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

PRINTED: 05/18/2009 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ALEXANDER HUMAN DEVELOPMENT CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 000 INITIAL COMMENTS	ID PREFIX TAG	STREE* 1470 ALE	T ADDRESS, CITY, STATE, ZIP CODE 1 HIGHWAY 111 SOUTH EXANDER, AR 72002 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	05/1	4/2009 (X5) COMPLETION DATE
ALEXANDER HUMAN DEVELOPMENT CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	1470 ALE	1 HIGHWAY 111 SOUTH EXANDER, AR 72002 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR	TION JLD BE	(X5) COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
W 000 INITIAL COMMENTS	Wo	000			
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 #14508 was unsubstantiated. Refer to Statements of Deficiencies with Event ID #'s 0ZO813 and TJRV13 for findings from the revisit survey of 5/14/09.					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATU			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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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED R 05/14/2009	
	04G001		B. WIN				
NAME OF PROVIDER OR SUPPLIER ALEXANDER HUMAN DEVELOPMENT CENTER			ļ	1	REET ADDRESS, CITY, STATE, ZIP CODE 14701 HIGHWAY 111 SOUTH ALEXANDER, AR 72002	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
TAG {W 000}	INITIAL COMMENTS Note: The CMS-2567 is an official, legal do remain unchanged excorrection, correction space. Any discreparcitation(s) will be reported (RO) for referr Inspector General (Conformation is inadver provider/supplier, the should be notified im A revisit survey was 5/14/09. 483.410(a)(1) GOVE The governing body budget, and operatin This STANDARD is Rewritten Deficiency Based on observation the client environment and sanitary conditionensure broken furnituand failure to maintain	(Statement of Deficiencies) cument. All information must except for entering the plan of a dates, and the signature ency in the original deficiency orted to the Dallas Regional al to the Office of the elG) for possible fraud. If retently changed by the estate Survey Agency (SA) mediately.	{W \(\frac{1}{2} \))000}	DEFICIENCY)	DPRIATE	DATE
	environment, the follomade:	n inspection of the client owing observations were					
	drawers in the chest	of drawers that were very oom had dirty blinds and a					
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	04G001		B. WIN			R 05/14/2009		
NAME OF PROVIDER OR SUPPLIER ALEXANDER HUMAN DEVELOPMENT CENTER				1	REET ADDRESS, CITY, STATE, ZIP CODE 4701 HIGHWAY 111 SOUTH ALEXANDER, AR 72002	1 00/1	4/2003	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
{W 104}	b. At 10:38 a.m. on 1 drawers had a broker the drawer was on the of drawers had 2 draw the third drawer) which the second drawer had a broker the track. d. At 11:35 a.m. on 3 drawers had a broker the track. d. At 11:30 a.m. on 3 bedside table had a broken in the bedside e. At 12:05 p.m., the surrounded by a fencium sitting on the to Premium Popcorn mi	ith 3 small, brown, crusty blinds. East: Room 144's chest of a third drawer (the back of e floor). Room 152's chest wers (the first full drawer and ch dropped when opened. ad no handle. East: Room 328's chest of a top drawer which was off East: Room 315's oak bottom drawer that fell to the pom 317 had both drawers e table next to the chest. food storage area e had a bottle of ground op shelf and 3 cases of	{W ·	104}				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING B. WING		G	R-C	
04G001		B. WIIN	<u> </u>		05/1	4/2009	
NAME OF PROVIDER OR SUPPLIER ALEXANDER HUMAN DEVELOPMENT CENTER			1	REET ADDRESS, CITY, STATE, ZIP CODE 14701 HIGHWAY 111 SOUTH ALEXANDER, AR 72002			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SI		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETION	
{W 000}	INITIAL COMMENTS		{W 000}				
{W 104}	is an official, legal doremain unchanged excorrection, correction space. Any discrepancitation(s) will be reported office (RO) for referrations a large of the should be notified immatched by the should be notified by the should be notified immatched by the should be notified by	IG) for possible fraud. If tently changed by the State Survey Agency (SA) mediately.	{W 1	104}			
	This STANDARD is a Rewritten Deficiency	not met as evidenced by:					
	the client environmen and sanitary condition ensure broken furnitu and failure to maintain	n, the facility failed to ensure at was maintained in safe n, as evidenced by failure to are was repaired or replaced n window blinds and window are:					
		inspection of the client owing observations were					
	drawers in the chest of unsteady. The TV Ro	South: Room 118 had 3 of drawers that were very boom had dirty blinds. There					
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	04G001		B. WIN	IG		R-C 05/14/2009	
NAME OF PROVIDER OR SUPPLIER ALEXANDER HUMAN DEVELOPMENT CENTER				14	EET ADDRESS, CITY, STATE, ZIP CODE 1701 HIGHWAY 111 SOUTH LEXANDER, AR 72002		#IZ000
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX S	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{W 104}	drawers had a broker the drawer was on the of drawers had 2 drawer the third drawer) which the second drawer had a broker the track. d. At 11:30 a.m. on 3 bedside table had a before when pulled. Resorted in the bedside e. At 12:05 p.m., the surrounded by a fencioumin sitting on the termium Popcorn mins of the desk was missing the termium to the desk was missing the termium to the termium popcorn on the desk was missing the termium to the termium popcorn on the desk was missing the termium to the termium popcorn on the desk was missing the termium to the termium popcorn on the termium popco	East: Room 144's chest of a third drawer (the back of e floor). Room 152's chest wers (the first full drawer and ch dropped when opened. ad no handle. East: Room 328's chest of a top drawer which was off East: Room 315's oak bottom drawer that fell to the bom 317 had both drawers e table next to the chest. food storage area e had a bottle of ground op shelf and 3 cases of	{W ·	104}			