STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045155	A. BUILDING ______ B. WING ______	C 09/20/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASH FLAT HEALTHCARE AND REHABILITATION CENTER	**66 OSBIRN LANE** **ASH FLAT, AR 72513**

(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
F 000	INITIAL COMMENTS Complaint # 12930, substantiated (all or in part) with deficiencies cited at F223, F225 and F226.	F 000		
F 223 SS=K	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Complaint #12930, substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure interventions were developed and implemented to assure freedom from abuse for 2 of 2 (Residents #1 and 2) case mix residents who resided on the locked unit. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Resident #1 and had the potential to affect 14 residents who resided on the locked unit according to the Registered Nurse (RN) consultant on 9/20/07 at 9:50 a.m. The facility was informed of the Immediate Jeopardy situation on 9/19/07 at 4:15 p.m. The findings are: 1. Resident #1 had diagnoses of Alzheimer's Disease and Dementia with Behavior Disturbance. The Admission Minimum Data Set (MDS) dated 6/17/07 documented the resident was moderately impaired in cognitive skills for	F 223		

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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daily decision making; required extensive assistance of one staff member for transfers, locomotion, dressing, eating and personal hygiene needs; and exhibited up to five days a week behaviors that included crying, tearfulness, and repetitive movements all of which were easily altered.

a. Skilled Nurses Notes dated 4/12/07 at 2:20 p.m. documented, "CNA (Certified Nursing Assistant) reports that she has heard r (resident) husband yelling & cussing at her... report to DON (Director of Nursing)."

A statement by the DON dated 4/12/07 at 3:00 p.m. documented, "Spoke with [Resident #1's husband] asked him if he had yelled or cussed at his wife, he denied that he 'yelled or cussed at my wife." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and the Office of Long Term Care (OLTC) and the resident was protected from further abuse.

b. Skilled Nurses Notes dated 4/18/07, no time noted, documented, "[Resident #1] was sitting in day rm (room) [with] lap belt on. She attempted to stand up. I was standing at the desk looking out into the day rm. [Resident #1's husband] walked up to her & [with] his fist punched [Resident #1] in the right shoulder area... 1 small bruise R (right) upper arm. Large bruise L (left) lower outer leg 3 inches long 2.5 inches wide."

1) A statement written by the Social Services Director (SSD) dated 4/18/07 documented, "R.N. [RN #1] reported to Dept. (Department) Head staff that after lunch, res (Resident) husband was out in dayroom [with] res, res started getting out

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of w/c (wheelchair) unassist & res husband hit at res to sit her back down in w/c, [Assistant Administrator] went to speak [with] res & husband, husband states, 'I would never hurt her. Was trying to get her back in w/c before she fell'."

2) A witness statement Licensed Practice Nurse (LPN) #1 dated 4/18/07 documented, "This nurse came to the nurses station after taking lunch, noticed that [RN #1] was visibly upset, RN stated she had seen [Resident #1's husband] hit [Resident #1] in the day room, noted that [Assistant Administrator] was out talking to [Resident #1 and husband]." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC the resident was protected from further abuse.

c. A statement written by the DON dated 4/20/07 documented, "Residents husband was taking Resident to bathroom when [LPN #3] heard Resident cry out 'Your hurting me', [LPN #3] came and got me. Red area noted to lt (left) upper arm, no bruising noted. Talked to [husband] about how the staff has to report abuse. Asked him if he had a hold of her shoulders while assisting her to the bathroom, he stated, 'yes'. Asked him how he was assisting her, he stated 'I had a hold of her shoulders and was telling her to turn and sit down, she wouldn't turn so I was trying to turn her when she yelled "your hurting me"'... Told him I understand, but he may be or gets upset when she is unable to do what is expected of her & that he needed to let the CNAs take care of her, because they have training to assist the elderly."

A statement written by the SSD dated 4/20/07

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documented, "Will watch for [husband] taking res to bathroom, so staff or this SSD can intervene & assist res [with] care... Spoke with DON to educate staff to intervene when they see [husband] to assist res [with] care ADLs (activities of daily living) toileting, etc." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse.

d. Skilled Nurses Notes dated 4/22/07 at 8:00 p.m. and signed by LPN #1 documented, "found bruises to resident left forearm top. One bruise 1 cm (centimeter) round, two bruises 2 cm round, one bruise 4 cm x (by) 3 cm, resident denies knowledge of getting them, physician faxed, DON notified."

e. Skilled Nurses Notes dated 4/23/07 and signed by the DON documented, "Resident's spouse upset over nursing staff checking bruises, talked to [husband] to inform him why we check bruises. He thought it was because he had grabbed her when she lost balance in bathroom, told him No, it was when she was in bathroom and he was trying to get her to turn around & she cried out 'your hurting me', he remembered her saying that, but is confused as to what happened, asked him if he remembered me talking to him that day, puzzled facial expression but did state he remembered."

f. The Release of Responsibility for Leave of Absence form documented the resident's husband checked her out of the facility on 5/16/07.

g. The Social Progress Notes dated 6/4/07

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F 223	Continued From page 4 documented, "res readmitted from home, has been out on leave with husband." The Admission Nursing Assessment dated 6/4/07 documented, "several bruises all about body"... diagram documented, "bruising on both arms" h. The Licensed Nurse Progress Notes dated 6/7/07 at 2:00 p.m. documented, "CNA reports while in DR (dining room) r husband hit her hand and abdomen when she tried to help put bib back on." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC the resident was protected from further abuse. The Care Plan dated 6/7/07 documented, "Problem Onset: Res puts bib back on after it being removed . . Approach: Instruct husband to stay calm & collected when dealing with res." i. Nurse's Notes dated 6/17/07 documented, "Res readmitted to N.H. (nursing home) after husband took res home. Husband stated "I just couldn't do it. I tried but I couldn't do it. It is just too much"... husband cont (continues) to feed res instead of letting her do it herself." j. Licensed Nurse Progress Notes dated 7/2/07 at 1:00 p.m. documented, "spouse attempted to toilet without assist from personnel, states resident tried to sit on floor and then fell." Nurse's Notes dated 7/2/07 documented, "Lighthouse coordinator spoke with husband about being on schedule for visitations to [increase] res participation in care & activities. Explained to husband that res can do more for herself than he allows her to. Husband stated,	F 223		

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F 223	Continued From page 5 'But she spills things on her' or 'Well, she doesn't do it right'..." k. On 9/18/07 at 5:13 p.m., the resident and her husband were at the dining room table. A male resident (Resident #8) seated beside Resident #1 was coughing loudly. Resident #1's husband slapped a bib down on the dining room table and stated, "Turn your head when you cough!... He's coughing right at you and not covering his mouth!" l. On 9/18/07 at 5:15 p.m., the resident's husband was pushing away her left hand as she reached for the baked beans on her plate without an eating utensil in her hand. He also laid one of his hands over hers as he cut her meat. He spoon fed the resident her meal. m. On 9/19/07 at 10:10 a.m., LPN #2 was asked how Resident #1's husband interacted with the resident, LPN #2 stated, "He gets impatient, he doesn't take the time to let her do for herself. He pulled her bib down when she pulled it up and he said, 'stop doing that, that's not what it's for' and snatched it away... one person told me they saw him get rough with her... I don't think he hit her... I think there was an investigation on that." LPN #2 was asked what was done if a resident was hit and the LPN stated, "...if we feel that it is malicious, call the police. If it's family, I don't know if the police are called." n. On 9/19/07 at 10:35 a.m., CNA #1 was asked if she had ever heard a family member talk ugly or mean to a resident and if so, what happened, CNA #1 stated, "Yes, [Resident #1's husband]. He doesn't want other residents around his wife... If a resident wanders into her room he tells them	F 223		

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to get out and leave her alone and don't bother her. I left [Resident #1] in her room to help another resident dress and [Resident #1's husband] walked in the other resident's room. The other resident [Resident #6] had on a dress I was helping her pull down. It was up to her waist. I told him he had to leave and could not come into someone else's room like that." When asked if she had reported this incident, she stated, "I told [LPN #1]. He complains about the man [Resident #8] who sits at their dining room table, he coughs so [Resident #1's husband] tells him not to cough or to cover his mouth. I told [Resident #1's husband] he couldn't tell anyone else what to do, he talks stern to them (other residents). I never saw him hit anyone... it bothers him for her to eat with her fingers." When asked if the resident was ever alone with her husband, the CNA stated, "He has a set time to leave, he can come 30 minutes before meals and stay 30 minutes after. We take her to the bathroom and then lay her down. He goes in for about 10-15 minutes to kiss her good bye, says 'I'm out of here' then says he forgot something and goes back in for about 5 minutes." When asked the last time he was alone with her, CNA #1 stated, "Yesterday between 1:00 and 1:30." When asked if she had ever heard of him slapping or hitting another resident, she stated, "I heard rumors that he slapped [Resident #2's] hand one evening a couple of months ago."

o. On 9/19/07 at 11:07 a.m., LPN #1 was asked if she had observed any family members being rough or ugly with any residents and if so who and what happened. LPN #1 stated, "I've heard slapping noises behind my back, but never witnessed it... [Resident #1 and husband] but he's trying to keep her from eating with her hands... I have to talk to him almost on a daily basis telling

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F 223	Continued From page 7 him she can't help herself... but just this morning I heard the resident say ouch, but I don't know if he slapped her or not... I just know he was trying to force food in her mouth... he has a problem with bibs... he wants to take the bibs from other residents... I'll turn around and he'll be jerking the bib from them... he'll get mad if residents go into his wife's room... He'll take them by the arm and lead them out of the room... His wife's roommate tells on him... He'll go in there and change the channels on her TV... That he gets rough with his wife... she'll say (roommate) he pushed her or did this or that with her (wife)... another family member reported that he slapped her or was mean to her... we try not to leave him completely alone with her very much... there was one incident where he drew back his hand to hit someone but when I asked him about it, he said he was just defending himself because he thought he was gonna be hit... I've got him going to an Alzheimer's support group next week, we just try to keep an eye on him." When asked if he's slapping her hands and she's hearing slapping noises, did she feel that was abuse, LPN #1 stated, "Yes. We're afraid if we push him, then he'll take her out of here and is she better off here where we can buffer or is she better off at home?" p. On 9/19/07 at 11:35 a.m., Kitchen Staff #1 was asked if she had ever seen a family member talk mean or hit a resident and if so, who and what happened, she stated, "Yes, [Resident #1's husband] was rough to his wife and to me that was abuse. He jerked her bib off... his fists came up (she demonstrated) and he grabbed the bib and jerked it down and his fists came down and hit her chest... He also hit her hand with a wet wash cloth then... I hear that it's still going on, that	F 223		

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F 223	Continued From page 8 he's rough with his wife, slaps at her and grabs her hands and squeezes... told the facility he was going to hurt someone and they needed to do something before he did." q. On 9/19/07 at 11:50 a.m., the Assistant Director of Nurses (ADON) was asked if she had received any reports of incidents between family and residents and if so, who and what happened, she stated, "[Resident #1's husband]. We've interviewed staff, talked to him... he doesn't mean to hurt her, he loves her, he's had a hard time accepting what's going on with her." The ADON was asked what she thought about the statement Kitchen Staff #1 made regarding her observation involving the bib. The ADON stated, "I guess you just have to know [Kitchen Staff #1] and how she is... He just does things spontaneously, he doesn't mean to." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC the resident was protected from further abuse. r. On 9/19/07 at 12:15 p.m., the DON stated, "I've talked to him [Resident #1's husband] many times about his behavior with his wife... I think he is demented and acts spontaneously to things she does... He has threatened to take her out of here, he gets upset, he doesn't see it as being mean... A couple of nights ago he grabbed an onion out of her hand to keep her from getting mustard on herself." She stated that other than monitoring there had been no other interventions, that the police had been called on 1 occasion, that the Quality Assurance team was not utilized (mostly she and the Social Services Director only) and that the Office of Long Term Care had not been notified. When asked if she felt any other	F 223		

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resident on the unit was at risk for harm, she stated, "There is a possibility for him to reach out and do the same, yes."

s. On 9/19/07 at 12:56 p.m., the Administrator was asked to describe how Resident #1's husband interacted with his wife and other residents, she stated, "He is demented, doesn't understand her disease, expects her to function as she used to, he gets frustrated... He taps her on the arm (she demonstrated), it's not hard, to get her attention." When the Administrator was asked about the circumstances of the 6/7/07 bib incident, she stated, "This was reported to me... I told staff to find out if it was abuse... I know her (Kitchen Staff #1) if her husband had done that to her she would have knocked him down... She is very assertive... She doesn't like [Resident #1's husband] talking to her (Resident #1) that way... I did not talk to [Kitchen Staff #1] I was told this by staff." When the Administrator was asked about the circumstances of the 4/18/07 allegation of the husband punching the resident's shoulder, she stated, "He did not punch the resident, that particular nurse does not like him... I did call the cops when [RN #1] was upset, he came in and said there was nothing for him to do. I've been told he takes the remote at times... and one of the residents picked up a bib off the table, he told her not to do that."

t. On 9/19/07 at 4:40 p.m., the resident's roommate was asked if she had heard Resident #1's husband talk mean to his wife, she stated, "Yes, he tells her to sit down, tries to get her to sit down, he pushes her down if she's getting up." When asked if she thought the husband was hurting his wife when doing this, she stated, "Yes." She also stated, "Today" when asked the

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F 223	Continued From page 10 last time the resident and her husband were alone in the room with the roommate present. u. On 9/20/07 at 10:19 a.m., a telephone interview was conducted with the Ombudsman. She stated that when she was in the facility on 7/17/07, the Administrator said they were having trouble with Resident #1's husband talking roughly to his wife... It's not abuse or anything... He's just not a nice person. When the Ombudsman was asked if the Administrator alarmed her in any way about the way he treated his wife, she stated, "No." 2. Resident #2 had diagnoses of Osteoporosis, Alzheimer's Disease and Psychosis. The Annual MDS dated 9/4/07 documented the resident was moderately impaired in cognitive skills for daily decision-making and had behaviors of wandering which occurred 4 to 6 days out of the last 7 days. a. On 9/19/07 at 10:34 a.m., CNA #1 was asked if she knew of Resident #1's husband doing anything inappropriate with Resident #2. She stated, "I heard he slapped [Resident #2's] hands, but I wasn't here, and you have to see it yourself. If I see something myself, I'll address it." She was asked if she reported it. She stated, "Yes, to [LPN #1]." b. On 9/19/07 at 12:14 p.m., the DON was asked if she knew of or had heard of an incident involving Resident #1's husband and Resident #2. She stated, "I know he jerked a bib out of her hands." The DON was asked if she knew if Resident #1's husband had ever touched or slapped Resident #2. She stated, "She reached across the table to get a sack or something. Someone heard a slap but doesn't know whether	F 223		

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he slapped a table or her. She didn't have a red mark." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC the resident was protected from further abuse.

3. The facility Abuse Prevention Program policy statement provided on 9/18/07 documented, "Definitions: "Abuse" is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Physical Abuse" includes hitting, slapping, pinching or kicking. It also includes controlling behavior through corporal punishment."

4. The Immediate Jeopardy was removed and the scope and severity reduced to an "H" on 9/19/07 at 5:17 p.m., when the following Plan of Removal was implemented:

a. The Administrator will be responsible for completion of actions.

b. The CQI (Continuous Quality Improvement) Director/Administrator will ensure compliance by review of medical records/reviewing 24 hour reports/will randomly ask staff questions regarding the abuse inservice to ensure effectiveness of training for the next 6 shifts/reviewing of the incident/accident reports daily x 5 days then weekly thereafter. Any negative findings will be corrected immediately by the appropriate designee and further education/in-servicing will be conducted as

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F 223	Continued From page 12 needed. c. Restrict visitation of husband during investigation process to supervised visits only. Resident #1's husband was informed on 9/19/07 at 3:30 p.m. by CQI Director, Administrator, and Director of Nurses that he could only visit with wife under the direct supervision of facility staff. That he was to stay in the lobby in the line of sight of facility staff. LPN, CNA or Department Head will be assigned to monitor visits and to keep him in their site at all times. Resident #1's husband will be restricted to supervised visits as long as his wife is a resident in this facility. d. Begin and complete inservicing of all staff regarding reporting/investigating/follow up reports of abuse/other inappropriate behavior. After educational in-services, staff will be able to identify/put interventions in place to prevent behavior. Facility will issue 30 day discharge notice to spouse/with notification of APS/if aberrant behavior continues. e. The CQI Director to inservice Administrator/DON/key personnel regarding following policies regarding abuse and state/federal guidelines by end of business day.	F 223		
F 225 SS=K	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would	F 225		

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F 225	Continued From page 13 indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #12930, substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure all allegations of abuse were thoroughly investigated, resident protection was provided to prevent further abuse and all allegations of abuse were reported to the local law enforcement agency and	F 225		

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the Office of Long Term (OLTC) in accordance with State Law for 2 of 2 (Resident #1 and 2) case mix residents who had an allegation of abuse. These failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Resident #1 and had the potential to affect 14 residents who resided on the locked unit according to the Registered Nurse (RN) consultant on 9/20/07 at 9:50 a.m. The facility was informed of the Immediate Jeopardy situation on 9/19/07 at 4:15 p.m. The findings are:

1. Resident #1 had diagnoses of Alzheimer's Disease and Dementia with Behavior Disturbance. The Admission Minimum Data Set (MDS) dated 6/17/07 documented the resident was moderately impaired in cognitive skills for daily decision making; required extensive assistance of one staff member for transfers, locomotion, dressing, eating and personal hygiene needs; and exhibited up to five days a week behaviors that included crying, tearfulness, and repetitive movements all of which were easily altered.

a. Skilled Nurses Notes dated 4/12/07 at 2:20 p.m. documented, "CNA (Certified Nursing Assistant) reports that she has heard r (resident) husband yelling & cussing at her... report to DON (Director of Nursing)."

A statement by the DON dated 4/12/07 at 3:00 p.m. documented, "Spoke with [Resident #1's husband] asked him if he had yelled or cussed at his wife, he denied that he 'yelled or cussed at my wife." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement

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and OLTC the resident was protected from further abuse.

b. Skilled Nurses Notes dated 4/18/07, no time noted, documented, "[Resident #1] was sitting in day rm (room) [with] lap belt on. She attempted to stand up. I was standing at the desk looking out into the day rm. [Resident #1's husband] walked up to her & [with] his fist punched [Resident #1] in the right shoulder area... 1 small bruise R (right) upper arm. Large bruise L (left) lower outer leg 3 inches long 2.5 inches wide."

1) A statement written by the Social Services Director (SSD) dated 4/18/07 documented, "R.N. [RN #1] reported to Dept. (Department) Head staff that after lunch, res (Resident) husband was out in dayroom [with] res, res started getting out of w/c (wheelchair) unassist & res husband hit at res to sit her back down in w/c, [Assistant Administrator] went to speak [with] res & husband, husband states, 'I would never hurt her. Was trying to get her back in w/c before she fell'."

2) A witness statement Licensed Practice Nurse (LPN) #1 dated 4/18/07 documented, "This nurse came to the nurses station after taking lunch, noticed that [RN #1] was visibly upset, RN stated she had seen [Resident #1's husband] hit [Resident #1] in the day room, noted that [Assistant Administrator] was out talking to [Resident #1 and husband]." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse.

c. A statement written by the DON dated 4/20/07 documented, "Residents husband was taking

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Resident to bathroom when [LPN #3] heard Resident cry out 'Your hurting me', [LPN #3] came and got me. Red area noted to lt (left) upper arm, no bruising noted. Talked to [husband] about how the staff has to report abuse. Asked him if he had a hold of her shoulders while assisting her to the bathroom, he stated, 'yes'. Asked him how he was assisting her, he stated 'I had a hold of her shoulders and was telling her to turn and sit down, she wouldn't turn so I was trying to turn her when she yelled "your hurting me"'... Told him I understand, but he may be or gets upset when she is unable to do what is expected of her & that he needed to let the CNAs take care of her, because they have training to assist the elderly."

A statement written by the SSD dated 4/20/07 documented, "Will watch for [husband] taking res to bathroom, so staff or this SSD can intervene & assist res [with] care... Spoke with DON to educate staff to intervene when they see [husband] to assist res [with] care ADLs (activities of daily living) toileting, etc." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse.

d. Skilled Nurses Notes dated 4/22/07 at 8:00 p.m. and signed by LPN #1 documented, "found bruises to resident left forearm top. One bruise 1 cm (centimeter) round, two bruises 2 cm round, one bruise 4 cm x (by) 3 cm, resident denies knowledge of getting them, physician faxed, DON notified."

e. Skilled Nurses Notes dated 4/23/07 and signed by the DON documented, "Resident's

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F 225	Continued From page 17 spouse upset over nursing staff checking bruises, talked to [husband] to inform him why we check bruises. He thought it was because he had grabbed her when she lost balance in bathroom, told him No, it was when she was in bathroom and he was trying to get her to turn around & she cried out 'your hurting me', he remembered her saying that, but is confused as to what happened, asked him if he remembered me talking to him that day, puzzled facial expression but did state he remembered." f. The Release of Responsibility for Leave of Absence form documented the resident's husband checked her out of the facility on 5/16/07. g. The Social Progress Notes dated 6/4/07 documented, "res readmitted from home, has been out on leave with husband." The Admission Nursing Assessment dated 6/4/07 documented, "several bruises all about body"... diagram documented, "bruising on both arms" h. The Licensed Nurse Progress Notes dated 6/7/07 at 2:00 p.m. documented, "CNA reports while in DR (dining room) r husband hit her hand and abdomen when she tried to help put bib back on." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse. The Care Plan dated 6/7/07 documented, "Problem Onset: Res puts bib back on after it being removed . . Approach: Instruct husband to stay calm & collected when dealing with res."	F 225		

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F 225	Continued From page 18 i. Nurse's Notes dated 6/17/07 documented, "Res readmitted to N.H. (nursing home) after husband took res home. Husband stated "I just couldn't do it. I tried but I couldn't do it. It is just too much"... husband cont (continues) to feed res instead of letting her do it herself." j. Licensed Nurse Progress Notes dated 7/2/07 at 1:00 p.m. documented, "spouse attempted to toilet without assist from personnel, states resident tried to sit on floor and then fell." Nurse's Notes dated 7/2/07 documented, "Lighthouse coordinator spoke with husband about being on schedule for visitations to [increase] res participation in care & activities. Explained to husband that res can do more for herself than he allows her to. Husband stated, 'But she spills things on her' or 'Well, she doesn't do it right'..." k. On 9/18/07 at 5:13 p.m., the resident and her husband were at the dining room table. A male resident (Resident #8) seated beside Resident #1 was coughing loudly. Resident #1's husband slapped a bib down on the dining room table and stated, "Turn your head when you cough!... He's coughing right at you and not covering his mouth!" l. On 9/18/07 at 5:15 p.m., the resident's husband was pushing away her left hand as she reached for the baked beans on her plate without an eating utensil in her hand. He also laid one of his hands over hers as he cut her meat. He spoon fed the resident her meal. m. On 9/19/07 at 10:10 a.m., LPN #2 was asked how Resident #1's husband interacted with the	F 225		

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resident, LPN #2 stated, "He gets impatient, he doesn't take the time to let her do for herself. He pulled her bib down when she pulled it up and he said, 'stop doing that, that's not what it's for' and snatched it away... one person told me they saw him get rough with her... I don't think he hit her... I think there was an investigation on that." LPN #2 was asked what was done if a resident was hit and the LPN stated, "...if we feel that it is malicious, call the police. If it's family, I don't know if the police are called."

n. On 9/19/07 at 10:35 a.m., CNA #1 was asked if she had ever heard a family member talk ugly or mean to a resident and if so, what happened, CNA #1 stated, "Yes, [Resident #1's husband]. He doesn't want other residents around his wife... If a resident wanders into her room he tells them to get out and leave her alone and don't bother her. I left [Resident #1] in her room to help another resident dress and [Resident #1's husband] walked in the other resident's room. The other resident [Resident #6] had on a dress I was helping her pull down. It was up to her waist. I told him he had to leave and could not come into someone else's room like that." When asked if she had reported this incident, she stated, "I told [LPN #1]. He complains about the man [Resident #8] who sits at their dining room table, he coughs so [Resident #1's husband] tells him not to cough or to cover his mouth. I told [Resident #1's husband] he couldn't tell anyone else what to do, he talks stern to them (other residents). I never saw him hit anyone... it bothers him for her to eat with her fingers." When asked if the resident was ever alone with her husband, the CNA stated, "He has a set time to leave, he can come 30 minutes before meals and stay 30 minutes after. We take her to the bathroom and then lay her down. He

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F 225	Continued From page 20 goes in for about 10-15 minutes to kiss her good bye, says 'I'm out of here' then says he forgot something and goes back in for about 5 minutes." When asked the last time he was alone with her, CNA #1 stated, "Yesterday between 1:00 and 1:30." When asked if she had ever heard of him slapping or hitting another resident, she stated, "I heard rumors that he slapped [Resident #2's] hand one evening a couple of months ago." o. On 9/19/07 at 11:07 a.m., LPN #1 was asked if she had observed any family members being rough or ugly with any residents and if so who and what happened. LPN #1 stated, "I've heard slapping noises behind my back, but never witnessed it... [Resident #1 and husband] but he's trying to keep her from eating with her hands... I have to talk to him almost on a daily basis telling him she can't help herself... but just this morning I heard the resident say ouch, but I don't know if he slapped her or not... I just know he was trying to force food in her mouth... he has a problem with bibs... he wants to take the bibs from other residents... I'll turn around and he'll be jerking the bib from them... he'll get mad if residents go into his wife's room... He'll take them by the arm and lead them out of the room... His wife's roommate tells on him... He'll go in there and change the channels on her TV... That he gets rough with his wife... she'll say (roommate) he pushed her or did this or that with her (wife)... another family member reported that he slapped her or was mean to her... we try not to leave him completely alone with her very much... there was one incident where he drew back his hand to hit someone but when I asked him about it, he said he was just defending himself because he thought he was gonna be hit... I've got him going to an Alzheimer's support group next week, we	F 225		

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just try to keep an eye on him." When asked if he's slapping her hands and she's hearing slapping noises, did she feel that was abuse, LPN #1 stated, "Yes. We're afraid if we push him, then he'll take her out of here and is she better off here where we can buffer or is she better off at home?"

p. On 9/19/07 at 11:35 a.m., Kitchen Staff #1 was asked if she had ever seen a family member talk mean or hit a resident and if so, who and what happened, she stated, "Yes, [Resident #1's husband] was rough to his wife and to me that was abuse. He jerked her bib off... his fists came up (she demonstrated) and he grabbed the bib and jerked it down and his fists came down and hit her chest... He also hit her hand with a wet wash cloth then... I hear that it's still going on, that he's rough with his wife, slaps at her and grabs her hands and squeezes... told the facility he was going to hurt someone and they needed to do something before he did."

q. On 9/19/07 at 11:50 a.m., the Assistant Director of Nurses (ADON) was asked if she had received any reports of incidents between family and residents and if so, who and what happened, she stated, "[Resident #1's husband]. We've interviewed staff, talked to him... he doesn't mean to hurt her, he loves her, he's had a hard time accepting what's going on with her." The ADON was asked what she thought about the statement Kitchen Staff #1 made regarding her observation involving the bib. The ADON stated, "I guess you just have to know [Kitchen Staff #1] and how she is... He just does things spontaneously, he doesn't mean to." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law

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F 225	Continued From page 22 enforcement and OLTC and the resident was protected from further abuse. r. On 9/19/07 at 12:15 p.m., the DON stated, "I've talked to him [Resident #1's husband] many times about his behavior with his wife... I think he is demented and acts spontaneously to things she does... He has threatened to take her out of here, he gets upset, he doesn't see it as being mean... A couple of nights ago he grabbed an onion out of her hand to keep her from getting mustard on herself." She stated that other than monitoring there had been no other interventions, that the police had been called on 1 occasion, that the Quality Assurance team was not utilized (mostly she and the Social Services Director only) and that the Office of Long Term Care had not been notified. When asked if she felt any other resident on the unit was at risk for harm, she stated, "There is a possibility for him to reach out and do the same, yes." s. On 9/19/07 at 12:56 p.m., the Administrator was asked to describe how Resident #1's husband interacted with his wife and other residents, she stated, "He is demented, doesn't understand her disease, expects her to function as she used to, he gets frustrated... He taps her on the arm (she demonstrated), it's not hard, to get her attention." When the Administrator was asked about the circumstances of the 6/7/07 bib incident, she stated, "This was reported to me... I told staff to find out if it was abuse... I know her (Kitchen Staff #1) if her husband had done that to her she would have knocked him down... She is very assertive... She doesn't like [Resident #1's husband] talking to her (Resident #1) that way... I did not talk to [Kitchen Staff #1] I was told this by staff." When the Administrator was asked about	F 225		

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the circumstances of the 4/18/07 allegation of the husband punching the resident's shoulder, she stated, "He did not punch the resident, that particular nurse does not like him... I did call the cops when [RN #1] was upset, he came in and said there was nothing for him to do. I've been told he takes the remote at times... and one of the residents picked up a bib off the table, he told her not to do that."

t. On 9/19/07 at 4:40 p.m., the resident's roommate was asked if she had heard Resident #1's husband talk mean to his wife, she stated, "Yes, he tells her to sit down, tries to get her to sit down, he pushes her down if she's getting up." When asked if she thought the husband was hurting his wife when doing this, she stated, "Yes." She also stated, "Today" when asked the last time the resident and her husband were alone in the room with the roommate present.

u. On 9/20/07 at 10:19 a.m., a telephone interview was conducted with the Ombudsman. She stated that when she was in the facility on 7/17/07, the Administrator said they were having trouble with Resident #1's husband talking roughly to his wife... It's not abuse or anything... He's just not a nice person. When the Ombudsman was asked if the Administrator alarmed her in any way about the way he treated his wife, she stated, "No."

2. Resident #2 had diagnoses of Osteoporosis, Alzheimer's Disease and Psychosis. The Annual MDS dated 9/4/07 documented the resident was moderately impaired in cognitive skills for daily decision-making and had behaviors of wandering which occurred 4 to 6 days out of the last 7 days.

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a. On 9/19/07 at 10:34 a.m., CNA #1 was asked if she knew of Resident #1's husband doing anything inappropriate with Resident #2. She stated, "I heard he slapped [Resident #2's] hands, but I wasn't here, and you have to see it yourself. If I see something myself, I'll address it." She was asked if she reported it. She stated, "Yes, to [LPN #1]."

b. On 9/19/07 at 12:14 p.m., the DON was asked if she knew of or had heard of an incident involving Resident #1's husband and Resident #2. She stated, "I know he jerked a bib out of her hands." The DON was asked if she knew if Resident #1's husband had ever touched or slapped Resident #2. She stated, "She reached across the table to get a sack or something. Someone heard a slap but doesn't know whether he slapped a table or her. She didn't have a red mark." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse.

3. The Immediate Jeopardy was removed and the scope and severity reduced to an "H" on 9/19/07 at 5:17 p.m., when the following Plan of Removal was implemented:

a. The Administrator will be responsible for completion of actions.

b. The CQI (Continuous Quality Improvement) Director/Administrator will ensure compliance by review of medical records/reviewing 24 hour reports/will randomly ask staff questions regarding the abuse inservice to ensure effectiveness of training for the next 6

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F 225	Continued From page 25 shifts/reviewing of the incident/accident reports daily x 5 days then weekly thereafter. Any negative findings will be corrected immediately by the appropriate designee and further education/in-servicing will be conducted as needed. c. Restrict visitation of husband during investigation process to supervised visits only. Resident #1's husband was informed on 9/19/07 at 3:30 p.m. by CQI Director, Administrator, and Director of Nurses that he could only visit with wife under the direct supervision of facility staff. That he was to stay in the lobby in the line of sight of facility staff. LPN, CNA or Department Head will be assigned to monitor visits and to keep him in their site at all times. Resident #1's husband will be restricted to supervised visits as long as his wife is a resident in this facility. d. Begin and complete inservicing of all staff regarding reporting/investigating/follow up reports of abuse/other inappropriate behavior. After educational in-services, staff will be able to identify/put interventions in place to prevent behavior. Facility will issue 30 day discharge notice to spouse/with notification of APS/if aberrant behavior continues. e. The CQI Director to inservice Administrator/DON/key personnel regarding following policies regarding abuse and state/federal guidelines by end of business day.	F 225		
F 226 SS=K	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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This REQUIREMENT is not met as evidenced by:
Complaint #12930, substantiated (all or in part) in these findings.

Based on observation, record review and interview, the facility failed to ensure their abuse prohibition policy and procedure was implemented regarding investigation of all allegations of abuse, resident protection to prevent further abuse and reporting all allegations of abuse to the local law enforcement agency and the Office of Long Term (OLTC) in accordance with State Law for 2 of 2 (Resident #1 and 2) case mix who had an allegation of abuse. These failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Resident #1 and had the potential to affect 14 residents who resided on the locked unit according to the Registered Nurse (RN) consultant on 9/20/07 at 9:50 a.m. The facility was informed of the Immediate Jeopardy situation on 9/19/07 at 4:15 p.m. The findings are:

1. The facility Abuse Prevention Program policy statement provided on 9/18/07 documented, "Definitions: "Abuse" is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Physical Abuse" includes hitting, slapping, pinching or kicking. It also includes controlling behavior through corporal punishment."

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F 226	Continued From page 27 The facility Abuse Prevention Program policy statement provided on 9/18/07 documented, "B. Prevention of Abuse: Employee Training & Interpretation: The facility will have appropriate orientation and training programs to, within its control, prevent resident abuse . . D. Investigation: The facility will promptly investigate all reported or suspected allegations of abuse . . E. Protection: The facility will have a system to protect the alleged victim from further abuse during the investigation . . Implementation: 2. While the investigation is being conducted, accused individuals not employed by the facility will be denied unsupervised access to the resident. Visits may only be made in designated areas approved by the administrator . . F. Reporting: Any alleged violations involving mistreatment, neglect, or abuse and misappropriation of resident property must be reported immediately to the administrator or designee. All reports will be promptly and thoroughly investigated . . Implementation: 1. The charge nurse will promptly start the investigation and immediately notify the administrator or designee. 2. The facility administrator or designee shall notify the Office of Long Term Care, the local police and others, of the suspected occurrence within the required reporting period as defined by Arkansas Department of Human Services, LTC-R-2000-20. 3. The facility administrator or designee shall send a written report of the results of the investigation to the Office of Long Term Care within the required reporting period as define by Arkansas Department of Human Services, LTC-R-2000-20." 2. Resident #1 had diagnoses of Alzheimer's	F 226		

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Disease and Dementia with Behavior Disturbance. The Admission Minimum Data Set (MDS) dated 6/17/07 documented the resident was moderately impaired in cognitive skills for daily decision making; required extensive assistance of one staff member for transfers, locomotion, dressing, eating and personal hygiene needs; and exhibited up to five days a week behaviors that included crying, tearfulness, and repetitive movements all of which were easily altered.

a. Skilled Nurses Notes dated 4/12/07 at 2:20 p.m. documented, "CNA (Certified Nursing Assistant) reports that she has heard r (resident) husband yelling & cussing at her... report to DON (Director of Nursing)."

A statement by the DON dated 4/12/07 at 3:00 p.m. documented, "Spoke with [Resident #1's husband] asked him if he had yelled or cussed at his wife, he denied that he 'yelled or cussed at my wife." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse.

b. Skilled Nurses Notes dated 4/18/07, no time noted, documented, "[Resident #1] was sitting in day rm (room) [with] lap belt on. She attempted to stand up. I was standing at the desk looking out into the day rm. [Resident #1's husband] walked up to her & [with] his fist punched [Resident #1] in the right shoulder area... 1 small bruise R (right) upper arm. Large bruise L (left) lower outer leg 3 inches long 2.5 inches wide."

1) A statement written by the Social Services

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Director (SSD) dated 4/18/07 documented, "R.N. [RN #1] reported to Dept. (Department) Head staff that after lunch, res (Resident) husband was out in dayroom [with] res, res started getting out of w/c (wheelchair) unassist & res husband hit at res to sit her back down in w/c, [Assistant Administrator] went to speak [with] res & husband, husband states, 'I would never hurt her. Was trying to get her back in w/c before she fell'."

2) A witness statement Licensed Practice Nurse (LPN) #1 dated 4/18/07 documented, "This nurse came to the nurses station after taking lunch, noticed that [RN #1] was visibly upset, RN stated she had seen [Resident #1's husband] hit [Resident #1] in the day room, noted that [Assistant Administrator] was out talking to [Resident #1 and husband]." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse.

c. A statement written by the DON dated 4/20/07 documented, "Residents husband was taking Resident to bathroom when [LPN #3] heard Resident cry out 'Your hurting me', [LPN #3] came and got me. Red area noted to lt (left) upper arm, no bruising noted. Talked to [husband] about how the staff has to report abuse. Asked him if he had a hold of her shoulders while assisting her to the bathroom, he stated, 'yes'. Asked him how he was assisting her, he stated 'I had a hold of her shoulders and was telling her to turn and sit down, she wouldn't turn so I was trying to turn her when she yelled "your hurting me"'... Told him I understand, but he may be or gets upset when she is unable to do what is expected of her & that he needed to let

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the CNAs take care of her, because they have training to assist the elderly."

A statement written by the SSD dated 4/20/07 documented, "Will watch for [husband] taking res to bathroom, so staff or this SSD can intervene & assist res [with] care... Spoke with DON to educate staff to intervene when they see [husband] to assist res [with] care ADLs (activities of daily living) toileting, etc." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse.

d. Skilled Nurses Notes dated 4/22/07 at 8:00 p.m. and signed by LPN #1 documented, "found bruises to resident left forearm top. One bruise 1 cm (centimeter) round, two bruises 2 cm round, one bruise 4 cm x (by) 3 cm, resident denies knowledge of getting them, physician faxed, DON notified."

e. Skilled Nurses Notes dated 4/23/07 and signed by the DON documented, "Resident's spouse upset over nursing staff checking bruises, talked to [husband] to inform him why we check bruises. He thought it was because he had grabbed her when she lost balance in bathroom, told him No, it was when she was in bathroom and he was trying to get her to turn around & she cried out 'your hurting me', he remembered her saying that, but is confused as to what happened, asked him if he remembered me talking to him that day, puzzled facial expression but did state he remembered."

f. The Release of Responsibility for Leave of Absence form documented the resident's

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husband checked her out of the facility on 5/16/07.

g. The Social Progress Notes dated 6/4/07 documented, "res readmitted from home, has been out on leave with husband." The Admission Nursing Assessment dated 6/4/07 documented, "several bruises all about body"... diagram documented, "bruising on both arms"

h. The Licensed Nurse Progress Notes dated 6/7/07 at 2:00 p.m. documented, "CNA reports while in DR (dining room) r husband hit her hand and abdomen when she tried to help put bib back on." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse.

The Care Plan dated 6/7/07 documented, "Problem Onset: Res puts bib back on after it being removed . . Approach: Instruct husband to stay calm & collected when dealing with res."

i. Nurse's Notes dated 6/17/07 documented, "Res readmitted to N.H. (nursing home) after husband took res home. Husband stated "I just couldn't do it. I tried but I couldn't do it. It is just too much"... husband cont (continues) to feed res instead of letting her do it herself."

j. Licensed Nurse Progress Notes dated 7/2/07 at 1:00 p.m. documented, "spouse attempted to toilet without assist from personnel, states resident tried to sit on floor and then fell."

Nurse's Notes dated 7/2/07 documented, "Lighthouse coordinator spoke with husband

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F 226	Continued From page 32 about being on schedule for visitations to [increase] res participation in care & activities. Explained to husband that res can do more for herself than he allows her to. Husband stated, 'But she spills things on her' or 'Well, she doesn't do it right'..." k. On 9/18/07 at 5:13 p.m., the resident and her husband were at the dining room table. A male resident (Resident #8) seated beside Resident #1 was coughing loudly. Resident #1's husband slapped a bib down on the dining room table and stated, "Turn your head when you cough!... He's coughing right at you and not covering his mouth!" l. On 9/18/07 at 5:15 p.m., the resident's husband was pushing away her left hand as she reached for the baked beans on her plate without an eating utensil in her hand. He also laid one of his hands over hers as he cut her meat. He spoon fed the resident her meal. m. On 9/19/07 at 10:10 a.m., LPN #2 was asked how Resident #1's husband interacted with the resident, LPN #2 stated, "He gets impatient, he doesn't take the time to let her do for herself. He pulled her bib down when she pulled it up and he said, 'stop doing that, that's not what it's for' and snatched it away... one person told me they saw him get rough with her... I don't think he hit her... I think there was an investigation on that." LPN #2 was asked what was done if a resident was hit and the LPN stated, "...if we feel that it is malicious, call the police. If it's family, I don't know if the police are called." n. On 9/19/07 at 10:35 a.m., CNA #1 was asked if she had ever heard a family member talk ugly	F 226		

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F 226	Continued From page 33 or mean to a resident and if so, what happened, CNA #1 stated, "Yes, [Resident #1's husband]. He doesn't want other residents around his wife... If a resident wanders into her room he tells them to get out and leave her alone and don't bother her. I left [Resident #1] in her room to help another resident dress and [Resident #1's husband] walked in the other resident's room. The other resident [Resident #6] had on a dress I was helping her pull down. It was up to her waist. I told him he had to leave and could not come into someone else's room like that." When asked if she had reported this incident, she stated, "I told [LPN #1]. He complains about the man [Resident #8] who sits at their dining room table, he coughs so [Resident #1's husband] tells him not to cough or to cover his mouth. I told [Resident #1's husband] he couldn't tell anyone else what to do, he talks stern to them (other residents). I never saw him hit anyone... it bothers him for her to eat with her fingers." When asked if the resident was ever alone with her husband, the CNA stated, "He has a set time to leave, he can come 30 minutes before meals and stay 30 minutes after. We take her to the bathroom and then lay her down. He goes in for about 10-15 minutes to kiss her good bye, says 'I'm out of here' then says he forgot something and goes back in for about 5 minutes." When asked the last time he was alone with her, CNA #1 stated, "Yesterday between 1:00 and 1:30." When asked if she had ever heard of him slapping or hitting another resident, she stated, "I heard rumors that he slapped [Resident #2's] hand one evening a couple of months ago." o. On 9/19/07 at 11:07 a.m., LPN #1 was asked if she had observed any family members being rough or ugly with any residents and if so who and what happened. LPN #1 stated, "I've heard	F 226		

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F 226	Continued From page 34 slapping noises behind my back, but never witnessed it... [Resident #1 and husband] but he's trying to keep her from eating with her hands... I have to talk to him almost on a daily basis telling him she can't help herself... but just this morning I heard the resident say ouch, but I don't know if he slapped her or not... I just know he was trying to force food in her mouth... he has a problem with bibs... he wants to take the bibs from other residents... I'll turn around and he'll be jerking the bib from them... he'll get mad if residents go into his wife's room... He'll take them by the arm and lead them out of the room... His wife's roommate tells on him... He'll go in there and change the channels on her TV... That he gets rough with his wife... she'll say (roommate) he pushed her or did this or that with her (wife)... another family member reported that he slapped her or was mean to her... we try not to leave him completely alone with her very much... there was one incident where he drew back his hand to hit someone but when I asked him about it, he said he was just defending himself because he thought he was gonna be hit... I've got him going to an Alzheimer's support group next week, we just try to keep an eye on him." When asked if he's slapping her hands and she's hearing slapping noises, did she feel that was abuse, LPN #1 stated, "Yes. We're afraid if we push him, then he'll take her out of here and is she better off here where we can buffer or is she better off at home?" p. On 9/19/07 at 11:35 a.m., Kitchen Staff #1 was asked if she had ever seen a family member talk mean or hit a resident and if so, who and what happened, she stated, "Yes, [Resident #1's husband] was rough to his wife and to me that was abuse. He jerked her bib off... his fists came	F 226		

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up (she demonstrated) and he grabbed the bib and jerked it down and his fists came down and hit her chest... He also hit her hand with a wet wash cloth then... I hear that it's still going on, that he's rough with his wife, slaps at her and grabs her hands and squeezes... told the facility he was going to hurt someone and they needed to do something before he did."

q. On 9/19/07 at 11:50 a.m., the Assistant Director of Nurses (ADON) was asked if she had received any reports of incidents between family and residents and if so, who and what happened, she stated, "[Resident #1's husband]. We've interviewed staff, talked to him... he doesn't mean to hurt her, he loves her, he's had a hard time accepting what's going on with her." The ADON was asked what she thought about the statement Kitchen Staff #1 made regarding her observation involving the bib. The ADON stated, "I guess you just have to know [Kitchen Staff #1] and how she is... He just does things spontaneously, he doesn't mean to." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse.

r. On 9/19/07 at 12:15 p.m., the DON stated, "I've talked to him [Resident #1's husband] many times about his behavior with his wife... I think he is demented and acts spontaneously to things she does... He has threatened to take her out of here, he gets upset, he doesn't see it as being mean... A couple of nights ago he grabbed an onion out of her hand to keep her from getting mustard on herself." She stated that other than monitoring there had been no other interventions, that the police had been called on 1 occasion, that the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASH FLAT HEALTHCARE AND REHABILITATION CENTER	66 OSBIRN LANE ASH FLAT, AR 72513

(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
F 226	Continued From page 36 Quality Assurance team was not utilized (mostly she and the Social Services Director only) and that the Office of Long Term Care had not been notified. When asked if she felt any other resident on the unit was at risk for harm, she stated, "There is a possibility for him to reach out and do the same, yes." s. On 9/19/07 at 12:56 p.m., the Administrator was asked to describe how Resident #1's husband interacted with his wife and other residents, she stated, "He is demented, doesn't understand her disease, expects her to function as she used to, he gets frustrated... He taps her on the arm (she demonstrated), it's not hard, to get her attention." When the Administrator was asked about the circumstances of the 6/7/07 bib incident, she stated, "This was reported to me... I told staff to find out if it was abuse... I know her (Kitchen Staff #1) if her husband had done that to her she would have knocked him down... She is very assertive... She doesn't like [Resident #1's husband] talking to her (Resident #1) that way... I did not talk to [Kitchen Staff #1] I was told this by staff." When the Administrator was asked about the circumstances of the 4/18/07 allegation of the husband punching the resident's shoulder, she stated, "He did not punch the resident, that particular nurse does not like him... I did call the cops when [RN #1] was upset, he came in and said there was nothing for him to do. I've been told he takes the remote at times... and one of the residents picked up a bib off the table, he told her not to do that." t. On 9/19/07 at 4:40 p.m., the resident's roommate was asked if she had heard Resident #1's husband talk mean to his wife, she stated, "Yes, he tells her to sit down, tries to get her to sit	F 226		

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F 226	Continued From page 37 down, he pushes her down if she's getting up." When asked if she thought the husband was hurting his wife when doing this, she stated, "Yes." She also stated, "Today" when asked the last time the resident and her husband were alone in the room with the roommate present. u. On 9/20/07 at 10:19 a.m., a telephone interview was conducted with the Ombudsman. She stated that when she was in the facility on 7/17/07, the Administrator said they were having trouble with Resident #1's husband talking roughly to his wife... It's not abuse or anything... He's just not a nice person. When the Ombudsman was asked if the Administrator alarmed her in any way about the way he treated his wife, she stated, "No." 3. Resident #2 had diagnoses of Osteoporosis, Alzheimer's Disease and Psychosis. The Annual MDS dated 9/4/07 documented the resident was moderately impaired in cognitive skills for daily decision-making and had behaviors of wandering which occurred 4 to 6 days out of the last 7 days. a. On 9/19/07 at 10:34 a.m., CNA #1 was asked if she knew of Resident #1's husband doing anything inappropriate with Resident #2. She stated, "I heard he slapped [Resident #2's] hands, but I wasn't here, and you have to see it yourself. If I see something myself, I'll address it." She was asked if she reported it. She stated, "Yes, to [LPN #1]." b. On 9/19/07 at 12:14 p.m., the DON was asked if she knew of or had heard of an incident involving Resident #1's husband and Resident #2. She stated, "I know he jerked a bib out of her hands." The DON was asked if she knew if	F 226		

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F 226	Continued From page 38 Resident #1's husband had ever touched or slapped Resident #2. She stated, "She reached across the table to get a sack or something. Someone heard a slap but doesn't know whether he slapped a table or her. She didn't have a red mark." There was no documentation in the clinical record that the allegation of abuse was investigated, reported to local law enforcement and OLTC and the resident was protected from further abuse. 4. The Immediate Jeopardy was removed and the scope and severity reduced to an "H" on 9/19/07 at 5:17 p.m., when the following Plan of Removal was implemented: a. The Administrator will be responsible for completion of actions. b. The CQI (Continuous Quality Improvement) Director/Administrator will ensure compliance by review of medical records/reviewing 24 hour reports/will randomly ask staff questions regarding the abuse inservice to ensure effectiveness of training for the next 6 shifts/reviewing of the incident/accident reports daily x 5 days then weekly thereafter. Any negative findings will be corrected immediately by the appropriate designee and further education/in-servicing will be conducted as needed. c. Restrict visitation of husband during investigation process to supervised visits only. Resident #1's husband was informed on 9/19/07 at 3:30 p.m. by CQI Director, Administrator, and Director of Nurses that he could only visit with wife under the direct supervision of facility staff. That he was to stay in the lobby in the line of sight	F 226		

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F 226	Continued From page 39 of facility staff. LPN, CNA or Department Head will be assigned to monitor visits and to keep him in their site at all times. Resident #1's husband will be restricted to supervised visits as long as his wife is a resident in this facility. d. Begin and complete inservicing of all staff regarding reporting/investigating/follow up reports of abuse/other inappropriate behavior. After educational in-services, staff will be able to identify/put interventions in place to prevent behavior. Facility will issue 30 day discharge notice to spouse/with notification of APS/if aberrant behavior continues. e. The CQI Director to inservice Administrator/DON/key personnel regarding following policies regarding abuse and state/federal guidelines by end of business day.	F 226		