



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,

DPSQA/Office of Long Term Care Survey & Certification Section

Saudie Biseretten
Administrative Services Manager

sgb

cc: DRA

PRINTED: 06/21/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		04L103	B. WING		C	
	ROVIDER OR SUPPLIER	0.2.00		STREET ADDRESS, CITY, STATE, ZIP CODE 1810 INDUSTRIAL DRIVE FORDYCE, AR 71742	06/14/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
N 000		7 (Statement of Deficiencies)	N 0	00		
	remain unchanged e correction, correction space. Any discrepal citation(s) will be rep Office (RO) for referr Inspector General (C information is inadve	accept for entering the plan of a dates, and the signature ncy in the original deficiency orted to the Dallas Regional al to the Office of the PIG) for possible fraud. If rently changed by the e State Survey Agency (SA)				
	Complaint #AR00028	3297 was unsubstantiated.				
N 156	-		N 1	56		
	permitted by the state restraint or seclusion	er licensed practitioner e and the facility to order must sign the restraint or e resident's record as soon				
	Based on record rev failed to ensure a phy was signed for 1 of 1 who required the use	ot met as evidenced by: view and interview, the facility ysician's order for a physical (Client #1) sampled client of a physical restraint. The				
_aboratory	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.

Facility ID: 3002

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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N 156	Continued From page findings are: Client #1 was admitted diagnoses Attention Equations and Post-Traumatic States a. An Emergency Sate Debriefing form dated "Physical Hold Date Restraint; Date: 5/6/22 Date & Time Remove 5/6/22 Time:1833 [6:3 Restraint Order Reced Doctor] Date: 5/6/22 b. A Physician's Order documented, "May be restraint not to exceed toward staff. T.O. [Terest (Registered Nurse) #1 Physician's signature c. On 6/13/22 at 2:01 Nursing was asked, "In Physician's order for the "No." NOTIFICATION OF PERMANNIA CER(s): 483.366 If the resident is a min subpart:	d on 1/13/22 and had Deficit/Hyperactivity Disorder Stress Disorder. fety Intervention and 15/6/22 documented, 2. [and] Time placed in 2.2 Time: 1813 [6:13 p.m.]; d from Restraint; Date: 33 p.m.]; Date & Time ived from MD [Medical Fime: 1813 [6:13 p.m.]" For dated 5/6/22 at 6:13 p.m. application of aggression elephone Order] [Doctor]/[RN 1]." There was no documented on the order. p.m., the Director of Do you have a signed the restraint?" She stated, PARENT(S) OR LEGAL	N			
	legal guardian(s) of the restrained or placed in	ne resident who has been no seclusion as soon as ation of each emergency				

l ` · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	201/1252 02 01/221/52	04L103	B. WING			06/	14/2022
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N 178	Based on record revifailed to ensure guard use of a physical rest sampled client who w restraint. The finding Client #1 was admitted diagnoses Attention E and Post-Traumatic States a. An Emergency Sate Debriefing form dated "Physical Hold Date Restraint; Date: 5/6/22 Time: 1833 [6:3] Restraint Order Reced Doctor] Date: 5/6/22 Guardian Notification All Interventions) Parequest to participate Interview: No notification Computer & phone ling b. A Nurse's Note dated documented, "Placed exceed 20 mins [minule fighting staff. Releated on elopement restriction X [times] 7 orders written & no pure present RT phone/cocampus @ present." documentation to individe notified of the unce. On 6/13/22 at 2:01	not met as evidenced by: iew and interview, the facility dians were notified of the raint for 1 of 1 (Client #1) ras placed in a physical is are: ed on 1/13/22 and had Deficit/Hyperactivity Disorder Otress Disorder. fety Intervention and if 5/6/22 documented, if & [and] Time placed in if [and] Time in [and] if [and] Time ived from MD [and] in [and] M	N	178			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	they went back and d email or anything or a	tated, "I don't see where ocumented they sent an	N	178			
N 209	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." 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.		N:	209			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
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N 209	@ 1436 [2:36 p.m.] for transportation. F [Emergency Room] Guardian aware 1 ER [with] glue applie [Doctor] apply suture b. On 6/14/22, at 9: was asked, "On 1/2; and got a laceration incident reported to stated, "I'm pretty su Manager reviewed t "Should that have be guess so." c. On 6/14/22, at 10 Nursing (DON) state and he said we have chart." The DON was occurrence reports in January [2022] we The DON was asked occurrences, that ar in chart?" She state would indicate the cis the nurse to docur the assessments an serious injury or incident the control of the control	ia TC [Telephone conference] Supervisor notified of need being sent to [Hospital] ER for further eval [evaluation]. 630 [4:30 p.m.] Return from ed to cut. Pt refused to let DR es" 43 a.m., the Risk Manager 7/22 the client stated he fell to his nose. Was this any State agencies?" He are it didn't." The Risk the regulation. He was asked, the reported?" He stated, "I 2:04 a.m., the Director of ed, "I talked to [Risk Manager] the never made that part of the as asked, "The Serious the stated, "Yes, this one the had a cut on the nose." d, "Any other serious the reported, are not included d, "Not the actual form that calling and stuff. Our practice ment on the occurrences and d notify the guardian if it is a deent."	N:	209			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
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N 209	to managing an repo damages, and loss States where the fac Tragic/Serious incide dome within the Stat notification of comple Management and Cli Departments The f classifications shall b Major injury or impair visitor's function is all medical intervention.	rting incidents of injury, Classifying Severity In ility is required to report ents to the State, it must be e requirements and etion to Corporate Risk inical Services following severity be used: Level II-Serious: rment in which the patient or tered requiring outside The Risk Manager should ent to the State as required	N 2	209			





Division of Provider Services & Quality Assurance 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,

Rubey Reper for

Sandra Broughton, Reviewer DPSQA/Office of Long Term Care

Survey & Certification Section

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APOC 07/12/2022 RR CR

PRINTED: 06/21/2022 FORM APPROVED OMB NO. 0938-0391

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NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
HABILITAT	ION CENTER, LLC		}	1810 INDUSTRIAL DRIVE FORDYCE, AR 71742		
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N 000	Initial Comments		N C	Step 1: Corrective Action:	a autorial nation	t aborto 7/11/2022
	is an official, legal do remain unchanged e correction, correction	7 (Statement of Deficiencies) cument. All information must xcept for entering the plan of n dates, and the signature ncy in the original deficiency		On 6/22/22 the Director of Nursing to ensure physician orders have belient #1. Step 2: Identification of others with affected: On 6/15/22, 6/22/22 and 6/15/22, 6/22/22 and 6/15/22, 6/22/22 and 6/15/22, 6/22/22 and 6/15/22	been signed timely the one potential of 6/29/22 the Direct	being lor of
	citation(s) will be rep Office (RO) for referr Inspector General (C information is inadve	orted to the Dallas Regional ral to the Office of the DIG) for possible fraud. If ortently changed by the	1100	Nursing audited 50% of charts out were noted to be in compliance as been corrected. Step 3: To ensure deficient practice On 6/24/22 Nursing staff have in-s	any potential issu e does not recur:	es have
	provider/supplier, the should be notified im	e State Survey Agency (SA) imediately.	***************************************	of having physician orders signed Step 4: Monitoring:		
	Complaint#AR0002	8297 was unsubstantiated.		Director of Nursing or designee weekly to ensure physician's order	ill audit medical c 's are signed timel	harts y.
N 156	Subpart G - Condition Psychiatric Residen	n compliance with §483, ons of Participation for tial Treatment Center : OF RESTRAINT OR	N	156		
	permitted by the sta restraint or seclusion	ner licensed practitioner te and the facility to order n must sign the restraint or ne resident's record as soon				
	This ELEMENT is not met as evidenced by: Based on record review and interview, the facility falled 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					
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE CtO	0/28/	(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 pareguards 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.

Facility ID: 3002

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
AND PLAN OF (JOKKEGTION		B. WING			0	C 6/14/2022
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N 156	diagnoses Attention and Post-Traumatic a. An Emergency S Debriefing form date "Physical Hold Date Sestraint; Date: 5/6/Date & Time Remove 5/6/22 Time:1833 [6] Restraint Order Report Doctor] Date: 5/6/22 b. A Physician's Order May restraint not to exceed toward staff. T.O. [7] (Registered Nurse) Physician's signature. c. On 6/13/22 at 2: Nursing was asked Physician's order for "No." NOTIFICATION Of GUARDIAN CFR(s): 483.366 If the resident is a subpart: 483.366(a) The facilegal guardian(s) or restrained or place.	ted on 1/13/22 and had Deficit/Hyperactivity Disorder Stress Disorder. afety Intervention and ed 5/6/22 documented, the & [and] Time placed in 6/22 Time: 1813 [6:13 p.m.]; wed from Restraint; Date: 6:33 p.m.]; Date & Time ceived from MD [Medical 2 Time: 1813 [6:13 p.m.]" Inder dated 5/6/22 at 6:13 p.m. be placed in a physical ed 20 minutes for aggression Telephone Order] [Doctor]/[RN 6-41]." There was no fire documented on the order. O1 p.m., the Director of 1, "Do you have a signed for the restraint?" She stated, F PARENT(S) OR LEGAL minor as defined in this cility must notify the parent(s) or of the resident who has been ed in seclusion as soon as initiation of each emergency		156 N 178			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1810 INDUSTRIAL DRIVE FORDYCE, AR 71742		
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N 178	This STANDARD is Based on record revifailed to ensure guar use of a physical ressampled client who vestraint. The finding Client #1 was admitted diagnoses Attention and Post-Traumatic a. An Emergency Scheriefing form date "Physical Hold Date "Physical Hold Date & Time Remov 5/6/22 Time:1833 [6] Restraint; Date: 5/6/22 Guardian Notification All Interventions) Frequest to participate Interview: No notification All Interview: No notification Computer & phone in the fighting staff. Releptaced on elopement extriction X [times] orders written & no present RT phone/coampus @ present. documentation to in been notified of the c. On 6/13/22 at 2:6	not met as evidenced by: iew and interview, the facility dians were notified of the traint for 1 of 1 (Client #1) was placed in a physical gs are: ed on 1/13/22 and had Deficit/Hyperactivity Disorder Stress Disorder. afety Intervention and d 5/6/22 documented, te & [and] Time placed in //22 Time: 1813 [6:13 p.m.]; red from Restraint; Date: dis33 p.m.]; Date & Time delived from MD [Medical delived from MD [MD [MD [MD] delived from MD [MD] delived from MD [MD] delived from MD [MD] delived	N 17	Step1 Corrective Action: On 6/24/2022 Director of Nursing developed and implemented protocol of how to ensure all affect are included in critical incident debriefing for cli 6/15/22 Director of Risk Management ensured the guardians had been notified of the physical restress that contained a critical incident. All critical debriefing practices been addressed in compliant potential issues corrected. Step 3: To ensure deficient practice does not recon 6/24/22 Director of Nursing and Milieu concentration of the physical restraint. Step 4: Monitoring: Director of Nursing or designee will conduct we audits to ensure all appropriate parties have engaged by the process appropriately.	ed parties ent #1. On nat the nint. I of being lited 25% of cal incident ce and any ur: fucted in- tified on the	

PRINTED: 06/21/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR IDENTIFICATION NUMBER: A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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N 178	they went back and email or anything or were down." FACILITY REPORTICER(s): 483.374(b): Staff must document the serious occurrer State Medicaid ager Protection and Advename of the person reported. A copy of maintained in the retincident and act facility. This ELEMENT is Based on record refailed to ensure a sreported to the requivas maintained in (Client #1) sampled requiring outside modiagnoses Attention and Post-Traumatical. A Nurse's Note documented, "Pt [I Pt states, "I was rustepped on my L [I ground, Didn't hav Slight swelling to Fismall] present. B	stated, "I don't see where documented they sent an a letter. The phone lines ING (3) It in the resident's record that nee was reported to both the ney and the State designated ocacy system, including the to whom the incident was the report must be esident's record, as well as in cident report logs kept by the not met as evidenced by: eview and interview, the facility erious occurrence was uired agencies and the report the medical record for 1 of 1 d client who sustained an injury nedical care. The findings are: litted on 1/13/22 and had in Deficit/Hyperactivity Disorder		209	Step 1: Corrective Action: Director of Nursing or designee have reviewed not on ensure proper guardian notification for client # Step 2: Identification of others with one potential affected: on 6/22/22 the Director of Nursing audicharts out of 162 charts to ensure proper notificat occurred. Charts were noted to be in compliance issues identified have been corrected. Step 3: To ensure practice does not recur: On 6/24/22 Nursing staff have been in -serviced notification practice/policy and what to do when technology issue. Step 4:Monitoring: Director of Nursing or Designee will audit Chartensure proper notification.	of being ted 25% of ion has and any	7/11/2022

Facility ID: 3002

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
		04L103	B, WING			1	4/2022	
HABILITA	TION CENTER, LLC	TATEMENT OF DEFICIENCIES	ID	18	REET ADDRESS, CITY, STATE, ZIP CODE 110 INDUSTRIAL DRIVE ORDYCE, AR 71742 PROVIDER'S PLAN OF CORRECTION			
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	COMPLETION DATE	
N 209	[Guardian] notified v ② 1436 [2:36 p.m.] for transportation. P [Emergency Room] Guardian aware 1 ER [with] glue applie [Doctor] apply suture b. On 6/14/22, at 9: was asked, "On 1/2 and got a laceration incident reported to stated, "I'm pretty si Manager reviewed t "Should that have b guess so." c. On 6/14/22, at 1: Nursing (DON) stat and he said we hav chart." The DON w Occurrence reports in January [2022] w The DON was aske occurrences, that a in chart?" She stat would indicate the is the nurse to doct the assessments a serious injury or inc d. The facility Incid Management Prog Risk Manager on 6 documented, "Polic Program technique loss prevention, sa of hazardous even	sa TC [Telephone conference] Supervisor notified of need It being sent to [Hospital] ER for further eval [evaluation]. 630 [4:30 p.m.] Return from ed to cut. Pt refused to let DR es" 43 a.m., the Risk Manager 7/22 the client stated he fell to his nose. Was this any State agencies?" He ure it didn't." The Risk the regulation. He was asked, een reported?" He stated, "I 0:04 a.m., the Director of ed, "I taiked to [Risk Manager] e never made that part of the as asked, "The Serious ere he had a cut on the nose." ed, "Any other serious re reported, are not included ed, "Not the actual form that calling and stuff. Our practice ument on the occurrences and nd notify the guardian if it is a	2		Step 1: Corrective Action: Director of Risk Management has updated index a qualifies as a serious occurrence. Step 2: Identification of others with one potential affected: On 6/22/22 the Director of Risk Manager reviewed critical incidents that have occurred wit 6 months to ensure compliance with the rule. All were noted to be in compliance and any issues had identified and corrected. Step 3: Ensure deficient practice doesn't recur: On 6/14/22 Director of Risk Management update of serious occurrence. Step 4: Mentoring: Director of Risk Manager or designee will review incidents to ensure appropriate reporting has occurred to the serious occurrence.	of being ement hin the last records we been d the index		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		04L103	B. WING				C
	ROVIDER OR SUPPLIER	042103	D. WING	1810 INC	ADDRESS, CITY, STATE, ZIP CODE DUSTRIAL DRIVE CE, AR 71742	<u> </u>	6/14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
N 209	to managing an repo damages, and loss States where the fac Tragic/Serious incide dome within the Stat- notification of comple Management and Cli Departments The f classifications shall to Major injury or impair visitor's function is all medical intervention.	rting incidents of injury, Classifying Severity In ility is required to report ents to the State, it must be e requirements and etion to Corporate Risk inical Services following severity be used: Level II-Serious: rment in which the patient or tered requiring outside The Risk Manager should ent to the State as required	N	209			





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,

DPSQA/Office of Long Term Care

Saudie Bisuston Administrative Services Manager

Survey and Certification Section

sgb

PRINTED: 07/26/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED R-C	
		04L103	B. WING				
L			D. WINO	STREET ADDRESS, CITY, STATE, ZIP CO		07/25/2022	
NAME OF PROVIDER OR SUPPLIER							
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{N 000}	Initial Comments		{N 0	00}			
	is an official, legal do remain unchanged excorrection, correction space. Any discrepar citation(s) will be reproffice (RO) for referr Inspector General (Conformation is inadve provider/supplier, the should be notified im	erich (PG) for possible fraud. If artently changed by the estate Survey Agency (SA) mediately. The first of					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	F		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.