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ARKADELPHIA HUMAN DEVELOPMENT CENTER	**1 PRATOR DRIVE ARKADELPHIA, AR 71923**

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W 000	INITIAL COMMENTS A complaint investigation was conducted on 5/19/09. Complaint #14516 was unsubstantiated.	W 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.

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	04G002	A. BUILDING 01 B. WING _____	02/23/2009

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K 000	INITIAL COMMENTS The findings on this statement of deficiencies demonstrate non-compliance with Title 42, Code of Regulations 483.70(a), life safety from fire. The requirement is not met, as evidenced by the facility's failure to meet the National Fire Protection Association code(s) cited.	K 000		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure the emergency generators had the appropriate signage posted, had the required annunciator panel to allow 24-hour monitoring and had weekly specific gravity battery testing completed as required. The failed practices had the potential to affect all 132 clients, as identified by Administration staff on 2/23/09. The findings are: On 2/23/09 from 9:30 a.m. to 11:30 a.m., the following observations were made: a. The emergency generators had maintenance-free batteries installed; therefore, were not undergoing weekly checks of the	K 144		4/9/09

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K 144	Continued From page 1 batteries' specific gravity as required. b. There was no annunciator panel for the generators, to allow them to be monitored for potential problems 24 hours per day. c. The generators were protected by a chain-link fence, but did not have the required, "No Smoking" signage posted.	K 144		

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W 000	INITIAL COMMENTS A complaint survey was conducted from 8/4/08 to 8/6/08. Complaint #13763 was substantiated (all or in part) with deficiencies cited at W102, W104 W122, W127 and W186.	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: Complaint #13763 was substantiated (all or in part) with these findings. Based on record review and interview, the facility failed to meet the requirements of 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 immediately develop and implement a comprehensive corrective and proactive plan to correct deficient practices that led to the elopement and subsequent death of Client #1. These failed practices resulted in Immediate Jeopardy which caused or could have caused serious injury, harm or death to Client #1 who eloped from the facility and subsequently drowned. The Administrator was informed of the Immediate Jeopardy on 8/4/08 at 4:30 p.m. The findings are:	W 102		9/5/08

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W 102	Continued From page 1	W 102		

1. The facility failed to meet the Standard of Governing Body at W104 as evidenced by the facility's failure to immediately develop and implement a comprehensive corrective and proactive plan to correct deficient practices that led to the elopement and subsequent death of Client #1. Refer to W104.

2. The facility failed to meet the Condition of Participation for Client Protections at W122 as evidenced by the facility's failure to provide supervision and protection to 1 (Client #1) of 1 (Client #1) sampled client with a history of elopement attempts. Refer to W122.

3. The facility failed meet the Standard of Protection of Client Rights as evidenced by the facility staff's failure to implement policies related to the proper supervision of clients, which resulted in the elopement and death of Client #1. Refer to W127

4. The facility failed meet the Standard of Direct Care Staff as evidenced by the facility's failure to provide sufficient direct care staff to meet the supervisory needs of the clients. Refer to W186

5. The Immediate Jeopardy was removed on 8/4/08 at 5:10 p.m. when the facility implemented the following plan of removal:

a. "The exterior doors of the game room in 285 Oak were changed to a key lock this morning. A key is required to enter and exit this room. These doors, like the bedroom doors that open into the woods, should remain locked at all times."

b. "The gate in the fence on the old road

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between 286 Oak and 287 Pine was secured with a chain and padlock yesterday but the chain was so loose that [Client #1] was able to open the gate enough to squeeze through. This was corrected last night and all gates were checked today and all were secure."

c. "The Individual Monitoring Report is being revised and will require that every person in every residence is accounted for every 30 minutes while they are in the residences. Groupings are posted and the group leader is responsible for entering the status of his/her group at 30 minute intervals. All entries are not to be done by one person; the status is to be entered by the group leader responsible for that person served."

d. "Documented in-service on this memo and the change in the individual monitoring form is to be completed with all staff beginning with the staff on duty this evening and completed with other staff as they come on duty. The new individual Monitoring Report will be implemented in every residence at 10:00 p.m. this evening."

e. "Effective immediately all managers, Program Supervisors, Program Coordinators and others as designated by their Service Area Directors will randomly monitor in the residences, asking to see the Individual Monitoring Report to ensure that it is being completed per the above instructions and they will also be making visual observations. This begins effective today. Those monitoring are to sign off (name, title, date and time) on the Individual Monitoring Report. Quality Assurance staff and I [Superintendent] will also be monitoring plus checking to ensure that others are randomly

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W 102	Continued From page 3 making rounds. Any exceptions found are to be reported directly to me by e-mail." f. "Any disruptive event that occurs at shift change or any time during the shift will be handled and then immediately followed by a head count to ensure that all people served in the residence are present." g. "The Maintenance Supervisor will develop a monitoring document to be utilized to check all gates in the security fence at least monthly. The form will provide space for the date and time of the check to be recorded, along with the signature and title of the person checking the gates and the status of the security of the gates. Any lack of security or tampering with the gates will be reported immediately to the Superintendent for investigation. The form will include space for a notation regarding the nature of the immediate repair or action taken to ensure the security of the facility and the safety of people served. The form will be used to document any time the gates are opened and closed, including all the information (date, time, employee, title, status of the security of the gates, reason for opening/closing the gates). Keys to the gates will be maintained only in Maintenance, the Superintendent's off and the Center vault. The form will be developed, implemented and incoming staff will be in-serviced on this procedure effective August 6, 2008."	W 102		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.	W 104		9/5/08

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This STANDARD is not met as evidenced by:
Complaint #13763 was substantiated (all or in part) with these findings.

Based on record review and interview, the facility failed to ensure adequate supervision and monitoring were provided for 1 (Client #1) of 1 (Client #1) sampled client with a history of elopement attempts. The facility also failed to immediately develop and implement a comprehensive corrective and proactive plan to correct deficient practices that led to the elopement and subsequent death of Client #1. The failed practices resulted in Immediate Jeopardy which caused or could have caused serious injury, harm or death to Client #1 who eloped from the facility and subsequently drowned. The Administrator was informed of the Immediate Jeopardy on 8/4/08 at 4:30 p.m. The findings are:

1. Client #1 had diagnoses of Profound Mental Retardation (MR) and Tonic-Clonic Seizure Disorder.

a. A Behavior Incident Report (BIR) dated 4/14/07 at 4:50 p.m. documented: "Behavior... running away. [Client #1] ate his supper and then left the kitchen. He went to the bathroom and then went into the game room, unlocked the door and ran out the door. Staff asked [Client #1] to stop and come back to the home. [Staff #1] kept running toward the parking lot while staff was trying to catch [Client #1] and escort him back to the home. Staff stopped [Client #1] on the service road before he could get off campus."

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b. A BIR dated 6/30/07 at 2:40 p.m. documented: "Behavior... Running away... [Client #1] ran outside he was brought back by recreation Supervisor."

c. The Individual Program Plan (IPP) dated 1/15/08 documented: "Barriers... Sometimes, I leave an area without telling anyone and they worry about my safety. I don't seem to be aware or afraid of dangerous situations... Services/Supports... Staff watch me while traveling to and from areas on-campus to make sure I follow my schedule. If I need to go to a place I don't usually go to, it is best if someone goes with me to make sure I don't wander off... Outcome... I participate in the life of the community... I'm not able to find my way around safely in the community so staff always goes with me to make sure I don't wander off and can get back to the Center without any problems."

d. The Vocational Assessment form dated 1/15/08 documented on page 4, "[Client #1] requires visual surveillance when on grounds."

e. A BIR dated 1/14/08 at 8:25 a.m. documented: "Behavior... Running away... Staff went to take a person serve to medical. Staff noticed [Client #1] looking out the window will [while] staff was assisting with another person serve. [Client #1] ran out of the building up the sidewalk to the Administration building. [Client #1] was escorted back to 285 Oak."

f. A memo dated 2/26/08 from the Living Unit 285 Oak Life Skills Trainer Supervisor documented a group schedule for the 6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m. shifts to follow when there were only 2 staff working in

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285 Oak. Client #1 was assigned to Group A. The memo documented, "Staff will indicate in the log which group they had that day or night."

g. On 8/4/08 at approximately 4:00 p.m., the Superintendent and Quality Assurance Coordinator (QAC) were interviewed and the following information was obtained:

1.) On 8/3/08 during the 6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m. shift change in Living Unit 285 Oak, Client #1 left the living unit through an unlocked door in the game room. The QAC described the locking mechanism on the game room door as a hand-operated turn-bolt type. The gate in the fence on the old road between Living Units 286 Oak and 287 Pine was secured with a chain and padlock; however, the chain was loose enough for Client #1 to squeeze through. Client #1 made his way to the spillway on the lower lake, where he drowned. There were 12 clients assigned to 2 staff (Staff #1 and #2) on the evening shift that day. The Superintendent and QAC both agreed that Client #1 only required a 1 staff to 8 clients level of supervision while in the living unit.

2.) The Superintendent stated the facility had an Accountability Policy which stated clients were to be, "supervised and accounted for at all times;" however, "the system was not followed yesterday [8/3/08]."

The facility's policy and procedure titled, "Accountability for People" dated December 2007 and revised July 2008 documented: "...Accountability for People. a. Shift Change. POLICY: Staff in the homes shall maintain accountability for an assigned group of people

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during the shift, to include documentation of their whereabouts at shift change. PROCEDURES: (1) Staff/people assignments shall be posted in each home by the Life Skills Trainer Supervisor. (2) Assigned alternate group leaders shall assume responsibility for the group in the event of the group leader's absence. (3) At the beginning of each shift, the whereabouts of all people shall be documented by staff in the log. The incoming staff shall review and verify the notation. Both staff shall sign the log to indicate the transfer of groups. (4) The supervisor in charge shall be immediately notified if the staff is unable to account for a person's whereabouts. (5) In the event of the absence of group leaders and alternates, staff assignments shall be made and documented in the log by the supervisor in charge."

3.) The QAC stated the 2:00 p.m. to 10:00 p.m. staff failed to sign off on the Accountability of People Log Sheet during the shift change. This was confirmed by the surveyor's review of the photocopied log sheet provided by the QAC at the time of the interview. No staff had signed off on the Log Sheet for the 2:00 p.m. to 10:00 p.m. shift on 8/3/08. There was an entry on the 2:00 p.m. time slot for Client #1, which documented: "AU [awake and up]." The client checks were documented hourly on the hour. The 6:00 a.m. to 2:00 p.m. shift had signed off on this sheet. The QAC stated there had not been a head count conducted between the day and evening shift staff.

4.) The QAC stated that due to a disruptive chain of events at shift change, Staff #1 and #2 on the evening shift had not ascertained the group assignments prior to Client #1's

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elopement. The QAC stated 8/3/08 was Staff #2's first time to be assigned to Living Unit 285 Oak and that Staff #2 was not familiar with the clients, inclusive of Client #1.

5.) Upon the surveyor's entrance to the facility on 8/4/08, the Quality Assurance Coordinator and Superintendent could not provide documentation of a new comprehensive, proactive plan of client supervision as a result of Client #1's death or any new inservices to staff related to client supervision. Prior to the citation of the Immediate Jeopardy at 4:30 p.m. on 8/4/08, the aforementioned staff confirmed the facility conducted hourly checks on the clients unless they were under some type of enhanced supervision. There was no new inservice of staff on correct client supervision or an increase in frequency of client head counts. The aforementioned staff stated they had checked the security of the gates in question, however the facility had not developed a plan to monitor the security of the gates.

h. The written statement of Staff #1 (a Life Skills Trainer I) was dated 8/3/08 at 3:39 p.m. and documented that upon arrival to the living unit at 2:00 p.m., he retrieved Client #3 from the kitchen. Staff #1 then escorted Client #4 back into the living unit as he [the client] was trying to go to the canteen. Staff #1 then took Client #2 to the restroom because he was seizure prone. While in the restroom Client #5 leaned on a basin, causing it to fall to the floor and break. After assisting Client #2, Staff #1 documented, "I called maintenance, they came and took out the broken basin and I cleaned up the floor. As I had seen everyone except [Client #1], I began to look for him. This was around 2:25 to 2:30 p.m.

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Unable to locate him, called the Program Supervisor to see if he was on an off campus trip." Staff #1's title is Life Skills Trainer (LST) I.

i. The written statement of Staff #2 (a Life Skills Trainer Trainee) was dated 8/3/08 at 9:03 p.m. and documented, "When I arrived at 285 Oak between 2:10 p.m. and 2:15 p.m. I met with [Staff #1] and he was in the front room area. [Staff #1] told me he was going to be in the restroom cause someone had broken the sink. I sat in the front room with seven people, (with two in the game room). After checking the game room and sitting down [Staff #1] notified me that he had to call maintenance man to fix the sink, and shortly afterwards that he had a person served missing, [Client #1]. This being my first time in 285 Oak, I had no visual idea of whom he was, nor was he where [Staff #1] assumed he was. [Staff #1] informed me that no head count was done by him and the 6-2 [6:00 a.m. to 2:00 p.m.] employee, so he could have been in the game room, or somewhere hiding in a corner cause he liked to be by himself. [Staff #1] searched outside and in while I monitored the other people served. Shortly after looking through the entire building inside and outside, [Staff #1] called the Program Supervisor and stated we had a person missing."

j. The written statement of Staff #3 was dated 8/3/08 at 2:30 p.m. and documented, "On August 3, 2008 about 2:30 p.m. [Staff #1] called and stated [Client #1] was missing. I ask [sic] him did he see [Client #1] when he arrive [sic] at 2 p.m. He stated [Client #1] wasn't their [sic]."

k. The written statement of Staff #4 was dated 8/3/08 at 7:00 a.m. and documented, "I went into

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the kitchen where a few people served were eating breakfast, [Client #1] being one of those persons served. After breakfast, a few went to bed, some were in the living room watching television and a few in the game room. [Client #1] was one of the few in the game room. The game room is normally where [Client #1] goes throughout the day. There is a door in the game room, which is not too far from the window, but it is kept locked. But a few person's served do know how to unlock the door. I have never observed [Client #1] unlocking any door or running off. The last time I saw [Client #1] was right before shift change. I was sitting on the couch with other people served and I looked through the game room windows and saw [Client #1] standing in the same spot he's always in, which is the window by the pinball machine."

l. A Maltreatment/Neglect Investigation form dated 8/3/08 and signed by the Superintendent documented, "[QAC] called me at home at 3:18 p.m. She was called at 3:15 p.m. by [Staff #3] LST [Life Skills Trainer] II who was supervising due to the fact that [Client #1] was missing. As I was talking w/ [with] [QAC] I looked out my kitchen window & [and] saw a [local law enforcement] Police Officer going down Lower Dam Pike at a high rate of speed with lights flashing. I told [QAC] to go to the center & assist with the search & I was going to the spillway in the direction of the officer. I met a member of the rescue squad, identified myself & told him I was searching for a client. He radioed a [local law enforcement] officer who sent a Sargent [sic] to talk with me. The rescue squad member advised me there was a body in the water just below the Spillway Dam. They allowed me to accompany them to the other side of the river.

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[QAC] brought a face sheet w/ [Client #1's] photo. At 4:15 p.m., I identified the body as that of [Client #1]. The officers advised that the body appeared as though it had been in the water since earlier this morning. The Coroner will determine time & cause of death. The State Police are currently investigating."

m. On 8/6/08, the QAC provided a faxed copy of the Log Sheets dated 8/3/08 for the 2:00 p.m. to 10:00 p.m. shift. Client #1's 2:00 p.m. hourly check on 8/3/08, which documented "AU" had a line crossed through it and both staff members (Staff #1 and #2) for the evening shift had full signatures on the sheets. The 10:00 p.m. to 6:00 a.m. shift had signed off on the log sheet and documented the hourly checks. Client #2 had half hour checks documented during hours of sleep from 10:00 p.m. to 6:00 a.m.

2. The Immediate Jeopardy was removed on 8/4/08 at 5:10 p.m. when the facility implemented the following plan of removal:

a. "The exterior doors of the game room in 285 Oak were changed to a key lock this morning. A key is required to enter and exit this room. These doors, like the bedroom doors that open into the woods, should remain locked at all times."

b. "The gate in the fence on the old road between 286 Oak and 287 Pine was secured with a chain and padlock yesterday but the chain was so loose that [Client #1] was able to open the gate enough to squeeze through. This was corrected last night and all gates were checked today and all were secure."

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c. "The Individual Monitoring Report is being revised and will require that every person in every residence is accounted for every 30 minutes while they are in the residences. Groupings are posted and the group leader is responsible for entering the status of his/her group at 30 minute intervals. All entries are not to be done by one person; the status is to be entered by the group leader responsible for that person served."

d. "Documented in-service on this memo and the change in the individual monitoring form is to be completed with all staff beginning with the staff on duty this evening and completed with other staff as they come on duty. The new individual Monitoring Report will be implemented in every residence at 10:00 p.m. this evening."

e. "Effective immediately all managers, Program Supervisors, Program Coordinators and others as designated by their Service Area Directors will randomly monitor in the residences, asking to see the Individual Monitoring Report to ensure that it is being completed per the above instructions and they will also be making visual observations. This begins effective today. Those monitoring are to sign off (name, title, date and time) on the Individual Monitoring Report. Quality Assurance staff and I [Superintendent] will also be monitoring plus checking to ensure that others are randomly making rounds. Any exceptions found are to be reported directly to me by e-mail."

f. "Any disruptive event that occurs at shift change or any time during the shift will be handled and then immediately followed by a head count to ensure that all people served in

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W 104	Continued From page 13 the residence are present." g. "The Maintenance Supervisor will develop a monitoring document to be utilized to check all gates in the security fence at least monthly. The form will provide space for the date and time of the check to be recorded, along with the signature and title of the person checking the gates and the status of the security of the gates. Any lack of security or tampering with the gates will be reported immediately to the Superintendent for investigation. The form will include space for a notation regarding the nature of the immediate repair or action taken to ensure the security of the facility and the safety of people served. The form will be used to document any time the gates are opened and closed, including all the information (date, time, employee, title, status of the security of the gates, reason for opening/closing the gates). Keys to the gates will be maintained only in Maintenance, the Superintendent's off and the Center vault. The form will be developed, implemented and incoming staff will be in-serviced on this procedure effective August 6, 2008."	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Complaint #13763 was substantiated (all or in part) with these findings. Based on record review and interview, the facility failed to meet the requirements of the Condition	W 122		9/5/08

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of Participation (CoP) for Client Protections (W122) as evidenced by the facility's failure to adequately supervise and protect 1 (Client #1) of 1 (Client #1) sampled client with a history of elopement attempts. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious injury, harm or death to Client #1 who eloped from the facility and subsequently drowned. The Administrator was informed of the Immediate Jeopardy on 8/4/08 at 4:30 p.m. The findings are:

1. The facility failed meet the Standard of Protection of Client Rights as evidenced by the facility staff's failure to implement policies related to the proper supervision of clients, which resulted in the elopement and death of Client #1. Refer to W127

2. The facility failed meet the Standard of Direct Care Staff as evidenced by the facility's failure to provide sufficient direct care staff to meet the supervisory needs of the clients. Refer to W186

3. The Immediate Jeopardy was removed on 8/4/08 at 5:10 p.m. when the facility implemented the following plan of removal:

a. "The exterior doors of the game room in 285 Oak were changed to a key lock this morning. A key is required to enter and exit this room. These doors, like the bedroom doors that open into the woods, should remain locked at all times."

b. "The gate in the fence on the old road between 286 Oak and 287 Pine was secured with a chain and padlock yesterday but the chain was so loose that [Client #1] was able to open the

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gate enough to squeeze through. This was corrected last night and all gates were checked today and all were secure."

c. "The Individual Monitoring Report is being revised and will require that every person in every residence is accounted for every 30 minutes while they are in the residences. Groupings are posted and the group leader is responsible for entering the status of his/her group at 30 minute intervals. All entries are not to be done by one person; the status is to be entered by the group leader responsible for that person served."

d. "Documented in-service on this memo and the change in the individual monitoring form is to be completed with all staff beginning with the staff on duty this evening and completed with other staff as they come on duty. The new individual Monitoring Report will be implemented in every residence at 10:00 p.m. this evening."

e. "Effective immediately all managers, Program Supervisors, Program Coordinators and others as designated by their Service Area Directors will randomly monitor in the residences, asking to see the Individual Monitoring Report to ensure that it is being completed per the above instructions and they will also be making visual observations. This begins effective today. Those monitoring are to sign off (name, title, date and time) on the Individual Monitoring Report. Quality Assurance staff and I [Superintendent] will also be monitoring plus checking to ensure that others are randomly making rounds. Any exceptions found are to be reported directly to me by e-mail."

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W 122	Continued From page 16 f. "Any disruptive event that occurs at shift change or any time during the shift will be handled and then immediately followed by a head count to ensure that all people served in the residence are present." g. "The Maintenance Supervisor will develop a monitoring document to be utilized to check all gates in the security fence at least monthly. The form will provide space for the date and time of the check to be recorded, along with the signature and title of the person checking the gates and the status of the security of the gates. Any lack of security or tampering with the gates will be reported immediately to the Superintendent for investigation. The form will include space for a notation regarding the nature of the immediate repair or action taken to ensure the security of the facility and the safety of people served. The form will be used to document any time the gates are opened and closed, including all the information (date, time, employee, title, status of the security of the gates, reason for opening/closing the gates). Keys to the gates will be maintained only in Maintenance, the Superintendent's off and the Center vault. The form will be developed, implemented and incoming staff will be in-serviced on this procedure effective August 6, 2008."	W 122		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS 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.	W 127		9/5/08

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W 127	Continued From page 17 This STANDARD is not met as evidenced by: Complaint #13763 was substantiated (all or in part) with these findings. Based on record review and interview, the facility failed to ensure adequate supervision and protection were provided to 1 (Client #1) of 1 (Client #1) sampled client with a history of elopement attempts. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious injury, harm or death to Client #1 who eloped from the facility and subsequently drowned. The Administrator was informed of the Immediate Jeopardy on 8/4/08 at 4:30 p.m. The findings are: 1. Client #1 had diagnoses of Profound Mental Retardation (MR) and Tonic-Clonic Seizure Disorder. a. A Behavior Incident Report (BIR) dated 4/14/07 at 4:50 p.m. documented: "Behavior... running away. [Client #1] ate his supper and then left the kitchen. He went to the bathroom and then went into the game room, unlocked the door and ran out the door. Staff asked [Client #1] to stop and come back to the home. [Staff #1] kept running toward the parking lot while staff was trying to catch [Client #1] and escort him back to the home. Staff stopped [Client #1] on the service road before he could get off campus." b. A BIR dated 6/30/07 at 2:40 p.m. documented: "Behavior... Running away... [Client #1] ran outside he was brought back by recreation Supervisor." c. The Individual Program Plan (IPP) dated 1/15/08 documented: "Barriers... Sometimes, I	W 127		

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leave an area without telling anyone and they worry about my safety. I don't seem to be aware or afraid of dangerous situations... Services/Supports... Staff watch me while traveling to and from areas on-campus to make sure I follow my schedule. If I need to go to a place I don't usually go to, it is best if someone goes with me to make sure I don't wander off... Outcome... I participate in the life of the community... I'm not able to find my way around safely in the community so staff always goes with me to make sure I don't wander off and can get back to the Center without any problems."

d. The Vocational Assessment form dated 1/15/08 documented on page 4, "[Client #1] requires visual surveillance when on grounds.

e. A BIR dated 1/14/08 at 8:25 a.m. documented: "Behavior... Running away... Staff went to take a person serve to medical. Staff noticed [Client #1] looking out the window will [while] staff was assisting with another person serve. [Client #1] ran out of the building up the sidewalk to the Administration building. [Client #1] was escorted back to 285 Oak."

f. A memo dated 2/26/08 from the Living Unit 285 Oak Life Skills Trainer Supervisor documented a group schedule for the 6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m. shifts to follow when there were only 2 staff working in 285 Oak. Client #1 was assigned to Group A. The memo documented, "Staff will indicate in the log which group they had that day or night."

g. On 8/4/08 at approximately 4:00 p.m., the Superintendent and Quality Assurance Coordinator (QAC) were interviewed and the

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following information was obtained:

1.) On 8/3/08 during the 6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m. shift change in Living Unit 285 Oak, Client #1 left the living unit through an unlocked door in the game room. The QAC described the locking mechanism on the game room door as a hand-operated turn-bolt type. The gate in the fence on the old road between Living Units 286 Oak and 287 Pine was secured with a chain and padlock; however, the chain was loose enough for Client #1 to squeeze through. Client #1 made his way to the spillway on the lower lake, where he drowned. There were 12 clients assigned to 2 staff (Staff #1 and #2) on the evening shift that day. The Superintendent and QAC both agreed that Client #1 only required a 1 staff to 8 clients level of supervision while in the living unit.

2.) The Superintendent stated the facility had an Accountability Policy which stated clients were to be, "supervised and accounted for at all times;" however, "the system was not followed yesterday [8/3/08]."

The facility's policy and procedure titled, "Accountability for People" dated December 2007 and revised July 2008 documented: "...Accountability for People. a. Shift Change. POLICY: Staff in the homes shall maintain accountability for an assigned group of people during the shift, to include documentation of their whereabouts at shift change. PROCEDURES: (1) Staff/people assignments shall be posted in each home by the Life Skills Trainer Supervisor. (2) Assigned alternate group leaders shall assume responsibility for the group in the event of the group leader's absence. (3) At the

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beginning of each shift, the whereabouts of all people shall be documented by staff in the log. The incoming staff shall review and verify the notation. Both staff shall sign the log to indicate the transfer of groups. (4) The supervisor in charge shall be immediately notified if the staff is unable to account for a person's whereabouts. (5) In the event of the absence of group leaders and alternates, staff assignments shall be made and documented in the log by the supervisor in charge."

3.) The QAC stated the 2:00 p.m. to 10:00 p.m. staff failed to sign off on the Accountability of People Log Sheet during the shift change. This was confirmed by the surveyor's review of the photocopied log sheet provided by the QAC at the time of the interview. No staff had signed off on the Log Sheet for the 2:00 p.m. to 10:00 p.m. shift on 8/3/08. There was an entry on the 2:00 p.m. time slot for Client #1, which documented: "AU [awake and up]." The client checks were documented hourly on the hour. The 6:00 a.m. to 2:00 p.m. shift had signed off on this sheet. The QAC stated there had not been a head count conducted between the day and evening shift staff.

4.) The QAC stated that due to a disruptive chain of events at shift change, Staff #1 and #2 on the evening shift had not ascertained the group assignments prior to Client #1's elopement. The QAC stated 8/3/08 was Staff #2's first time to be assigned to Living Unit 285 Oak and that Staff #2 was not familiar with the clients, inclusive of Client #1.

5.) As of 8/4/08 upon the Surveyor's entrance to the facility, the Quality Assurance Coordinator

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and Superintendent could not provide documentation of a new comprehensive, proactive plan of client supervision as a result of Client #1's death or any new inservices to staff related to client supervision. Prior to the citation of the Immediate Jeopardy at 4:30 p.m. on 8/4/08, the aforementioned staff confirmed the facility conducted hourly checks on the clients unless they were under some type of enhanced supervision. There was no new inservice of staff on correct client supervision or an increase in frequency of client head counts. The aforementioned staff stated they had checked the security of the gates in question, however the facility had not developed a plan to monitor the security of the gates.

h. The written statement of Staff #1 (a Life Skills Trainer I) was dated 8/3/08 at 3:39 p.m. and documented that upon arrival to the living unit at 2:00 p.m., he retrieved Client #3 from the kitchen. Staff #1 then escorted Client #4 back into the living unit as he [the client] was trying to go to the canteen. Staff #1 then took Client #2 to the restroom because he was seizure prone. While in the restroom Client #5 leaned on a basin, causing it to fall to the floor and break. After assisting Client #2, Staff #1 documented, "I called maintenance, they came and took out the broken basin and I cleaned up the floor. As I had seen everyone except [Client #1], I began to look for him. This was around 2:25 to 2:30 p.m. Unable to locate him, called the Program Supervisor to see if he was on an off campus trip." Staff #1's title is Life Skills Trainer (LST) I.

i. The written statement of Staff #2 (a Life Skills Trainer Trainee) was dated 8/3/08 at 9:03 p.m. and documented, "When I arrived at 285 Oak

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between 2:10 p.m. and 2:15 p.m. I met with [Staff #1] and he was in the front room area. [Staff #1] told me he was going to be in the restroom cause someone had broken the sink. I sat in the front room with seven people, (with two in the game room). After checking the game room and sitting down [Staff #1] notified me that he had to call maintenance man to fix the sink, and shortly afterwards that he had a person served missing, [Client #1]. This being my first time in 285 Oak, I had no visual idea of whom he was, nor was he where [Staff #1] assumed he was. [Staff #1] informed me that no head count was done by him and the 6-2 [6:00 a.m. to 2:00 p.m.] employee, so he could have been in the game room, or somewhere hiding in a corner cause he liked to be by himself. [Staff #1] searched outside and in while I monitored the other people served. Shortly after looking through the entire building inside and outside, [Staff #1] called the Program Supervisor and stated we had a person missing."

j. The written statement of Staff #3 was dated 8/3/08 at 2:30 p.m. and documented, "On August 3, 2008 about 2:30 p.m. [Staff #1] called and stated [Client #1] was missing. I ask [sic] him did he see [Client #1] when he arrive [sic] at 2 p.m. He stated [Client #1] wasn't their [sic]."

k. The written statement of Staff #4 was dated 8/3/08 at 7:00 a.m. and documented, "I went into the kitchen where a few people served were eating breakfast, [Client #1] being one of those persons served. After breakfast, a few went to bed, some were in the living room watching television and a few in the game room. [Client #1] was one of the few in the game room. The game room is normally where [Client #1] goes

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throughout the day. There is a door in the game room, which is not too far from the window, but it is kept locked. But a few person's served do know how to unlock the door. I have never observed [Client #1] unlocking any door or running off. The last time I saw [Client #1] was right before shift change. I was sitting on the couch with other people served and I looked through the game room windows and saw [Client #1] standing in the same spot he's always in, which is the window by the pinball machine."

I. A Maltreatment/Neglect Investigation form dated 8/3/08 and signed by the Superintendent documented, "[QAC] called me at home at 3:18 p.m. She was called at 3:15 p.m. by [Staff #3] LST [Life Skills Trainer] II who was supervising due to the fact that [Client #1] was missing. As I was talking w/ [with] [QAC] I looked out my kitchen window & [and] saw a [local law enforcement] Police Officer going down Lower Dam Pike at a high rate of speed with lights flashing. I told [QAC] to go to the center & assist with the search & I was going to the spillway in the direction of the officer. I met a member of the rescue squad, identified myself & told him I was searching for a client. He radioed a [local law enforcement] officer who sent a Sargent [sic] to talk with me. The rescue squad member advised me there was a body in the water just below the Spillway Dam. They allowed me to accompany them to the other side of the river. [QAC] brought a face sheet w/ [Client #1's] photo. At 4:15 p.m., I identified the body as that of [Client #1]. The officers advised that the body appeared as though it had been in the water since earlier this morning. The Coroner will determine time & cause of death. The State Police are currently investigating."

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m. On 8/6/08, the QAC provided a faxed copy of the Log Sheets dated 8/3/08 for the 2:00 p.m. to 10:00 p.m. shift. Client #1's 2:00 p.m. hourly check on 8/3/08, which documented "AU" had a line crossed through it and both staff members (Staff #1 and #2) for the evening shift had full signatures on the sheets. The 10:00 p.m. to 6:00 a.m. shift had signed off on the log sheet and documented the hourly checks. Client #2 had half hour checks documented during hours of sleep from 10:00 p.m. to 6:00 a.m.

2. The IJ was removed on 8/4/08 at 5:10 p.m. when the facility implemented the following plan of removal:

1.) "The exterior doors of the game room in 285 Oak were changed to a key lock this morning. A key is required to enter and exit this room. These doors, like the bedroom doors that open into the woods, should remain locked at all times."

2.) "The gate in the fence on the old road between 286 Oak and 287 Pine was secured with a chain and padlock yesterday but the chain was so loose that [Client #1] was able to open the gate enough to squeeze through. This was corrected last night and all gates were checked today and all were secure."

3.) "The Individual Monitoring Report is being revised and will require that every person in every residence is accounted for every 30 minutes while they are in the residences. Groupings are posted and the group leader is responsible for entering the status of his/her group at 30 minute intervals. All entries are not

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to be done by one person; the status is to be entered by the group leader responsible for that person served."

4.) "Documented in-service on this memo and the change in the individual monitoring form is to be completed with all staff beginning with the staff on duty this evening and completed with other staff as they come on duty. The new individual Monitoring Report will be implemented in every residence at 10:00 p.m. this evening."

5.) "Effective immediately all managers, Program Supervisors, Program Coordinators and others as designated by their Service Area Directors will randomly monitor in the residences, asking to see the Individual Monitoring Report to ensure that it is being completed per the above instructions and they will also be making visual observations. This begins effective today. Those monitoring are to sign off (name, title, date and time) on the Individual Monitoring Report. Quality Assurance staff and I [Superintendent] will also be monitoring plus checking to ensure that others are randomly making rounds. Any exceptions found are to be reported directly to me by e-mail."

6.) "Any disruptive event that occurs at shift change or any time during the shift will be handled and then immediately followed by a head count to ensure that all people served in the residence are present."

7.) "The Maintenance Supervisor will develop a monitoring document to be utilized to check all gates in the security fence at least monthly. The form will provide space for the date and time of the check to be recorded, along with the

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W 127	Continued From page 26 signature and title of the person checking the gates and the status of the security of the gates. Any lack of security or tampering with the gates will be reported immediately to the Superintendent for investigation. The form will include space for a notation regarding the nature of the immediate repair or action taken to ensure the security of the facility and the safety of people served. The form will be used to document any time the gates are opened and closed, including all the information (date, time, employee, title, status of the security of the gates, reason for opening/closing the gates). Keys to the gates will be maintained only in Maintenance, the Superintendent's off and the Center vault. The form will be developed, implemented and incoming staff will be in-serviced on this procedure effective August 6, 2008."	W 127		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Complaint #13763 was substantiated (all or in part) with these findings. Based on record review and interview, the facility failed to ensure staff implemented procedures to prevent neglect, as evidenced by failure to ensure adequate supervision and monitoring were provided for 1 (Client #1) of 1 sampled client with a history of elopement attempts, which resulted in the elopement and drowning death of Client #1. The findings are:	W 149		9/5/08

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W 149	Continued From page 27 1. The facility's policy and procedure titled, "Accountability for People" dated December 2007 and revised July 2008 documented: "...Accountability for People. a. Shift Change. POLICY: Staff in the homes shall maintain accountability for an assigned group of people during the shift, to include documentation of their whereabouts at shift change. PROCEDURES: (1) Staff/people assignments shall be posted in each home by the Life Skills Trainer Supervisor. (2) Assigned alternate group leaders shall assume responsibility for the group in the event of the group leader's absence. (3) At the beginning of each shift, the whereabouts of all people shall be documented by staff in the log. The incoming staff shall review and verify the notation. Both staff shall sign the log to indicate the transfer of groups. (4) The supervisor in charge shall be immediately notified if the staff is unable to account for a person's whereabouts. (5) In the event of the absence of group leaders and alternates, staff assignments shall be made and documented in the log by the supervisor in charge." 2. Client #1 had diagnoses of Profound Mental Retardation (MR) and Tonic-Clonic Seizure Disorder. a. A Behavior Incident Report (BIR) dated 4/14/07 at 4:50 p.m. documented: "Behavior... running away. [Client #1] ate his supper and then left the kitchen. He went to the bathroom and then went into the game room, unlocked the door and ran out the door. Staff asked [Client #1] to stop and come back to the home. [Staff #1] kept running toward the parking lot while staff was trying to catch [Client #1] and escort him	W 149		

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back to the home. Staff stopped [Client #1] on the service road before he could get off campus."

b. A BIR dated 6/30/07 at 2:40 p.m. documented: "Behavior... Running away... [Client #1] ran outside he was brought back by recreation Supervisor."

c. The Individual Program Plan (IPP) dated 1/15/08 documented: "Barriers... Sometimes, I leave an area without telling anyone and they worry about my safety. I don't seem to be aware or afraid of dangerous situations... Services/Supports... Staff watch me while traveling to and from areas on-campus to make sure I follow my schedule. If I need to go to a place I don't usually go to, it is best if someone goes with me to make sure I don't wander off... Outcome... I participate in the life of the community... I'm not able to find my way around safely in the community so staff always goes with me to make sure I don't wander off and can get back to the Center without any problems."

d. The Vocational Assessment form dated 1/15/08 documented on page 4, "[Client #1] requires visual surveillance when on grounds.

e. A BIR dated 1/14/08 at 8:25 a.m. documented: "Behavior... Running away... Staff went to take a person serve to medical. Staff noticed [Client #1] looking out the window will [while] staff was assisting with another person serve. [Client #1] ran out of the building up the sidewalk to the Administration building. [Client #1] was escorted back to 285 Oak."

f. A memo dated 2/26/08 from the Living Unit 285 Oak Life Skills Trainer Supervisor

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documented a group schedule for the 6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m. shifts to follow when there were only 2 staff working in 285 Oak. Client #1 was assigned to Group A. The memo documented, "Staff will indicate in the log which group they had that day or night."

g. On 8/4/08 at approximately 4:00 p.m., the Superintendent and Quality Assurance Coordinator (QAC) were interviewed and the following information was obtained:

1.) On 8/3/08 during the 6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m. shift change in Living Unit 285 Oak, Client #1 left the living unit through an unlocked door in the game room. The QAC described the locking mechanism on the game room door as a hand-operated turn-bolt type. The gate in the fence on the old road between Living Units 286 Oak and 287 Pine was secured with a chain and padlock; however, the chain was loose enough for Client #1 to squeeze through. Client #1 made his way to the spillway on the lower lake, where he drowned. There were 12 clients assigned to 2 staff (Staff #1 and #2) on the evening shift that day. The Superintendent and QAC both agreed that Client #1 only required a 1 staff to 8 clients level of supervision while in the living unit.

2.) The Superintendent stated the facility had an Accountability Policy which stated clients were to be, "supervised and accounted for at all times;" however, "the system was not followed yesterday [8/3/08]."

3.) The QAC stated the 2:00 p.m. to 10:00 p.m. staff failed to sign off on the Accountability of People Log Sheet during the shift change. This

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was confirmed by the surveyor's review of the photocopied log sheet provided by the QAC at the time of the interview. No staff had signed off on the Log Sheet for the 2:00 p.m. to 10:00 p.m. shift on 8/3/08. There was an entry on the 2:00 p.m. time slot for Client #1, which documented: "AU [awake and up]." The client checks were documented hourly on the hour. The 6:00 a.m. to 2:00 p.m. shift had signed off on this sheet. The QAC stated there had not been a head count conducted between the day and evening shift staff.

4.) The QAC stated that due to a disruptive chain of events at shift change, Staff #1 and #2 on the evening shift had not ascertained the group assignments prior to Client #1's elopement. The QAC stated 8/3/08 was Staff #2's first time to be assigned to Living Unit 285 Oak and that Staff #2 was not familiar with the clients, inclusive of Client #1.

5.) Upon the surveyor's entrance to the facility on 8/4/08, the Quality Assurance Coordinator and Superintendent could not provide documentation of a new comprehensive, proactive plan of client supervision as a result of Client #1's death or any new inservices to staff related to client supervision. Prior to the citation of the Immediate Jeopardy at 4:30 p.m. on 8/408, the aforementioned staff confirmed the facility conducted hourly checks on the clients unless they were under some type of enhanced supervision. There was no new inservice of staff on correct client supervision or an increase in frequency of client head counts. The aforementioned staff stated they had checked the security of the gates in question, however the facility had not developed a plan to monitor the

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security of the gates.

h. The written statement of Staff #1 (a Life Skills Trainer I) was dated 8/3/08 at 3:39 p.m. and documented that upon arrival to the living unit at 2:00 p.m., he retrieved Client #3 from the kitchen. Staff #1 then escorted Client #4 back into the living unit as he [the client] was trying to go to the canteen. Staff #1 then took Client #2 to the restroom because he was seizure prone. While in the restroom Client #5 leaned on a basin, causing it to fall to the floor and break. After assisting Client #2, Staff #1 documented, "I called maintenance, they came and took out the broken basin and I cleaned up the floor. As I had seen everyone except [Client #1], I began to look for him. This was around 2:25 to 2:30 p.m. Unable to locate him, called the Program Supervisor to see if he was on an off campus trip." Staff #1's title is Life Skills Trainer (LST) I.

i. The written statement of Staff #2 (a Life Skills Trainer Trainee) was dated 8/3/08 at 9:03 p.m. and documented, "When I arrived at 285 Oak between 2:10 p.m. and 2:15 p.m. I met with [Staff #1] and he was in the front room area. [Staff #1] told me he was going to be in the restroom cause someone had broken the sink. I sat in the front room with seven people, (with two in the game room). After checking the game room and sitting down [Staff #1] notified me that he had to call maintenance man to fix the sink, and shortly afterwards that he had a person served missing, [Client #1]. This being my first time in 285 Oak, I had no visual idea of whom he was, nor was he where [Staff #1] assumed he was. [Staff #1] informed me that no head count was done by him and the 6-2 [6:00 a.m. to 2:00 p.m.] employee, so he could have been in the

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game room, or somewhere hiding in a corner cause he liked to be by himself. [Staff #1] searched outside and in while I monitored the other people served. Shortly after looking through the entire building inside and outside, [Staff #1] called the Program Supervisor and stated we had a person missing."

j. The written statement of Staff #3 was dated 8/3/08 at 2:30 p.m. and documented, "On August 3, 2008 about 2:30 p.m. [Staff #1] called and stated [Client #1] was missing. I ask [sic] him did he see [Client #1] when he arrive [sic] at 2 p.m. He stated [Client #1] wasn't their [sic]."

k. The written statement of Staff #4 was dated 8/3/08 at 7:00 a.m. and documented, "I went into the kitchen where a few people served were eating breakfast, [Client #1] being one of those persons served. After breakfast, a few went to bed, some were in the living room watching television and a few in the game room. [Client #1] was one of the few in the game room. The game room is normally where [Client #1] goes throughout the day. There is a door in the game room, which is not too far from the window, but it is kept locked. But a few person's served do know how to unlock the door. I have never observed [Client #1] unlocking any door or running off. The last time I saw [Client #1] was right before shift change. I was sitting on the couch with other people served and I looked through the game room windows and saw [Client #1] standing in the same spot he's always in, which is the window by the pinball machine."

l. A Maltreatment/Neglect Investigation form dated 8/3/08 and signed by the Superintendent documented, "[QAC] called me at home at 3:18

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W 149	Continued From page 33 p.m. She was called at 3:15 p.m. by [Staff #3] LST [Life Skills Trainer] II who was supervising due to the fact that [Client #1] was missing. As I was talking w/ [with] [QAC] I looked out my kitchen window & [and] saw a [local law enforcement] Police Officer going down Lower Dam Pike at a high rate of speed with lights flashing. I told [QAC] to go to the center & assist with the search & I was going to the spillway in the direction of the officer. I met a member of the rescue squad, identified myself & told him I was searching for a client. He radioed a [local law enforcement] officer who sent a Sargent [sic] to talk with me. The rescue squad member advised me there was a body in the water just below the Spillway Dam. They allowed me to accompany them to the other side of the river. [QAC] brought a face sheet w/ [Client #1's] photo. At 4:15 p.m., I identified the body as that of [Client #1]. The officers advised that the body appeared as though it had been in the water since earlier this morning. The Coroner will determine time & cause of death. The State Police are currently investigating." m. On 8/6/08, the QAC provided a faxed copy of the Log Sheets dated 8/3/08 for the 2:00 p.m. to 10:00 p.m. shift. Client #1's 2:00 p.m. hourly check on 8/3/08, which documented "AU" had a line crossed through it and both staff members (Staff #1 and #2) for the evening shift had full signatures on the sheets. The 10:00 p.m. to 6:00 a.m. shift had signed off on the log sheet and documented the hourly checks. Client #2 had half hour checks documented during hours of sleep from 10:00 p.m. to 6:00 a.m.	W 149		
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care	W 186		9/5/08

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staff to manage and supervise clients in accordance with their individual program plans.

Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

This STANDARD is not met as evidenced by:
Complaint #13763 was substantiated (all or in part) with these findings.

Based on record review and interview, the facility failed to ensure sufficient direct care staff were available to provide adequate supervision and monitoring of 1 (Client #1) of 1 sampled client with a history of elopement. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious injury, harm or death to Client #1 who eloped from the facility and subsequently drowned. The Administrator was informed of the Immediate Jeopardy on 8/4/08 at 4:30 p.m. The findings are:

1. Client #1 had diagnoses of Profound Mental Retardation (MR) and Tonic-Clonic Seizure Disorder.

a. A Behavior Incident Report (BIR) dated 4/14/07 at 4:50 p.m. documented: "Behavior... running away. [Client #1] ate his supper and then left the kitchen. He went to the bathroom and then went into the game room, unlocked the door and ran out the door. Staff asked [Client #1] to stop and come back to the home. [Staff #1] kept running toward the parking lot while staff was trying to catch [Client #1] and escort him back to the home. Staff stopped [Client #1] on

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ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(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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the service road before he could get off campus."

b. A BIR dated 6/30/07 at 2:40 p.m. documented: "Behavior... Running away... [Client #1] ran outside he was brought back by recreation Supervisor."

c. The Individual Program Plan (IPP) dated 1/15/08 documented: "Barriers... Sometimes, I leave an area without telling anyone and they worry about my safety. I don't seem to be aware or afraid of dangerous situations... Services/Supports... Staff watch me while traveling to and from areas on-campus to make sure I follow my schedule. If I need to go to a place I don't usually go to, it is best if someone goes with me to make sure I don't wander off... Outcome... I participate in the life of the community... I'm not able to find my way around safely in the community so staff always goes with me to make sure I don't wander off and can get back to the Center without any problems."

d. The Vocational Assessment form dated 1/15/08 documented on page 4, "[Client #1] requires visual surveillance when on grounds.

e. A BIR dated 1/14/08 at 8:25 a.m. documented: "Behavior... Running away... Staff went to take a person serve to medical. Staff noticed [Client #1] looking out the window will [while] staff was assisting with another person serve. [Client #1] ran out of the building up the sidewalk to the Administration building. [Client #1] was escorted back to 285 Oak."

f. A memo dated 2/26/08 from the Living Unit 285 Oak Life Skills Trainer Supervisor documented a group schedule for the 6:00 a.m.

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to 2:00 p.m. and 2:00 p.m. to 10:00 p.m. shifts to follow when there were only 2 staff working in 285 Oak. Client #1 was assigned to Group A. The memo documented, "Staff will indicate in the log which group they had that day or night."

g. On 8/4/08 at approximately 4:00 p.m., the Superintendent and Quality Assurance Coordinator (QAC) were interviewed and the following information was obtained:

1.) On 8/3/08 during the 6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m. shift change in Living Unit 285 Oak, Client #1 left the living unit through an unlocked door in the game room. The QAC described the locking mechanism on the game room door as a hand-operated turn-bolt type. The gate in the fence on the old road between Living Units 286 Oak and 287 Pine was secured with a chain and padlock; however, the chain was loose enough for Client #1 to squeeze through. Client #1 made his way to the spillway on the lower lake, where he drowned. There were 12 clients assigned to 2 staff (Staff #1 and #2) on the evening shift that day. The Superintendent and QAC both agreed that Client #1 only required a 1 staff to 8 clients level of supervision while in the living unit.

2.) The Superintendent stated the facility had an Accountability Policy which stated clients were to be, "supervised and accounted for at all times;" however, "the system was not followed yesterday [8/3/08]."

The facility's policy and procedure titled, "Accountability for People" dated December 2007 and revised July 2008 documented: "...Accountability for People. a. Shift Change.

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POLICY: Staff in the homes shall maintain accountability for an assigned group of people during the shift, to include documentation of their whereabouts at shift change. PROCEDURES: (1) Staff/people assignments shall be posted in each home by the Life Skills Trainer Supervisor. (2) Assigned alternate group leaders shall assume responsibility for the group in the event of the group leader's absence. (3) At the beginning of each shift, the whereabouts of all people shall be documented by staff in the log. The incoming staff shall review and verify the notation. Both staff shall sign the log to indicate the transfer of groups. (4) The supervisor in charge shall be immediately notified if the staff is unable to account for a person's whereabouts. (5) In the event of the absence of group leaders and alternates, staff assignments shall be made and documented in the log by the supervisor in charge."

3.) The QAC stated the 2:00 p.m. to 10:00 p.m. staff failed to sign off on the Accountability of People Log Sheet during the shift change. This was confirmed by the surveyor's review of the photocopied log sheet provided by the QAC at the time of the interview. No staff had signed off on the Log Sheet for the 2:00 p.m. to 10:00 p.m. shift on 8/3/08. There was an entry on the 2:00 p.m. time slot for Client #1, which documented: "AU [awake and up]." The client checks were documented hourly on the hour. The 6:00 a.m. to 2:00 p.m. shift had signed off on this sheet. The QAC stated there had not been a head count conducted between the day and evening shift staff.

4.) The QAC stated that due to a disruptive chain of events at shift change, Staff #1 and #2

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on the evening shift had not ascertained the group assignments prior to Client #1's elopement. The QAC stated 8/3/08 was Staff #2's first time to be assigned to Living Unit 285 Oak and that Staff #2 was not familiar with the clients, inclusive of Client #1.

5.) Upon the surveyor's entrance to the facility on 8/4/08, the Quality Assurance Coordinator and Superintendent could not provide documentation of a new comprehensive, proactive plan of client supervision as a result of Client #1's death or any new inservices to staff related to client supervision. Prior to the citation of the Immediate Jeopardy at 4:30 p.m. on 8/408, the aforementioned staff confirmed the facility conducted hourly checks on the clients unless they were under some type of enhanced supervision. There was no new inservice of staff on correct client supervision or an increase in frequency of client head counts. The aforementioned staff stated they had checked the security of the gates in question, however the facility had not developed a plan to monitor the security of the gates.

h. The written statement of Staff #1 (a Life Skills Trainer I) was dated 8/3/08 at 3:39 p.m. and documented that upon arrival to the living unit at 2:00 p.m., he retrieved Client #3 from the kitchen. Staff #1 then escorted Client #4 back into the living unit as he [the client] was trying to go to the canteen. Staff #1 then took Client #2 to the restroom because he was seizure prone. While in the restroom Client #5 leaned on a basin, causing it to fall to the floor and break. After assisting Client #2, Staff #1 documented, "I called maintenance, they came and took out the broken basin and I cleaned up the floor. As I had

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seen everyone except [Client #1], I began to look for him. This was around 2:25 to 2:30 p.m. Unable to locate him, called the Program Supervisor to see if he was on an off campus trip." Staff #1's title is Life Skills Trainer (LST) I.

i. The written statement of Staff #2 (a Life Skills Trainer Trainee) was dated 8/3/08 at 9:03 p.m. and documented, "When I arrived at 285 Oak between 2:10 p.m. and 2:15 p.m. I met with [Staff #1] and he was in the front room area. [Staff #1] told me he was going to be in the restroom cause someone had broken the sink. I sat in the front room with seven people, (with two in the game room). After checking the game room and sitting down [Staff #1] notified me that he had to call maintenance man to fix the sink, and shortly afterwards that he had a person served missing, [Client #1]. This being my first time in 285 Oak, I had no visual idea of whom he was, nor was he where [Staff #1] assumed he was. [Staff #1] informed me that no head count was done by him and the 6-2 [6:00 a.m. to 2:00 p.m.] employee, so he could have been in the game room, or somewhere hiding in a corner cause he liked to be by himself. [Staff #1] searched outside and in while I monitored the other people served. Shortly after looking through the entire building inside and outside, [Staff #1] called the Program Supervisor and stated we had a person missing."

j. The written statement of Staff #3 was dated 8/3/08 at 2:30 p.m. and documented, "On August 3, 2008 about 2:30 p.m. [Staff #1] called and stated [Client #1] was missing. I ask [sic] him did he see [Client #1] when he arrive [sic] at 2 p.m. He stated [Client #1] wasn't their [sic]."

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k. The written statement of Staff #4 was dated 8/3/08 at 7:00 a.m. and documented, "I went into the kitchen where a few people served were eating breakfast, [Client #1] being one of those persons served. After breakfast, a few went to bed, some were in the living room watching television and a few in the game room. [Client #1] was one of the few in the game room. The game room is normally where [Client #1] goes throughout the day. There is a door in the game room, which is not too far from the window, but it is kept locked. But a few person's served do know how to unlock the door. I have never observed [Client #1] unlocking any door or running off. The last time I saw [Client #1] was right before shift change. I was sitting on the couch with other people served and I looked through the game room windows and saw [Client #1] standing in the same spot he's always in, which is the window by the pinball machine."

l. A Maltreatment/Neglect Investigation form dated 8/3/08 and signed by the Superintendent documented, "[QAC] called me at home at 3:18 p.m. She was called at 3:15 p.m. by [Staff #3] LST [Life Skills Trainer] II who was supervising due to the fact that [Client #1] was missing. As I was talking w/ [with] [QAC] I looked out my kitchen window & [and] saw a [local law enforcement] Police Officer going down Lower Dam Pike at a high rate of speed with lights flashing. I told [QAC] to go to the center & assist with the search & I was going to the spillway in the direction of the officer. I met a member of the rescue squad, identified myself & told him I was searching for a client. He radioed a [local law enforcement] officer who sent a Sargent [sic] to talk with me. The rescue squad member advised me there was a body in the water just

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below the Spillway Dam. They allowed me to accompany them to the other side of the river. [QAC] brought a face sheet w/ [Client #1's] photo. At 4:15 p.m., I identified the body as that of [Client #1]. The officers advised that the body appeared as though it had been in the water since earlier this morning. The Coroner will determine time & cause of death. The State Police are currently investigating."

m. On 8/6/08, the QAC provided a faxed copy of the Log Sheets dated 8/3/08 for the 2:00 p.m. to 10:00 p.m. shift. Client #1's 2:00 p.m. hourly check on 8/3/08, which documented "AU" had a line crossed through it and both staff members (Staff #1 and #2) for the evening shift had full signatures on the sheets. The 10:00 p.m. to 6:00 a.m. shift had signed off on the log sheet and documented the hourly checks. Client #2 had half hour checks documented during hours of sleep from 10:00 p.m. to 6:00 a.m.

2. The IJ was removed on 8/4/08 at 5:10 p.m. when the facility implemented the following plan of removal:

1.) "The exterior doors of the game room in 285 Oak were changed to a key lock this morning. A key is required to enter and exit this room. These doors, like the bedroom doors that open into the woods, should remain locked at all times."

2.) "The gate in the fence on the old road between 286 Oak and 287 Pine was secured with a chain and padlock yesterday but the chain was so loose that [Client #1] was able to open the gate enough to squeeze through. This was corrected last night and all gates were checked

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today and all were secure."

3.) "The Individual Monitoring Report is being revised and will require that every person in every residence is accounted for every 30 minutes while they are in the residences. Groupings are posted and the group leader is responsible for entering the status of his/her group at 30 minute intervals. All entries are not to be done by one person; the status is to be entered by the group leader responsible for that person served."

4.) "Documented in-service on this memo and the change in the individual monitoring form is to be completed with all staff beginning with the staff on duty this evening and completed with other staff as they come on duty. The new individual Monitoring Report will be implemented in every residence at 10:00 p.m. this evening."

5.) "Effective immediately all managers, Program Supervisors, Program Coordinators and others as designated by their Service Area Directors will randomly monitor in the residences, asking to see the Individual Monitoring Report to ensure that it is being completed per the above instructions and they will also be making visual observations. This begins effective today. Those monitoring are to sign off (name, title, date and time) on the Individual Monitoring Report. Quality Assurance staff and I [Superintendent] will also be monitoring plus checking to ensure that others are randomly making rounds. Any exceptions found are to be reported directly to me by e-mail."

6.) "Any disruptive event that occurs at shift change or any time during the shift will be

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W 186	Continued From page 43 handled and then immediately followed by a head count to ensure that all people served in the residence are present." 7.) "The Maintenance Supervisor will develop a monitoring document to be utilized to check all gates in the security fence at least monthly. The form will provide space for the date and time of the check to be recorded, along with the signature and title of the person checking the gates and the status of the security of the gates. Any lack of security or tampering with the gates will be reported immediately to the Superintendent for investigation. The form will include space for a notation regarding the nature of the immediate repair or action taken to ensure the security of the facility and the safety of people served. The form will be used to document any time the gates are opened and closed, including all the information (date, time, employee, title, status of the security of the gates, reason for opening/closing the gates). Keys to the gates will be maintained only in Maintenance, the Superintendent's off and the Center vault. The form will be developed, implemented and incoming staff will be in-serviced on this procedure effective August 6, 2008."	W 186		

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W 000	INITIAL COMMENTS A predetermined full survey was conducted from 2/19/09 to 3/9/09.	W 000		
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 observation, the facility failed to ensure doors, drawers, closets and window blinds were maintained in good repair. The failed practice had the opportunity to affect all 131 clients, as documented on the Intermediate Care Facility for Persons With Mental Retardation Survey Report form dated 3/9/09. The findings are: 1. On 2/23/09 at 2:35 p.m., the following observations were made in Living Unit 285: a. On the right end of the hall, the first and third drawers of the chest of drawers for the first bed dropped when opened. b. The third bed's closet/armoire had a hasp for a lock - no knobs. c. The fourth bed's chest had 4 drawers that fell out when opened. d. The first room on the right side of the hall had 3 drawers that fell out when opened. The second drawer had 1 side of the drawer missing. e. In the center bedroom, 3 closet doors had no	W 104		4/9/09

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 104	Continued From page 1 catch. f. The left door of the first closet did not catch on the magnet. g. The end closet's bottom drawer would not open at all. 2. On 2/23/09 at 2:15 p.m., the following observations were made in Living Unit 286: a. The kitchen had no salt and pepper shakers or napkin holders. b. The right end of the hall had broken blinds with rough edges. c. In the room on the left side of the hall, the armoire for the the first bed to the left of the door had a bottom drawer that was very hard to open. The last armoire's right door was also difficult to open. 3. On 2/25/09 at 9:50 a.m., the following observations were made in Living Unit 287: a. In the room on the left side of the hall, the right side of the first armoire door did not work properly. b. In the middle bedroom, two armoire's doors would not close. c. In the right end bedroom, 2 armoire's doors would not close. 4. On 2/25/09 at 10:30 a.m., the following observations were made in Living Unit 289:	W 104		

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W 104	Continued From page 2 a. In the kitchen, the third drawer from the end (the silverware drawer) fell out when opened. b. The back of an armoire in the right end bedroom was coming off and the middle drawer of a bedside table was very difficult to open. 5. On 2/25/09 at 1:15 p.m., the following observations were made in Living Unit 290: a. The bathroom had drawers that would fall out when opened. b. Three closet doors were hanging/rubbing on the floor. c. The left end bedroom had a drawer pull that came off when pulled. 6. On 2/25/09 at 1:30 p.m., the following observations were made in Living Unit 292: a. The first door on the right had an unstable middle drawer. b. The back left bedroom had insecure drawers in the armoire and chest. c. The middle bedroom hall door had broken and shattered wood around the door knob. d. In the bathroom on the hall wall, there were naked electrical wires sticking out of the wall. The supervisor stated maintenance was aware of the situation. 7. On 2/26/09 at 9:00 a.m., the following observations were made in Living Unit 293:	W 104		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	1 PRATOR DRIVE ARKADELPHIA, AR 71923

(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 104	Continued From page 3 a. The second, third and fourth drawers from the wall in the microwave cabinet were not secure. b. The left end of the hall had 3 armoires with doors that were sticking and a drawer that was missing a knob/handle.	W 104		
W 109	483.410(b) COMPLIANCE W FEDERAL, STATE & LOCAL LAWS The facility must be in compliance with all applicable provisions of Federal, State and local laws, regulations and codes pertaining to sanitation. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure all staff who handled clients' food kept their hair covered. The failed practice had the opportunity to affect all 131 clients, as documented on the Intermediate Care Facility for Persons With Mental Retardation Survey Report form dated 3/9/09. The findings are: 1. On 2/27/09 at 7:30 a.m. in Living Unit 289 during preparation and service of the breakfast meal, Staff #1's hair was loose from the hair net. 2. On 2/27/09 at 7:30 a.m. in Living Unit 287 during preparation and service of the breakfast meal, the Staff #2's hair was loose from the hair net.	W 109		4/9/09
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions.	W 441		4/6/09

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G002	A. BUILDING _____ B. WING _____	03/09/2009

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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 441	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure evacuation drills were conducted under varied weather conditions and using various evacuation routes. The failed practice had the opportunity to affect all 131 clients, as documented on the Intermediate Care Facility for Persons With Mental Retardation Survey Report form dated 3/9/09. The findings are: On 2/23/09 at 3:15 p.m., the facility's evacuation drill documentation for the past year was reviewed. There was no documentation of varied weather conditions or the use of various evacuation routes. Staff #3 was interviewed regarding the documentation. He stated he was unaware until recently that he should be document which exits were used during evacuation.	W 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G002	A. BUILDING _____ B. WING _____	C 04/14/2009

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W 000	INITIAL COMMENTS Complant 14408 was usnubstantiated.	W 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G002	A. BUILDING _____ B. WING _____	C 07/09/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARKADELPHIA HUMAN DEVELOPMENT CENTER	**1 PRATOR DRIVE ARKADELPHIA, AR 71923**

(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 Complaint 14661 was unsubstantiated.	W 000		

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

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