ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059
P: 501.320.6182
F: 501.682.6159
HUMANSERVICES.ARKANSAS.GOV

September 8, 2020

Doug Stadter, Administrator
Centers For Youth And Families Inc
6501 W 12th Street
Little Rock, AR 72225-1970

Dear Mr. Stadter:

On August 28, 2020, a Complaint Investigation survey was conducted at your facility by the Office of Long Term Care to determine if your facility was in compliance with Federal requirements for Psychiatric Residential Treatment Facilities participating in the Medicaid (Title XIX) Program. This survey found that your facility had deficiencies requiring correction/substantial correction prior to a revisit as specified in the attached CMS-2567.

Plan of Correction
A POC must be submitted within 10 calendar days of you receipt of the Statement of Deficiencies. Failure to submit a POC may result in termination. Include a completion date for each deficieny cited.

Amanda M Smith, RN Supervisor
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
Telephone (501) **320-3963;** Fax (501) 682-6159
or email to amanda.m.smith@dhs.arkansas.gov

Your Plan of Correction must also include the following:

a. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice;

b. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

c. Address what measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur;

d. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness.

e. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. Your facility is ultimately accountable for its own compliance. The plan of correction will serve as the facility's allegation of compliance. Unless otherwise stated on the PoC, the last completion date will be the date of alleged compliance.

Informal Dispute Resolution

In accordance with 42 CFR § 488.331, you have one opportunity to question deficiencies through an informal dispute resolution (IDR) process. To obtain an IDR, you must send your written request to Health Facility Services, Arkansas Department of Health within ten (10) calendar days from receipt of the Statement of Deficiencies. The request must state the specific deficiencies the facility wishes to challenge. The request should also state whether the facility wants the IDR to be performed by a telephone conference call, record review, or a face-to-face meeting.

An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

Please submit your request to:

Fax (501) 661-2165
Becky Bennett, Director
Health Facility Services
Arkansas Department of Health
5800 W 10th Street, Suite 400
Little Rock, AR 72204
Phone (501) 661-2201

If you have any questions, please call Amanda M Smith at 501-320-3963.

Sincerely,

Amanda M Smith

RN Supervisor
DPSQA/Office of Long Term Care
Survey & Certification Section

ams

cc: DRA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L101	A. BUILDING _____ B. WING _____	C 08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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 #AR00025375 was substantiated, all or in part, with these findings.	N 000		
N 207	FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious	N 207		

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
	04L101	A. BUILDING _____ B. WING _____	C 08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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 207	Continued From page 1 occurrence. The report must include - the name of the resident involved in the serious occurrence, - a description of the occurrence and, - the name, street address, and telephone number of the facility. This ELEMENT is not met as evidenced by: Complaint #AR00025375 was substantiated, all or in part, with these findings. Based on record review and interview, the facility failed to ensure a Serious Occurrence Report was submitted for 1 (Client #1) of 1 sampled clients who sustained a fractured arm during a physical restraint. The findings are: 1. Client #1 was admitted on 7/17/20 and had diagnoses of Disruptive Mood Dysregulation Disorder and Attention-Deficit Hyperactivity Disorder. a. A DHS (Department of Human Services) QA (Quality Assurance) Report Form, dated 8/24/20, documented, "...Client #1 been engaging in property destruction and attempted to incite a riot during the first day of school. She was in the process of unscrewing a screw on the desk. Staff attempted to verbally de-escalate the situation. Client #1 became aggressive toward staff, hitting the staff person in the face. Staff attempted to place the client in an ESI [Emergency Safety Intervention]. Client #1 was pulling back and resisting. Staff reports Client #1 began to say that her arm was hurting, staff went hands off. Client #1 sat on the ground. Nursing was notified to assess. Client was sent to [Hospital]. It was found that her left arm was broken..."	N 207		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L101	A. BUILDING _____ B. WING _____	C 08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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 207	Continued From page 2 b. On 8/28/20 at 3:02 p.m., the Program Director was asked, "Was a Serious Occurrence Report sent to OLTC [Office of Long Term Care]?" She stated, "Not that I'm aware of."	N 207		

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
04L101	CENTERS FOR YOUTH AND FAMILIES INC

Type of Survey (select all that apply)

A				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 30283	08/28/2020	08/28/2020	0.50	0.00	4.25	0.00	3.50	2.75
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.25

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.50

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059
P: 501.320.6182
F: 501.682.6159
HUMANSERVICES.ARKANSAS.GOV

September 21, 2020

Melissa Dawson, Administrator
Centers For Youth And Families Inc
6501 W 12th Street
Little Rock, AR 72225-1970

Dear Ms. Dawson:

On August 28, 2020, we conducted a Complaint Investigation survey at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and have approved your plan of correction and presume that you will achieve substantial correction by September 25, 2020.

We will be conducting a revisit of your facility to verify that substantial correction has been achieved and maintained.

If you have any questions, please contact your reviewer at (501) **320-3963**.

Sincerely,

Amanda M Smith

Amanda M Smith, RN Supervisor
DPSQA/Office of Long Term Care
Survey & Certification Section

ams

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L101	A. BUILDING _____ B. WING _____	C 08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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 #AR00025375 was substantiated, all or in part, with these findings.	N 000		
N 207	FACILITY REPORTING CFR(s): 483.374(b) Reporting of serious occurrences. The facility must report each serious occurrence to both the State Medicaid agency and, unless prohibited by State law, the State designated Protection and Advocacy system. Serious occurrences that must be reported include; - a resident's death; - a serious injury to a resident as defined in section §483.352 of this part; and - a resident's suicide attempt. (1) Staff must report any serious occurrence involving a resident to both the State Medicaid agency and the State designated Protection and Advocacy system by no later than close of business the next business day after a serious	N 207		

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

CEO 9.17.20

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
	04L101	A. BUILDING _____ B. WING _____	C 08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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 207	Continued From page 1 occurrence. The report must include - the name of the resident involved in the serious occurrence, - a description of the occurrence and, - the name, street address, and telephone number of the facility. This ELEMENT is not met as evidenced by: Complaint #AR00025375 was substantiated, all or in part, with these findings. Based on record review and interview, the facility failed to ensure a Serious Occurrence Report was submitted for 1 (Client #1) of 1 sampled clients who sustained a fractured arm during a physical restraint. The findings are: 1. Client #1 was admitted on 7/17/20 and had diagnoses of Disruptive Mood Dysregulation Disorder and Attention-Deficit Hyperactivity Disorder. a. A DHS (Department of Human Services) QA (Quality Assurance) Report Form, dated 8/24/20, documented, "...Client #1 been engaging in property destruction and attempted to incite a riot during the first day of school. She was in the process of unscrewing a screw on the desk. Staff attempted to verbally de-escalate the situation. Client #1 became aggressive toward staff, hitting the staff person in the face. Staff attempted to place the client in an ESI [Emergency Safety Intervention]. Client #1 was pulling back and resisting. Staff reports Client #1 began to say that her arm was hurting, staff went hands off. Client #1 sat on the ground. Nursing was notified to assess. Client was sent to [Hospital]. It was found that her left arm was broken..."	N 207	All "serious occurrences" reporting is initiated by on-site staff via internal incident report completed by the end of the shift and forwarded to risk management. 1. Centers has updated its Agency Decision Matrix checklist for reporting to include the State Medicaid agency and Disability Rights of Arkansas to be notified within mandated time frames. 2. The responsibility for reporting has been centralized to one individual in risk management to minimize reporting error. 3. Centers leadership will be notified immediately of a "serious occurrence" to ensure the reporting checklist is executed. 4. Updates to the matrix, reporting protocols and definition of "serious occurrences" were reviewed with Centers Leadership in Management Meeting. 5. Quality Assurance Committee will review percentage of accurate and timely reportings monthly.	9.16.20 9.16.20 9.16.20 9.16.20 9.25.20 Monthly thereafter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L101	A. BUILDING _____ B. WING _____	C 08/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(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 207	Continued From page 2 b. On 8/28/20 at 3:02 p.m., the Program Director was asked, "Was a Serious Occurrence Report sent to OLTC [Office of Long Term Care]?" She stated, "Not that I'm aware of."	N 207		

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059
P: 501.320.6182
F: 501.682.6159
HUMANSERVICES.ARKANSAS.GOV

October 28, 2020

Melissa Dawson, Administrator
Centers For Youth And Families Inc
6501 W 12th Street
Little Rock, AR 72225-1970

Dear Ms. Dawson:

During the Complaint Investigation follow-Up/revisit survey conducted on October 26, 2020, 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** Amanda M Smith **at (501) 682-6159 or email to** amanda.m.smith@dhs.arkansas.gov **@dhs.arkansas.gov as soon as possible. If you are signed up with the Electronic POC (E-POC) you must submit all information through the EPOC system.**

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 501-**320-3963**.

Sincerely,

Amanda M Smith

RN Supervisor
DPSQA/Office of Long Term Care
Survey and Certification Section

ams

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L101	A. BUILDING _____ B. WING _____	R-C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTERS FOR YOUTH AND FAMILIES INC	6501 W 12TH STREET LITTLE ROCK, AR 72225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 revisit was conducted on October 26, 2020 for all deficiencies cited on August 28, 2020. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{N 000}		

LABORATORY D RECTOR'S OR PROV DER/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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
04L101	CENTERS FOR YOUTH AND FAMILIES INC

Type of Survey (select all that apply)

A	D			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

D				

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor Use the surveyor's identification number

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID 1. 30283	10/26/2020	10/26/2020	0.50	0.00	3.75	0.00	2.50	1.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 0.50

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 0.50

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... **No**