

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

PRINTED: 07/21/2006
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 07/07/2006
NAME OF PROVIDER OR SUPPLIER FAYETTEVILLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 OLD MISSOURI RD FAYETTEVILLE, AR 72701	
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F 000	INITIAL COMMENTS	F 000		
F 164 SS=E	<p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 164		

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 164	<p>Continued From page 1</p> <p>by:</p> <p>Based on observation and record review, the facility failed to ensure privacy was provided during dressing for 1 (Resident #4) of 11 case mix residents (Resident #1 - 11) who required assistance with dressing. The facility failed to ensure privacy was provided during toileting for 1 (Resident #10) of 9 case mix residents (Residents #1 - 5 and 7 - 10) who required assistance with toileting. These failed practices had the potential to affect 71 residents who required assistance with dressing and 64 residents who required assistance with toileting according to the Resident Census and Conditions of Residents form dated 7/4/06. The findings are:</p> <p>1. Resident #10 had diagnoses of Dementia with Behavioral Disturbance, Anxiety Disorder and Osteoporosis. The Quarterly Minimum Data Set (MDS) dated 5/30/06 documented the resident was severely impaired in cognitive skills for daily decision making and dependent on staff for toilet use and bathing.</p> <p>On 7/6/06 at 11:45 a.m., CNA #2 and 3 took the resident to the bathroom in her room. The CNAs did not pull the privacy curtain and the door to the bathroom was left open while the CNAs and resident were in the bathroom. The resident's roommate was out of the room, but was ambulatory and the resident could have been seen from the hallway if the door were opened.</p> <p>2. Resident #4 had diagnoses of Cerebral Vascular Accident, Diabetes, and Depression. The Minimum Data Set (MDS) dated 5/1/06 documented the resident was moderately impaired in cognitive skills for daily decision</p>	F 164			

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F 164	Continued From page 2 making and totally dependent on 1 staff person for personal hygiene. On 7/4/06 at 11:35 a.m., CNA #3 and 9 closed the resident's door but did not the pull the privacy curtain. The CNA's removed the resident's clothing and transferred the resident from the wheelchair to a shower chair. CNA #3 transported the resident to the shower room and gave the resident a shower, then transported the resident to his room. The CNA closed the door and pulled the curtain between the resident in B bed, but did not pull the curtain around the resident to prevent exposure. The resident room door was opened by CNA #9 who entered to assist with dressing.	F 164			
F 170 SS=C	483.10(i)(1) MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure mail was delivered to the residents on Saturdays. This failed practice had the potential to affect all 88 residents. The findings are: 1. On 7/4/06 at 10:35 a.m., during the group interview, 4 of 4 alert and oriented residents stated the Activity Director delivered the mail during the week but did not work the weekend and they only got mail if the business office director was working on Saturday. 2. On 7/5/06 at 10:00 a.m., the Activity Director	F 170			

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F 170	Continued From page 3 was asked who delivered the mail and she stated, "I deliver it, but work Monday through Friday". When asked who would delivery the mail on Saturday, she stated, "Whoever is working delivers the mail, I guess." 3. On 7/5/06 at 9:20 a.m., the Administrator stated, "We have a locking box out on the street. Mail is delivered 6 days per week. The Activity Director delivers mail to residents during the week and the weekend manager delivers mail to residents on weekends or I should say they are supposed to deliver mail to residents on the weekends."	F 170			
F 223 SS=G	483.13(b), 483.13(b)(1)(i) ABUSE The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Complaint #11818 and 11842, substantiated (all or in part) in these findings. Based on record review and interview the facility failed to ensure physical abuse did not occur for 1 of 1 case mix resident (Resident #18) who was physically abused as evidenced by the facility's failure to ensure that staff assigned to work the secured unit received adequate training regarding the care of residents with dementia and behavioral symptoms and to ensure that staff	F 223			

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F 223	Continued From page 4 assigned to the secured unit which housed 10 residents, 8 of whom displayed behavioral symptoms, were adequately supervised. This failed practice resulted in actual harm to Resident #18 who was injured during an altercation between him and staff member and had the potential to affect the other 10 residents who resided on the secured unit per the Resident Roster Report received from the Administrator on 7/3/06. The findings are: 1. The facility's policy entitled "Abuse, Neglect and Exploitation" documented: a. " ...Standard: the Abuse coordinator in the facility is the Director of Nursing. Report allegations or suspected abuse, neglect or exploitation immediately to: State Agencies, Local Ombudsman Office, Director of Nursing, Administrator. 'Abuse' means the willful infliction of injury,... or punishment with resulting physical harm, pain or mental anguish... 'Physical Abuse' include hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment... Process:..... III. Response and Reporting of Abuse, Neglect and Exploitation. When abuse, neglect or exploitation is suspected, the Licensed Nurse 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... e) Obtain witness statements... Suspend the accused employee pending completion of the investigation. Remove the employee from resident care areas immediately... IV. Investigation of Alleged Abuse, Neglect and Exploitation. When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or	F 223			

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F 223	<p>Continued From page 5</p> <p>exploitation occur, an investigation is immediately warranted... a) Interview the involved residents, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. b) Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area and visitors in the area. Obtain witness statements... All statements should be signed and dated by the person making the statement..."</p> <p>b. "Tips for prevention of abuse, neglect and exploitation.... Train staff in appropriate interventions to deal with aggressive and/or catastrophic reactions by residents Recognize signs of burnout, frustration and stress in employees that might lead to abuse...React to all allegations 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 areas...Supervise staff to identify inappropriate behaviorsAssess, monitor, and develop appropriate plans of care for residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors...."</p> <p>2. Resident #18 had diagnoses of Dementia with Behavioral Disturbance, Alzheimer's Disease and Anxiety State. The Minimum Data Set (MDS) dated 6/21/06 documented the resident was moderately impaired in cognitive skills for daily decision making, had episodes of disorganized speech, mental function varied over the course of the day and had daily episodes of wandering behaviors that were not easily altered. The</p>	F 223			

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F 223	<p>Continued From page 6</p> <p>resident resided on the secured unit.</p> <p>a. Nursing Notes dated 6/10/06 at 4:45 p.m. and signed by LPN #2 documented, "Walked into resident's room to give meds, noticed blood on shirt, pillow case and arms. Further investigation found large knot with 1 - 1 1/2 inch gash present. Blood present not actively bleeding at this time. Arms with scratches and bruise to left hand noted. Nurse aide [#1] approached me while cleaning area and told me she witnessed another aide physically shove resident and fall to floor and then close door. She stated this happened around 3:00 (p.m.) and was scared to tell me. Called another nurse to evaluate and help with confrontation. Nurse aide [#3] stated that resident was hitting him and he shoved resident. Notified Administrator, RN (Registered Nurse) on call, [physician], APT (Adult Protective Agency) and family. Went back in to get statements. Aide in question was gone. Found bloody clothes hidden in hamper. Police arrived statement given. Left message with family no call back yet... Gait steady. Unable to find bloody towels. At 3:25 p.m. walked in - several residents sitting in DR (dining room). Nothing was said. Residents were all calm and I asked if everyone was OK. The girl nurses aide stated everything was OK..."</p> <p>1) A witness statement dated 6/12/06 and signed by LPN #2 documented: "I was in C hall [secure unit] about 3:30 p.m. doing check. All residents were ok. I saw [Resident #18] & saw nothing wrong. At 4:20 p.m. I went to pass meds in room and found [Resident #18] had blood on head and shirt and scratches on arm and bump on head. There was blood on his pillow and shirt. I asked [NA #3] about it and he said he [resident] had</p>	F 223			

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F 223	<p>Continued From page 7</p> <p>been scratching himself. I did an assessment. [NA #1] came and told me [NA #3] had done this and described incident as [NA#3] took [Resident #18's] arms and tussled him to bed. [Resident #18] swung on [NA #3] and [NA#3] threw him into bed on top of [Resident #3]. [Resident #18] went over bed to floor. Said [NA #3] then closed door also [NA #3] had shook fist at him [resident]. Said happened about 3:00 p.m. reported at 4:30 p.m. [NA #1] said [NA #3] took bloody clothes and put in hamper."</p> <p>2) A witness statement written by LPN #4 dated 6/12/06 documented, "I went to C hall because [NA #1] came to get me. She said [LPN #2] needs you. I examined [Resident #18] and found a knot on his head and scratches on his arms and hands. [LPN #2] said he found him like this when she went to give him meds and said she had to ask what happened. Later [NA #1] said she didn't report incident because she was afraid of [NA #3]. I looked for [NA #3] and found him in TV room with residents. He was looking at his hands. I then called Administrator for instructions. I went and got papers for I&A (Incident and Accident) and then returned to unit. [NA #3] was gone. He must have gone out back door of unit and gone over fence. I did not see him leave. I looked for clothes. Found them in dirty clothes hamper with lots of blood. Police took clothes when they took report. I did not tell [NA #3] to go home. [LPN #2] and talked about sending him home in front of him."</p> <p>3) A statement dated 6/12/06 and signed by NA #1 documented: "...About 3 PM resident was pushing [another resident] into his room and [NA #3] tried to stop him. Resident [#18] had raised fists to NA who then held resident's wrists. The</p>	F 223			

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F 223	Continued From page 8 NA pushed resident into room and onto bed which was directly behind him. Resident [#3] was in that bed. Resident [#18] and NA [#3] were shaking their fists at each other. Resident [#18] rolled over the bed and onto the floor while NA was still holding his wrists. NA did not go over bed but followed around end of bed while holding onto resident's wrists. During this time I [NA #1] am trying to pull [another resident] out of room. I did not see NA [#3] hit resident or say anything to him. I did not see resident [#18] hit his head on anything or get injured. At this time NA [#3] came to door of the room and shut it. I pushed [other resident] into hall and went to answer [another resident] call light. I took the [other resident] to the TV room. While doing this I heard noise from [Resident#18's] room like banging on the walls. I did not hear any voices or talking. A little later I saw [Resident #18] come from his room and go to TV room walking by himself. He had clean clothes on and looked cleaned up. He appeared OK. [NA #1] took clothing and towels that looked bloody to clothes hamper at end of hall and commented 'I think he learned his lesson.' Then NA [#3] left to go smoke a cigarette. He came back about 15 minutes later. Then I went to get a drink and thought I should tell a nurse what had happened. I went to nurses circle [outside secured unit] but did not see a nurse. I saw the med carts down the halls but did not see any nurse. I went back to the unit. I took resident for a smoke break and when I returned [LPN #2] was in [Resident #18's] room. When she asked what happened I told her. I was told in CNA school if I saw abuse to report it. I went to look for a nurse but when I didn't see one, I didn't do anything else. I don't remember any other training on abuse during facility orientation. I did not see NA [#3] hit Resident [#18] or [Resident #18] hit NA	F 223			

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F 223	<p>Continued From page 9</p> <p>[#3]. There were no threats or even voices during all this."</p> <p>b. The [Hospital] Emergency Record dated 6/10/06 at 6:51 p.m. documented, "...History of Present Illness: EMTs (Emergency Medical Technicians) report that pt (patient) and employee were involved in altercation and employee took pt (patient) into room and closed door. Pt has large hematoma to posterior skull and aprox (approximately) 1 cm (centimeter) lac (laceration) with bleeding controlled. Pressure drsg (dressing) applied. Has multiple scratches and bruising to face and arms. He is pleasantly confused. Unable to obtain any info (information) from pt... Chief Complaint: Patient present for evaluation of assault... Assault:... Assaulted with fist, LOC (loss of consciousness): None. Location: Injuries to forearm, Contusion/Abrasion: forearm... Physical exam:... Head:... abrasion over the occiput... Respiratory Chest:... Tenderness:, mild in intensity, Palpation of chest reproduces symptoms, tender l (left) lat (lateral) chest wall... Abdomen: Tenderness, in LUQ (left upper quadrant) which is mild in intensity... Upper extremity: abrasions and contusions over both forearms, worse being the r (right) forearm... Psychiatric:... Anxious affect... Diagnosis: Final:... multiple abrasions and contusions 2nd (secondary to assault..."</p> <p>c. Nursing Notes dated 6/11/06 at 12:30 a.m. documented, "Resident returned from hospital... Resident very nervous about 'that guy'... C/O (complaint of) pain in rib cage when he moves 'wrong'..."</p> <p>Nursing Notes dated 6/11/06 at 10:10 a.m. documented, "... States ribs sore... Reassured</p>	F 223			

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F 223	<p>Continued From page 10</p> <p>that the man would not be back, he states he's glad..."</p> <p>A Progress Note dated 6/11/06 at 6:15 p.m. documented, "There was an altercation on C hall in room 30 on 6/10/06. A nurses aide inflicted some trauma on [Resident #18]. He sustained a small abrasion in Occipital portion of scalp - bruised ribs on left and elbow abrasion. He was sent to [hospital] ER... Physical: Small laceration of scalp - 2 sutures present... Chest:... Tender in lateral aspect of T (thoracic) 6 - 7 - 8 - no ecchymosis. Ext (Extremities): Sore left elbow. Dx (Diagnosis): Trauma - head - ribs - elbow. A. Scalp hematoma B. 1 cm (centimeter) scalp abrasion - sutured C. Costochondritis - left chest ribs E. Abrasion left elbow... Rx (Treatment): 1. Sutures done... 3. Elbow pad... 6. Warm compress to ribs..."</p> <p>d. On 7/5/06 at 8:47 a.m., LPN #4 was asked if residents were present in the TV room with NA #3 on 6/10/06 when she and LPN #2 went to find NA #3 and LPN #4 stated "Yes". LPN #4 stated, "We asked [NA #3] what happened and he just looked dazed. We asked [NA #3] again what happened and he said [Resident #18] fell. The NA looked totally out of it. [LPN #2] and I started talking on the way out of the room and said should we send [NA #3] home and then decided not to talk in front of [NA #3]. So we left C hall (a closed unit) and I called the Administrator. When asked if LPN #2 left C hall with her, LPN #4 stated, "[LPN #2] came out with me, she was looking for statement and I&A forms [paperwork]". When asked how long were you gone from C hall, LPN #4 stated, "Maybe 3 - 4 minutes. I made 2 phone calls one to the Administrator and one to the nurse on call." When asked if any other staff were sent to C hall,</p>	F 223			

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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 72701		
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F 223	<p>Continued From page 11</p> <p>LPN #4 stated "No". When LPN # 4 was asked if the LPNs returned to the closed unit (C hall) together, LPN # 4 stated, "Yes". When asked what the LPNs did on return to C hall, LPN #4 stated, "I gave the female aide the statement form and told her to write it out. Then we asked where [NA #3] was and she said she didn't know." When asked if [NA #3] should have been removed from C hall, LPN # 4 stated, "Yes, we should have pulled [NA #3] out of the situation."</p> <p>On 7/5/06 at 9:20 a.m., LPN #2 stated that after they found NA #3 and questioned him "[LPN #4] and I went to the Nursing desk (off of C hall). I was looking for paper work and [LPN #4] called [Administrator] and called RN on call to tell them what happened and get advice." When asked how long the LPNs were at the nursing station, LPN #2 stated, "Only 2 - 3 minutes. We went right back and [NA #3] was gone." When asked why [NA #3] was left on C hall (closed unit) with residents present, LPN #2 stated, "You're right he could have done something else and [NA #1] wouldn't have done anything because [NA #1] didn't the first time. I shouldn't have left [NA #3] there."</p> <p>e. On 7/5/06 at 2:15 p.m., the Administrator was asked if NA #1 finished the shift on 6/10/06. The Administrator stated, "Yes, she did. I did not tell them to suspend [NA #1], not until I came in on Monday, 6/12/06, and talked with the nurses and learned she didn't report the incident for 1 1/2 hours."</p> <p>3. On 7/7/06 at 11:45 a.m. the Administrator stated that LPNs were not physically present at all times on the secured unit. He stated the LPNs went back to the secured unit for med passes and</p>	F 223			

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F 223	<p>Continued From page 12</p> <p>to check on things but they were not back there unless they needed to do something. He stated that charting and all that was done at the central nursing station, not on the secured unit.</p> <p>On 7/5/06 at 9:45 a.m., LPN #5 the Staff Development Nurse stated that she decides which CNAs and NAs are assigned to specific units and that on 6/10/06 there were 2 NAs (NA #1 and NA #3) assigned to C hall [the secured unit] on the 2 p.m. to 10 p.m. shift.</p> <p>The Resident Roster Report received from the Administrator on 7/3/06 at 5:17 p.m. documented C- hall [secured unit] housed 10 [11 including Resident #18 who was in the facility until 6/30/06] residents, 8 [9 including Resident #18 who was in the facility until 6/30/06] of whom displayed behavioral symptoms.</p> <p>4. The personnel file of NA #3 documented the employee was originally hired by the facility on 8/15/05 in housekeeping/laundry. A Pay Information and Change Form dated 8/22/05 documented: "self-termination/drinking on job." A Pay Information and Change Form dated 9/16/05 documented: "Reinstated." An Official Disciplinary Report dated 9/14/05 and signed by employee on 11/22/05 documented: "Employee came in drunk and I terminated him for this reason. He said that he went and got help for his problem. He will be coming back under supervision by Dept [Department Head] and Administrator during the day."</p> <p>A Pay Information and Change Form dated 3/9/06 documented: "Current employee changing to from housekeeping to CNA [NA (Nursing Assistant) wasn't certified at time of survey]." NA</p>	F 223			

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F 223	<p>Continued From page 13</p> <p>#3's name did not appear on the facility's "Dementia" training record.</p> <p>a. On 7/4/06 at 4:20 p.m. CNA #4 stated: "[NA #3] pretty easy going, my only problem was telling him what needed to be done - he was usually watching TV or standing around. Wasn't long ago that I smelled alcohol on him - I reported it told [CNA#13, the C- hall unit coordinator]." On 7/4/06 at 4:40 p.m., the C-hall Unit Coordinator stated that she was told that NA #3 smelled like alcohol and she did check it out. She stated that she could not smell alcohol on him and he did not act like he was intoxicated. She stated she did not report the allegation to anyone else.</p> <p>b. On 7/7/06 at 11:20 a.m. CNA#14 stated that she worked the 6:00 a.m. to 2:00 p.m. shift on C Hall (the secured unit). She stated that she had worked at the facility for 13 years in November. When asked about NA #3, she stated : "About 1 and ½ months ago in the afternoons I used to work for laundry one day (Resident name) and (Resident #25) were getting showers - the door was open the curtain was pulled on bed B (Resident Name). I knocked softly and walked in. (Resident name) was strapped in the shower chair with poncho on. [NA #3] acted startled and started messing with his pants - he was real close to the resident. I reported it to [Housekeeping supervisor] and we went to DON [Director of Nursing] to report it. I didn't see his pants open or anything as I was behind him but he was really close to the resident and I felt uncomfortable"</p> <p>On 7/7/06 at 11:55 a.m. the DON stated that she did not recall any concerns regarding NA #3 and [Resident #25].</p>	F 223			

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F 223	Continued From page 14 On 7/7/06 at 12:10 p.m. the Housekeeping Supervisor stated: "[CNA#14] came to me one day. She came to me and said something was wrong [NA #3] was adjusting pants/belt buckle and that the [Resident #25] only had a poncho on when she was on the shower chair. I asked 'did you see anything like his pants opened' and she said no just a feeling - as soon as she told me we headed right straight in there to talk with [DON] ...I know [CNA#14] was telling her [DON] about it, I heard her as I was leaving." 5. The personnel file of NA #3 documented the employee's hire date as 4/20/06. NA #1's name did not appear on the facility's "Dementia" training record.	F 223		
F 225 SS=G	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would 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	F 225		

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F 225	<p>Continued From page 15 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> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Complaint #11818 and 11842, substantiated (all or in part) in these findings.</p> <p>Based on record review and interview the facility failed to ensure that after an incident of abuse for 1 of 1 case mix resident (Resident #18) that other residents on the secured unit were protected to prevent further potential abuse. The facility failed to ensure protection was provided to prevent further potential abuse for 1 (Resident #25) of 4 case mix residents (Resident #18, 23, 24 and 25) who had an allegation of abuse reported. The facility failed to ensure staff immediately reported to their supervisor an incident of abuse for 1 (Resident #18) of 4 case mix residents (Resident #18, 23, 24 and 25) who had an allegation of abuse. The facility failed to investigate and report to the Office of Long Term Care (OLTC) an allegation of abuse for 1 (Resident #25) of 4 case</p>	F 225			

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F 225	<p>Continued From page 16</p> <p>mix residents (Resident #18, 23, 24 and 25) who had an allegation of abuse reported. The facility failed to ensure the local law enforcement agency was notified in accordance with State law and staff were interviewed as part of the investigation for 2 (Resident #23 and 24) of 4 case mix residents (Resident #18, 23, 24 and 25) who had an allegation of abuse reported. This failed practice resulted in actual harm to Resident #18 who was injured during an altercation between him and staff member and had the potential to affect all 88 residents. The findings are:</p> <p>1. Resident #18 had diagnoses of Dementia with Behavioral Disturbance, Alzheimer's Disease and Anxiety State. The Minimum Data Set (MDS) dated 6/21/06 documented the resident was moderately impaired in cognitive skills for daily decision making, had episodes of disorganized speech, mental function varied over the course of the day and had daily episodes of wandering behaviors that were not easily altered. The resident resided on the secured unit.</p> <p>a. Nursing Notes dated 6/10/06 at 4:45 p.m. and signed by LPN #2 documented, "Walked into resident's room to give meds, noticed blood on shirt, pillow case and arms. Further investigation found large knot with 1 - 1 1/2 inch gash present. Blood present not actively bleeding at this time. Arms with scratches and bruise to left hand noted. Nurse aide [#1] approached me while cleaning area and told me she witnessed another aide physically shove resident and fall to floor and then close door. She stated this happened around 3:00 (p.m.) and was scared to tell me. Called another nurse to evaluate and help with confrontation. Nurse aide [#3] stated that resident was hitting him and he shoved resident.</p>	F 225			

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F 225	<p>Continued From page 17</p> <p>Notified Administrator, RN (Registered Nurse) on call, [physician], APT (Adult Protective Agency) and family. Went back in to get statements. Aide in question was gone. Found bloody clothes hidden in hamper. Police arrived statement given. Left message with family no call back yet... Gait steady. Unable to find bloody towels. At 3:25 p.m. walked in - several residents sitting in DR (dining room). Nothing was said. Residents were all calm and I asked if everyone was OK. The girl nurses aide stated everything was OK..."</p> <p>1) A witness statement dated 6/12/06 and signed by LPN #2 documented: "I was in C hall [secure unit] about 3:30 p.m. doing check. All residents were ok. I saw [Resident #18] & saw nothing wrong. At 4:20 p.m. I went to pass meds in room and found [Resident #18] had blood on head and shirt and scratches on arm and bump on head. There was blood on his pillow and shirt. I asked [NA #3] about it and he said he [resident] had been scratching himself. I did an assessment. [NA #1] came and told me [NA #3] had done this and described incident as [NA#3] took [Resident #18's] arms and tussled him to bed. [Resident #18] swung on [NA #3] and [NA#3] threw him into bed on top of [Resident #3]. [Resident #18] went over bed to floor. Said [NA #3] then closed door also [NA #3] had shook fist at him [resident]. Said happened about 3:00 p.m. reported at 4:30 p.m. [NA #1] said [NA #3] took bloody clothes and put in hamper."</p> <p>2) A witness statement written by LPN #4 dated 6/12/06 documented, "I went to C hall because [NA #1] came to get me. She said [LPN #2] needs you. I examined [Resident #18] and found a knot on his head and scratches on his arms and</p>	F 225			

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F 225	Continued From page 18 hands. [LPN #2] said he found him like this when she went to give him meds and said she had to ask what happened. Later [NA #1] said she didn't report incident because she was afraid of [NA #3]. I looked for [NA #3] and found him in TV room with residents. He was looking at his hands. I then called Administrator for instructions. I went and got papers for I&A (Incident and Accident) and then returned to unit. [NA #3] was gone. He must have gone out back door of unit and gone over fence. I did not see him leave. I looked for clothes. Found them in dirty clothes hamper with lots of blood. Police took clothes when they took report. I did not tell [NA #3] to go home. [LPN #2] and talked about sending him home in front of him." 3) A statement dated 6/12/06 and signed by NA #1 documented: "...About 3 PM resident was pushing [another resident] into his room and [NA #3] tried to stop him. Resident [#18] had raised fists to NA who then held resident's wrists. The NA pushed resident into room and onto bed which was directly behind him. Resident [#3] was in that bed. Resident [#18] and NA [#3] were shaking their fists at each other. Resident [#18] rolled over the bed and onto the floor while NA was still holding his wrists. NA did not go over bed but followed around end of bed while holding onto resident's wrists. During this time I [NA #1] am trying to pull [another resident] out of room. I did not see NA [#3] hit resident or say anything to him. I did not see resident [#18] hit his head on anything or get injured. At this time NA [#3] came to door of the room and shut it. I pushed [other resident] into hall and went to answer [another resident] call light. I took the [other resident] to the TV room. While doing this I heard noise from [Resident#18's] room like banging on the walls. I	F 225			

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F 225	<p>Continued From page 19</p> <p>did not hear any voices or talking. A little later I saw [Resident #18] come from his room and go to TV room walking by himself. He had clean clothes on and looked cleaned up. He appeared OK. [NA #1] took clothing and towels that looked bloody to clothes hamper at end of hall and commented 'I think he learned his lesson.' Then NA [#3] left to go smoke a cigarette. He came back about 15 minutes later. Then I went to get a drink and thought I should tell a nurse what had happened. I went to nurses circle [outside secured unit] but did not see a nurse. I saw the med carts down the halls but did not see any nurse. I went back to the unit. I took resident for a smoke break and when I returned [LPN #2] was in [Resident #18's] room. When she asked what happened I told her. I was told in CNA school if I saw abuse to report it. I went to look for a nurse but when I didn't see one, I didn't do anything else. I don't remember any other training on abuse during facility orientation. I did not see NA [#3] hit Resident [#18] or [Resident #18] hit NA [#3]. There were no threats or even voices during all this."</p> <p>b. The [Hospital] Emergency Record dated 6/10/06 at 6:51 p.m. documented, "...History of Present Illness: EMTs (Emergency Medical Technicians) report that pt (patient) and employee were involved in altercation and employee took pt (patient) into room and closed door. Pt has large hematoma to posterior skull and aprox (approximately) 1 cm (centimeter) lac (laceration) with bleeding controlled. Pressure drsg (dressing) applied. Has multiple scratches and bruising to face and arms. He is pleasantly confused. Unable to obtain any info (information) from pt... Chief Complaint: Patient present for evaluation of assault... Assault:... Assaulted with</p>	F 225			

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F 225	<p>Continued From page 20</p> <p>fist, LOC (loss of consciousness): None. Location: Injuries to forearm, Contusion/Abrasion: forearm... Physical exam:... Head:... abrasion over the occiput... Respiratory Chest:... Tenderness:, mild in intensity, Palpation of chest reproduces symptoms, tender I (left) lat (lateral) chest wall... Abdomen: Tenderness, in LUQ (left upper quadrant) which is mild in intensity... Upper extremity: abrasions and contusions over both forearms, worse being the r (right) forearm... Psychiatric:... Anxious affect... Diagnosis: Final:... multiple abrasions and contusions 2nd (secondary to assault..."</p> <p>c. Nursing Notes dated 6/11/06 at 12:30 a.m. documented, "Resident returned from hospital... Resident very nervous about 'that guy'... C/O (complaint of) pain in rib cage when he moves 'wrong'..."</p> <p>d. Nursing Notes dated 6/11/06 at 10:10 a.m. documented, "... States ribs sore... Reassured that the man would not be back, he states he's glad..."</p> <p>e. A Progress Note dated 6/11/06 at 6:15 p.m. documented, "There was an altercation on C hall in room 30 on 6/10/06. A nurses aide inflicted some trauma on [Resident #18]. He sustained a small abrasion in Occipital portion of scalp - bruised ribs on left and elbow abrasion. He was sent to [hospital] ER... Physical: Small laceration of scalp - 2 sutures present... Chest:... Tender in lateral aspect of T (thoracic) 6 - 7 - 8 - no ecchymosis. Ext (Extremities): Sore left elbow. Dx (Diagnosis): Trauma - head - ribs - elbow. A. Scalp hematoma B. 1 cm (centimeter) scalp abrasion - sutured C. Costochondritis - left chest ribs E. Abrasion left elbow... Rx (Treatment): 1.</p>	F 225			

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F 225	<p>Continued From page 21</p> <p>Sutures done... 3. Elbow pad... 6. Warm compress to ribs..."</p> <p>f. On 7/5/06 at 8:47 a.m., LPN #4 was asked if residents were present in the TV room with NA #3 on 6/10/06 when she and LPN #2 went to find NA #3 and LPN #4 stated "Yes". LPN #4 stated, "We asked [NA #3] what happened and he just looked dazed. We asked [NA #3] again what happened and he said [Resident #18] fell. The NA looked totally out of it. [LPN #2] and I started talking on the way out of of the room and said should we send [NA #3] home and then decided not to talk in front of [NA #3]. So we left C hall (a closed unit) and I called the Administrator. When asked if LPN #2 left C hall with her, LPN #4 stated, "[LPN #2] came out with me, she was looking for statement and I&A forms [paperwork]". When asked how long were you gone from C hall, LPN #4 stated, "Maybe 3 - 4 minutes. I made 2 phone calls one to the Administrator and one to the nurse on call." When asked if any other staff were sent to C hall, LPN #4 stated "No". When LPN # 4 was asked if the LPNs returned to the closed unit (C hall) together, LPN # 4 stated, "Yes". When asked what the LPNs did on return to C hall, LPN #4 stated, "I gave the female aide the statement form and told her to write it out. Then we asked where [NA #3] was and she said she didn't know." When asked if [NA #3] should have been removed from C hall, LPN # 4 stated, "Yes, we should have pulled [NA #3] out of the situation."</p> <p>On 7/5/06 at 9:20 a.m., LPN #2 stated that after they found NA #3 and questioned him "[LPN #4] and I went to the Nursing desk (off of C hall). I was looking for paper work and [LPN #4] called [Administrator] and called RN on call to tell them</p>	F 225			

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F 225	<p>Continued From page 22</p> <p>what happened and get advice." When asked how long the LPNs were at the nursing station, LPN #2 stated, "Only 2 - 3 minutes. We went right back and [NA #3] was gone." When asked why [NA #3] was left on C hall (closed unit) with residents present, LPN #2 stated, "You're right he could have done something else and [NA #1] wouldn't have done anything because [NA #1] didn't the first time. I shouldn't have left [NA #3] there."</p> <p>g. Previous allegations regarding NA #3:</p> <p>1) On 7/4/06 at 4:20 p.m. CNA #4 stated: "[NA #3] pretty easy going, my only problem was telling him what needed to be done - he was usually watching TV or standing around. Wasn't long ago that I smelled alcohol on him - I reported it told [CNA#13, the C- hall unit coordinator]." On 7/4/06 at 4:40 p.m., the C-hall Unit Coordinator stated that she was told that NA #3 smelled like alcohol and she did check it out. She stated that she could not smell alcohol on him and he did not act like he was intoxicated. She stated she did not report the allegation to anyone else.</p> <p>2) On 7/7/06 at 11:20 a.m. CNA#14 stated that she worked the 6:00 a.m. to 2:00 p.m. shift on C Hall (the secured unit). She stated that she had worked at the facility for 13 years in November. When asked about NA #3, she stated : "About 1 and ½ months ago in the afternoons I used to work for laundry one day (Resident name) and (Resident name) were getting showers - the door was open the curtain was pulled on bed B (Resident Name-#25). I knocked softly and walked in. (Resident name) was strapped in the shower chair with poncho on. [NA #3] acted startled and started messing with his pants - he</p>	F 225			

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F 225	<p>Continued From page 23</p> <p>was real close to the resident. I reported it to [Housekeeping supervisor] and we went to DON [Director of Nursing] to report it. I didn't see his pants open or anything as I was behind him but he was really close to the resident and I felt uncomfortable"</p> <p>On 7/7/06 at 11:55 a.m., the Director of Nursing (DON) and the Administrator were asked if they had received any concerns from staff regarding NA #3. The DON stated, "No, I don't remember any". When asked if they recalled any concerns regarding NA #3 and Resident #25, the DON stated "No, I don't."</p> <p>On 7/7/06 at 12:10 p.m. the Housekeeping Supervisor stated: "[CNA#14] came to me one day. She came to me and said something was wrong [NA #3] was adjusting pants/belt buckle and that the [Resident #25] only had a poncho on when she was on the shower chair. I asked 'did you see anything like his pants opened' and she said no just a feeling - as soon as she told me we headed right straight in there to talk with [DON] ...I know [CNA#14] was telling her [DON] about it, I heard her as I was leaving."</p> <p>On 7/7/06 at 12:25 p.m., the Director of Nursing was asked if she recalled CNA #12 and the Housekeeping Supervisor coming to her with concerns regarding NA #3. The DON stated, "I don't remember it. If it was something of concern some one had told me I wouldn't have let it go." The DON was told of the concern expressed by CNA #12 during an interview regarding NA #3 and Resident #25 and was asked if it was investigated. The DON stated, "If she would have said anything that raised any red flags, I would have been on it." The Administrator stated, "If the</p>	F 225			

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F 225	<p>Continued From page 24</p> <p>resident was in a shower poncho what would be inappropriate in [NA #3] being close to her. Did the CNA say the word 'abuse'. I have to believe that whatever was conveyed to [DON] wasn't told to [DON] in that manner."</p> <p>h. On 7/5/06 at 2:15 p.m., the Administrator was asked if NA #1 finished the shift on 6/10/06. The Administrator stated, "Yes, she did. I did not tell them to suspend [NA #1], not until I came in on Monday, 6/12/06, and talked with the nurses and learned she didn't report the incident for 1 1/2 hours."</p> <p>2. An Office of Long Term Care (OLTC) Incident and Accident Report (I&A), DMS-7734, and the Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities, DMS-762, completed for Resident #23 documented the date and time of discovery of alleged abuse was 5/18/06 at 1:30 p.m.</p> <p>a. The Summary of Incident on the DMS-7734 documented, "NA [NA #2] stated that [Resident #23] was going down the hall and grabbed a passing CNA arm and wouldn't let it go. She stated the CNA slapped resident on hand because resident was squeezing arm."</p> <p>b. The steps taken to prevent continued abuse or neglect during the investigation documented, "Resident has been assessed by RN with no negative effects found.</p> <p>c. The DMS-762 documented that the law enforcement agency was not contacted until 5/19/06 at 11:30 p.m.</p>	F 225			

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F 225	<p>Continued From page 25</p> <p>d. On 7/5/06 at 2:15 p.m., the Administrator stated that NA [NA #2] stated the slap was actually a tapping on hand after which resident let go of the CNA's arm. The NA also stated that although she did not think the CNA handled the situation well there was no physical harm. The NA also stated that the CNA was not verbally abusive but NA #2 did not approve of the way handled..." The Administrator was asked if NA [NA #2] gave you the name of which CNA slapped the resident on the the hand and the Administrator stated, "[NA #2] stated she could not be specific about dates, times or person." When asked if any other residents were interviewed the Administrator stated, "Yes, the Social Worker did interview other residents (only did B and D halls) on the hall the resident lived on or passed through." The Administrator presented a document entitled "Laundry List" dated 5/19/06 - 5/26/06 that documented, "Residents interview with no complaints". There were check marks by all the names including 7 facility identified "non-responsive" residents. The Administrator was asked if staff had been questioned regarding this incident and the Administrator stated, "No, we didn't do facility a I&A so I guess we didn't do any." When asked why there was a delay in contacting the police, the Administrator stated, "I don't know. I forgot about it until the next day. It's on our I&A to remind me and since we didn't fill out I&A, I didn't think about it."</p> <p>3. The Office of Long Term Care (OLTC) Incident and Accident Report (I&A), DMS-7734, and the Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities, DMS-762, for Resident #24 documented the date and time of discovery was</p>	F 225			

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F 225	<p>Continued From page 26 5/18/06 at 1:30 p.m.</p> <p>a. The Summary of Incident documented, "NA [NA #2] stated that [Resident #24] was going down hall and grabbed a passing CNA [NA #4] scrub top. NA [NA #2] stated [NA #4] took hold of resident's hand and slung it off her."</p> <p>b. The DMS-762 documented that the law enforcement agency was not contacted until 5/19/06 at 11:30 p.m.</p> <p>c. The steps taken to prevent continued abuse or neglect during the investigation documented, "Resident has been assessed by RN with no negative findings.</p> <p>d. On 7/5/06 at 2:15 p.m., the Administrator stated that NA [NA #2] stated that action by CNA [NA #4] was actually pulling hand away from scrub top. Stated CNA did not act in a abusive manner. [NA #2] stated that she felt CNA should have handled it differently but did not say why she felt it was not handled correctly. [NA #4] stated in phone interview with Administrator that she did not remember incident. CNA not suspended..." The Administrator was asked if any other residents were interviewed and the Administrator stated, "All residents on B and D halls were done from 5/19/06 through 5/26/06 by the Social Worker." The Administrator was asked if staff had been questioned regarding this incident and the Administrator stated "No". When asked why there was a delay in contacting the police, the Administrator stated "I didn't fill out an I&A and I forgot to do it until next day." When asked if NA #4 was suspended the Administrator stated, "Not suspended, the reason I didn't was [NA #2] didn't think it was abuse, just mishandled."</p>	F 225			

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F 225	Continued From page 27 e. The Hours Worked Simplified Report documented that NA #4 worked on 5/18/06 from 6:00 a.m. to 2:00 p.m., 5/19/06 from 1:45 p.m. to 10:00 p.m., 5/21/06 from 2:00 p.m. until 6:00 a.m., 5/24/06 from 1:30 p.m. until 10:00 p.m. and 5/25/06 from 12:30 p.m. until 10:00 p.m. f. On 7/7/06 at 11:45 a.m., the Administrator was asked if the investigation of the alleged abuse was not completed until 5/26/06 and if [NA #4] continued to work and the Administrator stated, "It's probably true. I thought an allegation could be withdrawn on talking with the Administrator by the employee who then stated 'not properly handled'. Now I understand that once the word 'abuse' is said, it can't be taken back. I understand that now since you asked me about it and after talking with corporate."	F 225			
F 226 SS=G	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 #11818 and 11842, substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure their abuse policy and procedure was implemented by not protecting residents from the potential for further abuse after an incident of abuse for 1 of 1 case mix resident (Resident #18) who had been physically abused.	F 226			

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F 226	<p>Continued From page 28</p> <p>The facility failed to ensure protection was provided to prevent further potential abuse for 1 (Resident #25) of 4 case mix residents (Resident #18, 23, 24 and 25) who had an allegation of abuse reported. The facility failed to ensure staff immediately reported to their supervisor an incident of abuse for 1 (Resident #18) of 4 case mix residents (Resident #18, 23, 24 and 25) who had an allegation of abuse. The facility failed to investigate and report to the Office of Long Term Care (OLTC) an allegation of abuse for 1 (Resident #25) of 4 case mix residents (Resident #18, 23, 24 and 25) who had an allegation of abuse reported. The facility failed to ensure the local law enforcement agency was notified in accordance with State law and staff were interviewed as part of the investigation for 2 (Resident #23 and 24) of 4 case mix residents (Resident #18, 23, 24 and 25) who had an allegation of abuse reported. The facility failed to ensure references were checked and the Employment Clearance Registry (ECR) was checked prior to hiring staff. The facility also failed to ensure that staff assigned to work the secured unit received adequate training regarding the care of residents with dementia and behavioral symptoms and to ensure that staff assigned to the secured unit which housed 10 residents, 8 of whom displayed behavioral symptoms, were adequately supervised. This failed practice resulted in actual harm to Resident #18 who was injured during an altercation between him and staff member This failed practice caused actual harm to Resident #18 who required sutures and had the potential to affect all 88 residents. The findings are:</p> <p>1. The facility's policy entitled "Abuse, Neglect and Exploitation" documented:</p>	F 226			

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F 226	Continued From page 29 a. "...Standard: the Abuse coordinator in the facility is the Director of Nursing. Report allegations or suspected abuse, neglect or exploitation immediately to: State Agencies, Local Ombudsman Office, Director of Nursing, Administrator. 'Abuse' means the willful infliction of injury,... or punishment with resulting physical harm, pain or mental anguish... 'Physical Abuse' include hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment... Process:..... III. Response and Reporting of Abuse, Neglect and Exploitation. When abuse, neglect or exploitation is suspected, the Licensed Nurse 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... e) Obtain witness statements... Suspend the accused employee pending completion of the investigation. Remove the employee from resident care areas immediately... IV. Investigation of Alleged Abuse, Neglect and Exploitation. When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted... a) Interview the involved residents, if possible, and document all responses. If resident is cognitively impaired, interview the resident several times to compare responses. b) Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area and visitors in the area. Obtain witness statements... All statements should be signed and dated by the person making the statement..." b. "Tips for prevention of abuse, neglect and exploitation.... Train staff in appropriate	F 226			

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F 226	<p>Continued From page 30</p> <p>interventions to deal with aggressive and/or catastrophic reactions by residents Recognize signs of burnout, frustration and stress in employees that might lead to abuse...React to all allegations 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 areas...Supervise staff to identify inappropriate behaviorsAssess, monitor, and develop appropriate plans of care for residents with needs and behaviors which might lead to conflict or neglect, such as residents with a history of aggressive behaviors....."</p> <p>2. Resident #18 had diagnoses of Dementia with Behavioral Disturbance, Alzheimer's Disease and Anxiety State. The Minimum Data Set (MDS) dated 6/21/06 documented the resident was moderately impaired in cognitive skills for daily decision making, had episodes of disorganized speech, mental function varied over the course of the day and had daily episodes of wandering behaviors that were not easily altered. The resident resided on the secured unit.</p> <p>a. Nursing Notes dated 6/10/06 at 4:45 p.m. and signed by LPN #2 documented, "Walked into resident's room to give meds, noticed blood on shirt, pillow case and arms. Further investigation found large knot with 1 - 1 1/2 inch gash present. Blood present not actively bleeding at this time. Arms with scratches and bruise to left hand noted. Nurse aide [#1] approached me while cleaning area and told me she witnessed another aide physically shove resident and fall to floor and then close door. She stated this happened</p>	F 226			

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F 226	<p>Continued From page 31</p> <p>around 3:00 (p.m.) and was scared to tell me. Called another nurse to evaluate and help with confrontation. Nurse aide [#3] stated that resident was hitting him and he shoved resident. Notified Administrator, RN (Registered Nurse) on call, [physician], APT (Adult Protective Agency) and family. Went back in to get statements. Aide in question was gone. Found bloody clothes hidden in hamper. Police arrived statement given. Left message with family no call back yet... Gait steady. Unable to find bloody towels. At 3:25 p.m. walked in - several residents sitting in DR (dining room). Nothing was said. Residents were all calm and I asked if everyone was OK. The girl nurses aide stated everything was OK..."</p> <p>1) A witness statement dated 6/12/06 and signed by LPN #2 documented: "I was in C hall [secure unit] about 3:30 p.m. doing check. All residents were ok. I saw [Resident #18] & saw nothing wrong. At 4:20 p.m. I went to pass meds in room and found [Resident #18] had blood on head and shirt and scratches on arm and bump on head. There was blood on his pillow and shirt. I asked [NA #3] about it and he said he [resident] had been scratching himself. I did an assessment. [NA #1] came and told me [NA #3] had done this and described incident as [NA#3] took [Resident #18's] arms and tussled him to bed. [Resident #18] swung on [NA #3] and [NA#3] threw him into bed on top of [Resident #3]. [Resident #18] went over bed to floor. Said [NA #3] then closed door also [NA #3] had shook fist at him [resident]. Said happened about 3:00 p.m. reported at 4:30 p.m. [NA #1] said [NA #3] took bloody clothes and put in hamper."</p> <p>2) A witness statement written by LPN #4 dated</p>	F 226			

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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 72701		
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F 226	<p>Continued From page 32</p> <p>6/12/06 documented, "I went to C hall because [NA #1] came to get me. She said [LPN #2] needs you. I examined [Resident #18] and found a knot on his head and scratches on his arms and hands. [LPN #2] said he found him like this when she went to give him meds and said she had to ask what happened. Later [NA #1] said she didn't report incident because she was afraid of [NA #3]. I looked for [NA #3] and found him in TV room with residents. He was looking at his hands. I then called Administrator for instructions. I went and got papers for I&A (Incident and Accident) and then returned to unit. [NA #3] was gone. He must have gone out back door of unit and gone over fence. I did not see him leave. I looked for clothes. Found them in dirty clothes hamper with lots of blood. Police took clothes when they took report. I did not tell [NA #3] to go home. [LPN #2] and talked about sending him home in front of him."</p> <p>3) A statement dated 6/12/06 and signed by NA #1 documented: "...About 3 PM resident was pushing [another resident] into his room and [NA #3] tried to stop him. Resident [#18] had raised fists to NA who then held resident's wrists. The NA pushed resident into room and onto bed which was directly behind him. Resident [#3] was in that bed. Resident [#18] and NA [#3] were shaking their fists at each other. Resident [#18] rolled over the bed and onto the floor while NA was still holding his wrists. NA did not go over bed but followed around end of bed while holding onto resident's wrists. During this time I [NA #1] am trying to pull [another resident] out of room. I did not see NA [#3] hit resident or say anything to him. I did not see resident [#18] hit his head on anything or get injured. At this time NA [#3] came to door of the room and shut it. I pushed [other</p>	F 226			

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F 226	<p>Continued From page 33</p> <p>resident] into hall and went to answer [another resident] call light. I took the [other resident] to the TV room. While doing this I heard noise from [Resident#18's] room like banging on the walls. I did not hear any voices or talking. A little later I saw [Resident #18] come from his room and go to TV room walking by himself. He had clean clothes on and looked cleaned up. He appeared OK. [NA #1] took clothing and towels that looked bloody to clothes hamper at end of hall and commented 'I think he learned his lesson.' Then NA [#3] left to go smoke a cigarette. He came back about 15 minutes later. Then I went to get a drink and thought I should tell a nurse what had happened. I went to nurses circle [outside secured unit] but did not see a nurse. I saw the med carts down the halls but did not see any nurse. I went back to the unit. I took resident for a smoke break and when I returned [LPN #2] was in [Resident #18's] room. When she asked what happened I told her. I was told in CNA school if I saw abuse to report it. I went to look for a nurse but when I didn't see one, I didn't do anything else. I don't remember any other training on abuse during facility orientation. I did not see NA [#3] hit Resident [#18] or [Resident #18] hit NA [#3]. There were no threats or even voices during all this."</p> <p>b. The [Hospital] Emergency Record dated 6/10/06 at 6:51 p.m. documented, "...History of Present Illness: EMTs (Emergency Medical Technicians) report that pt (patient) and employee were involved in altercation and employee took pt (patient) into room and closed door. Pt has large hematoma to posterior skull and aprox (approximately) 1 cm (centimeter) lac (laceration) with bleeding controlled. Pressure drsg (dressing) applied. Has multiple scratches and</p>	F 226			

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F 226	<p>Continued From page 34</p> <p>bruising to face and arms. He is pleasantly confused. Unable to obtain any info (information) from pt... Chief Complaint: Patient present for evaluation of assault... Assault:... Assaulted with fist, LOC (loss of consciousness): None.</p> <p>Location: Injuries to forearm, Contusion/Abrasion: forearm... Physical exam:... Head:... abrasion over the occiput... Respiratory Chest:... Tenderness:, mild in intensity, Palpation of chest reproduces symptoms, tender I (left) lat (lateral) chest wall... Abdomen: Tenderness, in LUQ (left upper quadrant) which is mild in intensity... Upper extremity: abrasions and contusions over both forearms, worse being the r (right) forearm... Psychiatric:... Anxious affect... Diagnosis: Final:... multiple abrasions and contusions 2nd (secondary to assault..."</p> <p>c. Nursing Notes dated 6/11/06 at 12:30 a.m. documented, "Resident returned from hospital... Resident very nervous about 'that guy'... C/O (complaint of) pain in rib cage when he moves 'wrong'..."</p> <p>Nursing Notes dated 6/11/06 at 10:10 a.m. documented, "... States ribs sore... Reassured that the man would not be back, he states he's glad..."</p> <p>A Progress Note dated 6/11/06 at 6:15 p.m. documented, "There was an altercation on C hall in room 30 on 6/10/06. A nurses aide inflicted some trauma on [Resident #18]. He sustained a small abrasion in Occipital portion of scalp - bruised ribs on left and elbow abrasion. He was sent to [hospital] ER... Physical: Small laceration of scalp - 2 sutures present... Chest:... Tender in lateral aspect of T (thoracic) 6 - 7 - 8 - no ecchymosis. Ext (Extremities): Sore left elbow.</p>	F 226			

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F 226	<p>Continued From page 35</p> <p>Dx (Diagnosis): Trauma - head - ribs - elbow. A. Scalp hematoma B. 1 cm (centimeter) scalp abrasion - sutured C. Costochondritis - left chest ribs E. Abrasion left elbow... Rx (Treatment): 1. Sutures done... 3. Elbow pad... 6. Warm compress to ribs..."</p> <p>d. On 7/5/06 at 8:47 a.m., LPN #4 was asked if residents were present in the TV room with NA #3 on 6/10/06 when she and LPN #2 went to find NA #3 and LPN #4 stated "Yes". LPN #4 stated, "We asked [NA #3] what happened and he just looked dazed. We asked [NA #3] again what happened and he said [Resident #18] fell. The NA looked totally out of it. [LPN #2] and I started talking on the way out of the room and said should we send [NA #3] home and then decided not to talk in front of [NA #3]. So we left C hall (a closed unit) and I called the Administrator. When asked if LPN #2 left C hall with her, LPN #4 stated, "[LPN #2] came out with me, she was looking for statement and I&A forms [paperwork]". When asked how long were you gone from C hall, LPN #4 stated, "Maybe 3 - 4 minutes. I made 2 phone calls one to the Administrator and one to the nurse on call." When asked if any other staff were sent to C hall, LPN #4 stated "No". When LPN # 4 was asked if the LPNs returned to the closed unit (C hall) together, LPN # 4 stated, "Yes". When asked what the LPNs did on return to C hall, LPN #4 stated, "I gave the female aide the statement form and told her to write it out. Then we asked where [NA #3] was and she said she didn't know." When asked if [NA #3] should have been removed from C hall, LPN # 4 stated, "Yes, we should have pulled [NA #3] out of the situation."</p> <p>On 7/5/06 at 9:20 a.m., LPN #2 stated that after they found NA #3 and questioned him "[LPN #4]</p>	F 226			

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F 226	<p>Continued From page 36</p> <p>and I went to the Nursing desk (off of C hall). I was looking for paper work and [LPN #4] called [Administrator] and called RN on call to tell them what happened and get advice." When asked how long the LPNs were at the nursing station, LPN #2 stated, "Only 2 - 3 minutes. We went right back and [NA #3] was gone." When asked why [NA #3] was left on C hall (closed unit) with residents present, LPN #2 stated, "You're right he could have done something else and [NA #1] wouldn't have done anything because [NA #1] didn't the first time. I shouldn't have left [NA #3] there."</p> <p>e. On 7/5/06 at 2:15 p.m., the Administrator was asked if NA #1 finished the shift on 6/10/06. The Administrator stated, "Yes, she did. I did not tell them to suspend [NA #1], not until I came in on Monday, 6/12/06, and talked with the nurses and learned she didn't report the incident for 1 1/2 hours."</p> <p>f. On 7/7/06 at 11:45 a.m. the Administrator stated that LPNs were not physically present at all times on the secured unit. He stated the LPNs went back to the secured unit for med passes and to check on things but they were not back there unless they needed to do something. He stated that charting and all that was done at the central nursing station, not on the secured unit.</p> <p>1) On 7/5/06 at 9:45 a.m., LPN #5 the Staff Development Nurse stated that she decides which CNAs and NAs are assigned to specific units and that on 6/10/06 there were 2 NAs (NA #1 and NA #3) assigned to C hall [the secured unit] on the 2 p.m. to 10 p.m. shift.</p> <p>2) The Resident Roster Report received from the</p>	F 226			

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F 226	<p>Continued From page 37</p> <p>Administrator on 7/3/06 at 5:17 p.m. documented C- hall [secured unit] housed 10 [11 including Resident #18 who was in the facility until 6/30/06] residents, 8 [9 including Resident #18 who was in the facility until 6/30/06] of whom displayed behavioral symptoms.</p> <p>g. The personnel file of NA #3 documented the employee was originally hired by the facility on 8/15/05 in housekeeping/laundry. A Pay Information and Change Form dated 8/22/05 documented: "self-termination/drinking on job." A Pay Information and Change Form dated 9/16/05 documented: "Reinstated." An Official Disciplinary Report dated 9/14/05 and signed by employee on 11/22/05 documented: "Employee came in drunk and I terminated him for this reason. He said that he went and got help for his problem. He will be coming back under supervision by Dept [Department Head] and Administrator during the day."</p> <p>A Pay Information and Change Form dated 3/9/06 documented: "Current employee changing to from housekeeping to CNA [NA (Nursing Assistant) wasn't certified at time of survey]." NA #3's name did not appear on the facility's "Dementia" training record.</p> <p>h. History of previous allegations regarding NA #3</p> <p>1) On 7/4/06 at 4:20 p.m. CNA #4 stated: "[NA #3] pretty easy going, my only problem was telling him what needed to be done - he was usually watching TV or standing around. Wasn't long ago that I smelled alcohol on him - I reported it told [CNA#13, the C- hall unit coordinator]." On 7/4/06 at 4:40 p.m., the C-hall Unit Coordinator</p>	F 226			

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F 226	<p>Continued From page 38</p> <p>stated that she was told that NA #3 smelled like alcohol and she did check it out. She stated that she could not smell alcohol on him and he did not act like he was intoxicated. She stated she did not report the allegation to anyone else.</p> <p>2) On 7/7/06 at 11:20 a.m. CNA#14 stated that she worked the 6:00 a.m. to 2:00 p.m. shift on C Hall (the secured unit). She stated that she had worked at the facility for 13 years in November. When asked about NA #3, she stated : "About 1 and ½ months ago in the afternoons I used to work for laundry one day (Resident name) and (Resident #25) were getting showers - the door was open the curtain was pulled on bed B (Resident Name). I knocked softly and walked in. (Resident name) was strapped in the shower chair with poncho on. [NA #3] acted startled and started messing with his pants - he was real close to the resident. I reported it to [Housekeeping supervisor] and we went to DON [Director of Nursing] to report it. I didn't see his pants open or anything as I was behind him but he was really close to the resident and I felt uncomfortable"</p> <p>On 7/7/06 at 11:55 a.m., the Director of Nursing (DON) and the Administrator were asked if they had received any concerns from staff regarding NA #3. The DON stated, "No, I don't remember any". When asked if they recalled any concerns regarding NA #3 and Resident #25, the DON stated "No, I don't."</p> <p>On 7/7/06 at 12:10 p.m. the Housekeeping Supervisor stated: "[CNA#14] came to me one day. She came to me and said something was wrong [NA #3] was adjusting pants/belt buckle and that the [Resident #25] only had a poncho on when she was on the shower chair. I asked 'did</p>	F 226			

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F 226	<p>Continued From page 39</p> <p>you see anything like his pants opened' and she said no just a feeling - as soon as she told me we headed right straight in there to talk with [DON] ...I know [CNA#14] was telling her [DON] about it, I heard her as I was leaving."</p> <p>On 7/7/06 at 12:25 p.m., the Director of Nursing was asked if she recalled CNA #12 and the Housekeeping Supervisor coming to her with concerns regarding NA #3. The DON stated, "I don't remember it. If it was something of concern some one had told me I wouldn't have let it go." The DON was told of the concern expressed by CNA #12 during an interview regarding NA #3 and Resident #25 and was asked if it was investigated. The DON stated, "If she would have said anything that raised any red flags, I would have been on it." The Administrator stated, "If the resident was in a shower poncho what would be inappropriate in [NA #3] being close to her. Did the CNA say the word 'abuse'. I have to believe that whatever was conveyed to [DON] wasn't told to [DON] in that manner."</p> <p>h. The personnel file of NA #3 documented the employee's hire date as 4/20/06. NA #1's name did not appear on the facility's "Dementia" training record.</p> <p>3. An Office of Long Term Care (OLTC) Incident and Accident Report (I&A), DMS-7734, and the Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities, DMS-762, completed for Resident #23 documented the date and time of discovery of alleged abuse was 5/18/06 at 1:30 p.m.</p> <p>a. The Summary of Incident on the DMS-7734</p>	F 226			

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F 226	<p>Continued From page 40</p> <p>documented, "NA [NA #2] stated that [Resident #23] was going down the hall and grabbed a passing CNA arm and wouldn't let it go. She stated the CNA slapped resident on hand because resident was squeezing arm."</p> <p>b. The steps taken to prevent continued abuse or neglect during the investigation documented, "Resident has been assessed by RN with no negative effects found.</p> <p>c. The DMS-762 documented that the law enforcement agency was not contacted until 5/19/06 at 11:30 p.m.</p> <p>d. On 7/5/06 at 2:15 p.m., the Administrator stated that NA [NA #2] stated the slap was actually a tapping on hand after which resident let go of the CNA's arm. The NA also stated that although she did not think the CNA handled the situation well there was no physical harm. The NA also stated that the CNA was not verbally abusive but NA #2 did not approve of the way handled..." The Administrator was asked if NA [NA #2] gave you the name of which CNA slapped the resident on the the hand and the Administrator stated, "[NA #2] stated she could not be specific about dates, times or person." When asked if any other residents were interviewed the Administrator stated, "Yes, the Social Worker did interview other residents (only did B and D halls) on the hall the resident lived on or passed through." The Administrator presented a document entitled "Laundry List" dated 5/19/06 - 5/26/06 that documented, "Residents interview with no complaints". There were check marks by all the names including 7 facility identified "non-responsive" residents. The Administrator was asked if staff had been questioned regarding</p>	F 226			

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F 226	<p>Continued From page 41</p> <p>this incident and the Administrator stated, "No, we didn't do facility a I&A so I guess we didn't do any." When asked why there was a delay in contacting the police, the Administrator stated, "I don't know. I forgot about it until the next day. It's on our I&A to remind me and since we didn't fill out I&A, I didn't think about it."</p> <p>4. The Office of Long Term Care (OLTC) Incident and Accident Report (I&A), DMS-7734, and the Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long Term Care Facilities, DMS-762, for Resident #24 documented the date and time of discovery was 5/18/06 at 1:30 p.m.</p> <p>a. The Summary of Incident documented, "NA [NA #2] stated that [Resident #24] was going down hall and grabbed a passing CNA [NA #4] scrub top. NA [NA #2] stated [NA #4] took hold of resident's hand and slung it off her."</p> <p>b. The DMS-762 documented that the law enforcement agency was not contacted until 5/19/06 at 11:30 p.m.</p> <p>c. The steps taken to prevent continued abuse or neglect during the investigation documented, "Resident has been assessed by RN with no negative findings.</p> <p>d. On 7/5/06 at 2:15 p.m., the Administrator stated that NA [NA #2] stated that action by CNA [NA #4] was actually pulling hand away from scrub top. Stated CNA did not act in a abusive manner. [NA #2] stated that she felt CNA should have handled it differently but did not say why she felt it was not handled correctly. [NA #4] stated in</p>	F 226			

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F 226	<p>Continued From page 42</p> <p>phone interview with Administrator that she did not remember incident. CNA not suspended..." The Administrator was asked if any other residents were interviewed and the Administrator stated, "All residents on B and D halls were done from 5/19/06 through 5/26/06 by the Social Worker." The Administrator was asked if staff had been questioned regarding this incident and the Administrator stated "No". When asked why there was a delay in contacting the police, the Administrator stated "I didn't fill out an I&A and I forgot to do it until next day." When asked if NA #4 was suspended the Administrator stated, "Not suspended, the reason I didn't was [NA #2] didn't think it was abuse, just mishandled."</p> <p>e. The Hours Worked Simplified Report documented that NA #4 worked on 5/18/06 from 6:00 a.m. to 2:00 p.m., 5/19/06 from 1:45 p.m. to 10:00 p.m., 5/21/06 from 2:00 p.m. until 6:00 a.m., 5/24/06 from 1:30 p.m. until 10:00 p.m. and 5/25/06 from 12:30 p.m. until 10:00 p.m.</p> <p>f. On 7/7/06 at 11:45 a.m., the Administrator was asked if the investigation of the alleged abuse was not completed until 5/26/06 and if [NA #4] continued to work and the Administrator stated, "It's probably true. I thought an allegation could be withdrawn on talking with the Administrator by the employee who then stated 'not properly handled'. Now I understand that once the word 'abuse' is said, it can't be taken back. I understand that now since you asked me about it and after talking with corporate."</p> <p>5. On 7/5/06 at 10:10 a.m., during review of employee files the following concerns were noted:</p> <p>a. Housekeeping employee #1 was hired on</p>	F 226			

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F 226	Continued From page 43 5/11/06. There were 4 reference listed on the application but there was no documentation of reference checks being completed in the employee's file. The ECR was not checked until 5/22/06. b. Maintenance employee #1 was hired on 4/6/06. There were 4 references listed on the application but there was no documentation of reference checks being completed in the employee's file. c. Certified Nurses Assistant (CNA) #10 was hired on 4/13/06. The 8 reference checks were dated 4/14/06. d. Nurses Assistant (NA) #1 was hired on 4/20/06. The ECR was not checked between date of hire and termination on 6/22/06. e. On 7/5/06 at 11:05 a.m. the Office Assistant was asked if there were references for Housekeeping Employee #1 and the Office Assistant stated there were "None". When the Office Assistant was asked why, she stated "Dietary never does references, she started there and transferred to housekeeping". When asked if there were any references for Maintenance Employee #1 the Office Assistant stated "No". When the Office Assistant was asked what the start date for CNA #10 was, she stated 4/13/06. The Office Assistant was asked what date were the references checked. The Office Assistant stated 4/14/06. Both the Office Assistant and the Administrator stated that the reference checks were done late, after the employee started.	F 226			
F 241 SS=E	483.15(a) DIGNITY	F 241			

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F 241	<p>Continued From page 44</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure dignity was maintained by not keeping the soft belt restraint clean of food stains and not pulling the resident backward in a geri chair for 1 (Resident #10) of 3 case mix residents (Residents #3, 5 and 10) who had a soft belt restraint and 9 case mix residents (Resident # 1-5, 8, 9, 10 and 12) who were nonambulatory. These failed practices had the potential to affect 8 residents who had a soft belt restraint according to the listing provided by the Administrator on 7/7/06 at 1:00 p.m. and 61 residents who were nonambulatory according to the Resident Census and Conditions of Residents form dated 7/4/06. The findings are:</p> <p>Resident #10 had diagnoses of Dementia with Behavioral Disturbance, Anxiety Disorder and Osteoporosis. The Quarterly Minimum Data Set (MDS) dated 5/30/06 documented the resident was severely impaired in cognitive skills for daily decision making, dependent on staff for all activities of daily living and required a trunk restraint daily.</p> <p>a. A physician order dated 5/22/06 documented, "Broda chair may use Broda chair [with] soft belt while up..."</p> <p>b. On 7/3/06 at 6:05 p.m.; 7/4/06 at 8:50 a.m.,</p>	F 241			

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F 241	Continued From page 45 10:25 a.m., 11:55 a.m., 3:25 p.m., 6:05 p.m.; and 7/5/06 at 8:25 a.m., 12:00 p.m., and 4:15 p.m., the resident was in the Broda chair and there were 2 pink stains approximately 3 inches long and 1/8 inch wide on the soft belt restraint c. On 7/3/06 at 2:20 p.m., Certified Nursing Assistant (CNA) #1 rolled the resident down the hallway in a shower chair. The resident had a poncho type covering over the shoulders extending to the knees. The covering was bunched up at the belt area leaving the thigh and buttock area exposed bilaterally. CNA #1 rolled the resident past 4 residents in the hallway to the closed double doors on the end of C hall. The CNA stopped at the double doors and covered the resident's legs and sides with a sheet. d. On 7/7/06 at 2:10 p.m. the Director of Nursing (DON) was asked if residents should be fully covered when in shower chairs in the hallways. The DON stated "Yes".	F 241			
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: Based on record review and interview, the facility failed to ensure activities were provided on the weekends. The facility failed to ensure Activity Progress Notes were completed quarterly for 2 (Resident #2 and 11) of 23 case mix residents	F 248			

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F 248	<p>Continued From page 46</p> <p>(Resident #1 - 15 and 19 - 26) who participated in activities. The facility failed to ensure preferences were honored for 2 (Resident #9 and 11) of 23 case mix residents (Resident #1 - 15 and 19 - 26) who participated in activities. This failed practice had the potential to affect 78 residents who resided on the A, B, D, E and F Halls as documented on the Roster Matrix provided by the Administrator on 7/3/06 at 5:17 p.m. The findings are:</p> <p>1. The policy and procedure Titled Activity Participation Records received from the Administrator on 7/5/06 at 12:22 p.m. documented under Standard... Participation records are completed after each Level One and Level Two Programs, to reflect all participants in the group, or individual activity. Participation information for Level Three residents should be documented each time an independent resident chooses to attend and activity... Participation records should be reviewed prior to quarterly assessment and plan of care meetings to determine appropriateness of the activities plan of care.</p> <p>2. On 7/4/06 at 10:35 a.m., during the group interview, the residents stated there were no weekend activities.</p> <p>3. Resident #1 had diagnoses of Congestive Heart Failure, Neuropathy and Bi-Polar Disorder. The Minimum Data Set (MDS) dated 6/15/06 documented the resident was independent in cognitive skills for daily decision making, required limited assistance of one staff person for activities for daily living, and spent 1/3 to 2/3 of time in activities.</p>	F 248			

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F 248	<p>Continued From page 47</p> <p>The June 2006 Group Activity Participation Record did not document an activity for 6/3/06, 6/4/06, 6/10/06, 6/11/06, 6/16/06, 6/17/06, 6/18/06, 6/19/06, 6/24/06, 6/25/06, 7/1/06 and 7/2/06 which were a Friday, Saturday and Sunday.</p> <p>4. Resident #9 had diagnoses of Dementia and Dysphagia. The MDS dated 5/26/06 documented the resident was moderately impaired in cognitive skills for daily decision making, spent 1/3 to 2/3 of time in activities and preferred exercise, sports, music, religious activities, watching TV and talking.</p> <p>a. The June 2006 Group Activity Participation Record documented active religious activities on 6/7/06 and 6/14/06 and active physical programs on 6/1/06, 6/5/06, 6/6/06, 6/27/06 and 6/30/06 with no other preferred activities documented.</p> <p>b. The June 2006 Group Activity Participation Record did not document an activity for 6/3/06, 6/4/06, 6/10/06, 6/11/06, 6/16/06, 6/17/06, 6/18/06, 6/19/06, 6/24/06, 6/25/06, 7/1/06 and 7/2/06 which were a Friday, Saturday and Sunday.</p> <p>5. Resident #4 had diagnoses of Cerebral Vascular Accident, Diabetes, and Depression. The MDS dated 5/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making and spent 1/3 to 2/3 of time in activities.</p> <p>The June 2006 Group Activity Participation Record did not document an activity for 6/3/06, 6/4/06, 6/10/06, 6/11/06, 6/16/06, 6/17/06, 6/18/06, 6/19/06, 6/24/06, 6/25/06, 7/1/06 and</p>	F 248			

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F 248	<p>Continued From page 48 7/2/06 which were a Friday, Saturday and Sunday.</p> <p>6. Resident #11 had diagnoses of Chronic Paranoid Schizophrenia, Anxiety State and Parkinson's Disease. The Quarterly MDS dated 5/30/06 documented the resident was moderately impaired in cognitive skills for daily decision making, time awake as morning, afternoon and evening, average time involved in activities as some - from 1/3 to 2/3 of time, preferred activity setting in own room, day/activity room, and inside nursing home/off unit, with general activity preferences of music, reading/writing, spiritual/religious activities and talking or conversing.</p> <p>a. The plan of care revised on 6/13/06 documented, "Problem: 3/30/06 Impaired communication R/T (related to) cognitive deficits, expressive aphasia, problems finding the right words, answers are inappropriate at times, loses train of thought, wants to [go home], packs up apartment. Approaches: 6/30/06 Encourage [Resident #11] to attend activities. Orient [Resident #11] as needed. Have [Resident #11] make a list of things to do at apartment as a diversion when [Resident #11] gets anxious about it. Problem: 3/30/06 Potential for falls R/T (related to) Hx (history) of falls, Parkinson's, use of Zyprexa. Approach: 6/30/06 Involve resident in activities as tolerated. Problem: 3/30/06 Alteration in Nutrition - Potential for weight loss R/T Parkinson's. Approach: 6/30/06 Involve resident in food related activities as tolerated."</p> <p>b. The Activity Progress Note dated 3/17/06 documented, "I'm going to invite [Resident #11] to Gospel singing & (and) Bible Study & Sing Along."</p>	F 248			

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F 248	<p>Continued From page 49</p> <p>There were no progress notes for June 2006 available.</p> <p>c. The Activity Program Assessment dated 3/17/06 documented, "Intellectual Skills and Interest: R (Resident) reads magazines & likes music. Potential for Involvement: R may like Bible study or Gospel singing or 1:1 reading Bible."</p> <p>d. The Group Activity Participation Record for June and July 2006 did not document Bible study, gospel singing or Spiritual/Religious activities for the resident. There were no activities documented for the weekends for the resident. There was no documentation for one-on-one activities for the resident.</p> <p>7. Resident #2 had diagnoses of Lupus and Parkinson's Disease. The MDS dated 5/20/06 documented the resident was independent in cognitive skills for daily decision making, totally dependent on one staff person for activities for daily living, rarely gets out of her room but involved in activities 1/3 to 2/3 of time.</p> <p>a. The June 2006 Group Activity Participation Record did not document any activities on 6/3/06, 6/4/06, 6/10/06, 6/10/06, 6/16/06, 6/17/06, 6/18/06, 6/24/06 and 6/25/06 which were Friday, Saturday or Sunday.</p> <p>b. As of 7/5/06, the last Activity Progress Notes was dated 3/23/06.</p> <p>8. Resident #5 had diagnoses of Brain Neoplasm, Anxiety Disorder and Paranoid Schizophrenia. The MDS dated 6/12/06 documented the resident was severely impaired in cognitive skills for daily decision making, required total assist of one staff</p>	F 248			

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F 248	<p>Continued From page 50</p> <p>person for activities of day living and was involved in activities 1/3 to 2/3 of the time.</p> <p>The June 2006 Group Activity Participation Record did not document an activity for 6/3/06, 6/4/06, 6/10/06, 6/11/06, 6/16/06, 6/17/06, 6/18/06, 6/19/06, 6/24/06, 6/25/06, 7/1/06 and 7/2/06 which were a Friday, Saturday and Sunday.</p> <p>9. Resident #7 had diagnoses of Cerebral Vascular Accident, Subarachnoid Hemorrhage and Depression. The MDS dated 4/20/06 documented the resident was independent in cognitive skills for daily decision making, was totally dependent on two staff persons for activities for daily living and spent 1/3 to 2/3 of time in activities.</p> <p>The June 2006 Group Activity Participation Record did not document an activity for 6/3/06, 6/4/06, 6/10/06, 6/11/06, 6/16/06, 6/17/06, 6/18/06, 6/19/06, 6/24/06, 6/25/06, 7/1/06 and 7/2/06 which were a Friday, Saturday and Sunday.</p> <p>10. On 7/5/06 at 10:00 a.m., the Activity Director was asked regarding activities on weekends and she stated, "We have church on Sunday and on Saturdays we have board games or whatever they (residents) choose to do." When asked who was responsible for the activities on the weekends, she stated, "The head nurse, I guess. Oh, I guess I am". When AD was asked how residents were assisted to the activities, she stated, "Only myself". When asked regarding assessments she replied, "I only do assessments on admission".</p>	F 248			

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F 248	Continued From page 51 11. On 7/6/06 at 2:25 p.m., CNA #9 was asked what was her role in getting residents to activities and she stated, "I get them up, make sure they are dry or take them to the bathroom and make sure their clothes are clean." The CNA was asked regarding activities on the weekends and she stated, "They don't have much. They do have music in the afternoon". The CNA was asked if many residents attend the activities and she stated, "We don't have many that go but we used to have a lot. I don't know the reason for the change other than they do the same thing every week in and week out. I think they are bored." The CNA was asked if any of the residents had complained regarding the change in where activities were held and she stated, "The president of the council says it so confusing in the dining room with the trays being cleaned, other residents coming in and residents going out to smoke." 12. On 7/5/06 at 11:45 a.m., the Administrator stated it was the responsibility of the Activity Director for weekend activities and if she is not here, she is responsible for arranging the activities.	F 248			
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure the bathroom fixtures and furniture were clean and in good repair, the walls in resident room and	F 253			

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F 253	<p>Continued From page 52</p> <p>door facings were free of paint chips and gouges in the drywall, the vents were free of lint, the walls were free of scuff marks, privacy curtains were free of stains, call light coverings were secured to the wall, the wall paper was secured to the wall, ceiling tiles were free of stains, vinyl laminate was securely attached to the doors, floor tile was in good repair, trim was secured to the wall, and the ceiling tiles had no open areas. These failed practices had the potential to affect all 88 residents. The findings are:</p> <p>1. On 7/4/06 at 3:34 p.m., the following observations were made:</p> <p>a. The wallpaper below the window to the right of the front entrance was peeling away from the wall in an area measuring approximately 3 inches by 6 inches.</p> <p>b. Inside the entry door at the main entrance the ceiling tile had a brown stain measuring approximately 6 inches by 3 inches in diameter.</p> <p>c. The window located beside the piano had wallpaper peeling along the bottom of the window the length of the window sill.</p> <p>d. The right fire door on C Hall had the vinyl laminate coming loose across the entire length on the bottom of the door.</p> <p>e. The ceiling of the 1st closet on the left beside the television in the Social Dining Room had an open area measuring approximately 6 inches square.</p> <p>f. Both restrooms located on D Hall across from the dietary office had an area of wallpaper</p>	F 253			

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F 253	<p>Continued From page 53</p> <p>approximately 4 inches in width, peeling from the ceiling to the floor on 2 walls in each bathroom.</p> <p>g. In the Dining Room to the right of the dirty dish window, there was an area of missing floor tile approximately 3 inches by 4 inches and another area located to the right measuring approximately 2 inches by 2 inches. Along the wall to the left of the window, a piece of wooden trim measuring 36 inches was missing.</p> <p>h. The Janitor's Closet across from the Nurses Circle had an open area in the ceiling measuring approximately 2 1/2 feet by 18 inches.</p> <p>2. On 7/4/06 at 9:15 a.m., in Resident Room #65 the towel bar in the bathroom located above the commode had one end coming out of the wall and hanging askew. The raised commode seat had brown and yellow substances on the inside rim and the seat area. There was a gash in the wall measuring approximately 2 inches by 1 inch at the right side of the head of the bed. The bathroom vent fan in the ceiling had a layer of white dust on the fan.</p> <p>3. On 7/6/06 at 11:24 a.m. the following observations were made in Resident Room #43:</p> <p>a. The screen to the patio door was not in the track on the bottom of the door leaving a 1 inch gap along the bottom of the screen.</p> <p>b. The wall to the right of the patio door had the wall board coming loose from the cinder block leaving a 1 inch gap along the door frame.</p> <p>c. There was no corner trim on the right side of the door frame on the patio door.</p>	F 253			

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F 253	Continued From page 54 d. The curtain rod above the patio door was not attached on the left side causing the rod to hang down approximately 3 inches on the left side of the door. e. The linoleum on the bathroom floor around the drain located at the front of the commode was not glued down to the floor. 4. On 7/4/06 at 12:05 p.m., in Resident Room C34, the entry door frame had 2 areas of missing paint on both sides of the door frame approximately 12 inches long, 2 inches wide and up 36 inches from the floor. 5. On 7/4/06 at 12:10 p.m. the following observations were made in Resident Room C31: a. The screen was off the sliding glass door. b. There were multiple gray scuff marks under the heating/air conditioning unit. The scuff marks extended across the wall to the sliding glass door. The marks were approximately 30 inches long and ranged from 24 inches to 36 inches up from the floor. The scuff marks ranged from 1/4 inch to 3 inches in width. c. The top of the base board on the same wall had cracked/split wall paper on top of the base board 1/2 inch wide and 24 inches long. d. There were gray scuff marks on the wall between the bathroom and the entry door. The first scuff mark was 12 inches long, 1/4 inch wide and was approximately 36 inches up from the floor. The scuff mark was 2.5 inches long, 1/4 inch wide and was 18 inches up from the floor.	F 253			

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F 253	Continued From page 55 6. On 7/4/06 at 12:10 p.m., Resident #10's Broda chair had 3 areas of dried substances on the right side of the chair arm. The areas ranged from approximately 1/4 inch by 1/8 inch and was yellow in color, 1/4 inch in diameter and 1 inch by 1/4 inch. 7. On 7/6/06 at 1:45 p.m., in Resident Room C32 there was an area of peeled/scraped paint above the head of bed B that was approximately 2.5 inches long and wide. 8. On 7/4/06 at 8:25 a.m. in Resident Room E 56 the privacy curtain covering the patio doors to the right side of the resident's bed contained four brown colored stains approximately 6 inches by 3 inches, the metal covering on the call light was loose and not covering the hole in the wall completely, had a missing top screw and the plaster wall had a gouged area to the left side of the door 2 feet above floor, 6 inch in width and 2 feet long.	F 253			
F 309 SS=D	483.25 QUALITY OF CARE 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the Foley	F 309			

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F 309	<p>Continued From page 56</p> <p>catheter drainage tubing and bags were not positioned above the bladder for 1 of 1 (Resident #7) case mix resident who had an indwelling catheter. This failed practice had the potential to affect 1 resident who had an indwelling catheter as documented the Resident Census and Condition of Residents report dated 7/4/06. The findings are:</p> <p>1. The Policy and Procedures titled Catheters-Urinary Tract Infection Prevention provided by the Administrator on 7/7/06 at 1:00 p.m. documented under -Item 5. Urinary drainage bags should be kept below the bladder level to promote free flow of urine, by gravity.</p> <p>2. Resident #7 had diagnoses of Cerebral Vascular Accident, Subarachnoid Hemorrhage and Depression. The Minimum Data Set (MDS) dated 4/20/06 documented the resident was independent in cognitive skills for daily decision making, totally dependent on two staff persons for activities for daily living and had an indwelling catheter.</p> <p>a. The Care Plan dated 4/26/06 under Problem/Need... Potential for UTI (Urinary Tract Infection) R/T (related to) indwelling catheter.</p> <p>b. On 7/4/06 at 9:05 a.m., CNA (Certified Nursing Assistant) #5 and 6 placed the urinary catheter drainage bag on the bed at the resident's feet, then provided catheter care using proper technique. The mechanical lift sling was placed under the resident and attached to the lift. The catheter drainage bag was removed from the bed and hung on the handle of the lift above the resident's bladder. The resident was transferred to the wheelchair and the urinary drainage bag</p>	F 309			

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F 309	Continued From page 57 hung on the side of the wheelchair.	F 309			
F 323 SS=E	<p>3. On 7/7/06 at 3:00 p.m. the Director of Nursing was asked if the Foley bag should be hung on the lift and she stated, "No, I will immediately start training."</p> <p>483.25(h)(1) ACCIDENTS</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation the facility failed to ensure the telephone jacks were secured to the wall, furniture was free of sharp plastic corners, electrical outlets were in good repair and the doors were free of sharp, splintered edges. These failed practices had the potential to affect all 88 residents. The findings are:</p> <p>1. On 7/4/06 at 3:34 p.m., the following observations were made:</p> <p>a. The wing back chair located in the front lobby to the right of the entrance had a one inch triangle tear in the covering that was curling up and was sharp to the touch.</p> <p>b. The left fire door on A Hall had gouges with sharp, splintered edges along the hinged side of the door measuring 10 inches up from the floor and on the outside edge of the door measuring 32 inches up from the floor.</p> <p>c. The right fire door on D Hall had gouges with</p>	F 323			

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F 323	Continued From page 58 sharp, splintered edges along the hinged side of the door measuring 16 inches up from the floor. d. On D Hall, next to the Social Director's office, was an electrical outlet and the cover was cracked and missing a 2 inch piece on the right bottom corner. e. The Beauty Shop/Copy room had two surface mounted electrical outlets located to the right of the wash bowl that protruded from the wall approximately 2 inches with sharp corners on both outlets. f. The left fire door on E Hall had plastic laminate covering the door with a gouged, sharp area on the hinged side of the door measuring 17 inches up from the floor. 2. On 7/4/06 at 9:15 a.m., in Resident Room #65 the telephone jack outlet located at the bottom of the privacy curtain in the middle of the room was hanging by the wires approximately 6 inches under the open wall socket to the floor. 3. On 7/7/07 at 1:44 p.m., in Resident Room #51 the telephone jack outlet located mid way of the resident's low bed, where was hanging under the bed approximately 6 inches from the open wall socket to the floor. 4. On 7/4/06 at 9:00 a.m. in Resident Room B16 room the hall side wall approximately 2 feet from floor and mid wall the face plate on the electrical outlet was missing exposing the wiring.	F 323			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS The facility must ensure that it is free of	F 332			

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F 332	<p>Continued From page 59 medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review and interview of the 8:00 a.m. and 12:00 p.m. medication pass on 7/5/06 and the 8:00 a.m. medication pass on 7/6/06 the facility failed to ensure the medication error rate was less than 5%. Physician orders were not followed on 3 (Residents #14, 19 and 20) of 11 residents observed during the medication pass resulting in medication errors. Medication errors were made by 3 Licensed Practical Nurses (LPNs # 1, 2, and 3) of 5 nurses observed administering medications. The medication error rate was 6.52% based on administration of 46 medications with 3 errors observed. This failed practice had the potential to affect all 88 residents. The findings are:</p> <p>1. Resident #19 had a physician order dated 2/12/06 that documented "Calcium Carbonate 600 mg (milligrams) po (per mouth) bid (twice a day)..."</p> <p>On 7/5/06 at 8:50 a.m., LPN #1 administered Calcarb 600 mg with Vitamin D.</p> <p>2. Resident #14 had a physician order dated 6/5/06 that documented, "Combivent MDI (metered dose inhaler) 2 puffs inhalant q (every) 6 hrs (hours)..."</p> <p>a. On 7/5/06 at 12:06 p.m., LPN #2 administered 1 puff of the Combivent inhaler to the resident</p>	F 332			

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F 332	Continued From page 60 who was in the dining room on the C hall. Then 30 seconds later the LPN administered the second puff of the inhaler. There was no clock in the room and the LPN was not wearing a watch. The LPN stated, "I know I'm supposed to wait 2 minutes and I didn't. [Resident #14] gets impatient if I don't go ahead and give it to her." b. Centers for Medicaid and Medicare Services guidelines documented, "Medication Administered Via Metered Dose Inhalers (MDI): The use of MDI in other than the following ways (this includes use of MDI by the resident). This is an error if the person administering the drug did not do all the following:... If more than one puff is required, (whether the same medication or a different medication) wait approximately a minute between puffs." 3. Resident #20 had a physician order dated 12/17/03 that documented "ASA (Aspirin) 325 mg po q a.m. (every morning)..." On 7/6/06 at 7:55 a.m., LPN #3 administered Enteric Coated ASA 325 mg. When asked why Enteric Coated ASA was given, the LPN stated, "I didn't want to give that nasty tasting Bayer Asprin."	F 332		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced	F 371		

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F 371	<p>Continued From page 61</p> <p>by:</p> <p>Based on observation and interview the facility failed to ensure the dietary employees contained their hair with appropriate coverings and failed to ensure the floor under the dish machine was properly maintained for sanitary conditions. This failed practice had the potential to affect 71 residents who received regular and mechanical soft meal trays from the kitchen according to the diet list received on 7/3/06. The findings are:</p> <p>1. On 7/6/06 at 11:38 a.m., the floor located under the dish machine in the dirty dish room had an area measuring (in tiles) 3 tiles outward from the wall and 12 tiles long where the tiles had come up from the floor and the area was wet and the room had an offensive odor. In the area of missing tiles a PVC drain pipe was draining directly onto the floor, missing the drain by approximately 12 inches, leaving the entire area of floor wet. The drain in this area was open and was dispelling a soured odor of ruined potatoes. The entire area of floor with missing tiles was covered in a brown and black slimy substance.</p> <p>a. On 7/6/06 at 11:40 a.m., the Dietary Manager stated the floor had been like this for some time, since she started last August.</p> <p>b. On 7/6/06 at 3:50 p.m., the Administrator stated he had no contracts in progress for having the floor replaced.</p> <p>2. On 7/6/06 at 11:57 a.m., Dietary Employee #1 entered the kitchen through the door located next to the handwashing sink without a hair covering, passed by two carts containing uncovered desserts and into the dry storage room. The</p>	F 371			

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F 371	Continued From page 62 employee then came out of the dry storage room, walked to the dirty dish room, passing one cart of uncovered desserts on the way, turned back around and walked back to the dry storage room, passing the desserts once again, talked to the Dietary Manager, then went to the handwashing sink, passed the dessert cart, retrieved a hair net, and as the employee passed the dessert carts again was putting the hair net in place.	F 371			
F 426 SS=E	483.60(a) PHARMACY SERVICES - PROCEDURES A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were available for administration for 2 (Residents #18 and 21) of 21 case mix resident who received medications (Residents 1 - 21). This failed practice had the potential to affect all 88 residents. The findings are: 1. Resident #21 had a physician order dated 6/23/06 that documented, "Aricept (Donepezil HCL) 10 mg (milligram) 1 po (per mouth) qd (every day) DX (diagnosis) Dementia" a. The July 2006 Medication Administration Record (MAR) documented Aricept 10 mg at 8:00 a.m.	F 426			

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F 426	Continued From page 63 b. On 7/6/06 at 8:05 a.m., Licensed Practical Nurse #3 could not find the Aricept in the medication cart for administration at 8:00 a.m. c. On 7/6/06 at 8:12 a.m., LPN #3 stated the medication was not in the medication cart drawer or in the medication room. 2. Resident #18 had a physician order dated 4/29/06 that documented "Glipizide (Glucotrol) 2.5 mg po q a.m. NIDDM (Non Insulin Dependent Diabetes Mellitus)." a. The May 2006 MAR documented, "Glucotrol held, not stocked, ordered 5/28/06 at 1:20 a.m." b. The June 2006 MAR documented on 6/4/06 at 6:00 a.m. "Glipizide 2.5 mg po not available."	F 426			
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure gloves were changed after removing feces and before	F 441			

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F 441	<p>Continued From page 64</p> <p>completing incontinent care for 1 (Resident #9) of 7 (Resident #1, 4, 5, 7, 8, 9 and 10) case mix residents who were incontinent of bowel and/or bladder. The facility failed to ensure soiled incontinent briefs were placed in the 55 gallon Biohazard barrel. These failed practices had the potential to affect 43 resident who were incontinent of bowel and /or bladder according to the Resident Census and Conditions of Residents form dated 7/4/06 and 28 residents who resided on Halls D and E according to the Resident Roster Report dated 7/3/06. The findings are:</p> <p>1. Resident #9 had diagnoses of Dementia, UTI (Urinary Tract Infection) and Dysphagia. The Minimum Data set (MDS) dated 5/26/06 documented the resident was moderately impaired in cognitive skills for daily decision making, incontinent of bowel and bladder and totally dependent on one staff person for personal hygiene.</p> <p>a. The care plan updated 5/24/06 documented under "Problem/Need... incontinent of bowel and bladder R/T (related to) Dementia." with an approach of "Ck (check) Q (every) 2 hours for Incon(tinence), peri care after each episode."</p> <p>b. On 7/3/06 at 9:10 a.m., CNA (Certified Nursing Assistant) #7 and 8 transferred the resident to bed, removed the incontinent brief which was wet with urine and soiled with incontinent stool. The CNAs rolled the resident to the left and CNA #7 removed the incontinent stool using a wet wash cloth and a front to back technique, then cleaned the buttocks. The resident was rolled to the right and CNA #8 removed the stool from the buttocks with a clean wet wash cloth. The CNA's did not change their gloves. CNA #8 cleaned each groin</p>	F 441			

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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 07/07/2006
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 441	Continued From page 65 area with a clean wet wash cloth, then changed areas of the cloth and expressed the foreskin and cleaned the head of the penis, then cleaned the shaft of the penis. The resident was placed in a clean incontinent brief. The CNA's both cleaned stool from the resident and then CNA #8 cleaned the anterior areas of the resident without changing their gloves. c. On 7/7/06 at 3:00 p.m., the Director of Nursing was asked if the CNA's should change their gloves when cleaning the resident of bowel movement, "Yes, if I were to see them I would start immediate training."	F 441			
F 502 SS=E	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Dilantin level was obtained each month for 1 of 1 case mix resident (Resident #13) who had a physician order for a Dilantin level. This failed practice had the potential to affect 6 residents who had laboratory orders for Dilantin levels as identified by the	F 502			

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F 502	Continued From page 66 Administrator on 7/7/06. The findings are: Resident #13 had diagnoses of Mental Retardation, Convulsions and Seizure Disorder. The Quarterly Minimum Data Set dated 4/26/06 documented the resident was severely impaired in cognitive skills for daily decision making and the resident had an abnormal lab value in the last 90 days. a. A physician order dated 2/3/06 documented Dilantin level Q (every) month. b. The plan of care updated 5/16/06 documented "Problem: 2/17/06 Seizures & (and) inability to use L (left) side. Approach: Labs as ordered. Report abnormal to MD (medical doctor)." c. As of 7/6/06, there were no lab results for a Dilantin level in April, May or June 2006. d. On 7/6/06 at 11:05 a.m., the Medical Record Clerk stated, "I checked with the Lab first, we don't have any lab on (the resident) after 3/21/06, it wasn't drawn - human error."	F 502			
F 514 SS=E	483.75(I)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514			

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F 514	<p>Continued From page 67 and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure bowel movements were documented on the Medication Administration Record (MAR) as the plan of care directed for 2 (Residents #4 and #6) of 2 case mix residents who had a history of constipation. This failed practice had the potential to affect 1 resident who had a history of Intestine Impaction and 43 residents with a diagnosis of Constipation as identified by Administrator on 7/7/06. The findings are:</p> <p>1. Resident #6 had diagnoses of Intestine Impaction and Constipation. The Quarterly Minimum Data Set (MDS) dated 6/8/06 documented the resident was moderately impaired in cognitive skills for daily decision making, required limited assistance of one person for toilet use and was continent of bowel.</p> <p>a. The plan of care revised on 6/28/06 documented, "3/15/06 Resident is at risk for constipation R/T (related to) Hx (history) of problems, poor intake, Dx (Diagnosis) of constipation, Hx Impaction. Goal: Risk for constipation will be minimized in next 90 days. Approach: 1. 3/15/06 Monitor bowel movements for frequency, consistency, monitor bowel sounds as needed. Record BM's (bowel movements) on MAR (Medication Administration Record)."</p> <p>b. The MAR documented: "Bowl Movement S=small, M=medium, L=Large, X=X-Large,</p>	F 514		

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F 514	<p>Continued From page 68</p> <p>D=Diarrhea. Hour: 6A - 6 (6:00 a.m. - 6:00 p.m.), 6P - 6 (6:00 p.m. -6:00 a.m.)"</p> <p>c. The May 2006 MAR had no documentation if a bowel movement had occurred or not on 5/25/06, 5/26/06, 5/30/06 and 5/31/06 on both shifts. On 5/24/06, 5/27/06, and 5/29/06 there was no documentation for the 6A - 6 shift and on 5/23/06 and 5/28/06 there was no documentation on the 6P - 6 shift.</p> <p>d. The June 2006 MAR had no documentation if a bowel movement had a occurred or not on 6/9/06, 6/12/06 - 6/20/06, 6/22/06 - 6/30/06. On 6/8/06 and 6/10/06 there was no documentation for the 6A - 6 shift and on 6/21/06 there was no documentation on the 6P - 6 shift.</p> <p>e. The July 2006 MAR had no documentation if a bowel movement had a occurred or not from 7/1/06 - 7/4/06.</p> <p>f. On 7/5/06 at 12:10 p.m., Licensed Practical Nurse #1 was asked how she monitored resident's bowel habits with this documentation and she stated, "You can't and someone with [Resident #6's] history, that documentation is very important."</p> <p>2. On 7/7/06 at 3:00 p.m., the Director of Nurses stated "It is facility policy that BM's (bowel movements) should be documented on the MAR". She stated, if no BM's are documented the nurse should check with the resident to see if the resident had a BM or if they need a laxative. When asked where they should be documented, she stated "If the care plan directs MAR documentation, then what can I say?"</p>	F 514			

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F 514	Continued From page 69 3. Resident #4 had diagnoses of Cerebral Vascular Accident, Diabetes, and Depression. The MDS dated 5/1/06 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on 1 staff person for personal hygiene. a. The June 2006 MAR did not document on 25 days if the resident had a bowel moment b. The July 2006 MAR did not document on 2 days if the resident had a bowel moment. c. On 7/6/06 at 11:40 a.m., LPN #3 when shown the bowel movement record on Resident # 4 stated, "Oh my, I can see why you were looking at that, there are 1 to 9 day periods that nothing is charted but the CNAs are good to report if he complains and if he is uncomfortable will tell me."	F 514			