

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

PRINTED: 08/29/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045313	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2006
NAME OF PROVIDER OR SUPPLIER ST. ANDREWS PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3501 COLLEGE AVENUE CONWAY, AR 72032	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>Complaint #11929, unsubstantiated with unrelated deficiencies written at F225 and F226.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified</p>	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1 appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview the facility failed to ensure an allegation of abuse was immediately reported to the Administrator for 1 of 1 (Resident #3) case mix resident with an allegation of abuse. This failed practice had the potential to affect all 104 residents. The findings are:</p> <p>Resident #3 had diagnoses of Alzheimers Dementia, Schizophrenia, Hypertension, and Arthritis. The Annual Minimum Data Set dated 6/19/06 documented the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, fell in the past 31 - 180 days and did not require a restraint.</p> <p>a. The Nurses Notes dated 8/9/06 at 1:45 p.m. documented, "Res. (Resident) worked out of releasable soft belt and fell. Will change to soft belt. Also reinstated personal alarm in bed and w/c (wheelchair). Res. noted to have lg. (large) lump to left forehead. ...".</p> <p>b. The Incident Investigation Report dated 8/9/06 at 1:45 p.m. documented that the "resident worked self out of releasable soft belt and fell. Large lump on forehead. Res. confused, attempts self transfers."</p> <p>c. The Nurses Notes dated 8/10/06 at 10:00 a.m. documented, "Res, left eye swollen, purple and closed. She is verbal with clear speech. Knows</p>	F 225			

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F 225	Continued From page 2 family who has just arrived. In w/c with soft belt restraint, intact at this time. Family concerned about numerous falls in past 5 weeks. They are aware that she has had a decline in condition. Will speak with [physician] re: (regarding) further labs, PT (Physical Therapy) eval (evaluation), etc. and have his input re: next step to prevent falls. Spent considerable time with daughters [Daughter #1] and [Daughter #2], along with [Medical Records Supervisor] today discussing their concerns and staffs attempts at keeping res. safe..." d. On 8/16/06 at 12:10 p.m., the Assistant Director of Nursing (ADON) was asked what concerns had been expressed by the resident's family on 8/10/06. The ADON stated, "One daughter [Daughter # 2] insinuated in the hallway that she would not take up for the nursing home, that she wouldn't be surprised if some one didn't hit her." When the ADON was asked if this was an allegation of abuse, the ADON stated, "I took it as insinuation that she wanted to put that idea into peoples minds." The ADON was asked, "If the other daughter, [Daughter #1] had made that comment, what would you think". The ADON stated, "I would have been surprised and would have considered it an abuse allegation." The ADON also stated, "If there hadn't been witnesses to the fall we may have taken the allegation of some one hitting her more seriously." When asked who witnessed the fall, the ADON stated, "The fall was not witnessed. The room mate's family saw the resident on the floor and didn't tell any one. They thought she just liked to lay on the floor." The ADON was asked what should be done when there was an allegation of abuse. The ADON stated, "It should be investigated and reported to the DON (Director of	F 225			

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F 225	<p>Continued From page 3</p> <p>Nursing)." The ADON was asked if the DON had been notified of the family's comment and the ADON stated, "[DON] was aware that the family was here for a meeting. I don't think I came right out and told her that they thought she had been hit."</p> <p>e. On 8/16/06 at 12:55 p.m. Certified Nurses Assistant (CNA) #2 was asked if she heard the resident's family expressing any concerns last week and the CNA stated, "[Daughter #1] was trying to explain to her sister that her Mom's knees have been bothering her and that she can't get around like she used to, that she falls. The other sister [Daughter #2] said, 'I'm not going to take up for these people. I wouldn't be surprised that some one did hit her.'" CNA #2 was asked if any one witnessed the resident fall and the CNA stated, "No one saw the resident fall". CNA #2 was asked how did you find the resident on the floor and the CNA stated, "The resident was lying on the floor, face up be side the bed, next to the recliner. I saw her feet on the floor from the hallway."</p> <p>f. On 8/16/06 at 1:00 p.m., the Medical Records Supervisor was asked if she was present during [Resident #3's] family conservation in the hall way on 8/10/06. The Medical Records Supervisor stated, "Yes, the 2 daughters were present. One of them [Daughter #1] has POA (Power of Attorney). She was concerned and wanting answers as to what happened to her mother. The ADON was explaining who had reported that her mother [Resident #3] was on the floor and what the staff did. The other daughter [Daughter #2] was making accusations. I told them both that this was not an appropriate place to have this discussion and suggested that we go to the office.</p>	F 225			

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F 225	Continued From page 4 I heard the other sister [Daughter # 2] say 'How did we know that some one didn't punch mother?' The Medical Records Supervisor was asked did you consider that comment as an allegation of abuse. The Medical Records Supervisor stated, "I can't say that I did, that's why I wanted to discuss it further. During the discussion the comment was not made again..." The Medical Records Supervisor stated "I guess I didn't take it as an allegation. It was just 'back' chatter I heard while I was talking with [Daughter #1]. I didn't take it as an allegation. It was a heated situation and we needed to determine if it was a concern. It wasn't brought up again during the discussion in the office. The Medical Records Supervisor was asked did you investigate the allegation that [Resident #3] had been hit. The Medical Records Supervisor stated, "Not me personally. Any investigation would have been done by the DON or ADON and the first chain of command would have been [CFO (Chief Financial Officer)] and [Administrator]. It would have been brought to their attention if the investigation revealed any problem."	F 225			
F 226 SS=D	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: Based on record review and interview the facility failed to ensure the facility's abuse policy and procedure was implemented by not immediately reporting an allegation of abuse to the	F 226			

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F 226	Continued From page 5 Administrator for 1 of 1 (Resident #3) case mix resident with an allegation of abuse. The facility failed to ensure reference checks were completed for 2 of 5 new employees, Employment Clearance Registry (ECR) checks were completed for 1 of 5 new employees and abuse training was completed for 1 of 5 new employees. This failed practice had the potential to affect all 104 residents. The findings are: 1. The facility's policy entitled "Policy and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Mistreatment, Neglect, Abuse, Injuries or Unknown Source and Misappropriation of Resident's Property" documented "... Screening: A. All applicants for employment in the facility shall, at a minimum, have the following screening checks conducted: 1. Two reference checks. 2. Appropriate licensing board or registry check. ... Training: A. Upon hire, each new employee shall be informed of the obligation to report alleged violations... Reporting: A. Any employee who suspected an alleged violation shall immediately notify the Administrator or his/her designee." 2. Resident #3 had diagnoses of Alzheimers Dementia, Schizophrenia, Hypertension, and Arthritis. The Annual Minimum Data Set dated 6/19/06 documented the resident had short and long term memory problems, was moderately impaired in cognitive skills for daily decision making, fell in the past 31 - 180 days and did not require a restraint. a. The Nurses Notes dated 8/9/06 at 1:45 p.m. documented, "Res. (Resident) worked out of releasable soft belt and fell. Will change to soft	F 226			

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F 226	<p>Continued From page 6</p> <p>belt. Also reinstated personal alarm in bed and w/c (wheelchair). Res. noted to have lg. (large) lump to left forehead. ...".</p> <p>b. The Incident Investigation Report dated 8/9/06 at 1:45 p.m. documented that the "resident worked self out of releasable soft belt and fell. Large lump on forehead. Res. confused, attempts self transfers."</p> <p>c. The Nurses Notes dated 8/10/06 at 10:00 a.m. documented, "Res, left eye swollen, purple and closed. She is verbal with clear speech. Knows family who has just arrived. In w/c with soft belt restraint, intact at this time. Family concerned about numerous falls in past 5 weeks. They are aware that she has had a decline in condition. Will speak with [physician] re: (regarding) further labs, PT (Physical Therapy) eval (evaluation), etc. and have his input re: next step to prevent falls. Spent considerable time with daughters [Daughter #1] and [Daughter #2], along with [Medical Records Supervisor] today discussing their concerns and staffs attempts at keeping res. safe..."</p> <p>d. On 8/16/06 at 12:10 p.m., the Assistant Director of Nursing (ADON) was asked what concerns had been expressed by the resident's family on 8/10/06. The ADON stated, "One daughter [Daughter # 2] insinuated in the hallway that she would not take up for the nursing home, that she wouldn't be surprised if some one didn't hit her." When the ADON was asked if this was an allegation of abuse, the ADON stated, "I took it as insinuation that she wanted to put that idea into peoples minds." The ADON was asked, "If the other daughter, [Daughter #1] had made that comment, what would you think". The ADON</p>	F 226			

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F 226	<p>Continued From page 7</p> <p>stated, "I would have been surprised and would have considered it an abuse allegation." The ADON also stated, "If there hadn't been witnesses to the fall we may have taken the allegation of some one hitting her more seriously." When asked who witnessed the fall, the ADON stated, "The fall was not witnessed. The room mate's family saw the resident on the floor and didn't tell any one. They thought she just liked to lay on the floor." The ADON was asked what should be done when there was an allegation of abuse. The ADON stated, "It should be investigated and reported to the DON (Director of Nursing)." The ADON was asked if the DON had been notified of the family's comment and the ADON stated, "[DON] was aware that the family was here for a meeting. I don't think I came right out and told her that they thought she had been hit."</p> <p>e. On 8/16/06 at 12:55 p.m. Certified Nurses Assistant (CNA) #2 was asked if she heard the resident's family expressing any concerns last week and the CNA stated, "[Daughter #1] was trying to explain to her sister that her Mom's knees have been bothering her and that she can't get around like she used to, that she falls. The other sister [Daughter #2] said, 'I'm not going to take up for these people. I wouldn't be surprised that some one did hit her.'" CNA #2 was asked if any one witnessed the resident fall and the CNA stated, "No one saw the resident fall". CNA #2 was asked how did you find the resident on the floor and the CNA stated, "The resident was lying on the floor, face up be side the bed, next to the recliner. I saw her feet on the floor from the hallway."</p> <p>f. On 8/16/06 at 1:00 p.m., the Medical Records</p>	F 226			

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F 226	<p>Continued From page 8</p> <p>Supervisor was asked if she was present during [Resident #3's] family conservation in the hall way on 8/10/06. The Medical Records Supervisor stated, "Yes, the 2 daughters were present. One of them [Daughter #1] has POA (Power of Attorney). She was concerned and wanting answers as to what happened to her mother. The ADON was explaining who had reported that her mother [Resident #3] was on the floor and what the staff did. The other daughter [Daughter #2] was making accusations. I told them both that this was not an appropriate place to have this discussion and suggested that we go to the office. I heard the other sister [Daughter # 2] say 'How did we know that some one didn't punch mother?'" The Medical Records Supervisor was asked did you consider that comment as an allegation of abuse. The Medical Records Supervisor stated, "I can't say that I did, that's why I wanted to discuss it further. During the discussion the comment was not made again..." The Medical Records Supervisor stated "I guess I didn't take it as an allegation. It was just 'back' chatter I heard while I was talking with [Daughter #1]. I didn't take it as an allegation. It was a heated situation and we needed to determine if it was a concern. It wasn't brought up again during the discussion in the office. The Medical Records Supervisor was asked did you investigate the allegation that [Resident #3] had been hit. The Medical Records Supervisor stated, "Not me personally. Any investigation would have been done by the DON or ADON and the first chain of command would have been [CFO (Chief Financial Officer)] and [Administrator]. It would have been brought to their attention if the investigation revealed any problem."</p> <p>3. Housekeeping employee #1 was hired on</p>	F 226			

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F 226	<p>Continued From page 9</p> <p>5/23/06. As of 8/16/06 there was no documentation in the personnel file of references being checked.</p> <p>On 8/16/06 at 1:00 p.m., the Medical Records Supervisor stated, "I checked with the Maintenance Supervisor and he said he didn't do any reference checks because there was no work history. He didn't understand he should have done 2 personal references according to our policy."</p> <p>4. Maintenance Employee #1 was hired on 7/3/06. As of 8/16/06 the personnel file only documented that one reference check had been completed and there was no documentation the (ECR) check had been completed.</p> <p>On 8/16/06 at 1:00 p.m. the Medical Records Supervisor stated, "He [Maintenance Supervisor] did call [Hospital] but didn't write down what they said. He didn't do any other reference checks and he didn't call the Registry."</p> <p>5. Certified Nurses Assistant (CNA) #1 was rehired on 6/8/06. The Application for Employment documented the CNA was employed by the facility from 11/05 through 4/06. The employee's file documented abuse training was conducted on 11/23/05.</p> <p>On 8/16/06 at 1:00 p.m. the Medical Records Supervisor stated "We didn't do abuse training on rehire."</p>	F 226			