STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045146	A. BUILDING ______ B. WING ______	C 08/18/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONE COUNTY NURSING AND REHABILITATION CENTER	706 OAK GROVE STREET MOUNTAIN VIEW, AR 72560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #11937, unsubstantiated with unrelated deficiencies cited at F225 and F226.	F 000		
F 225 SS=E	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 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 225	Continued From page 1 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #11937, substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure an investigation was immediately initiated following an allegation of suspected abuse and the allegation was reported to the Office of Long Term (OLTC) and other State agencies in accordance with State law for 1 of 1 (Resident # 1) case mix residents. These failed practices had the potential to affect all 70 residents. The findings are: Resident #1 had diagnoses of Bipolar Disorder and Dementia with Behaviors. The Quarterly Minimum Data Set dated 7/25/06 documented the resident was severely impaired in cognitive skills for daily decision-making, expression of information was limited to making concrete requests, had episodes of disorganized speech, mental function that varied over the course of the day, and behavioral symptoms of wandering, physically abusive and resisted care. a. On 8/16/06 at 4:30 p.m., the Director of Nursing (DON) stated that on Monday 8/14/06, Resident #1's wife reported to her that the resident had told her he had been "manhandled" by staff. The DON stated she had reported this to the Administrator on 8/14/06.	F 225		

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F 225	Continued From page 2 b. A witness statement dated 8/14/06 and signed by CNA (Certified Nursing Assistant) #1 documented, "On August 9, 2006, Wednesday, we were feeding residents in the west hall dining room. [Resident #1] got up out of his wheelchair and started walking out. [LPN #1] was passing meds and went out and stood in front of him and told him he was not passing her, [Resident #1] stepped over and [LPN #1] stepped over in front of him again saying the same thing. So [Resident #1] turned around to go the other way. [LPN #1] told someone to hold her glasses, ran around the block wall, hollered for someone to get the wheelchair. [CNA #2 and LPN #1] got the wheelchair behind him and they shoved him down in the chair. [Resident #1] grabbed [LPN #1]'s arms so she told [CNA #3] to hold him and [LPN #1] twisted her arm out of his hand. Then she got the torso support and tighten it around him and pulled on the shoulder straps on him so tight that [Resident #1] was telling her to quit because she was going to bruise him." c. A witness statement dated 8/14/06 and signed by CNA #4 documented, "[Resident #1] got up out of his wheelchair and [LPN #1] stopped him so [Resident #1] turned around and practically running from her, so she took her glasses off and hollered get the wheelchair [LPN #1 and CNA #2] grabbed him and shoved him in the chair and [Resident #1] grabbed [LPN #1]'s arms and she twisted away and tightened his torso support on him and he was telling her to quit cause he was going to have bruises." d. An e-mail transmission dated 8/15/06 at 8:07 a.m. and addressed to [Associate Administrator] (AA) documented, "Subject: Abuse!! Dear Mr. [AA] we had an iccident (sic) at [facility] on wed.	F 225		

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F 225	Continued From page 3 (Wednesday) of last week involving a resident and a nurse and cna. They manhandled him and slammed him down in his chair. This nurse causes nothing but trouble at this nursing home. I believe you need to look into things. please don't mention who sent this to you." e. An e-mail transmission dated 8/15/06 at 10:43 a.m. documented, "I am forwarding your allegation of abuse to the Administrator of [facility] for investigation. While I do not know who you are, you e-mail implies that you are an employee, a resident or a family member. If you are an employee, than you are responsible for reporting to your supervisor, DON (Director of Nursing) and/or the Administrator any knowledge/suspicion of abuse or neglect of a resident." Both e-mail transmissions were provided by the Administrator on 8/16/06 at 1:15 p.m. f. On 8/16/06 at 4:30 p.m., the DON stated that the resident's daughter had come to her on Wednesday morning (8/16/06) asking what the facility had learned about the "abuse against her father". The DON stated she reported this conversation to the Administrator 8/16/06 at 10:30 a.m. g. On 8/17/06 at 1:30 p.m., CNA #1 stated, "I reported it (incident on 8/9/06) to my charge nurse [LPN #2] right after it happened and she told me to report it to the Administrator and I did. I saw the RN (Registered Nurse) supervisor talking to the resident and I told her about it too." The CNA was asked if she considered the incident to be abuse and she stated, "Yes, I did." h. On 8/17/06 at 4:25 p.m., the RN Supervisor stated, "I was at lunch when the incident occurred	F 225		

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F 225	Continued From page 4 (on 8/9/06) so I didn't actually see it. When I got back from lunch I noticed the resident was not eating so I went over to him to try to get him to eat. He was confused and was saying, "My brother-in-law beat me up I have bruises all over me" and was pulling his shirt collar down away from his neck and shoulders." The RN Supervisor stated she did not note any bruising or redness. The RN Supervisor stated that a couple of the CNA's came to her at that time and informed her of the incident that had occurred earlier in the dining room. She stated that she informed the Administrator on 8/9/06 that the CNA's "were upset" and had told her the resident had been handled "too rough". i. On 8/16/06 at 4:30 p.m., the Administrator stated that she first became aware of the allegation of abuse against Resident #1 on 8/16/06 at 10:30 a.m. when the resident's daughter reported it to the DON. The Administrator was asked when she first became aware of the incident involving the resident on 8/9/06 and she stated, "I knew about the incident that day (8/9/06) but I didn't consider that to be abuse. A couple of the CNA's just said they thought the nurse had been too rough with him." The Administrator was asked if an investigation had been initiated or witness statements had been obtained on 8/9/06 and she stated, "No". The Administrator was asked if she was aware of the concern expressed by Resident #1's wife on 8/14/06 that the resident had been "manhandled" and she stated "Yes, I didn't consider that to be an allegation of abuse but we did get witness statements at that time." The Administrator was asked about the allegation of abuse documented in the e-mail dated 8/15/06 and the Administrator stated, "The e-mail didn't name any names so I	F 225		

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F 225	Continued From page 5 wasn't sure if it was the same incident they were talking about." The Administrator was asked if there had been any other incidents that had occurred on that day that she was aware of and she stated, "No". The Administrator was asked when the state agency had been notified of the allegation of suspected abuse and she stated, "We're going to do that today." j. The Fax Activity Report provided by the Administrator on 8/18/06 documented the report was faxed to OLTC on 8/17/06 at 8:46 a.m.	F 225		
F 226 SS=E	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Complaint #11937, substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure their abuse policy and procedure was implemented by not immediately initiating an investigation following an allegation of suspected abuse and reporting the allegation to the Office of Long Term (OLTC) and other State agencies in accordance with State law for 1 of 1 (Resident # 1) case mix residents. These failed practices had the potential to affect all 70 residents. The findings are: 1. The Policy and Procedure for Abuse Prohibition provided by the Administrator on	F 226		

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F 226	Continued From page 6 8/16/06 at 4:30 p.m. documented, "Physical Abuse: includes hitting, slapping, kicking, handling a resident in a rough manner causing discomfort/pain through the use of any device or procedure. It also includes controlling behavior tent or using a restraint device for staff convenience. Any observation or knowledge of a potential or actual incident of abuse, neglect, or misappropriation of resident's property must immediately be reported to your Administrator. If you observe or suspect a reportable incident, you must immediately report it to your supervisor who will be held responsible for reporting to the Administrator. (For C.N.A.'s (Certified Nursing Assistant) report to your charge nurse and the charge nurse will report to the Administrator.) There is a limited time frame that your Administrator must lawfully abide by in reporting incidents to the Office of Long Term Care, that either actually occurred or are alleged to have occurred within the facility. The following events shall be reported to the Office of Long Term Care no later than 11:00 a.m. on the next business day following discovery by the facility.: any alleged, suspected or witnessed occurrences of abuse or neglect to residents." 2. Resident #1 had diagnoses of Bipolar Disorder and Dementia with Behaviors. The Quarterly Minimum Data Set dated 7/25/06 documented the resident was severely impaired in cognitive skills for daily decision-making, expression of information was limited to making concrete requests, had episodes of disorganized speech, mental function that varied over the course of the day, and behavioral symptoms of wandering, physically abusive and resisted care. a. On 8/16/06 at 4:30 p.m., the Director of	F 226		

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F 226	Continued From page 7 Nursing (DON) stated that on Monday 8/14/06, Resident #1's wife reported to her that the resident had told her he had been "manhandled" by staff. The DON stated she had reported this to the Administrator on 8/14/06. b. A witness statement dated 8/14/06 and signed by CNA #1 documented, "On August 9, 2006, Wednesday, we were feeding residents in the west hall dining room. [Resident #1] got up out of his wheelchair and started walking out. [LPN #1] was passing meds and went out and stood in front of him and told him he was not passing her, [Resident #1] stepped over and [LPN #1] stepped over in front of him again saying the same thing. So [Resident #1] turned around to go the other way. [LPN #1] told someone to hold her glasses, ran around the block wall, hollered for someone to get the wheelchair. [CNA #2 and LPN #1] got the wheelchair behind him and they shoved him down in the chair. [Resident #1] grabbed [LPN #1]'s arms so she told [CNA #3] to hold him and [LPN #1] twisted her arm out of his hand. Then she got the torso support and tighten it around him and pulled on the shoulder straps on him so tight that [Resident #1] was telling her to quit because she was going to bruise him." c. A witness statement dated 8/14/06 and signed by CNA #4 documented, "[Resident #1] got up out of his wheelchair and [LPN #1] stopped him so [Resident #1] turned around and practically running from her, so she took her glasses off and hollered get the wheelchair [LPN #1 and CNA #2] grabbed him and shoved him in the chair and [Resident #1] grabbed [LPN #1]'s arms and she twisted away and tightened his torso support on him and he was telling her to quit cause he was going to have bruises."	F 226		

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F 226	Continued From page 8	F 226		

d. An e-mail transmission dated 8/15/06 at 8:07 a.m. and addressed to [Associate Administrator] (AA) documented, "Subject: Abuse!! Dear Mr. [AA] we had an iccident (sic) at [facility] on wed. (Wednesday) of last week involving a resident and a nurse and cna. They manhandled him and slammed him down in his chair. This nurse causes nothing but trouble at this nursing home. I believe you need to look into things. please don't mention who sent this to you."

e. An e-mail transmission dated 8/15/06 at 10:43 a.m. documented, "I am forwarding your allegation of abuse to the Administrator of [facility] for investigation. While I do not know who you are, you e-mail implies that you are an employee, a resident or a family member. If you are an employee, than you are responsible for reporting to your supervisor, DON (Director of Nursing) and/or the Administrator any knowledge/suspicion of abuse or neglect of a resident." Both e-mail transmissions were provided by the Administrator on 8/16/06 at 1:15 p.m.

f. On 8/16/06 at 4:30 p.m., the DON stated that the resident's daughter had come to her on Wednesday morning (8/16/06) asking what the facility had learned about the "abuse against her father". The DON stated she reported this conversation to the Administrator 8/16/06 at 10:30 a.m.

g. On 8/17/06 at 1:30 p.m., CNA #1 stated, "I reported it (incident on 8/9/06) to my charge nurse [LPN #2] right after it happened and she told me to report it to the Administrator and I did. I saw the RN (Registered Nurse) supervisor talking to the resident and I told her about it too." The

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F 226	Continued From page 9 CNA was asked if she considered the incident to be abuse and she stated, "Yes, I did." h. On 8/17/06 at 4:25 p.m., the RN Supervisor stated, "I was at lunch when the incident occurred (on 8/9/06) so I didn't actually see it. When I got back from lunch I noticed the resident was not eating so I went over to him to try to get him to eat. He was confused and was saying, "My brother-in-law beat me up I have bruises all over me" and was pulling his shirt collar down away from his neck and shoulders." The RN Supervisor stated she did not note any bruising or redness. The RN Supervisor stated that a couple of the CNA's came to her at that time and informed her of the incident that had occurred earlier in the dining room. She stated that she informed the Administrator on 8/9/06 that the CNA's "were upset" and had told her the resident had been handled "too rough". i. On 8/16/06 at 4:30 p.m., the Administrator stated that she first became aware of the allegation of abuse against Resident #1 on 8/16/06 at 10:30 a.m. when the resident's daughter reported it to the DON. The Administrator was asked when she first became aware of the incident involving the resident on 8/9/06 and she stated, "I knew about the incident that day (8/9/06) but I didn't consider that to be abuse. A couple of the CNA's just said they thought the nurse had been too rough with him." The Administrator was asked if an investigation had been initiated or witness statements had been obtained on 8/9/06 and she stated, "No". The Administrator was asked if she was aware of the concern expressed by Resident #1's wife on 8/14/06 that the resident had been "manhandled" and she stated "Yes, I didn't consider that to be	F 226		

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F 226	Continued From page 10 an allegation of abuse but we did get witness statements at that time." The Administrator was asked about the allegation of abuse documented in the e-mail dated 8/15/06 and the Administrator stated, "The e-mail didn't name any names so I wasn't sure if it was the same incident they were talking about." The Administrator was asked if there had been any other incidents that had occurred on that day that she was aware of and she stated, "No". The Administrator was asked when the state agency had been notified of the allegation of suspected abuse and she stated, "We're going to do that today." j. The Fax Activity Report provided by the Administrator on 8/18/06 documented the report was faxed to OLTC on 8/17/06 at 8:46 a.m.	F 226		