

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

PRINTED: 03/27/2007
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 03/16/2007
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 309 SS=E	<p>Complaint # 12373 was unsubstantiated.</p> <p>Complaint # 12422 was substantiated (all or in part) with deficiencies cited at F309</p> <p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint # 12422 was substantiated (all or in part) with these findings:</p> <p>Based on observation, record review, and interviews, the facility failed to ensure cognitively impaired residents were protected from the sexually aggressive behaviors of other cognitively impaired residents as evidenced by the facility's failure to ensure sexually aggressive behaviors were assessed and that interventions were developed/implemented to prevent further incidents for 1 case-mix resident (Resident #7) who displayed sexually aggressive behaviors. These failed practices had the potential to affect 4 cognitively impaired female residents residing in the facility according to the Resident Level Quality Measure/Indicator Report dated 2/21/07. The findings are:</p> <p>1. Resident #7 had diagnoses of Non Insulin Diabetes Mellitus, Depressive Disorder, Bilateral</p>	F 309			

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 309	<p>Continued From page 1</p> <p>Above Knee Amputation, History of Spinal Cord Injury, Peripheral Vascular Disease, Borderline Mental Retardation and Arthritis. The Minimum Data Set (MDS) dated 10/15/06 documented the resident had moderately impaired cognitive skills for daily decision making, had no behavioral symptoms and required extensive to total assistance for most Activities of Daily Living (ADL's).</p> <p>a. Nurses Note dated 10/16/06 (no time) documented, "Met with [Resident #7] to discuss his need to fondle himself. There has been nurses report walking by his room and he was "masturbating" with the door open and curtain open. He has been asked to either close curtain or door before performing this act on self. He states, "I will agree to that." The 10/15/06 MDS failed to identify this sexually inappropriate behavior.</p> <p>b. Social Services Progress Notes dated 1/18/07 documented: "[Resident] was counseled on why he should not go into other resident's rooms. He agreed not to do this anymore."</p> <p>c. Nurse's Notes dated 1/21/07 at 6:15 p.m., by Licensed Practical Nurse (LPN) #1, documented: "Resident has an attraction to a female resident. He searches her out, goes into her room, pushes her wheel chair, tries to wash her face in the dining room with a wash rag. Resident has been told not to go into female residents room. Will monitor resident."</p> <p>d. Social Services Progress Notes dated 1/22/07 documented: "[Resident] was upset and discussed his concerns with myself and Administrator. He states, 'I feel my hearts</p>	F 309			

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F 309	Continued From page 2 growing bigger for her' another female... [Resident #6] We explained what interactions would be appropriate and inappropriate when in female [resident] presence. He seemed to have trouble understanding why he could not enter 'other females' rooms." e. Nurse's Notes dated 1/25/07 at 3:20 p.m., by LPN #1, documented, "Resident continually seeks out female resident, follows her everywhere, he leaned his head toward hers and female resident was going to kiss this resident until this nurse stopped them. Social worker #1, made aware." f. The Quarterly MDS dated 1/30/07 inaccurately documented the resident had no behavioral symptoms. g. Nurse's Notes dated 3/8/07 at 2:00 p.m., documented, "We are implementing a 15 minute monitoring system to maintain social appropriateness with other residents. Will monitor." h. Nurse's Notes dated 3/8/07 at 3:30 p.m. documented, "[Physician's name] notified of facility concern regarding social inappropriateness, [physician's name] directed that we notify the sister [name] to make a psychiatry appointment for resident and [physician's name] will follow up with any recommendations the psychiatrist has, referred [physician's name] directions to social worker." i. Nurse's Notes dated 3/10/07 at 11:00 a.m. documented, "Resident continually seeks out female resident and rubs her arms, holds her hand. Will monitor."	F 309			

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F 309	Continued From page 3 j. Nurse's Notes dated 3/10/07 at 12:00 p.m., documented, "Resident pushed (moves) other residents from their spot at the lunch table so he can sit next to female resident, requested he does not move other residents." k. Nurses Notes dated 3/10/07 at 2:30 p.m. documented, "Sitting near TV [television] holding female resident's [Resident #6] hand." l. On 3/15/07 at 5:00 p.m., Housekeeper #1 stated, "I was making 3:30 p.m. rounds [3/10/07], came off A hall to F hall. [Resident #7] chair was sitting close facing [Resident #6] side of chair. I saw her with her hand moving up and down in [Residents #7] crotch. I told [Registered Nurse (RN) #2] and she immediately separated them. " On 3/15/07 at 2:30 p.m., the Administrator stated the first incident on 3/10/07 was reported to her by RN #2 and a housekeeper. m. Nurse's Notes dated 3/10/07 at 8:30 p.m., documented: "Resident positioned his wheel chair so he was at the side of female resident's wheel chair on the right. He was holding female resident's hand on his crotch. Resident was confronted and told to stop because it was unacceptable behavior. Resident turned red. This nurse separated the two and returned female to her room, then spoke with resident about correct behavior. Social director [name], notified at 9:35 p.m., Administrator [name], notified also. Will continue to monitor the two residents." 1) An Incident/Accident Report dated 3/10/07 at 8:30 p.m., (both Residents #6 and #7 were listed)	F 309			

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F 309	Continued From page 4 documented: " ... Female [Resident #6] [and] male resident [Resident #7] sitting together near TV, female's right hand on male's crotch, male holding females hand in place while stroking hand. ... Is there a pattern/trend to this incident? ¼ Yes ... If yes explain: Seems to be obsessed with female. Actions taken: separated residents from contact. Male resident counseled on behavior, every 15 minute checks on where about of resident. ... Conclusion: 3/14/07 Family care plan meeting. Residents are to take a break from hanging out until Tuesday (3/20/07) and will re-evaluate and determine interaction." 2) On 3/15/07 at 10:20 a.m. LPN (Licensed Practical Nurse) #1 stated, "The incident I wrote about was the second incident. On 1/2/07, I (LPN #1) started noticing that he [Resident #7] was following her [Resident #6] and doing things for her. On 3/10/07, he was seeking her out. About 8:30 p.m., they were sitting together. I could see her hand. Her hand was placed on his genitals. He had his hand on hers and was stroking it. I took [Resident #6] to her room. I went back to him and said [Resident #7] that's not appropriate. He agreed. I called [Administrator] right away. She [Administrator] said watch them, they can sit together the rest of the weekend. I'll talk to him on Monday. Just watch them. I was upset, she [Administrator] didn't tell me to write an I & A (Incident and Accident) or anything. We are just monitoring and watching them. He [Resident #7] always like to take her down to the dining room by themselves. We had a meeting/in-service a couple of days ago with [RN (Registered Nurse) #1] and [RN #2]. The last I heard they [Resident #6 and #7] could be together, then not. I am confused. I try to keep them separated. I don't know what the status is right now."	F 309			

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F 309	Continued From page 5 n. Nurse's Notes dated 3/11/07 at 10:30 a.m. documented the resident's sister was notified of the 3/10/07 incident, she agreed that the 2 residents needed to be away from each other and that she would talk to her brother about the incident. o. Nurse's Notes dated 3/11/07 at 12:00 p.m., documented: "Director of Nursing (DON), notified and stated that residents need to be separated from each other." p. The Care Plan initiated 8/21/06 and reviewed/updated 10/12/07, 11/7/07 and 3/14/07, documented: "Date: 3/14/07 Problem: Knowledge deficit with appropriate social skills with opposite gender. Goals: Will have appropriate interaction with opposite gender. Approach: Family care plan meeting. Staff training. Resident training, instruct. Social service to educate 1 x 1 week 3/15/07. Redirection from staff when needed 3/15/07." The care plan failed to address the inappropriate sexual behaviors until 3/14/07 (approximately 5 months after identified onset). 1) Nurse's Notes dated 3/14/07 at 11 a.m. documented the Care Plan meeting was discussed with Resident #7, his family, the Social Service Director, Nursing, and the Administrator. The Notes documented: "[Resident #7's] relationship with other female [Resident #6] resident in facility. Discussed behaviors and rules of the facility not enter other resident's room. When with female resident friends he is not to let her touch him or him to touch her. [Resident #7] verbalized understanding."	F 309			

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F 309	<p>Continued From page 6</p> <p>2) On 3/16/07 at 9:30 a.m., Resident #7 stated that he had lived at the facility for about 3 to 4 months and this was the second time he had been at the facility. He stated he had a friend [Resident #6]. The Resident was asked if there had ever been any problems with being a friend to [Resident #6], the Resident stated, "There was one time that we had a meeting, with [Social Worker], [Administrator], [RN #1] and my sister and me. I had gone down to her [Resident #6] room and unlocked her [Resident #6] brakes, they want me to stay away from her until next Tuesday at 10:00 [a.m.]. There's been no sexual anything. There's been no touching or anything. You only touch if you are married. [Resident #6] has a mind of a 3 year old, you just don't do things like that."</p> <p>2. Resident #6 had diagnoses of Cerebral Palsy, Mental Retardation, Torsion Dystonia, Spondylosis, Hypertension, Seizure Disorder, Renal Insufficiency, and Osteoarthritis. The Quarterly Minimum Data Set dated 1/23/07 documented the resident was moderately impaired in cognitive skills for daily decision making, had socially inappropriate/disruptive behaviors, communicated by sounds, gestures, and grunts and was rarely understood, and required extensive to total assistance with all activities of daily living.</p> <p>a. The Resident Care Plan updated 10/19/06 documented: Impaired Communication related to CP (Cerebral Palsy)-speech is grunting, unable to voice needs, does grunt, uses gestures, Aphasic with an intervention to provide a communication/picture board if needed.</p> <p>b. An Activity Progress Note dated 1/11/07 (no</p>	F 309			

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F 309	<p>Continued From page 7</p> <p>time) documented: Resident is a real joy to be around. Loves everything you do for her. She now has a boyfriend, [Resident #7]. He (Resident #7) has taken her (Resident #6) under his wing and its really cute to watch. They'll go to the dining room and he just talks to her. It's real cute."</p> <p>c. Nurses Note dated 3/9/07 at 2300 (11:00 p.m.) documented, "¼ Does not speak, uses communication board [with] staff. Alert [with] confusion, child like manner."</p> <p>d. An Incident/Accident Report dated 3/10/07 at 8:30 p.m. documented: [Resident #6] and [Resident #7]. Female and Male resident sitting together near TV. Female's right hand on male's crotch. Male holding female's hand in place while stroking hand.</p> <p>e. As of 3/15/07 the resident's care plan last reviewed on 10/19/06 did not address the incident of Resident #7's sexually inappropriate behavior toward this resident. There were no documented interventions pn the care plan to protect the resident from further incidents.</p> <p>3. On 3/15/07 at 2:30 p.m., the Administrator was asked what can you tell me about the incident with (Resident #6 and #7) that was reported on 3/10/07 at 8:30 p.m. The Administrator stated, "[Resident #6] had her hand on [Resident #7]'s groin. The staff told me her hand was down to his crotch." The staff has been upset with the relationship between [name of Resident #6 and #7]. I had a meeting last Friday [3/9/07] related to the relationship. The staff said they were upset about the relationship, because [Resident #6] isn't able to make her needs known. The staff has</p>	F 309			

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F 309	Continued From page 8 talked together about this and they feel uncomfortable with the relationship. I didn't know that there was any intervention about 15 minute monitoring." When asked, did you not see the relationship of the hand close to the groin as sexual, the Administrator stated, "No, I didn't." 4. On 3/15/07 at 3:15 p.m. the Social Director was asked about the incident between Resident #6 and #7. The Social Director stated, "I Was told a staff member witnessed [Resident #6's] hand on [Resident #7's] crotch." When asked if she reported it to anyone, she stated, "No, I believe [LPN #1] reported it to [Administrator]." When asked, if she interviewed any other alert and oriented residents to see if they were uncomfortable around him [Resident #7], the Social Director stated, "I have asked the other residents if they have ever felt abused or neglected, not about [Resident #7]. "	F 309			