



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

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



CERTIFIED MAIL # 7006 3450 0003 0943 8660

October 1, 2008

Forrest Steele, Administrator
Jonesboro Human Development Center
4701 Colony Drive
Jonesboro, AR 72404

IMPORTANT NOTICE – PLEASE READ CAREFULLY

Dear Mr. Steele:

On September 17, 2008, the Office of Long Term Care conducted a recertification with complaint investigation survey to determine if your facility was in compliance with Federal requirements for Intermediate Care/Mental Retardation facilities participating in the Medicaid program. The facility failed to meet the Condition of Participation for Active Treatment Services. Specifically, the facility was not in compliance with the following requirements:

- 42CFR 483.440 Active Treatment Services**
- 42CFR 483.440(a)(1) Active Treatment**
- 42CFR 483.440(c)(6)(vi) Individual Program Plan**
- 42CFR 483.440(d)(1) Program Implementation**
- 42CFR 483.440(f)(1)(iii) Program Monitoring & Change**

The CMS 2567 “Statement of Deficiencies and Plan of Correction” with all deficiencies identified during the survey of September 17, 2008, is enclosed.

Remedies

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

Termination of the provider agreement effective December 16, 2008, if substantial compliance is not achieved by that date.

www.arkansas.gov/dhs
Serving more than one million Arkansans each year

Forrest Steele, Administrator
Page 2
October 1, 2008

Plan of Correction

A Plan of Correction (PoC) for the cited deficiencies must be completed and a completion date for each deficiency cited must be included. **It is imperative that an acceptable plan of correction be received by this office by October 11, 2008, to ensure a revisit can be conducted within 45 calendar days of the survey.** Termination will take place on **December 16, 2008**, if compliance is not achieved.

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

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

Your Plan of Correction must also include the following:

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

Forrest Steele, Administrator
Page 3
October 1, 2008

Informal Dispute Resolution

In accordance with 42 CFR § 488.331, you have one opportunity to question deficiencies through an informal dispute resolution (IDR) process. To obtain an IDR, you must send your written request to Health Facility Services, Arkansas Department of Health within ten (10) calendar days from receipt of the Statement of Deficiencies. The request must state the specific deficiencies the facility wishes to challenge. The request should also state whether the facility wants the IDR to be performed by a telephone conference call, record review, or a face-to-face meeting.

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

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

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

Appeal Rights

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

Director
Arkansas Department of Health and Human Services
P.O. Box 1437, Slot 201
Little Rock, AR 72203-1437

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

Forrest Steele, Administrator

Page 4

October 1, 2008

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

If you have any questions, please contact your reviewer, Lori Hobbs, RN, at (501) 682-8430.

Sincerely,

A handwritten signature in cursive script that reads "Judy Johnston".

Judy Johnston, Nursing Services Administrator

Office of Long Term Care

Survey & Certification Section

cc.: Ombudsman

DRC

DDS

file

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404	
(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 An extended survey was conducted from 9/8/08 through 9/17/08. The facility failed to meet the Condition of Participation (CoP) at Active Treatment.	W 000		
W 100	Complaint #13839 was unsubstantiated. 440.150(c) ICF SERVICES OTHER THAN IN INSTITUTIONS "Intermediate care facility services" may include services in an institution for the mentally retarded (hereafter referred to as intermediate care facilities for persons with mental retardation) or persons with related conditions if: (1) The primary purpose of the institution is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions; (2) The institution meets the standards in Subpart E of Part 442 of this Chapter; and (3) The mentally retarded recipient for whom payment is requested is receiving active treatment as specified in §483.440. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to meet the requirements of the Condition of Participation of Active Treatment Services at W195 and the Standard for Active Treatment at W196, as evidenced by the facility's failure to provide continuous, aggressive and consistent active treatment for 3 (Clients # 4, #5, and #13) of 14 (Clients #1 through #14) sampled clients whose active treatment programs were reviewed. The findings are:	W 100		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404	
(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 100	Continued From page 1 1. The facility failed to meet the standard of Active Treatment, as evidenced by failure to recognize and address behavioral problems for Clients #4, #5 and #13. Refer to W196. 2. The facility failed to ensure clients were provided with opportunities for choice and self-management, as evidenced by failure to ensure client growth and independence were promoted during meal service for Clients #1, #3 through #8, #10 and #11. Refer to W247. 3. The facility failed to ensure Individual Program Plans addressed a lack of progress toward identified objectives, as evidenced by failure of the QMRP to recognize or address documented behavioral problems for Clients #4, #5 and #13. Refer to W257.	W 100		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the medication nurse followed a system of documenting the administration of medications immediately after the medications were administered to the clients, even in the presence of a medication card system for the clients who resided in Residence 1800 during the 8:00 a.m. and 12:00 p.m. medication passes on 9/10/08. The findings are:	W 111		

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 111	Continued From page 2 1. On 9/10/08 at 3:08 p.m., medications were being prepared for the 5:00 p.m. medication pass. Licensed Practical Nurse (LPN) #1 requested the Medication Administration Record (MAR) book and began documenting the administration of medications were administered to the clients in Residence 1800 during the 8:00 a.m. and 12:00 p.m. medication passes that day. 2. On 9/10/08 at 3:20 p.m., LPN #2 was asked, "When do you document medications given?" The LPN stated, "We usually give them and come back to the facility and check them with our medication cards." 3. The facility's policy and procedure for documentation on the Medication Administration Record, provided by the Quality Assurance Coordinator on 9/17/08, documented: "All medications will be charted and initialed on the MAR immediately after it has been given. The medication cards will be used and compared to the MAR as the nurse signs off medications."	W 111			
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure privacy was provided during medication administration for 7 of 7 (Clients #11, #16, #17, #18, #19, #20 and #21) sampled clients who resided in Residence 400 and for 6 of 6 (Clients #3, #22, #23, #24, #25 and #26) sampled clients who resided in Residence	W 130			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 130	<p>Continued From page 3</p> <p>1200. The findings are:</p> <p>1. On 9/10/08 during the 5:00 p.m. medication pass, medications were administered in the kitchen area of Residence 400 to the following clients:</p> <p>a. Client #11 had a diagnosis of Mental Retardation.</p> <p>The client's medications were administered in the kitchen area, in the presence of 4 other clients and 2 staff members.</p> <p>b. Client #16 had a diagnosis of Mental Retardation.</p> <p>The client's medications were administered in the kitchen area, in the presence of 1 other client and 2 staff members.</p> <p>c. Client #17 had a diagnosis of Mental Retardation.</p> <p>The client's medications were administered in the kitchen area, in the presence of 3 other clients and 2 staff members.</p> <p>d. Client #18 had a diagnosis of Mental Retardation.</p> <p>The client's medications were administered in the kitchen area, in the presence of 6 other clients and 2 staff members.</p> <p>e. Client #19 had a diagnosis of Mental Retardation.</p> <p>The client's medications were administered in the</p>	W 130			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 130	Continued From page 4 kitchen area, in the presence of 7 other clients and 2 staff members. f. Client #20 had a diagnosis of Mental Retardation. The client's medications were administered in the kitchen area, in the presence of 5 other clients and 2 staff members. g. Client #21 had a diagnosis of Mental Retardation. The client's medications were administered in the kitchen area, in the presence of 4 other clients and one staff member. 2. On 9/17/08 during the 12:00 p.m. medication pass, Clients #3, #22, #23, #24, #25 and #26 were administered medications in the dining room area. Eight clients and 2 staff members were present in this area at the time of medication administration. 3. The facility's policy and procedure for Rights of Persons Receiving Services, provided by the Quality Assurance Manager on 9/17/08, documented: "...People will be provided privacy during care of personal needs and when receiving medical treatment."	W 130			
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review and	W 195			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 195	Continued From page 5 interview, the facility failed to meet the requirements for the Condition of Participation for Active Treatment Services, as evidenced by failure to ensure clients received continuous, competent training, supervision and support which promoted skills and independence, failure to identify and address behavioral problems, failure to provide meal services that promoted growth and independence for 9 (Clients #1, #3 through #8, #10 and #11) and failure to ensure the Qualified Mental Retardation Profession (QMRP) addressed documented behavior problems for 3 (Clients #4, #5 and #13) of 14 (Clients #1 through #14) sampled clients. 1. The facility failed to meet the standard of Active Treatment, as evidenced by failure to recognize and address behavioral problems for Clients #4, #5 and #13. Refer to W196. 2. The facility failed to ensure clients were provided with opportunities for choice and self-management, as evidenced by failure to ensure client growth and independence were promoted during meal service for Clients #1, #3 through #8, #10 and #11. Refer to W247. 3. The facility failed to ensure Individual Program Plans addressed a lack of progress toward identified objectives, as evidenced by failure of the QMRP to recognize or address documented behavioral problems for Clients #4, #5 and #13. Refer to W257.	W 195			
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health	W 196			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 196	<p>Continued From page 6</p> <p>services and related services described in this subpart, that is directed toward:</p> <p>(i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and</p> <p>(ii) The prevention or deceleration of regression or loss of current optimal functional status.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure active treatment programs included objectives and specialized training to promote as much independence as possible and failed to ensure the clients' progress or lack thereof was accurately measured to facilitate the development of necessary modifications in the active treatment plan to assist the clients in achieving their objectives for 3 (Clients # 4, #5, and #13) of 14 (Clients #1 through #14) sampled clients whose active treatment programs were reviewed. The findings are:</p> <p>1. Client #4 had diagnoses of Profound Mental Retardation, Attention Deficit Hyperactivity Disorder, Impulse Control Disorder and Seizure Disorder.</p> <p>a. The Individual Program Plan (IPP)/Annual Review dated 5/3/08 documented: "[Client #4] likes to go to the refrigerator and eat impulsively. Therefore the kitchen door is locked... The team continues to agree that [Client #4] should not participate in eating out in the community as his behavior regarding food is not appropriate for community settings... Personal Preferences: Likes: Activities involving food; Socializing;</p>	W 196			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 196	<p>Continued From page 7</p> <p>Having Choices; Enjoys eating all foods... Identified Strengths: [Client #4] eats independently; drinks independently; clears dishes with prompting; initiates social interaction; and makes some choices when provided options... Effective reinforcers: ...Food and Drinks... Supervision Needs: Eating: - [Client #4] can eat independently using his utensils. However, he needs sight supervision to prevent him from taking food from others and prompting to not eat with his fingers..." There was no documentation of any plan to assist the client with the acquisition of appropriate behaviors to allow the client to function with as much independence and self-determination as possible or of any training in the client's home to teach the client how to serve his own food or acquire appropriate socialization associated with sharing a meal with other people at the same table in a family style eating program.</p> <p>b. On 9/11/08 at 5:15 p.m., the client was observed during the evening meal service. The client was sitting at the dining table awaiting his meal. He got up from the table and went to get some chips and was redirected back to his chair by staff. The staff were preparing ham sandwiches for the clients and did not consult any of the clients, including Client #4, regarding what they wanted on their sandwiches or involve the clients in any preparing the meal. No condiments were placed on the table to allow clients the opportunity to learn to appropriately season their food.</p> <p>2. Client #5 had diagnoses of Profound Mental Retardation, Bipolar Disorder, Obsessive Compulsive Disorder and Premenopause.</p>	W 196			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 196	<p>Continued From page 8</p> <p>a. The IPP dated 10/10/07 documented: "[Client #5] is still disrobing often and will flush the clothes when given an opportunity. Staff persons are aware of this behavior and attempt to redirect [Client #5] as much as possible... Personal Preferences: ...likes to change her clothes; enjoys wearing an attends [incontinence brief]; likes to wear colored underwear; and if she gets something on her clothes, she wants to change them immediately... Service Objective... due to the behavior of invading others' property, staff persons will provide close monitoring of [client's] whereabouts..." There was no documentation under the Reinforcers section of the IPP regarding measures to address the client's behaviors by reinforcing positive behaviors with the specific likes that were documented under the Personal Preferences section.</p> <p>b. A Human Rights Committee (HRC) Phone Poll document dated 3/31/08 documented the Interdisciplinary Team (IDT) met on 3/25/08 and, "...recommended locking the closet doors for all ladies who live in 1400 [1400 Liberty Circle residence]. The team reported that [client] had had a recent increase of maladaptive behaviors which includes getting into other ladies' closets, taking their underwear and wiping herself...." The Phone Poll also documented that the plan to lock the closet doors was approved at this time and would be discussed again during the April 2008 Human Rights Committee (HRC) meeting. The Phone Poll also documented, "...the approval is contingent upon all the ladies having training objective to learn to open a lock."</p> <p>c. The HRC minutes dated 7/24/08 documented the committee was closely monitoring the locked closets in the 1400 Liberty Circle residence</p>	W 196			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 196	<p>Continued From page 9</p> <p>because, "[Client #5] pulls others' underwear and clothing items from their closet and wears them. Several behavior reports indicate [Client #5] is continuously trying to pry doors open and get into closets."</p> <p>d. On 9/11/08 at 5:30 p.m., staff in the client's residence were asked how the clients could access the belongings in their locked closets. The staff stated the clients, "just have to get staff to unlock them for them." The staff made no mention of any clients' keys.</p> <p>e. On 9/15/08 at 3:00 p.m., the Quality Assurance Coordinator (QAC) was interviewed regarding the locked closet doors. She stated the clients residing in the 1400 Liberty Circle residence, "have their own keys to access their closet when they want... There should be a new service objective at the back of their IPP." The Surveyor informed the QAC at this time that the staff in that residence had stated that the clients were dependent upon staff to open their closet doors and that no client keys had been mentioned. When the staff members were asked, "What if staff is busy?" the staff members stated the clients would have to wait.</p> <p>f. As of 9/15/08, the Monthly Plan Reviews and Progress Notes maintained by the Qualified Mental Retardation Professional (QMRP) did not include documentation regarding the objective to address this problem or of active treatment provided related to this problem.</p> <p>3. Client #13 had a diagnosis of Profound Mental Retardation.</p> <p>a. The Behavior Development Program dated</p>	W 196			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 196	<p>Continued From page 10</p> <p>4/9/07 documented: "TREATMENT PLAN: CORRECTIVE PROCEDURES: ...Visual contact should be maintained to allow staff the opportunity to intervene quickly enough to prevent property damage and/or aggression..."</p> <p>b. The IPP dated 8/23/07 documented: "Service Objective... to prevent behavior difficulties, I will receive redirection from inappropriate behaviors."</p> <p>c. On 9/11/08 at 4:55 p.m., in the 1500 Liberty Circle residence, the client was observed slapping and kicking another client in the Day Room. Staff intervened and redirected the client into an alcove attached to the Day Room where there was a rocking chair. The client did not sit down, but walked around the area, stepped out of the alcove and again began slapping the same client on the head, then hit another client on the head. Staff intervened and redirected the client back into the alcove. The client walked around the area playing with some strings and once the staff began talking to another client in the area, Client #13 jumped out of the alcove and slapped the same client very hard, making a loud popping sound. Before the staff could redirect him, he jumped back into the alcove. The client who was repeatedly slapped was shaking his head back and forth and stating, "Oh, oh, oh." The staff member who redirected the client stated he had to document a Behavior Report (BR).</p> <p>d. On 9/12/08, the BR for the 9/11/08 incident was reviewed, along with 31 other BR's for this client. Nineteen of the 31 BRs were for hitting or kicking other clients (some of the BR's referenced more than one client) from 8/11/08 to 9/11/08. There was no mention of this problem in any of the reports in the client's files.</p>	W 196			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 196	Continued From page 11	W 196			
W 247	<p>e. Fifteen Marks Reports dated from 8/11/08 to 9/11/08 documented possible bruising, red marks or swelling caused to other clients during this client's incidents of aggression.</p> <p>f. On 9/16/08, the Surveyor requested a copy of the current IPP, conducted on 8/27/08. Staff stated the IPP was not finished, but allowed the Surveyor to review the IPP. There was no documentation regarding the client's recent behavioral problems of aggression toward other clients.</p> <p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include opportunities for client choice and self-management.</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure the Individual Program Plan (IPP) included opportunities for choices and self-management or that clients were provided opportunities for choices and self management during meals, as evidenced by a lack of condiments on the dining tables during meals and failure to provide family-style dining for 9 (Clients #1, #3 through #8, #10 and #11) of 14 (Client's #1 through #14) sampled clients who were observed during meals. The failed practice had the potential to affect all 116 clients, as documented on the Intermediate Care Facility for Persons with Mental Retardation Survey Report form dated 9/17/08. The findings are:</p> <p>1. Client #6 had a diagnosis of Profound Mental Retardation and was prescribed a high</p>	W 247			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 247	<p>Continued From page 12</p> <p>calorie/high fiber diet. There was no physician order for a sodium restriction.</p> <p>a. The Individual Program Plan (IPP) Annual Review dated 2/6/08 documented: "Needed Services/Supports: Provide training to develop self-help skills. Continue to provide training to develop daily living skills... Reinforcers: Snacks, Mealtime... Dietary: ...[Client receives a high calorie/high protein diet... with Glucerna three times daily..." The Monthly Plan Review and Progress Note section documented: "...Obj [Objective] 12... I will open my Glucerna using verbal prompts or above for 100 sessions... SO [Support Objective] 5... Staff will encourage me to communicate my wants and needs through gestures and/or facial expressions..."</p> <p>b. On 9/9/08 at 7:35 a.m., 9/15/08 at 5:10 p.m. and 9/16/08 at 7:30 a.m. and 11:50 a.m., the client was observed during meals in the dining area of the living unit. There were no condiments on this or any other client's dining table. Staff were serving the clients while the clients were seated at the dining table, depriving the clients of the ability to learn portion control.</p> <p>2. Client #7 had a diagnosis of Profound Mental Retardation and was prescribed a high calorie/high protein mechanical diet. There was no physician order for a sodium restriction.</p> <p>a. The IPP Annual Review dated 4/16/08 documented: "...[Client] eats and drinks independently... requires monitoring to prevent him from taking food from others' plates...[Client] communicates some of wants and needs by reaching for desired items, specifically food, and will hold an empty container out when he wants</p>	W 247			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 247	<p>Continued From page 13 more..."</p> <p>b. On 9/9/08 at 7:25 a.m., 9/15/08 at 5:25 p.m. and 9/16/08 at 7:40 a.m. and 12:00 p.m., the client was observed during meals in the dining area of the living unit. There were no condiments on this or any other client's dining table. Staff were serving the clients while the clients were seated at the dining table, depriving the clients of the ability to learn portion control.</p> <p>3. Client #8 had a diagnosis of Severe Mental Retardation and was prescribed a low cholesterol diet. There was no physician order for a sodium restriction.</p> <p>a. The IPP Annual Review dated 9/28/07 documented: "Personal Preferences: ... Likes to eat. Likes to do what he wants to do. Enjoys activities that involve food... Identified Strengths: ...[Client] is verbal and makes his wants and needs known. Capable of following multi-step verbal/gestural direction... Capable of making some choices when provided options... eats independently... Dietary: ...[Client] has definite likes and dislikes for food preferences... His plate is served from the food cart... The Monthly Plan Review and Progress Note documented: "SO 9... to ensure optimal training opportunities and skill maintenance, I will be provided opportunities and encourage to participate in a variety of daily living activities..."</p> <p>b. On 9/9/08 at 7:40 a.m., 9/15/08 at 5:20 p.m. and 9/16/08 at 7:45 a.m. and 11:45 a.m., the client was observed during meals in the dining area of the living unit. There were no condiments on this or any other client's dining table. Staff were serving the clients while the clients were</p>	W 247			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 247	<p>Continued From page 14</p> <p>seated at the dining table, depriving the clients of the ability to learn portion control.</p> <p>4. Client #10 had a diagnosis of Profound Mental Retardation and was prescribed a regular mechanical soft diet. There was no physician order for a sodium restriction.</p> <p>a. The IPP Annual Review dated 3/4/08 documented: "Personal Preferences: ...A variety of foods... Identified Strengths: ...Makes choices... Has a good appetite... Eats/drinks independently... Needed Services/Supports: ...Training to improve social skills..."</p> <p>b. On 9/15/08 at 7:20 a.m. and 5:35 p.m., the client was observed during meals in the dining area of the living unit. There were no condiments on this or any other client's dining table. Staff were serving the clients while the clients were seated at the dining table, depriving the clients of the ability to learn portion control.</p> <p>5. Client #11 had a diagnosis of Severe Mental Retardation and was prescribed a regular diet.</p> <p>a. The IPP Annual Review dated 8/21/07 documented: "...Goal #1 - I want to maintain/improve my independence in self-help and daily living skills... Likes: ...Activities involving food... Identified Strengths: ...Can communicate some wants/needs... Can make choices when provided options... Capable of following verbal/gestural direction... Needed Services/Supports: ...Provide training to enhance self-help/daily living skills... During mealtime... he feeds himself independently and for the most part is a neat eater... Dietary: ...He is able to adequately eat using conventional utensils..."</p>	W 247			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 247	Continued From page 15 b. On 9/15/08 at 5:03 p.m., the client was observed during the evening meal in the dining area of the living unit. There were no condiments on this or any other client's dining table. Staff were serving the clients while the clients were seated at the dining table, depriving the clients of the ability to learn portion control. 6. Client #5 had a diagnosis of Profound Mental Retardation and was prescribed a no concentrated sweets diet. a. The IPP Annual Review dated 10/10/07 documented: "...[Client] likes a variety of food... likes to stay busy... follows simple directions... learns a task quickly... Needed Services/Supports... Training to develop daily living skills... Dietary: [Client] lacks functional and receptive language skills but makes her needs known through signs and noises... able to adequately feed herself using conventional utensils... Obj 17... I will peel my fruit, with physical prompts... Obj 20 - ...I will mix the packet of Crystal Light in the bottle of water, using verbal prompts... Obj 21... I will serve my meals from the food cart, using physical prompts..." b. On 9/12/08 at 7:00 a.m., the client was observed during the breakfast meal in the dining area of the living unit. There were no condiments on this or any other client's dining table. Staff were serving the clients while the clients were seated at the dining table, depriving the clients of the ability to learn portion control. 7. Client #1 had a diagnosis of Profound Mental Retardation and was prescribed a high calorie, high protein diet.	W 247			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 247	Continued From page 16 a. The IPP Annual Review dated 5/13/08 documented: "...Likes finger foods... Gestures to make wants and needs known. Follows simple directions paired with gestures. Eats and drinks independently... Makes choices/has preferences... Can complete assigned tasks... Needed Services/Supports: ...Continue training to develop self-help and daily-living skills... [Client] can eat independently... [Client's] plate is served from the food cart... Obj 16... I will open my milk or juice, with physical prompting..." b. On 9/16/08 at 5:10 p.m., the client was observed during the evening meal. There were no condiments on this or any other client's dining table. The staff made and served sandwiches to the clients with no assistance or input from the clients as to the contents of their sandwiches. 8. Client #3 had a diagnosis of Profound Mental Retardation and was prescribed a low cholesterol, weight reduction diet. On 9/12/08 at 7:30 a.m., the client was observed during the breakfast meal in the dining room of the living unit. There was no pepper or other condiments on this or any other client's dining table. Staff were serving the clients while the clients were seated at the dining table depriving the clients of the ability to learn portion control. 9. Client #4 had a diagnosis of Profound Mental Retardation and was prescribed a low cholesterol, weight reduction diet. a. The IPP Annual Review dated 5/30/08 documented: "...I want to improve my independence in self-help, daily living skills..."	W 247			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 247	Continued From page 17 [Client] likes to go to the refrigerator to eat impulsively... The team continues to agree that [client] should not participate in eating out in the community as his behavior regarding food is not appropriate for community settings... Likes: Activities involving food... Having choices... Eats independently... Can follow one-step directions... Makes some choices when provided options... Needed Services/Supports: ...Continue training and supports to enhance self-help, daily living skills... can eat independently using his utensils... His food is not salted after preparation to help prevent water retention... [Client] needs assistance to maintain an adequate nutrient intake; that is to plan, purchase and prepare a well balanced diet..." The Monthly Plan Review and Progress Note documented: "Obj 1... I will pour my drink in my cup, using verbal prompts... b. On 9/12/08 at 7:25 a.m., the client was observed during the breakfast meal in the dining room of the living unit. The were no condiments on this or any other client's dining table. Staff were serving the clients while the clients were seated at the dining table depriving the client's of the ability to learn portion control. 10. On 9/16/08 during a meal observation, a non-sampled client got up from the table, opened a cabinet, got a large container of salt, poured the salt into his hand and salted his food.	W 247			
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the	W 249			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 249	<p>Continued From page 18</p> <p>objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure behavioral objectives were implemented within 30 days of admission to the facility for 1 of 1 (Client #12) sampled client who was admitted to the facility in the past 3 months. The findings are:</p> <p>Client #12 was admitted to the facility on 7/16/08 and had diagnoses of Mental Retardation, Autistic Disorder and Anxiety Disorder.</p> <p>a. A Memorandum dated 9/2/08 documented: "...transferred from [another facility]. He resided in [another facility] from 4/26/07 until 7/16/08."</p> <p>b. Documentation provided by the Qualified Mental Retardation Professional (QMRP) on 9/11/08 indicated an Individual Program Plan (IPP) was developed for the client on 8/21/08 (36 days after admission).</p> <p>c. The master record and documentation for the direct care staff in the unit indicated the only objectives included for staff direction in providing care and services to the client were objectives that were developed at a facility where the client resided prior to his admission to this facility.</p> <p>d. As of 9/11/08, there was no documentation that behavioral objectives had been implemented for the client, other than those developed at a prior facility.</p>	W 249			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 249	Continued From page 19	W 249			
W 257	<p>e. On 9/11/08 at 2:27 p.m., the Quality Assurance Manager stated, "We've had the IPP but don't have it ready yet."</p> <p>483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE</p> <p>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.</p> <p>This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure the Qualified Mental Retardation Professional reviewed and revised Individual Program Plans (IPP's) as necessary to address behavioral issues for 3 (Clients #4, #5 and #13) of 14 (Clients #1 through #14) sampled clients whose IPP's were reviewed. The findings are:</p> <p>1. Client #13 had a diagnosis of Mental Retardation.</p> <p>a. The client's IPP dated 10/10/07 documented: "...Service Objective... invading others' property, staff persons will provide close monitoring of [client's] whereabouts..." The Monthly Plan Review and Progress Notes maintained by the Qualified Mental Retardation Professional (QMRP) did not address this objective or include any active treatment measures to assist the client with this objective.</p> <p>b. On 9/11/08 at 4:55 p.m., in the 1500 Liberty Circle residence, the client was observed</p>	W 257			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 257	<p>Continued From page 20</p> <p>slapping and kicking another client in the Day Room. Staff intervened and redirected the client into an alcove attached to the Day Room where there was a rocking chair. The client did not sit down, but walked around the area, stepped out of the alcove and again began slapping the same client on the head, then hit another client on the head. Staff intervened and redirected the client back into the alcove. The client walked around the area playing with some strings and once the staff began talking to another client in the area, Client #13 jumped out of the alcove and slapped the same client very hard, making a loud popping sound. Before the staff could redirect him, he jumped back into the alcove. The client who was repeatedly slapped was shaking his head back and forth and stating, "Oh, oh, oh." The staff member who redirected the client stated he had to document a Behavior Incident Report (BIR) and ask another staff to assist with the clients.</p> <p>c. On 9/12/08, the BIR for the 9/11/08 incident was reviewed, along with 31 other BIR's for this client. Nineteen of the 31 BIRs were for hitting or kicking other clients (some of the BIR's referenced more than one client) from 9/11/07 to 8/11/08. There was no mention of this problem in any of the reports in the client's files. The Qualified Mental Retardation Professional's documentation for this client did not address any problems with aggression toward other clients.</p> <p>2. Client #4 had a diagnosis of Profound Mental Retardation.</p> <p>a. The IPP Annual Review dated 5/30/08 documented: "...I want to improve my independence in self-help, daily living skills... [Client] likes to go to the refrigerator to eat</p>	W 257			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 257	<p>Continued From page 21</p> <p>impulsively... The team continues to agree that [client] should not participate in eating out in the community as his behavior regarding food is not appropriate for community settings... Likes: Activities involving food... Having choices... Eats independently... Can follow one-step directions... Makes some choices when provided options... Needed Services/Supports: ...Continue training and supports to enhance self-help, daily living skills... can eat independently using his utensils... His food is not salted after preparation to help prevent water retention... [Client] needs assistance to maintain an adequate nutrient intake; that is to plan, purchase and prepare a well balanced diet..." The Monthly Plan Review and Progress Note documented: "Obj 1... I will pour my drink in my cup, using verbal prompts..." The Team in the IPP failed to provide training in the clients' home by teaching a family style eating program where the clients could learn how to serve their own food and the appropriate socialization associated with sharing a meal with other people at the same table.</p> <p>b. On 9/12/08 at 7:25 a.m., the client was observed during the breakfast meal in the dining room of the living unit. There were no condiments on this or any other client's dining table. Staff were serving the clients while the clients were seated at the dining table depriving the client's of the ability to learn portion control in a family-style setting.</p> <p>3. Client #5 had diagnoses of Profound Mental Retardation, Bipolar Disorder, Obsessive Compulsive Disorder and Premenopause.</p> <p>a. The IPP dated 10/10/07 documented: "[Client #5] is still disrobing often and will flush the clothes</p>	W 257			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 257	<p>Continued From page 22</p> <p>when given an opportunity. Staff persons are aware of this behavior and attempt to redirect [Client #5] as much as possible... Personal Preferences: ...likes to change her clothes; enjoys wearing an attends [incontinence brief]; likes to wear colored underwear; and if she gets something on her clothes, she wants to change them immediately... Service Objective... due to the behavior of invading others' property, staff persons will provide close monitoring of [client's] whereabouts..." There was no documentation under the Reinforcers section of the IPP regarding measures to address the client's behaviors by reinforcing positive behaviors with the specific likes that were documented under the Personal Preferences section. As of 9/15/08, the Monthly Plan Reviews and Progress Notes maintained by the Qualified Mental Retardation Professional (QMRP) did not include documentation regarding the objective to address this problem or of active treatment provided related to this problem.</p> <p>b. The IPP Annual Review dated 10/10/07 also documented: "...[Client] likes a variety of food... likes to stay busy... follows simple directions... learns a task quickly... Needed Services/Supports... Training to develop daily living skills... Dietary: [Client] lacks functional and receptive language skills but makes her needs known through signs and noises... able to adequately feed herself using conventional utensils... Obj 17... I will peel my fruit, with physical prompts... Obj 20 - ...I will mix the packet of Crystal Light in the bottle of water, using verbal prompts... Obj 21... I will serve my meals from the food cart, using physical prompts..." The Team in the IPP failed to provide training in the clients' home by teaching a family style eating program</p>	W 257			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 257	Continued From page 23 where the clients could learn how to serve their own food and the appropriate socialization associated with sharing a meal with other people at the same table.	W 257			
W 441	On 9/12/08 at 7:00 a.m., the client was observed during the breakfast meal in the dining area of the living unit. There were no condiments on this or any other client's dining table. Staff were serving the clients while the clients were seated at the dining table, depriving the clients of the ability to learn portion control in a family-style setting. 483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure emergency evacuation drills were conducted at various times during the night shift. The findings are: 1. On 9/11/08, the facility's emergency evacuation drill reports were reviewed. The reports documented that since 11/19/07, three drills had been conducted on the 11:00 p.m. to 7:00 a.m. shift as follows: 12/18/07 at 6:20 a.m. 3/28/08 at 6:24 a.m. 6/27/08 at 6:15 a.m. No evacuation drills were documented for the 11:00 p.m. to 7:00 a.m. shift, except the 3 aforementioned drills, which all occurred during or close to shift change.	W 441			

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

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2008
NAME OF PROVIDER OR SUPPLIER JONESBORO HUMAN DEVELOPMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4701 COLONY DRIVE JONESBORO, AR 72404		
(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 24 2. On 9/11/08 at 2:12 p.m., the Quality Assurance Manager provided a list which documented the facility's shift changes occurred at 6:30 a.m., 2:30 p.m. and 10:30 p.m. 3. The facility's policy and procedure for evacuation drills was provided by the Quality Assurance Manager on 9/16/08 and documented that fire drills would be conducted at least quarterly on each shift; however, the policy and procedure did not address the need to incorporate and document various escape routes, times or fire locations into the evacuation drills.	W 441			