Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	04L106	12/04/2024
Name of Provider or Supplier	**Street Address, City, State**	
United Methodist Childrens Home	2002 S Fillmore St, Little Rock, AR	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
N0141	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(b) If the resident's treatment team physician is available, only he or she can order restraint or seclusion. This ELEMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure a physician order for a physical and/or chemical restraint was obtained for 2 clients (Client #1 and Client #2) of 3 clients chosen for the case mix. The findings are: 1. Review of Client #1's "Face Sheet," dated 12/03/24, revealed the client had diagnoses which included disruptive mood dysregulation disorder, history of child neglect and abuse, and autism. A review of the facility's seclusion and restraint log revealed Client #1 was placed in restraints on 08/26/2024 from 8:40 PM until 8:42 PM and again from 8:55 PM until 8:56 PM. The log also indicated Client #1 had been given a chemical restraint at 8:42 PM and again at 8:56 PM. A review of a "Nurse Progress Note," dated 08/26/2024 at 9:00 PM, indicated Client #1 had been placed in "several restraints" and given two (2) chemical restraints during the second shift. A review of the restraint and seclusion forms for 08/26/2024 indicated that Client #1 was given a chemical restraint at 8:42 PM and a chemical restraint at 8:56 PM. The nurse and physician signatures were electronically signed on 09/17/2024.

A review of a physician order for a chemical restraint, not specified with name of medication, was documented for 8:40 PM. An order for a physical restraint was documented as obtained at 8:40 PM.

Review of physician orders and medication order forms revealed there was not an order for the second chemical restraint that was given at 8:56 PM.

2. Review of Client #2's "Face Sheet," dated 12/04/24, revealed the client had diagnoses which included major depressive disorder with psychotic features, anorexia nervosa, oppositional defiant disorder, and history of neglect, physical and sexual abuse.

Review of the facility seclusion and restraint log indicated Client #2 had an emergency safety intervention (ESI) on 10/18/24 at 7:25 PM.

Review of a "Nurse Progress Note," signed by the Nurse Manager (NM) on 10/22/24, indicated Client #2 had to be placed in a physical restraint on 10/18/24 at 7:25 PM.

Review of an "Emergency Intervention packet," completed and signed by the NM on 10/22/24 at 12:09 PM and signed by the physician on 10/22/2024, indicated Client #2 was placed in a personal restraint on 10/18/24 at 7:25 PM.

Review of a seclusion/restraint order form dated 10/18/24 indicated a personal restraint team control order was put on the Electronic Client Record (ECR) on 10/22 /24 due to an agency nurse being on duty. The order was documented by the NM and electronically signed on 10/22/24 by the physician and the NM.

On 12/03/2024 at 11:20 AM, during an interview, the NM reported physician orders are supposed to be received at separate times for physician restraints and chemical restraints. The NM reported when using the ECR, a medication order must be placed on the " Medication Order Form" and to specify the name, dosage, and time the order was received for the medication ordered. The NM reported that medications may be documented in the nurses' progress notes or on the restraint seclusion emergency intervention form on the ECR. However, the nurses are supposed to complete a Medication Order Form that the physician is supposed to sign within 24 hours from the time the order was placed.

On 12/04/24 at 11:36 AM, during an interview, the NM reported she had contacted the agency nurse on 10/22/24, after reviewing the Critical Incident Record (CIR) and then contacted the physician to let him know the order was being entered late by the NM. The NM reported there was a binder at the nurse ' s station for agency nurses to use that contains paper documents to use, including physician order forms, if the agency nurse does not have access to the electronic medical record. The Surveyor requested a copy of the written physician order for 10/18/24. The NM reported she was unable to locate the written physician order. The NM was unable to provide any written documentation from the nurse on duty on 10/18/24, regarding the restraint.

Review of a facility policy, provided by the Compliance Specialist, titled, "[facility name] Procedures for the use of Personal or Chemical Restraints & Seclusion," with last revision date of "October 2016," specified in part as soon as possible, but no longer than one hour after the initiation of a restraint or seclusion, a licensed nurse must notify and obtain a physician order and document the time, date, name of person

	receiving the order; a chemical restraint or seclusion should never be initiated without receiving the physician's order first; if the order for a chemical restraint is received via telephone, the order must be documented as a verbal order and flagged for the physician to sign as soon as possible.