

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #11410 was substantiated (all or in part) with deficiencies cited at F248 and F249. Complaint #11449 was substantiated (all or in part) with deficiencies cited at F225, F226 and F250.	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	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.

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 225	<p>Continued From page 1</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> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11449 was substantiated (all or in part) in these findings.</p> <p>Based on record review and interview, the facility failed to investigate and report to the state agency allegations of abuse/neglect for 1 (Resident #1) of 6 case mix residents (resident #1 through #6). The failed practices had the potential to affect 36 cognitively impaired residents according to a list provided by the Administrator on 2/15/06. The findings are:</p> <p>1. Resident #1 had diagnoses of Encephalopathy, Diabetes Mellitus and Depressive Disorder. The annual Minimum Data Set (MDS) dated 11/17/05 documented the resident had modified independence in cognitive skills for daily decision making, short/long term memory problems, was verbally abusive, socially inappropriate and resisted care, required limited assistance of one staff person for activities of daily living and was wheeled by self or others.</p> <p>a. The Care Plan dated 11/18/05 documented a problem, "Resident exhibits behaviors of: yelling at staff; refuses to take meds at times; anger towards staff" and undated handwritten revisions to the same problem, "refuses care, throwing self</p>	F 225		

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701	
(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 225	<p>Continued From page 2</p> <p>to floor from low bed & [and] wheelchair thus sliding to the floor" with interventions dated 11/17/05 "Approach & speak to resident in a calm, pleasant & non-threatening manner, Monitor for episodes of behaviors & response to interventions" and "Avoid situations that trigger behaviors, Provide safety for resident and others. Report to nurse."</p> <p>b. Nurse's Notes dated 1/3/06 at 8:00 p.m. documented the resident was up in a wheelchair with a lap buddy, had "scooped self down into floor X [times] 4 in last 30 minutes. Res [resident] yelling out . . . proceeds to use obscenities and name calling. This nurse states "I won't speak to him when he's like that." That Nurse's Note entry was signed by Licensed Practical Nurse (LPN) #1.</p> <p>c. Nurse's Notes dated between 1/5/06 and 2/4/06 documented 13 separate entries that documented the resident was agitated, yelling, cursing, sliding out on floor when in wheelchair and/or had attempted to hit staff.</p> <p>d. Nurse's Notes dated 2/9/06 at 6:00 p.m. documented "Res. [resident] pushing self out of chair. Had also thrown lite cigarette into open area of smoke room that had to be extinguished. Res. had earlier poured 1/2 gal. (gallon) of sunny delight out of jug on the floor. Ativan 0.5mg given."</p> <p>e. Nurse's Notes dated 2/9/06 at, "00 [midnight]" documented, "Res. still up and down in bed. Ativan 0.5mg repeated due to aggressive behavior continuing. BS (blood sugar) 167%. Snack given. Was in room, but crawled to hall and started yelling out. Was put back in chair and</p>	F 225		

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 225	<p>Continued From page 3</p> <p>is sitting watching TV. Also received call from DON (Director of Nurses) and update was given." There was no documentation in Nurse's Notes at that time of any discussion that dealt with the treatment of the resident by nursing facility staff.</p> <p>f On 2/16/06 at 1:20 p.m. an interview was conducted with Certified Nursing Assistant (CNA) #1 and she was asked about the events that had occurred on the evening of 2/9/06. CNA #1 stated, "XXX (CNA #3's name) said to resident 'you need to crawl your butt up to your room and get yourself up,'" "XXX (LPN #1's first name) was at nurse's station, told resident 'you get yourself up yourself since you got yourself on the floor' and 'that resident is just going to stay on floor.'"</p> <p>g. On 2/16/06 at 1:20 p.m. CNA #1 also stated she and another CNA called the Administrator at that time and "told him I need to report to him XXX [Resident #1's name] is on floor and no one will help him and nuses were talking mean to him. I asked him do I call the cops. He told me no and said 'I will call the nurses and talk to them.'" CNA #1 further stated the Administrator called LPN #1, "She was mad and said XXX (Administrator's name) said to leave him on the floor. XXX (CNA #3's name) and XXX (LPN #1's name) went to smoke and stayed gone 30 minutes so we called another nurse."</p> <p>h. Nurse's Notes dated 2/9/06 at 10:00 p.m. and signed by LPN #1 documented, "Also received call from Admin. [Administrator] and he was updated of behavior. Res. in floor refusing to set in chair. Pillow and blanket given to resident until more calm." There was no documentation in the Nurse's Notes of a conversation with the Administrator as to the verbal statements made</p>	F 225			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 225	<p>Continued From page 4</p> <p>by CNA #3 to the resident, as reported by CNA #1. LPN #1 also documented a Nurse's Note dated 2/9/06 at "00 [midnight]" which demonstrated the LPN had not immediately been taken out of resident care areas and suspended pending investigation of allegation of abuse/neglect.</p> <p>i. On 2/15/06 at 11:10 a.m. an interview was conducted with LPN #2 (the "other" nurse CNA #1 called on the evening of 2/9/06) and she stated the following:</p> <p>(1) LPN #2 had received a call from CNA #1 at 11:30 p.m. on 2/9/06, the CNA told her "nurses mean to him [resident #1], nurses refuse to let CNA's pick him up."</p> <p>(2) LPN #2 also stated she instructed the CNA's to call the Director of Nursing (DON), the CNA's could not locate the number, so she called the DON herself. LPN #2 stated she informed the DON at that time "of what the CNA's told me," and that she had been told CNA #3 was telling the resident, "shut the hell up."</p> <p>(3) LPN #2 stated she left her home to drive to the facility and called the DON during the drive and the DON told her "everything is calmed down" and she did not need to go to the facility. LPN #2 also stated she phoned CNA #1 at the facility and was told, 'No, he's still trying to get to room!.'</p> <p>(4) LPN #2 stated "I called DON back and she said 'all I can do is call Administrator'." LPN #2 also stated, "I told her somebody's going to call police. I called CNA's and told them to call XXX [Administrator] and if that didn't work, they</p>	F 225			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 225	Continued From page 5 needed to call police." j. On 2/13/06 at 4:00 p.m. the Administrator was asked about the events of the evening on 2/9/06. He stated a CNA "had called him at home and said should I call the police . . . and I told them no, nurse was doing as care planned." At 4:15 p.m. the Administrator was asked if he knew, "of any occasion where a nurse may have said 'You can stay in the floor'" and he stated, "I don't doubt she may have said that, but as far as leaving him on the floor, no." k. On 2/14/06 at 12:20 p.m. the Administrator and DON were asked why a report to the state agency was not done and they stated, "I'm sorry I didn't see an allegation, no report. CNA felt they were ignoring him on the floor and nurse said same thing about the floor." During the same interview at 1:00 p.m. the regional Ombudsman entered the room and stated, "I've received several phone calls of him [Resident #1] being left on the floor for periods of time and exposed with sweats being pulled down while being dragged like a dog on his blanket." l. On 2/14/06 at 2:45 p.m. the Administrator stated, "we are doing an investigation in-house on a Behavior Problem, not as a 7734 [DMS-7734] is a form that documents allegations of abuse/neglect and is faxed to the state agency by 11:00 a.m. the next business day." m. On 2/15/06 at 8:40 a.m. the DON stated, "when we talked to XXX [LPN #2] on that night [2/9/06] was first information we got that there might be a problem with XXX [LPN #1]. [LPN #1] was suspended last night but so was XXX [LPN #2] for failing to report it to me when she called	F 225			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701	
(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 225	Continued From page 6 me." The DON's statement contradicted statements made by LPN #2 and CNA #1 to surveyors and also demonstrated that LPN #1 was not suspended or prevented access to residents until 5 days after the initial allegations of abuse/neglect were made to the Administrator and DON by CNA's and LPN #2. n. On 2/15/06 at 11:00 a.m. the Administrator stated he was, "going to go ahead and start 7734." At 11:05 a.m. the Administrator stated he had called law enforcement.	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. This REQUIREMENT is not met as evidenced by: Complaint #11449 was substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure Policy and Procedure for Abuse Prohibition was implemented regarding the investigation and reporting to the state agency allegations of abuse/neglect and the protection of residents from further potential abuse/neglect prior to and during investigation for 1 (Resident #1) of 6 case mix residents (Resident #1 - #6). The failed practices had the potential to affect 36 cognitively impaired residents according to a list provided by the Administrator on 2/15/06. The findings are:	F 226		

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 7 1. The facility's policy and procedure for abuse investigation documented a. "III. When abuse, neglect or exploitation is suspected, the Licensed Nurse should: c. Complete an incident report and initiate an investigation immediately," "e) Obtain witness statements following policy . . . Suspend the accused employee pending completion of the investigation. Remove the employee resident care areas immediately" and "Contact the state State Agency . . . to report the alleged abuse." b. "IV. When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted." 2. Resident #1 had diagnoses of Encephalopathy, Diabetes Mellitus and Depressive Disorder. The annual Minimum Data Set (MDS) dated 11/17/05 documented the resident had modified independence in cognitive skills for daily decision making, short/long term memory problems, was verbally abusive, socially inappropriate and resisted care, required limited assistance of one staff person for activities of daily living and was wheeled by self or others. a. The Care Plan dated 11/18/05 documented a problem, "Resident exhibits behaviors of: yelling at staff; refuses to take meds at times; anger towards staff" and undated handwritten revisions to the same problem, "refuses care, throwing self to floor from low bed & [and] wheelchair thus sliding to the floor" with interventions dated 11/17/05 "Approach & speak to resident in a calm, pleasant & non-threatening manner,	F 226			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 8 Monitor for episodes of behaviors & response to interventions" and "Avoid situations that trigger behaviors, Provide safety for resident and others. Report to nurse." b. Nurse's Notes dated 2/9/06 at 6:00 p.m. documented "Res. [resident] pushing self out of chair. . . Ativan 0.5mg given." c. Nurse's Notes dated 2/9/06 at, "00 [midnight]" documented, "Res. still up and down in bed. Ativan 0.5mg repeated due to aggressive behavior continuing. BS (blood sugar) 167%. Snack given. Was in room, but crawled to hall and started yelling out. Also received call from DON (Director of Nurses) and update was given." d. On 2/16/06 at 1:20 p.m. an interview was conducted with Certified Nursing Assistant (CNA) #1 and she was asked about the events that had occurred on the evening of 2/9/06. CNA #1 stated, "XXX (CNA #3's name) said to resident 'you need to crawl your butt up to your room and get yourself up,'" "XXX (LPN #1's first name) was at nurse's station, told resident 'you get yourself up yourself since you got yourself on the floor' and 'that resident is just going to stay on floor." e. On 2/16/06 at 1:20 p.m. CNA #1 also stated she and another CNA called the Administrator at that time and "told him I need to report to him XXX [Resident #1's name] is on floor and no one will help him and nurses were talking mean to him. I asked him do I call the cops. He told me no and said 'I will call the nurses and talk to them." f. Nurse's Notes dated 2/9/06 at 10:00 p.m. and signed by LPN #1 documented, "Also received	F 226			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 9</p> <p>call from Admin. [Administrator] and he was updated of behavior." There was no documentation in the Nurse's Notes of a conversation with the Administrator as to the verbal statements made by CNA #3 to the resident, as reported by CNA #1. LPN #1 also documented a Nurse's Note dated 2/9/06 at "00 [midnight]" which demonstrated the LPN had not immediately been taken out of resident care areas and suspended pending investigation of allegation of abuse/neglect.</p> <p>g. On 2/15/06 at 11:10 a.m. an interview was conducted with LPN #2 (the "other" nurse CNA #1 called on the evening of 2/9/06) and she stated she had received a call from CNA #1 at 11:30 p.m. on 2/9/06, the CNA told her "nurses mean to him [resident #1], nurses refuse to let CNA's pick him up." The LPN also stated she told the CNA's to call the Director of Nursing (DON), the CNA's could not locate the number, so she called the DON herself. LPN #2 stated she informed the DON at that time "of what the CNA's told me," and that she had been told CNA #3 was telling the resident, "shut the hell up."</p> <p>LPN #2 stated she left her home to drive to the facility and called the DON during the drive and the DON told her "everything is calmed down" and she did not need to go to the facility. LPN #2 also stated she phoned CNA #1 at the facility and was told, 'No, he's still trying to get to room'."</p> <p>LPN #2 stated "I called DON back and she said 'all I can do is call Administrator'." LPN #2 also stated, "I told her somebody's going to call police. I called CNA's and told them to call XXX [Administrator] and if that didn't work, they needed to call police."</p>	F 226			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 10 h. On 2/13/06 at 4:00 p.m. the Administrator was asked about the events of the evening on 2/9/06. He stated a CNA "had called him at home and said should I call the police . . . and I told them no, nurse was doing as care planned." i. On 2/14/06 at 12:20 p.m. the Administrator and DON were asked why a report to the state agency was not done and they stated, "I'm sorry I didn't see an allegation, no report. CNA felt they were ignoring him on the floor and nurse said same thing about the floor." During the same interview at 1:00 p.m. the regional Ombudsman entered the room and stated, "I've received several phone calls of him [Resident #1] being left on the floor for periods of time and exposed with sweats being pulled down while being dragged like a dog on his blanket." j. On 2/14/06 at 2:45 p.m. the Administrator stated, "we are doing an investigation in-house on a Behavior Problem, not as a 7734 [DMS(Division of Medical Services)-7734] is a form that documents allegations of abuse/neglect and is faxed to the state agency by 11:00 a.m. the next business day]." k. On 2/15/06 at 8:40 a.m. the DON stated, "when we talked to XXX [LPN #2] on that night [2/9/06] was first information we got that there might be a problem with XXX [LPN #1]. [LPN #1] was suspended last night but so was XXX [LPN #2] for failing to report it to me when she called me." LPN #1 was not suspended or prevented access to residents for 5 days after the initial allegations of abuse/neglect were made to the Administrator and DON by CNA's and LPN #2.	F 226			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 11 I. On 2/15/06 at 11:00 a.m. the Administrator stated he was, "going to go ahead and start 7734." At 11:05 a.m. the Administrator stated he had called law enforcement.	F 226			
F 248 SS=E	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #11410 was substantiated (all or in part) in these findings. Based on observation, record review and interview the facility failed to ensure that group and individual activities were planned based on assessed past life roles/interests; that activities offered, resident attendance and resident responses to activities were documented roles/interests; and that care plans addressed activities appropriate for each resident based on the comprehensive assessment for 2 (Residents #2 and #3) of 6 case-mix residents (Residents #1 thru #6). This failed practice had the potential to affect all 98 residents in the facility. The findings are: 1. The facility's Activity Policy and Procedure documented: "Purpose: To ensure the activity needs and interests of residents are identified. Standard: ...the facility must provide for an ongoing program of activities designed to meet, in	F 248			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 248	<p>Continued From page 12</p> <p>accordance with the comprehensive assessment, the interest and the physical, mental and psychosocial well being of each resident. The resident's activity plan must be developed in conjunction with the comprehensive assessment... and interviews with the resident and or/ the family members, observation of the resident, discussion with the facility staff and a review of the medical record...and functional abilities...provide information for staff to plan care that enables the resident to reach his/her highest practical level of functioning, through an activity program designed to support the residents goal for rehabilitation, and or discharge from the facility."</p> <p>2. The facility's Activity Record Keeping Policy and Procedure documented: "The Activity Director is responsible for maintaining appropriate departmental recordkeeping data: ...Record keeping is a vital part of the activity program as it assists in maintaining, planning, and developing the activity programs... The following records, as a minimum, are maintained by activity department personnel: Activity interest survey, Attendance records, Calendars of events, Activity progress notes, Individualized activity plan, Quarterly MDS [Minimum Data Set] assessments, Record of reviews and updates and other recordkeeping reports as necessary and appropriate. The Activity Director is responsible for obtaining, charting, and filing required reports."</p> <p>3. On 2/14/06 at 9:40 a.m., during Group Interview, 7 residents stated they did not have all the activities listed on the schedule; the church listed comes on Sunday morning, but they have not been told of any of the other activities.</p>	F 248			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 248	<p>Continued From page 13</p> <p>4. On 2/15/06 at 10:00 a.m., the Activity Director stated she did not keep any records or know she was to keep a record of residents who attend activities or that each resident had to be assessed and a Plan of Care written for each resident to meet their specific needs for appropriate activities and stated, "I am not certified as an Activity Director, I've been doing this since November."</p> <p>5. On 2/15/06 at 2:00 p.m., the Administrator stated "Normally the Activity Director keeps records of activities attended. There are activities scheduled on weekends, but I haven't come out to see if they are having them. I have hired a new Activity Director and I will send her to school. Our last certified Activity Director left the last of November or the first of December, I don't remember exactly."</p> <p>6. Resident #2 had diagnoses of Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. The Minimum Data Set (MDS) dated 11/1/05 documented the resident was independent in cognitive skills for daily decision-making, required some assistance for activities of daily living and spent some time in activities.</p> <p>As of 2/16/06 at 10:00 a.m., there was no initial activity survey, periodic activity reassessment or record of activity participation available for review in the clinical record for the resident. The Care Plan revised on 11/16/05 did not address an activity plan for the resident.</p> <p>7. Resident #3 had diagnoses of Congestive Heart Failure and Left Intertrochanteric Fracture. The MDS dated 11/11/05 documented the</p>	F 248			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 248	Continued From page 14 resident was independent in cognitive skills for daily decision-making, depended on staff for some assistance for activities of daily living and spent some time in activities. As of 2/16/06 at 10:00 a.m., there was no initial activity survey, periodic activity reassessment or record of activity participation available for review in the clinical record for the resident. The Care Plan revised on 11/23/05 did not address an activity plan for the resident.	F 248			
F 249 SS=E	483.15(f)(2) ACTIVITY DIRECTOR QUALIFICATIONS The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Complaint #11410 was substantiated (all or in part) in these findings. Based on record review and interview the facility	F 249			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 249	<p>Continued From page 15</p> <p>failed to ensure that the Activity Program was directed by a qualified professional and that activities were provided by qualified staff. This failed practice had the potential to affect 70 residents in the facility, according to documentation provided by the Director of Nursing (DON) on 2/13/06 at 4:15 p.m. The findings are:</p> <p>1. The facility's Activity Director Policy and Procedure documented: "The activity director is responsible for maintaining appropriate departmental recordkeeping data: General Purpose: To plan, develop, organize, implement, evaluate and direct the Activity Programs in accordance with current Federal, State and Local standards governing the facility, and as may be directed by the Administrator, to ensure that the emotional, recreational and social needs of the residents are met and maintained on an individual basis. Record keeping is a vital part of the activity program as it assists in maintaining, planning, and developing the activity programs... The following records, as a minimum, are maintained by activity department personnel: Activity interest survey, Attendance records, Calendars of events, Activity progress notes, Individualized activity plan, Quarterly MDS (Minimum Data Set) assessments, Record of reviews and updates and other recordkeeping reports as necessary and appropriate."</p> <p>2. On 2/14/06 at 9:40 a.m., during Group Interview, 7 residents stated they do not have all the activities listed on the schedule; the church listed comes on Sunday morning, but they have not been told of any of the other activities.</p> <p>3. On 2/15/06 at 10:00 a.m., the Activity Director</p>	F 249			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701	
(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 249	Continued From page 16 stated, "I am not certified as an Activity Director, I've been doing this since November." 4. On 2/15/06 at 2:00 p.m., the Administrator stated, "I have hired a new Activity Director and I will send her to school. Our last certified Activity Director left the last of November or the first of December, I don't remember exactly."	F 249		
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint #11449 was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure that medically related social services were provided as evidenced by the failure to develop appropriate behavioral interventions for 1 (Resident #1) of 2 (Residents #1 and #5) case mix residents who were identified to have Behavioral problems or Depression. This failed practice had the potential to affect 30 residents with behaviors, according to the facility Roster Matrix received on 2/13/06. The findings are: Resident #1 had diagnoses of Encephalopathy, Diabetes Mellitus and Depressive Disorder. The annual Minimum Data Set (MDS) dated 11/17/05	F 250		

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701	
(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 250	<p>Continued From page 17</p> <p>documented the resident had modified independence in cognitive skills for daily decision making, short/long term memory problems, was verbally abusive, socially inappropriate and resisted care, required limited assistance of one staff person for activities of daily living and was wheeled by self or others.</p> <p>a. The Care Plan dated 11/18/05 documented a problem, "Resident exhibits behaviors of: yelling at staff; refuses to take meds at times; anger towards staff" with interventions, "Approach & speak to resident in a calm, pleasant & non-threatening manner, Monitor for episodes of behaviors & response to interventions" and "Avoid situations that trigger behaviors, Provide safety for resident and others. Report to nurse."</p> <p>b. Nurse's Notes dated 1/3/06 at 8:00 p.m. documented the resident was up in a wheelchair with a lap buddy, had "scooped self down into floor X [times] 4 in last 30 minutes. Res [resident] yelling out . . . proceeds to use obscenities and have calling. This nurse states 'I won't speak to him when he's like that.'" That Nurse's Note entry was signed by Licensed Practical Nurse (LPN) #1 and did not document other interventions attempted or history of what interventions were successful for the resident.</p> <p>c. Nurse's Notes documented behavioral disturbances as follows: On 1/6/06 at 3:40 p.m. (found in floor) and at 10:15 p.m. (tried to grab CNA, hit her), 1/9/06 ("very agitated, yelling"), 1/10/06 (cursing staff, yelling and sliding out of chair) and 1/12/06 ("numerous behavioral episodes, increased agitation" and hitting/yelling at staff).</p>	F 250		

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 250	<p>Continued From page 18</p> <p>d. A "Psychiatric Consultation" dated 1/13/06 and signed by a physician documented, "staff reports increased irritability, agitation, and aggression over past week; Has required Ativan 1 mg [milligrams] IM [intramuscular] injection and 3 PRN [as needed] po [by mouth] doses over past week. Frequently slides out of chair," "Alert, calm when seen," and "Medications: Abilify 10 mg q [every] hs [bedtime], Restoril 15 mg q hs prn and Ativan .5 mg q 4 hr prn." There was no documentation of a physician order for a specific treatment plan that included interventions to attempt when the resident had behavioral episodes or instructions for staff if interventions were unsuccessful.</p> <p>e. Nurse's Notes documented behavioral disturbances as follows: On 1/14/06 at 1:55 p.m. (tipped over in wheelchair), at 6:00 p.m. (slid out of chair) and at 11:30 p.m. ("a little agitated"), 1/15/06 at 7:00 p.m. (agitation, slid out of chair).</p> <p>f. The Care Plan had handwritten revisions to the problem for behaviors dated 1/14/06 that documented a problem, "Rocks wheelchair and attempts to tip it over" with an intervention "Continue lap buddy and staff inservice on ADL assist, monitor closely." There was no revision documented at that time of possible behavioral modification techniques such as rewards, change in environment or specific staff assigned to the resident's care.</p> <p>g. Nurse's Notes documented as follows: On 1/17/06 at 6:00 p.m. ("slid out of chair all day, 4 X [times] in 10 minutes") at 6:30 p.m. (in floor 5 times in 45 minutes, "redirected with possible rewards, extra smoke privileges, etc. with no success) and at 11:30 p.m. (Administration of</p>	F 250			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 250	<p>Continued From page 19</p> <p>Ativan 1 mg IM), 1/18/06 (6 times out of chair in 1.5 hours), 1/19/06 (slipped under belt 3 times in 20 minutes), 1/23/06 (some agitation, out of chair 2 times), 2/3/06 (agitated) and 2/4/06 (cursing, out of wheelchair).</p> <p>h. A Psychiatric Consultation dated 2/6/06 and signed by a physician documented "Staff reports irritability, agitation, and aggression at baseline; Frequently slides out of chair; Curses at staff at times. 2/3, 2/4, 2/5 [2006] received prn Ativan for agitation" and "Behavior manageable per nursing staff." There was no documentation by the physician of recommended interventions for the continued behavioral symptoms or a request by the nursing facility for a treatment plan from the physician.</p> <p>i. Nurse's Notes dated 2/9/06 at 6:00 p.m. documented "Res. [resident] pushing self out of chair. Had also thrown lite cigarette into open area of smoke room that had to be extinguished. Res. had earlier poured 1/2 gal. (gallon) of sunny delight out of jug on the floor. Ativan 0.5mg given."</p> <p>j. Nurse's Notes dated 2/9/06 at, "00 [midnight]" documented, "Res. still up and down in bed. Ativan 0.5mg repeated due to aggressive behavior continuing. BS (blood sugar) 167. Snack given. Was in room, but crawled to hall and started yelling out."</p> <p>k. The Care Plan documented handwritten revisions on 2/13/06 for problems of, "refuses care, throwing self to floor from low bed & [and] wheelchair thus sliding to the floor" with interventions, "Offer food for comfort - redirection, Music therapy, soft belt as needed for safety and</p>	F 250			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 250	Continued From page 20 positioning, offer food when behavior occurs." l. On 2/13/06 at 3:54 p.m. the resident was sitting up in a wheelchair by the smoke room and was waiting for a cigarette. The resident was friendly at that time. On 2/14/06 at 8:35 a.m., 9:25 a.m. and 10:10 a.m. the resident did not demonstrate behavioral symptoms as described. m. On 2/13/06 at 4:00 p.m., the Administrator was asked about this resident's behavior and care. The Administrator stated the following: 1) "CNA did call me the other night at home and said should I call the police because he is in the floor. I said "No, nurse is doing as care planned." 2) The Administrator also stated, "CNAs do report nurses aren't giving him the attention he needs. I question the nurses and call his mother." 3) The Administrator also stated, "the nurse called me last week at night and I told her, yes, we can withhold his cigarette until he behaves. It is care planned not to reward bad behavior. The nurse asked if she could leave him in the floor until he would comply. I told her no, to call his mother." n. On 2/14/06 at 12:20 p.m., the DON was asked about this resident's behaviors and care. The DON stated, "He is OK on the other shift [6:00 a.m. - 6:00 p.m.] His behavior escalates on this [6:00 p.m. - 6:00 a.m.] shift with this nurse [LPN #1]." o. On 2/14/06 at 5:30 p.m. LPN #1 was asked to describe the events of the incident of 2/9/06. LPN #1 stated, "I wrote the events in my nurses notes	F 250			

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

PRINTED: 03/06/2006
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 02/16/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701		
(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 250	<p>Continued From page 21</p> <p>that night. It was killing our backs to keep picking him up. We got tired of it. I had called the Administrator. He said to leave him in the floor and call his mother. The Administrator and DON are aware of it. I don't see a problem. We are doing what we have been told to do."</p> <p>p. The Care Plan was copied in its entirety on 2/14/06 at 3:00 p.m. and there was no documentation of an approved recommendation to withhold the resident's cigarettes if behavioral disturbances occurred or documentation of success of that intervention, which involved negative, not positive, reinforcement. There was also no documentation of identification of a possible personality conflict with LPN #1 or interventions to address that issue.</p> <p>q. Social Service Progress Notes were copied on 2/14/06 at 3:00 p.m. The most recent documented entry was dated 9/26/05. Entries dated between 7/12/05 and 9/26/05 did not document information that concerned behaviors or a specific behavioral modification treatment plan for this resident.</p>	F 250			