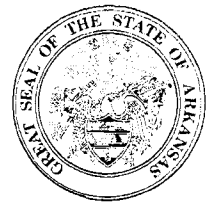




**Division of Medical Services  
Office of Long Term Care**

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 9087**

October 30, 2008

Judy Adams, Administrator  
Southeast Arkansas Human Development Center  
1 Center Circle  
Warren, AR 71671

Dear Ms. Adams:

On October 16, 2008, a recertification 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 ICF's/MR 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-2567L.

**Plan of Correction**

A Plan of Correction (PoC) must be completed for the cited deficiencies with a completion date for each deficiency cited. A revisit will be authorized after an acceptable PoC is received. The POC must be submitted by November 9, 2008, to:

Lori Hobbs, RN, 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;

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

Judy Adams, Administrator

Page 2

October 30, 2008

- 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 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.

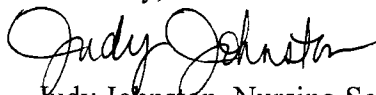
An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

Please submit your request **via fax** to:

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

If you have any questions, please call me 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: 10/30/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04G007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHEAST ARKANSAS HUMAN DEVELOPMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 CENTER CIRCLE WARREN, AR 71671</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)
W 000	INITIAL COMMENTS	W 000	
W 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure an injury of unknown origin was reported immediately to the local law enforcement agency for 1 of 1 (Client #9) sampled client who sustained an injury of unknown origin. The findings are:</p> <p>Client #9 had a diagnosis of Mental Retardation.</p> <p>a. An Incident Report dated 7/28/08 documented: "Date of incident: 7/26/08... Staff was bathing client and notice right ring finger was red and swollen. Nurse was summoned, doctor called and client ordered transported to [hospital] for x-ray. X-ray indicated very small fracture to right ring finger... CLPD [Cottage Life Program Director], Superintendent and mother were notified..." There was no documentation the injury of unknown origin was reported to the local law enforcement agency.</p> <p>b. Nurses Notes dated 7/26/08 at 5:30 p.m. documented: "Back from hospital + [and] [physician] states, 'She has a small fracture...'"</p>	W 153	

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.

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

PRINTED: 10/30/2008  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04G007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2008</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHEAST ARKANSAS HUMAN DEVELOPMENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 CENTER CIRCLE WARREN, AR 71671</b>
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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
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W 153

Continued From page 1

c. Nurses Notes dated 7/26/08 at 8:30 p.m. documented the client was administered 2 Extra Strength Tylenol for comfort.

d. The final Diagnostic Imaging Report documented: "The bones are normal. There is no fracture and no evidence of radiopaque foreign body." This report was documented as faxed to the facility on 7/28/08. This was a period of 2 days after the incident occurred, during which time the local law enforcement agency had not been notified of the client's injury, which was believed by the facility to be a fracture at that time.

e. On 10/14/08 at 9:30 a.m., the Administrator stated she did not understand that she was supposed to notify the police for "every" injury. She also stated the client, "did not have a fracture after all."

f. Arkansas Code Annotated 12-12-1701(b) (1) documented the following regarding incidents of abuse, neglect and injuries of unknown origin: "A report for a long term care facility resident shall be made (A) Immediately to the local law enforcement for the jurisdiction in which the long-term care facility is located; and (B) To the Office of Long-Term Care of the Division of Medical Services of the Department of Health and Human Services, under regulations of that office."

W 153

W 441

483.470(i)(1) EVACUATION DRILLS

The facility must hold evacuation drills under varied conditions.

This STANDARD is not met as evidenced by:

W 441

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

PRINTED: 10/30/2008  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04G007</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/16/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>SOUTHEAST ARKANSAS HUMAN DEVELOPMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 CENTER CIRCLE WARREN, AR 71671</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)	
W 441	<p>Continued From page 2</p> <p>Based on record review and interview, the facility failed to ensure evacuation drills were conducted in various weather conditions. The failed practice had the potential to affect all 76 clients, as documented on the Intermediate Care Facility for Persons with Mental Retardation Survey Report dated 10/16/08. The findings are:</p> <p>On 10/13/08, the facility's evacuation drill documentation for the past 12 months was reviewed. There was no documentation of the weather conditions at the time of the drills to show that drills were conducted under varying weather conditions.</p>	W 441		

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

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NAME OF PROVIDER OR SUPPLIER  <b>SOUTHEAST ARKANSAS HUMAN DEVELOPMENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1 CENTER CIRCLE WARREN, AR 71671</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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is in compliance with Title 42, Code of Federal Regulations 483.70(a), life safety from fire.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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