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)
N0142	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(c) A physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must order the least restrictive emergency safety intervention that is most likely to be effective in resolving the emergency safety situation based on consultation with staff. This ELEMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure physician orders for physical and chemical restraints were not received at the same time, to ensure the least restrictive emergency safety intervention was utilized, for 1 Client (Client #1) of 3 clients chosen for the case mix. The findings are: Review of Client #1's "Face Sheet," dated 12/3/24, 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 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. On 12/03/2024 at 11:20 AM, during an interview, the Nurse Manager (NM) reported physician orders are supposed to be received at separate times for physician restraints and chemical restraints. The NM reported when using the Electronic Client Record (ECR) a medication order must be placed on the "Medication Order Form" and to specify the name, dosage, and time the order was received of the medication ordered. The NM reported that medications may be documented in the nurse ' s 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. 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 documents 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.