

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/19/2007
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703	
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=E	<p>Complaint #12222, unsubstantiated. Complaint #12226, unsubstantiated.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>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 indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p>	F 225		

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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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that incidents of verbal and/or mental abuse and/or injuries of unknown origin were reported immediately to the Administrator and/or reported to the Office of Long Term Care (OLTC) and other State agencies in accordance with State law and/or thoroughly investigated and protection from further incidents provided for 6 (Residents # 1, 4, 7, 10, 11, and 12,) of 7 case mix residents with injuries of unknown origin and/or allegations of abuse (Residents # 1, 4, 7, 10, 11, 12, and 14). This failed practice had the potential to affect 95 residents in the facility according to the Resident Roster Report received from the Administrator on 12/27/06 at 10:37 a.m. The findings are: 1. Resident # 10 had a diagnosis of Dementia with inappropriate behavior. The significant Change Minimum data Set (MDS) dated 1/11/07 documented that the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, the resident wandered and had verbally abusive and socially inappropriate/disruptive behaviors that were not easily altered. a. The Care Plan reviewed on 9/14/06 documented, "Problem/Needs: Behavior/Mood indicators of wandering/pacing, occa [occasional] anger, acting out/tantrums, crying to go home, ... manipulative behavior, falling per choice ...". b. The Nurses Notes dated 10/28/06 at 9:15	F 225			

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F 225	<p>Continued From page 2</p> <p>p.m., by Licensed Practical Nurse (LPN) # 1 documented, "finished passing meds - CNA [Certified Nursing Assistant] approached stating I have something to tell you. Stated resident said she was mad because he forced himself on her. When he stated he was going to tell the nurse she stated I was kidding and not to tell. When LPN spoke with resident she denied the abuse. Stated she did not know what I was saying. Called Administrator @ 8:45 p.m., paged Dr. [Name] at 9:00 p.m., spoke with [City] police @ 9:05 p.m. Statements taken by both CNAs on unit. CNA directed not to have any contact with resident. ...".</p> <p>c. The Nurses Notes dated 10/30/06 at 4:30 p.m., documented, "Above incident reviewed and investigated. POC [plan of care] reviewed".</p> <p>d. The Nurses Notes dated 10/31/06 at 12:00 p.m. documented, "Body audit completed w [with] 1 x [by] 3 in [inch] bruise right [R with circle around it] FA [forearm] upper [arrow pointing up] right [R with circle around it] arm with [c with line over it] cm [centimeter] dia [diameter] bruise " .</p> <p>e. The DMS-7734 documented the date of Incident and Accident as 10/28/06 at 7:15 p.m. and indicated that the type of incident was sexual abuse. The DMS-7734 documented, "Steps taken to prevent continued abuse or neglect during the investigation ... Summary of incident "About 7:20 p.m. about taking another resident to smoke I can back to the unit and seen [Resident # 10] light on. When I went to the room, [CNA # 12], another C.N.A. [Certified Nurses Assistant] was putting on her oxygen. The C.N.A. left the room and the resident looked upset, I ask her what was wrong and she stated that she was</p>	F 225			

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F 225	Continued From page 3 mad, I ask her why are you mad and she stated because you forced your self on me. I ask what do you mean, she made me have sex. I stated you need to let me get the nurse and you need to repeat this to her. Resident stated please don't I was just kidding. The C.N.A. report it to the nurse. Suspension of employee accused began. All staff in-serviced regarding abuse. Note in chart, no men in resident's room. Will cont [continue] with investigation." f. The DMS-762 documented the date and time of the incident and discovery as 10/28/06 at 7:15 p.m. and indicated that the type of abuse was sexual. Section II Complete description of incident documented "At 7:15 p.m. after taking another resident to smoke, the C.N.A. went back to the hall. When he got on the hall he noticed that [Resident # 10] call light was on. When the C.N.A. entered the room another C.N.A. [CNA # 12] was putting [Resident # 10's] oxygen on and she left the room. The male C.N.A. noticed that the resident seemed upset, the C.N.A. ask the resident what was wrong, the resident stated that she was mad. The C.N.A. ask her 'Why are you mad'? The resident stated 'Because you forced yourself on me'. The C.N.A. ask 'what do you mean', the resident stated, 'you made me have sex'. The C.N.A. stated that 'you need to let me get the nurse and need to repeat this to her'. The resident stated 'Please don't I was just kidding'. At this time is when the C.N.A. sent and reported it to the nurse." Section III findings and Actions Taken: "... All witness involved have stated that [CNA # 8] did not do anything to [Resident # 10]. Other residents on the hall were interview regarding any issues with [CNA # 8] or any other C.N.A.'s. The findings were no. The police were notified and there were no finding. ... Section IV	F 225			

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F 225	Continued From page 4 - Notification/Status documented that the [City] Police Department was notified on 10/28/06 at 7:30 p.m. " . g. The [City] Police Department Information Report documented that they were notified of the incident on 10/28/06 at 9:04 p.m. h. The TimeCard Report documented that CNA # 8 clocked in on Saturday 10/28/06 at 1:36 p.m. and clocked out at 10:02 p.m.. CNA # 8 clocked in on Sunday 10/29/06 at 1:42 p.m. and clocked out at 3:51 p.m. i. On 1/17/07 at 2:10 p.m., LPN # 1 was asked to review the Nurses Notes dated 10/28/06 at 9:15 p.m.. LPN # 1 was asked if the documented times for Administrator notification was correct, if so why it took so long to notify the Administrator. LPN # 1 stated "Yes, the resident said nothing happened but the more I thought about it I thought I better call. I first thought it was [Resident # 10] being [Resident # 10]. I had been on the hall while [CNA #8] was outside assisting a resident to smoke". LPN # 1 was asked if Resident # 10 had said when CNA # 8 had forced her to have sex. LPN # 1 stated "No". LPN # 1 was asked if she sent CNA # 8 home (suspended employee). LPN # 1 stated "I don't remember, I told him not to have any contact with [Resident # 10], I thought we sent him home, maybe we moved him". j. On 1/17/07 at 4:55 p.m., LPN # 1 was asked if she had done a body audit to check for any perineal bruises, swelling, discharge, etc. LPN # 1 stated, "No, I guess I should have". k. On 1/18/07 at 5:25 p.m., the Administrator was	F 225			

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F 225	Continued From page 5 asked to review the Nurses Notes dated 10/28/06 at 9:15 p.m. and the DMS-762. The Administrator was asked how the times documented on the DMS-762 were determined. The Administrator stated, "It takes me an hour to get here & about 15 minutes to leave the house so I would have left about 7:45 so I was called at 7:30 p.m.. When I got here I asked if they had called the police yet - they said no". The Administrator was asked what time did you when document that the police had been notified. The Administrator stated, "7:30 p.m.". The Administrator was asked when were they were notified. The Administrator stated, "9:05 p.m. per Nurses Notes". The Administrator was asked what were the interventions for protection of the resident. The Administrator stated, "Suspended [CNA #8]". The Administrator was asked when was CNA # 8 was suspended. The Administrator stated, "Should have been right then". The Administrator was asked did you think about telling the LPN to send [CNA # 8] home. The Administrator stated, "No". The Administrator was asked were any interviews with other residents done. The Administrator stated, "Interviews were not done on other halls than C hall." The Administrator was asked how many times the residents were interviewed on C hall. The Administrator stated "Once, the policy says, " ... Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses ". The Administrator was asked if the residents on C hall were cognitively impaired. The Administrator stated, "Yes". The Administrator was asked if the policy entitled, "Abuse, Neglect and Exploitation", had any specific directions for investigating sexual abuse. The Administrator stated, "No".	F 225			

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F 225	<p>Continued From page 6</p> <p>The Administrator was asked when a body audit should have been done. The Administrator stated, "Right after the resident stated the CNA forced sex on her".</p> <p>l. There was no chronological documentation of the investigation other than witness statements, the DMS-7734 and the DMS-762.</p> <p>m. There was no documented suspension of CNA # 8. The employee time card did documented that CNA # 8 clocked out at 10:02 p.m., on 10/28/06, three hours after the allegation of "forced sex" and that CNA # 8 was present on 10/29/06 from 1:42 p.m., until 3:51 p.m..</p> <p>n. There was not a documented interview with Resident # 10's room mate. There were 3 resident interviews documented for Residents # 1, 4, and 10, but there were not multiple interviews as per policy for these cognitively impaired residents.</p> <p>o. There were no documented body audits for female residents that CNA # 8 had worked with. A body audit was not conducted for Resident # 10 until 3 days of the allegation of "forced sex".</p> <p>2. Resident # 1 had diagnoses of Dementia and Anxiety State. The Quarterly Minimum Data Set (MDS) dated 6/8/06 documented that the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making, had behaviors of wandering, verbally abusive, resisted care and the behaviors were not easily altered.</p> <p>a. The Nurses Notes dated 12/18/05 documented, "Skin audit, skin warm/dry, large</p>	F 225			

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F 225	Continued From page 7 black bruise noted on upper left arm ...". b. The Incident/Accident Report dated 12/18/06 documented "... 2. Description of incident to include injury ... This nurse observed large, approx [approximately] 2 1/2 cm [centimeter] in diameter, black bruise, when doing skin audit, when asked resident about the bruise, she stated 'I probably bumped into something honey', none of the employees present knew about the bruise. 3. Was any other person involved in the incident? ... Unknown. 4. List witness(s) and obtain witness statements. If applicable interview resident and roommate. None. ... 9. Summary of corrective action taken to prevent reoccurrence: First aid. Resident discharged 12/27/06". There were 3 signatures documented on the Non-Witness Statement. The 3 signatures were from the Treatment Nurse, the Unit Manager and Certified Nurse Assistant (CNA) # 10 who was working on the 6:00 a.m. to 2:00 p.m. shift at the time the injury was discovered. c. On 1/18/07 at 4:15 p.m., the Director of Nursing (DON) was asked to review the policy entitled "Abuse, Neglect and Exploitation". The DON was asked does anything in the policy tell you how to investigate an injury of unknown origin. The DON stated, "Not very clearly". The DON was asked if any witness statement were obtained regarding the bruise on the resident's upper arm. The DON stated, "Not filled out". The DON was asked if interviews were conducted with staff who worked with the resident prior to the injury being found. The DON stated, "None done". d. The DMS-7734 regarding resident # 1 documented, "Sexual" abuse occurred on	F 225			

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F 225	<p>Continued From page 8</p> <p>12/18/06 at 7:30 p.m.. ... Summary of Incident: CNA [#7] reported to [CNA #10] Unit Coordinator that on 12/18/06 Resident [#1] was yelling. [CNA #7] immediately responded to the loud voice. She opened the door and witnesses [CNA #8] lying in the bed next to the resident [#1] with his arm around the resident. Both resident and employee were fully clothed. [Resident # 1] was upset and yelling get out my room and leave me alone. [CNA # 7] reports that she stayed in the room with the resident while [CNA #8] left the room. The resident calmed down without further incident of yelling that evening. CNA [#8] was not on schedule on 12/18/06 when the alleged incident occurred according to facility and payroll records. Steps taken to prevent continued abuse or neglect during the investigation: CNA [#8] was suspended during the investigation. Interviews had started for staff and residents. Retraining of all staff has started. All female residents that CNA [# 8] had worked with in the past two weeks had body audits completed on 12/20/06 with no negative findings".</p> <p>e. The DMS-762 regarding Resident # 1 documented, "Verbal" abuse occurred on 12/18/06 at 8:30 p.m.. ... Section II - Completed Description of Incident: C.N.A. [Certified Nurses Assistant] [#7] reported to [CNA # 10] Unit Coordinator that on 12/18/06 Resident [#1] was yelling. [CNA # 7] immediately responded to the loud voice. She opened the door and witnessed [CNA # 8] lying in bed next to resident [#1] with his arm around the resident. Both resident and employee were fully clothed. [Resident #1] was upset and yelling get out of my room and leave me alone. Section III - Findings and Actions Taken: [Social Service Director (SSD)] interviewed C.N.A. [# 7] regarding date of</p>	F 225		

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F 225	Continued From page 9 incident, C.N.A. stated that was Monday the 18th. [SSD] explained that she was to be suspended due to there were reports that did not match and dates that did not match. C.N.A. [#7] came to the facility the next day and wrote a statement that she had stated the wrong date. It was Sunday the 17th. He was not scheduled Monday. ... Resident was questioned regarding the incident but did not remember any of it. Resident does have short or long term memory loss. A camera has been placed on the unit with volume and is being recorded in the administrator ' s office. No men are allowed to work on the unit. New Unit Director is being put into place. Monthly inservices regarding abuse will be provided. Monthly training will be provided to all staff that work on the unit. C.N.A. is also not allowed to work on unit. SSD ... will interview residents and staff weekly regarding any type of abuse". The DMS-762 also documented that the Administrator and Law Enforcement were notified on 12/20/06 but there was no time of notification documented. There was one resident interview documented (Resident # 15). There was a statement from CNA # 7 which documented "I was working on C-hall Monday 12/18/06, we had put all the resident to bed and [Resident #1] was asleep in her bed. I heard [Resident #1] screaming and cursing 'Get out of my room, leave me alone.' I went to see what was wrong and I found [CNA #8] in her bed with [Resident #1] with his arm around her. When I walked in her got up and said he was giving [Resident #1] a hard time. He then told [Resident # 1] he would leave her alone if she gave him a hug. She reluctantly did and we left the room and shut the door". There was a witness statement from CNA # 8 who stated the incident did not occur. A second written letter was present from CNA # 7 which stated she had	F 225			

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F 225	Continued From page 10 gotten the date of the incident mixed up and that it had occurred on 12/17/06, Sunday and not on 12/18/06. f. On 1/18/07 at 3:05 p.m., the Social Service Director (SSD) was as to describe what happened after CNA # 11 informed him that an allegation of abuse had been made by CNA # 7. The SSD described taking with CNA # 7 and getting statements, having the DON start body audits. Then stated that he started interviewing the residents. The SSD stated that he talked with residents # 15, 1, 4 and 10. The SSD stated that he did not write out anything for resident # 10 and that it "Could have been [Resident # 1] that I didn't have that written up on". The SSD stated that he inserviced staff next on reporting abuse and neglect in a timely manner. When asked if he had inserviced everyone in the building, the SSD stated. I doubt it. Seems like by that time the 1st shift had left or was leaving. From what I remember seems like I was catching them individually". When asked if they were signing anything, the SSD stated "Seems like". The SSD was given a copy of the 12/20/06 inservice education sign in sheet. The SSD was then asked if this was what you had the staff sign. The SSD stated "Seems like. I thought it was more than that". The SSD was asked why he did not in-service everyone. The SSD stated "At that point ... [long pause] I'm not sure, seem like it was getting close to supper and I know they were going to be busy". The SSD was asked if he came back later and tried to catch the others. The SSD stated, "I assumed that me, myself or the DON were going to continue to do the in servicing". The SSD was asked when did you suspend CNA # 8. The SSD stated, "Kind of difficult to say, I'm pretty sure it was close to 3:00	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
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F 225	Continued From page 11 p.m. on the 20th". The SSD was asked if there was anything in writing from talking/suspending CNA # 8. The SSD stated, "No". The SSD was asked for documentation of interviews with residents and staff that were to be done weekly regarding abuse. The SSD stated "I'm trying to think, probably not going to have anything. I'm pretty sure I don't have anything there". The SSD was asked did you interview the residents on C hall more that once as per you policy. The SSD stated No". The SSD was asked why residents on halls other than C hall had not been interviewed. The SSD stated "I thought [CNA #8] was only on C hall. I didn ' t think he'd had contact with other residents on other halls". The SSD was asked if the assignments sheets had been reviewed to determine if CNA # 8 had been on other halls. The SSD stated "Not far enough back to determine if he was on other units [halls] - looked back to December 16th or 17th". The SSD was asked if staff from other shift had been interviewed. The SSD stated "Yes, but didn't get written statements". The SSD was asked to review the policy entitled "Abuse, Neglect and Exploitation". The SSD was asked if the policy told him how to investigate allegations of sexual abuse. The SSD stated "Not as detailed as it should be". The SSD was asked if there were any specifics on how to investigate sexual abuse. The SSD stated "I haven't found any specifics yet". g. On 1/18/07 at 4:15 p.m., the Director of Nursing (DON) was asked to review the policy entitled "Abuse, Neglect and Exploitation". The DON was asked does anything in the policy tell you how to investigate allegations of sexual abuse. The DON stated, "No, it's pretty much up to common sense to look for bruising, emotional	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 12</p> <p>distress. I don't see where it's written in black and white. She would tear if any penetration had occurred but that wasn't what the accusation was - basically it was just being in bed with her". The DON was asked if that would not make her suspect possible sexual abuse. The DON stated, "No". When asked why not, the DON stated "My gut tells me no. I had not observed him [CNA # 8] with any residents being unusually fearful or uncomfortable around him ...". When asked how you make sure sexual abuse/intercourse didn't occur, the DON stated, "We check for bruising". The DON was asked to describe the body audit for Resident # 1. The DON stated that the Treatment Nurse and LPN # 1 did the body audit on the 22nd and then did a second one while the family - granddaughter and daughter went to the shower with them. They found no bruises except one on arm - it was nothing suspicious just a bump. The DON was asked if she had examined Resident # 1 herself. The DON stated, "No". The DON was asked if there was documentation of the body audits. The DON stated, "Personally, I don't know". The DON was asked if body audits had been done on all female residents on the closed unit (C hall). The DON stated, "No, I don't think so".</p> <p>h. On 1/18/06 at 5:25 p.m., the Administrator was asked if there was anything in writing for the suspension of CNA # 8. The Administrator stated, "I don't think so". The Administrator was asked if the investigation included any staff that was present on C hall other than CNA # 7 and 8. The Administrator stated, "No". When asked if statements had been obtained from staff relieving on C hall, the Administrator stated, "No". When asked if there was a statement from the Unit Manager, the Administrator stated, "No". The</p>	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 13 Administrator was asked if Resident # 1 had been interviewed about CNA # 8 being in bed with her. The Administrator stated, "No". The Administrator was asked how many residents had been interviewed about possible sexual abuse. The Administrator stated "One". The Administrator was asked if statements had been obtained from LPNs working on C hall (closed unit). The Administrator stated, "No statements". The Administrator was asked what was the outcome of the facility's investigation. The Administrator stated, "[CNA # 7] made a false statement. When asked if the investigation was thorough enough to make that determination, the Administrator stated, "No". The Administrator was asked if she knew where the documentation for the body audits were, did she have them. The Administrator stated, "No". The Administrator was asked if they had reviewed or revised the abuse policies following this allegation and investigation. The Administrator stated, "We need more specifics - what to do, how to do it, who to notify, time frame, more involvement as far as investigation goes. The Administrator was asked if she was aware that an injury of unknown origin was documented on 12/18/06 in an Incident/Accident Report. The Administrator stated, "Yes". When asked if the Incident/Accident Report had been tied into the investigation, the Administrator stated, "No". When asked who was supposed to be conducting the monthly inservices on abuse specified in the DMS-762, the Administrator stated, "[CNA # 11]. When asked if this had been done, the Administrator stated, "No". The Administrator was asked if the SSD was providing copies of the weekly staff and resident interviews on abuse. The Administrator stated, "No". When asked if she had requested the SSD interviews, the	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 14 Administrator stated, "No". 3. As of 1/18/07 the facility was unable to provide documentation or the documentation that was provided for the following: a. There was no chronological documentation of the investigation other than witness statements, the DMS-7734 and the DMS-762. b. There was no documented suspension of CNA # 8. The employee time card did documented that CNA # 8 clocked out on 12/19/06 at 8:30 p.m. and did not work again until 12/28/06. c. There were no witness statements from the Licensed Practical Nurses who worked on Saturday 12/16/06, Sunday 12/17/06 or Monday 12/18/06. d. There were no witness statements from staff that were relieving the CNAs for lunch or breaks or staff that might have been briefly on the unit during these dates. There were no witness statement from the staff on the following shift (10:00 p.m. to 6:00 a.m.) regarding the behavior of Resident # 1 following this alleged incident. e. There was no witness statement from the CNA # 10, the Unit Manager to whom CNA # 7 first reported the incident. f. There were no documented interviews with Resident # 1, nor were there interviews from residents in surrounding rooms who may have witnessed the incident. There was no documentation that CNA # 7 or # 8 were asked what resident were still up that might have had knowledge of this incident.	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 15 g. There were no documented body audits for female residents that CNA # 8 had worked with for the past two weeks. Nor was there a documented body audit for Resident # 1. h. The In-Service Education Report dated 12/20/06 documented signatures for 16 employees. The Active Employee Report received from the Administrator on 1/12/07 documented 107 total active employees. i. There was no outcome of the facility's investigation documented on the DMS-762. 4. Resident # 4 had diagnoses of Paranoid Schizophrenia and Anxiety State. The Quarterly Minimum Data Set dated 11/20/06 documented that the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making. a. The DMS-7734 regarding resident # 4 documented, "Verbal" abuse occurred on 12/18/06 at 8:30 p.m. ... Summary of Incident: CNA [CNA #7] reported to unit coordinator [CNA # 11] that she overheard CNA [CNA # 8] that her daughter was not ever going to come and pick her up. CNA [CNA # 7] took resident to room for bed. CNA [CNA # 8] was not on schedule the night of 12/18/06 when the alleged incident occurred according to facility and payroll records. Steps taken to prevent continued abuse or neglect during the investigation: CNA [CNA # 8] was suspended during the investigation. Interviewing of residents and staff have started. Retraining to Staff has started". b. The DMS-762 regarding Resident # 4	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
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F 225	Continued From page 16 documented, "Verbal" abuse occurred on 12/18/06 at 8:30 p.m." ... Section II - CNA [CNA #7] reported to unit coordinator [CNA # 11] that she overheard CNA [CNA # 8] that her daughter was not ever going to come and pick her up. CNA [CNA # 7] took resident to room for bed. CNA [CNA # 8] was not on schedule the night of 12/18/06 when the alleged incident occurred according to facility and payroll records. Section III - Findings and Actions Taken: [SSD] interviewed C.N.A. [# 7] regarding date of incident, C.N.A. stated that was Monday the 18th. [SSD] explained that she was to be suspended due to there were reports that did not match and dates that did not match. C.N.A. [#7] came to the facility the next day and wrote a statement that she had stated the wrong date. It was Sunday the 17th. ... Resident was questioned regarding the incident but did not remember any of it. Resident does have short or long term memory loss. A camera has been placed on the unit with volume and is being recorded in the administrator's office. No men are allowed to work on the unit. New Unit director is being put into place. Monthly inservices regarding abuse will be provided. Monthly training will be provided to all staff that work on the unit. C.N.A, is also not allowed to work on unit. SSD [name] will interview residents and staff weekly regarding any type of abuse. The DMS-762 documented that Law Enforcement were notified on 12/20/06 but there was no time of notification documented. There were two resident interviews documented, (Residents # 4 and 15). There was a statement from CNA # 7 which documented "[Resdient # 4] was waiting for her daughter she had some of her belongings in the T.V. room. [CNA #8] came in from lunch and started yelling at [Resident # 4] that her daughter was not ever going to cone and	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 17</p> <p>pick her up. [Resident # 4] was very upset and shaking and arguing with [CNA # 8] - [CNA # 8] said that if [Resident # 4] was still there tomorrow when he came to work the [Resident # 4] had to pay him \$500.00 I took [Resident # 4] to her room and got her calmed down and she went to sleep". There no witness statement from CNA # 8. A second written letter was present from CNA # 7 which stated she had gotten the date of the incident mixed up and that it had occurred on 12/17/06, Sunday and not on 12/18/06.</p> <p>c. On 1/18/06 at 5:25 p.m., the Administrator was asked if there was anything in writing for the suspension of CNA # 8. The Administrator stated, "I don't think so". The Administrator was asked if the investigation included any staff that were present on C hall other than CNA # 7 and 8. The Administrator stated, "No". When asked if statements had been obtained from staff relieving on C hall, the Administrator stated, "No". When asked if there was a statement from the Unit Manager, the Administrator stated "No". When asked if the DMS-762 included a statement form CNA # 8, the Administrator stated "No". The Administrator was asked if statements had been obtained from LPNs working on C hall (closed unit). The Administrator stated, "No statements". The Administrator was asked what was the outcome of the facility's investigation. The Administrator stated, "[CNA # 7] made a false statement. When asked if the investigation was thorough enough to make that determination, the Administrator stated, "No".</p> <p>5. As of 1/18/07 the facility was unable to provide documentation or the documentation that was provided for the following:</p>	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
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F 225	Continued From page 18 a. There was no chronological documentation of the investigation other than witness statements, the DMS-7734 and the DMS-762. b. There was no documented suspension of CNA # 8. The employee time card did documented that CNA # 8 clocked out on 12/19/06 at 8:30 p.m. and did not work again until 12/28/06. c. There were no witness statements from the Licensed Practical Nurses who worked on Saturday 12/16/06, Sunday 12/17/06 or Monday 12/18/06. d. There were no witness statements from staff that were relieving the CNAs for lunch or breaks or staff that might have been briefly on the unit during these dates. There were no witness statement from the staff on the following shift (10:00 p.m. to 6:00 a.m.) regarding the behavior of Resident # 4 following this alleged incident. e. There was no witness statement from the CNA # 10, the Unit Manager to whom CNA # 7 first reported the incident. f. There were 2 resident interviews documented from Resident # 4 and 15, however there was no documentation of multiple interviews with these cognitively impaired residents as per the facility's policy. g. The In-Service Education Report dated 12/20/06 documented signatures for 16 employees. The Active Employee Report received from the Administrator on 1/12/07 documented 107 total active employees. h. There was no outcome of the facility's	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
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F 225	Continued From page 19 investigation documented on the DMS-762. 6. Resident # 11 had diagnoses of Osteoarthritis and Joint Contracture. The Annual Minimum Data Set (MDS) dated 11/14/06 documented that the resident had short and long term memory problems, was severely impaired in cognitive skills for daily decision making, required extensive assistance with bed mobility and was dependent on staff for transfers. a. The Nurses Notes dated 11/7/06 at 8:30 p.m., by LPN # 2 documented, "Daughter reported noticing 2 inch red bruise on upper left [L with a circle around it] chest area. No [O with a slash across it] other injury noted. No [O with a slash across it] c/o [complaint pain] ...". There was no documentation of finding the resident on the floor, nor was there an Incident and Accident report for a fall/injury on this date. b. The Incident/Accident Report dated 11/7/06 documented, "... 2. Description of incident to include injury ... Red bruise noted left [L with a circle around it] upper chest area 2 inch circle. Daughter noticed it and reported it to [LPN # 1] ... 3. Was any other person involved in the incident? ... No. 4. List witness(s) and obtain witness statements. If applicable interview resident and roommate. 2 CNAs listed. ... 9. summary of corrective action taken to prevent reoccurrence: Blank." There were no signatures documented on the Non-Witness Statement. There were no statements from the 2 CNAs who were listed as witnesses. c. The DMS-7734 regarding resident # 11 documented, "Physical" abuse was reported on 11/7/06 at 7:00 p.m. "Summary of Incident: At	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 20</p> <p>7:00 p.m. on 11/7/06 [Resident # 11's] daughter reported that her mother told her someone hit her in the chest. C.N.A. and daughter looked at resident chest and there was a bruise. C.N.A. did report it to LPN on 11/7/06. LPN did not report it to the Administrator until 11/9/06. Steps taken to prevent continued abuse or neglect during the investigation: Disciplinary action has been taken in regards to the LPN not reporting timely. All staff members for the day and who provided care have been interviewed. In-service regarding reporting abuse or neglect has been started. Will cont [continue] with investigation".</p> <p>d. The DMS-762 regarding Resident # 11 documented, "Physical" abuse occurred on an unknown date."... Section II - Daughter stated that mother reported that someone hit her in the chest. Bruise present. Section III - Findings and Actions Taken: Resident is low bed due to fall precautions. Resident rolled out of low bed onto mat with arm under her. Have spoken with daughter regarding issues. Daughter stated that her mother rolls or tries to get out of bed often. Replace mat with thicker mat at bed side. Nurses and/or CNA will complete body audit when resident is find on mat". There were 2 witness statements from LPN # 2. The witness Statement dated 11/7/06 at 8:30 p.m. documented, "What did you see? Bruise 2 inch red on upper [arrow pointing up] on left [L with a circle around it]. ... do you have any other factual information pertaining to the incident investigation that you witnessed? I picked her up off floor matt in room next to low bed at 6:20 p.m". The second witness statement from LPN # 2 dated 11/9/07 at 1:00 p.m., documented, "On 11/7/06 at 8:00 p.m., daughter of Resident [# 11] reported to med a red palm size 2 inch bruise on upper [arrow pointing</p>	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
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F 225	<p>Continued From page 21</p> <p>up] left [L with a circle around it]. Daughter stated someone hit her there. [Resident # 11] very confused. No [O with slash through it] other injury noted. explained to daughter that I had picked her up myself off mat next to low bed at about 6:20 p.m.". The DMS-762 also documented that Law Enforcement were notified on 11/9/06 at 1:30 p.m.</p> <p>e. The [City] Police Department Information Report documented notification on 11/9/06 at 12:46 p.m.</p> <p>f. The [City] Police Department Report dated 12/8/06 documented, "On 11/9/06 at approximately 1:00 p.m., I arrived at [address] to take a report of an alleged assault and battery. There I spoke with the LPN [#2], who told me that the patient, [Resident # 11] suffers from Dementia. [LPN # 2] said the [Resident # 11's] daughter [name] thought someone punched [Resident # 11] in the chest because there was bruise on her upper left chest about the size of a palm. She thought that because she did not see how she could have gotten it by falling down. We have no suspect information. [LPN # 2] said at approximately 6:00 p.m. she had picked [Resident # 11] up from the floor and placed her back into bed".</p> <p>g. On 1/18/07 at 5:25 p.m., the Administrator was asked to review the facility Policy and Procedure entitled, "Abuse, Neglect and Exploitation". The Administrator was then asked if she could find anything in the policy that gave her directions on how to investigate and injury of unknown origin. The Administrator stated, "Yes, process number III down through V". The Administrator was then asked to review the facility's policy entitled</p>	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
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F 225	<p>Continued From page 22</p> <p>"Incidents and Accidents". The Administrator was then asked who should you get witness statements from according to this policy. The Administrator stated "Staff and residents - staff that worked that shift, previous shifts and staff on surrounding halls". The Administrator was asked what was done to protect Resident # 11. The Administrator stated, "[SSD] interviewed residents and staff to see if anything had occurred". The Administrator was asked how did the interviews protect the resident from possible abuse. The Administrator stated, "I guess it didn't". The Administrator was asked where are the resident interviews. The Administrator stated, "We don't have any". The Administrator was asked who are the Non-Witness statements from. The Administrator stated, "Day shift staff". The Administrator was asked who else should you have interviewed. The Administrator stated, "Evening and night staff". The Administrator was asked how she had determined what happened to cause the bruise. The Administrator stated, "Staff - [LPN # 2 and CNA # 12] told me that's what happened". The Administrator was asked should you have gotten another statement from them. The Administrator stated, "Yes".</p> <p>7. As of 1/18/07 the facility was unable to provide documentation or the documentation that was provided for the following:</p> <p>a. There was no chronological documentation of the investigation other than witness statements, the DMS-7734 and the DMS-762.</p> <p>b. There were no witness statements from the Licensed Practical Nurses who worked prior to LPN # 2's shift on 11/7/06.</p>	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 23</p> <p>c. There were 18 signatures on the "Non-witness statement" form from employees who work the day shift (6:00 a.m. to 2:00 p.m.) only. There were 3 witness statement from CNAs - 1 day shift and 2 evening shift CNAs. There were no witness statements from CNAs who work the night shift (10:00 p.m. to 6:00 a.m.).</p> <p>d. There were no resident interviews documented for Resident # 11 nor was the resident's room mate or residents in surrounding rooms interviewed. There was no documentation of body audits for other cognitively impaired residents on the hall the resident resided on or any other hall in the facility.</p> <p>8. Resident # 7 had diagnoses of Atherosclerotic Dementia and Agitation. the Annual Minimum Data Set (MDS) dated 1/11/07 documented that the resident had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also documented that the resident required extensive assistance for bed mobility and was dependent on staff for transfers.</p> <p>a. The Nurses Notes dated 12/28/06 at 2:45 p.m., documented, "On head to toe assessment by Tx [treatment] Nurse resident [r with a line over it] was found to have a bruise on left [L with a circle around it] ankle area. ...".</p> <p>b. The Incident Investigation/Follow-up report dated 12/28/06 at 11:15 a.m. documented "...2. Description of incident to include injury ... Tx Nurse doing body assessment found bruise on left [L with a circle around it] ankle area goes around foot. 3. Was any other person involved in the incident? ... No. 4. List witness(s) and obtain</p>	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 24</p> <p>witness statements. If applicable interview resident and roommate. None. ... 9. Summary of corrective action taken to prevent reoccurrence: Staff education on transfer proper technique." There were 10 signatures documented on the Non-Witness Statement.</p> <p>c. On 1/18/07 at 4:15 p.m., the DON was asked if the injury of unknown origin for this resident had been investigated correctly. The DON stated, "I don't remember seeing this I&A [Incident and Accident] report - No". The DON was asked are any of the staff signatures on the form (Non-Witness Statement) more than day shift. The DON stated, "Probably not because we only ask the people on that shift".</p> <p>d. On 1/18/07 at 5:25 p.m., the Administrator was asked to review the Non-witness statements obtained during this investigation. The Administrator was asked what shift the employees worked who signed the Non-Witness Statement. The Administrator stated, "Days". When asked if other shifts should have been interviewed, the Administrator stated, "Yes".</p> <p>9. Resident # 12 had diagnoses of Dementia and Alzheimer's Disease. Resident was admitted on 12/27/06. There was no MDS data available. The admission assessment documented that the resident was oriented to person, was independent with ambulation, some weakness to upper and lower extremities and required assistance with personal hygiene.</p> <p>a. The Nurses Notes dated 1/11/07 at 7:30 a.m. by LPN # 2 documented, "Large bump with bruises x [times] 2 bilat [bilateral] forehead with swelling noted. 3 cm [centimeter] lump noted on</p>	F 225		

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

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F 225	<p>Continued From page 25</p> <p>right [R with a circle around it] top eye. Brow area with [c with a line over it] bruising et [and] swelling. ... No [O with a slash through it] other injury noted. A/O [alert/oriented] x 1. confused. Easily redirected. No [O with a slash through it] c/o [complaint] pain.</p> <p>b. The Incident Investigation/Follow-up report dated 1/11/07 at 7:30 a.m. documented "...2. Upon arrival on shift, noted 3 cm lump with bruise on right [R with circle around it] eye brow + [and] bruise on left [L with a circle around it] forehead with [cc with line over it] lump. ... 3. Was any other person involved in the incident? ... No. 4. List witness(s) and obtain witness statements. If applicable interview resident and roommate. [Blank]. ... 9. Summary of corrective action taken to prevent reoccurrence: Chest of drawers was moved away from her bed." there was one witness statement from LPN # 2 who discovered the bruise of unknown origin. There were no witness statements from any other staff (Unit Manager, LPN on prior shift, CNAs on shift injury was discovered or CNAs on the shift(s) prior to discovery of the injury of unknown origin).</p> <p>c. On 1/18/07 at 4:15 p.m., the DON was asked if the injury of unknown origin for this resident had been investigated per policy. The DON stated, "Probably but I did not get witness statements ... I did speak with the night shift. The DON was asked if there was a statement from the staff on night shift. The DON stated, "No". The DON was again asked if the injury of unknown origin had been investigated per policy. The DON stated, "No. Yea, I dropped the ball".</p> <p>d. On 1/18/07 at 5:25 p.m., the Administrator was asked to review Incident Investigation/Follow-up</p>	F 225			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 26 report dated 12/28/06. The Administrator was asked if this was investigated thoroughly. The Administrator stated, "No". 10. On 1/17/06 at 10:40 a.m. CNA # 9 was interviewed regarding his knowledge of the allegations made by CNA #7 regarding Residents # 1 and # 4. CNA # 9 was asked when had CNA # 7 told him about her concerns. CNA # 9 stated, "[CNA # 7] talked about something on Saturday but I think it was Sunday when she said she'd come back in there and found resident's upset". When asked what time this occurred on Sunday (12/18/06), CNA # 9 replied, "After she got home around 10:30 p.m. or 11:00 p.m". CNA # 9 was asked what did you tell her. CNA # 9 stated, "She needed to report as soon as possible". CNA # 9 was asked when did CNA # 7 report this. CNA # 9 stated, "I can't remember if it was Monday or Tuesday ...". CNA # 9 was asked was there a reason you didn't tell her to call back to the nursing home to report these concerns. CNA # 9 stated, "No, I didn't think about calling back to let them know ...". CNA # 9 was asked if anyone had counseled/talked with him about reporting timely. CNA # 9 stated, "No". 11. On 1/18/07 at 5:45 p.m., the Administrator was asked does your abuse policy and procedure mention/tell you to notify the police. The Administrator stated "Uhuh [No]".	F 225			
F 226 SS=E	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			

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

PRINTED: 01/31/2007
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F 226	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that implementation of the facilities policy and procedure is operationalized to ensure that incidents of verbal and/or mental abuse and/or injuries of unknown origin were reported immediately to the Administrator and/or reported to the Office of Long Term Care (OLTC) and other State agencies in accordance with State law and/or thoroughly investigated and protection from further incidents provided for 6 (Residents # 1, 4, 7, 10, 11, and 12,)of 7 case mix residents with injuries of unknown origin and/or allegations of abuse (Residents # 1, 4, 7, 10, 11, 12, and 14). The facility also failed to ensure employees received facility specified training prior to working on the closed unit (C hall). This failed practice had the potential to affect 95 residents in the facility according to the Resident Roster Report received from the Administrator on 12/27/06 at 10:37 a.m. The findings are:</p> <p>1. The facility's Nursing Management Manual and the Social Service Manual policy entitled "Abuse, Neglect and Exploitation" documented "Standard: The Abuse coordinator in the facility is the director of Nursing or facility appointed designee. Report allegations or suspected abuse, neglect or exploitation immediately to: State Agencies, Local Ombudsman Office, Director of Nursing, Administrator ... Process: ...</p> <p>II. New employees should be educated, by the department manager, on abuse, neglect and exploitation during initial orientation. ... III. Response and Reporting of Abuse, Neglect and Exploitation ... When abuse, neglect or exploitation is suspected, the Licensed Nurse</p>	F 226			

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

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F 226	Continued From page 28 should: a) Respond to the needs of the resident and protect them from further incident b) Notify the director of Nursing and Administrator c) Complete an incident report and initiate an investigation immediately (policy NM.I-12) ... e) Obtain witness statements, following policy NM.I-12. Suspend the accused employee immediately IV. Investigation of Alleged Abuse, Neglect and Exploitation When suspicion of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. Components of an investigation may include: a) Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. interview all witnesses separately. Include room, residents in adjoining rooms, staff members in the area and visitors in the area. Obtain witness statements, according to policy NM.I-12. All statements should be signed and dated by the person making the statement. ... c) Document the entire investigation chronologically. V. Resident Protection After Alleged Abuse, Neglect and Exploitation ... g) Reassignment of nursing staff duties h) Time off for nursing staff ... For more information, refer to the Abuse Manual. Tips for the prevention and identification of abuse, neglect and exploitation are attached ... Tips For Prevention of Abuse, Neglect and Exploitation ... React to all allegation or questions of abuse by residents, family members, employees or visitors. Take appropriate actions when abuse, neglect or exploitation is suspected. ... Identify areas of the physical environment that may make abuse or neglect more likely to occur, such as secluded	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
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F 226	<p>Continued From page 29</p> <p>areas. ... Assess, monitor, and develop appropriate plans of care for residents with inappropriate sexual behavior, whether towards staff or other residents. ... Physical marks such as bruises or patterned appearances such as a hand print, belt or ring mark on a resident's body. Physical injury of a resident , of unknown source. ... Verbal abuse of a resident overheard. ...".</p> <p>2. The facility's Nursing Management Manual policy entitled "Incidents and Accidents" documented "Standard: An incident is an occurrence that may not be consistent with the routine operations of the facility or the routine care of a particular resident. It may involve an injury ... Examples include but are not limited to: fall/observed on floor ... skin tears/bruises ... In some circumstances, incidents may be reportable to state agencies. Examples include but are not limited to; allegations/suspensions of resident abuse ... Process: ... Documentation ... b) An Incident/Accident report should be completed (form NM.I-12). c) Witness Statement should be completed as follows: Employees in the area of the accident having no knowledge of the incident should be asked to sign form NM.I-12c. Employees having knowledge of, or who witnessed the incident, should be interviewed, and the nurse conducting the interview should complete form NM.I-12b. The employee should sign the form after completion. d) Initiate an investigation using form NM.I-12d. ...".</p> <p>3. Resident # 10 had a diagnosis of Dementia with inappropriate behavior. The significant Change Minimum data Set (MDS) dated 1/11/07 documented that the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, the</p>	F 226			

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

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F 226	<p>Continued From page 30</p> <p>resident wandered and had verbally abusive and socially inappropriate/disruptive behaviors that were not easily altered.</p> <p>a. The Care Plan reviewed on 9/14/06 documented, "Problem/Needs: Behavior/Mood indicators of wandering/pacing, occa [occasional] anger, acting out/tantrums, crying to go home, ... manipulative behavior, falling per choice ...".</p> <p>b. The Nurses Notes dated 10/28/06 at 9:15 p.m., by Licensed Practical Nurse (LPN) # 1 documented, "finished passing meds - CNA [Certified Nursing Assistant] approached stating I have something to tell you. Stated resident said she was mad because he forced himself on her. When he stated he was going to tell the nurse she stated I was kidding and not to tell. When LPN spoke with resident she denied the abuse. Stated she did not know what I was saying. Called Administrator @ 8:45 p.m., paged Dr. [Name] at 9:00 p.m., spoke with [City] police @ 9:05 p.m. Statements taken by both CNAs on unit. CNA directed not to have any contact with resident. ...".</p> <p>c. The Nurses Notes dated 10/30/06 at 4:30 p.m., documented, "Above incident reviewed and investigated. POC [plan of care] reviewed".</p> <p>d. The Nurses Notes dated 10/31/06 at 12:00 p.m. documented, "Body audit completed w [with] 1 x [by] 3 in [inch] bruise right [R with circle around it] FA [forearm] upper [arrow pointing up] right [R with circle around it] arm with [c with line over it] cm [centimeter] dia [diameter] bruise " .</p> <p>e. The DMS-7734 documented the date of Incident and Accident as 10/28/06 at 7:15 p.m.</p>	F 226			

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

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F 226	<p>Continued From page 31</p> <p>and indicated that the type of incident was sexual abuse. The DMS-7734 documented, "Steps taken to prevent continued abuse or neglect during the investigation ... Summary of incident "About 7:20 p.m. about taking another resident to smoke I can back to the unit and seen [Resident # 10] light on. When I went to the room, [CNA # 12], another C.N.A. [Certified Nurses Assistant] was putting on her oxygen. The C.N.A. left the room and the resident looked upset, I ask her what was wrong and she stated that she was mad, I ask her why are you mad and she stated because you forced your self on me. I ask what do you mean, she made me have sex. I stated you need to let me get the nurse and you need to repeat this to her. Resident stated please don't I was just kidding. The C.N.A. report it to the nurse. Suspension of employee accused began. All staff in-serviced regarding abuse. Note in chart, no men in resident's room. Will cont [continue] with investigation."</p> <p>f. The DMS-762 documented the date and time of the incident and discovery as 10/28/06 at 7:15 p.m. and indicated that the type of abuse was sexual. Section II Complete description of incident documented "At 7:15 p.m. after taking another resident to smoke, the C.N.A. went back to the hall. When he got on the hall he noticed that [Resident # 10] call light was on. When the C.N.A. entered the room another C.N.A. [CNA # 12] was putting [Resident # 10's] oxygen on and she left the room. The male C.N.A. noticed that the resident seemed upset, the C.N.A. ask the resident what was wrong, the resident stated that she was mad. The C.N.A. ask her 'Why are you mad'? The resident stated 'Because you forced yourself on me'. The C.N.A. ask 'what do you mean', the resident stated, 'you made me have</p>	F 226			

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

PRINTED: 01/31/2007
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703		
(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	<p>Continued From page 32</p> <p>sex'. The C.N.A. stated that 'you need to let me get the nurse and need to repeat this to her'. The resident stated 'Please don't I was just kidding'. At this time is when the C.N.A. sent and reported it to the nurse." Section III findings and Actions Taken: "... All witness involved have stated that [CNA # 8] did not do anything to [Resident # 10]. Other residents on the hall were interview regarding any issues with [CNA # 8] or any other C.N.A.'s. The findings were no. The police were notified and there were no finding. ... Section IV - Notification/Status documented that the [City] Police Department was notified on 10/28/06 at 7:30 p.m. " .</p> <p>g. The [City] Police Department Information Report documented that they were notified of the incident on 10/28/06 at 9:04 p.m.</p> <p>h. The TimeCard Report documented that CNA # 8 clocked in on Saturday 10/28/06 at 1:36 p.m. and clocked out at 10:02 p.m.. CNA # 8 clocked in on Sunday 10/29/06 at 1:42 p.m. and clocked out at 3:51 p.m.</p> <p>i. On 1/17/07 at 2:10 p.m., LPN # 1 was asked to review the Nurses Notes dated 10/28/06 at 9:15 p.m.. LPN # 1 was asked if the documented times for Administrator notification was correct, if so why it took so long to notify the Administrator. LPN # 1 stated "Yes, the resident said nothing happened but the more I thought about it I thought I better call. I first thought it was [Resident # 10] being [Resident # 10]. I had been on the hall while [CNA #8] was outside assisting a resident to smoke". LPN # 1 was asked if Resident # 10 had said when CNA # 8 had forced her to have sex. LPN # 1 stated "No". LPN # 1 was asked if she sent CNA # 8 home (suspended</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
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F 226	Continued From page 33 employee). LPN # 1 stated "I don't remember, I told him not to have any contact with [Resident # 10], I thought we sent him home, maybe we moved him". j. On 1/17/07 at 4:55 p.m., LPN # 1 was asked if she had done a body audit to check for any perineal bruises, swelling, discharge, etc. LPN # 1 stated, "No, I guess I should have". k. On 1/18/07 at 5:25 p.m., the Administrator was asked to review the Nurses Notes dated 10/28/06 at 9:15 p.m. and the DMS-762. The Administrator was asked how the times documented on the DMS-762 were determined. The Administrator stated, "It takes me an hour to get here & about 15 minutes to leave the house so I would have left about 7:45 so I was called at 7:30 p.m.. When I got here I asked if they had called the police yet - they said no". The Administrator was asked what time did you when document that the police had been notified. The Administrator stated, "7:30 p.m.". The Administrator was asked when were they were notified. The Administrator stated, "9:05 p.m. per Nurses Notes". The Administrator was asked what were the interventions for protection of the resident. The Administrator stated, "Suspended [CNA #8]". The Administrator was asked when was CNA # 8 was suspended. The Administrator stated, "Should have been right then". The Administrator was asked did you think about telling the LPN to send [CNA # 8] home. The Administrator stated, "No". The Administrator was asked were any interviews with other residents done. The Administrator stated, "Interviews were not done on other halls than C hall." The Administrator was asked how many times the residents were interviewed on C hall.	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/19/2007
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F 226	<p>Continued From page 34</p> <p>The Administrator stated "Once, the policy says, " ... Interview the involved resident, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses ". The Administrator was asked if the residents on C hall were cognitively impaired. The Administrator stated, "Yes". The Administrator was asked if the policy entitled, "Abuse, Neglect and Exploitation", had any specific directions for investigating sexual abuse. The Administrator stated, "No". The Administrator was asked when a body audit should have been done. The Administrator stated, "Right after the resident stated the CNA forced sex on her".</p> <p>l. There was no chronological documentation of the investigation other than witness statements, the DMS-7734 and the DMS-762.</p> <p>m. There was no documented suspension of CNA # 8. The employee time card did documented that CNA # 8 clocked out at 10:02 p.m., on 10/28/06, three hours after the allegation of "forced sex" and that CNA # 8 was present on 10/29/06 from 1:42 p.m., until 3:51 p.m..</p> <p>n. There was not a documented interview with Resident # 10's room mate. There were 3 resident interviews documented for Residents # 1, 4, and 10, but there were not multiple interviews as per policy for these cognitively impaired residents.</p> <p>o. There were no documented body audits for female residents that CNA # 8 had worked with. A body audit was not conducted for Resident # 10 until 3 days of the allegation of "forced sex".</p>	F 226		

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703		
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F 226	<p>Continued From page 35</p> <p>p. There was no evaluation of the facility ' s abuse policy for procedures to follow when investigating allegations of sexual abuse.</p> <p>4. Resident # 1 had diagnoses of Dementia and Anxiety State. The Quarterly Minimum Data Set (MDS) dated 6/8/06 documented that the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making, had behaviors of wandering, verbally abusive, resisted care and the behaviors were not easily altered.</p> <p>a. The Nurses Notes dated 12/18/05 documented, "Skin audit, skin warm/dry, large black bruise noted on upper left arm ...".</p> <p>b. The Incident/Accident Report dated 12/18/06 documented "... 2. Description of incident to include injury ... This nurse observed large, approx [approximately] 2 1/2 cm [centimeter] in diameter, black bruise, when doing skin audit, when asked resident about the bruise, she stated 'I probably bumped into something honey', none of the employees present knew about the bruise. 3. Was any other person involved in the incident? ... Unknown. 4. List witness(s) and obtain witness statements. If applicable interview resident and roommate. None. ... 9. Summary of corrective action taken to prevent reoccurrence: First aid. Resident discharged 12/27/06". There were 3 signatures documented on the Non-Witness Statement. The 3 signatures were from the Treatment Nurse, the Unit Manager and Certified Nurse Assistant (CNA) # 10 who was working on the 6:00 a.m. to 2:00 p.m. shift at the time the injury was discovered.</p> <p>c. On 1/18/07 at 4:15 p.m., the Director of</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
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F 226	<p>Continued From page 36</p> <p>Nursing (DON) was asked to review the policy entitled "Abuse, Neglect and Exploitation". The DON was asked does anything in the policy tell you how to investigate an injury of unknown origin. The DON stated, "Not very clearly". The DON was asked if any witness statement were obtained regarding the bruise on the resident's upper arm. The DON stated, "Not filled out". The DON was asked if interviews were conducted with staff who worked with the resident prior to the injury being found. The DON stated, "None done".</p> <p>d. The DMS-7734 regarding resident # 1 documented, "Sexual" abuse occurred on 12/18/06 at 7:30 p.m.. ... Summary of Incident: CNA [#7] reported to [CNA #10] Unit Coordinator that on 12/18/06 Resident [#1] was yelling. [CNA #7] immediately responded to the loud voice. She opened the door and witnesses [CNA #8] lying in the bed next to the resident [#1] with his arm around the resident. Both resident and employee were fully clothed. [Resident # 1] was upset and yelling get out my room and leave me alone. [CNA # 7] reports that she stayed in the room with the resident while [CNA #8] left the room. The resident calmed down without further incident of yelling that evening. CNA [#8] was not on schedule on 12/18/06 when the alleged incident occurred according to facility and payroll records. Steps taken to prevent continued abuse or neglect during the investigation: CNA [#8] was suspended during the investigation. Interviews had started for staff and residents. Retraining of all staff has started. All female residents that CNA [# 8] had worked with in the past two weeks had body audits completed on 12/20/06 with no negative findings".</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703		
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F 226	Continued From page 37 e. The DMS-762 regarding Resident # 1 documented, "Verbal" abuse occurred on 12/18/06 at 8:30 p.m.. ... Section II - Completed Description of Incident: C.N.A. [Certified Nurses Assistant] [#7] reported to [CNA # 10] Unit Coordinator that on 12/18/06 Resident [#1] was yelling. [CNA # 7] immediately responded to the loud voice. She opened the door and witnessed [CNA # 8] lying in bed next to resident [#1] with his arm around the resident. Both resident and employee were fully clothed. [Resident #1] was upset and yelling get out of my room and leave me alone. Section III - Findings and Actions Taken: [Social Service Director (SSD)] interviewed C.N.A. [# 7] regarding date of incident, C.N.A. stated that was Monday the 18th. [SSD] explained that she was to be suspended due to there were reports that did not match and dates that did not match. C.N.A. [#7] came to the facility the next day and wrote a statement that she had stated the wrong date. It was Sunday the 17th. He was not scheduled Monday. ... Resident was questioned regarding the incident but did not remember any of it. Resident does have short or long term memory loss. A camera has been placed on the unit with volume and is being recorded in the administrator ' s office. No men are allowed to work on the unit. New Unit Director is being put into place. Monthly inservices regarding abuse will be provided. Monthly training will be provided to all staff that work on the unit. C.N.A. is also not allowed to work on unit. SSD ... will interview residents and staff weekly regarding any type of abuse". The DMS-762 also documented that the Administrator and Law Enforcement were notified on 12/20/06 but there was no time of notification documented. There was one resident interview documented (Resident # 15). There was a statement from	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
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F 226	<p>Continued From page 38</p> <p>CNA # 7 which documented "I was working on C-hall Monday 12/18/06, we had put all the resident to bed and [Resident #1] was asleep in her bed. I heard [Resident #1] screaming and cursing 'Get out of my room, leave me alone.' I went to see what was wrong and I found [CNA #8] in her bed with [Resident #1] with his arm around her. When I walked in her got up and said he was giving [Resident #1] a hard time. He then told [Resident # 1] he would leave her alone if she gave him a hug. She reluctantly did and we left the room and shut the door". There was a witness statement from CNA # 8 who stated the incident did not occur. A second written letter was present from CNA # 7 which stated she had gotten the date of the incident mixed up and that it had occurred on 12/17/06, Sunday and not on 12/18/06.</p> <p>f. On 1/18/07 at 3:05 p.m., the Social Service Director (SSD) was as to describe what happened after CNA # 11 informed him that an allegation of abuse had been made by CNA # 7. The SSD described taking with CNA # 7 and getting statements, having the DON start body audits. Then stated that he started interviewing the residents. The SSD stated that he talked with residents # 15, 1, 4 and 10. The SSD stated that he did not write out anything for resident # 10 and that it "Could have been [Resident # 1] that I didn't have that written up on". The SSD stated that he inserviced staff next on reporting abuse and neglect in a timely manner. When asked if he had inserviced everyone in the building, the SSD stated. I doubt it. Seems like by that time the 1st shift had left or was leaving. From what I remember seems like I was catching them individually". When asked if they were signing anything, the SSD stated "Seems like". The SSD</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703		
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F 226	Continued From page 39 was given a copy of the 12/20/06 inservice education sign in sheet. The SSD was then asked if this was what you had the staff sign. The SSD stated "Seems like. I thought it was more than that". The SSD was asked why he did not in-service everyone. The SSD stated "At that point ... [long pause] I'm not sure, seem like it was getting close to supper and I know they were going to be busy". The SSD was asked if he came back later and tried to catch the others. The SSD stated, "I assumed that me, myself or the DON were going to continue to do the in servicing". The SSD was asked when did you suspend CNA # 8. The SSD stated, "Kind of difficult to say, I'm pretty sure it was close to 3:00 p.m. on the 20th". The SSD was asked if there was anything in writing from talking/suspending CNA # 8. The SSD stated, "No". The SSD was asked for documentation of interviews with residents and staff that were to be done weekly regarding abuse. The SSD stated "I'm trying to think, probably not going to have anything. I'm pretty sure I don't have anything there". The SSD was asked did you interview the residents on C hall more that once as per you policy. The SSD stated No". The SSD was asked why residents on halls other than C hall had not been interviewed. The SSD stated "I thought [CNA #8] was only on C hall. I didn ' t think he'd had contact with other residents on other halls". The SSD was asked if the assignments sheets had been reviewed to determine if CNA # 8 had been on other halls. The SSD stated "Not far enough back to determine if he was on other units [halls] - looked back to December 16th or 17th". The SSD was asked if staff from other shift had been interviewed. The SSD stated "Yes, but didn't get written statements". The SSD was asked to review the policy entitled "Abuse, Neglect and	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 226	Continued From page 40 Exploitation". The SSD was asked if the policy told him how to investigate allegations of sexual abuse. The SSD stated "Not as detailed as it should be". The SSD was asked if there were any specifics on how to investigate sexual abuse. The SSD stated "I haven't found any specifics yet". g. On 1/18/07 at 4:15 p.m., the Director of Nursing (DON) was asked to review the policy entitled "Abuse, Neglect and Exploitation". The DON was asked does anything in the policy tell you how to investigate allegations of sexual abuse. The DON stated, "No, it's pretty much up to common sense to look for bruising, emotional distress. I don't see where it's written in black and white. She would tear if any penetration had occurred but that wasn't what the accusation was - basically it was just being in bed with her". The DON was asked if that would not make her suspect possible sexual abuse. The DON stated, "No". When asked why not, the DON stated "My gut tells me no. I had not observed him [CNA # 8] with any residents being unusually fearful or uncomfortable around him ...". When asked how you make sure sexual abuse/intercourse didn't occur, the DON stated, "We check for bruising". The DON was asked to describe the body audit for Resident # 1. The DON stated that the Treatment Nurse and LPN # 1 did the body audit on the 22nd and then did a second one while the family - granddaughter and daughter went to the shower with them. They found no bruises except one on arm - it was nothing suspicious just a bump. The DON was asked if she had examined Resident # 1 herself. The DON stated, "No". The DON was asked if there was documentation of the body audits. The DON stated, "Personally, I don't know". The DON was asked if body audits had	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 226	Continued From page 41 been done on all female residents on the closed unit (C hall). The DON stated, "No, I don't think so". h. On 1/18/06 at 5:25 p.m., the Administrator was asked if there was anything in writing for the suspension of CNA # 8. The Administrator stated, "I don't think so". The Administrator was asked if the investigation included any staff that was present on C hall other than CNA # 7 and 8. The Administrator stated, "No". When asked if statements had been obtained from staff relieving on C hall, the Administrator stated, "No". When asked if there was a statement from the Unit Manager, the Administrator stated, "No". The Administrator was asked if Resident # 1 had been interviewed about CNA # 8 being in bed with her. The Administrator stated, "No". The Administrator was asked how many residents had been interviewed about possible sexual abuse. The Administrator stated "One". The Administrator was asked if statements had been obtained from LPNs working on C hall (closed unit). The Administrator stated, "No statements". The Administrator was asked what was the outcome of the facility's investigation. The Administrator stated, "[CNA # 7] made a false statement. When asked if the investigation was thorough enough to make that determination, the Administrator stated, "No". The Administrator was asked if she knew where the documentation for the body audits were, did she have them. The Administrator stated, "No". The Administrator was asked if they had reviewed or revised the abuse policies following this allegation and investigation. The Administrator stated, "We need more specifics - what to do, how to do it, who to notify, time frame, more involvement as far as investigation goes. The Administrator was	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 42</p> <p>asked if she was aware that an injury of unknown origin was documented on 12/18/06 in an Incident/Accident Report. The Administrator stated, "Yes". When asked if the Incident/Accident Report had been tied into the investigation, the Administrator stated, "No". When asked who was supposed to be conducting the monthly inservices on abuse specified in the DMS-762, the Administrator stated, "[CNA # 11]. When asked if this had been done, the Administrator stated, "No". The Administrator was asked if the SSD was providing copies of the weekly staff and resident interviews on abuse. The Administrator stated, "No". When asked if she had requested the SSD interviews, the Administrator stated, "No".</p> <p>5. As of 1/18/07 the facility was unable to provide documentation or the documentation that was provided for the following:</p> <p>a. There was no chronological documentation of the investigation other than witness statements, the DMS-7734 and the DMS-762.</p> <p>b. There was no documented suspension of CNA # 8. The employee time card did documented that CNA # 8 clocked out on 12/19/06 at 8:30 p.m. and did not work again until 12/28/06.</p> <p>c. There were no witness statements from the Licensed Practical Nurses who worked on Saturday 12/16/06, Sunday 12/17/06 or Monday 12/18/06.</p> <p>d. There were no witness statements from staff that were relieving the CNAs for lunch or breaks or staff that might have been briefly on the unit during these dates. There were no witness</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703		
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F 226	<p>Continued From page 43</p> <p>statement from the staff on the following shift (10:00 p.m. to 6:00 a.m.) regarding the behavior of Resident # 1 following this alleged incident.</p> <p>e. There was no witness statement from the CNA # 10, the Unit Manager to whom CNA # 7 first reported the incident.</p> <p>f. There were no documented interviews with Resident # 1, nor were there interviews from residents in surrounding rooms who may have witnessed the incident. There was no documentation that CNA # 7 or # 8 were asked what resident were still up that might have had knowledge of this incident.</p> <p>g. There were no documented body audits for female residents that CNA # 8 had worked with for the past two weeks. Nor was there a documented body audit for Resident # 1.</p> <p>h. The In-Service Education Report dated 12/20/06 documented signatures for 16 employees. The Active Employee Report received from the Administrator on 1/12/07 documented 107 total active employees.</p> <p>i. There was no outcome of the facility's investigation documented on the DMS-762.</p> <p>6. Resident # 4 had diagnoses of Paranoid Schizophrenia and Anxiety State. The Quarterly Minimum Data Set dated 11/20/06 documented that the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making.</p> <p>a. The DMS-7734 regarding resident # 4 documented, "Verbal" abuse occurred on</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
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F 226	<p>Continued From page 44</p> <p>12/18/06 at 8:30 p.m. ... Summary of Incident: CNA [CNA #7] reported to unit coordinator [CNA # 11] that she overheard CNA [CNA # 8] that her daughter was not ever going to come and pick her up. CNA [CNA # 7] took resident to room for bed. CNA [CNA # 8] was not on schedule the night of 12/18/06 when the alleged incident occurred according to facility and payroll records. Steps taken to prevent continued abuse or neglect during the investigation: CNA [CNA # 8] was suspended during the investigation. Interviewing of residents and staff have started. Retraining to Staff has started".</p> <p>b. The DMS-762 regarding Resident # 4 documented, "Verbal" abuse occurred on 12/18/06 at 8:30 p.m." ... Section II - CNA [CNA #7] reported to unit coordinator [CNA # 11] that she overheard CNA [CNA # 8] that her daughter was not ever going to come and pick her up. CNA [CNA # 7] took resident to room for bed. CNA [CNA # 8] was not on schedule the night of 12/18/06 when the alleged incident occurred according to facility and payroll records. Section III - Findings and Actions Taken: [SSD] interviewed C.N.A. [# 7] regarding date of incident, C.N.A. stated that was Monday the 18th. [SSD] explained that she was to be suspended due to there were reports that did not match and dates that did not match. C.N.A. [#7] came to the facility the next day and wrote a statement that she had stated the wrong date. It was Sunday the 17th. ... Resident was questioned regarding the incident but did not remember any of it. Resident does have short or long term memory loss. A camera has been placed on the unit with volume and is being recorded in the administrator's office. No men are allowed to work on the unit. New Unit director is being put</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 45</p> <p>into place. Monthly inservices regarding abuse will be provided. Monthly training will be provided to all staff that work on the unit. C.N.A, is also not allowed to work on unit. SSD [name] will interview residents and staff weekly regarding any type of abuse. The DMS-762 documented that Law Enforcement were notified on 12/20/06 but there was no time of notification documented. There were two resident interviews documented, (Residents # 4 and 15). There was a statement from CNA # 7 which documented "[Resdient # 4] was waiting for her daughter she had some of her belongings in the T.V. room. [CNA #8] came in from lunch and started yelling at [Resident # 4] that her daughter was not ever going to cone and pick her up. [Resident # 4] was very upset and shaking and arguing with [CNA # 8] - [CNA # 8] said that if [Resident # 4] was still there tomorrow when he came to work the [Resident # 4] had to pay him \$500.00 I took [Resident # 4] to her room and got her calmed down and she went to sleep". There no witness statement from CNA # 8. A second written letter was present from CNA # 7 which stated she had gotten the date of the incident mixed up and that it had occurred on 12/17/06, Sunday and not on 12/18/06.</p> <p>c. On 1/18/06 at 5:25 p.m., the Administrator was asked if there was anything in writing for the suspension of CNA # 8. The Administrator stated, "I don't think so". The Administrator was asked if the investigation included any staff that were present on C hall other than CNA # 7 and 8. The Administrator stated, "No". When asked if statements had been obtained from staff relieving on C hall, the Administrator stated, "No". When asked if there was a statement from the Unit Manager, the Administrator stated "No". When asked if the DMS-762 included a statement form</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 46</p> <p>CNA # 8, the Administrator stated "No". The Administrator was asked if statements had been obtained from LPNs working on C hall (closed unit). The Administrator stated, "No statements". The Administrator was asked what was the outcome of the facility's investigation. The Administrator stated, "[CNA # 7] made a false statement. When asked if the investigation was thorough enough to make that determination, the Administrator stated, "No".</p> <p>7. As of 1/18/07 the facility was unable to provide documentation or the documentation that was provided for the following:</p> <p>a. There was no chronological documentation of the investigation other than witness statements, the DMS-7734 and the DMS-762.</p> <p>b. There was no documented suspension of CNA # 8. The employee time card did documented that CNA # 8 clocked out on 12/19/06 at 8:30 p.m. and did not work again until 12/28/06.</p> <p>c. There were no witness statements from the Licensed Practical Nurses who worked on Saturday 12/16/06, Sunday 12/17/06 or Monday 12/18/06.</p> <p>d. There were no witness statements from staff that were relieving the CNAs for lunch or breaks or staff that might have been briefly on the unit during these dates. There were no witness statement from the staff on the following shift (10:00 p.m. to 6:00 a.m.) regarding the behavior of Resident # 4 following this alleged incident.</p> <p>e. There was no witness statement from the CNA # 10, the Unit Manager to whom CNA # 7 first</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 47 reported the incident.</p> <p>f. There were 2 resident interviews documented from Resident # 4 and 15, however there was no documentation of multiple interviews with these cognitively impaired residents as per the facility's policy.</p> <p>g. The In-Service Education Report dated 12/20/06 documented signatures for 16 employees. The Active Employee Report received from the Administrator on 1/12/07 documented 107 total active employees.</p> <p>h. There was no outcome of the facility's investigation documented on the DMS-762.</p> <p>8. Resident # 11 had diagnoses of Osteoarthritis and Joint Contracture. The Annual Minimum Data Set (MDS) dated 11/14/06 documented that the resident had short and long term memory problems, was severely impaired in cognitive skills for daily decision making, required extensive assistance with bed mobility and was dependent on staff for transfers.</p> <p>a. The Nurses Notes dated 11/7/06 at 8:30 p.m., by LPN # 2 documented, "Daughter reported noticing 2 inch red bruise on upper left [L with a circle around it] chest area. No [O with a slash across it] other injury noted. No [O with a slash across it] c/o [complaint pain] ...". There was no documentation of finding the resident on the floor, nor was there an Incident and Accident report for a fall/injury on this date.</p> <p>b. The Incident/Accident Report dated 11/7/06 documented, "... 2. Description of incident to include injury ... Red bruise noted left [L with a</p>	F 226		

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 48</p> <p>circle around it] upper chest area 2 inch circle. Daughter noticed it and reported it to [LPN # 1] ... 3. Was any other person involved in the incident? ... No. 4. List witness(s) and obtain witness statements. If applicable interview resident and roommate. 2 CNAs listed. ... 9. summary of corrective action taken to prevent reoccurrence: Blank." There were no signatures documented on the Non-Witness Statement. There were no statements from the 2 CNAs who were listed as witnesses.</p> <p>c. The DMS-7734 regarding resident # 11 documented, "Physical" abuse was reported on 11/7/06 at 7:00 p.m. "Summary of Incident: At 7:00 p.m. on 11/7/06 [Resident # 11's] daughter reported that her mother told her someone hit her in the chest. C.N.A. and daughter looked at resident chest and there was a bruise. C.N.A. did report it to LPN on 11/7/06. LPN did not report it to the Administrator until 11/9/06. Steps taken to prevent continued abuse or neglect during the investigation: Disciplinary action has been taken in regards to the LPN not reporting timely. All staff members for the day and who provided care have been interviewed. In-service regarding reporting abuse or neglect has been started. Will cont [continue] with investigation".</p> <p>d. The DMS-762 regarding Resident # 11 documented, "Physical" abuse occurred on an unknown date."... Section II - Daughter stated that mother reported that someone hit her in the chest. Bruise present. Section III - Findings and Actions Taken: Resident is low bed due to fall precautions. Resident rolled out of low bed onto mat with arm under her. Have spoken with daughter regarding issues. Daughter stated that her mother rolls or tries to get out of bed often.</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 49</p> <p>Replace mat with thicker mat at bed side. Nurses and/or CNA will complete body audit when resident is find on mat". There were 2 witness statements from LPN # 2. The witness Statement dated 11/7/06 at 8:30 p.m. documented, "What did you see? Bruise 2 inch red on upper [arrow pointing up] on left [L with a circle around it]. ... do you have any other factual information pertaining to the incident investigation that you witnessed? I picked her up off floor matt in room next to low bed at 6:20 p.m". The second witness statement from LPN # 2 dated 11/9/07 at 1:00 p.m., documented, "On 11/7/06 at 8:00 p.m., daughter of Resident [# 11] reported to med a red palm size 2 inch bruise on upper [arrow pointing up] left [L with a circle around it]. Daughter stated someone hit her there. [Resident # 11] very confused. No [O with slash through it] other injury noted. explained to daughter that I had picked her up myself off mat next to low bed at about 6:20 p.m.. ...". The DMS-762 also documented that Law Enforcement were notified on 11/9/06 at 1:30 p.m.</p> <p>e. The [City] Police Department Information Report documented notification on 11/9/06 at 12:46 p.m.</p> <p>f. The [City] Police Department Report dated 12/8/06 documented, "On 11/9/06 at approximately 1:00 p.m., I arrived at [address] to take a report of an alleged assault and battery. There I spoke with the LPN [#2], who told me that the patient, [Resident # 11] suffers from Dementia. [LPN # 2] said the [Resident # 11's] daughter [name] thought someone punched [Resident # 11] in the chest because there was bruise on her upper left chest about the size of a palm. She thought that because she did not see</p>	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 226	Continued From page 50 how she could have gotten it by falling down. We have no suspect information. [LPN # 2] said at approximately 6:00 p.m. she had picked [Resident # 11] up from the floor and placed her back into bed". g. On 1/18/07 at 5:25 p.m., the Administrator was asked to review the facility Policy and Procedure entitled, "Abuse, Neglect and Exploitation". The Administrator was then asked if she could find anything in the policy that gave her directions on how to investigate and injury of unknown origin. The Administrator stated, "Yes, process number III down through V". The Administrator was then asked to review the facility's policy entitled "Incidents and Accidents". The Administrator was then asked who should you get witness statements from according to this policy. The Administrator stated "Staff and residents - staff that worked that shift, previous shifts and staff on surrounding halls". The Administrator was asked what was done to protect Resident # 11. The Administrator stated, "[SSD] interviewed residents and staff to see if anything had occurred". The Administrator was asked how did the interviews protect the resident from possible abuse. The Administrator stated, "I guess it didn't". The Administrator was asked where are the resident interviews. The Administrator stated, "We don't have any". The Administrator was asked who are the Non-Witness statements from. The Administrator stated, "Day shift staff". The Administrator was asked who else should you have interviewed. The Administrator stated, "Evening and night staff". The Administrator was asked how she had determined what happened to cause the bruise. The Administrator stated, "Staff - [LPN # 2 and CNA # 12] told me that's what happened". The Administrator was asked should	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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F 226	<p>Continued From page 51</p> <p>you have gotten another statement from them. The Administrator stated, "Yes".</p> <p>9. As of 1/18/07 the facility was unable to provide documentation or the documentation that was provided for the following:</p> <p>a. There was no chronological documentation of the investigation other than witness statements, the DMS-7734 and the DMS-762.</p> <p>b. There were no witness statements from the Licensed Practical Nurses who worked prior to LPN # 2's shift on 11/7/06.</p> <p>c. There were 18 signatures on the "Non-witness statement" form from employees who work the day shift (6:00 a.m. to 2:00 p.m.) only. There were 3 witness statement from CNAs - 1 day shift and 2 evening shift CNAs. There were no witness statements from CNAs who work the night shift (10:00 p.m. to 6:00 a.m.).</p> <p>d. There were no resident interviews documented for Resident # 11 nor was the resident's room mate or residents in surrounding rooms interviewed. There was no documentation of body audits for other cognitively impaired residents on the hall the resident resided on or any other hall in the facility.</p> <p>10. Resident # 7 had diagnoses of Atherosclerotic Dementia and Agitation. the Annual Minimum Data Set (MDS) dated 1/11/07 documented that the resident had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also documented that the resident required extensive assistance for bed</p>	F 226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/19/2007
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F 226	<p>Continued From page 52</p> <p>mobility and was dependent on staff for transfers.</p> <p>a. The Nurses Notes dated 12/28/06 at 2:45 p.m., documented, "On head to toe assessment by Tx [treatment] Nurse resident [r with a line over it] was found to have a bruise to left [L with a circle around it] ankle area. ...".</p> <p>b. The Incident Investigation/Follow-up report dated 12/28/06 at 11:15 a.m. documented "...2. Description of incident to include injury ... Tx Nurse doing body assessment found bruise on left [L with a circle around it] ankle area goes around foot. 3. Was any other person involved in the incident? ... No. 4. List witness(s) and obtain witness statements. If applicable interview resident and roommate. None. ... 9. Summary of corrective action taken to prevent reoccurrence: Staff education on transfer proper technique." There were 10 signatures documented on the Non-Witness Statement.</p> <p>c. On 1/18/07 at 4:15 p.m., the DON was asked if the injury of unknown origin for this resident had been investigated correctly. The DON stated, "I don't remember seeing this I&A [Incident and Accident] report - No". The DON was asked are any of the staff signatures on the form (Non-Witness Statement) more than day shift. The DON stated, "Probably not because we only ask the people on that shift".</p> <p>d. On 1/18/07 at 5:25 p.m., the Administrator was asked to review the Non-witness statements obtained during this investigation. The Administrator was asked what shift the employees worked who signed the Non-Witness Statement. The Administrator stated, "Days". When asked if other shifts should have been</p>	F 226			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 226	Continued From page 53 interviewed, the Administrator stated, "Yes". 11. Resident # 12 had diagnoses of Dementia and Alzheimer's Disease. Resident was admitted on 12/27/06. There was no MDS data available. The admission assessment documented that the resident was oriented to person, was independent with ambulation, some weakness to upper and lower extremities and required assistance with personal hygiene. a. The Nurses Notes dated 1/11/07 at 7:30 a.m. by LPN # 2 documented, "Large bump with bruises x [times] 2 bilat [bilateral] forehead with swelling noted. 3 cm [centimeter] lump noted on right [R with a circle around it] top eye. Brow area with [c with a line over it] bruising et [and] swelling. ... No [O with a slash through it] other injury noted. A/O [alert/oriented] x 1. confused. Easily redirected. No [O with a slash through it] c/o [complaint] pain. b. The Incident Investigation/Follow-up report dated 1/11/07 at 7:30 a.m. documented "...2. Upon arrival on shift, noted 3 cm lump with bruise on right [R with circle around it] eye brow + [and] bruise on left [L with a circle around it] forehead with [cc with line over it] lump. ... 3. Was any other person involved in the incident? ... No. 4. List witness(s) and obtain witness statements. If applicable interview resident and roommate. [Blank]. ... 9. Summary of corrective action taken to prevent reoccurrence: Chest of drawers was moved away from her bed." there was one witness statement from LPN # 2 who discovered the bruise of unknown origin. There were no witness statements from any other staff (Unit Manager, LPN on prior shift, CNAs on shift injury was discovered or CNAs on the shift(s) prior to	F 226			

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

PRINTED: 01/31/2007
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703		
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F 226	<p>Continued From page 54 discovery of the injury of unknown origin).</p> <p>c. On 1/18/07 at 4:15 p.m., the DON was asked if the injury of unknown origin for this resident had been investigated per policy. The DON stated, "Probably but I did not get witness statements ... I did speak with the night shift. The DON was asked if there was a statement from the staff on night shift. The DON stated, "No". The DON was again asked if the injury of unknown origin had been investigated per policy. The DON stated, "No. Yea, I dropped the ball".</p> <p>d. On 1/18/07 at 5:25 p.m., the Administrator was asked to review Incident Investigation/Follow-up report dated 12/28/06. The Administrator was asked if this was investigated thoroughly. The Administrator stated, "No".</p> <p>12. On 1/17/06 at 10:40 a.m. CNA # 9 was interviewed regarding his knowledge of the allegations made by CNA #7 regarding Residents # 1 and # 4. CNA # 9 was asked when had CNA # 7 told him about her concerns. CNA # 9 stated, "[CNA # 7] talked about something on Saturday but I think it was Sunday when she said she'd come back in there and found resident's upset". When asked what time this occurred on Sunday (12/18/06), CNA # 9 replied, "After she got home around 10:30 p.m. or 11:00 p.m". CNA # 9 was asked what did you tell her. CNA # 9 stated, "She needed to report as soon as possible". CNA # 9 was asked when did CNA # 7 report this. CNA # 9 stated, "I can't remember if it was Monday or Tuesday ...". CNA # 9 was asked was there a reason you didn't tell her to call back to the nursing home to report these concerns. CNA # 9 stated, "No, I didn't think about calling back to let them know ...". CNA # 9 was asked if anyone</p>	F 226			

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

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F 226	Continued From page 55 had counseled/talked with him about reporting timely. CNA # 9 stated, "No".	F 226		
F 312 SS=E	13. On 1/18/07 at 5:45 p.m., the Administrator was asked does your abuse policy and procedure mention/tell you to notify the police. The Administrator stated "Uuh [No]". 483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure incontinent care was provided for 2 (Resident # 6 and 8) of 7 case mix residents who were incontinent of bowel and/or bladder. This failed practice had the potential to affect 72 residents according to the listing provided by medical records on 12/29/06 at 9:30 a.m. The findings are: 1. The facility's policy entitled "Perineal Care" documented "... I. General ... c) Remove any fecal matter or urine wiping with tissue from front to back. ...II. Female Resident a) Wash pubic area first ...". 2. Resident # 8 had a diagnosis of Dementia with Behavior Disturbance. The Annual Minimum Data Set (MDS) dated 11/7/06 documented that the resident had short and long term memory problems and was severely impaired in cognitive skills for daily decision making. The MDS also	F 312		

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F 312	Continued From page 56 documented that the resident was totally dependent on 2 plus persons for toilet use and was incontinent of bowel and bladder. a. The Care Plan documented "Problem/Needs ... Incontinent bowel/bladder ... Approach ... Pericare after each incontinent episode ... Observe for changes in skin ...". b. On 11/27/06 at 12:37 a.m. Certified Nursing Assistants (CNAs) # 1 and # 2 provided incontinent care. The CNAs changed the resident's brief, taking off a soiled brief that was wet with urine and put on a new brief. The CNAs failed to clean urine from the resident. c. On 12/28/06 at 4:50 p.m. the Director of Nursing (DON) was asked if perineal area should be cleaned between soiled and clean briefs. The DON stated "Definitely". 3. Resident # 6 has a diagnosis of Mental Retardation. The Quarterly MDS dated 8/23/06 documented short and long term memory problems and that the resident was moderately impaired in cognitive skills for daily decision making. The MDS also documented that the resident was totally dependent on 2 plus persons for toilet use and was incontinent of bowel and bladder. a. The Care Plan reviewed on 12/29/06 documented "Problem/Needs ... Incontinent bowel/bladder ... Approach Pericare after each incontinent episode ... Observe for changes in skin ...". b. On 12/28/06 at 8:35 a.m. CNAs # 4 and 5 provided incontinent care. During incontinent	F 312			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	Continued From page 57 care CNA # 5 failed to cleanse the pubic area of urine when cleaning the residents groins and mid labia area.	F 312			
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure residents were dried during incontinent care in order to prevent the possible development of pressure sores for 1 (Resident # 3) of 7 case mix residents who were incontinent of bowel and/or bladder. This failed practice had the potential to affect 72 residents according to the listing provided by medical records on 12/29/06 at 9:30 a.m. The findings are: 1. Resident # 3 had a diagnosis of Vascular Dementia with Delusions. The Medicare 14 day Minimum Data Set (MDS) dated 11/22/06 documented that the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making. The MDS also documented that the resident required extensive assistance for toilet use and was frequently incontinent of bowel. a. The Care Plan reviewed on 9/8/06	F 314			

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F 314	<p>Continued From page 58</p> <p>documented "Problem/Needs ... Incontinent bowel/bladder ... Approach ... Pericare after each incontinent episode ... Observe for changes in skin ... ".</p> <p>b. On 12/28/06 at 2:02 p.m. Certified Nursing Assistants (CNAs) provided incontinent care. CNA # 3 wet three wash cloths and applied soap to one wash cloth. CNA # 3 then put the wash cloths directly on top of the residents bedside table which had a vase of flowers, pictures, a water pitcher and a glass of water on it. CNA # 3 did not place the wash cloths on a clean area. Then CNA # 3 picked up the wash cloth that had soap and cleaned the resident's groin, pubic area, mid labia, buttocks and rectal area. Next CNA # 3 used two wet wash cloths which were picked up from the bedside table to rinse the resident. CNA # 3 then applied a new brief to the resident without drying the resident's skin.</p> <p>c. On 12/28/06 at 4:50 p.m. the Director of Nursing (DON) was asked if a resident should be dried when using wash cloths for incontinent care. The DON stated "Yes". The DON also stated that the resident should be cleaned with washcloths first then with two incontinent wipes because of the protective cream and barrier that were in the wipes.</p>	F 314			