Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	04L103	06/14/2022
Name of Provider or Supplier	**Street Address, City, State**	
Habilitation Center, Llc	1810 Industrial Drive, Fordyce, AR	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
N0000	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. Complaint #AR00028297 was unsubstantiated. The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center
N0156	ORDERS FOR USE OF RESTRAINT OR SECLUSION CFR(s): 483.358(j) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible. This ELEMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a physician's order for a physical was signed for 1 of 1 (Client #1) sampled client who required the use of a physical restraint. The findings are: Client #1 was admitted on 1/13/22 and had diagnoses Attention Deficit/Hyperactivity Disorder and Post-Traumatic Stress Disorder. a. An Emergency Safety Intervention and Debriefing form dated 5/6/22 documented,

	"Physical Hold... Date & [and] Time placed in Restraint; Date: 5/6/22 Time: 1813 [6:13 p.m.]; Date & Time Removed from Restraint; Date: 5/6/22 Time: 1833 [6:33 p.m.]; Date & Time Restraint Order Received from MD [Medical Doctor] Date: 5/6/22 Time: 1813 [6:13 p.m.]..." b. A Physician's Order dated 5/6/22 at 6:13 p.m. documented, "May be placed in a physical restraint not to exceed 20 minutes for aggression toward staff. T.O. [Telephone Order] [Doctor]/[RN (Registered Nurse) #1]." There was no Physician's signature documented on the order. c. On 6/13/22 at 2:01 p.m., the Director of Nursing was asked, "Do you have a signed Physician's order for the restraint?" She stated, "No."
N0178	NOTIFICATION OF PARENT(S) OR LEGAL GUARDIAN CFR(s): 483.366 If the resident is a minor as defined in this subpart: 483.366(a) The facility must notify the parent(s) or legal guardian(s) of the resident who has been restrained or placed in seclusion as soon as possible after the initiation of each emergency safety intervention. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure guardians were notified of the use of a physical restraint for 1 of 1 (Client #1) sampled client who was placed in a physical restraint. The findings are: Client #1 was admitted on 1/13/22 and had diagnoses Attention Deficit/Hyperactivity Disorder and Post-Traumatic Stress Disorder. a. An Emergency Safety Intervention and Debriefing form dated 5/6/22 documented, "Physical Hold... Date & [and] Time placed in Restraint; Date: 5/6/22 Time: 1813 [6:13 p.m.]; Date & Time Removed from Restraint; Date: 5/6/22 Time: 1833 [6:33 p.m.]; Date & Time Restraint Order Received from MD [Medical Doctor] Date: 5/6/22 Time: 1813 [6:13 p.m.]... Guardian Notification (Always Notify Guardian for All Interventions)... Parent/Legal Guardian request to participate in Post Intervention Interview: No notification RT [Related To] Computer & phone lines down campus wide..." b. A Nurse's Note dated 5/6/22 at 6:18 p.m. documented, "Placed in physical restraint not to exceed 20 mins [minutes] RT running from facility & fighting staff. Released @ [at] 1833 [6:33 p.m.] Placed on elopement precautions & unit restriction X [times] 72 hours for stated above: orders written & no precautions or notification @ present RT phone/computer lines down across campus @ present." There was no documentation to indicate the guardians had been notified of the use of a physical restraint. c. On 6/13/22 at 2:01 p.m., the Director of Nursing was asked, "Was the guardian notified of the restraint?" She stated, "I don't see where they went back and documented they sent an email or anything or a letter. The phone lines were down."
N0209	FACILITY REPORTING CFR(s): 483.374(b)(3)

Staff must document in the resident's record that the serious occurrence was reported to both the State Medicaid agency and the State designated Protection and Advocacy system, including the name of the person to whom the incident was reported. A copy of the report must be maintained in the resident's record, as well as in the incident and accident report logs kept by the facility.

This ELEMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a serious occurrence was reported to the required agencies and the report was maintained in the medical record for 1 of 1 (Client #1) sampled client who sustained an injury requiring outside medical care. The findings are:

Client #1 was admitted on 1/13/22 and had diagnoses Attention Deficit/Hyperactivity Disorder and Post-Traumatic Stress Disorder.

a. A Nurse's Note dated 1/27/22 at 2:32 p.m. documented, "Pt [Patient)] @ [at] nurse's station. Pt states, "I was running in the field & [and] stepped on my L [left] foot & fell face first onto the ground. Didn't have time to put my hands out. Slight swelling to R [right] of nose [with] cut [small] present. Bleeding stopped [with] applied pressure. 0/10 [zero of ten] pain noted. [Guardian] notified via TC [Telephone conference] @ 1436 [2:36 p.m.] Supervisor notified of need for transportation. Pt being sent to [Hospital] ER [Emergency Room] for further eval [evaluation]. Guardian aware... 1630 [4:30 p.m.] Return from ER [with] glue applied to cut. Pt refused to let DR [Doctor] apply sutures..."

b. On 6/14/22, at 9:43 a.m., the Risk Manager was asked, "On 1/27/22 the client stated he fell and got a laceration to his nose. Was this incident reported to any State agencies?" He stated, "I'm pretty sure it didn't." The Risk Manager reviewed the regulation. He was asked, "Should that have been reported?" He stated, "I guess so."

c. On 6/14/22, at 10:04 a.m., the Director of Nursing (DON) stated, "I talked to [Risk Manager] and he said we have never made that part of the chart." The DON was asked, "The Serious Occurrence reports?" She stated, "Yes, this one in January [2022] were he had a cut on the nose." The DON was asked, "Any other serious occurrences, that are reported, are not included in chart?" She stated, "Not the actual form that would indicate the calling and stuff. Our practice is the nurse to document on the occurrences and the assessments and notify the guardian if it is a serious injury or incident."

d. The facility Incident Reporting-Risk Management Program Policy, received from the Risk Manager on 6/14/22 at 1:02 p.m., documented, "Policy: The Risk Management Program techniques must proactively focus on loss prevention, safety promotion, and detection of hazardous events and circumstances. It must provide a systematic, multi-disciplinary approach to managing an reporting incidents of injury, damages, and loss... Classifying Severity... In States where the facility is required to report Tragic/Serious incidents to the State, it must be dome within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments... The following severity classifications shall be used:... Level II-Serious: Major injury or impairment in which the patient or visitor's function is altered requiring outside medical intervention... The Risk Manager should report a critical incident to the State as required by State-specific guidelines..."