaching or other discussion about the medications.	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

(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 371	Continued From page 17	W 371		

b. On 03/31/2021 at 9:05 a.m., LPN #1 was asked, "What is [Client #5's] SAMs (Self Administration of Medications) objective?" The LPN replied, "I don't think they want her giving her own medication, she has a history of drug seeking." LPN #1 was asked, "What about an objective to learn about her medications so she can participate and become more independent?" The LPN stated, "I don't know what it is." The LPN proceeded to find a clipboard with papers on a shelf, then stated, "It says here she is supposed to name her meds." The LPN was asked, "Did you have her do that this morning." She stated, "No."

c. On 04/01/2021 at 8:50 a.m., LPN#1 again administered medication in The Haley House and had just finished with Client #5. LPN #1 was asked for a copy of the medication training objectives for Client #5. The March objectives were no longer present on the clipboard, only medication teaching sheet dated for April (Picture was taken). The April training objective on the "House Med Teaching -April 2021 document the objective for Client #5 was "Name am meds without assistance." LPN #1 was asked, "If this is the second day you are in this house giving medications in the morning, and [Client #5] is supposed to be getting training on her AM medications according to this teaching plan, how is she getting trained on them if you aren't doing it?" She stated, "I teach at Boys Ranch, the other nurse does it." She was asked, "The nurse in the PM does it?" She stated, "Yes." She was asked, "If the objective is for [Client #5] to learn her morning medicines, how does the nurse in the evening do it? Isn't that confusing for [Client #5]?" LPN #1 answered, "She goes over the evening

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

(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 371	Continued From page 18 medications, they are the same, or about the same as the morning medicines." d. On 04/01/2021 at 9:45 a.m., a document named, "Haley House Med Teaching -March 2021", was received from the Assistant Director of Nursing (ADON). It documented Client #5 was to "Name am [morning] meds without assistance." The ADON was asked, "Is this objective part of the master treatment or active treatment plan?" She stated, "Yes." She was asked, "What is the process for developing this objective?" She answered, "Every month I get the sheets from the nurses on how the client is doing with their objective. Then I look at this guide ["Nursing written training program reference"], and I use it to develop the next month's objective." She was then asked, "Should each nurse work with the client every time they administer medicines to help the client achieve their objective?" She stated, "Yes, unless there is some reason not to, like the client is having a bad day."	W 371		
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 was stored and labeled to maintain freshness in 1 (Willow Creek) of 4 (Willow Creek, Oak Creek, Boys Ranch and Haley House) residences to prevent the potential for food borne illness. The findings are:	W 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] **FORDYCE, AR** [redacted]

(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 19 1. On 03/30/2021 at 8:23 a.m., the refrigerator, freezer and kitchen in Willow Creek were inspected with the following findings: a. The freezer had 7 shopping bags wrapped around unlabeled, undated items (Pictures were taken); Behavior Health Associate (BHA) #2 was asked, "Are these shopping bags wrapped around food?" She stated, "Yes." She was asked, "Should all these undated, unlabeled foods be in the freezer?" She stated, "No, I'm getting ready to throw them away." She was then asked, "What about the butter and cheese in the refrigerator with no date?" She stated, "Same." b. In the refrigerator there were 10 squeeze bottles, (not original containers), stored in the refrigerator door, none of which had caps on the tips. (Picture was taken). One bottle was labeled "Mayo 4/28/20", one was labeled "Barbeque 2020". Four of the squeeze bottles had no labels. (Pictures were taken). None of the squeeze bottles had expiration or use by dates on them. BHA #2 was asked, "Should all the bottles that are unlabeled, undated be in the refrigerator?" She stated, "No, except the kids remove them at lunch time." She was then asked, "What about the bottles dated 2020?" She replied, "No." c. A large plastic jar of ketchup was found on the kitchen counter, close to the refrigerator. Around the bottom of the jar lid was a large thick ring of dried red substance appearing to be ketchup (picture taken). BHA #2 was asked, "Should it have been left this way?" She stated, No, I'll throw it out." d. On 04/01/2021 at 3:33 p.m., the Administrator	W 454		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[redacted]	A. BUILDING _____ B. WING _____	04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCREEK OF ARKANSAS	[redacted] FORDYCE, AR [redacted]

(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 20 provided a document with the facility name titled "Chapter 16 - Nutrition Services." It documented, "All reusable food products should be stored using the proper procedures, legibly labeled, and dated."	W 454		

20210527 Millcreek of Arkansas State Licensure-routine [Redacted]

Arkansas Department of Human Services
Division of Child Care & Early Childhood Education
Placement & Residential Licensing Unit

Licensing Compliance Record

Agency Name: Millcreek [redacted] Person In Charge: [redacted]
Address: [redacted] Phone: [redacted]
Licensing Specialist: [redacted]
Date of Visit: 5 21 21 Purpose of Visit: Building and Grounds | Licensure

STANDARD REVIEWED	DISCUSSION/OBSERVATION	COMPLIANCE DATE	DATE CORRECTED
	TA - Sunshine Discussed with [redacted] about fire that happened ~~5-21~~ 5-15-21 at oak creek where children were moved to sunshine. [redacted] reported that incident was reported to licensing. This placement is temporary until oak creek repairs are complete. It was also discussed that placements in TCFMR program age 21 and over are considered adults by licensing and require seperate programming.		

COMMENTS of Person receiving form:

[redacted] 5/27/21
PERSON SIGNING AS RECEIVING DATE

[redacted] 5.27.21
LICENSING SPECIALIST DATE

DCCECE 521 PR

Arkansas Department of Human Services
Division of Child Care & Early Childhood Education
Placement & Residential Licensing Unit

Licensing Compliance Record

Agency Name: Mulberry **Person In Charge:** [redacted]
Address: [redacted] **Phone:** [redacted]
Licensing Specialist: [redacted]
Date of Visit: 5.27.21 **Purpose of Visit:** Building and Grounds JCTMR

STANDARD REVIEWED	DISCUSSION/OBSERVATION	COMPLIANCE DATE	DATE CORRECTED
	Specialist viewed building and grounds/areas used by children:		
	Haley's:	6.27.21	
409.6	Hole in the wall in Room 3	6.27.21	
409.6	Crack in the wall in Room 1	6.27.21	
409.9	Peeling in the wall (Paint) Room 2		
	Oak Creek's	6.27.21	
409.6	Weak spot in kitchen floor	6.27.21	
409.6	Crack in Bathroom wall	6.27.21	
409.6	Room 1 window where is a gap	6.27.21	
	Boys Ranch's		
409.6	Laundry door needs fixing	6.27.21	
408.1	Hornest Nest removal		
409.6	Bathroom light switch is broken	Willow Creek	
409.6	Toilet handle broken		
	Sunshine's	6.27.21	
409.6	Bathroom light switch isn't work		

COMMENTS of Person receiving form:

[redacted] 5/27/21
PERSON SIGNING AS RECEIVING **DATE**

[redacted] 5.27.21
LICENSING SPECIALIST **DATE**

DCCECE 521 PR

Arkansas Department of Human Services
Division of Child Care & Early Childhood Education
Placement & Residential Licensing Unit

Licensing Compliance Record

Agency Name: Millcreek of Arkansas **Person in Charge:** [redacted]
Address: [redacted] Fordyce, AR [redacted] **Phone:**
Licensing Specialist: [redacted]
Date of Visit: 5-27-21 **Purpose of Visit:** Monitor Visit (Bldg + Grounds)

STANDARD REVIEWED	DISCUSSION/OBSERVATION	COMPLIANCE DATE	DATE CORRECTED
901.2-	Ensure all children are accounted for at all times. Specialist [redacted] observed a child asleep in room and unattended by staffo in Kangaroo Hall Rm. 461.	NC	NC
911.6	Ensure all building shall be safe, clean, and in good repair. (Hole in wall outside nurse's station in Tiger Hall, Broken bathroom sink knob in Pebble Creek #1, Gazebo roof with exposed nails.	5/27/21	

COMMENTS of Person receiving form:

[redacted] 5/27/21
PERSON SIGNING AS RECEIVING DATE

[redacted] 5-27-21
LICENSING SPECIALIST DATE

DCCECE 521 PR

Arkansas Department of Human Services
Division of Child Care & Early Childhood Education
Placement & Residential Licensing Unit

Licensing Compliance Record

Agency Name: Mulcreek **Person In Charge:** [redacted]
Address: [redacted] **Phone:** [redacted]
Licensing Specialist:
Date of Visit: 5.27.21 **Purpose of Visit:** Monitor Visit / Building

STANDARD REVIEWED	DISCUSSION/OBSERVATION	COMPLIANCE DATE	DATE CORRECTED
	Specialist viewed building and grounds/ areas used by children:		
911.6	Rock Hill: Room 2 and 4 - Trim missing Peeling	6.27.21	
911.4	Plate missing in Main area	6.27.21	
911.6	Holes in wall in Room 8 and 9	6.27.21	
	Magnolia:		
911.6*	Painting - TA - Agency is working on painting	—	
911.6	Hall 2 bathroom is missing Showerhead	6.27.21	
911.15 (F)	Room 2 found Shoe strings	5.27.21	5.27.21
	Deerfield:		
910.1	playground: Broke swing and trash	6.27.21	

COMMENTS of Person receiving form:

[redacted] 5/27/21
PERSON SIGNING AS RECEIVING **DATE**

[redacted] 5.27.21
LICENSING SPECIALIST **DATE**

DCCECE 521 PR

Arkansas Department of Human Services
Division of Child Care & Early Childhood Education
Placement & Residential Licensing Unit

Licensing Compliance Record

Agency Name: Mill Creek of Arkansas **Person In Charge:** [redacted]
Address: [redacted] Fordyce, AR [redacted] **Phone:**
Licensing Specialist: [redacted]
Date of Visit: 5-27-21 **Purpose of Visit:** Monitor Visit (Bldg & Grounds)

STANDARD REVIEWED	DISCUSSION/OBSERVATION	COMPLIANCE DATE	DATE CORRECTED
R 908.8.	Ensure medication is logged at the time it's given. Specialist Breedlove reviewed med log dated 5/27/21 for [redacted] and noticed his 8am had'nt been initialed. Nurse advised she had given it to him but forgot to initial.	NC	NC
711.15f.	Ensure all drawstrings, shoe strings, large hair bands or other like items are removed or not left in child's room. (items may be used to inflict self-injury).	5/27/21	
	Zebra Hall Shoestrings Rm. 307 Student with string in hoodie (sweatshirt pullover)	5/27/21	
	Flamingo Hall Shoestrings Rm. 205	5/27/21	
	Kangaroo Hall Drawstring in Clothing Rm. 403	5/27/21	
	Tiger Hall Shoestring Rm. 207 Shoestring Day room	5/27/21	
	Pine Ridge Hall Shoestrings - Bedroom 5/7	5/27/21	

COMMENTS of Person receiving form:

[redacted] 5/27/21
PERSON SIGNING AS RECEIVING DATE

[redacted] 5-27-21
LICENSING SPECIALIST DATE

DCCECE 521 PR

20210618 Resource TJC complaint-report [Redacted]

Appendix 23

Appendix 23.

Final Accreditation Report

R.T.C. Resource Acquisition Corporation
[redacted]
Indianapolis, IN [redacted]

Organization Identification Number: [redacted]
Unannounced OQPS Event: 6/18/2021 - 6/18/2021

Program Surveyed
Behavioral Health Care and Human Services

Final Report: Posted 6/22/2021

The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	06/18/2021 - 06/18/2021	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

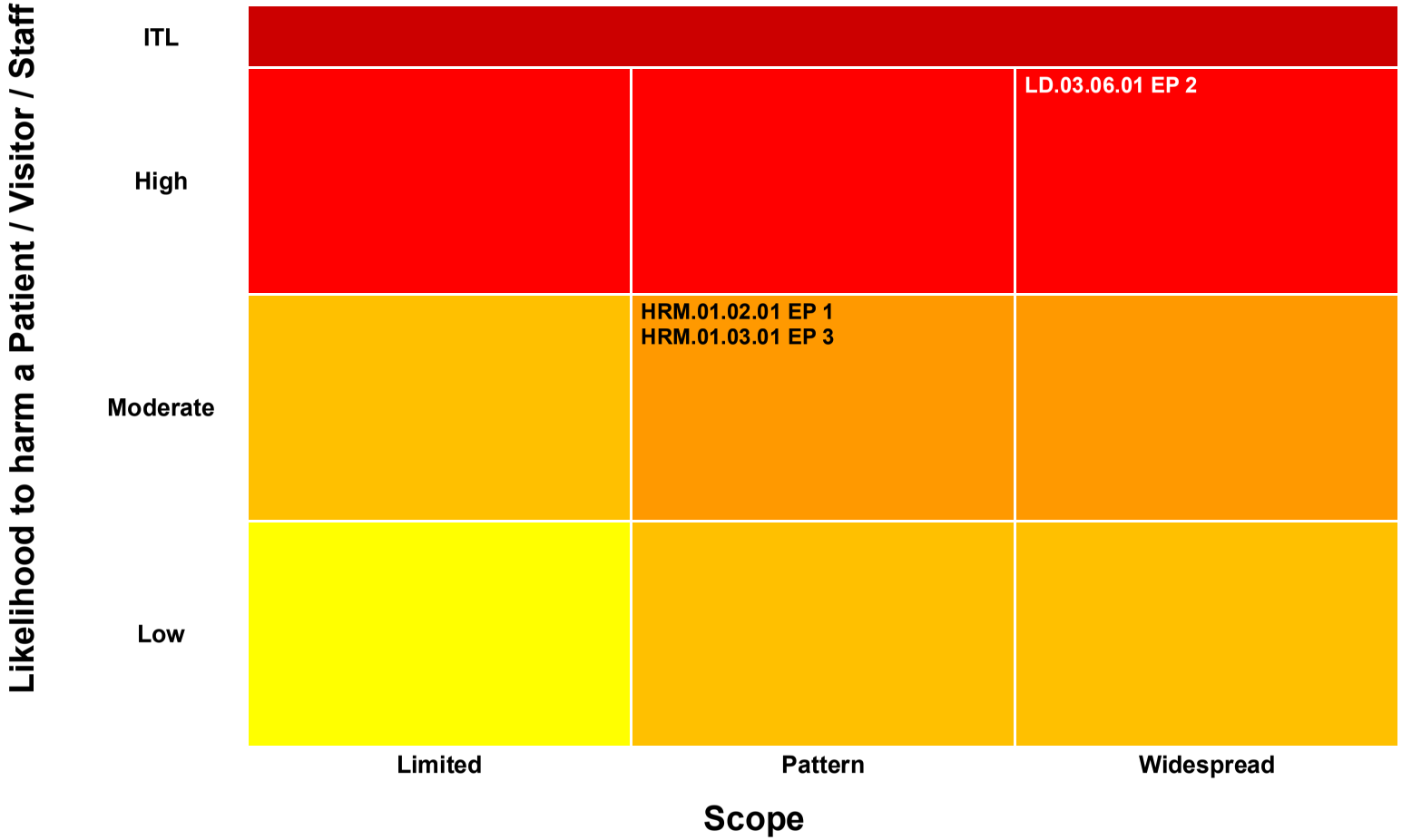
The Joint Commission
What's Next - Follow-up Activity

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	Included in the Evidence of Standard Compliance (within 60 calendar days)
HRM.01.02.01	1	Moderate / Pattern	✓
HRM.01.03.01	3	Moderate / Pattern	✓
LD.03.06.01	2	High / Widespread	✓

The Joint Commission
SAFER™ Matrix

Program: Behavioral Health Care and Human Services



The Joint Commission
Requirements for Improvement

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	EP Text	Observation
HRM.01.02.01	1	Moderate Pattern	The organization performs primary source verification of staff licensure, certification, or registration in accordance with law and regulation and organization policy at the time of hire and the time of renewal. Note 1: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 2: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary. Note 3: In some instances, a staff member may also work for another Joint Commission–accredited organization. If the other organization has completed primary source verification of the staff member's license, certification, or registration; can attest to that fact; and is willing to share that information with the behavioral health care or human services organization, then primary source verification does not need to be completed a second time by the organization. The credentialing information would need to be made available upon demand during a Joint Commission survey.	1) Observed in HR File Review at R.T.C. Resource Treatment Facility (1[redacted]Indianapolis, IN) site . In 2 of 3 patient records reviewed, there was no documentation of primary source verification for the Psychiatric Director in 2018 and there was none for the Clinical Director who was hired in 2019. Documentation of licensure for the Clinical Director consisted of a copy of the licensure card that was issued to this employee. This finding was verified the Human Resource Director.
HRM.01.03.01	3	Moderate Pattern	The organization orients staff on the following: - Policies and procedures related to job duties and responsibilities. - Their specific job duties and responsibilities. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7) - Sensitivity to cultural diversity based on their job duties and responsibilities. Note: Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization. - The rights of individuals served, including the ethical aspects of care, treatment, or services. (See also RI.01.07.03, EP 5) Completion of this orientation is documented.	1) Observed in HR File Review at R.T.C. Resource Treatment Facility ([redacted]Indianapolis, IN) site . In 2 of 3 HR files reviewed, there was no documentation that verified completion of orientation for the Director of Nursing and the Clinical Director. This finding was confirmed by the Human Resource Director.

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation
LD.03.06.01	2	High Widespread	Leaders provide for a sufficient number and mix of staff to support safe, quality care, treatment, or services.	1) Observed in Document Review at R.T.C. Resource Treatment Facility ([redacted] Indianapolis, IN) site . On October 15, 2020, the Indiana Department of Children Services placed a Resource referral hold on admissions and required a Plan for Correction. The Plan of Correction was recorded as November 13, 2020. The reasons given for this action included the following: 1.) four elopements between October 5, 2020 through October 12, 2020. One of these residents was already on elopement precautions, 2.) on October 17, 2020 several girls (11) were found to be engaging in sexually inappropriate activity, 3.) on October 18, 2020, Police responded to call about a female resident assaulting a staff nurse, and 4.) on October 11, 2020, an altercation with several residents with staff took place. A resident took a staff member's badge and along with the other residents ran through the facility. It was reported that some peers, on another unit, locked themselves in a bedroom and broke a window in an attempt to escape. The Police detained eight residents and three were sent to the hospital for psychological evaluation. The Interim CEO states that at the beginning of June, approximately 2 weeks prior to this special survey on Jun 18, 2021, the organization determined the need to close a residential unit and consolidate residents to improve staffing levels. He stated that after seeing a significant decrease in physical holds and administration of stat medications (October 2020: 97 holds and 50 stat medications to April 2020: 16 holds and 4 stat medications), the organization began to see an increase in these numbers in May of 2020. Leadership then made the decision to close a residential unit.

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
HRM.01.02.01	1	The organization verifies and evaluates staff qualifications.	The organization performs primary source verification of staff licensure, certification, or registration in accordance with law and regulation and organization policy at the time of hire and the time of renewal. Note 1: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 2: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary. Note 3: In some instances, a staff member may also work for another Joint Commission–accredited organization. If the other organization has completed primary source verification of the staff member's license, certification, or registration; can attest to that fact; and is willing to share that information with the behavioral health care or human services organization, then primary source verification does not need to be completed a second time by the organization. The credentialing information would need to be made available upon demand during a Joint Commission survey.
HRM.01.03.01	3	The organization provides orientation to staff.	The organization orients staff on the following: - Policies and procedures related to job duties and responsibilities. - Their specific job duties and responsibilities. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7) - Sensitivity to cultural diversity based on their job duties and responsibilities. Note: Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization. - The rights of individuals served, including the ethical aspects of care, treatment, or services. (See also RI.01.07.03, EP 5) Completion of this orientation is documented.
LD.03.06.01	2	Those who work in the organization are focused on improving safety and quality.	Leaders provide for a sufficient number and mix of staff to support safe, quality care, treatment, or services.

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

20210709 Millcreek of Arkansas state licensure-findings [Redacted]

Appendix 24.

Arkansas Department of Human Services
Division of Child Care & Early Childhood Education
Placement & Residential Licensing Unit

Licensing Compliance Record

Agency Name: Millcreek **Person In Charge:** [redacted]
Address: **Phone:**
Licensing Specialist: [redacted]
Date of Visit: 7/8/21 **Purpose of Visit:** B/G TA
Main Building

STANDARD REVIEWED	DISCUSSION/OBSERVATION	COMPLIANCE DATE	DATE CORRECTED
912.4	Bathrooms toilets need to cleaned on the following Units. Viewed rings of dirt and build up. Penguin, Zebra, Flamingo Cafe,	7/9/21	
912.2	Eagle Hall has 18 clients and only 1 working staff 2 dont work and the working shower is not draining properly	7/8/21	
913.5	Viewed beds that need new mattress due to excessive wear in the middle Zebra, Eagle, Kangaroo	7/30/21	
911.6	Bathrooms have missing knobs on showers (Penguin, Zebra, Kangaroo) Tiger Hall bathroom has peeling Epoxy in shower stall, Tiger Hall has peeling paint in stalls Eagle Hall toilet stall needs a new cover over flush button. Black/grey table needs to be replaced in room 609 (Eagle)	8/2/21	
911.15F	viewed tennis shoes w/ strings in a box on shelf in second room on right coming from the nurses station (Tiger Hall), Eagle room 603 viewed rope on empty luggage	7/8/21	

COMMENTS of Person receiving form:

[redacted] 7/8/21
PERSON SIGNING AS RECEIVING DATE

[redacted] 7/8/21
LICENSING SPECIALIST DATE

DCCECE 521 PR

Appendix 24.

Arkansas Department of Human Services
Division of Child Care & Early Childhood Education
Placement & Residential Licensing Unit

Licensing Compliance Record

Agency Name: Mill Creek **Person In Charge:** [redacted]

Address: **Phone:**

Licensing Specialist: [redacted]

Date of Visit: 7/8/21 **Purpose of Visit:** B&G, TA

STANDARD REVIEWED	DISCUSSION/OBSERVATION	COMPLIANCE DATE	DATE CORRECTED
911.6	Cafe walk in area needs to swept, excessive writing on boys bathroom wall shall be removed. Ceiling areas in halls need to be cleaned (removed dust & vents and remove webs)		

COMMENTS of Person receiving form:

[redacted] 7/8/21
PERSON SIGNING AS RECEIVING DATE

[redacted] 7/8/21
LICENSING SPECIALIST DATE

20210915 Resource-DCS-licensing review-report [Redacted]

Appendix 25.

DCS Audit Tool: Long Term Care and Emergency Shelter Care

Agency: RTC Resource **Main Address:** [redacted] Indianapolis IN 46203 **Main Phone Number:** [redacted]	**Dates of review**: 9/7/21 – 9/16/21
Administrator Name: [redacted] **Administrator Email**: [redacted] resourcetreatmentcenter.com **Other professional staff:** [redacted] R [redacted]	**Assigned Residential Licensing Specialist**: [redacted] **Assigned Clinical Service Specialist:** [redacted] **Specialists present during review:** N/A
Admissions Contact and email:	
License number(s): [redacted] **Effective License Dates:** Resource CCI, #[redacted] – 10/1/20 through 9/30/24 Cardinal Point group home, [redacted] – 10/1/20 through 9/30/24 Wind Rose group home for girls, [redacted] – 3/20/19 through 3/19/23 Resource PRTF, #[redacted] – 8/3/17 through 8/2/21	**Annual State Fire Marshal Inspection:** [redacted] – 2/3/21 – 2/3/21 – 2/8/21 – 2/8/21 **Annual Health, Food, and Sanitation (HFS) Survey:** [redacted] – 7/12/21 – 7/12/21 – 7/12/21 – 7/12/21 **Nutrition Program Approval:** [redacted] – 10/1/20 – 9/30/22 – 10/1/20 – 9/30/22 – 8/23/18 – 3/19/23 – 8/1/17 – 9/30/21 **Health Program Approval:** [redacted] – 10/1/20 – 9/30/22 – 10/1/20 – 9/30/22 – 8/6/18 – 3/19/23 – 8/1/17 – 9/30/21
Date background check review completed for each license: [redacted] – 8/2/21 – 9/8/21 – 9/8/21 – 9/9/21	

Program Service Categories/Specialty Programs:	**Description of any waivers/variances in place for agency licenses(s):**
1. **Open Residential** ☒ 2. **Emergency Shelter Care** ☐ 3. **Open Residential plus Emergency Shelter Care** ☐ 4. **Staff Secure/Intensive Residential** ☒ 5. **Secure Treatment** ☐ 6. **Independent Living/Residential Step Down** ☒ 7. **Short Term Diagnostic and Evaluation Services** ☐ 8. **Drug and Alcohol** ☐ 9. **Youth with Sexually Harmful Behavior** ☒ 10. **Developmental and Intellectual Disabilities** ☐ 11. **Teen Mom and Baby Program** ☐ 12. **Stabilization and Diagnostic Services** ☐ 13. **Sexually Exploited** ☐ **Any other specialty programs the agency is providing:**	#[redacted] – Waiver for [redacted] education for direct care supervisor Tyree Benson 9/1/20 #[redacted] – Waiver for [redacted] waiver for the requirement that all prospective employees, or institution employees, shall complete a separate application for employment prior to working in the Private Secure facility.

TREATMENT COMPONENTS AND DOCUMENTATION	**Probe/Source**	**Repeat**	**Comments**
1. The agency makes every effort to ensure the child maintains essential connections including visits and correspondence as approved by the placing agency. The agency does not take away essential connections as a means of punishment.	Child records Activity logs Treatment Plan Visitation logs Monthly notes CFTM notes		**Specialist reviewing: Residential Licensing specialist** **Impact Category: Direct** **Item Rating:** 3 **Findings:** For the files reviewed correspondence records, documentation of family therapy, CFTM notes and, documentation in the monthly treatment plan reviews indicated that Resource encouraged open communication with youth's family. The program descriptions for each program included open communication and private family visits (unless not approved by the placing agency) were every resident's right. **Required Action:** N/A **Additional Recommendations:** N/A

2. Services are provided to the child and family to adequately prepare them for the return home, including: • Providing avenues for communication • Addressing barriers to family therapy • Incorporating Parent/Guardian input into treatment plans, etc. • The method for achieving the child's permanency plan	Program Description Resident Handbook Interviews with families and children Clinical documentation Placing agency documentation		**Specialist reviewing: Residential Licensing specialist** **Impact Category: Direct** **Item Rating: 2** **Findings:** For the files reviewed the monthly reports documented services were provided and arranged for the youth and family. Family therapy notes and treatment team meeting notes documentation included the family and provided the families opportunity for input. However, the method for achieving the child's permanency plan was not consistently described. Not all monthly reports clearly indicated that that family input was incorporated into the planning and there was nothing indicating the parents were aware of the progress or lack of progress the youth was making. The therapy notes mainly addressed how the youth and family were feeling or, the status of their relationship at the time. For one youth the reports stated the mother and father should engage in family therapy but this was not documented as occurring. In the May report it stated the mother passed away but the reports for June and July state visitation is still taking place with the mother. The father is not mentioned. Then in the July report it states she is discharging to live with her sister's father in Georgia. For another youth the monthly reports stated she had visitation with the mother but then reported no family involvement. For some monthly reports the documentation of the youth's progress and the families' support of the youth as they moved toward discharge was clearly described. For some families the agency encouraged the families to come to the facility when the youth was struggling. For one youth the monthly reports clearly described improving relationships with the foster parents as she stated wanted to go to a group home but, her foster parent's wished her to return home. Monthly reports describe therapy regrading opening up positive communication with the family. For the youth on the SHB units the family notes clearly described the clarification process and addressed the impact of the youth's behavior with the family. For another transgender youth placed in the group home as a step down by probation, the monthly reports documented the parents were involved and all were ready for her to return home which was possibly occurring at court this month. Therapy notes addressed the need for her medical needs and

			adjustment during transition would be better met when she discharged. **Required Action:** **Additional Recommendations: Monthly reports should be reviewed thoroughly to insure that all information in the reports is accurate.**
3. The monthly reports include the following: a. Progress towards permanency plan goals. b. Progress towards treatment plan goals and objectives. c. Current needs of the child. d. Plans to meet the needs of the child. e. Specialized services are offered based on the individualized assessed needs.	Monthly Progress Reports Therapy Notes	**no**	**Specialist reviewing: Residential Licensing specialist** **Impact Category: Direct** **Item Rating: 1** **Findings: For the files reviewed the monthly reports did consistently state the permanency plan for the youth. However the progress reflected in the therapy and in the progress section of the monthly reports did not consistently relate it to the permanency plan or discharge plan. The notes on progress were vague describing an increase or decrease in behavior but did not address how this related to the permanency or discharge plan. The goal objectives described steps for achieving each goal but the interventions were the same month after month regardless of the youth's progress. Most youth had current needs the same month after month that were those needs identified at admission. The monthly reports included incidents from the month and were frequently discussed in the individual therapy notes. Strategies for reacting and coping were discussed in individual therapy sessions but it was unclear if the techniques were successful ad other techniques were offered in their place if they were not. The monthly reports did describe that services were being provided based on the youth's individual needs. Per the contract section D. "Responsibilities Relating to a Child in Residential Care. (5) Progress Reports";** The Contractor shall ensure that a progress report relating to the Child's current Case Plan and Treatment Plan is uploaded to the appropriate electronic record system by the 10th of each month and whenever necessary in conjunction with a court proceeding. The Contractor shall use any standard report form(s) required by DCS with relevant assessments, evaluations or other updates attached as necessary. Each progress report must specifically address the following: **· Progress toward Permanency Plan goals;** · Services provided, including behavioral health services (Contractor shall also keep case records that document, in detail, what services are being performed, what service

			provider is performing the services (if subcontracted), and the dates performed. This shall include a start and stop time on the case note); · **Treatment Plan goals and accomplishments;** · Current needs of the Child; · Plans to meet identified needs of the Child; · Projected discharge date; and · Any other information requested by the Placing Agency as it relates to the Child and family's progress. **Required Action:** **Additional Recommendations:**
4. Special precaution documentation includes the following: a. Rationale for initiation, including an initial assessment to identify behaviors that pose a risk to the child and/or others b. Ongoing assessment c. Documentation of supervision as indicated d. Rationale for discontinuation	Review policies and procedures Review of documentation	**no**	**Specialist reviewing: Clinical specialist** **Impact Category: Potential Risk** **Item Rating:** 1 **Findings:** Documentation provided for special precautions did reflect assessment and reassessment with rationale, however documentation of observation was not initialed 3x daily at 7:30 am, and 3:30 and 11:30pm. Instead "EOC" was printed in those time slots and there was no staff initialing documenting that youth was being observed. It is especially concerning that the forms have been this way and completed incorrectly for several months and there does not appear that anyone noticed or attempted to correct the errors. **Required Action:** Agency should ensure that all special precautions orders are followed with documentation of observation noted as ordered. Agency should also ensure there is an implemented process for oversight of documentation to catch and note any errors or deficits and corrections needed/made. **Additional Recommendations:** N/A
5. Documentation of 1:1 staffing reflects uninterrupted observation of resident, including staff assigned to the 1:1 (i.e. staff name, schedules, observation logs, etc.)	Review of staff schedules/assignments Review of observation documentation Review of staff documentation	**no**	**Specialist reviewing: Clinical specialist** **Impact Category: Potential Risk** **Item Rating:** 1 **Findings:** Nearly all documentation of observation reviewed had three time slots each day during which the 7:30 am, 3:30 and 11:30 pm slots had "EOC" printed on them and no staff initials. **Required Action:** Agency must ensure that documentation observation for 1:1 and special precautions is followed for all time slots. **Additional Recommendations:** Either amend these forms or create a separate form to note EOC round times to reduce

			potential for staff confusion as to what and where to document observation and EOC.
INCIDENT REPORTING AND DOCUMENATION	**Probe/Source**	**Repeat**	**Comments**
6. Incidents involving potential/suspected abuse and neglect are reported to the DCS hotline.	Incident Reports Policy and procedures Child records Agency Correspondence		**Specialist reviewing: Residential Licensing specialist** **Impact Category: Potential Risk** **Item Rating:** 2 **Findings:** Per review of the incident reports for the files reviewed if the report indicated potential/suspected abuse or neglect the DCS Hotline was called. Per the reports from the agency throughout the last year Resources Risk Management consistently reported incidents of suspected abuse and neglect to the DCS Hotline. **Required Action:** N/A **Additional Recommendations:** N/A
7. Critical incident reports are thorough and include all proper notifications to law enforcement and or placing agencies.	Critical Incident Reports DCS Critical Incident Report Categorization of Incidents Reported	**no**	**Specialist reviewing: Residential Licensing specialist** **Impact Category: Potential Risk** **Item Rating:** 1 **Findings:** For the critical incidents reviewed some reports were not thorough including a description of the antecedents to the behavior or incident. The incident report have a section for staff to indicate witnesses to the incident and this was frequently left blank. For a majority the date of the incident did not align with the date the report was written. Nursing notes and administrative reviews documented on the incident reports were sometimes dated several days later. Notification to the placing agency and parent/legal guardian were often several days after the incident occurred. According to the contract in section D under "Responsibilities Relating to a Child in Residential Care (11) Reporting Incidents", It is written "The Contractor shall report to the Placing Agency within 24 hours any issue concerning a child placed with the Contractor that impacts his or her health, case or Permanency Plan progression, welfare, or general well-being." **Required Action:** The Agency must insure that all critical incident reports are completed thoroughly including a thorough description of all contributing factors of the incident. The agency must also insure that systems and practices are followed for proper notification of incidents to the placing agencies and, parent/legal guardian if appropriate within 24 hours as required.

			Additional Recommendations: All incident reports should be reviewed for thoroughness by administration and any missing information or corrections made to insure all sections of each incident report are completed and the contents of the incident report reflects accurate information.
RESTRAINT/SECLUSION/TIME OUT	**Probe/Source**	**Repeat**	**Comments**
8. Restraint/seclusion is only utilized when a youth presents as a danger to self or others.	Review of Restraint/Seclusion policy and procedures Critical Incident documentation Staff logs Clinical notes Nursing notes		**Specialist reviewing: Residential Licensing specialist** **Impact Category: Potential Risk** **Item Rating:** 2 **Findings:** For the incident reports reviewed physical restraint techniques were only documented as utilized when the youth presented a danger to themselves or others. For the incident reports reviewed the narrative and intervention section noted that de-escalation techniques were attempted and if not successful the staff intervened with restraint. For those incidents when physical restraint was utilized there was documentation that the youth was assessed by a nurse. **Required Action:** N/A **Additional Recommendations:** N/A
MEDICAL SERVICES	**Probe/Source**	**Repeat**	**Comments**
9. Emergency care for the child is sought for serious injury or illness. If nursing staff are utilized, nursing documentation aligns with critical incidents.	Review of nursing notes Review of IRs and supporting documentation		**Specialist reviewing: Residential Licensing specialist** **Impact Category: Potential Risk** **Item Rating:** 2 **Findings:** For the files reviewed indicating youth required emergency medical services for serious injury or illness the nursing documentation on the incident report and in nursing notes documented that the physician was notified and the physician's orders followed. If ordered by the physician the youth was transported to the emergency room. **Required Action:** N/A **Additional Recommendations:** N/A
10. Agency documentation reflects pain assessment/management through to resolution.	Review of nursing notes and MARs Review of pain assessment forms	**no**	**Specialist reviewing: Residential Licensing specialist** **Impact Category: Potential Risk** **Item Rating:** 1 **Findings:** For the files reviewed meeting this criteria pain assessment and nursing notes did not consistently document that pain was monitored and managed through to complete resolution. For most youth the pain assessments were initiated but for some the last form indicated pain remained at a low level.

			Required Action: Resource must revise systems and practices to insure that documentation for any pain reported by the residents is managed through to resolution. **Additional Recommendations:** N/A
11. Physician documentation reflects rationale for medication(s). The agency shall obtain a written report at least every 30 days and the physician's actual observation of the child every 90 days for all youth who are prescribed psychotropic medication.	Review of physician documentation Agency policy and procedure Child records	no	**Specialist reviewing: Clinical specialist** **Impact Category: Potential Risk** **Item Rating: 1** **Findings:** Files reviewed revealed that several of the reviews were done further than 30 days apart. There was a physician signed review every month during the review period, however the quality of the documentation of those reviews was often poor. A number of the documents had incomplete medication names, medication names misspelled, incorrect dosage written, neglecting to copy medication correctly (ER for Extended Release medication showed up or not randomly through one file's documentation of medication prescribed), no mention of medication changes made during that review period, and in one case the discontinuation of one psychotropic medication and starting of a new one without mentioning it in the review. (or obtaining consent for the new medication). Some records had the medications for another youth handwritten in them then crossed out instead of just writing a new form with correct information. **Required Action:** Agency nurses should be trained in how to accurately copy medication orders, and the agency should put a process in place for review of these medical records to ensure that they are the correct medications, spelled well enough to be recognizable, correct dosage, and contain needed medication changes for that month. Doctor signing reviews should be encouraged to read the medication reviews and ensure they are written correctly before he signs them. **Additional Recommendations:** N/A
12. If the youth has required more than 3 "STAT" orders for psychotropic medication, the agency has developed a behavior management plan for the youth that includes: a. Specific target symptoms from the treatment plan b. Less-restrictive (non-medical) interventions to be exhausted prior to administering STAT medication	Review of documentation Child records Agency policy and procedure	**Yes** **rated 1, 2019** **rated 1, 2020**	**Specialist reviewing: Clinical specialist** **Impact Category: Potential Risk** **Item Rating:** 1 **Findings:** According to the contract in section D under "Responsibilities Relating to a Child in Residential Care", it is written: "Any behavior management plan must identify specific target symptoms from the Treatment Plan, less-restrictive (non-medical) interventions to be exhausted prior to administering the medication, and protocols for administration (e.g., route of administration, involvement of the Child,

c. Protocols for administration (route, child involvement, family notification, etc.) d. Documentation of at least monthly review by the treatment team			requirements for family notification, etc.). The behavior management plan must be approved by the prescribing physician, Clinical Director or CEO, and the parent/guardian prior to implementation and must be reviewed at least monthly by the treatment team." Behavior Management Plans provided do not clearly state the specific targeted behaviors that would trigger the use of a STAT medication. There were numerous triggers and responses listed, but nowhere was it made clear which of those behaviors would trigger use of a STAT medication and which would not. The plans provided do not have parent/guardian signatures. There were attached emails stating that the behavior plan had been sent, but no indication that the parent/guardian was involved in the process of developing or approving the behavior plan. There was no request to sign the plan or to respond with consent for the plan. One of the plans provided did not have a Clinical Director or CEO signature. The plans provided do not identify specific protocols to be utilized (medication to be used, route) **Required Action:** Agency must revise or develop behavior plans for STAT medication usage that meet the contractual requirements listed above. **Additional Recommendations:** N/A
13. Prior to implementation, the "STAT" Medication Behavior Management Plan has been approved and signed by: a. Prescribing Physician b. Clinical Director and/or CEO c. The parent and/or legal guardian	Review of documentation Child records Agency policy and procedure	**Yes** **rated 1, 2019** **rated 1, 2020**	**Specialist reviewing: Clinical specialist** **Impact Category: Potential Risk** **Item Rating:** 1 **Findings:** According to the contract in section D under "Responsibilities Relating to a Child in Residential Care", it is written: "Any behavior management plan must identify specific target symptoms from the Treatment Plan, less-restrictive (non-medical) interventions to be exhausted prior to administering the medication, and protocols for administration (e.g., route of administration, involvement of the Child, requirements for family notification, etc.). The behavior management plan must be approved by the prescribing physician, Clinical Director or CEO, and the parent/guardian prior to implementation and must be reviewed at least monthly by the treatment team." Behavior Management Plans provided do not clearly state the specific targeted behaviors that would trigger the use of a STAT medication. There were numerous triggers and responses

			listed, but nowhere was it made clear which of those behaviors would trigger use of a STAT medication and which would not. The plans provided do not have parent/guardian signatures. There were attached emails stating that the behavior plan had been sent, but no indication that the parent/guardian was involved in the process of developing or approving the behavior plan. There was no request to sign the plan or to respond with consent for the plan. One of the plans provided did not have a Clinical Director or CEO signature. The plans provided do not identify specific protocols to be utilized (medication to be used, route) **Required Action:** Agency must revise or develop behavior plans for STAT medication usage that meet the contractual requirements listed above. **Additional Recommendations:** N/A
14. Orders for PRN psychotropic medications have only been written after: a. Youth has received more than 3 STAT orders for psychotropic medications within a 30-day period b. The youth's medication regimen related to the use of STAT and ongoing medications has been reviewed c. The Behavior Plan has been developed and reviewed	Review of Dr. orders Review of documentation Child records Agency policy and procedure		**Specialist reviewing: Clinical specialist** **Impact Category: Potential Risk** **Item Rating**: N/A **Findings:** no youth have had PRN psychotropic medications prescribed during the review period. **Required Action:** N/A **Additional Recommendations:** N/A
ADDITIONAL REQUIREMENTS FOR PROGRAMS SERVING YOUTH WITH SEXUALLY HARMFUL BEHAVIORS	**Probe/Source**	**Repeat**	**Comments**
15. Agency ensures that court and treatment recommendations are followed related to home visits, community passes and contact with victims.	Review of clinical documentation, court orders, case plans, etc. Documentation of the communication of the expectations of court orders and treatment recommendations.		**Specialist reviewing: Clinical specialist** **Impact Category**: **Potential Risk** **Item Rating**: 3 **Findings**: Agency documentation indicated all court orders were followed. **Required Action**: N/A **Additional Recommendations**: N/A
16. Youth have received a sexual psychosexual evaluation by a specifically trained clinician prior to or within 14 days of placement.	Review of assessment		**Specialist reviewing: Clinical specialist** **Impact Category**: **Direct** **Yes** ☒ **No** ☐

			Findings: Agency had a sexual risk evaluation for each of the files reviewed, however there was no evidence provided that 2/3 youth had full risk assessments updated as required in the service standard. There was also no date listed anywhere on the one updated assessment provided. Date was implied by a date noted as to when the report was emailed to the referral agent, but no actual date on any of the reports. **Required Action**: Sexual risk assessments must have a date on them and also be regularly updated every 6 months as required in the service standard. **Additional Recommendations**: N/A
17. Clarification and safety planning are completed for all youth prior to being reunified with victims.	Review of clinical documentation		**Specialist reviewing: Clinical specialist** **Impact Category: Direct** **Item Rating:** 2 **Findings:** Agency provided clear documentation of working toward clarification with youth reviewed. No youth have yet been reunified with victims nor are they expected to in the near future, so this specific safety planning has not been completed. **Required Action:** N/A **Additional Recommendations:** N/A
18. Safety plans are developed and updated throughout the treatment process to match risk/needs/responsivity.	Review of documentation including monthly reports and safety plans	**no**	**Specialist reviewing: Clinical specialist** **Impact Category**: **Direct** **Item Rating**: 0 **Findings**: Safety plans were provided for the files reviewed, but there was no evidence provided that they were updated. **Required Action**: Agency should review and update safety plans regularly. **Additional Recommendations**: N/A
MISCELLANEOUS	**Probe/Source**	**Repeat**	**Comments**
19. Any other issues identified during the review process but not previously addressed by this tool.			**Impact Category: Potential Risk** **Item Rating:** 0 **Findings:** Youth LC had a new psychotropic medication prescribed on 3/2/21. There was no signed consent in the youth's record. **Required Action:** Agency will develop a process to ensure no new psychotropic medications are administered without first securing written consent from the guardian/referral source. **Additional Recommendations:** N/A

Reminders and Recommendations:
Overall strength based summary of review:
2021 COVID-19 Statement: **Pursuant to IC § 31-25-2-7 and IC § 31-27-2 *et seq*., and Executive Order 20-08, Directive for Hoosiers to Stay at Home, the Indiana Department of Child Services ("DCS") Residential Licensing Unit will conduct modified 2021 audits of licensed residential institutions. The Indiana Department of Child Services has provided "DCS Guidance for Various Programs and Stakeholders regarding COVID-19" at www.in.gov/dcs/4089.htm. Additional COVID-19 information for a Licensed Child Placement Agency can be found at: https://www.in.gov/dcs/files/coronavirus_faq_residential_providers.pdf.** **The Indiana Department of Child Services Residential Licensing Unit is conducting a streamlined 2021 audit tool due to the Public Health Emergency Declared for the Coronavirus Disease 2019 Outbreak. The Residential Licensing Unit has created this tool to capture the potential risk ratings, items identified by the Residential Licensing Unit as necessary to review, and all items that resulted in a Plan of Correction (POC) from your Agency's 2019 audit. As this is a streamlined tool, there may be items that are specific to your agency and discussed during the audit review that are not listed on this tool. However, all agencies are required to continue to adhere to all Indiana Code, Indiana Administrative Code, and all contractual obligations.**

Residential Licensing Specialist _____ Date _____

Clinical Services Specialist-Residential Liaison _____ Date _____

Residential Licensing Consultant Supervisor

Date

Rating Indicators for 2021 Residential Compliance Audits

During the Contract Compliance Audit, the following rating scale will be used to document compliance with each item.

0 Noncompliance

Required practice standards are not implemented, or are implemented in a cursory or haphazard manner such that program processes and/or outcomes are compromised. Significant omissions or exceptions to required practices are observed. Exceptions occur routinely, involvement of required individuals is not valued and/or policies and procedures are not developed. Health, safety and/or wellbeing of residents may be compromised.

1 Partial Compliance

Significant aspects of the program's observed service delivery practices deviate from written policies or protocols. Omissions or exceptions to recommended practices occur regularly, involvement of required individuals is limited or lacking, procedures are superficial or personnel are poorly informed about procedures. Required practices are implemented in an inconsistent, cursory or haphazard manner, to an extent that the program processes and outcomes may be compromised. Health, safety and/or wellbeing of residents may be compromised.

2 Acceptable Level of Compliance

The program meets a majority of the standard's requirements; service delivery is purposeful and goal-oriented. Appropriate policies and procedures are in place. Minor inconsistencies and not yet fully developed practices may be noted; however, these do not prevent demonstration of how services make a difference/achieve their intended purpose, and do not hamper service delivery or significantly diminish program quality.

3 Substantial Compliance

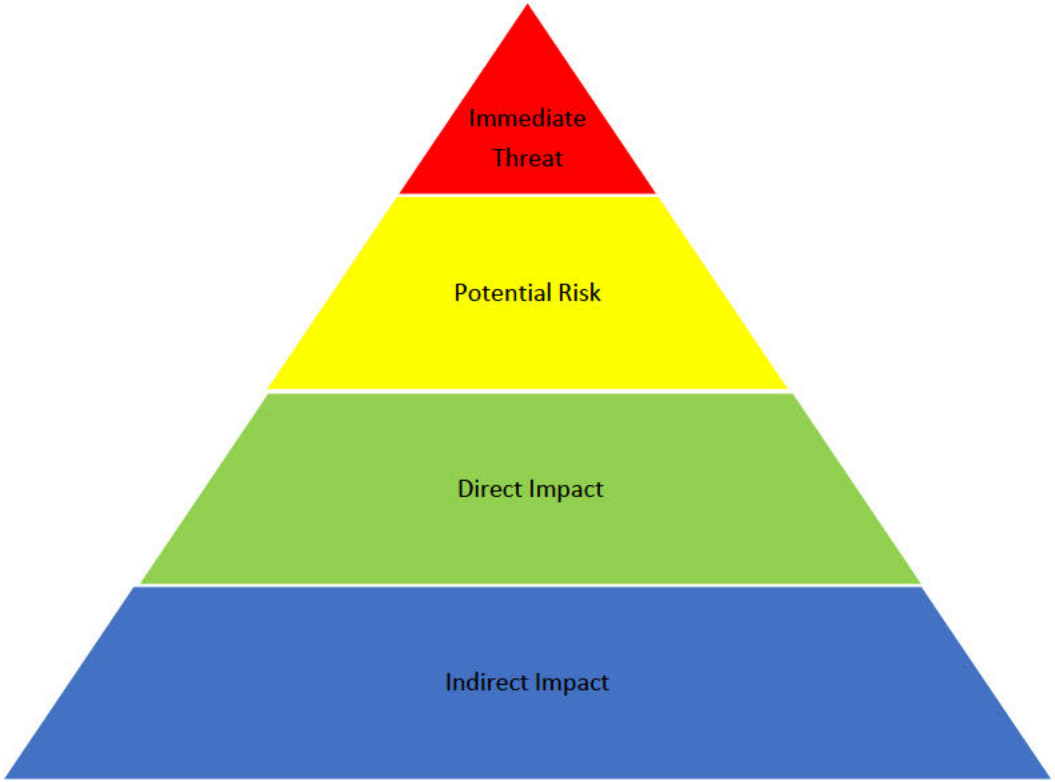
The program meets the standard's requirements of participation toward best practice such that any minor identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

4 Outstanding Performance

All elements or requirements of the standard are evident with rare or no exceptions. The program's service delivery practices and policies fully meet the standard and reflect "best practice" in the identified area.

Impact on Resident Health, Safety and Well Being

In addition to the rating scale, each item on the Residential Audit Tool will be categorized based on that item's potential impact on resident health, safety and well-being. Impact categories are defined as follows:



Immediate Threat: While not linked to any specific Residential Compliance item, immediate threats are identified during Residential Compliance Audits and represent an ***immediate threat*** to the health or safety of residents.

Potential Risk: This category is used to designate those items that directly impact the health, safety or wellbeing of residents (noncompliance presents a ***potential risk*** to residents).

Direct Impact: This category is used to designate those items that ***directly impact*** the quality of care, treatment and services, but not necessarily health, safety or wellbeing.

Indirect Impact: This category is used to designate those items that ***indirectly impact*** the quality of care, treatment and services.

The impact ratings will be used as follows:

Immediate Threat: any observation deemed an "Immediate Threat" during the Residential Compliance Audit will immediately be examined by DCS Licensing for investigation and follow up. For example, if a staff member is observed hitting a child during the Residential Compliance Audit, that incident would be reported to Licensing Staff.

Potential Risk: any "Potential Risk" item rated as a "0" (Noncompliance) or a "1" (Partial Compliance) during the Residential Compliance Audit will require a time-sensitive response from the provider. For example, if it is determined that youth are being restrained inappropriately, the provider may be given 10 days to implement an acceptable plan of correction. Failure to implement a plan of correction within the specified time frame may result in a placement hold being issued for that provider (until such time as the deficient practice has been corrected).

Direct/Indirect Impact: any "Direct Impact" or "Indirect Impact" item rated as a "0" (Noncompliance) or a "1" (Partial Compliance) will require a plan of correction from the provider to be completed within 30 days of receipt of the survey report.

Example:

Documentation reflects pain assessment/management
Item Category: Potential Risk
Item Rating: 1 – Partial Compliance
Finding: ABC Treatment Center completes an initial assessment of pain following critical incidents; however, there is no follow up assessment for residents who report pain.
Required Action: ABC Treatment Center will implement a pain assessment policy and corresponding protocol that includes periodic reassessment of pain, and coordination of medical care, until such time as the pain incident is resolved. The policy/protocol will be completed by 1/2/34.

20211008 Millcreek of Pontotoc Joint Commission Triennial Report [Redacted]

The Joint Commission

Preliminary Accreditation Report

Millcreek of Pontotoc

[redacted]

Pontotoc, MS [redacted]

Organization Identification Number: [redacted]
Unannounced Full Event: 10/5/2021 - 10/8/2021

Program Surveyed
Behavioral Health Care and Human Services

Preliminary Report: Posted 10/8/2021

Appendix 26.

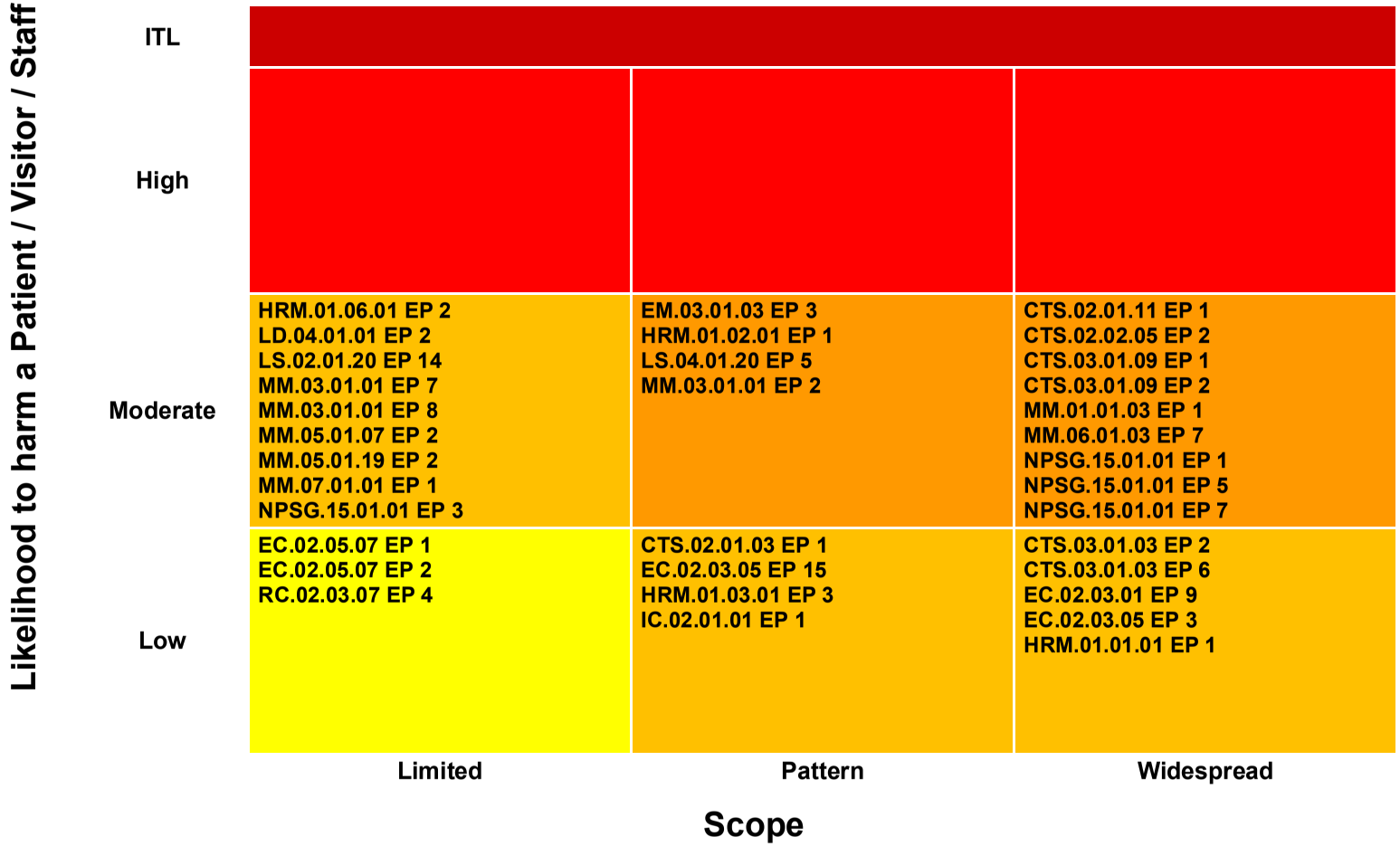
The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Behavioral Health Care and Human Services	10/05/2021 - 10/08/2021	Requirements for Improvement	Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.	Your official report will contain specific follow-up instructions regarding your survey findings.

The Joint Commission
SAFER™ Matrix

Program: Behavioral Health Care and Human Services



Appendix 26.

The Joint Commission
Requirements for Improvement

Program: Behavioral Health Care and Human Services

Standard	EP	SAFER™ Placement	EP Text	Observation
CTS.02.01.03	1	Low Pattern	The organization assesses each individual served in accordance with organization policy.	1). Observed in Record Review at Millcreek Golden Triangle ([redacted] Columbus, MS) site. It was observed that the psychosocial assessment for an 8-year-old female, admitted to the PHP/IOP/Day treatment program on 07/28/21 was signed by the therapist and dated as being completed on 08/03/21. The organization's policy requires that the biopsychosocial assessment be completed within 24-hours.
				2). Observed in Record Review at Woodland Acres Therapeutic Group Home ([redacted] West, Myrtle, MS) site. It was observed that the psychosocial assessment in the record of a 10-year-old male, admitted to the therapeutic group home on 09/09/21, had not been completed in full. Specifically, pages 6-9 had been left incomplete/blank, with the exception of the last section on page 9 in which the recommendation for treatment (individual therapy, group therapy, etc.) were notated, along with a signature of the clinician. This was verified by the Program Director.
				3). Observed in Record Review at Deer Creek Therapeutic Group Home ([redacted] Hollandale, MS) site. It was observed that the nursing assessment for a 16-year-old male, admitted to the therapeutic group home on 05/24/21, had not been completed in full. Specifically, there were numerous sections of the assessment that had not been completed including Social Behaviors, Nutrition, Sleep Habits, and information regarding if this client had any medical conditions, history of physical/sexual abuse or other trauma that would place him greater psychological risk during a restraint or seclusion. This was verified by the Program Director.
CTS.02.01.11	1	Moderate Widespread	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of 10 pounds or more in the last 3 months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting	1). Observed in Individual Tracer at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.In 2 out of 2 client records reviewed in the day treatment program, the nutritional screening did not include questions about weight loss or gain of 10 pounds or more in the last 3 months, decrease in food intake and/or appetite, dental problems and eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting. The nutritional screening did include information about food allergies. This was confirmed by the therapist and the Clinical Director.

Standard	EP	SAFER™ Placement	EP Text	Observation
				2). Observed in Record Review at Cedar Pointe Therapeutic Group Home ([redacted] Starkville, MS) site. It was observed that the nutrition screening used organization wide, did not meet the requirements of this element of performance as it did not address dental problems, weight gain/loss of 10 pounds or more in the last 3 months, or behaviors that may be indicators of an eating disorder. Furthermore, the screening did not appear to be used as a mechanism for identifying clients that required a full nutritional assessment.
CTS.02.02.05	2	Moderate Widespread	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis. Note: For child welfare: The agency also identifies family members, including from the family of origin and/or resource family, who may have experienced trauma, abuse, neglect, or exploitation. The agency defines which family members to include in this process.	1). Observed in Individual Tracer at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.In 4 out of 4 client records reviewed in the residential and day treatment programs, there was no information obtained about possible exploitation. In addition, there was no information obtained about abuse, neglect, exploitation and all other forms of trauma on an ongoing basis. This was confirmed by the Clinical Director.
				2). Observed in Record Review at Cedar Pointe Therapeutic Group Home ([redacted] Starkville, MS) site. It was observed that the organization's assessments screened for individuals that had experiences trauma, neglect and abuse (physical, sexual, emotional, etc.), however, the assessments did not screen specifically for exploitation.
CTS.03.01.03	2	Low Widespread	The plan for care, treatment, or services includes the following: - Goals that are expressed in a manner that captures the individual's words or ideas - Goals that build on the individual's strengths - Factors that support the transition to community integration when identified as a need during assessment - The criteria and process for the individual's expected successful transfer and/or discharge/termination of services, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01) Note 1: Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors. Note 2: For opioid treatment programs: For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.	1). Observed in Individual Tracer at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.In 4 out of 4 client records reviewed in the residential and day treatment programs, the goals on the treatment plan were not in the clients own words or in words that represent the client, but rather in clinical jargon. For example, goals included: "develop the essential social skills that will enhance the quality of interpersonal relationships" and the client "will express anger through appropriate verbalizations and healthy physical outlets on a consistent basis" . This was confirmed by the therapist and the Clinical Director.

Standard	EP	SAFER™ Placement	EP Text	Observation
				2). Observed in Record Review at Cedar Pointe Therapeutic Group Home ([redacted] Starkville, MS) site. It was observed that the goals in the treatment plan of a 15-year-old male, admitted to the therapeutic group home on 08/12/21, were not written in a way that captured the ideas of the student/individual served. For example, client "will be successful academically and complete goals on his IEP with 80% accuracy in order for him to be promoted to the 11th grade at Millcreek of Pontotoc."
				3). Observed in Record Review at Millcreek Golden Triangle ([redacted] Columbus, MS) site. In 3 out of 3 records reviewed at the PHP/IOP/Day treatment program, it was observed that the goals were not written in a way that captured the student/client's words or ideas. For example, client "will gain control of disturbing thoughts, feelings and impulses."
CTS.03.01.03	6	Low Widespread	The organization provides care, treatment, or services for each individual served according to the plan for care, treatment, or services.	1). Observed in Record Review at Deer Creek Therapeutic Group Home ([redacted] Hollandale, MS) site. It was observed that the treatment plans did not include interventions for the psychiatrist who was meeting with the client monthly, prescribing medications, monitoring for effectiveness/side effects, and adjusting medications as needed.
CTS.03.01.09	1	Moderate Widespread	The organization uses a standardized tool or instrument to monitor the individual's progress in achieving his or her care, treatment, or service goals. Note: Ideally, the tool or instrument monitors progress from the individual's perspective. The tool or instrument may be focused on a population or diagnostic category (such as depression or anxiety), or the tool or instrument may have a more global focus such as general distress, functional status, quality of life (especially in regard to intellectual/developmental disabilities and other physical and/or sensory disabilities), well-being, or permanency (especially in regard to foster care or other out-of-home care for children and youth).	1). Observed in Individual Tracer at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.In 2 out of 2 client records reviewed in the Day Treatment Program, there was no standardized instrument or tool used to measure treatment progress. The organization had not selected or implemented a standardized tool or instrument for the Day Treatment Programs. This was confirmed by the Clinical Director.
				2). Observed in Record Review at Millcreek Golden Triangle ([redacted] Columbus, MS) site. It was observed that the outpatient programs had not begun using an outcome measure tool to monitor the client's progress in treatment. This was verified by the Program Directors.

Standard	EP	SAFER™ Placement	EP Text	Observation
				3). Observed in Record Review at Woodland Acres Therapeutic Group Home ([redacted] West, Myrtle, MS) site. It was observed that this therapeutic group home had not begun using a standardized outcome measurement tool to monitor the client's progress. The Program Director reported this group home was scheduled to receive training and begin using standardized outcome measurement tools of 10/15/2021.
CTS.03.01.09	2	Moderate Widespread	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.	1). Observed in Individual Tracer at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.In 2 out of 2 residential client records reviewed, the Mindyra assessment was being used, however the results were not incorporated into the treatment plan in an effort to determine progress and/or completion of goals and objectives. This was confirmed by the therapist and Clinical Director.
				2). Observed in Record Review at Cedar Pointe Therapeutic Group Home ([redacted] Starkville, MS) site. It was observed that the results of the outcome measurement tool (the Mindyra), were not being used to inform the goals and objectives of the treatment plan. This was verified by the Program Director.
EC.02.03.01	9	Low Widespread	The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire's point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate individuals served, and how to evacuate to areas of refuge. Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2.	1). Observed in Environment of Care Session at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.The written fire response plan did not include how to contain smoke and fire, how to use a fire extinguisher and how to evacuate to areas of refuge, including the specific rally point outside for each location, including the three PRTF(residential) cottages, six group homes and five day treatment locations. The organization was able to describe the fire drill process and identify the rally points for each location. This was confirmed by the Risk Management Director.
EC.02.03.05	3	Low Widespread	Every 12 months, the organization tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14.	1). Observed in Environment of Care Session at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.The policy of the organization was to test smoke detectors at all locations monthly. The organization tested the smoke detectors, however did not document the results for each location on the inventory. This was confirmed by the Director of Maintenance and the Risk Management Director.

Standard	EP	SAFER™ Placement	EP Text	Observation
EC.02.03.05	15	Low Pattern	At least monthly, the organization inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.	1). Observed in Building Tour at Millcreek Golden Triangle ([redacted] Columbus, MS) site. It was observed that the PHP/IOP/Day treatment program/school had 3 vans they used to transport clients which were equipped with fire extinguishers. The Principal/Program Director reported there was not a process in place to conduct monthly inspections of these fire extinguishers.
				2). Observed in Building Tour at Woodland Acres Therapeutic Group Home ([redacted] West, Myrtle, MS) site. It was observed that the tag on the fire extinguisher in the kitchen of the group home was last dated as being inspected on 07/22/21. The organization completed monthly EOC rounds which documented fire extinguishers had been inspected for that month. However, this form did not provide details regarding how many fire extinguishers had been inspected in the home, locations of the fire extinguishers, etc. therefore, the surveyor was unable to determine if this fire extinguisher in the kitchen had been checked in August and September. This was verified by the CEO and the Program Director of the group home.
				3). Observed in Building Tour at Millcreek of Batesville ([redacted] Batesville, MS) site. It was observed that the PHP/IOP/Day treatment program did not have a process in place to conduct monthly inspections of the fire extinguishers in the vans used to transport children/adolescents. This was verified by the Principal of this location.
EC.02.05.07	1	Low Limited	At least monthly, the organization performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented. (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5)	1). Observed in Building Tour at Cedar Pointe Therapeutic Group Home ([redacted] Starkville, MS) site. It was observed that the group home had not been conducting monthly 30-second functional tests of their exit signs/emergency lighting. The Program Director of the group home reported he believed they tested the lighting system quarterly but was unable to provide documentation of the functional tests.

Standard	EP	SAFER™ Placement	EP Text	Observation
				2). Observed in Building Tour at Pecan Grove Therapeutic Group Home ([redacted] Lyon, MS) site. It was observed that the form in which the monthly functional tests of Exit signs/emergency lighting systems documented the emergency lights/exits signs as a "pass/fail" but did not specifically document that all lights in the home had been checked.
EC.02.05.07	2	Low Limited	Every 12 months, the organization performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1 1/2 hours. The test results and completion dates are documented. (See also LS.02.01.20, EP 39) (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5)	1). Observed in Building Tour at Cedar Pointe Therapeutic Group Home ([redacted] Starkville, MS) site. It was reported by the Program Director that the group home had been completing quarterly functional tests of the exit signs/emergency lighting system, however, they had not been conducting a 90-minute annual functional test of the exit signs/emergency lighting systems.
EM.03.01.03	3	Moderate Pattern	The organization conducts an exercise to test the emergency plan at least annually. Every other year, the organization's annual exercise is selected from one of the following: - A full-scale, community-based exercise. - When a community-based exercise is not possible, a facility-based, functional exercise. - If the organization experiences an actual emergency (natural or man-made) that requires activation of the emergency plan, the organization is exempt from engaging in its next required full-scale, community-based exercise or facility-based, functional exercise following the onset of the emergency event. In the opposite year, the organization's annual exercise includes, but is not limited to, one of the following: - A second full-scale, community-based exercise - A second facility-based, functional exercise - Mock disaster drill - Tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan Note: See the Glossary for the definitions of community-based exercise, full-scale exercise, and functional exercise.	1). Observed in Emergency Management Session at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.The group homes and day treatment programs located off of the main site were conducting tornado drills per the state requirement, however had not implemented a process to conduct other emergency drills, such as those identified on the HVA as having a high likelihood to occur. The PRTF(residential) and day treatment programs at the main site were conducting annual emergency drills that varied each year and were not all tornado drills. This was confirmed by the Director of Maintenance and the Risk Management Director.

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Standard	EP	SAFER™ Placement	EP Text	Observation
HRM.01.01.01	1	Low Widespread	Each position has a written job description that identifies the following: - The minimum qualifications of the position - The competencies of the position, which include the minimum skills, knowledge, and experience required for the position - The duties and responsibilities of the position Note: A written contract may replace a job description. (For more information on contracted services, refer to Standard LD.04.03.09.)	1). Observed in Competency Session at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site. It was observed that the contracts for the two contracted Psychiatrists and one contracted therapist reviewed did not include the duties and responsibilities of the position, instead the contracts were focused on compensation, liability insurance, etc. This was verified by the Director of HR.
HRM.01.02.01	1	Moderate Pattern	The organization performs primary source verification of staff licensure, certification, or registration in accordance with law and regulation and organization policy at the time of hire and the time of renewal. Note 1: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 2: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary. Note 3: In some instances, a staff member may also work for another Joint Commission–accredited organization. If the other organization has completed primary source verification of the staff member's license, certification, or registration; can attest to that fact; and is willing to share that information with the behavioral health care or human services organization, then primary source verification does not need to be completed a second time by the organization. The credentialing information would need to be made available upon demand during a Joint Commission survey.	1). Observed in HR File Review at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site. In 3 out of 6 licensed employee files, it was observed that the primary source verification had not been conducted at the time of hire and the time of renewal. The HR file for the Director of Nursing hired on 11/12/2018, a Therapist hired on 07/07/2020, and an LPN hired on 02/10/2020, all lacked evidence that a primary source verification had been completed at the time of hire. Furthermore, the license of the LPN reviewed was due to expire on 10/31/2020, and was not verified as being renewed until 02/05/2021. These were verified by the Director of HR.
HRM.01.03.01	3	Low Pattern	The organization orients staff on the following: - Policies and procedures related to job duties and responsibilities. - Their specific job duties and responsibilities. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7) - Sensitivity to cultural diversity based on their job duties and responsibilities. Note: Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization. - The rights of individuals served, including the ethical aspects of care, treatment, or services. (See also RI.01.07.03, EP 5) Completion of this orientation is documented.	1). Observed in HR File Review at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site. It was observed that the HR files for two contracted doctors and a contracted therapist did not include orientation/training on sensitivity to cultural diversity. This was verified by the Director of HR.

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Standard	EP	SAFER™ Placement	EP Text	Observation
HRM.01.06.01	2	Moderate Limited	Staff with the educational background, experience, or knowledge related to the skills being reviewed assess competence. Note: When a suitable individual cannot be found to assess staff competence, the organization can utilize an outside individual for this task. If a suitable individual inside or outside the organization cannot be found, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.	1). Observed in HR File Review at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site. It was observed that a competency assessment for a licensed therapist was completed by the CEO in February 2021, however, the CEO did not have the same educational background as a clinician, he had a degree in Healthcare Administration.
IC.02.01.01	1	Low Pattern	The organization implements its planned infection prevention and control activities and practices, including surveillance, to reduce the risk of infection. Note: The purpose of surveillance is to support the organization's efforts to reduce the risk of spreading infections where individuals are served. Information from the surveillance activities is used within the organization to improve processes and outcomes related to infection prevention and control.	1). Observed in Building Tour at Oak Hill Therapeutic Group Home ([redacted] Kosciusko, MS) site.The non-commercial dishwashers at the Oak Hill and Willow Springs group homes were not monitored to assess if the water was reaching sufficient high temperatures to sanitize the dishes thereby increasing the risk of infection. This was confirmed by the Program Director. Thermometers were obtained and the process for monitoring the temperatures was implemented onsite during the survey.
LD.04.01.01	2	Moderate Limited	The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations. Note: For child welfare agencies, this may also include contractual agreements with county or state authorities.	1). Observed in Medication Management Tracer at Millcreek of Kosciusko Day Treatment ([redacted] Kosciusko, MS) site.The name on the CLIA certificate at the Kosciusko Day Treatment was a former employee. The organization had not applied at the time of the survey to have the CLIA certificate updated to reflect the current employee overseeing waived testing at the Kosciusko location. This was confirmed by the CEO during the medication management session. .

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Standard	EP	SAFER™ Placement	EP Text	Observation
LS.02.01.20	14	Moderate Limited	Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text, refer to NFPA 101-2012: 18/19.2.5.1; 7.1.10.1; 7.5.1.1) Note 1: Wheeled equipment (such as equipment and carts currently in use, equipment used for lift and transport of individuals served, and medical emergency equipment not in use) that maintains at least five feet of clear and unobstructed corridor width is allowed, provided there is a fire plan and training program addressing its relocation in a fire or similar emergency. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (4)) Note 2: Where the corridor width is at least eight feet and the smoke compartment is fully protected by an electrically supervised smoke detection system or is in direct supervision of facility staff, furniture that is securely attached is allowed provided it does not reduce the corridor width to less than six feet, is only on one side of the corridor, does not exceed 50 square feet, is in groupings spaced at least 10 feet apart, and does not restrict access to building service and fire protection equipment. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (5))	1). Observed in Building Tour at Cedar Pointe Therapeutic Group Home ([redacted] Starkville, MS) site. It was observed that one of the means of egress from a client bedroom was obstructed. A client's dresser was observed to be positioned in front of a bedroom window that had been designated as a means of egress on the first floor. This was verified by the Program Director of the group home, and the dresser was moved away from the window immediately. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission.
LS.04.01.20	5	Moderate Pattern	Closet doors are capable of being opened from the inside, and bathroom doors are capable of being opened from the outside. (For full text, refer to NFPA 101-2012: 32/33.2.2.5.3; 32/33.2.2.5.4)	1). Observed in Building Tour at Oak Hill Therapeutic Group Home ([redacted], Kosciusko, MS) site.In the Oak Hill group home, the bathroom doors lock from inside and the staff were unaware of how to unlock the door and did not have access to the tool("key") that unlocks the door. The keys were obtained onsite during the survey and made available to all staff. This was confirmed by the Program Director. This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission.
MM.01.01.03	1	Moderate Widespread	The organization identifies, in writing, its high-alert and hazardous medications. * Note: This element of performance is also applicable to sample medications. Footnote *: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf. (See also EC.02.02.01, EP 2)	1). Observed in Document Review at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.The organization had not developed or implemented a list of hazardous medications that are prescribed, administered or stored. This was confirmed by the Director of Nursing.

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Standard	EP	SAFER™ Placement	EP Text	Observation
MM.03.01.01	2	Moderate Pattern	For organizations that store medications: The organization stores medications according to the manufacturers' recommendations or a pharmacist's instructions. Note: This element of performance is also applicable to sample medications.	1). Observed in Medication Management Tracer at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.In the Grapevine residential cottage, the medication refrigerator had not been monitored for appropriate temperature on 1/20/21, 1/21/21, 1/23/21, 1/25/21, 9/26/21 and 10/4/21. In addition, the refrigerator was out of range on multiple dates without a documented response. This was confirmed by the RN and Director of Nursing.
				2). Observed in Building Tour at Millcreek of Greenville ([redacted] Greenville, MS) site. It was observed that the refrigerator used to store medications at the PHP/IOP/Day treatment program did not have a means of capturing/recording the temperatures throughout the weekend/holidays when the program was closed. This was verified by the Nurse at this location and upon reviewing the temperature logs for this refrigerator.
MM.03.01.01	7	Moderate Limited	For organizations that store medications: The organization labels stored medications with the contents, expiration date, and any applicable warnings provided by the pharmacy. Note: This element of performance is also applicable to sample medications.	1). Observed in Individual Tracer at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.In the Grapevine residential cottage medication room, there was an open vial of tuberculin in the medication refrigerator that was not labeled with the expiration date. The organization's medication management policy required that open vials of tuberculin be labeled with the open date and expiration date of 28 days after opening. This was confirmed by the RN and the Director of Nursing.
MM.03.01.01	8	Moderate Limited	For organizations that store medications: The organization removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. (See also MM.05.01.19, EP 1) Note: This element of performance is also applicable to sample medications.	1). Observed in Medication Management Tracer at Willow Springs Therapeutic Group Home [redacted] Blue Springs, MS) site.In the medication refrigerator at the Willow Springs group home, multiple unopened insulin pens that had been discontinued for a resident were stored in the same refrigerator as other insulin to be administered. All of the insulin had been prescribed for the same resident. The resident was no longer using insulin pens as the resident had begun using an insulin pump. This was confirmed by the Program Director.

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Standard	EP	SAFER™ Placement	EP Text	Observation
MM.05.01.07	2	Moderate Limited	For organizations that prepare medications for administration: Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for medication preparation. Note: Sterile technique (also called aseptic technique) refers to practices that are designed to minimize exposure to germs and maintain sterility of the medication through the use of "no touch" procedures; the use of sterile gloves, supplies, and instruments (for example, needles and syringes); and the use of a sterile field. In contrast, clean technique refers to practices designed to reduce exposure to germs, and include the use of hand washing, clean instruments, and a clean environment. Clean technique does not require the use of sterile technique or sterile supplies. The technique used for medication preparation depends on the need for sterility (for example, intravenous solutions) versus cleanliness (for example, oral products).	1). Observed in Medication Management Tracer at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.In the medication room in the Grapevine residential cottage, the pill crusher had a large amount of accumulated white residue on it. This was confirmed by the RN and the Director of Nursing.
				2). Observed in Medication Management Tracer at Oak Hill Therapeutic Group Home ([redacted], Kosciusko, MS) site.In the medication room in the Oak Hill group home, the pill splitter had a white residue on it and had not been cleaned. This was confirmed by the Program Director.
				3). Observed in Medication Management Tracer at Millcreek of Greenville ([redacted] Greenville, MS) site.The method used to complete a count of narcotics was observed not to be a sterile, "no-touch" technique. In doing a count of the narcotics as part of the individual tracery activity, the nurse was observed to empty the bottle of medications into her bare hand and count them onto the 3-ring binder that contained the medication counts for narcotics.
MM.05.01.19	2	Moderate Limited	For organizations that administer medications: When the organization accepts unused, expired, or returned medications, it follows a process for destroying the medications or returning the medications to a pharmacy's control which includes procedures for preventing diversion. Note: This element of performance is also applicable to sample medications.	1). Observed in Medication Management Tracer at Millcreek of Batesville ([redacted] Batesville, MS) site. It was observed that the organization's policy titled Medication Management, section Medication Disposal, had not been followed. This policy stated "non-controlled substances are disposed of by placing them into a biohazard container which contains a mixture of equal parts bleach and water." In touring the medication room at the PHP/IOP/Day program, the biohazard container was observed to contain 3 pills without the mixture of bleach and water in the container. This was verified by the Principal/RN at this location.

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Standard	EP	SAFER™ Placement	EP Text	Observation
MM.06.01.03	7	Moderate Widespread	For organizations that allow self-administration of medications: When the individual's medications are prescribed or dispensed by the organization, the organization determines that the individual or the family member who administers the medication is competent at medication administration before allowing him or her to administer medications.	1). Observed in Individual Tracer at Oak Hill Therapeutic Group Home ([redacted], Kosciusko, MS) site.The organization did not have a process in place to determine the competence of the residents in the group homes who self-administer medication. This was confirmed by the Program Directors.
MM.07.01.01	1	Moderate Limited	For organizations that prescribe or administer medications: The organization monitors the side effects and effectiveness of the medications, as reported by the individual served or his or her family. Note: This element of performance is also applicable to sample medications.	1). Observed in Record Review at Millcreek Golden Triangle ([redacted] Columbus, MS) site. The record of a 9-year-old male, reflected he was given a pharmacological restraint of 1 mg of Ativan IM on 01/27/21 at 12:28 PM. The doctor had also ordered "vital signs every hour for 4 hours" following the injection, however, vital signs were documented 30 minutes after the injection, then the client was transported home at 1:10 PM due to the school day ending (shortened school days due to COVID). Therefore, the doctor's orders were not followed as ordered and side effects of the medication were not monitored by checking vital signs for 4 hours.
NPSG.15.01.01	1	Moderate Widespread	The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk (s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). Note: Noninpatient behavioral health care and human services settings and unlocked inpatient units do not need to be ligature resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).	1). Observed in Document Review at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.The organization had conducted an environmental risk assessment for the PRTF (residential), however it was not all inclusive and did not include a comprehensive list of all potential ligature risks in the environment. The 6 group homes and 5 day treatment programs did not have an environmental risk assessment that identified the potential hazards in the environment that could be used to commit suicide in an effort to educate staff regarding the risks and if a client is identified as a high risk for suicide, he/she would be placed on a 1:1. This was confirmed by the Director of Risk Management and the Clinical Director.
NPSG.15.01.01	3	Moderate Limited	Use an evidence-based process to conduct a suicide assessment of individuals served who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens individuals served for suicidal ideation and assesses the severity of suicidal ideation.	1). Observed in Individual Tracer at Willow Springs Therapeutic Group Home ([redacted] Blue Springs, MS) site.In one client record reviewed in the Willow Springs group home in which the client reported having suicidal ideation, the organization completed a suicide screening which was positive and there was no suicide risk assessment completed to determine the overall level of suicide risk. Despite not completing a suicide risk assessment, the organization implemented mitigation strategies including increased staffing and observation(Close Observation/not 1:1), as well as the development of a safety plan. This was confirmed by the Program Director.

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Standard	EP	SAFER™ Placement	EP Text	Observation
NPSG.15.01.01	5	Moderate Widespread	Follow written policies and procedures addressing the care of individuals served identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for individuals served at risk for suicide - Guidelines for reassessment - Monitoring individuals served who are at high risk for suicide	1). Observed in Document Review at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.The organization's suicide risk policy entitled "Special Procedures" Chapter 20, revised 02/20 was not reflective of the suicide risk procedure implemented in all programs, including residential, group homes and the day treatment programs. The organization was conducting a suicide risk assessment at the time of intake and the policy stated all clients are screened with the "Columbia Suicide Screen" at the time of admission. The policy did not include training to be provided and a competency assessment for all staff who work with individuals at risk for suicide. In addition, the policy did not specify that if a client is deemed to be at high risk for suicide, he/she would be placed on a 1:1. This was confirmed by the Clinical Director.
NPSG.15.01.01	7	Moderate Widespread	Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of individuals served at risk for suicide and take action as needed to improve compliance.	1). Observed in Data Session at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.The organization monitored that the suicide risk assessment was conducted at admission and discharge, however had not implemented a process to monitor the implementation of the suicide risk policies and procedures including the management of clients served at risk for suicide. For example, monitoring the policy requirement that if a client was deemed to be at moderate risk for suicide that a suicide assessment would be completed daily until the level dropped to low risk. In addition, while the organization was conducting chart review to determine compliance with suicide risk assessment at admission and discharge, there was no aggregated data to ensure compliance and/or identify opportunities for improvement. This was confirmed by the Clinical Director and the Risk Management Director.
RC.02.03.07	4	Low Limited	Verbal orders are authenticated within the time frame specified by law and regulation.	1). Observed in Individual Tracer at Millcreek of Pontotoc ([redacted] Pontotoc, MS) site.In one client record reviewed in the day treatment program, the medication orders at the time of admission on 8/6/21 had not been authenticated. This was confirmed by the Director of Nursing.
				2). Observed in Record Review at Millcreek Golden Triangle ([redacted] Columbus, MS) site. It was observed that a telephone order for a physical restraint at the PHP/IOP/Day program on 01/27/21 was not authenticated by the psychiatrist until 03/01/21. The organization's Medication Management policy stated it would be authenticated within 30 days for a day treatment program.

Standard	EP	SAFER™ Placement	EP Text	Observation
				3). Observed in Individual Tracer at Willow Springs Therapeutic Group Home [redacted] Blue Springs, MS) site.In one resident record reviewed at the Willow Oaks group home, the verbal admission orders, including all of the standing orders from 6/1/21 had not been authenticated until 9/29/21. The organization's policy requires that verbal orders for group homes be authenticated within 30 days. This was confirmed by the Program Director.

The Joint Commission

Appendix

Standard and EP Text

Program: Behavioral Health Care and Human Services

Standard	EP	Standard Text	EP Text
CTS.02.01.03	1	The organization performs screenings and assessments as defined by the organization's policy.	The organization assesses each individual served in accordance with organization policy.
CTS.02.01.11	1	The organization screens all individuals served for their nutritional status.	The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: - Food allergies - Weight loss or gain of 10 pounds or more in the last 3 months - Decrease in food intake and/or appetite - Dental problems - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting
CTS.02.02.05	2	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation.	The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis. Note: For child welfare: The agency also identifies family members, including from the family of origin and/or resource family, who may have experienced trauma, abuse, neglect, or exploitation. The agency defines which family members to include in this process.
CTS.03.01.03	2	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The plan for care, treatment, or services includes the following: - Goals that are expressed in a manner that captures the individual's words or ideas - Goals that build on the individual's strengths - Factors that support the transition to community integration when identified as a need during assessment - The criteria and process for the individual's expected successful transfer and/or discharge/termination of services, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01) Note 1: Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors. Note 2: For opioid treatment programs: For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.

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Standard	EP	Standard Text	EP Text
CTS.03.01.03	6	The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	The organization provides care, treatment, or services for each individual served according to the plan for care, treatment, or services.
CTS.03.01.09	1	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization uses a standardized tool or instrument to monitor the individual's progress in achieving his or her care, treatment, or service goals. Note: Ideally, the tool or instrument monitors progress from the individual's perspective. The tool or instrument may be focused on a population or diagnostic category (such as depression or anxiety), or the tool or instrument may have a more global focus such as general distress, functional status, quality of life (especially in regard to intellectual/developmental disabilities and other physical and/or sensory disabilities), well-being, or permanency (especially in regard to foster care or other out-of-home care for children and youth).
CTS.03.01.09	2	The organization assesses the outcomes of care, treatment, or services provided to the individual served.	The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.
EC.02.03.01	9	The organization manages fire risks.	The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire's point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate individuals served, and how to evacuate to areas of refuge. Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2.
EC.02.03.05	3	The organization maintains fire safety equipment and fire safety building features. Note: This standard does not require organizations to have the types of fire safety equipment and building features described in the elements of performance of this standard. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	Every 12 months, the organization tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented. Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14.
EC.02.03.05	15	The organization maintains fire safety equipment and fire safety building features. Note: This standard does not require organizations to have the types of fire safety equipment and building features described in the elements of performance of this standard. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.	At least monthly, the organization inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge. Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.

Standard	EP	Standard Text	EP Text
EC.02.05.07	1	The organization inspects, tests, and maintains emergency power systems. Note: This standard does not require organizations to have the types of emergency power equipment described in the elements of performance of this standard. However, if these types of emergency equipment exist within the building, then the following maintenance, testing, and inspection requirements apply. This does not apply to generators used only for convenience purposes.	At least monthly, the organization performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented. (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5)
EC.02.05.07	2	The organization inspects, tests, and maintains emergency power systems. Note: This standard does not require organizations to have the types of emergency power equipment described in the elements of performance of this standard. However, if these types of emergency equipment exist within the building, then the following maintenance, testing, and inspection requirements apply. This does not apply to generators used only for convenience purposes.	Every 12 months, the organization performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1 1/2 hours. The test results and completion dates are documented. (See also LS.02.01.20, EP 39) (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5)
EM.03.01.03	3	The organization evaluates the effectiveness of its Emergency Management Plan.	The organization conducts an exercise to test the emergency plan at least annually. Every other year, the organization's annual exercise is selected from one of the following: - A full-scale, community-based exercise. - When a community-based exercise is not possible, a facility-based, functional exercise. - If the organization experiences an actual emergency (natural or man-made) that requires activation of the emergency plan, the organization is exempt from engaging in its next required full-scale, community-based exercise or facility-based, functional exercise following the onset of the emergency event. In the opposite year, the organization's annual exercise includes, but is not limited to, one of the following: - A second full-scale, community-based exercise - A second facility-based, functional exercise - Mock disaster drill - Tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan Note: See the Glossary for the definitions of community-based exercise, full-scale exercise, and functional exercise.
HRM.01.01.01	1	The organization develops written job descriptions.	Each position has a written job description that identifies the following: - The minimum qualifications of the position - The competencies of the position, which include the minimum skills,

Standard	EP	Standard Text	EP Text
			knowledge, and experience required for the position - The duties and responsibilities of the position Note: A written contract may replace a job description. (For more information on contracted services, refer to Standard LD.04.03.09.)
HRM.01.02.01	1	The organization verifies and evaluates staff qualifications.	The organization performs primary source verification of staff licensure, certification, or registration in accordance with law and regulation and organization policy at the time of hire and the time of renewal. Note 1: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 2: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary. Note 3: In some instances, a staff member may also work for another Joint Commission–accredited organization. If the other organization has completed primary source verification of the staff member's license, certification, or registration; can attest to that fact; and is willing to share that information with the behavioral health care or human services organization, then primary source verification does not need to be completed a second time by the organization. The credentialing information would need to be made available upon demand during a Joint Commission survey.
HRM.01.03.01	3	The organization provides orientation to staff.	The organization orients staff on the following: - Policies and procedures related to job duties and responsibilities. - Their specific job duties and responsibilities. (See also IC.01.05.01, EP 6; IC.02.01.01, EP 7) - Sensitivity to cultural diversity based on their job duties and responsibilities. Note: Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization. - The rights of individuals served, including the ethical aspects of care, treatment, or services. (See also RI.01.07.03, EP 5) Completion of this orientation is documented.
HRM.01.06.01	2	Staff are competent to perform their job duties and responsibilities.	Staff with the educational background, experience, or knowledge related to the skills being reviewed assess competence. Note: When a suitable individual cannot be found to assess staff competence, the organization can utilize an outside individual for this task. If a suitable individual inside or outside the organization cannot be found, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.

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Standard	EP	Standard Text	EP Text
IC.02.01.01	1	The organization implements its infection prevention and control plan.	The organization implements its planned infection prevention and control activities and practices, including surveillance, to reduce the risk of infection. Note: The purpose of surveillance is to support the organization's efforts to reduce the risk of spreading infections where individuals are served. Information from the surveillance activities is used within the organization to improve processes and outcomes related to infection prevention and control.
LD.04.01.01	2	The organization complies with law and regulation.	The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations. Note: For child welfare agencies, this may also include contractual agreements with county or state authorities.
LS.02.01.20	14	The organization maintains the integrity of the means of egress. Note: This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.	Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text, refer to NFPA 101-2012: 18/19.2.5.1; 7.1.10.1; 7.5.1.1) Note 1: Wheeled equipment (such as equipment and carts currently in use, equipment used for lift and transport of individuals served, and medical emergency equipment not in use) that maintains at least five feet of clear and unobstructed corridor width is allowed, provided there is a fire plan and training program addressing its relocation in a fire or similar emergency. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (4)) Note 2: Where the corridor width is at least eight feet and the smoke compartment is fully protected by an electrically supervised smoke detection system or is in direct supervision of facility staff, furniture that is securely attached is allowed provided it does not reduce the corridor width to less than six feet, is only on one side of the corridor, does not exceed 50 square feet, is in groupings spaced at least 10 feet apart, and does not restrict access to building service and fire protection equipment. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (5))
LS.04.01.20	5	The organization maintains the integrity of the means of escape. Note 1: This standard applies to small behavioral health care settings that provide sleeping arrangements for 4 to 16 individuals served as a required part of their care, treatment, or services. Note 2: If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply. Note 3: See Standard EC.02.03.03 for fire drill requirements.	Closet doors are capable of being opened from the inside, and bathroom doors are capable of being opened from the outside. (For full text, refer to NFPA 101-2012: 32/33.2.2.5.3; 32/33.2.2.5.4)
MM.01.01.03	1	The organization safely manages high-alert and hazardous medications. Note: This standard is applicable to organizations that engage in any of the medication management processes.	The organization identifies, in writing, its high-alert and hazardous medications. * Note: This element of performance is also applicable to sample

Standard	EP	Standard Text	EP Text
			medications. Footnote *: For a list of high-alert medications, see https://www.ismp.org/recommendations. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf. (See also EC.02.02.01, EP 2)
MM.03.01.01	2	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization stores medications according to the manufacturers' recommendations or a pharmacist's instructions. Note: This element of performance is also applicable to sample medications.
MM.03.01.01	7	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization labels stored medications with the contents, expiration date, and any applicable warnings provided by the pharmacy. Note: This element of performance is also applicable to sample medications.
MM.03.01.01	8	The organization safely stores medications. Note: This standard is applicable only to organizations that store medications at their sites.	For organizations that store medications: The organization removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. (See also MM.05.01.19, EP 1) Note: This element of performance is also applicable to sample medications.
MM.05.01.07	2	The organization safely prepares medications for administration. Note: This standard is applicable only to organizations that prepare medications for administration.	For organizations that prepare medications for administration: Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for medication preparation. Note: Sterile technique (also called aseptic technique) refers to practices that are designed to minimize exposure to germs and maintain sterility of the medication through the use of "no touch" procedures; the use of sterile gloves, supplies, and instruments (for example, needles and syringes); and the use of a sterile field. In contrast, clean technique refers to practices designed to reduce exposure to germs, and include the use of hand washing, clean instruments, and a clean environment. Clean technique does not require the use of sterile technique or sterile supplies. The technique used for medication preparation depends on the need for sterility (for example, intravenous solutions) versus cleanliness (for example, oral products).
MM.05.01.19	2	The organization safely manages unused, expired, or returned medications. Note: This standard is applicable only to organizations that administer medications.	For organizations that administer medications: When the organization accepts unused, expired, or returned medications, it follows a process for destroying the medications or returning the medications to a pharmacy's control which includes procedures for preventing diversion. Note: This element of performance is also applicable to sample medications.

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Standard	EP	Standard Text	EP Text
MM.06.01.03	7	Self-administered medications are administered safely and accurately. Note: The term "self-administered medication(s)" may refer to medications administered by a family member.	For organizations that allow self-administration of medications: When the individual's medications are prescribed or dispensed by the organization, the organization determines that the individual or the family member who administers the medication is competent at medication administration before allowing him or her to administer medications.
MM.07.01.01	1	The organization monitors individuals served to determine the effects of their medication(s). Note: This standard is applicable only to organizations that prescribe or administer medications.	For organizations that prescribe or administer medications: The organization monitors the side effects and effectiveness of the medications, as reported by the individual served or his or her family. Note: This element of performance is also applicable to sample medications.
NPSG.15.01.01	1	Reduce the risk for suicide.	The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). Note: Noninpatient behavioral health care and human services settings and unlocked inpatient units do not need to be ligature resistant. The expectation for these settings is to conduct a risk assessment to identify potential environmental hazards to individuals served, identify individuals who are at high risk for suicide, and take action to safeguard these individuals from the environmental risks (for example, continuous monitoring in a safe location while awaiting transfer to higher level of care and removing objects from the room that can be used for self-harm).
NPSG.15.01.01	3	Reduce the risk for suicide.	Use an evidence-based process to conduct a suicide assessment of individuals served who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens individuals served for suicidal ideation and assesses the severity of suicidal ideation.
NPSG.15.01.01	5	Reduce the risk for suicide.	Follow written policies and procedures addressing the care of individuals served identified as at risk for suicide. At a minimum, these should include the following: - Training and competence assessment of staff who care for individuals served at risk for suicide - Guidelines for reassessment - Monitoring individuals served who are at high risk for suicide
NPSG.15.01.01	7	Reduce the risk for suicide.	Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of individuals served at risk for suicide and take action as needed to improve compliance.

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Standard	EP	Standard Text	EP Text
RC.02.03.07	4	Qualified staff receive and record verbal orders. Note: Verbal orders may include medication, laboratory tests, dietary, or restraint and seclusion.	Verbal orders are authenticated within the time frame specified by law and regulation.

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Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

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Appendix

Report Section Information

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

20211015 Resource licensure survey [Redacted]

Eric Holcomb, Governor
Terry J. Stigdon, Director
Indiana Department of Child Services
Room E306 – MS47
302 W. Washington Street
Indianapolis, Indiana 46204-2738

317-234-KIDS
FAX: 317-234-4497

www.in.gov/dcs

Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-5556

(Sent via email)

10/15/21

[redacted] CEO/Administrator
RTC Resource
[redacted]
Indianapolis, Indiana [redacted]

Re: License [redacted] & Residential Treatment Services Provider Contract [redacted] "Contract")

Dear Mr. [redacted]

On Thursday, October 15, 2021, the Indiana Department of Child Services (DCS), Residential Licensing Specialists conducted an unannounced tour of the facility, Licenses [redacted]

During the tour units were found to be out of compliance with staff supervision ratios. The finding of the deficient staff to child ratios presents a potential risk for security of youth placed in the agency. DCS finds an immediate need for corrective action by the agency to guarantee the agency is ensuring the safety for all youth residing at the facility. As we work together toward our mutual goal of providing services of the highest quality DCS is requiring a Plan of Correction to address the concerns described below by the end of the business today, no later than 3:30pm. The Plan of Correction must detail how Resource plans to remedy the concerns for ensuring all units are staffed per the required ratios as well as provide evidence of the remedial measures described in the required actions below.

465 IAC 2-9-50 / 465 IAC 2-11-50
Direct care personnel; child-staff ratios
Findings: During the tour not all units met the requirements for staff to child ratios.
The Serenity SHB CCI unit was found to have one staff for five youth. The required ratio for SHB Service Standard programming is 1:4.
The Reach PSF unit was found to have one staff with one youth when we first entered the unit.
Per the code the facility shall have at least two direct care workers whenever one or more child is

present. While we were on the unit ten girls returned to the unit with two staff and only one other staff remained on the unit leaving a ratio of 1:10 and a 1:1. The required ratio for PSF is 1:4. The Unity PSF unit was found to have one staff for two youth. Per the code the facility shall have at least two direct care workers whenever one or more child is present. The unit had two staff and an additional staff shadowing for training. With an additional youth programming on this unit the ratio was 2:9. The required ratio is 1:4.

Required Action:

1. Resource must provide the census and staffing schedules for each unit each shift to the Residential Licensing Specialist going forward from the date today, 10/15/21 until DCS is satisfied that staffing ratios are ensured as required by code and notifies the agency that this is no longer required
2. Plan to ensure that units will be consistently monitored during each shift to ensure the units are staffed as required.
3. Develop and implement systems and practices that will ensure that staff understand the necessity for maintaining required staff ratios.

In accordance with Section 34 [Notice to Parties] of the Contract, the Plan of Correction and all the documentation requested herein shall be submitted to DCS by close of business on October 15, 2021, to the [redacted]@dcs.in.gov. Please contact Foster Flint, DCS Licensing Specialist via email or by phone at [redacted] if you have any questions regarding this matter.

Sincerely

[redacted]

Residential Licensing Specialist
Placement Support and Compliance
Indiana Department of Child Services

[redacted]

Residential Licensing Supervisor
Placement Support and Compliance
Indiana Department of Child Services

cc: Clinical Services Specialist

On 10/15 at 4:30pm [redacted] and [redacted] conducted an unannounced visit at Resource Treatment Facility. We checked in while a new admission was arriving. Administration was paged but did not respond and we were told they were in a meeting. We waited in the lobby for approximately 15 minutes. During our wait the receptionist discovered a snake in a box behind the front desk. The box also contained a pair of shoes. The receptionist stated the box had been there for some time and she had moved it several times but did not see the snake. It is unclear how the snake got in the box.

After about 15 minutes [redacted] a nurse, came to the lobby. I requested that she take us on a tour and she agreed.

We first entered the Serenity SHB unit. There were two youth sitting at a table drawing and three youth were in the dayroom watching television with the lights off. This is not in ratio for 1:4 as it was a ratio of 1:5. (One boy was off of the unit with the other staff and the other was with his therapist). The staff was seated on a chair outside of the day room and had a clear view of the two boys drawing but, would not have been able to view the entire dayroom where the boys were watching television in the dark. The staff did not seem to understand what was meant by being in ratio and allowed the boys to be out of sight, in a dark room. This makes me question what type of training this staff had prior to working on an SHB unit.

We then went through the Courage CCI unit. There was a staff and one girl seated at a counter. This was a 1:1 staff for the girl. When entering the unit there was a wet spot on the floor – a small puddle to the left of the entrance. The day room had empty cups sitting around on the floor. We then entered the Peace unit directly off the Courage unit. When we entered the girls were in the dayroom at the far end of the hall and a staff was seated outside the door. Loud inappropriate music with foul language was heard coming from the room. It was immediately turned off. Another staff appeared, from where I am not sure. These 5 other girls that were residing on what would be the Peace unit were the girls involved in the elopement and incident involving the police on 10/10. There were two staff. One was a 1:1. One girl was on LOS precautions. This would be in ratio. There were hygiene bins found in almost every room or, products were in their showers. All room were in disarray with clothing and other items strewn all over in the rooms. When talking to the girls they stated they are not allowed off the unit since the elopement.

We then entered the Reach PSF unit. There was one staff seated with resident [redacted] She said she was her 1:1 staff. However, as this a PSF unit there should have been two staff present. The staff was also found to have two other residents QF observation sheets and those residents were not present. It was unclear why she had the sheets and if she had been filling them out. [redacted] said she was unit restriction for aggression and was not allowed to leave the unit. [redacted] had some minor scabs on her right knee she said she got from horseplaying with the other girls. She said she had not reported the injuries and had not had a nurse look at the scabs. There were laundry bags sitting in the hallway outside the doors of the rooms. It was explained that it was laundry day but not why the bags were sitting in the hallway. All bedrooms were in disarray with clothing and other items strewn around the room. One bathroom had a small cup containing press on fingernails by the sink that were pointed and could potentially be used for injury to themselves or others. As were touring the rooms ten girls came back to the unit with two staff. However, one of the staff left immediately after the girls were all on the unit leaving one staff with ten girls and the 1:1 with [redacted] The other staff was said to be with three girls doing their laundry. This would be out of ratio on the unit and for the girls off of the unit doing their laundry. While

we their [redacted] Chief Nursing Officer arrived. At that same time a supervisor entered the unit and was told that the unit needed two other staff immediately to be in ratio. He began to leave the unit instead of staying but was told to stay on the unit until staff could arrive. Staff that were present on the unit also gave [redacted] the two walkie talkies they had and said they were not working. During a brief conversation with girls one girl stated that staff do not treat them with respect and that is why they do not respect staff. Several of the other girls stated they are not getting their phone calls and that the phone located on the unit is not working. While we were talking with girls the supervisor left the unit. When I pointed this out [redacted] stated she "had the manpower in the building and they were getting two staff to come to the unit". We left the unit and entered the cafeteria where 5 girls were eating with two staff. This was in ratio.

We the went to the Unity PSF unit. There was one staff with two boys. One was in the hallway roaming around and the other was in an office making a phone call. This would be out of ratio for PSF requiring two staff present. The staff present stated the other 7 boys were in the gym with one staff and another staff shadowing. This is also out of ratio as one staff was still shadowing.

We then concluded the tour with [redacted] and [redacted] assured that she had the manpower in the building and would make sure staff were on the units per the required ratio.

20220329 Resource - Referral hold letter-DCS licensing [Redacted]

Eric J. Holcomb, Governor
Terry J. Stigdon, Director

Indiana Department of Child Services
[redacted]
Indianapolis, Indiana [redacted]

317-234-KIDS
FAX: [redacted]

www.in.gov/dcs

Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-5556

March 29, 2022

Via Email Only

[redacted], CEO/Administrator

RTC Resource

[redacted]

Indianapolis, Indiana [redacted]

Email: [redacted]@resourcetreatmentcenter.com

NOTICE OF REFERRAL HOLD

Re: License [redacted] Residential Treatment Services Provider Contract [redacted] ("Contract")

Dear Mr. Reckelhoff,

The Indiana Department of Child Services (DCS) is aware of the serious license and contractual issues that have occurred at RTC Resource Acquisition Corporation (Contractor) regarding a lack of compliance with required staff to child ratios and adequate supervision. There is evidence of increased safety concerns based on the frequency and type of abuse and neglect reports that have been recently conveyed and documentation reviewed. These issues are serious in nature and have posed, and continue to pose, risk to children currently in the care of the Contractor. To thoroughly assess these serious concerns and to work with the Contractor to ensure an effective plan of correction (POC) is in place, DCS hereby gives notice to the Contractor, in accordance with Section 34 [Notice to Parties] of Contract [redacted] that a referral hold has been placed on the Contractor's license referenced above, effective immediately.

The DCS Residential Licensing Division will provide the Contractor a detailed account of concerns, request a POC be submitted by the Contractor that must detail how the Contractor plans to remedy the identified concerns, and require proof of the remedial measures described in the

POC. If you have any questions about this notice, please contact the undersigned at [redacted] or [redacted] at [redacted]

Sincerely,

[redacted]

[redacted] MBA, LCSW
Assistant Deputy Director
Child Welfare Services

Cc: [redacted], MS
[redacted]
[redacted]
[redacted]
File

20220329 Resource 30 day notice to comply [Redacted]

Eric J. Holcomb, Governor
Terry J. Stigdon, Director

Indiana Department of Child Services
Room E306 – MS47
302 W. Washington Street
Indianapolis, Indiana 46204-2738

317-234-KIDS
FAX: 317-234-4497

www.in.gov/dcs

Child Support Hotline: 800-840-8757
Child Abuse and Neglect Hotline: 800-800-5556

April 8, 2022

Via E-mail Only
[redacted], CEO
Resource Treatment Center
[redacted]
Indianapolis, Indiana [redacted]
[redacted]@resourcetreatmentcenter.com

Re: Residential Treatment Services Provider Contract [redacted] ("Contract") & 30 Days' Notice

Dear Mr [redacted]

The Indiana Department of Child Services ("DCS") is following up on its "NOTICE OF REFERRAL HOLD" that was issued to Resource Treatment Center ("Contractor" or "Agency") on March 29, 2022 as a result of serious license and contractual issues that have occurred at the Agency. These issues, identified herein, are serious in nature and pose risks to youth placed at the Agency.

1. **March 11 – March 13, 2022 Video Tapes & March 15, 2022 Tour of Facility.**

On March 15, 2022, a DCS Residential Licensing Specialist ("RLS") viewed video tapes for the Reach Unit and conducted a tour of the facility. The video recordings viewed were for the Reach Unit during the period from March 11 – March 13, 2022 and showed that the Reach Unit was found to be staffed with only one staff for the 2nd and 3rd shifts. The required ratio should be 1:4 for the 2nd shift and 2 awake staff for 3rd shift.

A tour of the facility was conducted on March 15, 2022, by the RLS and the Unity Unit was found to be out of compliance with staff supervision ratios. The Unity Unit was found to have one direct care staff on the unit with two youth. Per the code for private secure licenses the facility shall have at least two direct care workers whenever one child or more is present. These finding of the deficient staff to child ratios present a potential risk for the security of youth placed at the Agency under licenses [redacted] and [redacted]. As a result, a plan of correction ("POC") by the Contractor was required to guarantee the Agency was ensuring the safety for all youth residing at the facility to address the concerns for the failure to maintain required staff to youth ratios within 10 days and

by no later than March 27, 2022. The POC required the Agency to develop systems and practices to remedy the concerns for ensuring all units were staffed per the required ratios and to provide unit schedules and staff timecards as verification that the staff scheduled to work were working on all units each day for review by the RLS.

2. Plan of Correction & Visit to Facility on March 25, 2022.

The Agency submitted a POC on March 25, 2022 that described the systems and practices that would be implemented to monitor the staff scheduled to work on each unit and remedy the deficiency in the required staff ratios. The Agency provided schedules and verification that staff had reported to work for each day and each shift from 03/16/22 – 03/25/22 for the RLS to review daily. However, when the RLS and a child protective services investigator visited the facility on March 25th in response to additional allegations of abuse and neglect reported to the hotline, video reviewed showed that the Reach Unit once again did not have adequate staff present on the unit on March 22nd and March 23rd.

3. March 22, 2022 Video Reviewed.

The review of video of the Reach Unit showed that March 22nd , beginning at 9:08 pm, there was only one staff present on the unit even though there were 12 youth on the unit and the requirement for the unit is a staff ratio of 1:4; thus, there should have been 3 staff. The only staff present was viewed sitting outside a resident room from 9:08 pm until approximately 9:36 pm.

The Agency explained that the staff was positioned outside the resident's room as the youth was placed on a line-of-sight precaution. The assigned staff got up one time at 9:29 pm to allow the youth who was placed on a line-of-sight precautions to use the restroom then sat back down. As this staff was assigned to remain in line of sight and there was no additional staff, it was not possible to conduct any bed checks.

The video reviewed showed that the assigned staff got up at 9:35 pm to go to another resident's room after the resident had tied a mask string around her neck and then called for a nurse. The supervisor for the building then had to be stationed outside the youth's room who had tied the string around her neck. This would not have allowed the supervisor to be available for other units during the shift.

4. March 23, 2022 Video Reviewed.

The video reviewed on March 23, 2022 for the Reach Unit showed that beginning at 7:10 pm there were only two staff present on the unit even though there were 12 youth on the unit and based on the required ratio of 1:4, 3 staff were required. One resident was on a line-of-sight precautions. The resident who was on a line-of-sight precautions and staff were seated in the dayroom, but the staff maintaining line of sight leaves the dayroom at 7:13pm. When the staff left the dayroom, the youth was no longer in line of sight, and the youth begins to self-injure by cutting her arms under the sleeve of her shirt. Another resident discovered what she did and alerted staff at 7:16pm. Due

to inadequate staff supervision the special precautions for a maintaining a line of sight for the youth was not implemented to fidelity.

5. March 24, 2022 Video Reviewed.

Prior to leaving the building on March 25, 2022, the RLS also viewed video from March 24th . At 8:57 pm., two residents on the Sexually Harmful Behavior ("SHB") unit were left unmonitored in a dayroom on the unit. The youth are seen touching each other over and under their clothing with the lights off until another resident comes into the room at 9:03 pm and tells them to stop. When walking through the building the unit was found to have 6 boys on the separate SHB units with only 3 staff. The units should have had a ratio of 1:4. There were 6 boys on each of these units which required a minimum of 2 staff on each unit.

6. March 28, 2022 Discussion of Video Reviews & Findings with the Administrator.

The RLS discussed the videos reviewed and findings with [redacted], the administrator and CEO, on March 28, 2022. Mr. [redacted]f stated that there are currently some crucial issues that are affecting the ratios on the units. According to Mr. [redacted] these are due to staff calling off and staff not ensuring the units are covered prior to leaving the units. Furthermore, according to Mr.[redacted], the Agency has 10 vacancies with no current relief staff employed to adequately cover all units and all shifts for the current census without the need for mandating of overtime or administration and other non-direct care employees working in place of direct care staff. It was also determined that the current practices for ensuring the units are staffed as required is not working.

NOTICE OF BREACH OF CONTRACT & THIRTY DAYS TO CURE

As a result of the above issues, in accordance with Section 46 [Termination for Default and Termination or Suspension for Additional Reasons] of the Contract, the Contractor is hereby put on thirty days' notice that it is in breach of subsection 1.D. [Administrative Duties], subsection 1.E. [Responsibilities Relating to a Child in Residential Care], section 10 [Compliance with Laws], section 30 [Licensing Standards], and section 49 [Work Standards] of the Contract. Therefore, the Contractor has thirty days from the date of this letter to complete an updated Plan of Correction that details the following:

1. The Agency must develop policies and procedures for how the Agency will ensure that the Agency's environment of care has the required number of direct care staff (Behavioral Health Assistants) scheduled for each unit and for each shift daily and that the required number of supervisors are scheduled for the required number of direct care staff each shift. These policies and procedures should include how the Agency administration will ensure adherence to the requirement that each unit maintains the required staffing during each shift and that active supervision is available during each shift for all units.

2. The Agency must provide the staff schedules and verification that the staff on the schedule worked as scheduled for each unit and each shift to the RLS daily. The documentation should

include how many shifts were covered by employees other than direct care staff and how many shift were covered by mandating staff. This should include documentation that the Agency administration has verified that each shift for each unit is staffed and had supervision available as required by the Indiana Administrative Code and the Contract.

3. The Agency must submit the current census and the employee manning table to the RLS weekly until it can be determined that the Agency has employed sufficient staff to meet the required ratios for the current census as required by 465 IAC 2-9-50/2-11- 50 and has sufficient relief staff as required by IAC 465 2-9-53(c)/2-11-53(c).

4. The Agency shall make sure its POC sufficiently provides the information and documentation as request and includes the following:

    a. How the corrective action can be accomplished (i.e., what process and/or systems will be changed or implemented to correct the deficiency);
    b. Who will be responsible for implementing each component;
    c. How will adherence be monitored, sustained, and evaluated to ensure new practice(s) remain in place;
    d. The timeline for implementation; and
    e. How staff will be trained in any of the new process/systems identified.

This Plan of Correction is due electronically to your licensing consultant at [redacted]@dcs.in.gov as soon as possible but no later than thirty days from the date of this letter.

Finally, DCS has determined that an unannounced follow up visits will be conducted at the Agency to ensure the implementation of some Agency practices that have been cited at the time of and, prior to the referral hold. The frequency and information collected during on-going visits will be at the discretion of DCS. If you have any questions about this letter, please contact [redacted] at [redacted]@dcs.in.gov

[redacted]
Child Welfare Services

Cc: [redacted]
[redacted]
[redacted]
[redacted]
[redacted]@dcs.in.gov
[redacted]g@dcs.in.gov
[redacted]s@dcs.in.gov

20220412 Millcreek AR AFMC licensure survey findings [Redacted]

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

afmc SM
Improving health care. Improving lives.

April 12, 2022

Habilitation Center, LLC
Attn: [redacted], Chief Executive Officer
[redacted]@millcreekbehavioralhealth.com
[redacted]
Fordyce, Arkansas[redacted]

The Division of Provider Services and Quality Assurance 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 for Under 21. The Medicaid Manual for Inpatient Psychiatric Services for Under Age 21 was used in the completion of this report.

Any observations and deficiencies found and noted during the Inpatient Psychiatric Inspection of Care (IOC) conducted at the following service site on the specified dates can be found below:

Habilitation Center, LLC
Provider ID# : [redacted]
Onsite Inspection Date: March 28, 2022

Inspection of Care Summary

Facility Tour:

Upon arrival to facility, AFMC staff was promptly greeted at the entrance by a Habilitation Centers, LLC staff member and a COVID-19 screening was conducted and temperatures noted. AFMC was immediately taken to a conference room where they were met by the Chief Executive Officer.

A tour of the facility was completed with the Director of Risk Management and the Director of Nursing. Staff were able to answer all questions regarding the facility. The following is a list of environmental observations per unit/dormitory that was noted by AFMC staff during the facility tour:

- Kangaroo Dormitory had several wires hanging down from the television in the day room.
- Tiger Dormitory had a broken light switch cover in the bathroom, a broken socket cover in the dayroom, excessive wires hanging from behind the television in the day room, and the epoxy in the bathroom was damaged.
- The dining/cafeteria had a few broken floor tiles throughout, and the floors had excessive debris.
- Zebra Dormitory had exposed wires from behind the television in the day room and a plunger in the bathroom.
- Zebra, Flamingo, and Penguin Dormitories each had a wooden handled plunger in the bathroom which could easily be used as a weapon. Facility staff removed those plungers to a locked, secure location during the facility tour.
- Deer Field Dormitory bathroom door jams had rusted out at the bottom and were painted over.

- Rock Hill Dormitory bathroom door jams had rusted out at the bottom and were painted over. The bathrooms were excessively dirty and a strong, old urine smell was noted. There were also gnats flying in and around the toilets and a small roach was seen crawling across the floor.
- Pine Ridge Dormitory bathroom door jams had rusted out at the bottom and were painted over.

Facility Review-Policies and Procedures:

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

Personnel Records- Licenses, Certifications, Training:

There were fifty-four personnel records requested; ten (25%) professional staff and forty-four (25%) paraprofessional staff. During the review of the personnel records, no deficiencies were noted.

General Observations:

[redacted] had a letter dated 03/23/2022 from the Division of Child Care and Early Childhood Education indicating that this staff did not meet the requirements to work with children based on background check results. A background check and child maltreatment check were provided for the staff.

Clinical Summary

As a part of the Quality of Care survey of the IOC, an active Fee for Service (FFS) Medicaid client list was requested, client and/or guardian interviews were conducted, and a clinical record review was completed. The following is a summary of findings and noted deficiencies.

Client/Guardian Interviews:

No active FFS Medicaid clients were currently admitted at the time of IOC. Therefore, there were no client interviews were conducted.

Program Activity/Service Milieu Observation:

Groups of six to ten residents were in several classrooms. The classrooms were adequately staffed and residents appeared to be engaged in the classrooms. Multiple dormitories had groups that were adequately staffed. Several groups had staff and residents that did not appeared to be engaged. Penguin Dormitory had several clients in a group setting who were sleeping as well as two clients who had behaviors that were escalating. Pine Ridge Dormitory AFMC staff noted that two of the three staff were on their cell phones instead of engaging with clients. This was reported to the CEO as a safety concern after the facility tour.

Medication Pass:

No Medicaid clients received medications during a medication pass while AFMC staff was onsite. Due to the observation of non-Medicaid clients not being complaint with the HIPAA minimal necessary rule, no medication pass was observed. AFMC RN visited with the Habilitation Centers, LLC Health medication nurse who was able to show AFMC RN the facility policies and procedures regarding medication administration, narcotic count/reconciliation/handling, and medication discrepancies. Tour of medication room completed with the Habilitation Centers, LLC medication nurse and no discrepancies with medication storage, cleanliness of medication room, and knowledge of medication dispensing found.

Clinical Record Review Deficiencies:

No active FFS Medicaid clients were currently admitted at the time of IOC. Therefore, there were no clinical records reviews conducted.

Respectfully,

AFMC Inspection Team

[redacted]@afmc.org

Improving health care. Improving lives.
1020 W. 4TH ST., SUITE 300
LITTLE ROCK, AR 72201 • afmc.org

20220506 Millcreek Pontotoc licensure-group homes [Redacted]

DEPARTMENT OF MENTAL HEALTH

State of Mississippi

239 North Lamar Street
1101 Robert E. Lee Building
Jackson, Mississippi 39201

601-359-1288
FAX 601-359-6295
TDD 601-359-6230

Wendy D. Bailey - Executive Director

[redacted]
Millcreek of Pontotoc
[redacted]
Pontotoc, MS [redacted]

Dear Mr. [redacted]

A Department of Mental Health Certification Visit of Millcreek of Pontotoc was conducted on May 4-6, 2022. Enclosed is the Written Report of Findings.

Millcreek of Pontotoc has the opportunity to achieve compliance with certification requirements by submitting a Plan of Compliance for all deficiencies to the DMH Division of Certification within thirty (30) days of the signature date of this letter. The plan must include:

A. A description of how the deficiencies will be corrected;

B. A description of the mechanisms to be implemented to ensure continued compliance with the standards cited during the review, and;

C. Time frame for the completion for each correction.

Plans of Compliance must be submitted to the Division of Certification at [redacted]dmh.ms.gov using the DMH Plan of Compliance form located in the DMH Record Guide; Section K- Administrative Information.

DMH will notify you within thirty (30) days of the date of submission of the Plan of Compliance if further information is needed or the Plan of Compliance is approved.

If you have any questions or concerns, please contact [redacted] at [redacted]@dmh.ms.gov.

Sincerely,

[redacted]
Director
Division of Certification

5-19-22
Date

DEPARTMENT OF MENTAL HEALTH
WRITTEN REPORT OF FINDINGS

Provider: Millcreek of Pontotoc

Dates of Visit: May 4-6, 2022

Reviewers: [redacted]

PROGRAMS, SERVICES, AND DEFICIENCIES

Millcreek of Pontotoc
[redacted] *Pontotoc, MS* [redacted]
Therapeutic Group Home

Rule 2.5.D
There is no documentation of the provider utilizing the Web Infrastructure for Treatment Services (WITS) to maintain current and accurate data for submission to DMH as outlined in the DMH 2020 Operational Standards.

PERSONNEL REVIEW

Rule 12.4.A.4
Person-Centered, Recovery Oriented Systems of Care training is not being completed by all staff.

Rule 12.4.A.9
Staff are not completing (2) hours of training in cultural competency and (2) hours of training in ethics.

RECORD REVIEW

Rule 2.5.C
The Individual Service Plan did not address trauma history.

The Individual Service Plan goals are not written in the person's own words with a person-centered recovery-oriented focus.

PROGRAM REVIEW

Cedar Pointe Therapeutic Group Home
[redacted] *Starkville, MS* [redacted]
Capacity 10

Rule 29.3.C.2
A staff person with a Bachelor's degree was not included in every shift while children/youth are awake.

Deer Creek Therapeutic Group Home
[redacted] *Hollandale, MS* [redacted]
Capacity 10

No deficiencies found.

Oak Hill Therapeutic Group Home
[redacted] *Kosciusko, MS* [redacted]
Capacity 10

Rule 29.3.C.2
A staff person with a Bachelor's degree was not included in every shift while children/youth are awake.

Pecan Grove Therapeutic Group Home
[redacted] *MS* [redacted]
Capacity 8

No deficiencies found.

Willow Springs Therapeutic Group Home
[redacted] *Blue Springs, MS* [redacted]
Capacity 10

No deficiencies found.

Woodland Acres Therapeutic Group Home
[redacted] *Myrtle, MS* [redacted]
Capacity 8

No deficiencies found.

AcadianaTreatmentCenter [No Redactions Required]

Residential Treatment Centers

For the purposes of this response, residential treatment facilities are defined as psychiatric residential treatment facilities (42 CFR § 483.352), qualified residential treatment programs (42 USC § 672(k)(4)), therapeutic boarding schools, therapeutic residential treatment centers, non-medical residential centers, congregate care facilities for youth, wilderness camps or therapy programs, boot camps, and behavior modification facilities—that are intended to address youth's behavioral, emotional, mental health, or substance use needs.

Acadiana Treatment Center

DESCRIPTION	*RESPONSE*
Facility Location	Sunset, LA
Licensing Body(ies)	State of Louisiana, Department of Health and Hospitals
Accreditation(s)	CARF, Residential Treatment: Integrated: AOD/MH (Children and Adolescents)
Patient Populations Served	*Ages Served:* 12-17 *Primary state of residence:* Louisiana *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders *Typical types of mental or behavioral health concerns:* ADHD, Anxiety, Bipolar, Depression, PTSD, Self-Harm
Size Of Program	42 beds
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, Therapeutic Education
Average Length of Stay	2017: N/A 2018: N/A 2019: 68.8 days 2020: 113.2 days 2021: 120.2 days

CovePREP [No Redactions Required]

Residential Treatment Centers

For the purposes of this response, residential treatment facilities are defined as psychiatric residential treatment facilities (42 CFR § 483.352), qualified residential treatment programs (42 USC § 672(k)(4)), therapeutic boarding schools, therapeutic residential treatment centers, non-medical residential centers, congregate care facilities for youth, wilderness camps or therapy programs, boot camps, and behavior modification facilities—that are intended to address youth's behavioral, emotional, mental health, or substance use needs.

Cove PREP (White Deer Run, LLC)

DESCRIPTION	*RESPONSE*
Facility Location	Torrance, PA
Licensing Body(ies)	Pennsylvania Department of Human Services
Accreditation(s)	CARF, Residential Treatment: Mental Health (Juvenile Justice)
Patient Populations Served	*Ages Served:* 12-20 *Primary state of residence:* Pennsylvania, Ohio, Tennessee, Texas, Illinois, and others. *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders Diagnostic Services *Typical types of mental or behavioral health concerns:* ADHD, Anxiety, Bipolar, Depression, PTSD, Self-Harm, Sexually Maladaptive Behaviors
Size Of Program	34 beds
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, Therapeutic Education Assessments: Physical Assessment, Health Services Assessment, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment, Occupational Therapy Assessment, Nutritional Assessment, Educational Assessment, Legal Assessment, Psychosexual Assessment & Recreational Assessment
Average Length of Stay	2017: 191.5 days 2018: 316.0 days 2019: 324.0 days 2020: 358.6 days 2021: 192.0 days

LittleCreekBehavioralHealth [No Redactions Required]

Residential Treatment Centers

For the purposes of this response, residential treatment facilities are defined as psychiatric residential treatment facilities (42 CFR § 483.352), qualified residential treatment programs (42 USC § 672(k)(4)), therapeutic boarding schools, therapeutic residential treatment centers, non-medical residential centers, congregate care facilities for youth, wilderness camps or therapy programs, boot camps, and behavior modification facilities—that are intended to address youth's behavioral, emotional, mental health, or substance use needs.

Little Creek Behavioral Health (Habilitation Centers, LLC.)

DESCRIPTION	*RESPONSE*
Facility Location	Conway, AR
Licensing Body(ies)	Arkansas Department of Human Services, Division of Child Care and Early Childhood Education
Accreditation(s)	Joint Commission, Behavioral Health Care Accreditation Program
Patient Populations Served	*Ages Served:* 6-18 *Primary state of residence:* Ohio, Texas, Montana, Arizona, Pennsylvania, Alaska, and others. *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders *Typical types of mental or behavioral health concerns:* ADHD, Anxiety, Bipolar, Depression, PTSD, Self-Harm
Size Of Program	64 beds
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, & Therapeutic Education Assessments: Physical Assessment, Health Services Assessment, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment, Occupational Therapy Assessment, Nutritional Assessment, Educational Assessment, Legal Assessment, & Recreational Assessment Deaf and Hard of Hearing services for those needing Residential Treatment.
Average Length of Stay	2017: Not applicable 2018: Not applicable 2019: Not applicable 2020: 205 days 2021: 234 days

MillCreekBehavioralHealth [No Redactions Required]

Residential Treatment Centers

For the purposes of this response, residential treatment facilities are defined as psychiatric residential treatment facilities (42 CFR § 483.352), qualified residential treatment programs (42 USC § 672(k)(4)), therapeutic boarding schools, therapeutic residential treatment centers, non-medical residential centers, congregate care facilities for youth, wilderness camps or therapy programs, boot camps, and behavior modification facilities—that are intended to address youth's behavioral, emotional, mental health, or substance use needs.

MillCreek Behavioral Health (Habilitation Centers, LLC.)

DESCRIPTION	*RESPONSE*
Facility Location	Fordyce, AR
Licensing Body(ies)	Arkansas Department of Human Services, Division of Child Care and Early Childhood Education – Psychiatric Residential Treatment Facility Arkansas Department of Human Services - Intermediate Care Facility for Individuals with Development Disabilities
Accreditation(s)	Joint Commission, Behavioral Health Care Accreditation Program
Patient Populations Served	*Ages Served:* 6-17 *Primary state of residence:* Arkansas, Texas, Montana, Illinois, New Mexico, Alaska, Louisiana, Arizona, and others. *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders *Typical types of mental or behavioral health concerns:* Depressive disorders, Anxiety disorders, Bipolar disorder, Impulse control disorders, Attention-deficit/hyperactivity disorder (ADHD), Oppositional defiant disorder, Posttraumatic stress disorder (PTSD), Reactive attachment disorder, & Non-suicidal self-harm
Size Of Program	61 beds, Intermediate Care; 97 beds, Residential Facility; 126 beds, Psychiatric Residential Treatment Facility
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, & Therapeutic Education Assessments: Physical Assessment, Health Services Assessment, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment, Occupational Therapy Assessment, Nutritional Assessment, Educational Assessment, Legal Assessment, & Recreational Assessment
Average Length of Stay	2017: 163.40 days 2018: 178.14 days 2019: 195.31 days 2020: 175.02 days

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2021: 208.58 days
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MillCreekMagee [No Redactions Required]

Residential Treatment Centers

For the purposes of this response, residential treatment facilities are defined as psychiatric residential treatment facilities (42 CFR § 483.352), qualified residential treatment programs (42 USC § 672(k)(4)), therapeutic boarding schools, therapeutic residential treatment centers, non-medical residential centers, congregate care facilities for youth, wilderness camps or therapy programs, boot camps, and behavior modification facilities—that are intended to address youth's behavioral, emotional, mental health, or substance use needs.

Millcreek of Magee (Rehabilitation Centers, LLC.)

DESCRIPTION	*RESPONSE*
Facility Location	Magee, MS
Licensing Body(ies)	Mississippi State Department of Health - Institution for the Aged and Infirmed
Accreditation(s)	Joint Commission, Behavioral Health Care Accreditation Program
Patient Populations Served	*Ages Served:* 13-21 *Primary state of residence:* Mississippi, Montana, Tennessee, New Mexico, New Hampshire, and others. *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders *Typical types of mental or behavioral health concerns:* Depressive disorders, Anxiety disorders, Bipolar disorder, Impulse control disorders, Attention-deficit/hyperactivity disorder (ADHD), Oppositional defiant disorder, Posttraumatic stress disorder (PTSD), Reactive attachment disorder, & Non-suicidal self-harm
Size Of Program	125 beds, Institution for the Aged or Infirmed, ICF-ID; 57 beds, Psychiatric Residential Treatment Facility
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, & Therapeutic Education Assessments: Physical Assessment, Health Services Assessment, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment, Occupational Therapy Assessment, Nutritional Assessment, Educational Assessment, Legal Assessment, & Recreational Assessment
Average Length of Stay	2017: 187.6 (PRTF); 423.5 (ICF-ID) 2018: 190.0(PRTF); 494.0 (ICF-ID) 2019: 176.5 (PRTF); 453.3 (ICF-ID) 2020: 156.5 (PRTF); 451.8 (ICF-ID) 2021: 129.6 (PRTF); 415.4 (ICF-ID)

MillCreekPontotoc [No Redactions Required]

Residential Treatment Centers

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Millcreek of Pontotoc (Rehabilitation Centers, LLC.)

DESCRIPTION	*RESPONSE*
Facility Location	Pontotoc, MS
Licensing Body(ies)	Mississippi State Department of Health - Institution for the Aged and Infirmed - Psychiatric Residential Treatment Facility Mississippi Department of Child Protection Services – Residential Therapeutic Child Care Mississippi Department of Mental Health – Therapeutic Group Homes
Accreditation(s)	Joint Commission, Behavioral Health Care Accreditation Program
Patient Populations Served	*Ages Served:* 12-21 *Primary state of residence:* Mississippi, Tennessee, West Virginia, Vermont, and others. *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders *Typical types of mental or behavioral health concerns:* Depressive disorders, Anxiety disorders, Bipolar disorder, Impulse control disorders, Attention-deficit/hyperactivity disorder (ADHD), Oppositional defiant disorder, Posttraumatic stress disorder (PTSD), Reactive attachment disorder, & Non-suicidal self-harm
Size Of Program	48 beds, Therapeutic Group Home; 51 beds, Psychiatric Residential Treatment Facility
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, & Therapeutic Education Assessments: Physical Assessment, Health Services Assessment, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment, Occupational Therapy Assessment, Nutritional Assessment, Educational Assessment, Legal Assessment, & Recreational Assessment
Average Length of Stay	2017: 145.9 days (PRTF); 207.6 (TGH) 2018: 156.0 days (PRTF); 245.3 (TGH)

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2019: 125.0 days (PRTF); 205.6 (TGH)
2020: 135.9 days (PRTF); 147.7 (TGH)
2021: 150.7 days (PRTF); 196.0 (TGH)
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PineyRidgeTreatmentCenter [No Redactions Required]

Residential Treatment Centers

For the purposes of this response, residential treatment facilities are defined as psychiatric residential treatment facilities (42 CFR § 483.352), qualified residential treatment programs (42 USC § 672(k)(4)), therapeutic boarding schools, therapeutic residential treatment centers, non-medical residential centers, congregate care facilities for youth, wilderness camps or therapy programs, boot camps, and behavior modification facilities—that are intended to address youth's behavioral, emotional, mental health, or substance use needs.

Piney Ridge Treatment Center

DESCRIPTION	*RESPONSE*
Facility Location	Fayetteville, AR
Licensing Body(ies)	Arkansas Department of Human Services, Division of Child Care and Early Childhood Education
Accreditation(s)	Joint Commission, Behavioral Health Care Accreditation Program
Patient Populations Served	*Ages Served:* 5-18 *Primary state of residence:* Arkansas, Montana, Texas, Alaska, Florida, Wyoming, Oklahoma, Ohio, Nebraska, and others. *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders Sexual Maladaptive Behavior *Typical types of mental or behavioral health concerns:* Depressive disorders, Anxiety disorders, Bipolar disorder, Impulse control disorders, Attention-deficit/hyperactivity disorder (ADHD), Oppositional defiant disorder, Posttraumatic stress disorder (PTSD), Reactive attachment disorder, & Non-suicidal self-harm
Size Of Program	15 beds, Therapeutic Group Home; 102 beds, Psychiatric Residential Treatment Facility
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, & Therapeutic Education Assessments: Physical Assessment, Health Services Assessment, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment, Occupational Therapy Assessment, Nutritional Assessment, Educational Assessment, Legal Assessment, Psychosexual Assessment & Recreational Assessment
Average Length of Stay	2017: 274.2 (PRTF); 3774.8 (TGH) 2018: 283.8 (PRTF); 450.6 (TGH) 2019: 272.8 (PRTF); 344.0 (TGH) 2020: 219.1 (PRTF); 275.0(TGH) 2021: 230.2 (PRTF); 303.6 (TGH)

ResourceTreatmentCenter [No Redactions Required]

Residential Treatment Centers

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Resource Treatment Center (RTC Resource Acquisition Corporation)

DESCRIPTION	*RESPONSE*
Facility Location	Indianapolis, IN
Licensing Body(ies)	Indiana Department of Child Services – Private Secure Facility, Child Caring Institution, & Group Home
Accreditation(s)	Joint Commission, Behavioral Health Care Accreditation Program
Patient Populations Served	*Ages Served:* 11-21 *Primary state of residence:* Indiana, Illinois, Ohio, Florida, Nevada, Texas, New Mexico, New Hampshire, and others. *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders Sexual Maladaptive Behavior *Typical types of mental or behavioral health concerns:* Depressive disorders, Anxiety disorders, Bipolar disorder, Impulse control disorders, Attention-deficit/hyperactivity disorder (ADHD), Oppositional defiant disorder, Posttraumatic stress disorder (PTSD), Reactive attachment disorder, & Non-suicidal self-harm
Size Of Program	40 beds, Therapeutic Group Home; 62 Child Caring Institution (RTC); 31 beds, Psychiatric Residential Treatment Facility
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, & Therapeutic Education Assessments: Physical Assessment, Health Services Assessment, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment, Occupational Therapy Assessment, Nutritional Assessment, Educational Assessment, Legal Assessment, Psychosexual Assessment & Recreational Assessment
Average Length of Stay	2017: 133.5 days (TGH); 203.1 (PRTF); 157.9 (RTC) 2018: 163.3 days (TGH); 169.7 (PRTF); 143.6 (RTC) 2019: 80.5 days (TGH); 233.2 (PRTF); 153.9 (RTC) 2020: 189.0 days (TGH); 192.8 (PRTF); 217.6 (RTC)

	2021: 191.7 days (TGH); 175.3 (PRTF); 215.4 (RTC)

SUWSCarolinas [No Redactions Required]

Residential Treatment Centers

For the purposes of this response, residential treatment facilities are defined as psychiatric residential treatment facilities (42 CFR § 483.352), qualified residential treatment programs (42 USC § 672(k)(4)), therapeutic boarding schools, therapeutic residential treatment centers, non-medical residential centers, congregate care facilities for youth, wilderness camps or therapy programs, boot camps, and behavior modification facilities—that are intended to address youth's behavioral, emotional, mental health, or substance use needs.

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DESCRIPTION	*RESPONSE*
Facility Location	Old Fort, NC
Licensing Body(ies)	NC Department of Health and Human Services,
Accreditation(s)	CARF: Residential Treatment, Behavioral Health
Patient Populations Served	*Ages Served:* 10-17 *Primary state of residence:* North Carolina and others. *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders *Typical types of mental or behavioral health concerns:* Depressive disorders, Anxiety disorders, Bipolar disorder, Impulse control disorders, Attention-deficit/hyperactivity disorder (ADHD), Oppositional defiant disorder, Posttraumatic stress disorder (PTSD), Reactive attachment disorder, & Non-suicidal self-harm
Size Of Program	133 beds, Residential Therapeutic Camps-Children & Adolescents
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, & Therapeutic Education Assessments: Physical Assessment, Health Services Assessment, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment, Occupational Therapy Assessment, Nutritional Assessment, Educational Assessment, Legal Assessment, Psychosexual Assessment & Recreational Assessment
Average Length of Stay	2017: 61.6 days 2018: 70.8 days 2019: 69.1 days 2020: 71.4 days 2021: 71.0 days

VillageBehavioralHealth [No Redactions Required]

Residential Treatment Centers

For the purposes of this response, residential treatment facilities are defined as psychiatric residential treatment facilities (42 CFR § 483.352), qualified residential treatment programs (42 USC § 672(k)(4)), therapeutic boarding schools, therapeutic residential treatment centers, non-medical residential centers, congregate care facilities for youth, wilderness camps or therapy programs, boot camps, and behavior modification facilities—that are intended to address youth's behavioral, emotional, mental health, or substance use needs.

Village Behavioral Health

DESCRIPTION	*RESPONSE*
Facility Location	Louisville, TN
Licensing Body(ies)	TN Department of Mental Health and Substance Abuse Services
Accreditation(s)	Joint Commission: Behavioral Health Programs
Patient Populations Served	*Ages Served:* 10-17 *Primary state of residence:* Tennessee, North Carolina, Kentucky, Illinois, South Carolina, Colorado, and others. *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders Substance Use Disorders *Typical types of mental or behavioral health concerns:* Depressive disorders, Anxiety disorders, Bipolar disorder, Impulse control disorders, Attention-deficit/hyperactivity disorder (ADHD), Oppositional defiant disorder, Posttraumatic stress disorder (PTSD), Reactive attachment disorder, & Non-suicidal self-harm
Size Of Program	40 beds, Alcohol & Drug Residential Treatment for Children & Youth; 105 beds, Mental Health Residential for Children & Youth
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, & Therapeutic Education Assessments: Physical Assessment, Health Services Assessment, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment, Occupational Therapy Assessment, Nutritional Assessment, Educational Assessment, Legal Assessment, Psychosexual Assessment & Recreational Assessment
Average Length of Stay	2017: 70.6 days 2018: 77.4 days 2019: 96.7 days 2020: 77.8 days 2021: 73.3 days

YouthCare [No Redactions Required]

Residential Treatment Centers

For the purposes of this response, residential treatment facilities are defined as psychiatric residential treatment facilities (42 CFR § 483.352), qualified residential treatment programs (42 USC § 672(k)(4)), therapeutic boarding schools, therapeutic residential treatment centers, non-medical residential centers, congregate care facilities for youth, wilderness camps or therapy programs, boot camps, and behavior modification facilities—that are intended to address youth's behavioral, emotional, mental health, or substance use needs.

YouthCare of Utah

DESCRIPTION	*RESPONSE*
Facility Location	Draper, UT
Licensing Body(ies)	State of Utah, Department of Human Services, Office of Licensing
Accreditation(s)	Joint Commission: Behavioral Health Programs
Patient Populations Served	*Ages Served:* 10-17 *Primary state of residence:* Utah, Arizona, Colorado, North Carolina, Nevada, Hawaii, and others. *Typical reason(s) for placement:* Mental Health & Behavioral Health Disorders Substance Use Disorders *Typical types of mental or behavioral health concerns:* Depressive disorders, Anxiety disorders, Bipolar disorder, Impulse control disorders, Attention-deficit/hyperactivity disorder (ADHD), Oppositional defiant disorder, Posttraumatic stress disorder (PTSD), Reactive attachment disorder, & Non-suicidal self-harm
Size Of Program	48 Mental Health & Substance Abuse Residential Treatment 10 Mental Health & Substance Abuse Day Treatment (PHP) 16 Mental Health & Substance Abuse Intermediate Secure Care
Services Offered	Residential: Group Therapy, Individual Therapy, Medication Management, Case Management, & Therapeutic Education Assessments: Physical Assessment, Health Services Assessment, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment, Occupational Therapy Assessment, Nutritional Assessment, Educational Assessment, Legal Assessment, Psychosexual Assessment & Recreational Assessment
Average Length of Stay	2017: 111.4 days (RTC); 36.5 (PHP) 2018: 86.2 days (RTC); 34.6 (PHP) 2019: 81.8 days (RTC); 36.6 (PHP) 2020: 111.4 days (RTC); 42.3 (PHP) 2021: 92.3 days (RTC); 27.1 (PHP)

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Center	Program Name	Oracle Center & Program Code	Program Address	Licensing Body	License Number/ Provider ID	Accreditations	Type of Facility	Ages Served	Primary State of Residence	Primary reason for placement	Types of MH/IDD/BH conditions	Licensed Capacity	Actual Capacity	Services Offered (including treatment and educational services)	Ratio of Staff to Youth	Notes
Arizona	Casa Amistad	[redacted]	[redacted] Boulevard Tucson, AZ [redacted]	Arizona Dept of Health Services	[redacted]	The Joint Commission	Behavioral Health Residential Facility	5 to 18 years of age	Arizona	Respite Services	MH/BH	8	[redacted]	Respite Services - day/overnight	1:8 day/ 1:10 night	
Arizona	Casa Ensueno	[redacted]	[redacted] Tucson, AZ	Arizona Dept of Health Services	[redacted]	The Joint Commission	Behavioral Health Residential Facility	5 to 18 years of age	Arizona	Respite Services	MH/BH	7	[redacted]	Respite Services - day/overnight	1:8 day/1:10 night	
Arizona	Casa Valor	[redacted]	[redacted] Monte Tucson AZ	Arizona Dept of Health Services	[redacted]	The Joint Commission	Behavioral Health Residential Facility	5 to 18 years of age	Arizona	Respite Services	MH/BH	10	[redacted]	Respite Services - day/overnight	1:8 day/ 1:10 night	
Arizona	Casa Sol	[redacted]	[redacted] Tucson, AZ	Arizona Dept of Health Services	[redacted]	The Joint Commission	Behavioral Health Residential Facility	5 to 18 years of age	Arizona	Respite Services	MH/BH	6	[redacted]	Respite Services - day/overnight	1:8 day/ 1:10 night	
Arizona	Eugie 5	[redacted]	[redacted] Scottsdale, AZ	Arizona Dept of Health Services	[redacted]	The Joint Commission	Behavioral Health Residential Facility	5 to 18 years of age	Arizona	Respite Services	MH/BH	10	[redacted]	Program is not currently being operated	Program is not currently being operated	
Arizona	Eugie 4	[redacted]	[redacted] Scottsdale, AZ	Arizona Dept of Health Services	[redacted]	The Joint Commission	Behavioral Health Residential Facility	5 to 18 years of age	Arizona	Respite Services	MH/BH	10	[redacted]	Program is not currently being operated	Program is not currently being operated	
Arizona	Eugie 3	[redacted]	[redacted] Scottsdale, AZ	Arizona Dept of Health Services	[redacted]	The Joint Commission	Behavioral Health Residential Facility	5 to 18 years of age	Arizona	Respite Services	MH/BH	8	[redacted]	Program is not currently being operated	Program is not currently being operated	
Arizona	Eugie 2	[redacted]	[redacted] Scottsdale, AZ	Arizona Dept of Health Services	[redacted]	The Joint Commission	Behavioral Health Residential Facility	5 to 18 years of age	Arizona	Respite Services	MH/BH	10	[redacted]	Program is not currently being operated	Program is not currently being operated	
Arizona	Broadway Campus	[redacted]	[redacted] Boulevard Tucson, AZ	Arizona Dept of Health Services	[redacted]	The Joint Commission	Behavioral Health Residential Facility	8 to 17 years of age	Arizona	Short-Term Residential	MH/BH	24	[redacted]	Clinical and Behavioral	1:6 day/ 1:10 night	
Arizona	Sweetwater Campus	[redacted]	[redacted] Scottsdale, AZ	Arizona Dept of Health Services	[redacted]	The Joint Commission	Behavioral Health Inpatient Facility	5 to 18 years of age	Arizona	Therapeutic Rsidential	MH/BH	52	[redacted]	Clinical and Behavioral; Education	1:6 day/ 1:10 night	
Colorado	Devereux Colorado	N/A	[redacted] Westminster, CO	Department of Human Services Office of Behavioral Health	[redacted]	The Joint Commission	Psychiatric Residential Treatment Facility	7 to 18 years of age	any		MH/BH	47	[redacted]	Program is not currently being operated	1:8 day; 1:16 night	
Colorado	Shelter Care	[redacted]	[redacted] Westminster, CO	Department of Human Services Office of Behavioral Health	[redacted]	The Joint Commission	RCCF - Shelter Care designation	3 to 18 years of age	ORR placement	Border placement	MH/BH	30	[redacted]	Educational, Clinical, and Vocational Services	1:8 day; 1:16 night	
Colorado	Therapeutic	[redacted]	[redacted] Westminster, CO	Department of Human Services Office of Behavioral Health	[redacted]	The Joint Commission	*RCCF - Therapeutic Designation*	3 to 18 years of age	ORR placement	Therapeutic residential needs	MH/BH	10	[redacted]	Educational, Clinical, and Vocational Services	1:4 day; 1:8 night	In process of increasing licensed capacity to 20
Colorado	Cleo Wallace Academy	[redacted]	[redacted] Westminster, CO	Department of Human Services Office of Behavioral Health	[redacted]	The Joint Commission	*RCCF - Day Treatment*	5 to 18 years of age	Colorado	Out of Placement	MH/BH	35	[redacted]	Educational, Clinical, and Vocational Services	1:10	In process of increasing licensed capacity to 90 - physical plant inspection scheduled for 8/11
Connecticut	Devereux-Glenholme	[redacted]	[redacted] Washington, CT	CT State Department of Children and Families	[redacted]	NEASC	Child Care Facility	8 to 21	Connecticut	Special Education	BH	104	[redacted]	Educational, Clinical, Behavioral	Max 1:12	
Connecticut	Devereux Glenholme School	[redacted]	[redacted] Washington, CT	CT State Department of Education	[redacted]	NEASC	Department of Education	8 to 21	Connecticut	Special Education	BH	104	[redacted]	Educational, Clinical, Behavioral	Max 1:12	
Florida	Titusville Cottage	[redacted]	[redacted] Titusville, FL	State of Florida Department of Children and Families	[redacted]	The Joint Commission	Residential Group Care	12 through 17	Florida	FFPSA - At Risk placement (EBD)	BH	6	[redacted]	Clincial and Behavioral	1:3 day; 1:3 night	
Florida	Titusville Lodge	[redacted]	[redacted] Titusville, FL [redacted]	State of Florida Department of Children and Families	[redacted]	The Joint Commission	Residential Group Care	12 through 17	Florida	FFPSA - At Risk placement (EBD)	BH	12	[redacted]	Clincial and Behavioral	1:4 day; 1:6 night	
Florida	Viera Campus - Unit 6	[redacted]	[redacted] Viera, FL [redacted]	State of Florida Department of Children and Families	[redacted]	The Joint Commission	Residential Group Care	5 through 18	Florida	FFPSA - At Risk placement (EBD & IDD)	BH and IDD	26	[redacted]	Clinical and Behavioral; Education	1:4 day; 1:6 night	
Florida	Orlando RGC	[redacted]	[redacted] Orlando, FL [redacted]	State of Florida Department of Children and Families	[redacted]	The Joint Commission	Residential Group Care	12 through 17	Florida	FFPSA - At Risk placement (EBD)	BH	12	[redacted]	Clincial and Behavioral	1:4 day; 1:6 night	

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Center	Program Name	Oracle Center & Program Code	Program Address	Licensing Body	License Number/ Provider ID	Accreditations	Type of Facility	Ages Served	Primary State of Residence	Primary reason for placement	Types of MH/IDD/BH conditions	Licensed Capacity	Actual Capacity	Services Offered (including treatment and educational services)	Ratio of Staff to Youth	Notes
Florida	Viera Campus - Unit 5	[redacted]	[redacted] Viera, FL [redacted]	State of Florida Department of Children and Families	[redacted]	The Joint Commission	Residential Group Care	5 through 18	Florida	FFPSA - At Risk placement (EBD)	BH	10	[redacted]	Clinical and Behavioral; Education	1:4 day; 1:6 night	
Florida	Orlando SIPP	[redacted]	[redacted] Orlando, FL [redacted]	AHCA	[redacted]	The Joint Commission	Residential Treatment Center for Children & Adolescents		Florida	Theuraputic Treatment	BH		[redacted]	Clinical and Behavioral; Education	1:4 day; 1:6 night	
Florida	Viera Hospital - Units 1-4	[redacted]	[redacted] Viera, FL [redacted]	AHCA		The Joint Commission	Residential Treatment Center for Children & Adolescents	5 through171	Florida	Theuraputic Treatment	BH and IDD	100	[redacted]	Clinical and Behavioral; Education	1:4 day; 1:6 night	
Florida	Brevard Boys STGH	[redacted]	[redacted] Titusville, FL [redacted]	AHCA	[redacted]	The Joint Commission	Residential Treatment Center for Children & Adolescents	12 though 17	Florida	Theuraputic Treatment	BH	12	[redacted]	Clincial and Behavioral	1:3 day/ 1:4 night	
Georgia	Psychiatric Residential	[redacted]	[redacted] Kennesaw, GA	Georgia Department of Community Health	[redacted]	The Joint Commission	Residential Mental Health Facility	10 through 21	GA	Therapeutic treatment	BH and IDD	134	[redacted]	Clinical and education	1:5 first shift; 1:4 second shift, 1:8 third shift	
Massachusetts	Devereux - ASD	[redacted]	[redacted] Rutland MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Residential Campus	6 Through 21	MA	Therapeutic residential needs	ASD/BH	46	[redacted]	Clinical, behavioral, psychiatric, medical, educational	1:3 day/1:6 overnight	
Massachusetts	Devereux - Boys Program	[redacted]	[redacted] Rutland MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Residential Campus	6 Through 21	MA	Therapeutic residential needs	MH/BH	24	[redacted]	PROGRAM NOT CURRENTLY OPERATING	1:3 day/1:6 overnight	
Massachusetts	Devereux East Meadow Group Home	[redacted]	[redacted] Rutland MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Intensive on campus group home	6 Through 21	MA	Therapeutic intensive group home needs	ASD/BH/MH	12	[redacted]	Clinical, behavioral, psychiatric, medical	1:3 day/1:6 overnight	
Massachusetts	Devereux-Hillcrest Group Home	[redacted]	[redacted] Rutland MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Intensive on campus group home	12 through 21	MA	Therapeutic intensive group home needs	ASD/BH/MH	12	[redacted]	Clinical, behavioral, psychiatric, medical	1:3 day/1:6 overnight	
Massachusetts	Devereux Center-Gate House	[redacted]	[redacted] Rutland, MA	Massachusetts Department of Early Education and Care	[redacted]	COA	Group Home	12 through 21	MA	Therapeutic group home needs	ASD/BH	9	[redacted]	Clinical, behavioral, psychiatric, medical	1:3 day/1:6 overnight	
Massachusetts	Devereux-Hillside Group Home	[redacted]	[redacted] Rutland MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Intensive on campus group home	12 through 21	MA	Therapeutic intensive group home needs	MH/BH	10	[redacted]	Clinical, behavioral, psychiatric, medical	1:3 day/1:6 overnight	
Massachusetts	Devereux-Girl's Program	[redacted]	[redacted] Rutland MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Residential Campus	12 Through 21	ma	Therapeutic residential needs	MH/BH	18	[redacted]	Clinical, behavioral, psychiatric, medical, educational	1:3 awake/1:6 overnight	
Massachusetts	Devereux -Trafford House	[redacted]	[redacted] Rutland, MA	Massachusetts Department of Early Education and Care	[redacted]	COA	Group Home	12 through 21	ma	Therapeutic group home needs	MH/BH	12	[redacted]	clinical, behavioral, medical	1:4 awake/1:6 overnight	
Massachusetts	Devereux Fentress	[redacted]	[redacted] Rutland MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Group Home	12 through 21	ma	Therapeutic group home needs	MH/BH	8	[redacted]	clinical, behavioral, medical	1:4 awake/1:6 overnight	
Massachusetts	Devereux - Cathy house group home	[redacted]	[redacted] Fitchberg, MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Group Home	6 Through 21	MA	Therapeutic group home needs	IDD, Non verbal ASD	8	[redacted]	Clinical, behavioral, psychiatric, medical	1:2 Awake/1:4 asleep	License exp. date 1/31/22 however renewal in process. Delay due to covid related state delays. License remains current while in renewal process.
Massachusetts	Devereux - Devon house group home	[redacted]	[redacted] Fitchberg, MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Group Home	6 Through 21	MA	Therapeutic group home needs	IDD, Non verbal ASD	9	[redacted]	Clinical, behavioral, psychiatric, medical	1:2 Awake/1:4 asleep	License exp. date 9/2/21 however renewal in process. Delay due to covid related state delays. License remains current while in renewal process.

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Center	**Program Name**	**Oracle Center & Program Code**	**Program Address**	**Licensing Body**	**License Number/ Provider ID**	**Accreditations**	**Type of Facility**	**Ages Served**	**Primary State of Residence**	**Primary reason for placement**	**Types of MH/IDD/BH conditions**	**Licensed Capacity**	**Actual Capacity**	**Services Offered (including treatment and educational services)**	**Ratio of Staff to Youth**	**Notes**
Massachusetts	Devereux-Paxton House	[redacted]	[redacted] Paxton MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Emergency residences	4 through 12	MA	Emergency, short term, out of home therapeutic placement	MH/BH	6	[redacted]	clinical, behavioral, medical	1:3 awake/1:6 overnight	License exp. date 8/28/21 however renewal in process. Delay due to covid related state delays. License remains current while in renewal process.
Massachusetts	Devereux-Webster House		[redacted] Webster MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	COA	Emergency residences	4 through 12	MA	Emergency, short term, out of home therapeutic placement	MH/BH	9		clinical, behavioral, medical	1:3 awake/1:6 overnight	License exp. date 6/22/22 however renewal in process. Delay due to covid related state delays.License remains current while in renewal process.
Massachusetts	Devereux - New Beginnings		[redacted] Rutland MA [redacted]	Massachusetts Department of Early Education and Care	[redacted]	None	Short term ORR shelter program	5 through 12	N/A	Short-Term Shelter	MH	12		clinical, medical, educational, placement	1:4 awake/1:6 overnight	
New York	Devereux Red Hook Residential Campus	[redacted]	[redacted] Red Hook NY [redacted]	Office for People with Developmental Disabilities (OPWDD)	[redacted]	N/A	Residential Campus	5-21 (post graduates will be over 21 while awaiting adult placement)	NY	Educational	IDD, ASD	92		Residential, behavioral support	2-4:10-12 day&evening, 2-3 awake:10-12 on overnight	Ratio varies by census and behavioral/supervision needs of home at that time.
New York	ICF-Lower Hook		[redacted] Rhinebeck, NY [redacted]	Office for People with Developmental Disabilities (OPWDD)	[redacted]	N/A	ICF Group Home	5-21 (post graduates will be over 21 while awaiting adult placement)	NY	Educational	IDD, ASD	5		Residential, behavioral support	3:5 day/evening, 1 awake:3 on overnight or 1 awake/1 sleep:5 on overnight	
New York	ICF-Livingston		[redacted] Livingston NY [redacted]	Office for People with Developmental Disabilities (OPWDD)	[redacted]	N/A	ICF Group Home	5-21 (post graduates will be over 21 while awaiting adult placement)	NY	Educational	IDD, ASD	5		Residential, behavioral support	1 awake/1 sleep: 4= on overnight	
New York	ICFKinderhook		[redacted] Kinderhook, NY [redacted]	Office for People with Developmental Disabilities (OPWDD)	[redacted]	N/A	ICF Group Home	5-21 (post graduates will be over 21 while awaiting adult placement)	NY	Educational	IDD, ASD	5		Residential, behavioral support	Program is not currently being operated	Currently vacant
New York	ICF-Gretna		[redacted] Pleasant Valley, NY [redacted]	Office for People with Developmental Disabilities (OPWDD)	[redacted]	N/A	ICF Group Home	5-21 (post graduates will be over 21 while awaiting adult placement)	NY	Educational	IDD, ASD	5		Residential, behavioral support	2:5 day/evening, 1 awake:3 on overnight or 1 awake/1 sleep:5 on overnight	
New York	ICF-Cornell		[redacted] Red Hook, NY [redacted]	Office for People with Developmental Disabilities (OPWDD)	[redacted]	N/A	ICF Group Home	5-21 (post graduates will be over 21 while awaiting adult placement)	NY	Educational	IDD, ASD	10		Residential, behavioral support	3-4:10 day/evening, 2 awake/1 sleep: 7+ on overnight or 1 awake/1 sleep : 4-6 on overnight	
New York	ICF-Red Hook		[redacted] Red Hook, NY [redacted]	Office for People with Developmental Disabilities (OPWDD)	[redacted]	N/A	ICF Group Home	5-21 (post graduates will be over 21 while awaiting adult placement)	NY	Educational	IDD, ASD	5		Residential, behavioral support	2:5 day/evening, 1 awake:3 on overnight or 1 awake/1 sleep:5 on overnight	

CONFIDENTIAL																
Center	Program Name	Oracle Center & Program Code	Program Address	Licensing Body	License Number/ Provider ID	Accreditations	Type of Facility	Ages Served	Primary State of Residence	Primary reason for placement	Types of MH/IDD/BH conditions	Licensed Capacity	Actual Capacity	Services Offered (including treatment and educational services)	Ratio of Staff to Youth	Notes
Pennsylvania	Mapleton Annex	[redacted]	[redacted] Malvern, PA [redacted]	PA Dept. of Human Services	[redacted]	Joint Commission	Residential Services - Institutional based, dependent & delinquent, PRTF	10-17 years of age	PA	Residential	MH/BH	16	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Mapleton Main Residence	[redacted]	[redacted] Malvern, PA [redacted]	PA Dept. of Human Services	[redacted]	Joint Commission	Residential Services - Institutional based, dependent & delinquent, PRTF	10-17 years of age	PA	Residential	MH/BH	20	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Mapleton Carriage House	[redacted]	[redacted] Malvern, PA [redacted]	PA Dept. of Human Services	[redacted]	Joint Commission	Residential Services - Institutional based, dependent & delinquent, PRTF	10-17 years of age	PA	Residential	MH/BH	12	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Brandywine - Brook 1	[redacted]	[redacted] Glenmoore, PA [redacted]	PA Dept. of Human Services	[redacted]	Joint Commission	Residential Services - Institutional based, dependent & delinquent, PRTF	7-17 years of age	PA	Residential	MH/BH	24	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Brandywine - Croft Cottage	[redacted]	[redacted] Glenmoore, PA [redacted]	PA Dept. of Human Services	[redacted]	Joint Commission	Residential Services - Institutional based, dependent & delinquent, PRTF	7-17 years of age	PA	Residential	MH/BH	8	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Brandywine - Shrader	[redacted]	[redacted] Glenmoore, PA [redacted]	PA Dept. of Human Services	[redacted]	Joint Commission	Residential Services - Institutional based, dependent & delinquent, PRTF	7-17 years of age	PA	Residential	MH/BH	12	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Brandywine - Brier 1	[redacted]	[redacted] Glenmoore, PA [redacted]	PA Dept. of Human Services	[redacted]	Joint Commission	Residential Services - Institutional based, dependent & delinquent, PRTF	7-17 years of age	PA	Residential	MH/BH	24	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Brandywine - Dormitory 1 - Schwartz	[redacted]	[redacted] Glenmoore, PA [redacted]	PA Dept. of Human Services	[redacted]	Joint Commission	Residential Services - Institutional based, dependent & delinquent, PRTF	7-17 years of age	PA	Residential	MH/BH	16	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Brandywine - Dormitory 2 - Green	[redacted]	[redacted] Glenmoore, PA [redacted]	PA Dept. of Human Services	[redacted]	Joint Commission	Residential Services - Institutional based, dependent & delinquent, PRTF	7-17 years o f age	PA	Residential	MH/BH	16	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	King Rd.	[redacted]	[redacted] West Chester, PA [redacted]	PA Dept. of Human Services	[redacted]	Non-accredited	Residential Services - Community based, dependent & delinquent, Child Residential	5-22 years of age	PA	Residential Treatment	ASD/MH/BH	8	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	

CONFIDENTIAL																
Center	Program Name	Oracle Center & Program Code	Program Address	Licensing Body	License Number/ Provider ID	Accreditations	Type of Facility	Ages Served	Primary State of Residence	Primary reason for placement	Types of MH/IDD/BH conditions	Licensed Capacity	Actual Capacity	Services Offered (including treatment and educational services)	Ratio of Staff to Youth	Notes
Pennsylvania	100 Genuardi Circle	[redacted]	[redacted] West Chester, PA [redacted]	PA Dept. of Human Services	[redacted]	Non-accredited	Residential Services - Community based, dependent & delinquent, Child Residential	5-22 years of age	PA	Residential Treatment	ASD/MH/BH	24	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	101 Genuardi Circle (Glenloch)	[redacted]	[redacted] West Chester, PA [redacted]	PA Dept. of Human Services	[redacted]	Non-accredited	Residential Services - Community based, dependent & delinquent, Child Residential	5-22 years of age	PA	Residential Treatment	ASD/MH/BH	24	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	102 Genuardi Circle/Donovan	[redacted]	[redacted] West Chester, PA [redacted]	PA Dept. of Human Services	[redacted]	Non-accredited	Residential Services - Community based, dependent & delinquent, Child Residential	5-22 years of age	PA	Residential Treatment	ASD/MH/BH	24	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Jackson B	[redacted]	[redacted] West Chester, PA [redacted]	PA Dept. of Human Services	[redacted]	Non-accredited	Residential Services - Community based, dependent & delinquent, Child Residential	5-22 years of age	PA	Residential Treatment	ASD/MH/BH	12	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Ann/Larua Villa	[redacted]	[redacted] West Chester, PA [redacted]	PA Dept. of Human Services	[redacted]	Non-accredited	Residential Services - Community based, dependent & delinquent, Child Residential	5-22 years of age	PA	Residential Treatment	ASD/MH/BH	41	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Greenway	[redacted]	[redacted] West Chester, PA [redacted]	PA Dept. of Human Services	[redacted]	Non-accredited	Residential Services - Community based, dependent & delinquent, Child Residential	5-22 years of age	PA	Residential Treatment	ASD/MH/BH	19	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Brumer Building - Reed Program	[redacted]	[redacted] West Chester, PA [redacted]	PA Dept. of Human Services	[redacted]	Non-accredited	Residential Services - Community based, dependent & delinquent, Child Residential	5-22 years of age	PA	Residential Treatment	ASD/MH/BH	30	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Pennsylvania	Carriage Place	[redacted]	[redacted] West Chester, PA [redacted]	PA Dept. of Human Services	[redacted]	Non-accredited	Residential Services - Community based, dependent & delinquent, Child Residential	5-22 years of age	PA	Residential Treatment	ASD/MH/BH	13	[redacted]	Clinical, Psychiatric, Residential behavioral support	1:8/1:16 overnight	
Texas	Behavioral Health Residential, Autism/IDD Residential	[redacted]	[redacted] League City, Texas [redacted]	Texas Health & Human Services Commission	[redacted]	The Joint Commission-Behavioral Health	Residential Treatment Center	6-18 years	Texas	Residential Treatment	ASD/MH/BH	88	[redacted]	Residential Behavioral Health/Mental Health, Education	1:5/1:11 overnight 1:2+1/1:5 overnight STAIRS	
Texas	UCS	[redacted]	[redacted] Victoria, Texas [redacted]	Texas Health & Human Services Commission	Unlicensed	None	ORR	5-15 years	Texas	Unaccompanied alien children	Trauma Informed Care	36	[redacted]	Emergency Shelter, Clinical, Education	1:8/1:15 overnight	

DEV-S_001160 [Redacted]

NEW YORK STATE OF OPPORTUNITY. | Justice Center for the Protection of People with Special Needs

KATHY HOCHUL
Governor

DENISE M. MIRANDA
Executive Director

Notice to Provider of Investigation Determination

March 24, 2023

JC-OGC-PD

[redacted]
DEVEREUX FOUNDATION (THE)
[redacted]
RED HOOK, NY [redacted]

Re: [redacted]
Incident Number: 101-22672349088
Incident Reported Date: September 23, 2022
External Reference Number: [redacted]

Dear [redacted]

[redacted] an individual receiving services at your facility or provider agency, was named as an alleged victim in a report of abuse or neglect accepted by the Vulnerable Persons' Central Register (VPCR). This letter contains the results of the investigation of that report.

Allegation 1
Subject: [redacted] | Service Recipient: [redacted]

It was alleged that on or about September 23, 2022, while at DEVEREUX FOUNDATION, INC., located at [redacted] RED HOOK, New York, a Custodian, committed Neglect against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 2 Neglect pursuant to Social Services Law § 493(4)(b).

The investigation revealed the subject failed to report in a timely manner that the service recipient was missing.

Allegation 2
Subject: [redacted] | Service Recipient: [redacted]

It was alleged that on or about September 23, 2022, while at DEVEREUX FOUNDATION, INC., located at [redacted] RED HOOK, New York, a Custodian, committed Neglect against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 2 Neglect pursuant to Social Services Law § 493(4)(b).

The investigation revealed the subject failed to report in a timely manner that the service recipient was missing.

Allegation 3

Subject: [redacted] **Service Recipient:** [redacted]

It was alleged that on or about or between September 22, 2022 and September 23, 2022, while at DEVEREUX FOUNDATION, INC., located at [redacted] RED HOOK, New York, a Custodian, committed Neglect against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 2 Neglect pursuant to Social Services Law § 493(4)(b).

The investigation revealed the subject failed to conduct proper bed checks.

Allegation 4
Subject: [redacted] **Service Recipient:** [redacted]

It was alleged that on or about or between September 22, 2022 and September 23, 2022, while at DEVEREUX FOUNDATION, INC., located at [redacted] RED HOOK, New York, a Custodian, committed Obstruction against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 2 Obstruction pursuant to Social Services Law § 493(4)(b).

The investigation revealed the subject falsified documentation related to the health, safety, and welfare of the service recipient.

Allegation 5
Subject: [redacted] **Service Recipient:** [redacted]

It was alleged that on or about September 23, 2022, while at DEVEREUX FOUNDATION, INC., located at [redacted] RED HOOK, New York, a Custodian, committed Obstruction against/to a Service Recipient.

This allegation has been SUBSTANTIATED as Category 2 Obstruction pursuant to Social Services Law § 493(4)(b).

The investigation revealed the subject falsified documentation related to the health, safety, and welfare of the service recipient

A person or facility/provider against whom allegations of abuse or neglect have been substantiated has the right to request an amendment of this determination within 30 days. If this determination is not challenged, the results will be confirmed in the VPCR. In the event this matter is appealed and the determination is amended, you will receive appropriate notification.

Allegation 6
Subject: [redacted] **Service Recipient:** [redacted]

It was alleged that on or about September 23, 2022, while at DEVEREUX FOUNDATION, INC., located at [redacted] RED HOOK, New York, a Custodian, committed Neglect against/to a Service Recipient.

This allegation of Neglect has been UNSUBSTANTIATED. The report of this unsubstantiated

finding will now be sealed pursuant to Social Services Law §§ 493(3)(d) and 496(1).

An "unsubstantiated" finding means there was not enough evidence to confirm that an incident occurred or that the incident occurred but did not rise to the level of abuse and/or neglect.

As to any unsubstantiated finding(s), the employee(s) has/have been advised that this finding does not preclude you, as the employer, from taking employment action, including the commencement of disciplinary action that you determine to be appropriate, and that is consistent with any applicable collective bargaining agreement.

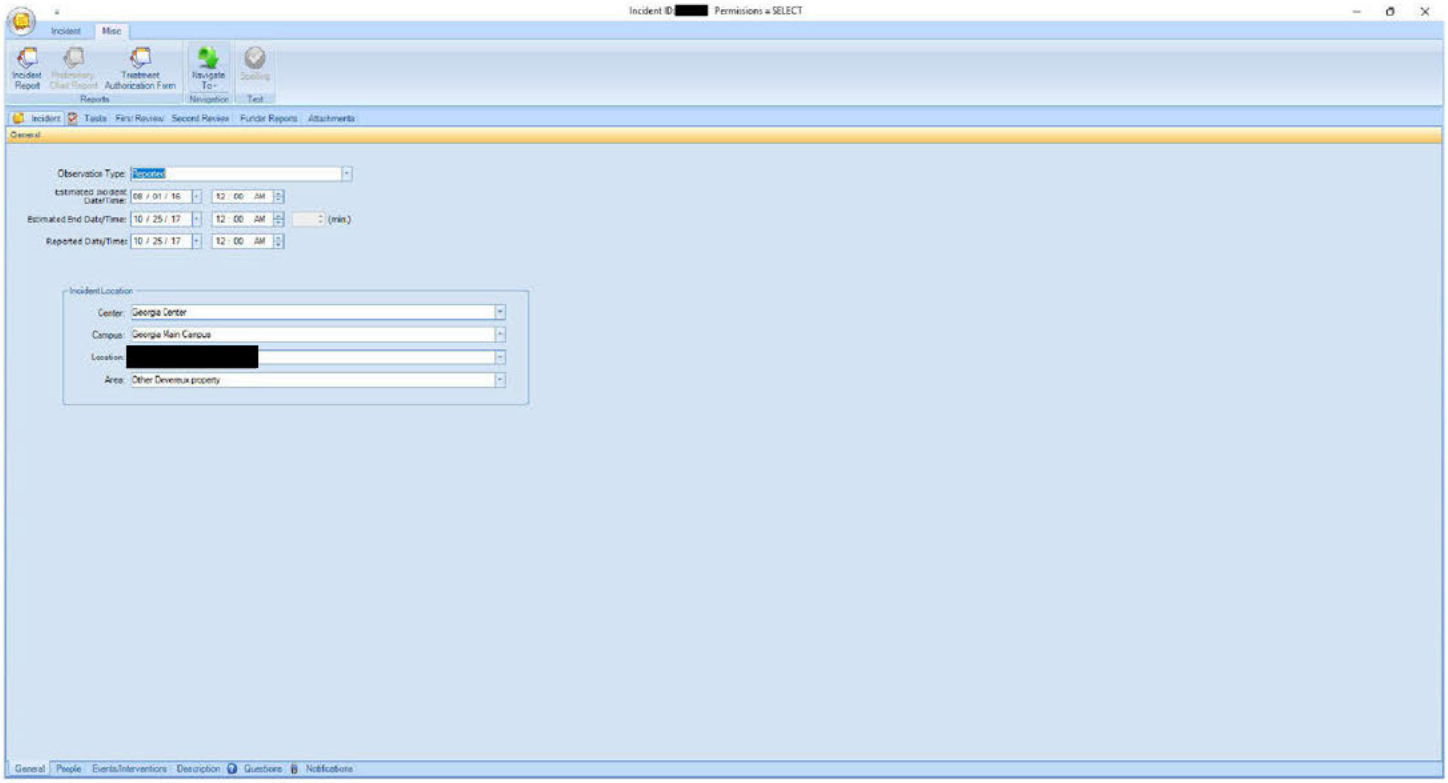
The Justice Center has identified areas of concern that are detailed in the investigation report. You should work with your state oversight agency to take actions to address and remediate these concerns, and any other issues or concerns that it would be appropriate to address based on review of the incident. The Justice Center has the authority to monitor your implementation of a plan of correction, including appraising timeliness and the safety, security and quality of care provided to service recipients.

Please visit the Justice Center website, Prevent Abuse tab at: https://www.justicecenter.ny.gov/prevent-abuse for resources on preventing abuse and neglect of people receiving services.

Office of General Counsel
NYS Justice Center for the Protection of People with Special Needs
161 Delaware Avenue
Delmar, NY 12054

cc: Office for People With Developmental Disabilities

DEV-S_001163 [Redacted]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Misc
Incident Report
Preliminary Chart Report
Treatment Authorization Form
Navigate To
Spelling
Reports
Navigation
Text
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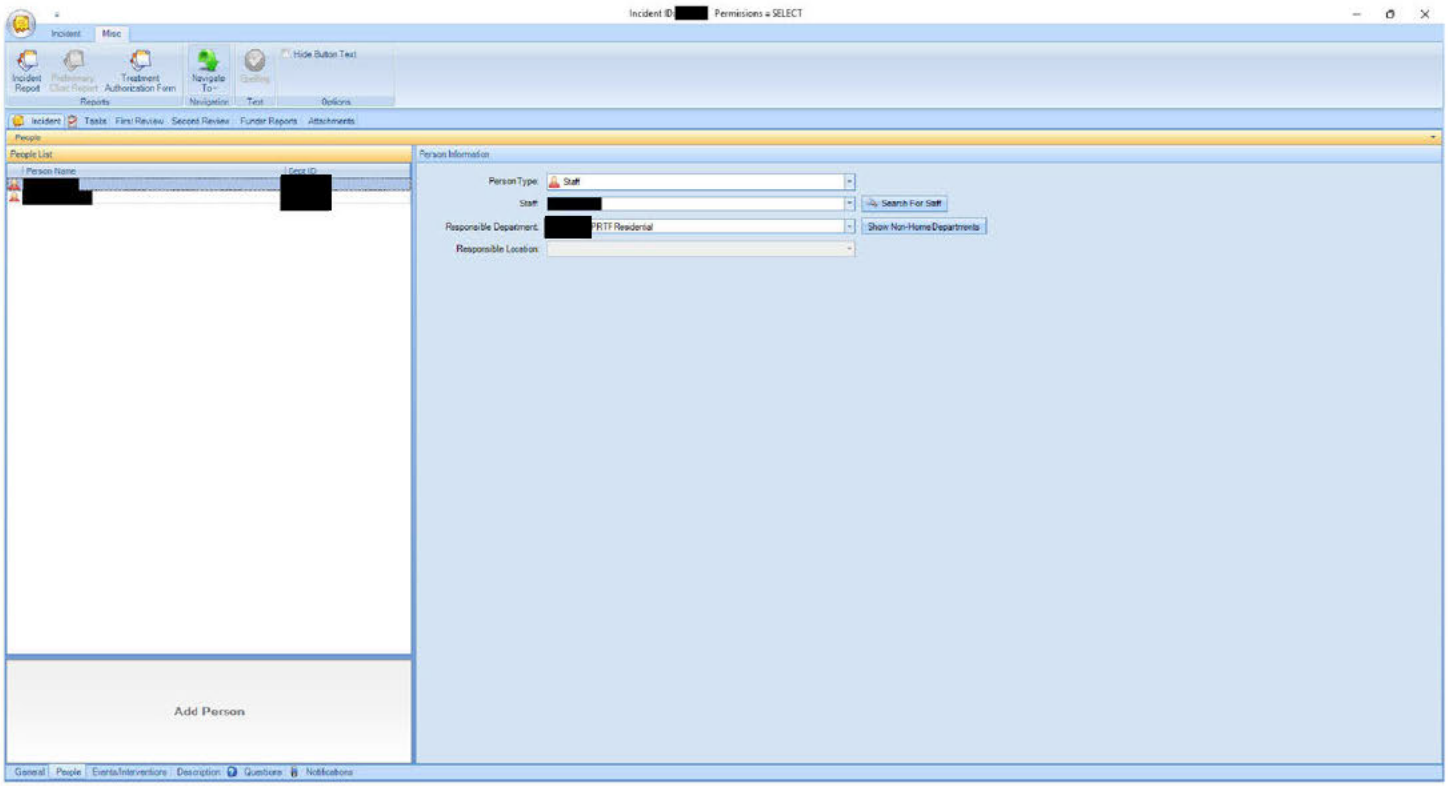
Tasks
First Review
Second Review
Funder Reports
Attachments
General
Observation Type: Reported
Estimated Incident Date/Time: 08 / 01 / 16 12 : 00 AM
Estimated End Date/Time: 10 / 25 / 17 12 : 00 AM (min.)
Reported Date/Time: 10 / 25 / 17 12 : 00 AM
Incident Location
Center: Georgia Center
Campus: Georgia Main Campus
Location: [redacted]
Area: Other Devereux property
General
People
Events/Interventions
Description
Questions
Notifications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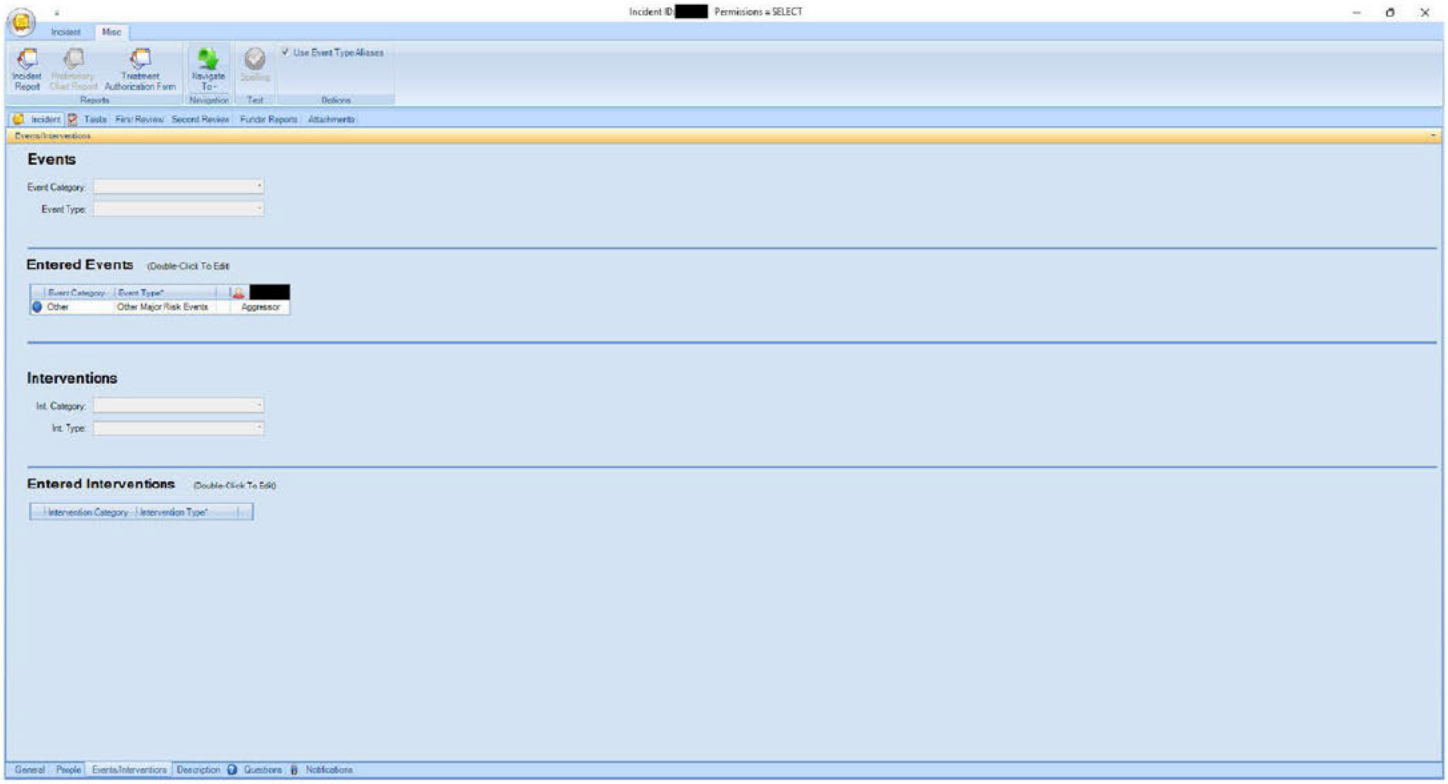
Incident
Misc
Incident Report
Preliminary Chart Report
Treatment Authorization Form
Navigate To
Spelling
Hide Button Text
Reports
Navigation
Text
Options
Incident
Tasks
First Review
Second Review
Funder Reports
Attachments
People
People List
Person Name
Case ID
[redacted]
Person Information
Person Type: Staff
Staff: [redacted]
Search For Staff
Responsible Department: [redacted] PRTF Residential
Show Non-Home Departments
Responsible Location:
Add Person
General
People
Events/Interventions
Description
Questions
Notifications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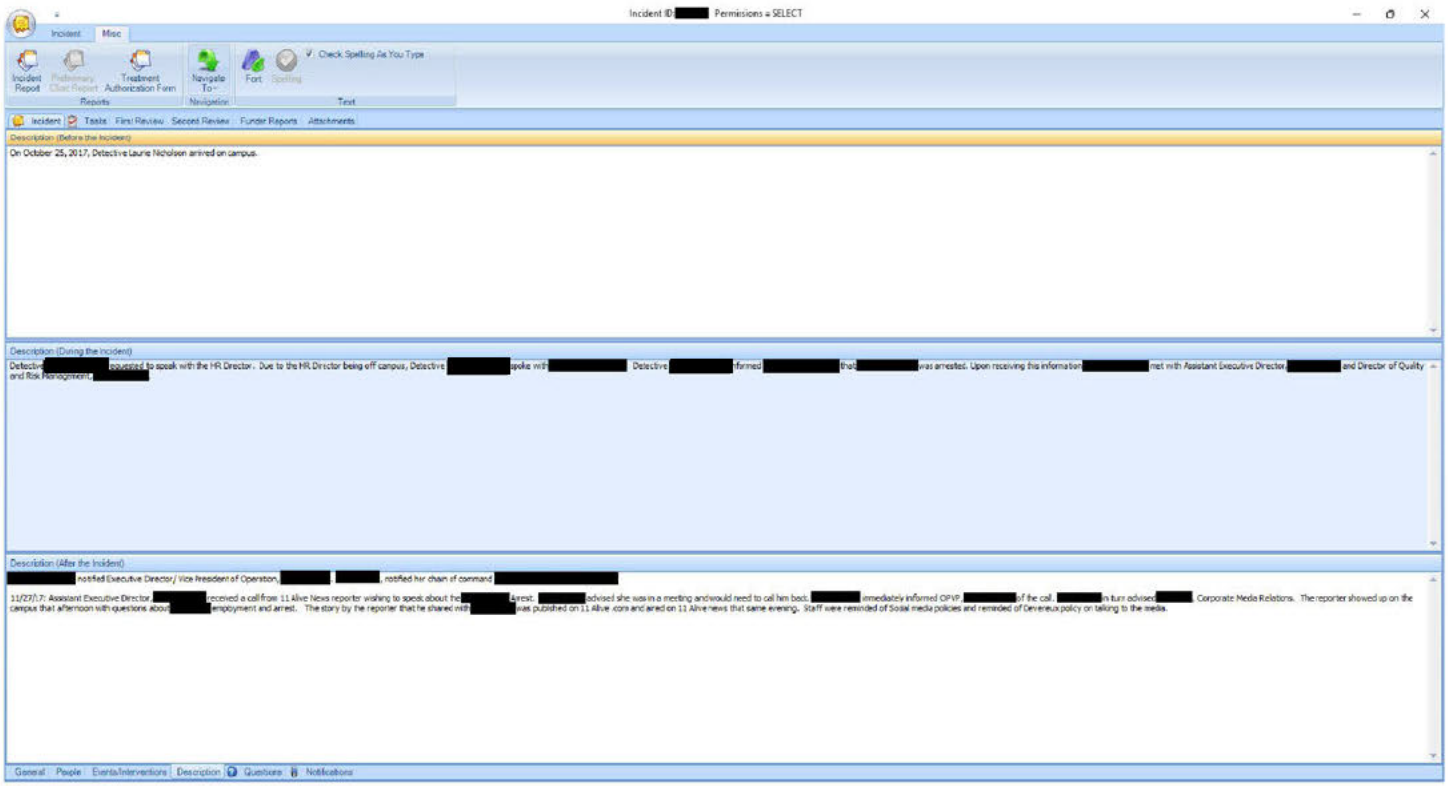
Incident
Misc
Incident Report
Preliminary Chair Report
Treatment Authorization Form
Navigate To
Spelling
Use Event Type Aliases
Reports
Navigation
Text
Options
Incident
Tasks
First Review
Second Review
Funder Reports
Attachments
Events/Interventions
Events
Event Category:
Event Type:
Entered Events
(Double-Click To Edit
Event Category
Event Type*
[redacted]
Other
Other Major Risk Events
Aggressor
Interventions
Int. Category:
Int. Type:
Entered Interventions
(Double-Click To Edit)
Intervention Category
Intervention Type*
General
People
Events/Interventions
Description
Questions
Notifications


Incident ID: [redacted] Permissions = SELECT
Incident
Misc
Incident Report
Preliminary Chair Report
Treatment Authorization Form
Navigate To
Font
Spelling
Check Spelling As You Type
Reports
Navigation
Text
Incident
Tasks
First Review
Second Review
Funder Reports
Attachments
Description (Before the Incident)
On October 25, 2017, Detective Laurie Nicholson arrived on campus.
Description (During the Incident)
Detective [redacted] requested to speak with the HR Director. Due to the HR Director being off campus, Detective [redacted] spoke with [redacted]. Detective [redacted] informed [redacted] that [redacted] was arrested. Upon receiving this information [redacted] met with Assistant Executive Director, [redacted] and Director of Quality and Risk Management, [redacted]
Description (After the Incident)
[redacted] notified Executive Director/ Vice President of Operation, [redacted] [redacted], notified her chain of command [redacted]
11/27/17: Assistant Executive Director, [redacted] received a call from 11 Alive News reporter wishing to speak about the [redacted] arrest. [redacted] advised she was in a meeting and would need to call him back. [redacted] immediately informed OPVP [redacted] of the call. [redacted] in turn advised [redacted] Corporate Media Relations. The reporter showed up on the campus that afternoon with questions about [redacted] employment and arrest. The story by the reporter that he shared with [redacted] was published on 11 Alive .com and aired on 11 Alive news that same evening. Staff were reminded of Social media policies and reminded of Devereux policy on talking to the media.
General
People
Events/Interventions
Description
Questions
Notifications

DEV-S_001165 [Redacted]

PerformCARE

Critical Incident Report

Date of Report: _____

Name of Member (Last, First, MI) MA Identifier Number	Provider Name Promise Number/Type
[redacted]	Brier [redacted]
Member Address, including Country	Provider Address Level of Care
[redacted]	[redacted] Residential/RTF
	Glenmoore, PA [redacted]
Member Telephone	Provider Contact Name and Telephone Number
	[redacted]
Date of Birth	Date of Admission and Discharge (if Applicable)
[redacted]	05/05/2016
Location of Incident and Provider Staff Involved	Date of Incident Time of Incident
Bedroom	10/23/2016 07:00 PM

Check type of Incident *(Please refer to Perform Care Policy & Procedure PR-008 Critical Incident Reporting for Definitions)*

Suicide attempt
Was the Member assessed by crisis or nurse?
Yes No
Medication error
Was the Member assessed by a nurse?
Yes No
✔ Any event requiring the services of the fire department, or law enforcement agency
An injury or illness (non-psychiatric) of a Member requiring medical treatment more intensive than first aid
A Member who is out of contact with staff for more than 24 hours without prior arrangement, or a Member who is in immediate jeopardy because he/she is missing for any period of time
Was the Member assessed by crisis or nurse?
Yes No
✓ Abuse or alleged abuse involving a Member
Family
✓ Peer
Staff
Other

Seclusion
Restraint
Chemical Mechanical Manual
Was the Member injured as part of a restraint?
Yes No
Was the Member assessed by a nurse?
Yes No
Death of a Member
Any fire, disaster, flood, earthquake, tornado, explosion, or unusual occurrence that necessitates the temporary shelter in place or relocation of residents
Provider Preventable Conditions (PPC)
Was the Member assessed by a nurse?
Yes No
Other incident identified by the Provider as Critical, Adverse or Unusual. Please specify:
Physical aggression
Impatient hospitalization
Self injurious behaviors
Other:

Describe what happened and any circumstances that may have precipitated the incident. ***Use additional sheets if necessary.***

Clients [redacted] and [redacted] were all roommates. Upon returning from a therapeutic home visit, client [redacted] noticed some items missing from his side of room. Client [redacted] reported the missing items to staff [redacted] Staff [redacted] questioned client [redacted] about client [redacted] missing items. Client [redacted] reported to staff [redacted] that his roommate [redacted] stole the items from client [redacted] Staff [redacted] asked client [redacted] why did he not report that client [redacted] had been stealing? Client [redacted] stated he did not tell because he was "afraid".

Outcome/Resolution of event: ***Use additional sheets if necessary.***

Staff [redacted] asked client [redacted] what he was afraid of? It was at that moment client [redacted] reported client [redacted] had been forcing him (client [redacted]) to perform oral sex on client [redacted] Staff [redacted] transitioned client [redacted] to supervisor [redacted] Client [redacted] reported to supervisor [redacted] that client [redacted] had forced him (Client [redacted]) to perform oral sex on client [redacted] Supervisor [redacted] continued to question client [redacted] on when, where, and what time did these incidents occur. Client [redacted] reported it happen Friday, 10/21 at bedtime, Saturday, 10/22 at bedtime,& Sunday, 10/23 at 9:00am. Supervisor [redacted] questioned client [redacted] on what occurred and Client [redacted] did not know what supervisor [redacted] was talking about. Supervisor [redacted] explained the allegations made by client [redacted] and Client [redacted] denied doing anything sexual. Both clients were seen by nurse [redacted]

Treating Physician's Name and Statement (if applicable)

What action has been taken to prevent reoccurrence? ***Use additional sheets if necessary.***

Fax [redacted] [redacted] PA [redacted] 04/28/15

Supervisor [redacted] notified child line and spoke with reporter [redacted] and completed a CY 47 form. Nurse [redacted] spoke with both clients. Client [redacted] explained his version of what occurred to nurse [redacted] Client [redacted] was later seen by nurse [redacted] Nurse [redacted] asked client [redacted] to check his genital area. Client [redacted] refused stating he was uncomfortable. The parent/guardian of both clients were notified of the incident. Program director [redacted] and the state police were notified. State police officer [redacted] arrived on campus took information of both clients. Nursing: Client [redacted] denies the incident and states his room mate is only trying to get him in trouble. [redacted] refused assessment by the Nurse. Client [redacted] was assessed and no signs of physical trauma was noted.	
Mandatory Notification Completed: Child Line Older Adults Protective Services Other: County:_____	Name of County Representative Notified & Office: Name of Relative or Guardian Notified & Relationship:
Submitted by: Name / Title Byron Lee / Program Director	Signature and Date [redacted] 10/24/16

Fax [redacted] [redacted] PA [redacted] 04/28/15

DEV-S_001167 [Redacted]

Reportable Incident Investigation - Facility Review

Client Name: [redacted]
Program: Brier
Date of incident: 10/21,22,23/2016
RADAR # [redacted]
Administrator: [redacted]

Type of Incident:

	An injury or trauma of a child requiring inpatient treatment at a hospital
	An injury or trauma of a child requiring outpatient treatment at a hospital not to include minor injuries (sprains/cuts)
	A violation of child's rights
x	Intimate sexual contact between children, consensual or otherwise
	A child absence from the premises for 4 hours or more w/o approval of staff persons, or 30 minutes (immediate jeopardy)
	An incident requiring services of the fire or police departments
	Other - as defined by 3800.16 (death, suicide attempt, abuse/misuse of child's funds, outbreak of disease, closure)

Incident Report entered: 10/23/2016
HCSIS report # /entered: 10/24/16 - [redacted]

Investigated by: Not investigated by DHS/OCYF

For allegations of abuse:
Alleged perpetrator: [redacted]
Safety plan: 10/23/2016
OCYF Client interview: N/A
OCYF Staff interview: N/A

Incident summary: [redacted] reported that he was afriad because [redacted] had been forcing him to perform oral sex on him. [redacted] reported to staff this happened Friday at bedtime on 10/21, Saturday at bedtime on 10/22 and Sunday at 9 am on 10/23/16. [redacted] denies the incident and states that [redacted] is only trying to get him in trouble.

Plan of action: (immediate) Safety plan implemented. [redacted] and [redacted] have been moved to separate wings in the program. Childline was called and [redacted] received the call. State Police were notified and came out to gather information.

Follow up: No further follow up/contact from police. CLOSED.

Was video review complete (check): [ ] Yes [ ] No [ ] No camera for this area

Any corrective action plans identified: [ ] Yes [ ] No
If yes, please explain:

Any improvement opportunities identified: [ ] Yes [ ] No
If yes, please explain:

Completed by: N/A
Title:
Date: N/A

Please attach any shift/residential/MHT notes; nursing progress notes; statements; staff training and clearances to facility review (as applicable).

Revised 1/5/16

Client name:

Date of incident:

Program:

Incident type:

HCSIS Report #:

Summary:

DEV-S_001169 [Redacted]

COMMUNITY CARE
Behavioral Health Organization

Unusual Incident Report Form
All Counties

Provider Name: Brandywine - Brier

Consumer Name: [redacted]

Telephone Number: [redacted]

Date of Birth: [redacted]

Contact Person: [redacted]

Date Reported: 10/23/2016

Level of Care: Residential/RTF

Time Reported: 07:00 PM

Consumer County of Residence: [redacted] (* See list below for fax number)

Type of Incident:

- ☐ Death
- ☐ Potentially Lethal Suicide Attempt
- ☐ Homicide by Member
- ☐ Sexual/Physical Abuse/Neglect Incurred by Member
- ☐ Serious Physical/Sexual Assault/Neglect by Member
- ☐ Sexual/Physical Abuse Allegation Against Provider
- ☐ Staff Assault
- ☐ Injury/Illness While on Provider Site Requiring Medical Attention
- ☐ Injury/Illness While on Provider Site Requiring Hospitalization
- ☐ Member Injury Due to Restraint/Seclusion
- ☐ Elopement from Facility
- ☐ Elopement While on Therapeutic Leave/Pass
- ☐ RTF: Consensual Sexual Contact Between Peers
- ☐ RTF to Inpatient
- ☑ Police Involvement
  - ☐ Arrest ☐ No Arrest
- ☐ Juvenile Detention Placement
- ☐ Fire While on Provider Site
- ☐ Self Injuring Behavior
- ☐ Adverse Effect of Medication Requiring Medical Attention
- ☐ Other

Please Describe the Incident in Detail (Use Additional Pages If Needed):

Clients [redacted] and [redacted] were all roommates. Upon returning from a therapeutic home visit, client [redacted] noticed some items missing from his side of room. Client [redacted] reported the missing items to staff [redacted] Staff [redacted] questioned client [redacted] about client [redacted] missing items. Client [redacted] reported to staff [redacted] that his roommate [redacted] stole the items from client [redacted] Staff [redacted] asked client [redacted] why did he not report that client [redacted] had been stealing? Client [redacted] stated he did not tell because he was "afraid".
Staff [redacted] asked client [redacted] what he was afraid of? It was at that moment client [redacted] reported client [redacted] had been forcing him (client [redacted]) to perform oral sex on client [redacted] Staff [redacted] transitioned client [redacted] to supervisor [redacted] Client [redacted] reported to supervisor [redacted] that client [redacted] had forced him (Client [redacted]) to perform oral sex on client [redacted] Supervisor [redacted] continued to question client [redacted] on when, where, and what time did these incidents occur. Client [redacted] reported it happen Friday, 10/21 at bedtime, Saturday, 10/22 at bedtime,& Sunday, 10/23 at 9:00am. Supervisor [redacted] questioned client [redacted] on what occurred and Client [redacted] did not know what supervisor [redacted] was talking about. Supervisor [redacted] explained the allegations made by client [redacted] and Client [redacted] denied doing anything sexual. Both clients were seen by nurse [redacted]

Please Describe Actions Taken and/or Expected Follow Up Steps:

☐ ChildLine Contacted ☐ Police Notified ☑ Guardian Contacted ☑ Other

Supervisor [redacted] notified child line and spoke with reporter P ID384 and completed a CY 47 form. Nurse [redacted] spoke with both clients. Client [redacted] explained his version of what occurred to nurse [redacted] Client [redacted] was later seen by nurse [redacted] Nurse [redacted] asked client [redacted] to check his genital area. Client [redacted] refused stating he was uncomfortable. The parent/guardian of both clients were notified of the incident. Program director [redacted] and the state police were notified. State police officer [redacted] arrived on campus took information of both clients.

Nursing: Client [redacted] denies the incident and states his room mate is only trying to get him in trouble. [redacted] refused assessment by the Nurse. Client [redacted] was assessed and no signs of physical trauma was noted.

Reporting Staff's Signature: [redacted] Date of Report: 10/24/16

[redacted] Program Director, Tel#: [redacted]

DEV-S_001172 [Redacted]

RADAR - Incident Report

Devereux ADVANCED BEHAVIORAL HEALTH | UNLOCKING HUMAN POTENTIAL™

Incident ID:	[redacted]	Center:	[redacted]
Incident Date:	11/04/19	Campus	Brandywine
Incident Time:	06:30 AM	Location	Brier

Description:

(Before The Incident)
gUpon arrival Program Supervisor noticed client[redacted] crying and stating he needed to see the nurse. Client stated he was jumped by Staff.

(During The Incident)
Client[redacted] stated that 3 different staff slammed him on the ground, slapped him on the face and kicked him in the back. Child Line called and injuries reported. Client identified staff[redacted] as one of the staff that hit him in the face.

(After The Incident)
[redacted] parents arrived at 11:30 AM. Both parents spoke to PD[redacted] At that time client[redacted] identified the other staff that was aggressive towards him. Client also stated that client[redacted] went in his room earlier (Without permission) that morning and punched him in the chest. [redacted] stated that he responded and kicked[redacted] to get out his room. Client [redacted] stated that he got into a physical altercation with his room mate[redacted] when staff ask peer to remove furniture from the area. [redacted] stated that all his belongings fell out and he became upset and hit his room mate[redacted] As a result the both began to fight. Parents stated they were taking child to Brandywine Emergency room for to make sure no internal injuries. When client returns he will be placed on 1:1 around the clock. There will also be a room change with peer[redacted] and [redacted]

Nursing Assessment:
Client[redacted] was brought to the nurse's station accompanied by staff. Client[redacted] was crying. Nurse[redacted] asked client [redacted] what was wrong. Client[redacted] stated "They jumped me". Nurse[redacted] asked "who?" Client[redacted] stated "staff". Nurse[redacted] asked which staff and client[redacted] stated "there was 3 of them". He did identify one. Client[redacted] denied knowing what the other 2 staff member's names were. Client[redacted] stated "they threw me down and I hit my head". Nurse[redacted] assessed client[redacted]'s head and noted red marks on client[redacted]'s left side of his head. Client[redacted] stated "They kicked me in my head, my back, and my stomach". Nurse[redacted] asked client[redacted] to lift up his shirt to show nurse[redacted] where he was kicked. Nurse[redacted] noted multiple red marks on client[redacted]'s back and chest. Client[redacted] stated that the other alleged perpetrator slapped him in his face, as he pointed to the right side of his face, and it burns. Client[redacted] has a red mark on his chin and a scratch above his left eye and the left side of client[redacted]'s face is red. Client[redacted] has a red mark on his right upper arm. Client[redacted] has a red mark on his left elbow. Client[redacted] has red marks which appears to be scratches on the back of his neck. BP: 140/90, P 130, Pulse Ox 97%, R22. Client [redacted] states he has a headache 10/10 on the pain scale. Client[redacted]'s pupils are equal, round and reactive to light. Client[redacted] stated his "vision was blurrier than normal but it's because he was crying". Client[redacted] stated he was a little dizzy. Client[redacted]'s speech is clear. Client[redacted] is awake and alert. Client[redacted] is able to ambulate without difficulty and has a steady gait. Client[redacted] denies any injury or pain to his legs. There appeared to be no new marks on client[redacted]'s legs. Nurse[redacted] had client[redacted] and the staff stay with nurse[redacted] to observe him. Nurse[redacted] provided ice to client[redacted] for his head. Photos obtained. Nurse[redacted] took client[redacted]'s vitals again. BP 100/78. P 134. Nurse [redacted] encouraged client[redacted] to keep ice on the client[redacted]'s head to help with the headache. Nurse[redacted] informed supervisor[redacted] that a safety plan needs to be put into place and that client[redacted] is now on bedrest and 1:1 Supervision. Program supervisor[redacted] contacted program director[redacted]. Nurse[redacted] contacted nurse manager[redacted] Nurse[redacted] reassessed client[redacted]s pain level. Client[redacted] stated his back hurt 6 or 7/10. Nurse[redacted] asked client[redacted] what his pain level was for his headache and client[redacted] stated 5 or 6/10. Client[redacted] stated his head was throbbing. Nurse[redacted] encouraged to continue to ice it off and on since that seemed to have brought the pain down from earlier. Nurse[redacted] contacted program director[redacted] to make sure he is aware that a safety plan needs to be put into place. Program director [redacted] was already working on it. Nurse[redacted] contacted client[redacted]'s therapist to let her know that child line was being called. Child line was called. Nurse[redacted] spoke to [redacted] operator 402. The attending psychiatrist[redacted] was contacted. An order for 1:1 supervision at all times was started.

RADAR - Incident Report

Devereux ADVANCED BEHAVIORAL HEALTH | UNLOCKING HUMAN POTENTIAL™

Client [redacted]'s mom came to campus and took client [redacted] to Brandywine hospital to be evaluated.

Staff have been placed in administrative leave pending outcome of investigation.

Outcome of ER visit not known. Parent did not return [redacted] to campus at this time and took him home.

[redacted]

MR Number	Individual	DOB	Age	Admit	Resp. Department	Resp. Location
[redacted]			14	09/17/19	Brandywine Brier	Brier

Event Class	Event Category	Event Type	Event Role
Event	Injury	Injury (Event Related)	Victim/Subject
Event	Allegations of Abuse	Physical	Victim/Subject
Intervention	Medical Interventions	Nursing Assessment	Victim/Subject
Intervention	Medical Interventions	Emergency room visit	Victim/Subject

Person ID	Staff	Resp. Department	Resp. Location
[redacted]		Brandywine Brier	Brier

Event Class	Event Category	Event Type	Event Role
Event	Allegations of Abuse	Physical	Aggressor
Intervention	People Operations	Paid administrative leave	Victim/Subject

Person ID	Staff	Resp. Department	Resp. Location
[redacted]		Brandywine Brier	Brier

Event Class	Event Category	Event Type	Event Role
Event	Allegations of Abuse	Physical	Aggressor
Intervention	People Operations	Paid administrative leave	Victim/Subject

Person ID	Staff	Resp. Department	Resp. Location
[redacted]		Brandywine Brier	Brier

Event Class	Event Category	Event Type	Event Role
Event	Allegations of Abuse	Physical	Aggressor
Intervention	People Operations	Paid administrative leave	Victim/Subject

RADAR - Incident Report

Devereux ADVANCED BEHAVIORAL HEALTH | UNLOCKING HUMAN POTENTIAL™

Person ID	Staff	Resp. Department	Resp. Location
[redacted]		Brandywine Medical	

Event Class	Event Category	Event Type	Event Role
Intervention	Medical Interventions	Nursing Assessment	Initiator

DEV-S_001175 [Redacted]

Incident Investigation
Devereux PA CBHS

Program: Brier
Individual(s) or Person(s) involved: [redacted] client. Staff: [redacted]
Date of Incident: 11/4/19
Type of Incident: Allegation of abuse
Incident: [redacted] reported to Program Supervisor [redacted] that he was "jumped by staff." [redacted] alleged 3 different staff slammed him to the ground, slapped him in the face and kicked him in the back.

Documentation (attachments):

(1) RADAR [redacted]
(2) Statement from [redacted] with addendum
(3) Statement from [redacted] with addendum
(4) Statement from [redacted]
(5) Statement from [redacted]
(6) Statement from [redacted]

Interview with [redacted] 11/13/19:

Detective [redacted] requested QM to join interview with [redacted] where [redacted] provided additional information that she witnessed staff [redacted] stomping and kicking [redacted] when he was down on the ground. [redacted] stated she heard a loud noise and went into the room and observed [redacted] on the ground with [redacted] over her and she attempted to grab his legs in anticipation of placing [redacted] in a restraint but stated she could not due to [redacted] not initiate securing upper arms. She stated she got up and moved from the room and from the doorway, observed [redacted] kicking [redacted] repeatedly. [redacted] said [redacted] was threatening [redacted] and stating "that he's been acting up all weekend, that she doesn't feel supported here and is tired of this place".

Interview with [redacted] 11/13/19:

Detective [redacted] also requested QM to sit in on interview and [redacted] confirmed his statement of observing [redacted] kicking/stomping on [redacted]. He also indicated that both female staff [redacted] were instigating and escalating the situation. He heard [redacted] threatening to show [redacted] "how they do it in Coatesville."

Report to QM: [redacted] stated he was on opposite wing and was requested by supervisor [redacted] to come over and assist due to incident of physical aggression by peers as she wasn't able to help "because she is on light duty".

Other areas of review/findings identified as improvement opportunities:

Review effectiveness of supervisors on light duty/no client contact being able to assist in crisis situations. Risk area?

DEV-S_001178 [Redacted]

IN THE CIRCUIT COURT
OF THE EIGHTEENTH JUDICIAL CIRCUIT
IN AND FOR BREVARD COUNTY, FLORIDA

STATE OF FLORIDA Titusville Police Department Case No. 2022-00053467

VS.

[redacted] Court Case No.

AFFIDAVIT FOR ARREST WARRANT

State of Florida
County of Brevard

BEFORE ME, Detective [redacted], a sworn law enforcement officer, personally came Detective [redacted] of the Titusville Police Department, who being duly sworn deposes and says: that Affiant has reason to believe and does believe that probable cause exists for the arrest of [redacted], **black male, date of birth is** [redacted], **last four of SSN:** [redacted], **approximtley 6'0" in height and 280 pounds, with a last known address of** [redacted] for a violation of the laws of the State of Florida, to wit: **Attempted Sexual Battery Upon a Child by Person in Familial or Custodial Control**, contrary to section 794.011(8)(b), Florida Statutes, **Sexual Performance by a Child**, contrary to section 827.071(2), Florida Statutes, **Child Abuse**, contrary to section 827.03(2)(c), Florida Statutes, and **Battery**, contrary to section 784.03(1)(a)1, Florida Statutes, which occurred at **Devereux Advanced Behavioral Health, Titusville Campus,** [redacted] **location of offense.**

THE FACTS tending to establish the grounds for this application and the probable cause of Affiant believing that such facts exist are as follows:

On July 12, 2022, at approximately 1639 hours Titusville Police Department responded to [redacted] in reference to a child abuse allegation. There was a joint response with the Department of Children and Families.

A Titusville Police Officer and Detectives arrived on scene and spoke with the program manager [redacted] advised a [redacted] male resident at Devereux identified as [redacted] made allegations of sexual misconduct with a Devereux employee. [redacted] explained she spoke with [redacted] and he alleged an employee by the name of [redacted] had been sexually molesting him since he arrived at Devereux on 12/17/2021. [redacted] disclosed [redacted] was touching him inappropriately and he did not feel safe. [redacted] had the administration access to go through [redacted] cell phone. She noticed several conversations between [redacted] and [redacted] over Instagram messages. There were several photographs and videos sent from [redacted] to [redacted] but it appeared some were possibly deleted. [redacted] explained the photos and videos appeared to be sexually explicit. At that point she contacted authorities.

[redacted] explained [redacted] was previously disciplined a couple of months ago for suppling the juvenile residents with electronic cigarette "vapes" as well as communicating with them on social media and text messages.

[redacted] was interviewed in reference to the allegations. [redacted] explained when he first arrived at Devereux [redacted] would try to hug him. He told [redacted] he does not like being touched but [redacted] continued to hug him. Based upon statements from [redacted] exhibited grooming behavior towards [redacted] by allowing him to smoke his "vape" as well as giving him survival tips for the facility. During this time [redacted] was in a restricted area of Devereux with limited access to personal items including cell phones. He was only allowed an electronic table that was provided by Devereux. [redacted] said [redacted] one day asked him to add him on the social media platform Instagram which [redacted] did. [redacted] would message [redacted] on Instagram telling him which residents he should hang out with.

On 02/14/2022 [redacted] was transferred to the less restricted area of Devereux allowing him access to his cell phone. Initially, [redacted] stayed in a room by himself during which time [redacted] would frequently enter his room under the guise of checking on his well being. During this time the grooming behaviors continued at which they progressed to [redacted] touching [redacted] on his body. [redacted] disclosed that [redacted] began to touch him on his private areas but did not clarify if this was over or beneath the clothing. [redacted] then stayed in a room with one other roommate. While [redacted] s roommate was in the shower [redacted] would enter his room and touch [redacted] on all areas of his body. This included his penis and his buttocks. [redacted] only touched [redacted] in these areas with his hands above and beneath the clothes. [redacted] advised [redacted] did not penetrate him anywhere on his body.

[redacted] began to solicit [redacted] by buying him a "vape" pen (electronic cigarette). After buying [redacted] the "vape" [redacted] would solicit and pressure [redacted] into sending him unclothed naked photographs of himself. [redacted] stated he smoked the "vapes" only while he was in the shower to conceal the smoke and prevent getting caught. [redacted] stated [redacted] requested while he was in the shower he send photos and videos to him.

[redacted] disclosed around late February 2022 [redacted] entered his room and told [redacted] "let me taste it" referring to performing oral sex on [redacted] [redacted] explained when [redacted] made the statement he attempted to place his hands into the front of [redacted] pants towards his penis and was standing in close proximity. [redacted] told him no and pushed him away. [redacted] did not continue because other employees were walking in the hallway near the room.

[redacted] explained [redacted] solicited him by saying if [redacted] sent a video of himself masturbating in the shower he would give [redacted] his old cell phone when he upgraded his cell phone. [redacted] said either on July 9th or 10th was the last time he sent [redacted] a video of himself masturbating in the shower. The video [redacted] explained the photographs and pictures were sent via IMessage or Instagram message. [redacted] stated when he did not send naked photos or videos [redacted] was asking for, [redacted] would mistreat him. [redacted] further explained [redacted] would try to entice the other juvenile residents to fight him or not allow [redacted] to have extra food/snacks. [redacted] advised he did not feel safe at Devereux while [redacted] was working. He did not like people touching him and felt uncomfortable when [redacted] would touch him. [redacted] said one of

the times he asked [redacted] if he could play music on his cell phone, [redacted] gave [redacted] his cell phone and allowed him access to the cell phone. While on [redacted]'s cell phone [redacted] was uncomfortable with the photographs and videos that he was pressured into sending to [redacted]. With the intention of deleting the photos he sent [redacted], he went into the photo album and noticed several naked photos and videos of himself. He also recognized images of another juvenile who previously resided at Devereux. These images depicted the resident as unclothed and masturbating in a similar to how [redacted] presented himself in his images.

[redacted] alleged [redacted] touched him every single day while he was at Devereux. This started from hugs escalating to touching his penis and buttocks. [redacted] was unable to give an exact number but claimed he sent approximately 20 photographs or videos to [redacted] between February and July of 2022. It should be noted as an employee of Devereux, [redacted] is in custodial control of not only [redacted] but other residents. As such he is required to provide for the care and safety of the residents.

Video sworn statements were collected from all parties interviewed.

Based on the above facts, statements and physical evidence provided, your Affiant has probable cause to believe and does believe that the above listed probable cause, all leads to the substantiation that defendant, [redacted], has committed a violation of the laws of the State of Florida, to wit: **Attempted Sexual Battery Upon a Child by Person in Familial or Custodial Control**, contrary to section 794.011(8)(b), Florida Statutes, **Sexual Performance by a Child**, contrary to section 827.071(2), Florida Statutes, **Child Abuse**, contrary to section 827.03(2)(c), Florida Statutes, and **Battery**, contrary to section 784.03(1)(a)1, Florida Statutes.

Your Affiant, Detective [redacted] (hereinafter referred to as Your Affiant) is a sworn Law Enforcement Officer employed by the Titusville Police Department currently assigned to the Criminal Investigation Division. Your affiant has been employed with the Titusville Police Department since August 2019. During that time, Your Affiant has conducted criminal investigations of violent persons crime, such as robberies, homicides, several drug-related crimes, traffic related crimes, and others. Your Affiant has attended and completed training in Basic SWAT School, Field Training Officer, and Speed Measurement Techniques. Additionally, Your Affiant has a Bachelors of Science in Criminal Justice from the University of Central Florida and is currently pursuing a Masters of Public Administration degree from the Florida Institute of Technology.

WHEREAS, your Affiant makes this affidavit and prays for the issuance of an Arrest Warrant with authority to effect the arrest of [redacted] for the violation of the laws of the State of Florida, to wit: **Attempted Sexual Battery Upon a Child by Person in Familial or Custodial Control**, contrary to section **794.011(8)(b)**, Florida Statutes, **Sexual Performance by a Child**, contrary to section **827.071(2)**, Florida Statutes, **Child Abuse**, contrary to section **827.03(2)(c)**, Florida Statutes, and **Battery**, contrary to section **784.03(1)(a)1**, Florida Statutes.

[redacted]

Titusville Police Department
Affiant

SWORN TO AND SUBSCRIBED BEFORE ME THIS 13 DAY OF July, A.D. 2022 BY DETECTIVE DEAL (Affiant) WHO IS PERSONALLY KNOWN TO ME OR WHO PRODUCED _____ AS IDENTIFICATION.

[redacted]

SWORN LAW ENFORCEMENT OFFICER
TITUSVILLE POLICE DEPARTMENT
BREVARD COUNTY, FLORIDA

IN THE CIRCUIT COURT
OF THE EIGHTEENTH JUDICIAL CIRCUIT
IN AND FOR BREVARD COUNTY, FLORIDA

STATE OF FLORIDA Titusville Police Department Case No. 2022-00053467

VS.

[redacted] Court Case No.

WARRANT FOR ARREST

IN THE NAME OF THE STATE OF FLORIDA, TO ALL AND SINGULAR, THE SHERIFFS AND THEIR DULY SWORN DEPUTIES OF THE STATE OF FLORIDA:

WHEREAS, AN AFFIDAVIT HAS BEEN MADE BY [redacted] of the Titusville Police Department, Brevard County, Florida, and it appears to the Court, from having read said affidavit, that there is sufficient probable cause to believe that between February 14, 2022 through July 11, 2022, the defendant [redacted], did commit a violation of the laws of the State of Florida, to wit: **Attempted Sexual Battery Upon a Child by Person in Familial or Custodial Control**, contrary to section **794.011(8)(b)**, Florida Statutes, **Sexual Performance by a Child**, contrary to section **827.071(2)**, Florida Statutes, **Child Abuse**, contrary to section **827.03(2)(c)**, Florida Statutes, and **Battery**, contrary to section **784.03(1)(a)1**, Florida Statutes, which occurred at **Devereux Advanced Behavioral Health, Titusville Campus, 1850 S. Deleon Avenue, Titusville, Brevard County, Florida, 32780 location of offense.**

[redacted]

[redacted]
BLACK MALE, DOB [redacted]
LAST FOUR OF SSN: [redacted]
6'0" 280 LBS
LKA: [redacted]

YOU ARE THEREFORE COMMANDED TO ARREST INSTANTER the said defendant, [redacted], and bring him before me to be dealt with according to law.

Attempted Sexual Battery by Person in Custodial Control (F-1), Bond Amount $ 15,000

Sexual Performance by a Child (F-2) Bond Amount $ 15,000

Child Abuse (F-3), Bond Amount $ 5,000

Battery (M-1), Bond Amount $ 1,000

Conditions of release: No contact with [redacted] No contact with minors under 18

No use of social media No return to Devereux in Titusville

GIVEN UNDER MY HAND AND SEAL THIS 13th DAY OF July, 2022.

[redacted]
JUDGE OF THE CIRCUIT/COUNTY COURT
EIGHTEENTH JUDICIAL CIRCUIT
BREVARD COUNTY, FLORIDA

PROBABLE CAUSE AFFIDAVIT

FORM PURPOSE: On View (PC Arrest) ____ Capias Request ____ Summoned/Cited (NTA) ____ Taken into Custody (Warrant/Capias Arrest) X AMENDED ____ JUVENILE YES ____ NO X Referral ____ Civil Citation ____

ADMINISTRATIVE

Arresting Agency ORI	Arresting Agency Name	Arresting Agency Case/Arrest Number	OBTS Number
FL0050000	BREVARD COUNTY SHERIFF'S OFFICE	[redacted]	[redacted]

FDLE (SID) Number	FBI Number	DOC Number	Transport Time	Jail Date / Time	Jail Booking Number	Booking Agency ORI
				07/13/2022 17:45	[redacted]	FL0050000

Location of Arrest (Include Name of Business)	City	Location of Offense (Business Name, Address	City)
[redacted]		[redacted]	

Offense Date OR Date Range	Arrest Date / Time	Charge Type (Check as many as apply)	Evidence Confiscated (Check as many as apply)
07/13/2022	07/13/2022 17:45	Felony X Misdemeanor ____ Traffic ____ Ordinance ____	Vehicle ____ Firearm ____ Property ____

DEFENDANT / JUVENILE

Name (Last, Suffix)	Name (First)	Name (Middle)	Alias and Type	Date of Birth	Age	Jacket Number
[redacted]	[redacted]	[redacted]		[redacted]	32	[redacted]

Race	Ethnicity	Sex	Height	Weight	Eye Color	Hair Color
B-Black	Non-Hispanic	Male	6' 0	300	Brown	Black

Scars, Marks, Tattoos, Unique Physical Features (Location, Type, Description)

Local Address (Street, Apt. Number)	City, State, Zip	Phone/Type (include area code)	Primary Language English Y
[redacted]			English
Permanent Address (Street, Apt. #) or Parent's Name if Juvenile	City, State, Zip	Phone/Type (include area code)	Complexion: Dark
Business Address (Name, Street) or School if Juvenile	City, State, Zip	Phone/Type (include area code)	Build: Heavy

Driver's License State / Number / Type	Social Security Number*	INS Number	Place of Birth	Citizenship
[redacted]	[redacted]		FL	U.S. Citizen

Residence Type:	Mark All that Apply (Y, N, Unk)	Suspected of Using (Y, N, Unk)
City X County ____ Florida ____ Out of State ____	Homeless N Sex Offender N Gang Affiliation N	Drugs ____ Alcohol ____ Computer/Handheld Device ____

PARENT Driver's License State / Number / Type	PARENT Social Security Number	Juvenile Civil Citation Not Referred Explanation	Juvenile Facility
	--		

*Collection of social security numbers from an arrested individual is to verify identity and may be shared with other law enforcement agencies.

CHARGE

PC ____ Capias ____ Warrant X Additional Charge ____ Date Issued 07/13/2022 Writ Aff. ____ Domestic Violence ____ Order of Arrest ____

Charge Description	Counts	F.S. / Ord.	Statute / Ordinance Number	Reclassifier
Sex Battery by Custodian Victim >12 <18	1	F.S. X / Ord. ____	794.011.8b	

Drug Activity	Drug Type	Amount / Unit	Bond Amount	Warrant / Citation / Court Number
			$,15,000.00	052022CF036503

PROBABLE CAUSE

The undersigned certifies and swears that he/she has just and reasonable grounds to believe and does believe that the above named Defendant committed the following violation of law

On the _____ day of _____ at _____ ____AM ____PM (Specifically include facts constituting cause for arrest)

Confidential Victim Information Included - YES ____ NO X

In accordance with F.S.S. 938.27, I hereby request reimbursement of investigative costs consisting of _____ hrs @ $_____ per hr and/or _____ miles @ _____ per mile for a total of $_____.

Affidavit Attached: Yes _____ No _____ Continue for: Narrative _____ Charges _____

NOTICE TO APPEAR

Mandatory Appearance in Court

Location (Court and Address) Division #

Date: Month _____ Day _____ Year _____ Time _____ ____AM ____ PM

I AGREE TO APPEAR AT THE TIME AND PLACE DESIGNATED TO ANSWER THE OFFENSE CHARGED OR TO PAY THE FINE SUBSCRIBED. I UNDERSTAND THAT SHOULD I WILLFULLY FAIL TO APPEAR BEFORE THE COURT AS REQUIRED BY THIS NOTICE TO APPEAR, THAT I MAY BE HELD IN CONTEMPT OF COURT AND A WARRANT FOR MY ARREST OR A TAKE INTO CUSTODY ORDER SHALL BE ISSUED.

Signature of Defendant / Juvenile	Signature of Juvenile's Parent/Custodian	Release to: (Name)	Date	Time

ADMINISTRATIVE

Hold for Other Agency Name:	Verified By:	Do Not Bond Out Reason ____ Hold for 1st Appearance (Adults Only)

I swear/affirm the above and attached statements are true and correct X on 07/13/2022	Officer's/Complaintant's Signature: Electronically Signed	ID# [redacted]	Officer's/Complaintant's Name (Printed) [redacted]
Sworn and Subscribed before me, the undersigned authority this _____ day of 07/13/2022	Notary Signature: Electronically Signed	Notary Name (Printed) [redacted]	Notary/Law Enforcement Officer in Performance of Official Duties. Personally Known X ID ____

BCJC (Jail)

[redacted] STATE VS [redacted] [redacted]

AGENCY NAME: BREVARD COUNTY SHERIFF'S OFFICE — BREVARD COUNTY, FLORIDA — Arresting Agency Case Number [redacted]

Continuation Page 2 of 2

Defendant / Juvenile Name (Last, Suffix)	Defendant / Juvenile Name (First)	Defendant / Juvenile Name (Middle)	OBTS Number
[redacted]	[redacted]	[redacted]	[redacted]

CO DEF

Co-Defendant Name (Last, First, Middle)	Race	Sex	Date of Birth/Age	Juvenile (Y or N)

Arrested ____ At Large ____ Cited ____ Felony ____ Misdemeanor ____

Co-Defendant Name (Last, First, Middle)	Race	Sex	Date of Birth/Age	Juvenile (Y or N)

Arrested ____ At Large ____ Cited ____ Felony ____ Misdemeanor ____

CHARGE

PC ____ Capias ____ Warrant X Additional Charge ____ — Date Issued 07/13/2022 — Writt Aff. ____ Domestic Violence ____ Order of Arrest ____

Charge Description	Counts	F.S. / Ord.	Statute / Ordinance Number	Reclassifier
Use/Allow Child to Engage in Sex	1	F.S. X / Ord. ____	827.071.2	

Drug Activity	Drug Type	Amount / Unit	Bond Amount	Warrant / Citation / Court Number
			$,15,000.00	052022CF036503

CHARGE

PC ____ Capias ____ Warrant X Additional Charge ____ — Date Issued 07/13/2022 — Writt Aff. ____ Domestic Violence ____ Order of Arrest ____

Charge Description	Counts	F.S. / Ord.	Statute / Ordinance Number	Reclassifier
Child Abuse WO Great Bodily Harm-Simple Asslt	1	F.S. X / Ord. ____	827.03.2c	

Drug Activity	Drug Type	Amount / Unit	Bond Amount	Warrant / Citation / Court Number
			$,5,000.00	052022CF036503

CHARGE

PC ____ Capias ____ Warrant X Additional Charge ____ — Date Issued 07/13/2022 — Writt Aff. ____ Domestic Violence ____ Order of Arrest ____

Charge Description	Counts	F.S. / Ord.	Statute / Ordinance Number	Reclassifier
Touch or Strike	1	F.S. X / Ord. ____	784.03.1a1.	

Drug Activity	Drug Type	Amount / Unit	Bond Amount	Warrant / Citation / Court Number
			$,1,000.00	052022CF036503

VEHICLE*

Year	Make	Model	VIN	Tag / Tag State	Primary Color	Secondary Color

* If Applicable, provide information related to the vehicle involved in the crime.

[redacted] CIR COURT AW REF ATTEMPT SEX BATT BY PERSON IN CUSTODIAL CONTROL BOND 15000, SEX PERFORMANCE BY A CHILD BOND 15000, CHILD ABUSE BOND 5000, BATTERY BOND 1000, TOTAL BOND 36000 JDG [redacted]

Officer's/Complaintant's Signature	Dpt	Officer's/Complaintant's Name (Printed)
Electronically Signed	[redacted]	[redacted]

Filing [redacted] STATE VS [redacted]

[redacted]

DEV-S_001190 [Redacted]

Devereux ADVANCED BEHAVIORAL HEALTH | UNLOCKING HUMAN POTENTIAL™

Preliminary Report - Not Final (Level 2 Review - Reviewed)

Individual: [redacted]
MR Number: [redacted]
Incident ID: [redacted]
Incident Date: 07/13/22

Individual Information

Date Of Birth: [redacted]
Primary Diagnosis: [redacted]
Admit Date: 02/07/13
Resp. Dept: FL Titusville RGC Lodge

General Incident Information

Inc. Date/Time: 07/13/22 01:00 PM
Center: 430
End Time: 01:15 PM (15 min.)
Campus: Community Residential
Reported: 07/13/22 01:00 PM
Inc. Location: RGC Lodge

Description:

(Before The Incident)
[redacted] notified staff [redacted] and [redacted] around 1 pm on 7/13/2022 that he wanted to disclose something to them.

(During The Incident)
individual [redacted] met with [redacted] And [redacted] and informed them that another staff member [redacted] was sexually inappropriate towards him. [redacted] alleges that staff [redacted] touched him on his penis about a month after he was admitted in march 2022.

(After The Incident)
A call was then made to the DCF abuse hot line, call was accepted by [redacted]

Update: It is noted that [redacted] was placed on administrative leave on 7/12/2022 due to previous allegations. All evidence was handed over to detectives and DCF. In addition, individual spoke with the sexual abuse rapid team through DCF. Please refer to IR [redacted]. DCF investigation still pending at this time.

Update: 7/13 Devereux was notified of [redacted]'s arrest and terminated employment. At this time the case is restricted.

Incident Staff

Staff	Title
[redacted]	Program Supervisor
[redacted]	Direct Support Professional
[redacted]	Program Director

Devereux ADVANCED BEHAVIORAL HEALTH | UNLOCKING HUMAN POTENTIAL™

Preliminary Report - Not Final (Level 2 Review - Reviewed)

Individual: [redacted]
MR Number: [redacted]
Incident ID: [redacted]
Incident Date: 07/13/22

Events

Event Type	Event Role
Sexual	Victim/Subject

What kind of sexual event(s) did this involve? Physical contact - Fondling

Was the sexual event consensual? No, not consensual

Interventions

Intervention Category	Intervention Type	Intervention Role
Allegation Interventions	Abuse Hotline Call Made (Accepted)	Victim/Subject
Emergency Service Involvement	Police Notification	Victim/Subject

Time emergency services arrived? 1:30 PM

Time emergency services departed? 3:30 PM

Time called: 2:00 PM

Additional detail: None at this time

Reviews

Risk Management reviewed by [redacted]/Program Manager on 07/13/22 03:57 PM

Incident created by [redacted]/Program Manager on 07/13/22 04:11 PM

First review approved by [redacted]/Quality Assurance Specialist on 07/14/22 08:57 AM

Second review approved by [redacted]/Quality Improvement Manager on 01/24/23 01:18 PM

Notifications

Method	Relationship	Person Notified	Date/Time Notified	Notified By
Phone - Successful	Program Director/Administrator	[redacted]	07/13/22 12:00 AM	[redacted]
E-mail	Case Manager	[redacted]	07/13/22 12:00 AM	[redacted]
E-mail	Payer/Funding Agency	[redacted]	07/14/22 11:15 AM	[redacted]
E-mail	Payer/Funding Agency		07/14/22 11:15 AM	[redacted]
E-mail	Payer/Funding Agency		07/14/22 11:15 AM	[redacted]
	Comment: [redacted]			
SIR Submission	Payer/Funding Agency	[redacted]	07/14/22 4:44 PM	[redacted]
SIR Submission	Payer/Funding Agency	[redacted]	07/14/22 5:17 PM	[redacted]

Appendix 53. DEV-S_001196 [Redacted]

Devereux ADVANCED BEHAVIORAL HEALTH | UNLOCKING HUMAN POTENTIAL™

Preliminary Report - Not Final (Level 2 Review - Reviewed)

Individual: [redacted]
MR Number: [redacted]
Incident ID: [redacted]
Incident Date: 09/23/22

Individual Information

Date Of Birth: 09/05/04
Admit Date: 05/31/17
Resp. Dept: Campus Residential
Primary Diagnosis: [redacted]

General Incident Information

Est. Date/Time: 09/23/22 06:45 AM
End Time: 07:30 AM (45 min.)
Discovered: 09/23/22 06:45 AM
Center: 360
Campus: Red Hook Campus
Inc. Location: [redacted]

Description:

(Before The Incident)
At 6:30am [redacted] was in his room sleeping. Staff [redacted] was assisting [redacted] changing his wet bedding and taking to the laundry after which assisting him taking his shower. Staff [redacted] and staff [redacted] were sitting on the hall way.

(During The Incident)
At 6.45 am, staff [redacted] went to [redacted]s bedroom to do the regular 15 minutes bed check and discovered that [redacted] was not in his bed and the window was opened. Staff [redacted] checked his room, his closets and notified Staff [redacted] and staff [redacted] that [redacted] was not in his room. All the staffs checked the bathrooms and other rooms with staff [redacted] going round the house to check but [redacted] was not seen. At 6.55am, staff [redacted] notified the EOD [redacted] that [redacted] was not in his room and in the house. Staff [redacted] later called 911 as the staffs continued to search for [redacted]. After 30 minutes the police came to the house for investigations and there after took staff [redacted], staff [redacted] and staff [redacted] for further investigations leaving the morning staffs to take care of other individuals.

(After The Incident)
The EOD [redacted] was notified who later called 911

Incident Staff

Staff	Title
[redacted]	Direct Support Professional
[redacted]	Direct Support Professional
[redacted]	Direct Care Professional
[redacted]	Residential Specialist

Reviews

Incident created by [redacted]/Direct Support Professional on 09/23/22 11:53 AM

First review approved by [redacted]/Director of Campus Services on 09/24/22 10:59 PM

Devereux ADVANCED BEHAVIORAL HEALTH | UNLOCKING HUMAN POTENTIAL™

Preliminary Report - Not Final (Level 2 Review - Reviewed)

Individual: [redacted]
MR Number: [redacted]
Incident ID: [redacted]
Incident Date: 09/23/22

Individual Information

Date Of Birth: [redacted] Primary Diagnosis: F84.0
Admit Date: 02/26/20
Resp. Dept: Campus Residential

General Incident Information

Est. Date/Time: 09/23/22 06:45 AM Center: 360
End Time: 07:30 AM (45 min.) Campus: Red Hook Campus
Discovered: 09/23/22 06:45 AM Inc. Location: [redacted]

Description: (Before The Incident)
At 6:30am [redacted] was in his room sleeping. Staff [redacted] was assisting [redacted] changing his wet bedding and taking to the laundry after which assisting him taking his shower. Staff [redacted] and staff [redacted] were sitting on the hall way.

(During The Incident)
At 6.45 am, staff [redacted] went to [redacted]s bedroom to do the regular 15 minutes bed check and discovered that [redacted] was not in his bed and the window was opened. Staff [redacted] checked his room, his closets and notified Staff [redacted] and staff [redacted] that [redacted] was not in his room. All the staffs checked the bathrooms and other rooms with staff [redacted] going round the house to check but [redacted] was not seen. At 6.55am, staff [redacted] notified the EOD [redacted] that [redacted] was not in his room and in the house. Staff [redacted] later called 911 as the staffs continued to search for [redacted]. After 30 minutes the police came to the house for investigations and there after took staff [redacted], staff [redacted] and staff [redacted] for further investigations leaving the morning staffs to take care of other individuals.

(After The Incident)
The EOD [redacted] was notified who later called 911

Incident Staff

Staff	Title
[redacted]	Direct Support Professional
[redacted]	Direct Support Professional
[redacted]	Direct Care Professional
[redacted]	Residential Specialist

Devereux ADVANCED BEHAVIORAL HEALTH | UNLOCKING HUMAN POTENTIAL™

Preliminary Report - Not Final (Level 2 Review - Reviewed)

Individual: [redacted]
MR Number: [redacted]
Incident ID: [redacted]
Incident Date: 09/23/22

Events

Event Type	Event Role
Neglect - QI Only	Victim/Subject
Death	Victim/Subject
Person Type:	
Beyond Boundary of Devereux Location	Victim/Subject
Was a search for the individual(s) conducted? Yes	
Who conducted search? Staffs and Police	
Where did they search? Everywhere within Devereux facility and the surroundings	
Has the individual returned? No	
Media Involvement	Victim/Subject

Interventions

Intervention Category	Intervention Type	Intervention Role
Emergency Service Involvement	Police Notification	Victim/Subject
Time emergency services arrived? 7:25 AM		
Time emergency services departed? 11:30 AM		
Time called: 7:10 AM		

Reviews

Incident created by [redacted]/Direct Support Professional on 09/23/22 11:53 AM

First review approved by [redacted]/Director of Campus Services on 09/24/22 10:59 PM

Notifications

Method	Relationship	Person Notified	Date/Time Notified	Notified By
Phone - Successful	EOD	[redacted]	09/23/22 6:55 AM	[redacted]
Phone - Successful	Police/Law Enforcement		09/23/22 7:05 AM	[redacted]

DEV-S_001199 [Redacted]

Section	5: DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS
Standard	5-1: Staff can describe/know the Individuals' supervision needs.
Decision	Not met – SOD - IJSOD
Rationale	Based on record review, interview with facility staff and observations on 9/28/22 and 9/29/22, it was determined that the staff did not provide the safeguard needs of the Individuals served. This standard is not met. Findings include: During morning observations on 9/28/22, and per interview with staff, Individual #1's supervision level is 1:1. During the observation, Individual #1 was observed to sit in the kitchen with the assigned day staff while the staff prepared the breakfast to the diet consistency of each individual. During this time, Individual #1 was observed to leave the kitchen and go to their bedroom and or dining room area several times and then return to the kitchen. The staff remained in the kitchen. Further review of this Individual's Clinical Summary dated 5/27/22 verified their supervision level as 1:1. Interview with the Clinician and Director of Clinical Services on 9/29/22 stated the reason for the 1:1 was due to an incident that happened in the school setting in May, 2022 where this Individual engaged in oral sex with an Individual who also resides in Individual #1 's home. Per review of the Supervision Policy, Chapter 4 Section 21, staff are to be assigned to provide the 1:1 supervision with range of scanning. If the staff needs to change out supervision, the receiving DSP will document on the activity sheet signature page the change in assignment. A review of the activity sheet signature page revealed that the staff did not change out supervision nor did they maintain the 1:1 supervision with range of scanning per the agency policy. These findings were verified with the Director and Assistant Director of Campus Services on 9/289/22. An immediate Plan of Corrective Action was taken on site. A systemic response is still required.
Reference	633.4(a)(4)(ix)
Citation	No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity.

Appendix 54.

Plan of Correction For Standard 5-1	Standard 5-1: Staff can describe/know the Individuals' supervision needs.
Immediate Action	On 9/29/22, the Director of Campus Services (DCS) and the Assistant Director of Residential Services (ADRS) immediately implemented two corrective actions. First, a 1:1 Supervision Staff Guidance document was developed to supplement and enhance Supervision Policy, Chapter 4 Section 21. The new 1:1 Supervision Staff Guidance document simplifies for staff that a transfer of 1:1 supervision requires the following: (a) transfer of supervisions cards; (b) documenting the transfer on the Individual's activity sheet; and (c) directs that staff cannot assume any additional duties that may impede their responsiveness to the needs of their assigned Individual. See Attachment 1 – 1:1 Supervision Staff Guidance document. Second, on 9/29/22 the DCS reviewed the 1:1 Supervision Staff Guidance document with every Direct Service Professional on shift on this campus that evening. The staff identified in the Statement of Deficiency Summary ([redacted]) who did not maintain 1:1 supervision of Individual #1 is not scheduled to return to work until 10/19/22. On 10/19/22 a Supervisor will meet with [redacted] and retrain this staff on the 1:1 Supervision Staff Guidance document before they are permitted to resume work with any Individuals.
Systemic Action	New staff orientation will be updated to include the 1:1 Supervision Staff Guidance document by 11/15/22. The 1:1 Supervision Staff Guidance document will be a required component of the existing Supervision Policy (Chapter 4, Section 21) and the New Staff Training and Orientation.
Ongoing Monitoring	Beginning on 10/18/22, the Quality Improvement Specialist will complete a weekly audit of all new and modified training requirements. This review will include comparing training document signatures against the residential staff roster to ensure all residential staff have been trained in identified areas. This review will also verify that the 1:1 Supervision Staff Guidance document is reviewed with all residential staff. This enhanced oversight will remain in effect until responsibility for the training of the 1:1 Supervision Staff Guidance document is completely incorporated into the New Staff Training and Orientation Class beginning 11/15/22.

Appendix 54.

Section	5: DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS
Standard	5-3 Individuals receive support while eating in accordance with their assessed and observed needs.
Decision	Not met – SOD
Rationale	Based on record verification and a 9/28/22 breakfast observation, it cannot be assured that Individuals are provided with the necessary dining supports identified in their plans to ensure a safe dining experience. Specifically: Record verification revealed that Individual #5's (TABS [redacted]) January 2022 mealtime screening identified that the Individual requires staff prompts/assistance to cut their food to bite size pieces and verbal prompts for pacing. Individual #5's 2/24/22 nutrition screening also identifies that Individual #5 requires support to reduce eating speed and for cutting foods. During a 9/28/22 breakfast observation, the surveyor observed the Individual being served a whole, uncut round sausage patty measuring approximately 2 ½ inches wide and a scrambled round eggy patty measuring approximately 2 inches wide. Individual #5 was observed spearing their food with a fork and putting half of the sausage patty into their mouth immediately followed by a whole egg patty. In addition, surveyors observed the individual with a whole slice of toast on their fork and the individual was taking bites off of this. Staff did not provide assistance or prompt the Individual to cut the food into bite size pieces or to slow their rate of eating. In addition, bite size pieces is not consistent language per the OPWDD Choking Initiative Prevention Program. Consequently, it cannot be assured that the facility provides necessary dining supports identified in their plans to ensure a safe dining experience.
Reference	633.4(a)(4)(ix-x) & (xvii)
Citation	No person shall be denied: (ix) services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity; (x) appropriate and humane health care and the opportunity, to the extent possible, to have input either personally or through parent(s), or guardian(s), or correspondent to participate in the choice of physician and dentist; or the opportunity to obtain a second medical opinion; (xvii) a balanced and nutritious diet.

Plan of Correction For Standard 5-3	Standard 5-3 Individuals receive support while eating in accordance with their assessed and observed needs.
Immediate Action	Individual #5's mealtime screening was updated on 9/30/22 by the Speech Therapist to comply with the OPWDD Choking Initiative Prevention Program. See Attachment 2 – Mealtime Screening for Individual #5. Effective 9/30/22 Individual #5's meal time screening tool is reviewed with all staff who work with Individual #5 prior to beginning to their shift. See Attachment 3 – Mealtime Screening with Training – Individual #5. The Qualified Intellectual Disability professional (QIDP) will complete a mealtime observation by 10/20/22 to ensure that staff are correctly implementing Individual #5's meal time screening.
Systemic Action	Occupational Therapy (OT), Physical Therapy (PT) and Speech Therapy (ST) staff reviewed all campus residential mealtime plans as of 9/30/22. Each plan was reviewed to ensure the plan language complies with the OPWDD Choking Initiative Prevention Program. Any plans identified as non-compliant were updated and reviewed by staff assigned to work with the Individuals prior to beginning their shift. See Attachment 4 – Mealtime Screening with Training – Individuals #1, #7, #9 (Attachment 4 includes samples of update Mealtime Screenings of Individuals not identified in this Plan of Corrective Action). On 10/17/22 the Occupational Therapist, Registered/Licensed (OTR/L) Director of Occupational Therapy trained all campus QIDPs in the OPWDD Choking Initiative Prevention Program. The training included and emphasized that it is the responsibility of the QIDPs to ensure that all mealtime plans submitted to the treatment record are reviewed for appropriate OPWDD Choking Initiative Prevention Program language prior to forwarding the mealtime plans to the programs. All campus QIDP's will complete a mealtime observation of their assigned area by 10/21/22. All mealtime screenings will be documented on the mealtime screening tool. The QIDP will report any identified issues (failure of staff to implement plan, lack of adaptive equipment) to the immediate attention of the DCS, the Senior QIDP and the OT/PT/SP staff for immediate remedial action.
Ongoing Monitoring	The Senior QIDP maintains and monitors a mealtime tracking spreadsheet. Effective 12/1/22, the Senior QIDP must notify the Operations Committee of any late meal time plans so the Committee can identify the challenges associated with lateness and promptly address them.

Section	5: DELIVERY OF SAFEGUARDS, SERVICES, SUPPORTS
Standard	5-6 There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
Decision	Not met – SOD
Rationale	Based on record review and interview with staff from 9/28/22 to 9/30/22, it was determined that staff are not adequately trained in the individuals plans. This standard is not met. Findings include: 1.A review of training records revealed that four of the ten staff working in the residence have not been trained on Individual 2's 7/2021 BIP and there is no documentation of staff re-training in response to the 8/8/22 Treatment Team Meeting when it was identified that staff reports on the frequency of LWOP (that the Individual leaves the dorm "all the time") was not consistent with behavioral data. 2. A review of training records revealed that 2 out of 12 staff have not been trained in Individual #6's BIP dated 3/22 or Individual #7's BIP dated 8/22. 3. A review of training records revealed that 3 out of 14 staff have not been trained in Individual #4's BIP dated 9/21. 4. A review of training records revealed that 2 out of 21 staff have not been trained in Individual #3's BIP dated 4/22. The above findings were verified with the Assistant Director of Campus Services on 9/30/22.
Reference	633.4(a)(4)(ix)
Citation	No person shall be denied: services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely and humanely, with full respect for the individual's dignity and personal integrity.

Appendix 54.

Plan of Correction For Standard 5-6	Standard 5-6 There are adequate staff scheduled, present and on-duty to meet the observed needs of individuals.
Immediate Action	1. The BIP for Individual #2 was updated on 9/29/22 to include a window alarm to address elopement behavior. The window alarm plan was approved by the Human Rights Committee on 9/29/22 and the window alarm was installed on 9/30/22. See Attachment 7 – Window Alarm Request. Beginning 9/30/22 all staff who work with Individual #2 are being re-trained on Individual #2's updated BIP prior to working Individual #2. See Attachment 5 – Human Rights Committee Action Form. 2. Beginning 9/29/22 the 2 staff who were identified as not trained in Individual #6 and Individual #7's BIPs received training on each BIP prior to staff working with Individual #6 or #7. See Attachment 6 – Individual #6 Risk Factor Sheet and Attachment 6a – Individual #7 Risk Factor Sheet. 3. Beginning 9/29/22 the 3 staff who were identified as not trained in Individual #4's BIPs received training on the BIP prior to staff working with Individual #4. See Attachment 6b – Individual #4 Risk Factor Sheet. 4. Beginning 9/29/22 the 3 staff who were identified as not trained in Individual #3's BIPs received training on the BIP prior to staff working with Individual #3. See Attachment 6c – Individual #3 Risk Factor Sheet.
Systemic Action	Beginning on 9/30/22 the DCS created a supplemental training document that identifies the types of behaviors that must be reported in the behavior reporting management systems known as "Teach Me" and "RADAR." The training document was reviewed with all residential shaft beginning 10/1/22 as they arrived for their shift. On 12/1/22 the QIDP department will assume monitoring and oversight of the timeliness and documentation of BIPs and staff training. The Senior QIDP will update the QIDP audit tool by 11/15/22 to include review of BIPs and associated training records. The QIDP audit tool will identify that the QIDP is responsible to address audit deficiencies.
Ongoing Monitoring	The QIDP will monitor all audit deficiencies to resolution. Beginning 10/18/22 the Quality Improvement Specialist will perform a weekly audit of all new or modified training documents. This audit will include a comparison of the training document signatures against the residential staff roster to ensure all residential staff have been trained in identified areas including the reporting requirements for "Teach Me" and "RADAR." This enhanced oversight will remain in place until such time as the training on this procedure is transferred to New Staff Orientation and Training. The training coordinator will add the Teach Me and RADAR document to the new staff orientation staff training materials effective 11/15/22. Effective 12/1/22 any audit deficiency not resolved within 15 days will be submitted to the Operations Committee for immediate attention.

Section	6. RIGHTS PROTECTIONS
Standard	6-12: Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.
Decision	Not met – SOD - IJSOD
Rationale	Based on review of incidents and interview with staff on 9/29/22, it was determined that the initial immediate protections in place are not adequate and/or not implemented in a timely manner. This standard is not met. Findings include: 1. A review of Incident #[redacted] revealed the agency was to conduct an agency-wide retraining on the importance of documenting bed checks and retrain staff on supervision levels. There is no written evidence of staff being retrained on supervision levels. Per interview with the staff on 9/29/22, the agency's intention was to retrain staff on this individual's supervision level and not retrain all staff on all individual's supervision levels. The agency has not adequately put in place immediate protections for all individuals served. In addition, the agency has not completed the agency -wide retraining on the importance of documenting bed checks in a timely manner. The agency initiated this initial immediate protection on 9/25/22 and to date, 34 out of 89 staff have received this training. An Immediate Plan of Corrective Action was obtained on site. A systemic response is still required. 2. Review of IRMA (MIN#[redacted]) identified that on 8/7/22, the Individual eloped from the premises and could not be located for approximately forty minutes. Review of the 8/8/22 Treatment Team notes revealed that the team discussed the utilization of a door/window alarm and determined that there wasn't enough documentation to present to the Human Rights Committee (HRC) and noted that the alarms would require a BSP which would take three weeks to develop and one week for approval from HRC prior to implementation. During an 9/29/22 interview, the Director of Clinical Services agreed that the severity of the 8/7/22 incident of LWOP warranted the utilization of a door/window alarm on an emergency basis and could not explain why this did not occur. The immediate protections assessed for this individual is not adequate. The above findings were confirmed with the Director of QA and the Director of Campus Services on 9/29/22 and on 10/5/22.

Appendix 54.

Section 6: RIGHTS PROTECTIONS – Continued Standard 6-12: Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	
Reference	624.5(f)(2-3) Pre 01/01/16
Citation	(f) (2) When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person shall be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (f) (3) When appropriate, an individual receiving services shall be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility.
Reference	624.5(g)(1-3) Post 01/01/16
Citation	Immediate protections. (1) A person's safety must always be the primary concern of the chief executive officer (or designee). He or she must take necessary and reasonable steps to ensure that a person receiving services who has been harmed receives any necessary treatment or care and, to the extent possible, take reasonable and prudent measures to immediately protect individuals receiving services from harm and abuse. (2) When appropriate, an employee, intern, volunteer, consultant, or contractor alleged to have abused or neglected a person must be removed from direct contact with, or responsibility for, all persons receiving services from the agency. (3) When appropriate, an individual receiving services must be removed from a facility when it is determined that there is a risk to such individual if he or she continues to remain in the facility.

Plan of Correction For Standard 6-12	6-12: Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.
Immediate Action	1. The staff responsible for the direct oversight and supervision of the Individual that was the subject of Incident #[redacted] were terminated. See Attachment 8 and 8a – Staff Termination. Additionally, on 9/23/22, as a response to Incident #[redacted] an additional night Executive On Duty (EOD) and other support staff were on duty to conduct overnight tours of the residential units. An additional awake night staff was assigned to the residence that was the subject of Incident #[redacted] as well as additional sleep rate staff. On 9/25/22 the DCS sent a Bed Check Guidance training document to all residential staff. This training document identifies how to complete a physical bed check of an individual and the how to document the bed check in accordance with policy, and steps to be taken if an Individual is not present during a bed check. This Bed Check Guidance training document was approved by OPWDD as sufficient on 9/28/22. See Attachment 9 – Supervision Notes. Inadvertently, the Bed Check Guidance document was sent to employees without a "read receipt" verification, however, staff provided in-person reviews of the Bed Check Guidance with residential staff. Additionally, a training on the Bed Check Guidance document was conducted on 9/25/22, 9/26/22, and 9/27/22. Beginning on 9/28/22 all remaining direct care staff received training when arriving for their shift. 2. On 9/29/22 Individual #2's updated BIP was approved by the Human Rights Committee. All staff working with this Individual were trained in the updated BIP, including training on the use of the window alarm. The window alarm was installed on 9/30/2022. See Attachment 5 – Human Rights Committee Action Form.
Systemic Action	1. Beginning on 9/30/22, the overnight EOD began monitoring bed check sheets twice per shift to ensure completion. The EOD will sign and note the time of each bed check sheet, and immediately address any issues. Any bed checks not properly completed will result in disciplinary action. See Attachment 13 – EOD Rounds Responsibility. Effective 11/15/22 the Bed Check Guidance document will be reviewed at new staff orientation and training. The training coordinator will update the Supervision training materials to include the bed check guidance document by 11/15/22. 2. Beginning 11/1/22 if a treatment team member identifies a challenge in addressing a risk behavior, or in developing a plan to address such behavior they have the responsibility to notify the DCS and Clinical Director so that a plan may be put in place in a timely manner.

Plan of Correction For Standard 6-12 – Continued 6-12: Initial measures to protect individuals receiving services from harm and abuse, were implemented immediately.	
Ongoing Monitoring	1. Beginning 10/18/22 the Quality Improvement Specialist will conduct a weekly training document audit, to ensure that all residential staff been trained in identified areas, including Bed Check, and incident tracking tools. This audit responsibility will remain in place until enhanced training is part of new staff orientation and training. 2. Beginning 11/1/22 an HRC tracking tool will be used to ensure timeliness of response on plans. If a plan is not approved the HRC Chair will work with the Clinician to have it corrected. The tracking tool will monitor plans for resubmission and resolution. Beginning 11/1/22 the Records Coordinator will send the BIP tracking tool to Clinicians and QIDPs monthly. QIDPs are responsible for all plans being updated prior to a due date, and will escalate any potential delay to the DCRS, Sr. QIDP, and Clinical Director. The Sr. QIDP will work with the Operations Committee to ensure all challenges with a timely BIP are identified and addressed.

Section	10i: RISK AREA – BEHAVIORAL SUPPORTS – GENERAL
Individual TABS ID	[redacted]
Standard	Standard 10i-3: Behavior Supports are revised as needed
Decision	Not met – SOD
Rationale	Record verification and a 9/29/22 interview with the Clinician and Director of Clinical Services identified that Behavior Support Plans (BSP)/(BIP) are not thoroughly reviewed by clinical staff on a semiannual basis to reevaluate the effectiveness of the strategies in the plan and need for revisions. This standard is not met. Specifically: Record verification identified that Individual #2 (TABS[redacted]) has a 7/2021 Behavior Intervention Plan (BIP) which targets "leaving the program without permission" (LWOP). During a 9/29/22 interview with the Clinician and Director of Clinical Services it was revealed that there was no semiannual review of the 7/2021 BIP as required. Review of the agency's electronic documentation of behavioral incidents (RADAR occurrence [redacted]) revealed that on 8/6/22, the individual left the program without supervision" (LWOP). During a 9/29/22 interview the Clinician and Director of Clinical Services it was revealed that there was no semiannual review of the 7/2021 BIP as required. Review of the agency's electronic documentation of behavioral incidents (RADAR occurrence [redacted]) revealed that on 8/6/22, the Individual left the program without supervision and was walking down the driveway towards Route 9. Additional staff were required to return the Individual to the residence. Review of IRMA (MIN#[redacted]) identified that on 8/7/22, the Individual eloped from the premises and could not be located for approximately forty minutes. Review of the 8/8/22 Treatment Team notes revealed that the team discussed the utilization of a door/window alarm and determined that there wasn't enough documentation to present to the Human Rights Committee (HRC) and noted that the alarms would require a BIP which would take three weeks to develop and one week for approval from HRC prior to implementation. During an 9/29/22 interview, the Director of Clinical Services agreed that the severity of the 8/7/22 incident of LWOP warranted the utilization of a door/window alarm on an emergency basis and could not explain why this did not occur. Review of the agency's electronic documentation of behavioral incidents (RADAR occurrence [redacted]) revealed that on 9/10/22, the Individual went "beyond the boundary of the program" and Behavior Support staff were required to assist in returning the Individual to the residence.

Section 10: RISK AREA - BEHAVIORAL SUPPORTS – GENERAL - Continued	
Rationale - Continued	Record verification identified that a meeting to review the effectiveness of the BSP did not occur until 9/15/22 and the BIP was updated to include the utilization of a window alarm on 9/28/22. To date, the window alarms are not in place. Consequently, it cannot be assured that Individuals' BIPs are reviewed by clinical staff on a semiannual basis to determine effectiveness and the need for revisions.
Reference	633.16(e)(2)(ix)
Citation	All behavior support plans must: include a schedule to review the effectiveness of the interventions included in the behavior support plan no less frequently than on a semi-annual basis, including examination of the frequency, duration, and intensity of the challenging behavior(s) as well as the replacement behaviors.

Appendix 54.

Plan of Correction For Standard 10i-3	Standard 10i-3: Behavior Supports are revised as needed
Immediate Action	On 9/29/22 Individual #2's updated BIP was approved by the Human Rights Committee and all staff assigned to work with Individual #2 were trained in the updated plan. The window alarm was installed on 9/30/22. See Attachment 5 – HRC Action Form. An internal review of Individual #2's BIP confirmed that staff were not consistently documenting elopement behavior in RADAR. On 10/2/22 DCS sent an email to all residential staff containing supplemental training information to reinforce to staff how to properly update and review BIPs. See Attachment 11 – TeachMe/RADAR Training. This information was reviewed with staff prior to their next shift.
Systemic Action	Effective 11/1/22, the DCRS and Clinical Director will advise all Clinicians and QIDPs that they are responsible for notifying the DCRS and Clinical Director promptly if any treatment teams encounter a challenge in addressing a risk behavior or in developing and/or updating a BIP to address risk behavior. The QIDP will follow the issue until closed.
Ongoing Monitoring	The Records Coordinator (RC) maintains oversight of all campus residential BIP due dates. Beginning 11/1/22 the RC will send the BIP due date tracking tool to Clinicians and QIDPs monthly. QIDPs are responsible for all plans being updated prior to a due date, and will escalate any potential delay to the DCRS, Senior QIDP and Clinical Director. Beginning on 11/1/22, the HRC will utilize a due date tracking tool for the submission and response of HRC requests. If a plan is not approved, the HRC chair will send the plan to the Clinician for correction. New plans must be submitted by the Clinician within 5 days for timely review in HRC weekly meetings. The HRC minute-taker will notify the Operations Committee of any new plan that is not timely.

Appendix 54.

Section	10i: RISK AREA – BEHAVIOR SUPPORTS - GENERAL
Standard	10i-1: Behavior Supports are provided per the written plan
Individual TABS ID	[redacted]
Decision	Not met – SOD
Rationale	Individual #4's (TABS [redacted]) 9/21 BIP requires periodic supervision with 15-minute checks and arm's length supervision when near roads and parking lots. Review of staff assigned sheets from May 2022-September 2022 revealed that there is no documentation to verify that 15-minute checks were implemented per their plan as there are blanks. There was no documentation to verify staff assignment and supervision during the following times; 7a-9a shift; 5/30/22, 6/30/22, 7/4/22, 9/26/22. 9a-11p shift; 8/6/22 3p-11p shift 5/23/22, 7/18/22, 7/24/22, 8/5/22, 8/12/22. Consequently, it cannot be assured that the supervision levels identified in Individuals' BIPs are being implemented as per their plans.
Individual TABS ID	[redacted]
Decision	Not met - SOD
Rationale	Record verification cannot assure that the facility implements Individuals' Behavior Support Plans (BSP)/BIP as per their plans. Specifically: Individual #3's (TABS [redacted], 10/21 BIP requires periodic observation with 15 minute checks and arm's length supervision when crossing roads and parking lots. Review of the staff assigned sheets from April 2022 to September 2022 revealed there is no documentation to verify that 15- minute checks were implemented per their plan as there are blanks. Examples include but are not limited to: 7a-9a shift; 4/4/22-4/7/22, 4/12/22-4/14/22, 7/16/22, 7/24/22. 3p-11p shift; 8/2/22-8/5/22, 8/7/22, 8/10/22-8/11/22. 11p-7a shift; 7/17/22.7a-11p shift; 8/13 and there is no documentation during any shifts from 7/18/22- 7/21/22.
Reference	633.16(b)(28)
Citation	A written plan that outlines specific interventions designed to support, develop or increase replacement or alternative behaviors and/or modify or control a person's challenging behavior. The plan is a component of a person's overall plan of services. Agencies may use other equivalent terms for such plans. (See subdivision [e] of this section.)

Plan of Correction For Standard 10i-1	10i-1: Behavior Supports are provided per the written plan
Individual TABS ID	[redacted]
Individual TABS ID	[redacted]
Immediate Action	Beginning 9/29 Emails were sent to programs identifying the Level of Supervision for Residents for multiple campuses. These detailed the level of supervision, including necessity for checks and the manner of supervision (i.e. observation, arm's length). Staff signed an acknowledgment that they read, understood, and agreed to follow the level of supervision for each Resident. See Attachment 15 – Supervision Review. Beginning 11/1/22 the programs will utilize a revised Activity Tracking Schedule that will capture supervision assignments and supervision transfers. The Activity Tracing Schedule will allow for consistent documentation of staff assignments, supervision levels and 15-minute checks. Additionally, the Residential department will enhance their Planned Activity Learning System (PALS) to model the ICF active treatment schedule. See Attachment 12 – PALS Form. The enhanced system will identify daily activities, the time frame for the activities, and staff assigned to each activity.
Systemic Action	On 10/19/22 residential staff reviewed Devereux's policy 4.21 Supervision Policy regarding One-to-One staffing, which includes supervision, and transfer of supervision, as well as enhanced supervision levels. See Attachment 15 – Supervision Review. Beginning 11/1/22, with PALS adoption, the QIDPs will provide PALs oversight and will notify the ADRS and Senior QIDP of any documentation lapse. The ADRS will be responsible for identifying and addressing challenges associated with document completion. The QIDP will monitor the PALs process. If PALS documentation issues are not resolved within 7 days, the QIDP will escalate the matter to the Operations Committee. Staff failing to comply with the PALS documentation process will be subject to discipline.
Ongoing Monitoring	On 10/14/22, 10/21/22 and as needed, staff are updated about changes to observation and checks that must be updated on Activity Tracking by the QIDP. Beginning 11/1/22 the QIDP will provide PALs oversight and complete a monthly audit to monitor compliance.

Appendix 54.

Additional Deficiencies	
Reference	633.24(d)(1)
Rationale	(1) Agencies shall submit a request for an MHL 16.34 check to OPWDD in accordance with section 16.34 of the Mental Hygiene Law, to the extent permitted by section 16.34 of the Mental Hygiene Law. Based on a record review and interview with facility staff on 9/28/22, it was determined that the agency did not submit a request for MHL 16.34 OPWDD. This standard is not met. Findings include: A review of the MHL 16.34 spreadsheet provided to the surveyor revealed that there were 4 Domestic staff and 22 International staff that the agency did not submit a MHL 16.34 request to OPWDD. Interview with the Human Resources staff on 9/28/22 verified these findings.

Plan of Correction For - Additional Deficiencies	
Reference	633.24(d)(1)
Corrective Action	OPWDD Form 152 notes "If the Provider of Services agency has certified the applicant has no employment/volunteer history with OPWDD, the agency may hire the applicant and must retain this form as documentation." See Attachment 14 – OPWDD Form 152. OPWDD Form 152 was not submitted for international staff because they do not have previous employment in the United States, and therefore, have not worked in an OPWDD certified setting. OPWDD Form 152 was also not submitted for domestic staff that attested not to have had previous employment in an OPWDD certified setting. Beginning 11/1/22 Devereux People Operations Department will ensure that OPWDD Form 152 is completed for all domestic and international staff regardless of attestation.

Agency Representative: [redacted]	Title: EXECUTIVE DIRECTOR
Signature: [redacted]	Date: 10/24/2022

Appendix 54.

DEV-S_001215 [Redacted]

Devereux ADVANCED BEHAVIORAL HEALTH | MASSACHUSETTS & RHODE ISLAND

INTERNAL INVESTIGATION REPORT
CONFIDENTIAL

To: [redacted] Executive Director
[redacted] Assistant Executive Director

CC: [redacted] Campus Administrator
[redacted] Residential Director
[redacted] Director of Quality Improvement

From: [redacted], Clinical Supervisor

Re: [redacted] investigation

Date: 12/14/2020

Summary of allegations / notifications:
A report was received from South Wing student [redacted] on 12/14/20 indicating that on Saturday 12/12/20 he entered the staff office and obtained a syringe needle from the open closet. [redacted] reported that he mixed a solution of Windex and Aftershave and injected himself with this mixture using the syringe on 12/12/20 and 12/1420. When [redacted] made the report he handed over the syringe and showed his arm to staff which had two raised bumps on it. [redacted] was assessed by Devereux nursing department. Nursing assessment noted that [redacted] had two injection sites to lower inner left forearm; the area was hard to the touch and student reported that it hurt. [redacted] was sent ER for further assessment.

Initial Actions:
12/14/2020-Student was sent to the hospital for evaluation
12/14/2020-An internal investigation was initiated by [redacted] Clinical Supervisor.
12/14/2020-A 51A report was filed with the Department of Children and Families by [redacted], Campus Administrator
12/16/2020-The Department of Early Education and Care was notified via the LEAD system by [redacted] Campus Administrator.
12/16/2020-staff [redacted] was placed on no unmonitored contact.

Document Review
Discharge paperwork from Heywood Hospital was received. The discharge paperwork stated that [redacted] was seen for a Section 12 psychiatric evaluation. No medical evaluation was conducted per the discharge paperwork.

Video Review
Video review was completed for 12/12/20. At approximately 2:36pm staff [redacted] is seen in the staff office. Both of the closets in the staff office had their doors open. [redacted] is seen sitting

at the staff desk on the computer. [redacted] is seen walking into the office and looking in both closets [redacted] touches the top of the needle disposal box, which is attached to the inside of one of the closets doors, and then touches the bottom part. [redacted] is talking with [redacted] and walking around the staff office, looking around the entire time. [redacted] then walks to the back of the office and is off camera view. [redacted] walks back onto camera view and is again looking around the office. Another student walks into the office and is talking with [redacted] while [redacted] continues to look around and is then seen looking in the other closet for something. [redacted] is then seen walking out of the staff office and going to his bedroom. At no point is a syringe seen throughout the video review. When [redacted] leaves the staff office both of his hands are open and his palms can be seen with nothing in them.

Student Interview

[redacted] South Wing Student, 12/30/20

[redacted] reported he couldn't recall the day he got the needle. At first [redacted] reported that he got it on Monday and used it on Saturday. However, further in the conversation when I asked about how long it was he had the needle before using it, he reported it wasn't Monday and that it was "Saturday or maybe Friday, I can't really remember." [redacted] reported that this was planned, he knew where the needles were kept, and that he waited for a time when staff wasn't paying as much attention to get the needle. [redacted] stated that he got the needle from the staff office from the closet on the left as you're looking at the door (the door that has the hypodermic needle disposal container). [redacted] and the investigator looked in the closet and he said staff has moved things out of that closet. [redacted] reported that he was sent to the staff office to get his media, which used to be stored there, and that the box of diabetic needles for one of the other students also used to be stored there and that's where he got it. [redacted] stated that neither items are in that closet now because the needles and the student's media have been moved. [redacted] pointed out the locked box and said there used to be another box without a lock with needles in it, which is where he got the needle he used. When asked if it was a clean or used needle, he reported that he assumed it was clean. When asked what he did with it once he got it, he reported that he hid it in his pocket. When asked if there were any staff in the office when he was sent to get his media he said he wasn't sure and couldn't really remember. [redacted] was asked if someone was with him or working on the computer or if he's typically sent to get things from the office without staff. [redacted] stated there may have been someone working on the computer, but he couldn't remember and wasn't sure who it was. When asked if he remembered which staff were working that day he reported that he couldn't remember. When asked what time this occurred, he reported that they usually start allowing media at 1pm on weekends, but couldn't remember which day he got it so couldn't really give me a timeframe of when this occurred.

[redacted] was again interviewed on 1/5/21 and reported that he only obtained shaving cream from his ADL box and did not obtain Windex. [redacted] was unclear about how he got the shaving cream into the syringe and said "I just put it in."

Staff Interviews

[redacted] South Wing Staff, 12/15/20

[redacted] confirmed that she was working at South Wing on 12/12/20. When asked if student [redacted] accessed the staff office during her shift on 12/12/20, [redacted] reported that [redacted] went into the staff office with staff [redacted]. [redacted] reported initially that she was not sure of the

reason that they went into the office. However, [redacted] then reported that [redacted] was doing phone calls with the students and, as a result, multiple students were going in and out of the office. When asked what time this was occurring, she reported that it was after lunch and when asked specifically she said after 12:00pm. When asked if [redacted] would have access to the office during medication pass, [redacted] reported that nurses pass medications by the kitchen. [redacted] reported that she's not aware of any other time the office might have been open for him to gain access. When asked if [redacted] exhibited any different behavior than normal on Saturday 12/12/20 or yesterday 12/14/20 during shift she denied his exhibiting any behavior that was out of the ordinary.

[redacted] **School Staff, 12/15/2020 and 12/30/2020**

[redacted] reported that Staff [redacted] spoke with him today (12/15/20), before he left campus from his shift, and showed him where student [redacted] reportedly got the syringe from in the staff office. [redacted] reported not recalling [redacted] having access to that area of the staff office at all. [redacted] stated that there are some needles for a student who has them because they're diabetic and the needles are stored in the closet. [redacted] reported that the closet is to the right of the door where you enter the office and is always locked. [redacted] stated that inside that closet is also a bin where they dispose of used needles. [redacted] reported that he didn't have much information about the incident other than [redacted] telling him that [redacted] injected himself with something.

When asked if [redacted] entered the staff office on 12/12/20 when he was working, [redacted] reported that [redacted] was in the doorway of the staff office but never got things out of the staff office. [redacted] reported that sometimes students come in the doorway to ask for things (for example, asking for something out of the kitchen) when he's inside the office doing the red book (communication log) or completing RADARs (incident reports). [redacted] reported that he was completing RADAR reports in the office and [redacted] came to the door. [redacted] stated that he usually allows only one student at a time to come talk with him and if another student attempts to join he asks them to leave. [redacted] reported that he doesn't remember having to ask [redacted] to leave the office on that day and therefore doesn't believe he was trying to enter with another student. When asked if [redacted] made a phone call with [redacted], [redacted] reported that he did not make a phone call for [redacted] during that shift and that the only time [redacted] would have entered the office would have been to talk to him or ask for something. When asked what time he in the office completing RADAR reports, [redacted] reported that it was from 1:00pm to 2:30pm. When asked if [redacted] had exhibited any suspicious or different behavior recently, [redacted] reported that [redacted] sometimes tries to bring a speaker to school but that he usually completes pocket checks. [redacted] noted that last Thursday (12/10/20) [redacted] completely refused a pocket check for school, which he assumed was related to the speakers. However, [redacted] reported that [redacted] has never completely refused and [redacted] was given a response for that behavior. When asked about any other factors that might contribute to determining the timeline of when [redacted] may have gotten access to the syringe, [redacted] reported that staffing Saturday was terrible. [redacted] stated "it was me, [redacted] and an Arbor staff so I could totally see it happening that day." [redacted] also reported that he was out of area with another student that morning, leaving the Arbor staff and staff [redacted] alone on the unit with the rest of the students. When asked if it was possible that [redacted] got into the staff office while he was out of area with the other student, [redacted] reported that it's possible but unlikely because the office is typically locked. However, he reported that that day was very hectic and they were understaffed.

Video was reviewed with staff [redacted] on 12/30/2020. [redacted] watched the video footage and acknowledged that it was a hectic day and that the unit was understaffed. He noted that the closets were left open. When asked if they are typically left open, he reported that they should be locked.

However, later in the conversation reported that closets used to be locked diligently and students were not allowed in the office due to a former student who used to steal items. He reported that since the former student discharged things have become more relaxed and that closets are left open more frequently. He reported that he is more diligent with the closet on the right side of the door, because it contains chemicals. Around 2:28pm in the video footage student [redacted] is out of sight of the camera behind [redacted] and he reported remembering that [redacted] came into the office and thought that [redacted] was asking him for either a DVD or Reese's candy at that time and that was the purpose of his entering the office. [redacted] noted that since this incident, students are no longer allowed in the office and he has been more diligent in locking the closets and shutting the door.

Findings:

1. Following video review, it can be determined that student [redacted] had access to both closets in the staff office due to the closets being open at the time he was in the staff office.
2. Following video review and staff interviews it can be determined that staff did not see [redacted] with the syringe at any point, and video review did not show [redacted] with the syringe at any point.
3. Following staff interview and video review it is likely that [redacted] obtained the needle from the closet in the staff office due to it not being closed and locked.
4. From student's report, it cannot be determined that [redacted] injected himself with Windex and aftershave. Although not determined by medical assessment or staff witnessing, [redacted] is reporting he injected himself with shaving cream from his own hygiene products and no other substances.
5. Following document review, [redacted] was medically and psychiatrically assessed and returned to Devereux on 12/18/20.

Additional Findings

1. Following staff interviews it can be determined that the South Wing unit was limited in their staffing on Saturday, 12/12/20, due to a large amount of call outs for the shift due to illness. There were three staff on shift on 12/12/20 during the 7am-3pm shift and 12 students, which decreased the ratio to 1 to 4. This was not reported to the Department of Early Education and Care.

Recommendations:

1. It is recommended that all closets be locked in the South Wing staff office at all times.
2. It is recommended that staff [redacted] be retrained in Staff Supervisory Guidelines.
3. It is recommended that a staffing plan be established with the South Wing unit to ensure adequate staffing for all shifts.
4. It is recommended that anytime ratio is lowered due to staff call outs this is reported to the Department of Early Education and Care the following business day.

Investigator: [redacted] Date: 1/8/21