



**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 9032

October 23, 2008

Mark Stitch, Administrator
Alexander Human Development Center
14701 Highway 111 South
Alexander, AR 72002

Dear Mr. Stitch:

On October 13, 2008, the Office of Long Term Care conducted a revisit survey to verify that your facility had achieved and maintained compliance. The revisit survey conducted verified that your facility was in compliance with Conditions of Participation for Client Protections and that substantial progress has been made in corrections to the deficiencies cited on the complaint survey of September 2, 2008. However, the revisit survey on October 13, 2008, found that your facility had deficiencies requiring correction.

The CMS-2567L survey report is enclosed for your reference.

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. A revisit will be authorized after an acceptable PoC is received. The PoC must be received by November 2, 2008, and sent 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;

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- d. How the facility will monitor its corrective actions/performance to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change to ensure that solutions are permanent; and
- e. When corrective action must be accomplished.

Informal Dispute Resolution

In accordance with 42 CFR § 488.331, you have one opportunity to question deficiencies through an informal dispute resolution (IDR) process. To obtain an IDR, you must send your written request to Health Facility Services, Arkansas Department of Health within ten (10) calendar days from receipt of the Statement of Deficiencies. The request must state the specific deficiencies the facility wishes to challenge. The request should also state whether the facility wants the IDR to be performed by a telephone conference call, record review, or a face-to-face meeting. An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

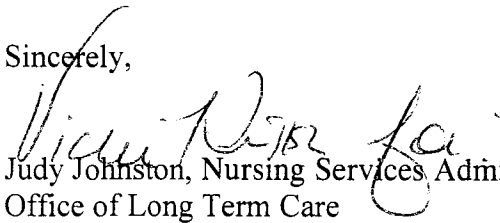
Please submit your request via fax to:

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

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 Sandra Broughton, Reviewer (501) 682-8430.

Sincerely,


Judy Johnston, Nursing Services Administrator
Office of Long Term Care
Survey & Certification Section

cc: Ombudsman
DDS
DRC
file

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 04G001	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/13/2008
Name of Facility ALEXANDER HUMAN DEVELOPMENT CENTER		Street Address, City, State, Zip Code 14701 HIGHWAY 111 SOUTH ALEXANDER, AR 72002

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>W0102</u> Reg. # <u>483.410</u> LSC _____	Correction Completed 10/02/2008	ID Prefix <u>W0104</u> Reg. # <u>483.410(a)(1)</u> LSC _____	Correction Completed 10/02/2008	ID Prefix <u>W0122</u> Reg. # <u>483.420</u> LSC _____	Correction Completed 10/02/2008
ID Prefix <u>W0127</u> Reg. # <u>483.420(a)(5)</u> LSC _____	Correction Completed 10/02/2008	ID Prefix <u>W0153</u> Reg. # <u>483.420(d)(2)</u> LSC _____	Correction Completed 10/02/2008	ID Prefix <u>W0331</u> Reg. # <u>483.460(c)</u> LSC _____	Correction Completed 10/02/2008
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
State Agency				
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO				

Followup to Survey Completed on: 9/2/2008	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>	YES	NO
YES	NO		