



**Division of Medical Services  
Office of Long Term Care**

P.O. Box 8059 slot S-404 · Little Rock, AR 72203-8059  
Ph 501-682-8430 · Fax: 501-682-6159 · TDD: 501-682-6789  
<https://www.medicaid.state.ar.us/InternetSolution/General/units/oltc/index.aspx>



**CERTIFIED MAIL # 7006 3450 0003 0943 8462**

September 15, 2008

Mark Stitch, Administrator  
Alexander Human Development Center  
14701 Highway 111 South  
Alexander, AR 72002

**IMPORTANT NOTICE – PLEASE READ CAREFULLY**

Dear Mr. Stitch:

On September 2, 2008, the Office of Long Term Care conducted a complaint survey to determine if your facility was in compliance with Federal requirements for Intermediate Care/Mental Retardation facilities participating in the Medicaid program. **This survey found that your facility was not in compliance with conditions of participation that resulted in Immediate Jeopardy, as specified in the attached CMS 2567. The Immediate Jeopardy was removed on August 27, 2008.** The facility failed to meet the Condition of Participation for Client Protections. Specifically, the facility was not in compliance with the following requirements:

<b>42CFR 483.410</b>	<b>Governing Body and Management</b>
<b>42CFR 483.410(a)(1)</b>	<b>Governing Body</b>
<b>42 CFR 483.420</b>	<b>Client Protections</b>
<b>42CFR 483.420(a)(5)</b>	<b>Protection of Clients Rights</b>
<b>42CFR 483.420(d)(2)</b>	<b>Staff Treatment of Clients</b>
<b>42CFR 483.420(d)(3)</b>	<b>Staff Treatment of Clients</b>
<b>42CFR 483.460(c)</b>	<b>Nursing Services</b>

The CMS 2567L “Statement of Deficiencies and Plan of Correction” with all deficiencies identified during the complaint survey on September 2, 2008 is enclosed.

**Remedies**

Based on the deficiencies cited, we are recommending to the State Medicaid Agency (SMA) the immediate imposition of the following remedies:

[www.arkansas.gov/dhs](http://www.arkansas.gov/dhs)  
Serving more than one million Arkansans each year

**Termination of the provider agreement effective December 1, 2008, if substantial compliance is not achieved by that date.**

**Plan of Correction**

A Plan of Correction (PoC) for the cited deficiencies must be completed and a completion date for each deficiency cited must be included. **It is imperative that an acceptable plan of correction be received by this office by September 25, 2008, to ensure a revisit can be conducted within 45 calendar days of the survey.** Termination will take place on **December 1, 2008**, if compliance is not achieved.

A revisit will be authorized after an acceptable PoC is received. The PoC must be faxed to:

Lori Hobbs, Reviewer  
OLTC Survey & Certification Section  
P.O. Box 8059, Slot 404  
Little Rock, AR 72203-8059  
Telephone (501) 682-8430; Fax (501) 682-6159

**Your Plan of Correction must also include the following:**

- a. How the corrective action will be accomplished for individuals found to have been affected by the deficient practice;
- b. How the facility will identify other individuals who have the potential to be affected by the same deficient practice, and how the facility will act to protect individuals in similar situations;
- c. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- d. How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; and
- e. When corrective action must be accomplished.

**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 deficiency 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.

Mark Stitch, Administrator

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September 15, 2008

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 via fax to:

Connie Melton, Section Chief  
Health Facility Services  
Arkansas Department of Health and Human Services  
5800 West 10<sup>th</sup> Street, Suite 400  
Little Rock, AR 72204  
(501) 661-2201  
Fax (501) 661-2165

**Appeal Rights**

To appeal a sanction regarding licensure and certification, you or your legal counsel must make a written request to:

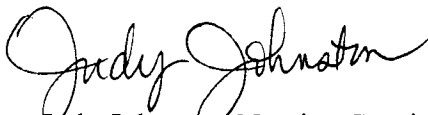
Director  
Arkansas Department of Health and Human Services  
P.O. Box 1437, Slot 210  
Little Rock, AR 72203-1437

Pursuant to Appendix A of the Long Term Care Provider Manual, the Chairman must receive the request within sixty (60) days of receipt of this letter. The request must state the basis for the appeal with supporting documentation attached.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

If you have any questions, please contact Lori Hobbs, Reviewer or myself at (501) 682-8430.

Sincerely,



Judy Johnston, Nursing Services Administrator  
Office of Long Term Care  
Survey & Certification Section

cc: Ombudsman  
DRC  
DDS  
file

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

PRINTED: 09/17/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04G001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/02/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALEXANDER HUMAN DEVELOPMENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>14701 HIGHWAY 111 SOUTH</b> <b>ALEXANDER, AR 72002</b>	
(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
W 000	INITIAL COMMENTS  A complaint survey was conducted from 8/25/08 through 9/2/08. An Immediate Jeopardy (IJ) was identified at W127 (Client Protections), which resulted in the Conditions of Participation at W102 (Governing Body) and W122 (Client Protections) being found out of compliance on 8/27/08 at 1:06 p.m. The IJ was removed on 8/27/08 at 1:32 p.m.	W 000		
W 102	483.410 GOVERNING BODY AND MANAGEMENT  The facility must ensure that specific governing body and management requirements are met.  This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to meet the requirements for the Condition of Participation for Governing Body and Management, as evidenced by the facility's failure to meet the Condition of Participation (CoP) for Client Protections (W122) and the facility's failure to have a system in place to ensure when the Administrator was informed of alleged abuse, the local law enforcement agency was notified as required, failure to initiate an immediate investigation and failure to immediately provide protection from further potential abuse during the investigative period for 1 (Client #1) of 4 sampled clients (Clients #1 through #4). The facility failed to develop and implement a comprehensive, corrective and proactive plan to provide protection	W 102		

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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W 102	<p>Continued From page 1</p> <p>for clients who were the alleged victims of physical abuse. The failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death to Client #1 and had the potential to affect all 115 clients who resided in the facility, as documented on the Current Listing of Clients provided by the facility on 8/25/08. The facility was informed of the Immediate Jeopardy condition on 8/27/08 at 1:06 p.m. The findings are:</p> <ol style="list-style-type: none"> <li>1. The facility failed to meet the Standard of Governing Body at W104, as evidenced by failure to develop and implement policies to correct deficient practices related to failure to initiate an abuse investigation and notify the local law enforcement agency immediately upon the Administrators discovery of the physical abuse allegation and failure to immediately implement protective measures to prevent further potential abuse during the investigative period. Refer to W104.</li> <li>2. The facility failed to meet the requirements for the Condition of Participation for Client Protections at W122, as evidenced by the facility's failure to implement policies related to the immediate notification of the local law enforcement agency, failure to immediately initiate an abuse investigation and failure to immediately implement protective measures to prevent further potential abuse upon the Administrator's discovery of the abuse allegation. Refer to W122.</li> <li>3. The facility failed to meet the Standard of Protection of Client's Rights, as evidenced by the facility's failure to implement policies and procedures for the immediate notification of local</li> </ol>	W 102			

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W 102	Continued From page 2 law enforcement officials, immediate initiation of an abuse investigation and immediate provision of protective measures to prevent further potential abuse during the investigative period. Refer to W127.  4. The facility failed to meet the Standards of Staff Treatment of Clients, as evidenced by the facility's failure to ensure local law enforcement officials were immediately notified of an alleged incident of staff-to-client physical abuse (Refer to W153), failure to ensure the Administrator immediately initiated an abuse investigation (Refer to W154) and failure to ensure protection from further potential abuse was immediately provided during the investigation process (Refer to W155).  5. The Immediate Jeopardy was removed on 8/27/08 at 1:32 p.m. when the facility implemented the following plan of removal:  a. The facility identified the existence of a deficient practice with client protections and the Superintendent was placed on Administrative Leave commencing 8/27/08.  b. The facility identified the alleged perpetrator and was placed on Administrative Leave on 8/25/08.  c. A full investigation was initiated on 8/25/08.  d. The facility immediately started inservice related to notification of Superintendent during the absence of the current Superintendent. The inservice will include retraining related to the policy and procedure of reporting abuse, either physical, sexual, verbal, misappropriation of	W 102			

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W 102	Continued From page 3 property and injuries of unknown origin. This inservice will be provided by training staff including supervisors for each person as they come to work starting on the current shift. This training will be ongoing and will include all employees who are off as they return to work. The facility will assure and train staff that [Acting Superintendent] or his designee will be made immediately aware of any situation that includes abuse, misappropriation of property and corrective action taken immediately.	W 102			
W 104	483.410(a)(1) GOVERNING BODY  The governing body must exercise general policy, budget, and operating direction over the facility.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure policies and procedures were implemented to initiate an abuse investigation, notify local law enforcement officials and provide protection from further potential abuse during the investigative period immediately upon the Administrator's discovery of an allegation of staff-to-resident physical abuse for 1 (Client #1) of 4 sampled clients (Clients #1 through #4). The failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death to Client #1 and had the potential to affect all 115 clients who resided in the facility, as documented on the Current Listing of Clients provided by the facility on 8/25/08. The facility was informed of the Immediate Jeopardy condition on 8/27/08 at 1:06 p.m. The findings are:  Client #1 had a diagnosis of Profound Mental	W 104			

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W 104	<p>Continued From page 4 Retardation.</p> <p>a. A Department of Health and Human Services (DHHS) Incident Report dated 8/25/08 documented the following:</p> <p>1.) "[Client #2] reported to [Superintendent] on 8/22/08 at approximately 11:00 p.m. that on Friday, 8/22/08 at 12:30 p.m., he [Client #2] walked into the kitchen at Main Street and saw staff, [Staff #1], hit client, [Client #1], with a metal pipe. Incident was also reported to [Staff #2], Life Skills staff on 8/24/08 at 10:25 p.m. and [Staff #2] reported to [Staff #3], Shift Coordinator, who made all necessary contacts. Medical evaluated [Client #1], and no bruising noted. [Staff#1], Life Skills staff, was placed on Administrative Leave on 8/25/08 at 7:00 a.m."</p> <p>2.) The Incident Report documented the local law enforcement agency was not notified until 8/24/08 at 10:45 p.m., a period of almost 48 hours after the Superintendent was made aware of the allegation. The client's guardian was not notified until 8/24/08 at 11:38 p.m.</p> <p>b. On 8/27/08 at 11:00 a.m., the Quality Assurance Manager and facility Investigator were interviewed as follows.</p> <p>1.) The Investigator stated, "The client [Client #2] called [Superintendent] at home that night on the telephone." The Quality Assurance Manager stated, "[Superintendent] did know of the incident that night [8/22/08], but looked at the incident globally and not per incident." When asked if required notifications, investigation procedures and protective measures were implemented, the Quality Assurance Manager stated no</p>	W 104			

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W 104	Continued From page 5 notifications were made, no protections were put in place and no investigation was initiated, despite notification of and awareness of the allegation by the Superintendent.  2.) The Investigator stated the alleged perpetrator (Staff #1) did work over the weekend in the cottage in which the alleged abuse took place and was not placed on Administrative leave until Monday, 8/25/08 at 7:00 a.m.  c. The Department of Human Services, Division of Developmental Disabilities (DDS) Services, DDS Director's Office Policy Manual Policy number 3004-1 titled, "Maltreatment Prohibition, Prevention, Reporting and Investigation" was provided by the facility Investigator on 8/27/08 at 2:30 p.m. and documented the following:  1.) "Each facility shall do all that is within its control to prevent occurrences of maltreatment and to report and investigate maltreatment when it occurs."  2.) "Maltreatment - Actions which include, but are not limited to, physical, verbal, psychological, or sexual abuse, neglect, exploitation, misappropriation of property and violation of rights of individuals receiving services."  3.) "Neglect means those acts or omissions... any person who is entrusted with the care... failure to take reasonable action to protect from abandonment, abuse, sexual abuse, sexual exploitation, neglect where the existence of such condition was known or should have been known."  4.) "Appendix B... persons required to report	W 104			

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W 104	Continued From page 6 abuse: "...A facility administrator."  d. The Immediate Jeopardy was removed on 8/27/08 at 1:32 p.m. when the facility implemented the following plan of removal:  1.) The facility identified the existence of a deficient practice with client protections and the Superintendent was placed on Administrative Leave commencing 8/27/08.  2.) The facility identified the alleged perpetrator and was placed on Administrative Leave on 8/25/08.  3.) A full investigation was initiated on 8/25/08.  4.) The facility immediately started inservice related to notification of Superintendent during the absence of the current Superintendent. The inservice will include retraining related to the policy and procedure of reporting abuse, either physical, sexual, verbal, misappropriation of property and injuries of unknown origin. This inservice will be provided by training staff including supervisors for each person as they come to work starting on the current shift. This training will be ongoing and will include all employees who are off as they return to work. The facility will assure and train staff that [Acting Superintendent] or his designee will be made immediately aware of any situation that includes abuse, misappropriation of property and corrective action taken immediately.	W 104			
W 122	483.420 CLIENT PROTECTIONS  The facility must ensure that specific client protections requirements are met.	W 122			

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W 122	Continued From page 7  This <b>CONDITION</b> is not met as evidenced by: Based on record review and interview, the facility failed to meet requirements for the Condition of Participation (CoP) for Client Protections, as evidenced by failure to implement policies and procedures for notification of the local law enforcement agency, initiation of an abuse investigation and provision of protection from further potential abuse immediately upon discovery by the Administrator of an allegation of staff-to-client physical abuse for 1 (Client #1) of 4 sampled clients (Clients #1 through #4). The failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death to Client #1 and had the potential to affect all 115 clients who resided in the facility, as documented on the Current Listing of Clients provided by the facility on 8/25/08. The facility was informed of the Immediate Jeopardy condition on 8/27/08 at 1:06 p.m. The findings are:  1. The facility failed to meet the Standard of Protection of Client's Rights, as evidenced by the facility's failure to implement policies and procedures for the immediate notification of local law enforcement officials, immediate initiation of an abuse investigation and immediate provision of protective measures to prevent further potential abuse during the investigative period. Refer to W127.  2. The facility failed to meet the Standards of Staff Treatment of Clients, as evidenced by the facility's failure to ensure local law enforcement officials were immediately notified of an alleged incident of staff-to-client physical abuse (Refer to	W 122			

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W 122	Continued From page 8 W153), failure to ensure the Administrator immediately initiated an abuse investigation (Refer to W154) and failure to ensure protection from further potential abuse was immediately provided during the investigation process (Refer to W155).  3. The Immediate Jeopardy was removed on 8/27/08 at 1:32 p.m. when the facility implemented the following plan of removal:  a. The facility identified the existence of a deficient practice with client protections and the Superintendent was placed on Administrative Leave commencing 8/27/08.  b. The facility identified the alleged perpetrator and was placed on Administrative Leave on 8/25/08.  c. A full investigation was initiated on 8/25/08.  d. The facility immediately started inservice related to notification of Superintendent during the absence of the current Superintendent. The inservice will include retraining related to the policy and procedure of reporting abuse, either physical, sexual, verbal, misappropriation of property and injuries of unknown origin. This inservice will be provided by training staff including supervisors for each person as they come to work starting on the current shift. This training will be ongoing and will include all employees who are off as they return to work. The facility will assure and train staff that [Acting Superintendent] or his designee will be made immediately aware of any situation that includes abuse, misappropriation of property and corrective action taken immediately.	W 122			

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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	
W 127	<p>483.420(a)(5) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that immediately upon the Administrator's (Superintendent's) discovery of an allegation of staff-to-client physical abuse, an abuse investigation was initiated, local law enforcement notified and protective measures to prevent further potential abuse were implemented for 1 (Client #1) of 4 sampled clients (Clients #1 through #4). The failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death to Client #1 and had the potential to affect all 115 clients who resided in the facility, as documented on the Current Listing of Clients provided by the facility on 8/25/08. The facility was informed of the Immediate Jeopardy condition on 8/27/08 at 1:06 p.m. The findings are:</p> <p>Client #1 had a diagnosis of Profound Mental Retardation.</p> <p>a. A Department of Health and Human Services (DHHS) Incident Report dated 8/25/08 documented the following:</p> <p>1.) "[Client #2] reported to [Superintendent] on 8/22/08 at approximately 11:00 p.m. that on Friday, 8/22/08 at 12:30 p.m., he [Client #2] walked into the kitchen at Main Street and saw staff, [Staff #1], hit client, [Client #1], with a metal</p>	W 127			

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W 127	<p>Continued From page 10</p> <p>pipe. Incident was also reported to [Staff #2], Life Skills staff on 8/24/08 at 10:25 p.m. and [Staff #2] reported to [Staff #3], Shift Coordinator, who made all necessary contacts. Medical evaluated [Client #1], and no bruising noted. [Staff#1], Life Skills staff, was placed on Administrative Leave on 8/25/08 at 7:00 a.m."</p> <p>2.) The Incident Report documented the local law enforcement agency was not notified until 8/24/08 at 10:45 p.m., a period of almost 48 hours after the Superintendent was made aware of the allegation. The client's guardian was not notified until 8/24/08 at 11:38 p.m.</p> <p>b. On 8/27/08 at 11:00 a.m., the Quality Assurance Manager and facility Investigator were interviewed as follows.</p> <p>1.) The Investigator stated, "The client [Client #2] called [Superintendent] at home that night on the telephone." The Quality Assurance Manager stated, "[Superintendent] did know of the incident that night [8/22/08], but looked at the incident globally and not per incident." When asked if required notifications, investigation procedures and protective measures were implemented, the Quality Assurance Manager stated no notifications were made, no protections were put in place and no investigation was initiated, despite notification of and awareness of the allegation by the Superintendent.</p> <p>2.) The Quality Assurance Manager stated the Superintendent was placed on Administrative Leave by the Director of DDS, effective 8/27/08.</p> <p>3.) The Investigator stated the alleged perpetrator (Staff #1) did work over the weekend</p>	W 127			

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W 127	<p>Continued From page 11</p> <p>in the cottage in which the alleged abuse took place and was not placed on Administrative leave until Monday, 8/25/08 at 7:00 a.m.</p> <p>c. The Department of Human Services, Division of Developmental Disabilities (DDS) Services, DDS Director's Office Policy Manual Policy number 3004-1 titled, "Maltreatment Prohibition, Prevention, Reporting and Investigation" was provided by the facility Investigator on 8/27/08 at 2:30 p.m. and documented the following:</p> <p>1.) "Each facility shall do all that is within its control to prevent occurrences of maltreatment and to report and investigate maltreatment when it occurs."</p> <p>2.) "Maltreatment - Actions which include, but are not limited to, physical, verbal, psychological, or sexual abuse, neglect, exploitation, misappropriation of property and violation of rights of individuals receiving services."</p> <p>3.) "Neglect means those acts or omissions... any person who is entrusted with the care... failure to take reasonable action to protect from abandonment, abuse, sexual abuse, sexual exploitation, neglect where the existence of such condition was known or should have been known."</p> <p>4.) "Appendix B... persons required to report abuse: ...A facility administrator."</p> <p>d. The Immediate Jeopardy was removed on 8/27/08 at 1:32 p.m. when the facility implemented the following plan of removal:</p> <p>1.) The facility identified the existence of a</p>	W 127			

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W 127	Continued From page 12 deficient practice with client protections and the Superintendent was placed on Administrative Leave commencing 8/27/08.  2.) The facility identified the alleged perpetrator and was placed on Administrative Leave on 8/25/08.  3.) A full investigation was initiated on 8/25/08.  4.) The facility immediately started inservice related to notification of Superintendent during the absence of the current Superintendent. The inservice will include retraining related to the policy and procedure of reporting abuse, either physical, sexual, verbal, misappropriation of property and injuries of unknown origin. This inservice will be provided by training staff including supervisors for each person as they come to work starting on the current shift. This training will be ongoing and will include all employees who are off as they return to work. The facility will assure and train staff that [Acting Superintendent] or his designee will be made immediately aware of any situation that includes abuse, misappropriation of property and corrective action taken immediately.	W 127		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.  This STANDARD is not met as evidenced by:	W 153		

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W 153	<p>Continued From page 13</p> <p>Based on record review and interview, the facility failed to ensure the local law enforcement agency was immediately notified of an allegation of staff-to-client physical abuse for 1 (Client #1) of 4 sampled clients (Clients #1 through #4). The failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death to Client #1 and had the potential to affect all 115 clients who resided in the facility, as documented on the Current Listing of Clients provided by the facility on 8/25/08. The facility was informed of the Immediate Jeopardy condition on 8/27/08 at 1:06 p.m. The findings are:</p> <p>Client #1 had a diagnosis of Profound Mental Retardation.</p> <p>a. A Department of Health and Human Services (DHHS) Incident Report dated 8/25/08 documented the following:</p> <p>1.) "[Client #2] reported to [Superintendent] on 8/22/08 at approximately 11:00 p.m. that on Friday, 8/22/08 at 12:30 p.m., he [Client #2] walked into the kitchen at Main Street and saw staff, [Staff #1], hit client, [Client #1], with a metal pipe. Incident was also reported to [Staff #2], Life Skills staff on 8/24/08 at 10:25 p.m. and [Staff #2] reported to [Staff #3], Shift Coordinator, who made all necessary contacts. Medical evaluated [Client #1], and no bruising noted. [Staff#1], Life Skills staff, was placed on Administrative Leave on 8/25/08 at 7:00 a.m."</p> <p>2.) The Incident Report documented the local law enforcement agency was not notified until 8/24/08 at 10:45 p.m., a period of almost 48 hours after the Superintendent was made aware of the</p>	W 153			

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W 153	<p>Continued From page 14 allegation.</p> <p>b. On 8/27/08 at 11:00 a.m., the Quality Assurance Manager and facility Investigator were interviewed. The Investigator stated, "The client [Client #2] called [Superintendent] at home that night on the telephone." The Quality Assurance Manager stated, "[Superintendent] did know of the incident that night [8/22/08], but looked at the incident globally and not per incident." When asked if required notifications were made, the Quality Assurance Manager stated no immediate notifications were made.</p> <p>c. Arkansas Code Annotated 12-12-1708(3)(b)(1) documented: "A report for a long-term care facility resident shall be made: (A) Immediately to the local law enforcement agency for the jurisdiction in which the long-term care facility is located."</p> <p>d. The Immediate Jeopardy was removed on 8/27/08 at 1:32 p.m. when the facility implemented the following plan of removal:</p> <ol style="list-style-type: none"> <li>1.) The facility identified the existence of a deficient practice with client protections and the Superintendent was placed on Administrative Leave commencing 8/27/08.</li> <li>2.) The facility identified the alleged perpetrator and was placed on Administrative Leave on 8/25/08.</li> <li>3.) A full investigation was initiated on 8/25/08.</li> <li>4.) The facility immediately started inservice related to notification of Superintendent during the absence of the current Superintendent. The inservice will include retraining related to the</li> </ol>	W 153			

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W 153	Continued From page 15	W 153			
W 155	<p>policy and procedure of reporting abuse, either physical, sexual, verbal, misappropriation of property and injuries of unknown origin. This inservice will be provided by training staff including supervisors for each person as they come to work starting on the current shift. This training will be ongoing and will include all employees who are off as they return to work. The facility will assure and train staff that [Acting Superintendent] or his designee will be made immediately aware of any situation that includes abuse, misappropriation of property and corrective action taken immediately.</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p> <p>The facility must prevent further potential abuse while the investigation is in progress.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure protection from further potential abuse was provided immediately upon the Administrator's (Superintendent's) knowledge of an allegation of staff-to-client physical abuse for 1 (Client #1) of 4 sampled clients (Clients #1 through #4). The failed practice resulted in Immediate Jeopardy, which caused or could have caused serious harm, injury or death to Client #1 and had the potential to affect all 115 clients who resided in the facility, as documented on the Current Listing of Clients provided by the facility on 8/25/08. The facility was informed of the Immediate Jeopardy condition on 8/27/08 at 1:06 p.m. The findings are:</p> <p>Client #1 had a diagnosis of Profound Mental Retardation.</p>	W 155			

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W 155	Continued From page 16  a. A Department of Health and Human Services (DHHS) Incident Report dated 8/25/08 documented: "[Client #2] reported to [Superintendent] on 8/22/08 at approximately 11:00 p.m. that on Friday, 8/22/08 at 12:30 p.m., he [Client #2] walked into the kitchen at Main Street and saw staff, [Staff #1], hit client, [Client #1], with a metal pipe. Incident was also reported to [Staff #2], Life Skills staff on 8/24/08 at 10:25 p.m. and [Staff #2] reported to [Staff #3], Shift Coordinator, who made all necessary contacts. Medical evaluated [Client #1], and no bruising noted. [Staff#1], Life Skills staff, was placed on Administrative Leave on 8/25/08 at 7:00 a.m. [a period of over 48 hours after the Administrator was aware of the allegation]."  b. On 8/27/08 at 11:00 a.m., the Quality Assurance Manager and facility Investigator were interviewed as follows.  1.) The Investigator stated, "The client [Client #2] called [Superintendent] at home that night on the telephone." The Quality Assurance Manager stated, "[Superintendent] did know of the incident that night [8/22/08], but looked at the incident globally and not per incident." When asked if protective measures were implemented, the Quality Assurance Manager stated no immediate protections were put in place.  2.) The Investigator stated the alleged perpetrator (Staff #1) did work over the weekend in the cottage in which the alleged abuse took place and was not placed on Administrative leave until Monday, 8/25/08 at 7:00 a.m.  c. The Immediate Jeopardy was removed on	W 155			

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W 155	Continued From page 17 8/27/08 at 1:32 p.m. when the facility implemented the following plan of removal:  1.) The facility identified the existence of a deficient practice with client protections and the Superintendent was placed on Administrative Leave commencing 8/27/08.  2.) The facility identified the alleged perpetrator and was placed on Administrative Leave on 8/25/08.  3.) A full investigation was initiated on 8/25/08.  4.) The facility immediately started inservice related to notification of Superintendent during the absence of the current Superintendent. The inservice will include retraining related to the policy and procedure of reporting abuse, either physical, sexual, verbal, misappropriation of property and injuries of unknown origin. This inservice will be provided by training staff including supervisors for each person as they come to work starting on the current shift. This training will be ongoing and will include all employees who are off as they return to work. The facility will assure and train staff that [Acting Superintendent] or his designee will be made immediately aware of any situation that includes abuse, misappropriation of property and corrective action taken immediately.	W 155			
W 331	483.460(c) NURSING SERVICES  The facility must provide clients with nursing services in accordance with their needs.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 331			

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W 331	<p>Continued From page 18</p> <p>failed to ensure nursing services were provided, as evidenced by failure to provide a medicated shampoo as ordered by the Advanced Practice Nurse (APN) to treat a fungal scalp infection for 1 (Client #2) of 4 sampled clients (Clients #1, #2, #3 and #4). The findings are:</p> <p>Client #2 had diagnoses of Intermittent Explosive Disorder, Severe Mental Retardation, Generalized Convulsive Epilepsy and Mild Spastic Paraplegia and wore a helmet for protection due to falls.</p> <p>a. Monthly Progress Notes dated 7/16/08 by the Advanced Nurse Practitioner (APN) documented: "...seen in the clinic today for multiple bruises down the middle of his back, across the front of his upper chest and around the subclavicular area... He [Client #2] does wear a helmet because he is prone to fall although no falls have been reported... The helmet was removed while in the clinic and there was an atrocious smell that was coming from his head. There was a very strong stench from his head when the helmet was removed. On further inspections there were multiple wounds around where the helmet fits his head in the back and along the left side that extends up around the front hairline and there were massive amounts of thick, scaly, debris which is some type of fungus that has developed under his helmet... I will order some medicated shampoo for his head and his helmet needs to be disinfected or a new one ordered. Staff were given instructions to do this upon departure from the clinic..."</p> <p>b. As of 8/25/08, there was no documentation on the Physician Orders sheets or Medication Administration Records for July and August 2008 to indicate that a medicated shampoo or other</p>	W 331			

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W 331	Continued From page 19 treatment for a fungal scalp infection had been initiated for the client.  c. On 08/26/08 at 2:25 p.m., the Director of Nursing documented the following statement, "We just never followed up on the order and the client has not been receiving the shampoo." The Director of Nursing stated at this time that a policy had been put into place to provide for disinfecting helmets for all clients who utilized helmets and, "He [Client #2] is now receiving his bath on the day shift and his scalp looks better."	W 331			