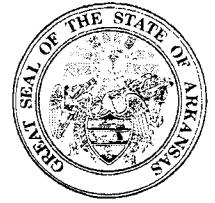




**Division of Medical Services
Office of Long Term Care**

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 # 7004 1350 0002 7236 5658

May 14, 2008

Calvin Price, Administrator
Conway Human Development Center
150 East Siebenmorgen Rd.
Conway, AR 72032

Dear Mr. Price:

On April 30, 2008, a recertification with complaint investigation survey was conducted at your facility by the Office of Long Term Care to determine if your facility was in compliance with Federal requirements for ICF/MRs participating in the Medicaid (Title XIX) Program. This survey found that your facility had deficiencies requiring correction/substantial correction prior to a revisit as specified in the attached CMS-2567L.

Plan of Correction

A Plan of Correction (PoC) must be completed for the cited deficiencies with a completion date for each deficiency cited. A revisit will be authorized after an acceptable PoC is received. The POC must be submitted by May 24, 2008, 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;

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Calvin Price, Administrator

Page 2

May 14, 2008

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.

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.

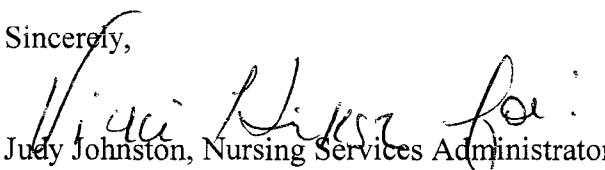
An incomplete informal dispute resolution procedure will not delay the effective date of any enforcement action. Informal dispute resolution in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss the findings.

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

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

If you have any questions, please call me at (501) 682-8430.

Sincerely,


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

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OMB NO. 0938-0391

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|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04G004 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 04/30/2008 |
| NAME OF PROVIDER OR SUPPLIER CONWAY HUMAN DEVELOPMENT CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 150 EAST SIEBENMORGEN ROAD CONWAY, AR 72032 | | |
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| W 000 | INITIAL COMMENTS A full survey was conducted from 3/17/08 through 4/30/08 with deficiencies cited at W378, W380, W386, W411, W454 and W460. | W 000 | | | |
| W 378 | Complaint #13266 was substantiated (all or in part) with no deficiency cited. 483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of temperature. | W 378 | | | |
| W 380 | This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure medications were stored at the proper temperature. The findings are: 1. On 4/1/08 at 2:25 p.m., 5 amps of Phenergan 25 milligrams per milliliter (mg/ml) for Client #62 were stored in the Unit 7 refrigerator. 2. Lexi-Comp's Drug Information Handbook for Nursing 2007 documented the following regarding storage of Phenergan: "Storage: Injection: store at room temperature." 483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of humidity. | W 380 | | | |
| | This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure inhalant medications were stored under proper conditions of humidity, as evidenced by failure to store the unit-dose vials in their foil pouches until | | | | |

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

TITLE

(X6) DATE

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

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| W 380 | <p>Continued From page 1 ready for administration. The findings are:</p> <p>1. The Manufacturer-Specific Instructions for Ipratropium Bromide (DuoNeb) documented: "How supplied: Ipratropium Bromide 0.5 mg [milligrams] and Albuterol Sulfate 3.0 mg is supplied as a 3 milliliters (ml) sterile solution for nebulization in sterile low-density polyethylene unit-dose vials. Store in pouch until time of use."</p> <p>a. On 3/31/08 at 11:30 a.m., the generic vials of DuoNeb for the following clients who resided in Willow I - Side A were not stored in their foil pouches:</p> <p>Client #51 - 27 vials. Client #52 - 28 vials. Client #53 - 28 vials. Client #54 - 43 vials. Client #55 - 29 vials.</p> <p>b. On 3/31/08 at 1:45 p.m., the generic vials of DuoNeb for the following clients who resided in Willow I - Side B were not stored in their foil pouches:</p> <p>Client #56 - 15 vials. Client #57 - 17 vials. Client #61 - 8 vials.</p> <p>2. The manufacturer's package insert for Albuterol and Atrovent updrafts documented: "Store unused vials in the foil pouch."</p> <p>a. On 3/31/08 at 1:45 p.m., there were 22 vials of Atrovent for Client #58 that were not stored in their foil pouches.</p> <p>b. On 3/31/08 at 2:25 p.m., there were 27 vials of</p> | W 380 | | |

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| W 380 | Continued From page 2 Albuterol for Client #59 and 52 vials of Albuterol for Client #60 that were not stored in their foil pouches. | W 380 | | |
| W 386 | <p>483.460(l)(4) DRUG STORAGE AND RECORDKEEPING</p> <p>The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308).</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure reconciliation of controlled medication inventory was periodically conducted, documented in the Narcotic Book and signed by 2 Nurses. The facility also failed to ensure each administered dose of narcotic medication was documented in the Narcotic Book with the date and time of administration. The findings are:</p> <p>1. The facility's Policy and Procedure dated 7/25/06 and titled, "Schedule Drug Count" documented: "...First, a count is made by two (2) nurses of the controlled drugs in the schedule(s) being counted at this time. Once the count is made, the Date, Time and Schedules Counted columns are filled in with the correct information. Then each nurse signs on the same line, in a Signature column."</p> <p>2. On 4/1/08 at 9:30 a.m., the Narcotic Reconciliation Book for Unit 31 was audited with the following findings:</p> | W 386 | | |

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| W 386 | Continued From page 3 a. Narcotic counts conducted on 2/14/08, 3/1/08, 3/10/08 and 3/12/08 did not document a second Nurse's signature to verify that the count was correct. On 4/30/08 at 10:45 a.m., Registered Nurse (RN) #1 stated, "The narcotic count is supposed to be counted and witnessed by 2 people." b. Doses #77 and #78 of Lorazepam 1 milligram (mg) for Client #63 were documented as administered on 3/28/08; however, there was no signature by the administering nurse (Licensed Practical Nurse #1) for those doses. c. Dose #43 of Lorazepam 2 mg for Client #64 was documented as administered to the client, but there was no signature by the administering nurse. d. Dose #15 of Ambien 5 mg for Client #65 was documented as administered on 3/28/08, but no administering nurse signature or time was documented. 3. On 4/1/08 at 10:15 a.m., the Narcotic Reconciliation Book for Unit #32 was audited. No signature, time or date was documented by the administering nurse for doses #82 and #83 of Lorazepam 1 mg for Client #66. | W 386 | | |
| W 411 | 483.470(b)(1)(iii) CLIENT BEDROOMS Bedrooms must accommodate no more than four clients unless granted a variance under paragraph (b)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure | W 411 | | |

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| W 411 | Continued From page 4 bedrooms did not house more than four clients in 2 of 31 living areas on campus. The findings are: 1. On 4/29/08, the two client bedroom areas in Willow 1 housed 11 clients in each of two (East and West) bedrooms. 2. On 4/29/08, the two bedroom areas in Willow 2 housed 7 clients in the South bedroom and 6 clients in the North bedroom. | W 411 | | |
| W 454 | 483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure potentially hazardous foods were properly stored in the refrigerators. The facility failed to ensure clients who received their dinner meals from the HTT cafeteria were protected from potentially contaminated beverages and failed to use proper infection control techniques when offering care to multiple clients. The failed practices had the potential to affect 16 clients on Cypress 16, 10 clients on Cedar 28, 12 clients on Cedar 25, 15 clients on Cedar 6, 10 clients on Birch 20, 17 clients on Birch 9, 17 clients on Birch 10, 18 clients on Birch 11, 31 clients who took their meals from the HTT cafeteria, 18 clients on 28 Cedar and 18 clients on 9 Birch. The findings are: 1. On 3/18/08 at 3:52 p.m., the following food and beverage products were improperly stored in the refrigerators: a. On Cedar 28, a plastic glass 1/2 full of a | W 454 | | |

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| W 454 | Continued From page 5 frozen vanilla milkshake was stored uncovered in the freezer with a spoon frozen in the contents and no date or label. b. On Birch 9, sliced turkey partially covered in aluminum foil and dated 3/17/08 was exposed to air in the refrigerator. 2. On 3/19/08 during the evening meal, Client #5 was dining in the HTT dining room. The client took his empty soda bottle to the insulated cooler that contained tea and put the cooler's spigot into the mouth of the bottle and filled the bottle with tea. 3. Client #3 had a diagnosis of Profound Mental Retardation. On 4/9/08 at 7:30 a.m., a male staff member was observed shaving this client with an electric razor. When the staff person finished shaving Client #3, he shaved three other clients with the same electric razor without cleaning the razor or changing heads on the razor. 4. Client #31 had a diagnosis of severe Mental Retardation. On 4/23/08 at 8:10 a.m., a female staff member who was wearing gloves applied sunscreen to Client #31's face. Without changing gloves, the staff person applied sunscreen to another client's face and arms. | W 454 | | |
| W 460 | 483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. | W 460 | | |

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| W 460 | Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and record review, the facility failed to ensure physician-ordered therapeutic diets were provided for 2 of 2 clients with physician orders for pudding consistency liquids (Clients #3 and #50). This failed practice had the potential to affect 16 clients with physician orders for liquids to be thickened to pudding consistency, according to the Registered Dietitian on 4/17/08. The findings are: 1. Client #3 had a diagnosis of Profound Mental Retardation and a history of aspiration and Pneumonia. a. A Swallowing Study Report dated 2/21/07 documented: "...due to risk of aspiration and the recent history of pneumonia recommend fluids thickened to pudding consistency ... Safe to continue chopped diet." b. A physician order dated 8/31/07 documented Thick-it was to be added to thin liquids and food to provide a pudding consistency diet. c. The Diet List dated 3/18/08 documented the client was to receive a blended diet with weight maintenance, no concentrated sweets, a divided plate, Thick-it in thin liquids to pudding consistency, no added salt, 1 and 1/2 scoop Unifiber in 8 ounces of liquid, seconds on meat, a citrus shake and 16 ounces of liquid. The Diet List also documented the client was at high risk for choking and/or aspiration. d. On 4/10/08 during the noon meal, the client was served taco beef, blended beans, blended | W 460 | | |

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| W 460 | Continued From page 7 spinach and applesauce. The taco beef had the consistency of ground meat. The blended beans and spinach had a runny consistency and were more pourable than the pudding-thickened liquids on the client's plate. 2. Client #50 had diagnoses of Profound Mental Retardation and Frequent Pneumonia. a. A physician order dated 2/8/08 documented Thick-it was to be added to all liquids to provide a pudding consistency. b. The Diet List dated 3/18/08 documented the client was at high risk for choking and/or aspiration. c. On 4/10/08 during the noon meal, the client was served blended beans that were runny and pourable instead of pudding consistency and melting ice cream that was not pudding thick. d. According to dysphagia guidelines, pudding thick liquids should hold their own shape, not be pourable and usually eaten with a spoon. | W 460 | | |

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| K 000 | <p>INITIAL COMMENTS</p> <p>This facility is in compliance with Title 42, Code of Federal Regulations 48.470(j), life safety from fire.</p> | K 000 | | |

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

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