STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045220	A. BUILDING ______ B. WING _____	**08/01/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAYETTEVILLE HEALTH AND REHABILITATION CENTER	**3100 OLD MISSOURI RD** **FAYETTEVILLE, AR 72703**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 0223

Level of harm - Immediate jeopardy

Residents Affected - Some

Protect each resident from all abuse, physical punishment, and being separated from others.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Complaint # (AR 370) was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure Residents #1 and #6, who were cognitively impaired, were free from abuse. The facility identified an incident where Resident #1 physically injured CNA #1 to increase the risk of staff to resident abuse but failed to ensure the planned intervention was implemented. The facility failed to ensure witnessed staff to resident verbal/mental abuse involving Certified Nursing Assistant (CNA) #1 was immediately reported to the Administrator/Designee to ensure residents were protected from the potential of further abuse for 2 of 2 (Residents #1 and #6) case mix residents who were cognitive impaired. The failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident #1 who was cognitively impaired and who alleged staff to resident abuse. According to a list provided by the Director of Nursing (DON) on 8/1/14 at 2:28 p.m., this failed practice had the potential to affect 34 residents in the facility who were cognitively impaired. The facility was informed of the Immediate Jeopardy on 8/1/14 at 12:25 p.m. The findings are. 1. Resident #1 had [DIAGNOSES REDACTED]. The Medicare 30-day Minimum Data Set (MDS) with an
Assessment Reference Date (ARD) of 7/16/14 documented the resident scored 5 (0-7 indicates severe impairment) on a Brief Interview for Mental Status, required extensive assistance from 2 person for transfers, dressing, toilet use, bathing and hygiene. a. The Resident Care Plan dated 6/20/14 documented, .Problem Onset: 10/9/2013 - Behavior Management required .combative with care/resistive to care. b. The Behavioral Health Center psychiatric evaluation dated 6/10/14 documented, .Pt also has refused assistance with ADLs (activities of daily living). Pt (patient) is a 73 y/o (year old) wm (white male) who presents from (nursing home) after punching staff causing injury . c. An Office of Long Term Care (OLTC) Division of Medical Services (DMS) -7734 form dated 7/28/14 documented, .At 9:00 a.m. on 7/28/14, (Resident #1) reported to SSD (Social Services Director) that during a shower his ' nipples were twisted ' and something was put in his ' butthole. ' Head to toe assessment of resident revealed a red discolored area to his left forearm measuring 7 x 7 cm (centimeters), no other injuries were noted at that time. Records reviewed showed that (CNA #1) had given (Resident #1) his shower on Saturday evening 7/26/14. CNA #1 was immediately suspended pending investigation. Police, MD (medical doctor) and family were notified and an officer came to the facility to interview the resident with family and staff present. Collection of statements from alert and oriented resident as well as other staff members has begun, investigation continues . 1) On 8/1/14 at 8:41 p.m., the Weekend RN Supervisor was asked what she knew about the abuse allegation reported by (Resident #1) concerning (CNA #1). She stated she noticed (Resident #1) in the dining room drinking coffee around 4:00 p.m. Sunday (7/27/14). She stated, (Resident #1) was quiet and distant that day. There was something odd about his behavior, not himself. The Weekend RN Supervisor stated when she was asked if she knew (CNA #1) was not supposed to provide care to (Resident #1)? She stated, I had no knowledge (CNA #1) was not supposed to work with (Resident #1), because I would not have scheduled him there. I would just switch halls. If I had an idea at all, any suspicion, I would just change the assignment. The Weekend RN Supervisor's report dated 7/26/14 and 7/27/14 documented, (Resident #1) change in behavior. 2) The DMS witness statement (no date provided) (not timed) signed by the DON, documented, .I received a call from the facility regarding (Resident #1's son) being concerned because his Dad had acted differently on Sunday 7/27/14 when he took him for coffee. When he had returned to the facility there question about bruising on both his Dad's hands. (Resident #1's son) said he thought they were old, but was worried about his Dad's change in behavior. Weekend RN (Registered Nurse) Supervisor called and informed me at about 3:00 p.m. I could not come to the facility to interview the resident at that time. I called (Administrator) and asked if she could and she said she could. Then on Monday morning in morning meeting we talked about it and asked SSD to talk to (Resident #1). She said she would and afterwards she reported he had his nipples twisted and a finger shoved up his butt. The investigation then began. I did a head to toe assessment on resident at 11:30, he was cooperative, there was a red area to left forearm 7 x 7 cm, 4 bruises to back of both hands. No other areas noted on resident, denied pain to areas. 3) The DMS witness statement dated 7/30/14 signed 7/31/14 (not timed) by the Administrator, documented, .On 7/27/14, I got a call from DON that (Resident #1's son) was upset re: his Dad. He had spoken to weekend supervisor and said that his Dad was quiet on their ride to get coffee and appeared upset when he brought him back to the facility. spoke to Weekend supervisor about his Dad's change in behavior - there was discussion about his arms and the bruises - not sure what related to DON was unable to come to facility, but called me and said (around 3ish pm) that (Resident #1) appeared upset and sad and that there were bruises on his arm. I came around 4:30 p.m. and spoke to resident and asked what was wrong. He wouldn't say anything, but sad and distant. I did look at Resident #1's arms and left upper arm was bruised. I did talk to Weekend RN Supervisor and asked her to get witness statements from staff re: bruises and if they know origin . 4) The DMS witness statement dated 7/28/14 documented by the SSD, .On Monday, 7/28 SSD ask to go see resident, he had been tearful earlier in the morning and didn't want to go to breakfast. Resident told SSD that he had a shower and the staff person that showered him was ' ruff, ' Said he twisted his nipples and rubbed too hard and staff person stuck his finger up residents butt, resident became tearful again. SSD reported to Administrator and residents son contacted. On 7/31/14 at 6:15 p.m., the Social Service Director (SSD) was asked if she knew about the allegation of sexual abuse reported by (Resident #1). She stated, In the morning meeting on 7/28/14 the Administrator and the DON (Director of Nursing) asked me to talk to (Resident #1) based on the weekend supervisor's report. I was told that (Resident #1) had issues over the weekend and they told me what he had told nursing. I talked to him and asked him what happened during his shower over the weekend. During the interview he did not voluntarily say any one's name. But he did say that boy. The SSD stated (Resident #1) made the allegation (of abuse) to her and she reported it to the Administrator. 5) The physician's progress notes dated 7/29/14 at 1:21 p.m. documented, I was asked to see (Resident #1) today by the DON because there was a reportable incident yesterday. (Resident #1) reported that there was a CNA on his floor, whom he does not like, who was responsible for his care in the shower 2 days ago. He reports that the CNA used his finger to penetrate his anus repeatedly. He also used a shower nozzle to slap against his penis. He was also grabbed strongly on his left arm. The patient seems quite upset about this and was able to recall the event in pretty significant detail. He really doesn't have any pain with defecation at this point, and his bowel movements have been normal. He does have some bruising around this left wrist. His penis is normal, and he has no dysuria, and is not suffering bruising in his groin anteriorly. He is alert and cooperative with exam today. .Left wrist: shows dorsal ecchymosis, about the size of the palm of a hand that appears within 1 to 3 day of age. Genitalia Exam: Reveals normal uncircumcised male. His testes are distended. There is no scrotal ecchymosis or penile ecchymosis. I could see no hernia. There are no skin abrasions in the groin region. Anus Exam: Reveals normal tone. There is one (1) small superficial, less than one (1) centimeter, abrasion on the right buttock, about 4 cm from his anus. It appears pretty fresh as there is no scabbing, but there is no active bleeding either. I could see no anal

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

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAYETTEVILLE HEALTH AND REHABILITATION CENTER	**3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0223 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) trauma and no other ecchymosis noted.I cannot say for sure whether this lesion is directly attributable to the trauma of 2 days ago, but it is certainly consistent with that age of injury. d. On 7/31/14 at 7:00 p.m., CNA #2 was asked if she had ever heard or seen (CNA #1) be abusive toward (Resident #1). She stated that about a month ago while giving care to (Resident #1), (Resident #1) calls (CNA #1) ' Rambo ' and raised his voice directed toward (CNA #1). He (Resident #1) would ball up his fist, and (CNA #1) would say to him, ' If you think you're going to do anything, I'll pop you. (CNA #1) would be nice to him but (Resident #1) acted like he was going to hit him. (CNA #1) said to (Resident #1), ' If you think you're going to hit me, it will be the last time. Then he would back up. I told (CNA #1) maybe you shouldn't have said that. But that's all he said. e. On 7/31/14 at 8:29 p.m., LPN #1 was asked if she was aware of any abusive behavior by (CNA #1) toward (Resident #1). She stated, He (Resident #1) is very aggressive, mean, angered easily, been that way ever since I've been here. (CNA #1) kinda antagonizes him. I told him several times to stop it. Before (Resident #1) left out to the behavioral health center, he punched (CNA #1) in the face and stomach. He's really combative with showers. Before the behavioral health center, (CNA #1) gave him his showers. LPN #1 then stated that (CNA #1) was taken off the hall before he (Resident #1) went to the behavioral health center (6/20/14) about a month or so ago. LPN #1 was asked, So why did (CNA #1) go back on the hall? LPN #1 stated, That's a really good question. I don't know and he (Resident #1) doesn't like (CNA #3) either. He's called him all kinds of names. E Hall is a really heavy hall and we need muscle down there. LPN #1 was asked if the conflict between (CNA #1) and (Resident #1) had been reported to the DON? LPN #1 stated, Yes, (DON) knows, because of (CNA #1) being punched and they did take (CNA #1) off that hall when (Resident #1) came back from (behavioral health center). LPN #1 was asked then why did (CNA #1) go back on the hall the 26th (7/26/14)? LPN #1 stated, I don't know. If he worked Sunday on that hall, they probably should've known better. f. On 7/31/14 at 6:35 p.m., CNA #3 was asked if he knew of any abusive behavior toward (Resident #1) by (CNA#1). He stated, (Resident #1) would get really upset because (CNA #1) would keep egging him on and a couple of months ago, (Resident #1) punched him in the face twice and made his lip bleed. I didn't see it; I just saw his (CNA #1's) face after. (CNA #1) disrespects (Resident #1). I never knew (CNA #1) was not supposed to work E Hall. (CNA #1) never made that statement. I heard that the bruise on (Resident #1) was caused by (CNA #1). (Resident #1) said (CNA #1) did it. CNA #3 was asked if he believed (CNA #1) caused the bruising. CNA #3 stated, It's a big possibility because of the way (CNA #1) talked in front of (Resident #1). CNA #3 was asked did he ever report anything about (CNA #1). He stated, Yes. They made me fill out a witness statement when (CNA #1) called me a faggot the first time in front of (Resident #1). Ever since then (Resident #1) calls me a faggot when I provide care. Yesterday, I had to step outside the building in order for me to cool my head, clear my thoughts because it upsets me. Yesterday was the very first time I was told to take someone with me to provide care to (Resident #1). g. On 7/31/14 at 6:55 p.m., the Staffing Coordinator/LPN #2 was asked about (CNA #1) working on E Hall with (Resident #1). The Staffing Coordinator stated that CNA #1 was not supposed to work with (Resident #1) since June 2014 because I think (Resident #1) assaulted (CNA #1). (Resident #1) punched (CNA #1) in the face. I flipped him to E Hall Saturday (7/26/14) at noon because we had call ins. He was told not to have direct care with (Resident #1). (DON) told me that he was not to work with the resident because of what happened back in June. I don't know why he singled the resident out to give him a shower. On 7/31/14 at 7:15 p.m., (CNA #1's) time sheet was reviewed. According to the time sheet, (CNA #1) worked the 2:00 p.m. to 10:00 p.m. (2/10) shift on 7/26/14 and according to the CNA assignment sheet; CNA #1 worked E Hall where Resident #1 resided. h. On 8/1/14 at 11:00 a.m., the Administrator was asked why (CNA#1) was allowed to work after she was aware of reported abuse by (CNA #1) toward (Resident #1). She stated, I don't think of it as failure (by the facility) because he (CNA #1) was not assigned to (Resident #1). He was assigned to E Hall. He (CNA #1) knew he was not supposed to work with that resident. He made a conscious choice to do that. She was asked did the weekend staff know he wasn't supposed to be with (Resident #1)? She stated, I don't know if I even considered that an issue. The responsibility lies with (CNA #1). He could've told the nurses that he couldn't work with him. I can't just side and blame nursing. He's an adult. She was asked if the facility identified an issue with the Staff Coordinator assigning (CNA #1) and instructing him to work E Hall where (Resident #1) resided even though she knew (CNA #1) was not supposed to? The Administrator stated, But what part goes back to the CNA; to use discernment? It doesn't always fall back on nursing. She was asked so are you saying it is all the CNA's fault? The Administrator stated, No. I'm not saying it's all the CNA's fault. But CNAs have responsibility too. I'm not taking away that we couldn't have done somewhat better. i. On 8/1/14 at 12:42 p.m., the DON was asked how information is reported to the weekend staff about resident care? She stated, Well a lot of the carry over is because (Weekend RN supervisor) is here on Friday to inform weekend. Generally, I will post in the med.(medication) room and the break room information. A lot of it is based on (Weekend RN Supervisor). The DON was asked if the facility identified an issue with the Staff Coordinator assigning (CNA #1) down E Hall where (Resident #1) resided even though she knew CNA #1 was not supposed to work E Hall? The DON stated, (CNA #1) was a grown adult. I would expect that he would know better. I would expect not to tell him every single time not to provide care to (Resident #1). I don't hold (Staffing Coordinator) accountable. There was another CNA on that hall that could've given him a shower. Even though he was on the hall there were 23 other residents he could've cared for. j. On 8/1/14 at 1:00 p.m., during a body audit of Resident #1, surveyor was able see from thighs up. Chest and abdomen was clear. The buttocks were clear with feces present. There was a large dark purple bruise to his dorsal left hand, and a large bluish discoloration just above his left wrist toward his forearm. 2. Resident #6 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an assessment reference date of 7/17/14 documented the resident scored 2 (0-7 indicates severe impairment) on a Brief Interview for Mental Status, required total assistance of 2 persons for bed mobility, transfers, toileting and bathing and required extensive assistance of 1+ persons for eating and personal hygiene. a. On 7/31/14 at 7:00 p.m., CNA #2 was asked if she was aware of anyone being verbally abusive to Resident #6. CNA #2 stated, (Resident #6) was having episodes of diarrhea one evening about a month and half ago. I was helping him (CNA #1) change (Resident #2). He said to (Resident #6), 'your only reason for living is[***]ing.' Then (Licensed Practical Nurse (LPN)) #1 gave him a verbal warning. I heard her tell him this was his verbal warning. b. On 7/31/14 at 8:29 p.m., LPN #1 was asked, Has there been any problems with other residents and (CNA #1)? LPN #1 stated, Yes, (Resident 6), I was doing my PEG (Percutaneous Endoscopic Gastric) tube, this was probably a month and a half ago and I don't remember which CNA was with him, but he told (Resident #6), '.all you have to do in life is[***]' He was irritated because she needed to be cleaned up. I actually had to stop my PEG tube, I went to that room and I said you need to come find me when you are done. So I went back to finish my PEG and he never did come find me. I went and found him. I asked (CNA #1), Do you want to tell me why you said that to (Resident #1), and she's had a bad stroke. You shouldn't say that to anybody. She understands what you say. You do understand that's verbal abuse right? He said ' No. ' I said, I'm sure you didn't. I was extremely upset. I told him he was not to go back in that room for the rest of the night. I told him this was the one and only verbal warning he will ever get from me. I did tell (Director of Nursing (DON)) about it. I've not been doing this for very long. LPN #1 was asked, When did you inform the (DON)? LPN #1 stated, It was the next day. I went into her office and told her. I may have even told her that night too. I can't remember. c. On 8/1/14 at 12:42 p.m., the DON was asked if any verbal abuse involving (Resident #6) by (CNA #1) had been reported to her. The DON stated she was unaware of anything occurring between (CNA #1) and (Resident #6). She stated nothing was ever reported to her. 3. The Immediate Jeopardy was removed on 8/1/14 at 2:15 p.m. and the scope and severity reduced to an H when the facility implemented the following plan of removal: 1) (CNA #1) was suspended on 7/28/14 by Administrator and has not returned to work. 2) Police were notified on 7/28/14 by DON at 12:45 p.m. Administration began interviews with staff and residents starting on 7/28/14 at 11:00 a.m. Any negative findings were corrected immediately. MD assessed Resident #1 on 7/29/14 at 1:21 p.m. On 7/30/14, body audits were started by Nursing Management at 10:30 a.m. on Hall that (CNA #1) last worked and completed by 7/31/14 at 12 p.m. 3) Abuse/Neglect in-service originally started on 7/29/14 at 6 a.m. by Nursing Management. Nursing Management staff began in-services on Abuse/Neglect Reporting and Behavior Modification starting at 11:00 p.m. on 7/31/14 to all staff present and will in-service all shifts prior to start of shifts until all employees have been in-serviced. Any employee who is out will not return to work until instructed. Administrator in-serviced Staff Development LPN on 8/1/14 at 1:30 p.m. on following specific interventions involving known resident and staff conflict and to ensure employee is not to perform direct care on resident in question. On 7/31/14 at 10:00 p.m., DON and Administrator were in-serviced by Regional Nurse Consultant on communicating with weekend management and evening and night shift on interventions specific to residents and staffing needs. 4) DON/designee to perform random interviews of staff and residents daily x2 weeks starting on 8/1/14. Then DON/Designee to perform random interviews of staff and residents 3 x a week until substantial compliance is achieved.
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or**

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F 0225

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)
mistreatment of residents.
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Complaint # (AR 370) was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure witnessed staff to resident verbal/mental abuse involving Certified Nursing Assistant (CNA) #1 was immediately reported to the Administrator/designee and that planned interventions involving CNA #1 to reduce the risk of staff to resident abuse was communicated and implemented to ensure 2 of 2 (Residents #1 and #6) cognitive impaired case mix residents were protected from the potential of further abuse and to ensure prompt investigation. The failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident #1 who was cognitively impaired and who alleged staff to resident abuse. According to a list provided by the Director of Nursing (DON) on 8/1/14 at 2:28 p.m., this failed practice had the potential to affect 34 residents in the facility who were cognitively impaired. 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I was told that (Resident #1) had issues over the weekend and they told me what he had told nursing. I talked to him and asked him what happened during his shower over the weekend. During the interview he did not voluntarily say any one's name. But he did say that boy. The SSD stated (Resident #1) made the allegation (of abuse) to her and she reported it to the Administrator. 5) The physician's progress notes dated 7/29/14 at 1:21 p.m. documented, I was asked to see (Resident #1) today by the DON because there was a reportable incident yesterday. (Resident #1) reported that there was a CNA on his floor, whom he does not like, who was responsible for his care in the shower 2 days ago. He reports that the CNA used his finger to penetrate his anus repeatedly. He also used a shower nozzle to slap against his penis. He was also grabbed strongly on his left arm. The patient seems quite upset about this and was able to recall the event in pretty significant detail. He really doesn't have any pain with defecation at this point, and his bowel movements have been normal. He does have some bruising around this left wrist. His penis is normal, and he has no dysuria, and is not suffering bruising in his groin anteriorly. He is alert and cooperative with exam today. .Left wrist: shows dorsal ecchymosis, about the size of the palm of a hand that appears within 1 to 3 day of age. Genitalia Exam: Reveals normal uncircumcised male. His testes are distended. There is no scrotal ecchymosis or penile ecchymosis. I could see no hernia. There are no skin abrasions in the groin region. Anus Exam: Reveals normal tone. There is one (1) small superficial, less than one (1) centimeter, abrasion on the right buttock, about 4 cm from his anus. It appears pretty fresh as there is no scabbing, but there is no active bleeding either. I could see no anal trauma and no other ecchymosis noted.I cannot say for sure whether this lesion is directly attributable to the trauma of 2 days ago, but it is certainly consistent with that age of injury. d. On 7/31/14 at 7:00 p.m., CNA #2 was asked if she had ever heard or seen (CNA #1) be abusive toward (Resident #1). She stated that about a month ago while giving care to (Resident #1), (Resident #1) calls (CNA #1) ' Rambo ' and raised his voice directed toward (CNA #1). He (Resident #1) would ball up his fist, and (CNA #1) would say to him, ' If you think you're going to do anything, I'll pop you. (CNA #1) would be nice to him but (Resident #1) acted like he was going to hit him. (CNA #1) said to (Resident #1), ' If you think you're going to hit me, it will be the last time. Then he would back up. I told (CNA #1) maybe you shouldn't have said that. But that's all he said. e. On 7/31/14 at 8:29 p.m., LPN #1 was asked if she was aware of any abusive behavior by (CNA #1) toward (Resident #1). She stated, He (Resident #1) is very aggressive, mean, angered easily, been that way ever since I've been here. (CNA #1) kinda antagonizes him. I told him several times to stop it. Before (Resident #1) left out to the behavioral health center, he punched (CNA #1) in the face and stomach. He's really combative with showers. Before the behavioral health center, (CNA #1) gave him his showers. LPN #1 then stated that (CNA #1) was taken off the hall before he (Resident #1) went to the behavioral health center (6/20/14) about a month or so ago. LPN #1 was asked, So why did (CNA #1) go back on the hall? LPN #1 stated, That's a really good question. I don't know and he (Resident #1) doesn't like (CNA #3) either. He's called him all kinds of names. E Hall is a really heavy hall and we need muscle down there. LPN #1 was asked if the conflict between (CNA #1) and (Resident #1) had been reported to the DON? LPN #1 stated, Yes, (DON) knows, because of (CNA #1) being punched and they did take (CNA #1) off that hall when (Resident #1) came back from (behavioral health center). LPN #1 was asked then why did (CNA #1) go back on the hall the 26th (7/26/14)? LPN #1 stated, I don't know. If he worked Sunday on that hall, they probably should've known better. f. On 7/31/14 at 6:35 p.m., CNA #3 was asked if he knew of any abusive behavior toward (Resident #1) by (CNA#1). He stated, (Resident #1) would get really upset because (CNA #1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **045220**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **08/01/2014**
NAME OF PROVIDER OF SUPPLIER **FAYETTEVILLE HEALTH AND REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703**	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) would keep egging him on and a couple of months ago, (Resident #1) punched him in the face twice and made his lip bleed. I didn't see it; I just saw his (CNA #1's) face after. (CNA #1) disrespects (Resident #1). I never knew (CNA #1) was not supposed to work E Hall. (CNA #1) never made that statement. I heard that the bruise on (Resident #1) was caused by (CNA #1). (Resident #1) said (CNA #1) did it. CNA #3 was asked if he believed (CNA #1) caused the bruising. CNA #3 stated, It's a big possibility because of the way (CNA #1) talked in front of (Resident #1). CNA #3 was asked did he ever report anything about (CNA #1). He stated, Yes. They made me fill out a witness statement when (CNA #1) called me a faggot the first time in front of (Resident #1). Ever since then (Resident #1) calls me a faggot when I provide care. Yesterday, I had to step outside the building in order for me to cool my head, clear my thoughts because it upsets me. Yesterday was the very first time I was told to take someone with me to provide care to (Resident #1). g. On 7/31/14 at 6:55 p.m., the Staffing Coordinator/LPN #2 was asked about (CNA #1) working on E Hall with (Resident #1). The Staffing Coordinator stated that CNA #1 was not supposed to work with (Resident #1) since June 2014 because I think (Resident #1) assaulted (CNA #1). (Resident #1) punched (CNA #1) in the face. I flipped him to E Hall Saturday (7/26/14) at noon because we had call ins. He was told not to have direct care with (Resident #1). (DON) told me that he was not to work with the resident because of what happened back in June. I don't know why he singled the resident out to give him a shower. On 7/31/14 at 7:15 p.m., (CNA #1's) time sheet was reviewed. According to the time sheet, (CNA #1) worked the 2:00 p.m. to 10:00 p.m. (2/10) shift on 7/26/14 and according to the CNA assignment sheet; CNA #1 worked E Hall where Resident #1 resided. h. On 8/1/14 at 11:00 a.m., the Administrator was asked why (CNA#1) was allowed to work after she was aware of reported abuse by (CNA #1) toward (Resident #1). She stated, I don't think of it as failure (by the facility) because he (CNA #1) was not assigned to (Resident #1). He was assigned to E Hall. He (CNA #1) knew he was not supposed to work with that resident. He made a conscious choice to do that. She was asked did the weekend staff know he wasn't supposed to be with (Resident #1)? She stated, I don't know if I even considered that an issue. The responsibility lies with (CNA #1). He could've told the nurses that he couldn't work with him. I can't just side and blame nursing. He's an adult. She was asked if the facility identified an issue with the Staff Coordinator assigning (CNA #1) and instructing him to work E Hall where (Resident #1) resided even though she knew (CNA #1) was not supposed to? The Administrator stated, But what part goes back to the CNA; to use discernment? It doesn't always fall back on nursing. She was asked so are you saying it is all the CNA's fault? The Administrator stated, No. I'm not saying it's all the CNA's fault. But CNAs have responsibility too. I'm not taking away that we couldn't have done somewhat better. i. On 8/1/14 at 12:42 p.m., the DON was asked how information is reported to the weekend staff about resident care? She stated, Well a lot of the carry over is because (Weekend RN supervisor) is here on Friday to inform weekend. Generally, I will post in the med.(medication) room and the break room information. A lot of it is based on (Weekend RN Supervisor). The DON was asked if the facility identified an issue with the Staff Coordinator assigning (CNA #1) down E Hall where (Resident #1) resided even though she knew CNA #1 was not supposed to work E Hall? The DON stated, (CNA #1) was a grown adult. I would expect that he would know better. I would expect not to tell him every single time not to provide care to (Resident #1). I don't hold (Staffing Coordinator) accountable. There was another CNA on that hall that could've given him a shower. Even though he was on the hall there were 23 other residents he could've cared for. j. On 8/1/14 at 1:00 p.m., during a body audit of Resident #1, surveyor was able see from thighs up. Chest and abdomen was clear. The buttocks were clear with feces present. There was a large dark purple bruise to his dorsal left hand, and a large bluish discoloration just above his left wrist toward his forearm. 2. Resident #6 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an assessment reference date of 7/17/14 documented the resident scored 2 (0-7 indicates severe impairment) on a Brief Interview for Mental Status, required total assistance of 2 persons for bed mobility, transfers, toileting and bathing and extensive assistance of 1+ persons for eating and personal hygiene. a. On 7/31/14 at 7:00 p.m., CNA #2 was asked if she was aware of anyone being verbally abusive to Resident #6. CNA #2 stated, (Resident #6) was having episodes of diarrhea one evening about a month and half ago. I was helping him (CNA #1) change (Resident #2). He said to (Resident #6), 'your only reason for living is[***]ing.' Then (Licensed Practical Nurse (LPN)) #1 gave him a verbal warning. I heard her tell him this was his verbal warning. b. On 7/31/14 at 8:29 p.m., LPN #1 was asked, Has there been any problems with other residents and (CNA #1)? LPN #1 stated, Yes, (Resident 6), I was doing my PEG (Percutaneous Endoscopic Gastric) tube, this was probably a month and a half ago and I don't remember which CNA was with him, but he told (Resident #6), '.all you have to do in life is[***]' He was irritated because she needed to be cleaned up. I actually had to stop my PEG tube, I went to that room and I said you need to come find me when you are done. So I went back to finish my PEG and he never did come find me. I went and found him. I asked (CNA #1), Do you want to tell me why you said that to (Resident #1), and she's had a bad stroke. You shouldn't say that to anybody. She understands what you say. You do understand that's verbal abuse right? He said ' No. ' I said, I'm sure you didn't. I was extremely upset. I told him he was not to go back in that room for the rest of the night. I told him this was the one and only verbal warning he will ever get from me. I did tell (Director of Nursing (DON)) about it. I've not been doing this for very long. LPN #1 was asked, When did you inform the (DON)? LPN #1 stated, It was the next day. I went into her office and told her. I may have even told her that night too. I can't remember. c. On 8/1/14 at 12:42 p.m., the DON was asked if any verbal abuse involving (Resident #6) by (CNA #1) had been reported to her. The DON stated she was unaware of anything occurring between (CNA #1) and (Resident #6). She stated nothing was ever reported to her. 3. The Immediate Jeopardy was removed on 8/1/14 at 2:15 p.m. and the scope and severity reduced to an H when the facility implemented the following plan of removal: 1) (CNA #1) was suspended on 7/28/14 by Administrator and has not returned to work. 2) Police were notified on 7/28/14 by DON at 12:45 p.m. Administration began interviews with staff and residents starting on 7/28/14 at 11:00 a.m. Any negative findings were corrected immediately. MD assessed Resident #1 on 7/29/14 at 1:21 p.m. On 7/30/14, body audits were started by Nursing Management at 10:30 a.m. on Hall that (CNA #1) last worked and completed by 7/31/14 at 12 p.m. 3) Abuse/Neglect in-service originally started on 7/29/14 at 6 a.m. by Nursing Management. Nursing Management staff began in-services on Abuse/Neglect Reporting and Behavior Modification starting at 11:00 p.m. on 7/31/14 to all staff present and will in-service all shifts prior to start of shifts until all employees have been in-serviced. Any employee who is out will not return to work until instructed. Administrator in-serviced Staff Development LPN on 8/1/14 at 1:30 p.m. on following specific interventions involving known resident and staff conflict and to ensure employee is not to perform direct care on resident in question. On 7/31/14 at 10:00 p.m., DON and Administrator were in-serviced by Regional Nurse Consultant on communicating with weekend management and evening and night shift on interventions specific to residents and staffing needs. 4) DON/designee to perform random interviews of staff and residents daily x2 weeks starting on 8/1/14. Then DON/Designee to perform random interviews of staff and residents 3 x a week until substantial compliance is achieved.
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Develop policies that prevent mistreatment, neglect, or abuse of residents or theft of resident property.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 370) was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure staff implemented the facility's abuse policy and procedure as evidenced by the facility ' s failures to ensure witnessed staff to resident verbal/mental abuse involving Certified Nursing Assistant (CNA) #1 was immediately reported to the Administrator/designee and that planned interventions involving CNA #1 to reduce the risk of staff to resident abuse was communicated and implemented to ensure 2 of 2 (Residents #1 and #6) cognitive impaired case mix residents were protected from the potential of further abuse and to ensure prompt investigation. The failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident #1 who was cognitively impaired and who alleged staff to resident abuse. According to a list provided by the Director of Nursing (DON) on 8/1/14 at 2:28 p.m., this failed practice had the potential to affect 34 residents in the facility who were cognitively impaired. The facility was informed of the Immediate Jeopardy on 8/1/14 at 12:25 p.m. The findings are. 1. The facility's Nursing Management Manual Policy Title: Abuse, Neglect, Misappropriation of Resident Property, Injuries of Unknown Source effective date 3/26/14 documented, .Each employee has an obligation to report any incident immediately that could constitute an instance of abuse or neglect. to the Administrator or the Director of Nursing or the Department Supervisor. .The facility will report all instances of alleged or suspected abuse, including verbal or mental abuse . in the following manner: Investigation and Reporting Steps Notify the DON of any unusual situation in the facility, whether reportable or not. 2. Resident #1 had [DIAGNOSES REDACTED]. The Medicare 30-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/16/14 documented the resident scored 5 (0-7 indicates severe impairment) on a Brief Interview for

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAYETTEVILLE HEALTH AND REHABILITATION CENTER	**3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703**

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F 0226

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 4)
Mental Status, required extensive assistance from 2 person for transfers, dressing, toilet use, bathing and hygiene. a. The Resident Care Plan dated 6/10/14 documented, .Problem Onset: 10/9/2013 - Behavior Management required .combative with care/resistive to care. b. The Behavioral Health Center psychiatric evaluation dated 6/10/14 documented, .Pt also has refused assistance with ADLs (activities of daily living). Pt (patient) is a 73 y/o (year old) wm (white male) who presents from (nursing home) after punching staff causing injury . c. An Office of Long Term Care (OLTC) Division of Medical Services (DMS) -7734 form dated 7/28/14 documented, .At 9:00 a.m. on 7/28/14, (Resident #1) reported to SSD (Social Services Director) that during a shower his ' nipples were twisted ' and something was put in his ' butthole. ' Head to toe assessment of resident revealed a red discolored area to his left forearm measuring 7 x 7 cm (centimeters), no other injuries were noted at that time. Records reviewed showed that (CNA #1) had given (Resident #1) his shower on Saturday evening 7/26/14. CNA #1 was immediately suspended pending investigation. Police, MD (medical doctor) and family were notified and an officer came to the facility to interview the resident with family and staff present. Collection of statements from alert and oriented resident as well as other staff members has begun, investigation continues . 1) On 8/1/14 at 8:41 p.m., the Weekend RN Supervisor was asked what she knew about the abuse allegation reported by (Resident #1) concerning (CNA #1). She stated she noticed (Resident #1) in the dining room drinking coffee around 4:00 p.m. Sunday (7/27/14). She stated, (Resident #1) was quiet and distant that day. There was something odd about his behavior, not himself. The Weekend RN Supervisor stated when she was asked if she knew (CNA #1) was not supposed to provide care to (Resident #1)? She stated, I had no knowledge (CNA #1) was not supposed to work with (Resident #1), because I would not have scheduled him there. I would just switch halls. If I had an idea at all, any suspicion, I would just change the assignment. The Weekend RN Supervisor's report dated 7/26/14 and 7/27/14 documented, (Resident #1) change in behavior. 2) The DMS witness statement (no date provided) (not timed)signed by the DON, documented, .I received a call from the facility regarding (Resident #1's son) being concerned because his Dad had acted differently on Sunday 7/27/14 when he took him for coffee. When he had returned to the facility there question about bruising on both his Dad's hands. (Resident #1's son) said he thought they were old, but was worried about his Dad's change in behavior. Weekend RN (Registered Nurse) Supervisor called and informed me at about 3:00 p.m. I could not come to the facility to interview the resident at that time. I called (Administrator) and asked if she could and she said she could. Then on Monday morning in morning meeting we talked about it and asked SSD to talk to (Resident #1). She said she would and afterwards she reported he had his nipples twisted and a finger shoved up his butt. The investigation then began. I did a head to toe assessment on resident at 11:30, he was cooperative, there was a red area to left forearm 7 x 7 cm, 4 bruises to back of both hands. No other areas noted on resident, denied pain to areas. 3) The DMS witness statement dated 7/30/14 signed 7/31/14 (not timed) by the Administrator, documented, .On 7/27/14, I got a call from DON that (Resident #1's son) was upset re: his Dad. He had spoken to weekend supervisor and said that his Dad was quiet on their ride to get coffee and appeared upset when he brought him back to the facility. spoke to Weekend supervisor about his Dad's change in behavior - there was discussion about his arms and the bruises - not sure what related to DON was unable to come to facility, but called me and said (around 3ish pm) that (Resident #1) appeared upset and sad and that there were bruises on his arm. I came around 4:30 p.m. and spoke to resident and asked what was wrong. He wouldn't say anything, but sad and distant. I did look at Resident #1's arms and left upper arm was bruised. I did talk to Weekend RN Supervisor and asked her to get witness statements from staff re: bruises and if they know origin . 4) The DMS witness statement dated 7/28/14 documented by the SSD, .On Monday, 7/28 SSD ask to go see resident, he had been tearful earlier in the morning and didn't want to go to breakfast. Resident told SSD that he had a shower and the staff person that showered him was ' ruff, ' Said he twisted his nipples and rubbed too hard and staff person stuck his finger up residents butt, resident became tearful again. SSD reported to Administrator and residents son contacted. On 7/31/14 at 6:15 p.m., the Social Service Director (SSD) was asked if she knew about the allegation of sexual abuse reported by (Resident #1). She stated, In the morning meeting on 7/28/14 the Administrator and the DON (Director of Nursing) asked me to talk to (Resident #1) based on the weekend supervisor's report. I was told that (Resident #1) had issues over the weekend and they told me what he had told nursing. I talked to him and asked him what happened during his shower over the weekend. During the interview he did not voluntarily say any one's name. But he did say that boy. The SSD stated (Resident #1) made the allegation (of abuse) to her and she reported it to the Administrator. 5) The physician's progress notes dated 7/29/14 at 1:21 p.m. documented, I was asked to see (Resident #1) today by the DON because there was a reportable incident yesterday. (Resident #1) reported that there was a CNA on his floor, whom he does not like, who was responsible for his care in the shower 2 days ago. He reports that the CNA used his finger to penetrate his anus repeatedly. He also used a shower nozzle to slap against his penis. He was also grabbed strongly on his left arm. The patient seems quite upset about this and was able to recall the event in pretty significant detail. He really doesn't have any pain with defecation at this point, and his bowel movements have been normal. He does have some bruising around this left wrist. His penis is normal, and he has no dysuria, and is not suffering bruising in his groin anteriorly. He is alert and cooperative with exam today. .Left wrist: shows dorsal ecchymosis, about the size of the palm of a hand that appears within 1 to 3 day of age. Genitalia Exam: Reveals normal uncircumcised male. His testes are distended. There is no scrotal ecchymosis or penile ecchymosis. I could see no hernia. There are no skin abrasions in the groin region. Anus Exam: Reveals normal tone. There is one (1) small superficial, less than one (1) centimeter, abrasion on the right buttock, about 4 cm from his anus. It appears pretty fresh as there is no scabbing, but there is no active bleeding either. I could see no anal trauma and no other ecchymosis noted.I cannot say for sure whether this lesion is directly attributable to the trauma of 2 days ago, but it is certainly consistent with that age of injury. d. On 7/31/14 at 7:00 p.m., CNA #2 was asked if she had ever heard or seen (CNA #1) be abusive toward (Resident #1). She stated that about a month ago while giving care to (Resident #1), (Resident #1) calls (CNA #1) ' Rambo ' and raised his voice directed toward (CNA #1). He (Resident #1) would ball up his fist, and (CNA #1) would say to him, ' If you think you're going to do anything, I'll pop you. (CNA #1) would be nice to him but (Resident #1) acted like he was going to hit him. (CNA #1) said to (Resident #1), ' If you think you're going to hit me, it will be the last time. Then he would back up. I told (CNA #1) maybe you shouldn't have said that. But that's all he said. e. On 7/31/14 at 8:29 p.m., LPN #1 was asked if she was aware of any abusive behavior by (CNA #1) toward (Resident #1). She stated, He (Resident #1) is very aggressive, mean, angered easily, been that way ever since I've been here. (CNA #1) kinda antagonizes him. I told him several times to stop it. Before (Resident #1) left out to the behavioral health center, he punched (CNA #1) in the face and stomach. He's really combative with showers. Before the behavioral health center, (CNA #1) gave him his showers. LPN #1 then stated that (CNA #1) was taken off the hall before he (Resident #1) went to the behavioral health center (6/20/14) about a month or so ago. LPN #1 was asked, So why did (CNA #1) go back on the hall? LPN #1 stated, That's a really good question. I don't know and he (Resident #1) doesn't like (CNA #3) either. He's called him all kinds of names. E Hall is a really heavy hall and we need muscle down there. LPN #1 was asked if the conflict between (CNA #1) and (Resident #1) had been reported to the DON? LPN #1 stated, Yes, (DON) knows, because of (CNA #1) being punched and they did take (CNA #1) off that hall when (Resident #1) came back from (behavioral health center). LPN #1 was asked then why did (CNA #1) go back on the hall the 26th (7/26/14)? LPN #1 stated, I don't know. If he worked Sunday on that hall, they probably should've known better. f. On 7/31/14 at 6:35 p.m., CNA #3 was asked if he knew of any abusive behavior toward (Resident #1) by (CNA#1). He stated, (Resident #1) would get really upset because (CNA #1) would keep egging him on and a couple of months ago, (Resident #1) punched him in the face twice and made his lip bleed. I didn't see it; I just saw his (CNA #1's) face after. (CNA #1) disrespects (Resident #1). I never knew (CNA #1) was not supposed to work E Hall. (CNA #1) never made that statement. I heard that the bruise on (Resident #1) was caused by (CNA #1). (Resident #1) said (CNA #1) did it. CNA #3 was asked if he believed (CNA #1) caused the bruising. CNA #3 stated, It's a big possibility because of the way (CNA #1) talked in front of (Resident #1). CNA #3 was asked did he ever report anything about (CNA #1). He stated, Yes. They made me fill out a witness statement when (CNA #1) called me a faggot the first time in front of (Resident #1). Ever since then (Resident #1) calls me a faggot when I provide care. Yesterday, I had to step outside the building in order for me to cool my head, clear my thoughts because it upsets me. Yesterday was the very first time I was told to take someone with me to provide care to (Resident #1). g. On 7/31/14 at 6:55 p.m., the Staffing Coordinator/LPN #2 was asked about (CNA #1) working on E Hall with (Resident #1). The Staffing Coordinator stated that CNA #1 was not supposed to work with (Resident #1) since June 2014 because I think (Resident #1) assaulted (CNA #1). (Resident #1) punched (CNA #1) in the face. I flipped him to E Hall Saturday (7/26/14) at noon because we had call ins. He was told not to have direct care with (Resident #1). (DON) told me that he was not to work with the resident because of what happened back in June. I don't know why he singled the resident out to give him a shower. On 7/31/14 at 7:15 p.m., (CNA #1's) time sheet was reviewed. According to the time sheet, (CNA #1) worked the 2:00 p.m. to 10:00 p.m. (2/10) shift

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NAME OF PROVIDER OF SUPPLIER **FAYETTEVILLE HEALTH AND REHABILITATION CENTER**		STREET ADDRESS, CITY, STATE, ZIP **3100 OLD MISSOURI RD FAYETTEVILLE, AR 72703**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) on 7/26/14 and according to the CNA assignment sheet, CNA #1 worked E Hall where Resident #1 resided. h. On 8/1/14 at 11:00 a.m., the Administrator was asked why (CNA#1) was allowed to work after she was aware of reported abuse by (CNA #1) toward (Resident #1). She stated, I don't think of it as failure (by the facility) because he (CNA #1) was not assigned to (Resident #1). He was assigned to E Hall. He (CNA #1) knew he was not supposed to work with that resident. He made a conscious choice to do that. She was asked did the weekend staff know he wasn't supposed to be with (Resident #1)? She stated, I don't know if I even considered that an issue. The responsibility lies with (CNA #1). He could've told the nurses that he couldn't work with him. I can't just side and blame nursing. He's an adult. She was asked if the facility identified an issue with the Staff Coordinator assigning (CNA #1) and instructing him to work E Hall where (Resident #1) resided even though she knew (CNA #1) was not supposed to? The Administrator stated, But what part goes back to the CNA; to use discernment? It doesn't always fall back on nursing. She was asked so are you saying it is all the CNA's fault? The Administrator stated, No. I'm not saying it's all the CNA's fault. But CNAs have responsibility too. I'm not taking away that we couldn't have done somewhat better. i. On 8/1/14 at 12:42 p.m., the DON was asked how information is reported to the weekend staff about resident care? She stated, Well a lot of the carry over is because (Weekend RN supervisor) is here on Friday to inform weekend. Generally, I will post in the med.(medication) room and the break room information. A lot of it is based on (Weekend RN Supervisor). The DON was asked if the facility identified an issue with the Staff Coordinator assigning (CNA #1) down E Hall where (Resident #1) resided even though she knew CNA #1 was not supposed to work E Hall? The DON stated, (CNA #1) was a grown adult. I would expect that he would know better. I would expect not to tell him every single time not to provide care to (Resident #1). I don't hold (Staffing Coordinator) accountable. There was another CNA on that hall that could've given him a shower. Even though he was on the hall there were 23 other residents he could've cared for. j. On 8/1/14 at 1:00 p.m., during a body audit of Resident #1, surveyor was able see from thighs up. Chest and abdomen was clear. The buttocks were clear with feces present. There was a large dark purple bruise to his dorsal left hand, and a large bluish discoloration just above his left wrist toward his forearm. 3. Resident #6 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an assessment reference date of 7/17/14 documented the resident scored 2 (0-7 indicates severe impairment) on a Brief Interview for Mental Status, required total assistance of 2 persons for bed mobility, transfers, toileting and bathing, and required extensive assistance of 1+ persons for eating and personal hygiene. a. On 7/31/14 at 7:00 p.m., CNA #2 was asked if she was aware of anyone being verbally abusive to Resident #6. CNA #2 stated, (Resident #6) was having episodes of diarrhea one evening about a month and half ago. I was helping him (CNA #1) change (Resident #2). He said to (Resident #6), 'your only reason for living is[***]ing.' Then (Licensed Practical Nurse (LPN)) #1 gave him a verbal warning. I heard her tell him this was his verbal warning. b. On 7/31/14 at 8:29 p.m., LPN #1 was asked, Has there been any problems with other residents and (CNA #1)? LPN #1 stated, Yes, (Resident 6), I was doing my PEG (Percutaneous Endoscopic Gastric) tube, this was probably a month and a half ago and I don't remember which CNA was with him, but he told (Resident #6), '.all you have to do in life is[***]' He was irritated because she needed to be cleaned up. I actually had to stop my PEG tube, I went to that room and I said you need to come find me when you are done. So I went back to finish my PEG and he never did come find me. I went and found him. I asked (CNA #1), Do you want to tell me why you said that to (Resident #1), and she's had a bad stroke. You shouldn't say that to anybody. She understands what you say. You do understand that's verbal abuse right? He said ' No. ' I said, I'm sure you didn't. I was extremely upset. I told him he was not to go back in that room for the rest of the night. I told him this was the one and only verbal warning he will ever get from me. I did tell (Director of Nursing (DON)) about it. I've not been doing this for very long. LPN #1 was asked, When did you inform the (DON)? LPN #1 stated, It was the next day. I went into her office and told her. I may have even told her that night too. I can't remember. c. On 8/1/14 at 12:42 p.m., the DON was asked if any verbal abuse involving (Resident #6) by (CNA #1) had been reported to her. The DON stated she was unaware of anything occurring between (CNA #1) and (Resident #6). She stated nothing was ever reported to her. 4. The Immediate Jeopardy was removed on 8/1/14 at 2:15 p.m. and the scope and severity reduced to an H when the facility implemented the following plan of removal: 1) (CNA #1) was suspended on 7/28/14 by Administrator and has not returned to work. 2) Police were notified on 7/28/14 by DON at 12:45 p.m. Administration began interviews with staff and residents starting on 7/28/14 at 11:00 a.m. Any negative findings were corrected immediately. MD assessed Resident #1 on 7/29/14 at 1:21 p.m. On 7/30/14, body audits were started by Nursing Management at 10:30 a.m. on Hall that (CNA #1) last worked and completed by 7/31/14 at 12 p.m. 3) Abuse/Neglect in-service originally started on 7/29/14 at 6 a.m. by Nursing Management. Nursing Management staff began in-services on Abuse/Neglect Reporting and Behavior Modification starting at 11:00 p.m. on 7/31/14 to all staff present and will in-service all shifts prior to start of shifts until all employees have been in-serviced. Any employee who is out will not return to work until instructed. Administrator in-serviced Staff Development LPN on 8/1/14 at 1:30 p.m. on following specific interventions involving known resident and staff conflict and to ensure employee is not to perform direct care on resident in question. On 7/31/14 at 10:00 p.m., DON and Administrator were in-serviced by Regional Nurse Consultant on communicating with weekend management and evening and night shift on interventions specific to residents and staffing needs. 4) DON/designee to perform random interviews of staff and residents daily x2 weeks starting on 8/1/14. Then DON/Designee to perform random interviews of staff and residents 3 x a week until substantial compliance is achieved.