STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G007	A. BUILDING ____ B. WING ____	10/16/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEAST ARKANSAS HUMAN DEVELOPMENT CENTER	1 CENTER CIRCLE WARREN, AR 71671

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A fundamental recertification survey was conducted on 10/13/08 through 10/16/08.	W 000		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: 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: Client #9 had a diagnosis of Mental Retardation. 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. b. Nurses Notes dated 7/26/08 at 5:30 p.m. documented: "Back from hospital + [and]	W 153		11/9/08

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

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W 153	Continued From page 1 [physician] states, 'She has a small fracture...'" 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.	W 441		11/9/08

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W 441	Continued From page 2 This STANDARD is not met as evidenced by: 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: 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.	W 441		

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W 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A fundamental survey was conducted from 11/30/09 through 12/3/09.	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 observations and interview, the facility failed to ensure drawers in cabinets, TV stands and chest of drawers were in good repair; contact paper was not used on bathroom vanities or kitchen cabinets; bathroom floors, walls, assistive devices and showers were clean and in good repair; there were locks in place on bathroom doors; the doors were free of rough edges and splinters, baseboards were clean; dishes were stored inverted and silverware was properly stored; the oven handle was in place; toothbrushes were properly stored and identified,	W 104		

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W 104	Continued From page 1	W 104		

toilet paper holders functioned properly; bathroom drains functioned properly and a bathroom wall was sealed after replacement. These failed practices had the potential to affect 16 clients who resided in the Cuthbertson Group Home, Lipton Group Home and took their meals in Building 7 (Central Kitchen and Dining). The findings are:

1. On 12/2/09 at 9:05 a.m., the following observations were made in Cuthbertson Group Home.

a. In the Dining room, the top left drawer in the side board fell when pulled out 3-4 inches. The drawer contained silverware.

b. Going down the right hall, the 1st bedroom on the right had a 5 drawer chest just inside the door and the 2nd and 3rd drawers fell when opened 4-6 inches. The top drawer of the 5 drawer chest on the outside wall, fell when pulled out approximately 4 inches. In the bathroom, the medicine cabinet had contact paper on the inside. The tub/shower had black and brown discoloration on the grout between the tiles around the top of the tub. Both corners of the tile on top of the tub had a v-shaped space that was black (tile was white) in color.

c. The bedroom on the left had a broken door latch plate and rough wood was exposed. There was also a piece of wood, approximately 6 x 4 inches, behind the outside knob that had splinters. The bathroom had a blackish-brown substance on the tiles next to the tub; a blackish-brown substance was on the tiles behind the toilet; a blackish-brown substance and dirt were in the corners under the vanity; and contact

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W 104	Continued From page 2 paper was in the interior of the medicine cabinet with loose corners. d. In the last bedroom on the left, in the corners under the vanity in the bathroom was dirt. The shower had a blackish-brown substance on the grout on the left end, 2 tiles up and at the base, and the right end had a blackish-brown substance 2 tiles up the wall. The bathroom door did not have a lock and there was dust on the top of the baseboard and on the floor around the walls. e. In the last bedroom on the right, the bathroom had missing tiles and cracks in the corners under the vanity and the paint was chipped. There was a blackish-brown substance on the floor behind the toilet and all around the back wall of the shower 8 tiles up the wall. The medicine cabinet had contact paper on the interior with loose corners. There was no lock on the bathroom door for privacy. 2. On 12/2/09 at 9:50 a.m., the following observations were made in Lipton Group Home. a. The following observations were made in the kitchen: 1) In the top cabinet next to the outside door there was a styrofoam bowl with a plastic spoon in it on the middle shelf. 2) The bottom of the 2nd top drawer was broken and fiberboard was exposed. 3) In the 1st shelf to the right of the vent-a-hood, a cereal bowl was stored with the open end up.	W 104		

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W 104	Continued From page 3 4) Over the vent-a-hood there was a cup with a spoon on the 1st shelf on the left and a plastic bowl right side up on the right. 5) The bottom drawer of the oven had a hole where the pull handle was supposed to be and it had a rough edges. b. The following observation were made in the first bedroom on the right: 1) There was a cord hanging just inside the door between the door and the light switch. 2) The second drawer of the TV stand and chest dropped on the 3rd drawer, when pulled open 4-6 inches, the 3rd drawer did not open and the other TV stand and 3 drawer chests 2nd drawer also fell when pulled open 3-4 inches, resting on the 3rd drawer. 3) There was chipped tiles under the sink with cracks around the top of the tiles and a blackish-brown substance and dust was in both corners. 4) The medicine cabinet had contact paper on the interior surface which was falling down. 5) The screws were out of the latch plate on the hall door. 6) There was a blackish-brown substance around the floor behind the toilet and on the base of the toilet. 7) There were no names on the toothbrushes on the vanity and there was a toothbrush in a cabinet to the right of the vanity with a hair brush	W 104		

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W 104	Continued From page 4 and no cover. c. The following observation were made in the bedroom on the left: 1) The 3 drawers in the 3 drawer chest were unstable. The top drawer handle was very difficult to pull. 2) Drawer # 3, 4 and of the 5 drawer chest on the outside dropped down when pulled out 4-6 inches. 3) In the bathroom the corners of the vanity and edges of the tiles were dirty. On the shower head was a blackish-brown substance, the metal toilet paper holder wouldn't close, and the baseboards were dirty. 4) The hall door latch had exposed wood. d. The following observations were made of last bedroom on the right: 1) The baseboards were dusty. 2) The door going into the bathroom was scraped and had splinters. 3) In the bathroom there was dirt and a blackish-brown substance was under the vanity. There was contact paper in the interior of the medicine cabinet. On the shower head was a blackish-brown substance, in the corners of the shower there was a black substance; and in the left end of the shower stall there was a blackish-brown substance. There was a metal assistive device on the toilet and the paint was peeling from the legs.	W 104		

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e. In the last bedroom on the left, there was a 4 drawer chest with broken handles and the 3rd drawer would not close completely. The water was running in the toilet, there was dirt was under the vanity, and a black substance was all around the bottom of the shower up 2 to 3 tiles.

3. On 12/3/09 at 8:05 am, the Administrator and the Assistant Administrator were interviewed on environmental findings. The Administrator was surprised since she makes environmental checks for herself. She wasn't aware of most of the items listed.

4. On 12/3/09 at 9:00 a.m. Building #7, containing the kitchen and dining room, were observed. The Men's restroom adjacent to the entry to the dining room housed a single stall with a commode. Inside the stall was a floor drain between the commode and the doorway. The floor drain, the base of the commode and the floor area around both were covered with a brown malodorous substance.

a. On 12/3/09 at 9:30 a.m., an interview was initiated with the Janitor assigned to building #7. He reported the floor drain was non-functional as an outgoing drain, but "every time it rains, water come up from the drain" causing a puddle of brown colored water inside the stall. He added that he mopped up the water each time it was present in the stall but over time the area had become discolored due to the drainage problem. He said he didn't know if the maintenance department had been notified of the problem.

b. On 12/3/09 at 9:45 a.m., an interview was initiated with the Maintenance Supervisor

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W 104	Continued From page 6 regarding the condition of the floor and the drain in the Men's restroom in Building #7. He reported Maintenance had not been notified of the problem with the condition of the floor in the restroom. 5. On 12/1/09 at 1:00 p.m., an environmental review was initiated in Cottage 14. The West Bathroom contained a shower area with tile slanted at a slight angle to promote water drainage to a center floor drain. One of the tiles at the entry to the shower was broken resulting in an approximately one inch hole in the floor exposing the underlying grout. The hole contained a dark brown substance. Along the back wall of the shower area an approximately one half inch gap existed between the wall and the floor. This gap allowed water to seep into the interior wall promoting the mildew and mold growth visible along this gap. On 12/1/09 at 1:20 p.m. an interview was initiated with the Home Supervisor who reported the back wall of the shower area had recently been replaced due to cracks in the tiles and grout and mildew growth in those areas. The new wall had never been sealed	W 104		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.	W 124		

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W 124	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was a signed consent form for the use of psychoactive medications utilized for inappropriate behaviors for 3 (Clients #1, 7 and 9) of 9 (Clients #1, 2, 4, 5, 6, 7, 9, 10 and 11) sampled clients who received psychoactive medications for behaviors. The findings are: 1. Client #1 had diagnoses of Mild Mental Retardation (MR), Schizoaffective Disorder, Hypothyroidism, Non-Insulin Dependent Diabetes Mellitus, Hypertension, Asthma, Seizure Disorder, Edentulous and Anemia. a. The Physician's Drug Order sheet signed by the physician on 10/30/09 documented Depakote ER (extended release) 250 mg (milligrams) three tablets every p.m., Seroquel 100 mg twice a day and Haldol Decanoate 100 mg intramuscular injection every 2 weeks. b. The signed consent form for the Depakote ER was signed by the guardian on 4/3/08. The consent form also documented, "Note: This consent is good for one year from the date of signature unless revoked by the Individual/Parent/Guardian." There was no other consent form in the medical record for the use of Depakote ER. c. As of 12/2/09, there was no signed consent form in the medical record for the use of the Seroquel. d. On 12/3/09 at 8:35 a.m., Staff Members #2, 3 and 4 confirmed there were no current consents for the use of Depakote or Seroquel and stated the consents must have "fallen through the	W 124		

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cracks."

2. Client #9 had diagnoses of Moderate MR, Oppositional Defiant Disorder, Mood Disorder due to Anoxia and Encephalitis, Cerebral Palsy and Seizure Disorder.

a. The Physician's Drug Order sheet signed by the physician on 10/30/09 documented Thorazine 100 mg twice a day, Clonidine 0.1 mg three times a day and Lithium 600 mg three times a day.

b. As of 12/3/09, there was no signed consent in the medical record for the use Clonidine.

c. On 12/3/09 at 10:20 a.m., Staff Member #2 stated the client took the Clonidine for inappropriate behaviors, but was unable to locate a signed consent.

3. Client # 7 had diagnoses of Autistic Disorder, PICA, Anxiety Disorder, Severe Mentally Retarded, and Seizure Disorder.

a. The Individual Program Plan (IPP) dated 4/29/09 documented Seroquel was increased during the past year. A consultation on March 10, 2009 with the Psychiatrist and the evening dose of Seroquel was increased at that time.

b. The IPP documented Side effects included abdominal pain/cramps, dizziness, drowsiness, headache and rash. The Seroquel may also interact with Carbamazepine and could alter the Carbamazepine and Blood levels could become too high. Seroquel may also interact with Depakote and might block the breakdown of Seroquel in the body. This can increase

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W 124	Continued From page 9 Seroquel effectiveness, but also increase the risk of side effects from Seroquel such as drowsiness, nausea, dry mouth, irregular heartbeats and dizziness. c. A form dated 11/25/09 documented under Present Medications, Seroquel 50 mg one tablet every A.M. and a second order for Seroquel 100 mg by mouth each P.M. d. As of 12/3/09 there was no documentation in the medical record of a signed consent form for the use of Seroquel. e. On 12/3/09 at 11:10 a.m., the Director of Nursing stated she looked through the Master record and there was no consent for Seroquel.	W 124		
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure Individual Program Plans (IPP) were updated to include behavior problems during meal time for 2 of 2 (Clients #14 and #15) sampled clients who had behavior concerns during meal times. The findings are: 1. Client #14 had diagnoses of Mild Mental Retardation; Severe Hearing Loss; Cardiac Arrhthymias; Postmenopausal and Obsessive Compulsive Disorder.	W 260		

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Continued From page 10

a. The IPP/Annual Review meeting was conducted on 3/5/09. On page 8 of the IPP, at the bottom of the page, documented, "... Due to [Client #14] having episodes where she used a knife to threaten her peers, she sits at mealtime away from others and staff monitors her use of knives..."

The IPP on page 8 also documented, "After discussion, it was agreed that [Client #14] does not need a behavior support plan at this time."

b. There were 5 Behavior Report Forms dated 1/11/09, 1/14/09, 1/23/09, 1/28/09, and 9/23/09 that documented inappropriate behavior in the dinning room.

2. Client #15 had diagnoses of Severe Mental Retardation; Impulse Control Disorder, NOS (not otherwise specified); Intermittent Explosive Disorder in remission; and Delusional Disorder, Persecutory Type.

a. The IPP/Annual Review meeting was conducted on 6/18/09. On page 2 documented the client participated in a behavior support plan for self-stimulation and noncompliance. There was no documentation of any problems in the dinning room during meals.

b. On page 12 of the IPP under item #9, second paragraph, documented the client did not particularly care for her peers looking at her and did not like things or people invading her space.

c. The Behavior Management Program, implemented 10/21/08, documented in the last paragraph, "[Client #15's] STIM [self-stimulation] typically involves pounding on a table with her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G007	A. BUILDING ___ B. WING ___	12/03/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHEAST ARKANSAS HUMAN DEVELOPMENT CENTER	1 CENTER CIRCLE WARREN, AR 71671

(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 260	Continued From page 11 fist to get attention. Please ignore as long as it does not cause injury and use these instances [to] provide instruction, modeling and feedback of appropriate social behavior." 3. On 12/1/09 at 5:15 p.m., Client #14 and 15's table settings were placed at another area away from the other clients. Staff #5 was asked why and she stated that they caused problems at the tables and that it was much better when they were separated. She also stated they had been that way for over a year. 4. On 12/3/09 at 1:00 p.m., the Administrator was surprised about the seating arrangements for Client #14 and #15. She stated that she was unaware of this situation.	W 260		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Human Rights Committee (HRC) assured there were signed consent forms for the used of psychoactive medications for 2 (Clients #1 and 9) of 9 (Clients #1, 2, 4, 5, 6, 7, 9, 10 and 11) sampled clients who received psychoactive mediations. The findings are: 1. Client #1 had diagnoses of Mild Mental Retardation (MR), Schizoaffective Disorder, Hypothyroidism, Non-Insulin Dependent Diabetes Mellitus, Hypertension, Asthma, Seizure	W 263		

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	04G007	A. BUILDING ______ B. WING ______	12/03/2009

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SOUTHEAST ARKANSAS HUMAN DEVELOPMENT CENTER	1 CENTER CIRCLE WARREN, AR 71671

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W 263	Continued From page 12 Disorder, Edentulous and Anemia. a. The Physician's Drug Order sheet signed by the physician on 10/30/09 documented Depakote ER (extended release) 250 mg (milligrams) three tablets every p.m., Seroquel 100 mg twice a day and Haldol Decanoate 100 mg intramuscular injection every 2 weeks. b. The signed consent form for the Depakote ER was signed by the guardian on 4/3/08. The consent form also documented, "Note: This consent is good for one year from the date of signature unless revoked by the Individual/Parent/Guardian." There was no other consent form in the medical record for the use of Depakote ER. c. As of 12/2/09, there was no signed consent form in the medical record for the use of the Seroquel. d. On 12/3/09 at 8:35 a.m., Staff Members #2, 3 and 4 confirmed there were no current consents for the use of Depakote or Seroquel and stated the consents must have "fallen through the cracks." 2. Client #9 had diagnoses of Moderate MR, Oppositional Defiant Disorder, Mood Disorder due to Anoxia and Encephalitis, Cerebral Palsy and Seizure Disorder. a. The Physician's Drug Order sheet signed by the physician on 10/30/09 documented Thorazine 100 mg twice a day, Clonidine 0.1 mg three times a day and Lithium 600 mg three times a day.	W 263		

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W 263	Continued From page 13 b. As of 12/3/09, there was no signed consent in the medical record for the use of Clonidine. c. On 12/3/09 at 10:20 a.m., Staff Member #2 stated the client took the Clonidine for inappropriate behaviors, but was unable to locate a signed consent. 3. On 12/3/09 at 1:35 p.m., Staff Member #3 confirmed the HRC minutes dated 1/13/09 through 12/1/09, did not address the lack of signed consents for the use of psychoactive medications for Client #1 and 9.	W 263		
W 369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that medications were administered without error for 2 of 2 sampled clients (Clients #12 and 13) observed during medication pass. The findings are: 1. Client #13 had diagnoses of Severe Mental Retardation (MR), Functional Enuresis, Disruptive Behavior Disorder in remission, Dementia due to cerebral calcifications, Cataracts treated surgically with lens implant, Hepatitis B carrier, 3rd degree AV Block with Syncope, Hypothyroidism, Constipation and Blind in Left Eye. a. The Physician's Orders sheet signed on 10/30/09 documented, Pred Forte ophthalmic	W 369		

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W 369	Continued From page 14 drops 2 drops to the right eye. b. On 12/1/09 at 4:10 p.m., Licensed Practical Nurse (LPN) #1 administered 2 drops Pred Forte AC 1% ophthalmic solution to the client's left eye. The surveyor asked the nurse which eye she administered the drops into and she pointed to the left eye. The surveyor asked to look at the directions on the container with the nurse and she said, "Yes, it should have been the right eye." 2. Client #12 had diagnoses of Profound Mental Retardation, Disruptive Behavior Disorder, Generalized Seizure Disorder, Severe Bilateral Pes Planovalgus, and History of Hydrocephalus. a. A form dated 10/21/09 documented under Present Medications Depakote Syrup 250 mg [milligrams]/5cc [cubic centimeters] give 20cc by mouth, twice a day. b. On 12/2/09 at 6:15 a.m., LPN #1 measured the Depakote Syrup in a plastic medication cup and leaned down to see if the dose was correct. LPN #1 poured the medication into another plastic cup that had a lid. LPN #1 continued to set up other medications. At 6:40 a.m., LPN #1 was asked to get a syringe and measure the Depakote Syrup. The LPN got two 10cc syringes. With the first one she pulled up 10cc and the second syringe she pulled up 4 cc. LPN #1 stated, "That's not enough." She then poured more syrup into the cup and pulled up 6cc into the syringe.	W 369		
W 483	483.480(d)(2) DINING AREAS AND SERVICE The facility must provide table service for all clients who can and will eat at a table, including	W 483		

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	04G007	A. BUILDING ____ B. WING ____	12/03/2009

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W 483	Continued From page 15 clients in wheelchairs. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all clients took meals at a table for 2 of 2 (Client #14 and #15) of sampled clients who were not seated at a table during meals. The findings are: 1. Client #14 had diagnoses of Mild Mental Retardation; Severe Hearing Loss; Cardiac Arrhthymias; Postmenopausal and Obsessive Compulsive Disorder. a. The IPP/Annual Review meeting was conducted on 3/5/09. On page 8 of the IPP, at the bottom of the page, documented, "... Due to [Client #14] having episodes where she used a knife to threaten her peers, she sits at mealtime away from others and staff monitors her use of knives..." The IPP on page 8 also documented, "After discussion, it was agreed that [Client #14] does not need a behavior support plan at this time." b. There were 5 Behavior Report Forms dated 1/11/09, 1/14/09, 1/23/09, 1/28/09, and 9/23/09 that documented inappropriate behavior in the dinning room. 2. Client #15 had diagnoses of Severe Mental Retardation; Impulse Control Disorder, NOS (not otherwise specified); Intermittent Explosive Disorder in remission; and Delusional Disorder, Persecutory Type. a. The IPP/Annual Review meeting was	W 483		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 483	Continued From page 16 conducted on 6/18/09. On page 2 documented the client participated in a behavior support plan for self-stimulation and noncompliance. There was no documentation of any problems in the dinning room during meals. b. On page 12 of the IPP under item #9, second paragraph, documented the client did not particularly care for her peers looking at her and did not like things or people invading her space. c. The Behavior Management Program, implemented 10/21/08, documented in the last paragraph, "[Client #15's] STIM [self-stimulation] typically involves pounding on a table with her fist to get attention. Please ignore as long as it does not cause injury and use these instances [to] provide instruction, modeling and feedback of appropriate social behavior." 3. On 12/1/09 at 5:15 p.m., Client #14 and 15's table settings were placed in another area away from the other clients and not at a table. Staff #5 was asked why and she stated that they caused problems at the tables and that it was much better when they were separated. She also stated they had been that way for over a year.	W 483		

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	04G007	A. BUILDING 01 B. WING	10/22/2008

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K 000	INITIAL COMMENTS The facility is in compliance with Title 42, Code of Federal Regulations 483.70(a), life safety from fire.	K 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
	04G007	A. BUILDING **01** B. WING	**12/03/2009**

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K 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. This facility is in compliance with Title 42, Code of Federal Regulations 48.470(j), life safety from fire.	K 000		

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

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