ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059

June 21, 2022

Brady Serafin, Administrator
Habilitation Center, Llc
P.O. Box 727
Fordyce, AR 71742

Dear Mr. Serafin:

On June 14, 2022 a Complaint 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.

Sandra Broughton, Reviewer
OLTC, Survey & Certification Section
PO Box 8059, Slot S404
Little Rock, AR 72201-4608
(501) **320-6182**
email to Sandra.Broughton@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 or the requirement for timely submission of an acceptable plan of correction. 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:

IDR/IIDR Program Coordinator
Health Facilities Services
5800 West 10th Street, Suite 400
Little Rock, AR 72204
Phone: 501-661-2201
Fax: 501-661-2165
ADH.HFS@Arkansas.gov

If you have any questions, please contact your Reviewer.

Sincerely,

Sandra Broughton
Administrative Services Manager

DPSQA/Office of Long Term Care
Survey & Certification Section

sgb

cc: DRA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L103	A. BUILDING _____ B. WING _____	C 06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HABILITATION CENTER, LLC	1810 INDUSTRIAL DRIVE FORDYCE, AR 71742

(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. Complaint #AR00028297 was unsubstantiated.	N 000		
N 156	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a physician's order for a physical was signed for 1 of 1 (Client #1) sampled client who required the use of a physical restraint. The	N 156		

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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N 156	Continued From page 1 findings are: Client #1 was admitted on 1/13/22 and had diagnoses Attention Deficit/Hyperactivity Disorder and Post-Traumatic Stress Disorder. a. An Emergency Safety Intervention and Debriefing form dated 5/6/22 documented, "Physical Hold... Date & [and] Time placed in Restraint; Date: 5/6/22 Time: 1813 [6:13 p.m.]; Date & Time Removed from Restraint; Date: 5/6/22 Time:1833 [6:33 p.m.]; Date & Time Restraint Order Received from MD [Medical Doctor] Date: 5/6/22 Time: 1813 [6:13 p.m.]..." b. A Physician's Order dated 5/6/22 at 6:13 p.m. documented, "May be placed in a physical restraint not to exceed 20 minutes for aggression toward staff. T.O. [Telephone Order] [Doctor]/[RN (Registered Nurse) #1]." There was no Physician's signature documented on the order. c. On 6/13/22 at 2:01 p.m., the Director of Nursing was asked, "Do you have a signed Physician's order for the restraint?" She stated, "No."	N 156		
N 178	NOTIFICATION OF PARENT(S) OR LEGAL GUARDIAN CFR(s): 483.366 If the resident is a minor as defined in this subpart: 483.366(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention.	N 178		

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N 178	Continued From page 2	N 178		

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure guardians were notified of the use of a physical restraint for 1 of 1 (Client #1) sampled client who was placed in a physical restraint. The findings are:

Client #1 was admitted on 1/13/22 and had diagnoses Attention Deficit/Hyperactivity Disorder and Post-Traumatic Stress Disorder.

a. An Emergency Safety Intervention and Debriefing form dated 5/6/22 documented, "Physical Hold... Date & [and] Time placed in Restraint; Date: 5/6/22 Time: 1813 [6:13 p.m.]; Date & Time Removed from Restraint; Date: 5/6/22 Time:1833 [6:33 p.m.]; Date & Time Restraint Order Received from MD [Medical Doctor] Date: 5/6/22 Time: 1813 [6:13 p.m.]... Guardian Notification (Always Notify Guardian for All Interventions)... Parent/Legal Guardian request to participate in Post Intervention Interview: No notification RT [Related To] Computer & phone lines down campus wide..."

b. A Nurse's Note dated 5/6/22 at 6:18 p.m. documented, "Placed in physical restraint not to exceed 20 mins [minutes] RT running from facility & fighting staff. Released @ [at] 1833 [6:33 p.m.] Placed on elopement precautions & unit restriction X [times] 72 hours for stated above: orders written & no precautions or notification @ present RT phone/computer lines down across campus @ present." There was no documentation to indicate the guardians had been notified of the use of a physical restraint.

c. On 6/13/22 at 2:01 p.m., the Director of Nursing was asked, "Was the guardian notified of

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N 178	Continued From page 3 the restraint?" She stated, "I don't see where they went back and documented they sent an email or anything or a letter. The phone lines were down."	N 178		
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: Based on record review and interview, the facility failed to ensure a serious occurrence was reported to the required agencies and the report was maintained in the medical record for 1 of 1 (Client #1) sampled client who sustained an injury requiring outside medical care. The findings are: Client #1 was admitted on 1/13/22 and had diagnoses Attention Deficit/Hyperactivity Disorder and Post-Traumatic Stress Disorder. a. A Nurse's Note dated 1/27/22 at 2:32 p.m. documented, "Pt [Patient)] @ [at] nurse's station. Pt states, "I was running in the field & [and] stepped on my L [left] foot & fell face first onto the ground. Didn't have time to put my hands out. Slight swelling to R [right] of nose [with] cut [small] present. Bleeding stopped [with] applied pressure. 0/10 [zero of ten] pain noted.	N 209		

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N 209	Continued From page 4	N 209		

[Guardian] notified via TC [Telephone conference] @ 1436 [2:36 p.m.] Supervisor notified of need for transportation. Pt being sent to [Hospital] ER [Emergency Room] for further eval [evaluation]. Guardian aware... 1630 [4:30 p.m.] Return from ER [with] glue applied to cut. Pt refused to let DR [Doctor] apply sutures..."

b. On 6/14/22, at 9:43 a.m., the Risk Manager was asked, "On 1/27/22 the client stated he fell and got a laceration to his nose. Was this incident reported to any State agencies?" He stated, "I'm pretty sure it didn't." The Risk Manager reviewed the regulation. He was asked, "Should that have been reported?" He stated, "I guess so."

c. On 6/14/22, at 10:04 a.m., the Director of Nursing (DON) stated, "I talked to [Risk Manager] and he said we have never made that part of the chart." The DON was asked, "The Serious Occurrence reports?" She stated, "Yes, this one in January [2022] were he had a cut on the nose." The DON was asked, "Any other serious occurrences, that are reported, are not included in chart?" She stated, "Not the actual form that would indicate the calling and stuff. Our practice is the nurse to document on the occurrences and the assessments and notify the guardian if it is a serious injury or incident."

d. The facility Incident Reporting-Risk Management Program Policy, received from the Risk Manager on 6/14/22 at 1:02 p.m., documented, "Policy: The Risk Management Program techniques must proactively focus on loss prevention, safety promotion, and detection of hazardous events and circumstances. It must provide a systematic, multi-disciplinary approach

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N 209	Continued From page 5 to managing an reporting incidents of injury, damages, and loss... Classifying Severity... In States where the facility is required to report Tragic/Serious incidents to the State, it must be dome within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments... The following severity classifications shall be used:... Level II-Serious: Major injury or impairment in which the patient or visitor's function is altered requiring outside medical intervention... The Risk Manager should report a critical incident to the State as required by State-specific guidelines..."	N 209		

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P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059

July 12, 2022

Brady Serafin, Administrator
Habilitation Ceneter. Inc.
P.O. Box 727
Fordyce, AR 71742

Dear Mr. Serafin:

On June 14, 2022, 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 July 11, 2022.

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:**Sandra Broughton at 501-320-6182 or email to sandra.broughton@dhs.arkansas.gov.**

Sincerely,

Rodney Ryser for
Sandra Broughton, Reviewer
DPSQA/Office of Long Term Care
Survey & Certification Section

sb

APOC
07/12/2022
RR RR

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

PRINTED: 06/21/2022
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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N 156	The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a physician's order for a physical was signed for 1 of 1 (Client #1) sampled client who required the use of a physical restraint. The	N 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (X6) DATE 6/28/22

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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: Based on record review and interview, the facility failed to ensure a serious occurrence was reported to the required agencies and the report was maintained in the medical record for 1 of 1 (Client #1) sampled client who sustained an injury requiring outside medical care. The findings are: Client #1 was admitted on 1/13/22 and had diagnoses Attention Deficit/Hyperactivity Disorder and Post-Traumatic Stress Disorder. a. A Nurse's Note dated 1/27/22 at 2:32 p.m. documented, "Pt [Patient)] @ [at] nurse's station. Pt states, "I was running in the field & [and] stepped on my L [left] foot & fell face first onto the ground. Didn't have time to put my hands out. Slight swelling to R [right] of nose [with] cut [small] present. Bleeding stopped [with] applied pressure. 0/10 [zero of ten] pain noted.	N 209	Step 1: Corrective Action: Director of Nursing or designee have reviewed nursing notes to ensure proper guardian notification for client #1. Step 2: Identification of others with one potential of being affected: on 6/22/22 the Director of Nursing audited 25% of charts out of 162 charts to ensure proper notification has occurred. Charts were noted to be in compliance and any issues identified have been corrected. Step 3: To ensure practice does not recur: On 6/24/22 Nursing staff have been in –serviced on notification practice/policy and what to do when there is a technology issue. Step 4:Monitoring: Director of Nursing or Designee will audit Charts weekly to ensure proper notification.	7/11/2022

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(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 4 [Guardian] notified via TC [Telephone conference] @ 1436 [2:36 p.m.] Supervisor notified of need for transportation. Pt being sent to [Hospital] ER [Emergency Room] for further eval [evaluation]. Guardian aware... 1630 [4:30 p.m.] Return from ER [with] glue applied to cut. Pt refused to let DR [Doctor] apply sutures..." b. On 6/14/22, at 9:43 a.m., the Risk Manager was asked, "On 1/27/22 the client stated he fell and got a laceration to his nose. Was this incident reported to any State agencies?" He stated, "I'm pretty sure it didn't." The Risk Manager reviewed the regulation. He was asked, "Should that have been reported?" He stated, "I guess so." c. On 6/14/22, at 10:04 a.m., the Director of Nursing (DON) stated, "I talked to [Risk Manager] and he said we have never made that part of the chart." The DON was asked, "The Serious Occurrence reports?" She stated, "Yes, this one in January [2022] were he had a cut on the nose." The DON was asked, "Any other serious occurrences, that are reported, are not included in chart?" She stated, "Not the actual form that would indicate the calling and stuff. Our practice is the nurse to document on the occurrences and the assessments and notify the guardian if it is a serious injury or incident." d. The facility Incident Reporting-Risk Management Program Policy, received from the Risk Manager on 6/14/22 at 1:02 p.m., documented, "Policy: The Risk Management Program techniques must proactively focus on loss prevention, safety promotion, and detection of hazardous events and circumstances. It must provide a systematic, multi-disciplinary approach	N 209	Step1: Corrective Action: Director of Risk Management has updated index as to what qualifies as a serious occurrence. Step 2: Identification of others with one potential of being affected: On 6/22/22 the Director of Risk Management reviewed critical incidents that have occurred within the last 6 months to ensure compliance with the rule. All records were noted to be in compliance and any issues have been identified and corrected. Step 3: Ensure deficient practice doesn't recur: On 6/14/22 Director of Risk Management updated the index of serious occurrence. Step 4: Mentoring: Director of Risk Manager or designee will review all incidents to ensure appropriate reporting has occurred.	7/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L103	A. BUILDING _____ B. WING _____	C 06/14/2022

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HABILITATION CENTER, LLC	1810 INDUSTRIAL DRIVE FORDYCE, AR 71742

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N 209	Continued From page 5 to managing an reporting incidents of injury, damages, and loss... Classifying Severity... In States where the facility is required to report Tragic/Serious incidents to the State, it must be dome within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments... The following severity classifications shall be used:... Level II-Serious: Major injury or impairment in which the patient or visitor's function is altered requiring outside medical intervention... The Risk Manager should report a critical incident to the State as required by State-specific guidelines..."	N 209		

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Provider Services
& Quality Assurance
P.O. Box 8059, Slot S404
Little Rock, AR 72203-8059

July 26, 2022

Brady Serafin, Administrator
Habilitation Center, Llc
P.O. Box 727
Fordyce, AR 71742

Dear Mr.. Serafin:

During the Revisit survey conducted on July 25, 2022, your facility was found to be in compliance with program requirements. **Please email the signed CMS 2567 Sandra.Broughton@dhs.arkansas.gov.**

If you have any questions, please contact your reviewer:**Sandra Broughton at 501-320-6182 or email to Sandra.Broughton@dhs.arkansas.gov.**

Sincerely,

Sandra Broughton
Administrative Services Manager

DPSQA/Office of Long Term Care
Survey and Certification Section

sgb

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04L103	A. BUILDING _____ B. WING _____	R-C 07/25/2022

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{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 July 25, 2022 for all deficiencies cited on June 14, 2022. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{N 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.