STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045192	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS OF HARRISON AT TIMS HEALTH AND REHABILIT	202 TIMS AVENUE HARRISON, AR 72601

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # , (AR 720), was substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure the physician was immediately consulted regarding significant changes in mental or psychosocial status for 1 of 1 (Residents #5) case mix resident who voiced an intent to commit suicide and 1 of 1 (Resident # 7) case mix resident who voiced feelings of being better off dead. The facility failed to ensure the physician was immediately consulted regarding resident ' s refusal for treatment for 1 of 1 (Resident #5) case mix resident who had voiced an intent to kill self and refused admission to a behavioral unit. The failed practices resulted in immediate jeopardy which caused or could have caused serious harm, injury or death to Resident # 5, who had voiced her intent to hang herself and was found unresponsive following a hanging attempt after one on one monitoring was discontinued with her refusal to be admitted to a Behavioral Health Care Unit, Resident #7 who voiced feelings of being better off dead and had the potential to affect 2 residents in the facility who had stated an intent to kill themselves since 9/1/15 according to the listing received from the Minimum Data Set (MDS) Coordinator on 10/23/15, 3 residents with physician orders [REDACTED]. The facility was notified of the Immediate Jeopardy condition on 10/22/15 at 4:25 p.m. The findings are: 1. The facility's policy titled Change in a Resident's Condition or Status documented . 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: . d. A significant change in the resident's physical/emotional/mental condition; . f. Refusal of treatment . 2. A 'significant change' of condition is a decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions . c. Requires interdisciplinary review and/or revision to the care plan . 2. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/2/15 documented the resident scored 10 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status;, had no signs or symptoms of [MEDICAL CONDITION]; had no thoughts of better off dead; and scored 2 (1 - 4 indicates minimal depression) on the Patient Health Questionnaire. a. The Care Plan dated 4/3/15 and updated on 9/8/15 documented, I have behaviors . 9/8/15 I have voiced [MEDICAL CONDITION] . Approaches: . 9/8/15 Notify MD/APN (Medical Doctor/Advanced Practice Nurse) of my [MEDICAL CONDITION] . b. The Departmental Notes dated 9/8/15 at 8:42 p.m. and signed by Licensed Practical Nurse (LPN #2) documented, Resident crying and verbally aggressive toward staff. This nurse sat and talked with resident for 20 (minutes) in order to get resident to take her medications that included (Klonopin) (used to treat Panic Disorder). Resident stated to this nurse and other staff that she was 'going to hang herself because she could not get out of here'. Resident placed on 1 on 1 monitoring for suicidal ideation, and administrator notified. 1) On 10/23/15 at 9:00 a.m., APN # 1 was asked, On 9/8/15 the 3:00 p.m. to 11:00 p.m. charge nurse documented that the Administrator was notified of (Resident # 5's) statement that she was going to hang herself. Were you notified? APN # 1 stated, No, and my husband is her doctor and was not notified either. The first I heard of it was when I walked in the building on 9/9/15 and I saw her and recommended an in-patient psych admit. 2) On 10/23/15 at 10:12 a.m., the residents attending physician was asked, Were you notified on 9/8/15 of (Resident # 5's) statement that she was going to hang herself? Resident # 5's attending physician stated, No. c. The Departmental Notes dated 9/9/15 at 1:25 p.m. and signed by the Social Services Director (SSD) documented, Earlier on this date, SSD spoke with the resident regarding her statement of wanting to hang herself made on 9/8/15. The resident stated she did say that to staff. SSD interviewed the resident to complete the Geriatric Depression Scale. The resident score was 9. Due to the client's answers and responses, the clients depression only appears to be situational and possibly attention seeking. Administrator and Nurse Practitioner were notified of the scores. Further analysis will take place. On 10/22/15 at 10:55 a.m., the SSD was asked, The 9/9/15 entry in the Departmental Notes, what had happened? The SSD stated, I was told about (LPN # 2's report) and was told to see her and I went to do the Geriatric Depression Scale. The SSD was asked, What did you tell the Nurse Practitioner? The SSD stated, Everything (Resident # 5) was saying - 'I'll do whatever it takes to get out of here, whether it's jump the fence or kill myself'. I did tell (APN # 1) I would feel more comfortable if we referred this over to (name of Behavioral Health). (APN # 1) said yes. The SSD was asked, Did (Name of Behavioral Health) come out? The SSD stated, Yes. I was in the room when she refused. The SSD was asked, Did you tell (APN # 1) that (Resident # 5) had refused admission to behavioral health? The SSD stated, No. d. A SOAP (Subjective, Objective, Assessment and Plan) note dated 9/9/15 and signed by Advanced Practice Nurse (APN) #1 documented, . Chief Complaint: Patient has told staff that she plans to kill herself, I have been asked to see her. I know her very well and I have taken care of her since she first admitted to LTC (Long Term Care). Today she is in her room with her son. She is defiant and irrational. She will not deny a desire to harm herself. She is fixated on 'leaving'. No specific reason. She is delusional - saying (she) has the ability to get on a plane or in a car and move to California, where her son says she lived [AGE] years ago. I can't redirect her. Her mood is labile. Active Diagnoses: [REDACTED]. Mood - her mood has always been labile, she is frequently anxious and gets only periodically, she is confused today which is worse than usual, she is wild and I am not able to redirect her, her son is not, she threatens to harm herself but does not have a plan in mind. Objective: . Mood - she is anxious, she is having delusional thoughts of driving to California, getting a job, she will not contract for safety with me or her son. Plan: Suicidal threat - she is more confused than usual today, more delusional than I am used to seeing her. I thought I would easily get her to contract for safety but I can't. Her son is here - we discussed the spot she has put herself in by telling staff that she would kill herself. Since she will not retract or clarify the statement then I think it's in her best interest to go to an (in-patient) psych unit. The son is in agreement. I spoke to the social worker and to the acting DON (Director of Nursing) and asked them to make the referral. I expect them to come out today. Case (discussed with) Dr. (name of resident's attending physician, who is also the facility's Medical Director) and he agrees with plan. e. The (Name) Behavioral Health Pre-Admission Screening form documented Date: 9/10/15. Time: 7:30 a.m. Responsible Party/Relationship: Self . Presenting Symptoms: . (Suicidal Ideation) . Depressed . Behavior: . Verbally aggressive . Summary: (Patient) has a history of Depression and Anxiety. (Patient) currently has passive death wish but no plan to commit suicide. (Nursing facility) reports suicidal statements . Physician Recommendations (and) Family/Guardian Response: . MSW (Medical Social Worker) recommends admission to (name of behavioral health), Dr. (name) has accepted (patient) . No

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) Admission Indicated due to: (Patient) accepted for admission to (name of behavioral health) however (patient) is refusing to come and has no designee or family that will be surrogate . As of 10/19/15 at 1:35 p.m., there was no departmental note found in the clinical record that documented any family member had been contacted or that the Nurse Practitioner or Physician had been notified of the resident's refusal to be admitted to behavioral health unit on 9/10/14. The One on One Contact Forms documented residents observations were started on 9/8/15 at 8:30 p.m. and resident observations stopped on 9/10/15 at 6:45 a.m. f. A SOAP note dated 9/11/15 and signed by APN #1 documented, . Chief Complaint: Nurses tell me patient is still here, she is not saying she is going to kill herself but she is distressed, moody, anxious and delusional. She has been combative and refusing basic care. The nurse has asked me to review her meds and see what I can do to help her psychological distress. I did review her meds after taking to 3 nurses about her recent and current behaviors. See chart for order change . A physician order [REDACTED]. g. The Departmental Notes dated 9/13/15 at 1:46 a.m. documented, This nurse was called to resident's room at 1715 (5:15 p.m. 9/12/15) by CNA (Certified Nurse Assistant). Upon entering the room, this nurse observed resident to be non-responsive with a cloth tied around her neck. This nurse immediately had another nurse call 911. We removed the cloth from around resident's neck and sternal rubbed her for about 4 minutes before getting her eyes to fluttering. Resident also noted to have a pair of scissors which later this nurse found that another resident had given them to her and assisted her in cutting the cloth. Resident came around and was fighting with CNAs to get cloth back to put back around her neck. CNAs kept a tight grip on cloth until EMTs (Emergency Medical Technicians) arrived. Ambulance arrived at 1725 (5:25 p.m.) along with (name of town Police Department) to do formal evaluation and reports. EMTs helped to get resident away from the closet when resident became very combative and cursing them. EMTs and officers asked resident multiple times if she wanted to harm herself and resident stated yes, she wanted to kill herself. EMT asked resident how she planned on doing this and resident stated that she was going to choke herself. EMTs took resident to ER after thorough investigation and report was done with resident. After the resident left the facility, this nurse had all staff on 3:00 p.m. to 11:00 p.m. do a witness statement whether they had contact with resident or not. After talking with some of the CNAs, they reported that this resident had been seen talking with another resident (Resident # 12). This nurse approached resident and asked if this resident had said anything to her about trying to kill herself. Resident stated that she was very emotional talking about wanting to get out of here. Resident also reported that she was talking about how her kids left her here to die and she would rather be dead. Resident also stated that (Resident # 5) had repeatedly mentioned that her husband had killed himself years ago by shooting himself in the head. When (Resident # 5) asked resident to cut the cloth, resident asked (Resident # 5) 'What are you going to do, hang yourself?' Resident said that (Resident # 5) began to cry even more. Resident did admit to helping (Resident # 5) cut the cloth but she said she had no idea why she wanted this done . Around 8:30 p.m. one of the nurses from (Behavioral health/geri-psych) called reported that resident had been admitted . 1) The (name) EMS (Emergency Medical Services Patient Encounter form dated 9/12/15 documented, . Date: 9/12/15 . Reason for Transfer or Dispatch Reason: Attempted hanging . Time: 6:00 p.m. (Blood pressure) 163/96, (pulse) 100, (respirations) 20 . Chief Complaint: (Attempted) hanging. Edge of sheet around door knob and around neck, pushing back with legs in wheelchair . staff stated may have been (unresponsive) (prior to arrival) of EMS. Awake (and) alert (and) able to answer questions . 2) The Resident Incident Report dated 9/12/15 at 5:15 p.m. documented, . Associate Involved: (CNA # 4) . This nurse was called to resident's room . Narrative of Investigation: . Upon investigation it was determined resident had attempted to hang herself utilizing cut up sheets where she place around her neck and tied to her closet door knob, where she then propped her lower extremities off the floor. Staff was previously in room [ROOM NUMBER] - 10 minutes before setting up dinner tray where resident got up from bed to eat dinner without any difficulties or irrational statements leading up to incident. Staff found resident unresponsive, called 911 immediately and removed sheets to arouse after noting she was not responding. Stayed with resident until EMS arrived. Resident had days before been assessed by a house visit from the Behavioral Health unit . Resident was a candidate for inpatient care due to previous behaviors and statements, but refused to go to receive treatment. Currently admitted to Behavioral unit. 6. New Intervention: In-service staff on [MEDICAL CONDITION] pending in-service from behavioral health representative with nurses on suicidal threats and interventions . 3) The Verification of Investigation form signed by the Administrator documented, . Date/Time of Occurrence: 9/12/15 7:00 p.m. Provided detailed description of event/allegation: Resident found hanging from a cut bed sheet on closet. Assessment of Resident/Describe Injury: Resident was found unresponsive with cut cloth around her neck. Causal/Contributing Factor and Observations: Resident asked another resident to cut the bed sheet and had expressed the desire to harm herself to the resident. Resident had been upset that her family had not been visiting as often as she thought they should have. She does not like living in Arkansas and wishes she had never came. Specific Recommendations/Interventions Taken to Prevent Reoccurrence: One on one with resident on alerting staff if a resident makes statements of self-harm. Offer the resident the opportunity to locate another facility if she chooses. Was Abuse/Neglect Substantiated? No. Provide Summary of Investigative Findings: Resident had been assessed by (name) Behavioral health on the 9th for placement for increased symptoms of depression. Placement was offered to resident but resident denied wanting placement. On 9/12/15, resident requested another resident cut a bed sheet for her and expressed an idea of wanting to die. Resident did not alert staff to (Resident # 5's) statement. Resident was found at 7:00 p.m. with material around her throat. Staff removed her from immediate harm and she remained one on one until EMS took over care for the resident. She was then taken to (hospital name) under a suicide hold. h. On 10/21/15 at 10:00 a.m., APN # 1 was asked, Was (Resident # 5) treated by you? APN stated, Yes. APN # 1 presented progress noted dated 9/9/15 and 9/11/15. APN # 1 was asked, Did you recommend that the resident was safe to stop the 1 to 1 monitoring? APN # 1 stated, No one asked me that. When I was there on 9/9/15 her family was there but no staff was present. She kept repeating she was going to kill herself and I recommended a psych referral. I told (Acting DON) and (SSD) that she needed an in-patient psych referral and someone did come out and they saw her. I did not know she was still in the building on Friday (9/11/15) until a nurse casually asked me to review her meds. I reviewed her meds and I didn't ask about the psych referral on Friday. APN # 1 was asked, Did you know the resident was not one on one on Friday, 9/11/15? APN # 1 stated, You are they first person to even ask me about one on one monitoring. No I was only asked to look at her meds. I was told she would not consent to the psych admit but I'm not sure if she (LPN # 4) said that on Friday (9/11/15) or Monday (9/14/15) after all that happened. The son had already consented and the resident was delusional so I don't know why she wasn't sent to the psych unit. On Monday (9/14/15) I was told by the nurses she had asked for scissors all day Saturday (9/12/15) and even got a resident to cut her sheets. She carried out a plan to commit suicide over the course of a day and that's very high level functioning. i. The Quality Assessment and Assurance Committee form dated 9/29/15, received from the Administrator on 10/22/15 at 3:00 p.m., documented, Topic: Note: Resident attempted suicide. Process Owner: All Departments. Summary of Analysis should include trends and root cause analysis: Improve documentation using the behavior monitoring sheets contained in MARs (Medication Administration Records). Review medical record for indications missed to show staff how to identify possible harm to resident before (it) gets to that point. Speak with (name) Behavioral (Health) on inservice to be conducted to include a better understanding of warning signs of suicidal thoughts in the elderly. Inservice with staff on more effective documentation in respect to resident behaviors and changes in condition. j. On 10/20/15 at 9:20 a.m. the Administrator was asked for any [MEDICATION NAME] for Resident # 5. The Administrator stated, We did an internal investigation after she attempted to hang herself. We had behavioral health come out and see and they recommended admission. She refused. Her BIMS was 15 and she refused to go. She had the right to refuse. k. On 10/22/15 at 10:35 a.m., LPN # 4 stated she had been the Acting Assistant Director of Nurses (ADON) since August 2015. LPN # 4 was asked, What do you know about (Resident # 5's) threats to kill herself? LPN # 4 stated, I knew she had threatened to kill herself. LPN #4 was asked, When did you tell (APN # 1) that (Resident # 5) would not go to in-patient psych? LPN # 4 stated That was after she'd tried to hang herself. l. On 10/22/15 at 12:27 p.m., the Administrator was asked, Did you know about the 9/8/15 happening documented by (LPN # 2) when (Resident # 5) threatened to hang herself? The Administrator stated, No. He told me she was crying and upset but not that she wanted to hang herself. The Administrator was asked, On 9/9/15 what did you know about this situation? The Administrator stated, That was when I told (SSD) she needed to talk with (APN # 1) about behavioral health and possible admit to geri-psych. The Administrator was asked, Geri-psych came on 9/10/15? The Administrator stated Yes. The

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F 0157 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) Administrator was asked, Did you know they recommended in-patient admission? The Administrator stated, Yes and that she had refused placement. The Administrator was asked, Were you informed on 9/12/15 when the resident attempted to hang herself? The Administrator stated, Yes. The Administrator was asked, What's been done since this to prevent re-occurrence? The Administrator stated, We did an in-service on reporting increased symptoms of depression. We started a behavior monitoring sheet. We started that this month and who the nurse needed to report increased behaviors to. The Administrator was asked, Why do in-services on reporting increased symptoms when they did that? There was no response from the Administrator. This surveyor requested copies of the in-services. The Administrator was asked, Were you notified on 9/8/15 as per the departmental notes? The Administrator stated, No. The Administrator was asked, Who else needed to be notified on 9/8/15? The Administrator stated The DON, the doctor and her family. The Administrator was asked Do you know if (APN # 1) or physician were asked before the 1 to 1/every 15 minutes checks were stopped or when the resident refused admit to geri-psych? The Administrator stated No. m. On 10/23/15 at 5:15 p.m., the Administrator was asked, Do you have any documented in-services that were done since (Resident # 5) attempted to hang herself on notification or suicidal ideation, etc. prior to 10/22/15? The Administrator stated, No. 2. Resident # 7 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 8/28/15 documented the resident scored 14 (13 - 15 indicates cognitively intact) on the Brief Interview for Mental Status, had thoughts of better off dead on 12 - 14 days (nearly every day), had a safety notification completed, and scored 12 (10 - 14 indicates moderate depression) on a Patient Health Questionnaire . The Signature of Person Completing the Assessment documented the Social Service Director (SSD) completed Section D Mood of the MDS on 8/28/15. a. On 10/22/15 at 10:55 a.m., the SSD was asked, For the MDS done 8/28/15, you completed the Mood Section? The SSD stated, Yes. The SSD was asked, Did the resident state he was having thoughts of better off dead and he said this occurred almost daily? The SSD stated, Yes. The SSD was asked, Did you do a safety notification? The SSD stated, I told the hall (charge) nurse. I know now that I need to tell (Administrator) and (DON) and (APN # 1). I learned that yesterday (10/21/15). The SSD was asked, Did he verbalize any plan for suicide? The SSD stated, No he said he was jealous of his roommate and could not understand why his wife did not visit him. The SSD was asked, Did you go back and monitor (Resident # 7) after 8/28/15? The SSD stated Yes but I didn't document it. b. The Departmental Notes dated 8/28/15 at 3:32 p.m. and electronically signed by LPN # 1 contained no documentation to indicate the resident stated he would be better off dead. c. On 10/21/15 at 2:07 p.m., LPN # 1 was asked, Has any resident stated to you they were going to kill themselves? LPN # 1 stated No, but (Resident # 7) says 'Sometimes I feel like I'd be better off dead'. LPN # 1 was asked How long ago did he say that? LPN # 1 stated Several months ago. It was only once and I contacted Social and we monitored him for several days and he never said anything after that. LPN # 1 was asked, Did you tell the physician or the Advance Practice Nurse? LPN # 1 stated, No. d. On 10/21/15 at 11:35 a.m., APN # 1 was asked, Were you told (Resident # 7) had expressed feelings of being better off dead on 8/28/15? APN # 1 stated, I don't think so I would have done an intervention for that. I was asked on 8/31/15 to clarify his ICD 10 (International Statistical Classification of Diseases and Related Health Problems) [DIAGNOSES REDACTED]. I wasn't told anything about expression of better off dead. 4. The Immediate Jeopardy was removed and the scope/severity reduced to H on 10/22/15 at 5:00 p.m. when the facility implemented the following Plan of Removal: 1) Beginning on 10/22/15 at 5:00 p.m., residents in the facility were assessed for statements regarding being better off dead or statements of intent of self-harm by completing the PHQ 9 from MDS 3.0 section D for all residents who had not had the PHQ 9 completed since 10/19/15. There were 6 residents who answered yes to thoughts of being better off dead. There was one resident that stated yes to intent to commit self-harm. Seven residents were immediately placed on one-on-one monitoring and the physician was immediately notified. The one resident who answered yes to the question of intent to commit self-harm was transferred out to (name of hospital) behavioral health on 10/22/15 at approximately 8:00 p.m. 2) All nursing staff was in-serviced beginning on 10/22/15 at 10:00 p.m. and training will be ongoing to include new hires and staff returning from leave. Training will take place before staff works on the floor. Training will be done by CEO (Chief Executive Officer)/DON/Designee and in-service sign in sheets used. Training will include that all residents who answer yes to being better off dead (will) have further questioning to determine if they intend to commit self-harm. If the resident states they would be better off dead but have no ideation of self-harm, the nurse will provide notification to the physician of the resident's mood status. If the resident states they intend to commit self-harm then the resident will immediately be placed on one on one monitoring and physician will be immediately notified. Additionally, staff will notify the DON and CEO when the resident answers yes to better off dead or intent for self-harm. Licensed staff will document (every) shift regarding the resident's mood status. This training will be done by the CEO/DON/Designee. 3) On 10/22/15 at 10:00 a.m., a one on one in-service was completed with the Social Service Director by the MDS Consultant regarding the above. 4) The DON/Designee will ensure that one-on-one is initiated immediately following a resident's statement to commit self-harm and that physician is notified of the intent to harm self. The DON/Designee will assess nursing notes daily to ensure that one on one monitoring is continued, further notification is made to the physician prn (as needed), and that documentation is completed (every) shift for the resident's current mood status and any continued verbiage of intent of self-harm. Monitoring will be ongoing daily for thirty days. If any negative findings are identified, they will be reported immediately to the DON/Designee and/or CEO and corrective action will be taken. All documentation will be reviewed for completeness.
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 mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 768) was substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure all allegations of abuse were immediately reported to the Administrator/Designee, to ensure all allegations of abuse were investigated and that residents were protected from the potential of further abuse during the investigation for 2 of 2 (Residents # 6 and 8) case mix residents who were cognitively impaired and were subjects of staff to resident abuse allegations. The failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident # 6 who repeatedly told staff of an abuse allegation and a staff member allegation of a witnessed abuse of Resident # 8 and had the potential to affect 51 residents who were cognitively impaired according a list received from the Nurse Consultant on 10/28/15. The facility was notified of the Immediate Jeopardy condition on 10/22/15 at 4:25 p.m. The findings are: 1. Resident # 6 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/26/15 documented the resident scored 5 (0 - 7 indicates severe impairment) on the Brief Interview for Mental Status; had no inattention, disorganized thinking, altered level of consciousness or psychomotor [MEDICAL CONDITION]; and had no physical or verbal behaviors directed toward others. a. The Departmental Notes dated 8/17/15 at 11:33 a.m. and electronically signed by the Social Service Director (SSD) documented, The resident reported a male CNA (Certified Nurse Assistant) came into his room last night and punched him in the face. The resident could not remember what time this event occurred. The resident did not know the name of the staff member. The resident did not have any clear visible marks or bruises to his face the resident stated again he was punched in the face. The resident stated he did not know why the event occurred. The resident stated he was asleep when it happened. The resident then said this had happened 3 nights in a row. The resident stated he got mad in the dining room one day and punched the man in the face. The resident could not remember what the confrontation in the dining room occurred. The resident stated he was physically healthy and had no other aliments at this time. 1) On 10/22/15 at 10:55 a.m., the SSD was asked to review the departmental note for 8/17/15. The SSD was asked, On 8/17/15,

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F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 3) what had happened? The SSD stated, Nursing staff told me a male CNA punched him (Resident #6) in the face and he was distraught. I was asked to go talk to him. The SSD was asked, What is that a complaint of? The SSD stated, A grievance. The SSD was asked, Are you sure? The SSD stated, It's an abuse allegation. The SSD was asked, What are you to do with an abuse allegation? The SSD stated, Now I know to write a grievance and do an investigation and report it. The SSD was asked, Now? The SSD stated, I was just told that today. The SSD was asked, Which nurse asked you to talk with him? The SSD stated, I don't recall. It could have been (Administrator), the Administrator or any nurse. The SSD was asked, Did the resident ever name a CNA? The SSD stated, No . 2) On 10/22/15 at 12:27 p.m., the Administrator was asked Did you know (Resident # 6) had reported he was punched in the face on 8/17/15? The Administrator stated, No. The Administrator was asked, Was this investigated? The Administrator stated, No, it was never reported on any I & A (incident and accident), grievance or witness statement. b. The Grievance Form dated 10/13/15 provided by the Administrator on 10/21/15 had a hand written statement attached to the Grievance Form dated 10/13/15 documented, (Resident # 6) states that when his tray was delivered this morning the man was rude and wouldn't get him his clothes. (Resident # 6) could not identify the staff member. Spoke (with) (Resident # 9) and she stated (Resident # 6) told her that during supper the other night (can't recall night) the staff was mean. When asked if she knew what about she stated no. 10/13/15 (Resident # 6) approached me following lunch and asked if anyone had told me about the (expletive) hole from the weekend that wanted me to turn the TV down. I asked if he was talking about the person we discussed this morning. He asked me 'Did I talk to you this morning?' I explained yes we discussed the incident at breakfast. He stated he didn't know what I was talking about but the other (expletive) hole needs to be taken out back. Resident could not identify who he was talking about but thought his name could be Saru. No employee or resident in facility by that name. c. On 10/20/15 at 10:48 a.m., the resident propelled up to this surveyor in a wheelchair and stated he needed to complain. The resident was asked, What about? The resident stated, About an employee that works here, (Name # 1). He's the one that slaps me on the (expletive) and pokes me in the forehead with his finger and calls me a little girl. The resident was asked, When does he do this? The resident stated, At night. The resident was asked, Is (Name # 1) the only one you have problems with? The resident stated, It's either (Name # 1) or (Certified Nurses Assistant (CNA) # 14). I'm not sure of the name. The resident was asked, What time of night does he work, late night to mornings or supper to bed time? The resident stated, Supper to bed time. d. On 10/20/15 at 10:52 a.m. the Administrator was asked, Have you had any complaints from (Resident # 6) related to staff? The Administrator stated, He complained last Wednesday (10/14/15). He told his girlfriend (Resident # 9) and she told me and we interviewed him and his story kept changing as to time frames and what happened. We did a staff in-service on perception and attitude. This surveyor requested a witness statement form from the Administrator to document an allegation. e. On 10/20/15 at 4:05 p.m., CNA # 15 was asked, Do you have concerns that abuse or neglect is occurring in the facility? CNA #15 stated, More than I've ever heard of it. CNA #15 was asked, Is that because residents or staff are telling you? CNA #15 stated, Residents mostly. Here lately it's staff members who told me. CNA #15 was asked, Which residents and what have they said? CNA #15 stated, (Resident # 6). He complained that (CNA #14) yanked him off the toilet and slapped him on the butt. We told him lets go talk to (Acting DON # 1), she was the acting DON and he said he'd already told her. CNA #15 was asked, When was that? CNA #15 stated, Thursday (10/15/15) or Friday 10/16/15) last week. CNA #15 was asked, Have you told anyone other than the charge nurse about these concerns you told me about? CNA #15 stated, I sent (Administrator) a text message the next day and I asked her in person if she knew about the incident with (Resident # 6). CNA #15 was asked, Did you fill out a witness statement regarding this? CNA # 15 stated, No, but they asked me for one today but not in the last 7 days. f. On 10/20/15 at 4:42 p.m., CNA # 16 was asked, Do you have any concerns that abuse or neglect is occurring in the facility? CNA # 16 stated, Yes. CNA #16 was asked, What are these concerns? CNA # 16 stated, Last week (Resident # 6) told us that he put his light on during supper and the CNA answered it and the CNA was rough with him and jerked him off the toilet, didn't clean him and did not put a brief on him . We reported it, (CNA #15) and I and we told him to tell the nurse. CNA # 16 was asked, Which nurse did you tell? CNA #16 stated, Our Acting DON, (Acting DON # 1) . I don't recall what charge nurse we told. CNA #16 was asked, Did you fill out a witness statement? CNA #16 stated, No, we weren't asked to . We mentioned this to (Administrator) and she said she interviewed (Resident # 6) and he told her 3 different versions of the story but he repeated this verbalization to the Treatment Nurse (LPN # 7) and to (CNA # 15). g. On 10/22/15 at 10:04 a.m., CNA # 9 was asked, Do you work with (Resident # 6)? CNA # 9 stated, Yes. CNA # 9 was asked, Has he ever told you he's been yanked off the toilet and his butt slapped? CNA # 9 stated, Yes and he's also told me a certain CNA has left him in a poopy brief after sitting him on the toilet. CNA #9 was asked, When did he tell you this? CNA # 9 stated, 10/13/15. CNA #9 was asked, What did you do?' CNA # 9 stated, I told the nurse (LPN # 1). CNA #9 was asked, Did any one ask you to fill out a witness statement? CNA #9 stated, I'm pretty sure they did but I got bumped to D hall and forgot. CNA #9 was asked, Which CNA was he complaining about? CNA #9 stated, (CNA #14). h. On 10/22/15 at 12:27 p.m., the Administrator was asked, The grievance dated 10/13/15, what exactly did the girlfriend (Resident # 9) say? The Administrator stated, She said (Resident # 6) said a staff member had been mean to him. I was going up the hall and (LPN # 7) said (Resident # 6) had reported that a CNA had been rough with him and had not gotten his clothes when he asked for them. The Administrator was asked, Did you ask (LPN # 7) for a witness statement? The Administrator stated, No. The Administrator was asked, Did you interview (Resident # 6)? The Administrator stated, Yes and I asked him if anyone had hit him and what had happened and he replied he (CNA) was rude and would not get me my clothes. I asked who and he said (Name # 2), I don't know, a short guy. The Administrator was asked, (CNA # 9) did not report that (Resident # 6) stated he'd been yanked off the toilet and slapped? The Administrator stated, No and she admitted that to me this a.m. The Administrator was asked, Had you been told by any staff member or by (Acting DON # 1) of concerns from other CNAs related to (Resident # 6) being yanked off the toilet and slapped on the bottom? The Administrator stated, No. The Administrator was asked, Had you been texted on this regarding (Resident # 6) being slapped? The Administrator stated, No, that CNA, (CNA # 15) came to my office and asked if I knew about (Resident # 6). I said yes but she didn't say what and she turned around and left. The Administrator was asked, Did you call her back and ask what about (Resident # 6)? The Administrator stated, No. i. On 10/23/15 at 9:50 a.m., LPN # 7 was asked, Any concerns from (Resident # 6) regarding treatment from any one? LPN # 7 stated, Yes. LPN # 7 was asked, What did he say? LPN # 7 stated, That (CNA #14) was rough with him and wouldn't give him his clothes. Then he went down the hall and stopped at the next kiosk and stopped the CNA and said 'Did you hear about (CNA # 14) and the CNA said 'What about him?' and (Resident # 6) told the CNA he smacked me on the (expletive) and at that point I just put my stuff in the cart and went to (Administrator's) office and told her. LPN #7 was asked, You told her he said he's been smacked on the (expletive)? LPN # 7 stated, Yes. LPN # 7 was asked, When was that? LPN # 7 stated, One day last week. LPN # 7 was asked, Who was the CNA that (Resident # 6) was talking to? LPN # 7 stated, (CNA # 19), I think he had stayed over. LPN #7 was asked, Is (CNA # 19) here today? LPN #7 stated, Yes. LPN # 7 was asked, Could you go get him and come back with him? I need to try and get you two to pin down what day this happened on. LPN #7 left at 10:01 a.m. j. On 10/23/15 at 10:23 a.m., LPN #7 and CNA #19 brought in time records to compare what days they had worked together last week. LPN #7 stated, We don't have any idea what day. It was not on the 13th because I was off that day. I'm almost certain it was the 15th. We, (CNA #19), myself, and (CNA #14) were all here on that day, the 15th. LPN #7 and CNA #19 were asked, Did (Resident # 6) report this to you on a day that (CNA #14) worked a day shift? CNA # 19 stated, Yes, (Resident # 6) said he was rough with him and didn't wipe my (expletive) before he pulled my drawers up. LPN # 7 and CNA #19 were asked, Did (Resident # 6) say he'd been slapped? LPN # 7 stated, I thought he said (CNA # 14) had smacked him around. LPN #7 was asked, You told (Administrator) this? LPN # 7 stated, Yes. CNA # 19 stated, Since (LPN # 7) was going to tell (Administrator) I didn't report it. LPN #7 and CNA #19 were asked, Did either of you fill out a witness statement? LPN # 7 stated, Not then. We usually wait till we are asked and I wasn't asked for one until today. I'm certain I reported this to (Administrator) on 10/15/15. k. The employee time report provided by the Administrator on 10/23/15 at 9:12 a.m. documented CNA #14 worked on 10/13/15 from 2:49 p.m. to 11:11 p.m.; on 10/14/15 from 2:48 p.m. to 11:15 p.m.; on 10/15/15 from 6:53 a.m. to 11:00 p.m.; on 10/16/15 from 2:50 p.m. to 11:05 p.m.; and on 10/19/15 from 2:48 p.m. to 11:17 p.m. 2. Resident # 8 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 8/7/15 documented the resident had severely impaired cognitive skills for daily decision making per a Staff Assessment of Mental Status (SAMS); had inattention,

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	045192	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS OF HARRISON AT TIMS HEALTH AND REHABILIT	202 TIMS AVENUE HARRISON, AR 72601

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

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F 0225 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 4) disorganized thinking, altered level of consciousness, and psychomotor [MEDICAL CONDITION] behaviors that were always present; and had no physical or verbal behaviors that were directed toward others. a. On 10/20/15 at 4:05 p.m., CNA # 15 was asked, Do you have concerns that abuse or neglect is occurring in the facility? CNA #15 stated, More than I've ever heard of it. CNA #15 was asked, Is that because residents or staff are telling you? CNA # 15 stated, Residents mostly. Here lately it's staff members who told me. I was told by (LPN # 6) and Housekeeper # 2 about an aide slapping a resident's hand . (Housekeeper # 2) told me about it . and I asked him if he filled out a witness statement and he said no, he was told to sign a paper saying he would report abuse to his supervisor. b. On 10/22/15 at 8:12 a.m. ,Housekeeper # 2 was asked, Have you ever seen any resident slapped by a staff member? Housekeeper #2 stated, Yes. Housekeeper # 2 was asked, Who was the resident? Housekeeper # 2 stated, (Resident # 8). Housekeeper #2 was asked, What happened? Housekeeper #2 stated, I was cleaning a room, coming out of the room when I turned around to go to my cart. (Resident # 8) was in her wheelchair in the hall at the linen cart and (Resident # 8) grabbed a CNA by her smock or shirt. I think it was (CNA #17). (Resident #8) had just reached up to get her snack, to get an oatmeal cake and the CNA took her hand and swatted the resident on the forearm. I told (LPN # 6) - she was right there passing meds. I asked (LPN # 6) did you see that and she said yes and I'm watching that. Housekeeper #2 was asked, That was all she said? Housekeeper #2 stated, Yes and from what I gather she went and told her supervisor but not while I seen it. Housekeeper #2 was asked, Did you tell anyone else? Housekeeper #2 stated, No, but I had to sign a paper that I had to tell my supervisor if it happened again. c. On 10/22/15 at 8:37 a.m. ,the Housekeeping Supervisor was asked, Have you ever seen any resident slapped by a staff member? The Housekeeping Supervisor stated, No. The Housekeeping Supervisor was asked, Have any of your staff reported that you? The Housekeeping Supervisor stated, No. I heard (Housekeeper #2) taking about it and I instructed him to let me know. The Housekeeping Supervisor was asked, When you heard him say that, who did you tell? The Housekeeping Supervisor stated, I told (LPN # 6). The Housekeeping Supervisor was asked, Did you ask (Housekeeper #2) to fill out a witness statement? The Housekeeping Supervisor stated, No, I failed to do that. Housekeeper #2 was asked, What did you understand (Housekeeper # 2) to say? The Housekeeping Supervisor stated, I understood him to say the CNA had slapped (Resident # 8's) hand. The Housekeeping Supervisor was asked, Is that abuse? The Housekeeping Supervisor stated, Yes and I'll go get a witness statement. The Housekeeping Supervisor was asked, What are you going to do after you get the witness statement? The Housekeeping Supervisor stated, Report it. The Housekeeping Supervisor was asked, How long ago did this happen? The Housekeeping Supervisor stated, Last week. The Housekeeping Supervisor was asked, Did you miss an important part of the incident? The Housekeeping Supervisor stated, Yes. I should have reported this last week. I'll go and take care of this right now. The Housekeeping Supervisor was asked to bring this surveyor a copy of Housekeeper # 2's witness statement and a copy of the disciplinary counseling done with Housekeeper #2. d. The Employee Warning Notice received from the Housekeeping Supervisor on 10/22/15 documented Employee Name: (Housekeeper # 2). Date of Incident: 10/12/15. Nature of Incident: Rule Violation. Description of Incident: On (page) 17 in your employee handbook it states if you see abuse or neglect or feel that you saw it you immediately come to you supervisor. If your supervisor is not available you report it to the ADON - Assistant Director of Nursing. Degree of Discipline: Document Counseling. Plan of Correction: If (Housekeeper # 2) feels he had witnessed abuse/neglect he will report directly to me or ADON. e. On 10/22/15 at 9:30 a.m., LPN # 6 was asked, Do you know anything about (Resident # 8) being slapped? LPN # 6 stated, I was there on the hall. I was 3 or 4 doors down from the resident and the housekeeper was only 1 door down from the resident. The resident and CNA were in the middle of the hall. The resident had gotten a snack from somewhere and had a handful of them. She was on a pureed diet and the aide was trying to get the snacks from her. The resident was getting combative when (CNA #18) was trying to get them and the resident slapped (CNA # 18) and you could hear a slap. I told (CNA #18) you need to just stop and let her be. That's when the housekeeper said 'Oh my god, did you just see that, she slapped her.' My initial thought was he's telling me that the resident slapped the CNA. I told (Housekeeper # 2) the resident is hitting her and she (CNA #18) is just trying to protect herself. LPN #6 was asked, Did you think he was alleging the CNA had slapped the resident? LPN # 6 stated, No. 3. The Immediate Jeopardy was removed and the scope/severity reduced to E on 10/22/15 at 5:00 p.m. when the facility implemented the following Plan of Removal: a. Beginning on 10/22/15 at 5:00 p.m., the facility identified 48 cognitively impaired residents at risk for abuse who scored below 13 on their BIMS from Section C of the MDS 3.0. b. Beginning at 5:00 p.m. on 10/22/15 body audits were initiated for these cognitively impaired residents with no significant findings. c. On 10/22/15 a one on one abuse training was conducted with the CEO (Chief Executive Officer/Administrator) by the RN (Registered Nurse) Regional MDS Consultant. Beginning on 10/22/15 a.m., all staff were in-serviced and training will be ongoing to include new hires and staff returning from leave. Training will take place before staff works on the floor. Training will be done by the CEO/DON/Designee and in-service sheets used. Training will include: a review of the abuse policy including identification of types of abuse, immediate resident protection to include the removal/suspension of the alleged perpetrator, reporting guidelines and investigation protocol. Training includes a verbal notification to the charge nurse of supervisor in charge, if the DON and/or CEO are not present in the facility. The charge nurse or supervisor will notify the CEO or DON immediately. The charge nurse or supervisor will remove the alleged abuser from the facility immediately and (the alleged abuser) will not be allowed in the facility pending the outcome of the investigation. d. The CEO/DON/designee will follow up on any verbal and written allegations of abuse and is to ensure the resident is protected, ensure the alleged perpetrator is suspended, and the investigative protocol is initiated and is completed per policy. Monitoring will be ongoing for 30 days to include evaluation of injuries of unknown origin for indications of potential abuse by the DON/designee; review of body audits for any indications of potential abuse by the treatment nurse or designee; random interviews will be conducted by CEO/DON/designee with 3 staff members per week covering all shifts to ensure staff knowledge of the abuse prohibition policy; and the CEO/DON /designee will conduct random interviews with 1 cognitively intact resident and 2 cognitively impaired residents regarding staff treatment toward them and other residents. Any negative findings will be reported immediately to the DON and CEO and corrective action taken.
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 768) was substantiated (all or in part) in these findings. Based on record review, and interview, the facility failed to their Abuse Prohibition policy and procedure was implemented to ensure all allegations of staff to resident abuse were immediately reported to the Administrator/Designee, to ensure all allegations of abuse were investigated and that residents were protected from the potential of further abuse during the investigation for 2 of 2 (Residents # 6 and 8) case mix residents who were cognitively impaired and were subjects of staff to resident abuse allegations. The failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident # 6 who repeatedly told staff of an abuse allegation and a staff member allegation of a witnessed abuse of Resident # 8 and had the potential to affect 51 residents who were cognitively impaired according a list received from the Nurse Consultant on 10/28/15. The facility was notified of the Immediate Jeopardy condition on 10/22/15 at 4:25 p.m. The findings are: 1. The facility's policy titled Abuse Prohibition documented, . Policy: . The facility shall ensure that all alleged violations are reported immediately to the administrator or the administrative designee. The administrator designee shall ensure that the violations are investigated and reported to the appropriate regulatory agency in accordance with federal and state law. Procedure: . Training Employees: Prevention, Intervention and Detection. All new staff will receive training on the following information during general orientation and annually thereafter: . How to report suspected or witnessed abuse, neglect or misappropriation of resident property . Actions that must be taken if resident abuse or neglect is witnessed, for the protection and safety of the resident . Protection: In order to provide protection to the resident during an investigation the following will be done: The alleged abuser will be removed from the facility immediately, and

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 5) not allowed in the facility, pending the outcome of the investigation . Reporting and Response to Alleged Incidents: . All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property shall be reported IMMEDIATELY after discovery to the Administrator or the DON (Director of Nursing) . If neither is in the facility when such incidents occur or are discovered after hours, the report will be given to the Charge Nurse or Supervisor in charge. The Charge Nurse or Supervisor must immediately contact the Administrator or the DON of the incident . 2. Resident # 6 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/26/15 documented the resident scored 5 (0 - 7 indicates severe impairment) on the Brief Interview for Mental Status; had no inattention, disorganized thinking, altered level of consciousness or psychomotor [MEDICAL CONDITION]; and had no physical or verbal behaviors directed toward others. a. The Departmental Notes dated 8/17/15 at 11:33 a.m. and electronically signed by the Social Service Director (SSD) documented, The resident reported a male CNA (Certified Nurse Assistant) came into his room last night and punched him in the face. The resident could not remember what time this event occurred. The resident did not know the name of the staff member. The resident did not have any clear visible marks or bruises to his face the resident stated again he was punched in the face. The resident stated he did not know why the event occurred. The resident stated he was asleep when it happened. The resident then said this had happened 3 nights in a row. The resident stated he got mad in the dining room one day and punched the man in the face. The resident could not remember what the confrontation in the dining room occurred. The resident stated he was physically healthy and had no other aliments at this time. 1) On 10/22/15 at 10:55 a.m., the SSD was asked to review the departmental note for 8/17/15. The SSD was asked, On 8/17/15, what had happened? The SSD stated, Nursing staff told me a male CNA punched him (Resident #6) in the face and he was distraught. I was asked to go talk to him. The SSD was asked, What is that a complaint of? The SSD stated, A grievance. The SSD was asked, Are you sure? The SSD stated, It's an abuse allegation. The SSD was asked, What are you to do with an abuse allegation? The SSD stated, Now I know to write a grievance and do an investigation and report it. The SSD was asked, Now? The SSD stated, I was just told that today. 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CNA #16 stated, No, we weren't asked to . We mentioned this to (Administrator) and she said she interviewed (Resident # 6) and he told her 3 different versions of the story but he repeated this verbalization to the Treatment Nurse (LPN # 7) and to (CNA # 15). g. On 10/22/15 at 10:04 a.m., CNA # 9 was asked, Do you work with (Resident # 6)? CNA # 9 stated, Yes. CNA # 9 was asked, Has he ever told you he's been yanked off the toilet and his butt slapped? CNA # 9 stated, Yes and he's also told me a certain CNA has left him in a poopy brief after sitting him on the toilet. CNA #9 was asked, When did he tell you this? CNA # 9 stated, 10/13/15. CNA #9 was asked, What did you do?' CNA # 9 stated, I told the nurse (LPN # 1). CNA #9 was asked, Did any one ask you to fill out a witness statement? CNA #9 stated, I'm pretty sure they did but I got bumped to D hall and forgot. CNA #9 was asked, Which CNA was he complaining about? CNA #9 stated, (CNA #14). h. On 10/22/15 at 12:27 p.m., the Administrator was asked, The grievance dated 10/13/15, what exactly did the girlfriend (Resident # 9) say? The Administrator stated, She said (Resident # 6) said a staff member had been mean to him. I was going up the hall and (LPN # 7) said (Resident # 6) had reported that a CNA had been rough with him and had not gotten his clothes when he asked for them. The Administrator was asked, Did you ask (LPN # 7) for a witness statement? The Administrator stated, No. The Administrator was asked, Did you interview (Resident # 6)? The Administrator stated, Yes and I asked him if anyone had hit him and what had happened and he replied he (CNA) was rude and would not get me my clothes. I asked who and he said (Name # 2), I don't know, a short guy. The Administrator was asked, (CNA # 9) did not report that (Resident # 6) stated he'd been yanked off the toilet and slapped? The Administrator stated, No and she admitted that to me this a.m. The Administrator was asked, Had you been told by any staff member or by (Acting DON # 1) of concerns from other CNAs related to (Resident # 6) being yanked off the toilet and slapped on the bottom? The Administrator stated, No. The Administrator was asked, Had you been texted on this regarding (Resident # 6) being slapped? The Administrator stated, No, that CNA, (CNA # 15) came to my office and asked if I knew about (Resident # 6). I said yes but she didn't say what and she turned around and left. The Administrator was asked, Did you call her back and ask what about (Resident # 6)? The Administrator stated, No. i. On 10/23/15 at 9:50 a.m., LPN # 7 was asked, Any concerns from (Resident # 6) regarding treatment from any one? LPN # 7 stated, Yes. LPN # 7 was asked, What did he say? LPN # 7 stated, That (CNA #14) was rough with him and wouldn't give him his clothes. Then he went down the hall and stopped at the next kiosk and stopped the CNA and said 'Did you hear about (CNA # 14) and the CNA said 'What about him?' and (Resident # 6) told the CNA he smacked me on the (expletive) and at that point I just put my stuff in the cart and went to (Administrator's) office and told her. LPN #7 was asked, You told her he said

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	045192	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS OF HARRISON AT TIMS HEALTH AND REHABILIT	202 TIMS AVENUE HARRISON, AR 72601

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

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F 0226 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 6) he's been smacked on the (expletive)? LPN # 7 stated, Yes. LPN # 7 was asked, When was that? LPN # 7 stated, One day last week. LPN # 7 was asked, Who was the CNA that (Resident # 6) was talking to? LPN # 7 stated, (CNA # 19), I think he had stayed over. LPN #7 was asked, Is (CNA # 19) here today? LPN #7 stated, Yes. LPN # 7 was asked, Could you go get him and come back with him? I need to try and get you two to pin down what day this happened on. LPN #7 left at 10:01 a.m. j. On 10/23/15 at 10:23 a.m., LPN #7 and CNA #19 brought in time records to compare what days they had worked together last week. LPN #7 stated, We don't have any idea what day. It was not on the 13th because I was off that day. I'm almost certain it was the 15th. We, (CNA #19), myself, and (CNA #14) were all here on that day, the 15th. LPN #7 and CNA #19 were asked, Did (Resident # 6) report this to you on a day that (CNA #14) worked a day shift? CNA # 19 stated, Yes, (Resident # 6) said he was rough with him and didn't wipe my (expletive) before he pulled my drawers up. LPN # 7 and CNA #19 were asked, Did (Resident # 6) say he'd been slapped? LPN # 7 stated, I thought he said (CNA # 14) had smacked him around. LPN #7 was asked, You told (Administrator) this? LPN # 7 stated, Yes. CNA # 19 stated, Since (LPN # 7) was going to tell (Administrator) I didn't report it. LPN #7 and CNA #19 were asked, Did either of you fill out a witness statement? LPN # 7 stated, Not then. We usually wait till we are asked and I wasn't asked for one until today. I'm certain I reported this to (Administrator) on 10/15/15. k. The employee time report provided by the Administrator on 10/23/15 at 9:12 a.m. documented CNA #14 worked on 10/13/15 from 2:49 p.m. to 11:11 p.m.; on 10/14/15 from 2:48 p.m. to 11:15 p.m.; on 10/15/15 from 6:53 a.m. to 11:00 p.m.; on 10/16/15 from 2:50 p.m. to 11:05 p.m.; and on 10/19/15 from 2:48 p.m. to 11:17 p.m. 2. Resident # 8 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 8/7/15 documented the resident had severely impaired cognitive skills for daily decision making per a Staff Assessment of Mental Status (SAMS); had inattention, disorganized thinking, altered level of consciousness, and psychomotor [MEDICAL CONDITION] behaviors that were always present; and had no physical or verbal behaviors that were directed toward others. a. On 10/20/15 at 4:05 p.m., CNA # 15 was asked, Do you have concerns that abuse or neglect is occurring in the facility? CNA #15 stated, More than I've ever heard of it. CNA #15 was asked, Is that because residents or staff are telling you? CNA # 15 stated, Residents mostly. Here lately it's staff members who told me. I was told by (LPN # 6) and Housekeeper # 2 about an aide slapping a resident's hand . (Housekeeper # 2) told me about it . and I asked him if he filled out a witness statement and he said no, he was told to sign a paper saying he would report abuse to his supervisor. b. On 10/22/15 at 8:12 a.m. ,Housekeeper # 2 was asked, Have you ever seen any resident slapped by a staff member? Housekeeper #2 stated, Yes. Housekeeper # 2 was asked, Who was the resident? Housekeeper # 2 stated, (Resident # 8). Housekeeper #2 was asked, What happened? Housekeeper #2 stated, I was cleaning a room, coming out of the room when I turned around to go to my cart. (Resident # 8) was in her wheelchair in the hall at the linen cart and (Resident # 8) grabbed a CNA by her smock or shirt. I think it was (CNA #17). (Resident #8) had just reached up to get her snack, to get an oatmeal cake and the CNA took her hand and swatted the resident on the forearm. I told (LPN # 6) - she was right there passing meds. I asked (LPN # 6) did you see that and she said yes and I'm watching that. Housekeeper #2 was asked, That was all she said? Housekeeper #2 stated, Yes and from what I gather she went and told her supervisor but not while I seen it. Housekeeper #2 was asked, Did you tell anyone else? Housekeeper #2 stated, No, but I had to sign a paper that I had to tell my supervisor if it happened again. c. On 10/22/15 at 8:37 a.m. ,the Housekeeping Supervisor was asked, Have you ever seen any resident slapped by a staff member? The Housekeeping Supervisor stated, No. The Housekeeping Supervisor was asked, Have any of your staff reported that you? The Housekeeping Supervisor stated, No. I heard (Housekeeper #2) taking about it and I instructed him to let me know. The Housekeeping Supervisor was asked, When you heard him say that, who did you tell? The Housekeeping Supervisor stated, I told (LPN # 6). The Housekeeping Supervisor was asked, Did you ask (Housekeeper #2) to fill out a witness statement? The Housekeeping Supervisor stated, No, I failed to do that. Housekeeper #2 was asked, What did you understand (Housekeeper # 2) to say? The Housekeeping Supervisor stated, I understood him to say the CNA had slapped (Resident # 8's) hand. The Housekeeping Supervisor was asked, Is that abuse? The Housekeeping Supervisor stated, Yes and I'll go get a witness statement. The Housekeeping Supervisor was asked, What are you going to do after you get the witness statement? The Housekeeping Supervisor stated, Report it. The Housekeeping Supervisor was asked, How long ago did this happen? The Housekeeping Supervisor stated, Last week. The Housekeeping Supervisor was asked, Did you miss an important part of the incident? The Housekeeping Supervisor stated, Yes. I should have reported this last week. I'll go and take care of this right now. The Housekeeping Supervisor was asked to bring this surveyor a copy of Housekeeper # 2's witness statement and a copy of the disciplinary counseling done with Housekeeper #2. d. The Employee Warning Notice received from the Housekeeping Supervisor on 10/22/15 documented Employee Name: (Housekeeper # 2). Date of Incident: 10/12/15. Nature of Incident: Rule Violation. Description of Incident: On (page) 17 in your employee handbook it states if you see abuse or neglect or feel that you saw it you immediately come to you supervisor. If your supervisor is not available you report it to the ADON - Assistant Director of Nursing. Degree of Discipline: Document Counseling. Plan of Correction: If (Housekeeper # 2) feels he had witnessed abuse/neglect he will report directly to me or ADON. e. On 10/22/15 at 9:30 a.m., LPN # 6 was asked, Do you know anything about (Resident # 8) being slapped? LPN # 6 stated, I was there on the hall. I was 3 or 4 doors down from the resident and the housekeeper was only 1 door down from the resident. The resident and CNA were in the middle of the hall. The resident had gotten a snack from somewhere and had a handful of them. She was on a pureed diet and the aide was trying to get the snacks from her. The resident was getting combative when (CNA #18) was trying to get them and the resident slapped (CNA # 18) and you could hear a slap. I told (CNA #18) you need to just stop and let her be. That's when the housekeeper said 'Oh my god, did you just see that, she slapped her.' My initial thought was he's telling me that the resident slapped the CNA. I told (Housekeeper # 2) the resident is hitting her and she (CNA #18) is just trying to protect herself. LPN #6 was asked, Did you think he was alleging the CNA had slapped the resident? LPN # 6 stated, No. 3. The Immediate Jeopardy was removed and the scope/severity reduced to E on 10/22/15 at 5:00 p.m. when the facility implemented the following Plan of Removal: a. Beginning on 10/22/15 at 5:00 p.m., the facility identified 48 cognitively impaired residents at risk for abuse who scored below 13 on their BIMS from Section C of the MDS 3.0. b. Beginning at 5:00 p.m. on 10/22/15 body audits were initiated for these cognitively impaired residents with no significant findings. c. On 10/22/15 a one on one abuse training was conducted with the CEO (Chief Executive Officer/Administrator) by the RN (Registered Nurse) Regional MDS Consultant. Beginning on 10/22/15 a.m., all staff were in-serviced and training will be ongoing to include new hires and staff returning from leave. Training will take place before staff works on the floor. Training will be done by the CEO/DON/Designee and in-service sheets used. Training will include: a review of the abuse policy including identification of types of abuse, immediate resident protection to include the removal/suspension of the alleged perpetrator, reporting guidelines and investigation protocol. Training includes a verbal notification to the charge nurse of supervisor in charge, if the DON and/or CEO are not present in the facility. The charge nurse or supervisor will notify the CEO or DON immediately. The charge nurse or supervisor will remove the alleged abuser from the facility immediately and (the alleged abuser) will not be allowed in the facility pending the outcome of the investigation. d. The CEO/DON/designee will follow up on any verbal and written allegations of abuse and is to ensure the resident is protected, ensure the alleged perpetrator is suspended, and the investigative protocol is initiated and is completed per policy. Monitoring will be ongoing for 30 days to include evaluation of injuries of unknown origin for indications of potential abuse by the DON/designee; review of body audits for any indications of potential abuse by the treatment nurse or designee; random interviews will be conducted by CEO/DON/designee with 3 staff members per week covering all shifts to ensure staff knowledge of the abuse prohibition policy; and the CEO/DON /designee will conduct random interviews with 1 cognitively intact resident and 2 cognitively impaired residents regarding staff treatment toward them and other residents. Any negative findings will be reported immediately to the DON and CEO and corrective action taken.
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # , (AR 720), was substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure necessary care and services were provided Residents #5

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 7) and #7 to attain or maintain the highest practicable physical and mental well-being, in accordance with the plan of care and acceptable standards of practice. The facility failed to ensure the physician was immediately consulted regarding significant changes in mental or psychosocial status for 1 of 1 (Residents #5) case mix resident who voiced an intent to commit suicide and 1 of 1 (Resident # 7) case mix resident who voiced feelings of being better off dead. The facility failed to ensure the physician was immediately consulted regarding resident ' s refusal for treatment for 1 of 1 (Resident #5) case mix resident who had voiced an intent to kill self and refused admission to a behavioral unit. The facility failed to ensure ongoing one on one monitoring was provided after a verbal threat to commit suicide for 1 of 1 (Residents #5) case mix resident who threatened suicide. The failed practices resulted in immediate jeopardy which caused or could have caused serious harm, injury or death to Resident # 5, who had voiced her intent to hang herself and was found unresponsive following a hanging attempt after one on one monitoring was discontinued with her refusal to be admitted to a Behavioral Health Care Unit, Resident #7 who voiced feelings of being better off dead and had the potential to affect 2 residents in the facility who had stated an intent to kill themselves since 9/1/15 according to the listing received from the Minimum Data Set (MDS) Coordinator on 10/23/15, 3 residents with physician orders [REDACTED]. The facility was notified of the Immediate Jeopardy condition on 10/22/15 at 4:25 p.m. The findings are: 1. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/2/15 documented the resident scored 10 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status;, had no signs or symptoms of [MEDICAL CONDITION]; had no thoughts of better off dead; and scored 2 (1 - 4 indicates minimal depression) on the Patient Health Questionnaire. a. The Care Plan dated 4/3/15 and updated on 9/8/15 documented, I have behaviors . 9/8/15 I have voiced [MEDICAL CONDITION] . Approaches: . 9/8/15 Notify MD/APN (Medical Doctor/Advanced Practice Nurse) of my [MEDICAL CONDITION] . b. The Departmental Notes dated 9/8/15 at 8:42 p.m. and signed by Licensed Practical Nurse (LPN #2) documented, Resident crying and verbally aggressive toward staff. This nurse sat and talked with resident for 20 (minutes) in order to get resident to take her medications that included (Klonopin(used to treat Panic Disorder). Resident stated to this nurse and other staff that she was 'going to hang herself because she could not get out of here'. Resident placed on 1 on 1 monitoring for suicidal ideation, and administrator notified. c. The Departmental Notes dated 9/9/15 at 1:25 p.m. and signed by the Social Services Director (SSD) documented, Earlier on this date, SSD spoke with the resident regarding her statement of wanting to hang herself made on 9/8/15. The resident stated she did say that to staff. SSD interviewed the resident to complete the Geriatric Depression Scale. The resident score was 9. Due to the client's answers and responses, the clients depression only appears to be situational and possibly attention seeking. Administrator and Nurse Practitioner were notified of the scores. Further analysis will take place. On 10/22/15 at 10:55 a.m., the SSD was asked, The 9/9/15 entry in the Departmental Notes, what had happened? The SSD stated, I was told about (LPN # 2's report) and was told to see her and I went to do the Geriatric Depression Scale. The SSD was asked, What did you tell the Nurse Practitioner? The SSD stated, Everything (Resident # 5) was saying - 'I'll do whatever it takes to get out of here, whether it's jump the fence or kill myself'. I did tell (APN # 1) I would feel more comfortable if we referred this over to (name of Behavioral Health). (APN # 1) said yes. The SSD was asked, Did (Name of Behavioral Health) come out? The SSD stated, Yes. I was in the room when she refused. The SSD was asked, Did you tell (APN # 1) that (Resident # 5) had refused admission to behavioral health? The SSD stated, No. d. A SOAP (Subjective, Objective, Assessment and Plan) note dated 9/9/15 and signed by Advanced Practice Nurse (APN) #1 documented, . Chief Complaint: Patient has told staff that she plans to kill herself, I have been asked to see her. I know her very well and I have taken care of her since she first admitted to LTC (Long Term Care). Today she is in her room with her son. She is defiant and irrational. She will not deny a desire to harm herself. She is fixated on 'leaving'. No specific reason. She is delusional - saying (she) has the ability to get on a plane or in a car and move to California, where her son says she lived [AGE] years ago. I can't redirect her. Her mood is labile. Active Diagnoses: [REDACTED]. Mood - her mood has always been labile, she is frequently anxious and gets only periodically, she is confused today which is worse than usual, she is wild and I am not able to redirect her, her son is not, she threatens to harm herself but does not have a plan in mind. Objective: . Mood - she is anxious, she is having delusional thoughts of driving to California, getting a job, she will not contract for safety with me or her son. Plan: Suicidal threat - she is more confused than usual today, more delusional than I am used to seeing her. I thought I would easily get her to contract for safety but I can't. Her son is here - we discussed the spot she has put herself in by telling staff that she would kill herself. Since she will not retract or clarify the statement then I think it's in her best interest to go to an (in-patient) psych unit. The son is in agreement. I spoke to the social worker and to the acting DON (Director of Nursing) and asked them to make the referral. I expect them to come out today. Case (discussed with) Dr. (name of resident's attending physician, who is also the facility's Medical Director) and he agrees with plan. e. The (Name) Behavioral Health Pre-Admission Screening form documented Date: 9/10/15. Time: 7:30 a.m. Responsible Party/Relationship: Self . Presenting Symptoms: . (Suicidal Ideation) . Depressed . Behavior: . Verbally aggressive . Summary: (Patient) has a history of Depression and Anxiety. (Patient) currently has passive death wish but no plan to commit suicide. (Nursing facility) reports suicidal statements . Physician Recommendations (and) Family/Guardian Response: . MSW (Medical Social Worker) recommends admission to (name of behavioral health), Dr. (name) has accepted (patient) . No Admission Indicated due to: (Patient) accepted for admission to (name of behavioral health) however (patient) is refusing to come and has no designee or family that will be surrogate . As of 10/19/15 at 1:35 p.m., there was no departmental note found in the clinical record that documented any family member had been contacted or that the Nurse Practitioner of Physician had been notified of the resident's refusal to be admitted to behavioral health unit on 9/10/14. f. A SOAP note dated 9/11/15 and signed by APN #1 documented, . Chief Complaint: Nurses tell me patient is still here, she is not saying she is going to kill herself but she is distressed, moody, anxious and delusional. She has been combative and refusing basic care. The nurse has asked me to review her meds and see what I can do to help her psychological distress. I did review her meds after taking to 3 nurses about her recent and current behaviors. See chart for order change . 1) A physician order [REDACTED]. 2) The One on One Contact Forms documented resident observations were started on 9/8/15 at 8:30 p.m. and resident observations stopped on 9/10/15 at 6:45 a.m. The CNA assignment sheets dated from 9/8/15 through 9/12/15 were reviewed. There was no staff member who was documented as providing 1 on 1 monitoring during this time. The assignment sheets for 9/12/15 for the 3:00 p.m. to 11:00 p.m. shift were reviewed. CNA #s 5, 11, and 12 were assigned to Resident # 5's hall on 9/12/15 for the 3:00 p.m. to 11:00 p.m. shift. There was no indication that any of these CNAs provided 1 on 1 monitoring of the resident during this time frame. g. The Departmental Notes dated 9/13/15 at 1:46 a.m. documented, This nurse was called to resident's room at 1715 (5:15 p.m. 9/12/15) by CNA (Certified Nurse Assistant). Upon entering the room, this nurse observed resident to be non-responsive with a cloth tied around her neck. This nurse immediately had another nurse call 911. We removed the cloth from around resident's neck and sternal rubbed her for about 4 minutes before getting her eyes to fluttering. Resident also noted to have a pair of scissors which later this nurse found that another resident had given them to her and assisted her in cutting the cloth. Resident came around and was fighting with CNAs to get cloth back to put back around her neck. CNAs kept a tight grip on cloth until EMTs (Emergency Medical Technicians) arrived. Ambulance arrived at 1725 (5:25 p.m.) along with (name of town Police Department) to do formal evaluation and reports. EMTs helped to get resident away from the closet when resident became very combative and cursing them. EMTs and officers asked resident multiple times if she wanted to harm herself and resident stated yes, she wanted to kill herself. EMT asked resident how she planned on doing this and resident stated that she was going to choke herself. EMTs took resident to ER after thorough investigation and report was done with resident. After the resident left the facility, this nurse had all staff on 3:00 p.m. to 11:00 p.m. do a witness statement whether they had contact with resident or not. After talking with some of the CNAs, they reported that this resident had been seen talking with another resident (Resident # 12). This nurse approached resident and asked if this resident had said anything to her about trying to kill herself. Resident stated that she was very emotional talking about wanting to get out of here. Resident also reported that she was talking about how her kids left her here to die and she would rather be dead. Resident also stated that (Resident # 5) had repeatedly mentioned that her husband had killed himself years ago by shooting

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 8) himself in the head. When (Resident # 5) asked resident to cut the cloth, resident asked (Resident # 5) 'What are you going to do, hang yourself?' Resident said that (Resident # 5) began to cry even more. Resident did admit to helping (Resident # 5) cut the cloth but she said she had no idea why she wanted this done . Around 8:30 p.m. one of the nurses from (Behavioral health/geri-psych) called reported that resident had been admitted . 1) The (name) EMS (Emergency Medical Services) Patient Encounter form dated 9/12/15 documented, . Date: 9/12/15 . Reason for Transfer or Dispatch Reason: Attempted hanging . Time: 6:00 p.m. (Blood pressure) 163/96, (pulse) 100, (respirations) 20 . Chief Complaint: (Attempted) hanging. Edge of sheet around door knob and around neck, pushing back with legs in wheelchair . staff stated may have been (unresponsive) (prior to arrival) of EMS. Awake (and) alert (and) able to answer questions . 2) The (hospital) Emergency Department Record dated 9/12/15 at 6:04 p.m. documented, . Arrival Date/Time: 9/12/15 6:04 p.m . Stated Complaint: Attempted hanging . Physical Assessment . Glasgow Coma Scale . Eye opening: Spontaneous . Motor: Obeys commands . Verbal: Oriented . Per (Nursing Home), per EMS (Emergency Medical Services) (patient) tied cord of sheet around door knob, around neck and initially was pale and unresponsive. On arrival of EMS (patient) awake and alert, (patient) stated 'I want out of there', referring to (nursing home) . Patient Discharge or Departure: discharge date : 9/12/15. Discharge time: 8:22 p.m. Discharge order: Transfer to psych . 9/12/15 6:04 p.m. 5:57 p.m. actual arrival of (patient) . with alleged hanging from sheet at (nursing home) Per (nursing home) on their arrival (patient) was pale and unresponsive but on arrival of EMS, (patient) alert and awake. No visible signs of strangulation noted. No redness or marks visible. (Respirations) even and unlabored. (Patient) admits of intentionally attempted to hang self due to fact that she does not like the (nursing home) and does not want to reside there . 3) The Diagnostic Imaging Report documented . Visit Date: 9/12/15 . Exam: Cervical spine . Order (diagnosis): tried to hang self . Impression: . without evidence of hangman's fracture . h. The Resident Incident Report dated 9/12/15 at 5:15 p.m. documented, . Associate Involved: (CNA # 4) . This nurse was called to resident's room . Narrative of Investigation: . Upon investigation it was determined resident had attempted to hang herself utilizing cut up sheets where she place around her neck and tied to her closet door knob, where she then propped her lower extremities off the floor. Staff was previously in room [ROOM NUMBER] - 10 minutes before setting up dinner tray where resident got up from bed to eat dinner without any difficulties or irrational statements leading up to incident. Staff found resident unresponsive, called 911 immediately and removed sheets to arouse after noting she was not responding. Stayed with resident until EMS arrived. Resident had days before been assessed by a house visit from the Behavioral Health unit . Resident was a candidate for inpatient care due to previous behaviors and statements, but refused to go to receive treatment. Currently admitted to Behavioral unit. 6. New Intervention: In-service staff on [MEDICAL CONDITION] pending in-service from behavioral health representative with nurses on suicidal threats and interventions . On 10/21/15 at 2:55 p.m., CNA # 4 was asked, Have you ever worked with (Resident # 5)? CNA # 4 stated, Yes, that day she hung herself (9/12/15). I'm the one who found her that night. She was okay when she got her dinner and I was on call lights and found her. CNA #4 was asked, About what time was that? CNA # 4 stated, About 5:15 p.m. to 5:30 p.m., I walked past her room and I saw her in the corner by her dresser. She was between the closet door and her dresser. She had one end of the sheet tied around the closet door handle and the other end wrapped around her neck a couple of times. She had her feet pushing against the door and she was leaning back in the wheelchair with her head back and she was holding onto the sheet around her neck. CNA #4 was asked, She had a grip on the sheet when you found her? CNA # 4 stated, Yes and she didn't want to let it go. CNA #4 was asked, She had her legs straight and was pushing back from the door when you found her? CNA # 4 stated, Yes. CNA #4 was asked, Was she responsive? CNA #4 stated, No, it took 4 to 5 minutes for her to answer us. CNA #4 was asked, Was she still breathing and still had a pulse? CNA #4 stated, Yes. CNA #4 was asked, The only thing she wasn't doing was responding? CNA #4 stated, Yes and then she opened her eyes and said 'Leave me alone, I'm dying'. i. The Verification of Investigation form signed by the Administrator documented, . Date/Time of Occurrence: 9/12/15 7:00 p.m. Provided detailed description of event/allegation: Resident found hanging from a cut bed sheet on closet. Assessment of Resident/Describe Injury: Resident was found unresponsive with cut cloth around her neck. Causal/Contributing Factor and Observations: Resident asked another resident to cut the bed sheet and had expressed the desire to harm herself to the resident. Resident had been upset that her family had not been visiting as often as she thought they should have. She does not like living in Arkansas and wishes she had never came. Specific Recommendations/Interventions Taken to Prevent Reoccurrence: One on one with resident on alerting staff if a resident makes statements of self-harm. Offer the resident the opportunity to locate another facility if she chooses. Was Abuse/Neglect Substantiated? No. Provide Summary of Investigative Findings: Resident had been assessed by (name) Behavioral health on the 9th for placement for increased symptoms of depression. Placement was offered to resident but resident denied wanting placement. On 9/12/15, resident requested another resident cut a bed sheet for her and expressed an idea of wanting to die. Resident did not alert staff to (Resident # 5's) statement. Resident was found at 7:00 p.m. with material around her throat. Staff removed her from immediate harm and she remained one on one until EMS took over care for the resident. She was then taken to (hospital name) under a suicide hold. j. On 10/21/15 at 10:00 a.m., APN # 1 was asked, Was (Resident # 5) treated by you? APN stated, Yes. APN # 1 presented progress noted dated 9/9/15 and 9/11/15. APN # 1 was asked, Did you recommend that the resident was safe to stop the 1 to 1 monitoring? APN # 1 stated, No one asked me that. When I was there on 9/9/15 her family was there but no staff was present. She kept repeating she was going to kill herself and I recommended a psych referral. I told (Acting DON) and (SSD) that she needed an in-patient psych referral and someone did come out and they saw her. I did not know she was still in the building on Friday (9/11/15) until a nurse casually asked me to review her meds. I reviewed her meds and I didn't ask about the psych referral on Friday. APN # 1 was asked, Did you know the resident was not one on one on Friday, 9/11/15? APN # 1 stated, You are they first person to even ask me about one on one monitoring. No I was only asked to look at her meds. I was told she would not consent to the psych admit but I'm not sure if she (LPN # 4) said that on Friday (9/11/15) or Monday (9/14/15) after all that happened. The son had already consented and the resident was delusional so I don't know why she wasn't sent to the psych unit. On Monday (9/14/15) I was told by the nurses she had asked for scissors all day Saturday (9/12/15) and even got a resident to cut her sheets. She carried out a plan to commit suicide over the course of a day and that's very high level functioning. k. The Quality Assessment and Assurance Committee form dated 9/29/15 documented, Topic: Note: Resident attempted suicide. Process Owner: All Departments. Summary of Analysis should include trends and root cause analysis: Improve documentation using the behavior monitoring sheets contained in MARs (Medication Administration Records). Review medical record for indications missed to show staff how to identify possible harm to resident before (it) gets to that point. Speak with (name) Behavioral (Health) on inservice to be conducted to include a better understanding of warning signs of suicidal thoughts in the elderly. Inservice with staff on more effective documentation in respect to resident behaviors and changes in condition. l. CNA interviews were conducted regarding one to one monitoring of Resident #5 from 9/8/15 - 9/12/15: 1) On 10/21/15 at 3:30 p.m., CNA # 6 was asked, Has any resident stated to you they were going to kill themselves? CNA # 6 stated Yes, just one. CNA #6 was asked, Who? CNA # 6 stated, (Resident # 5). We were at the nurses station and she said she wanted to go to California with her brother or son and then she said I'll just kill myself. CNA # 6 was asked, What happened after that? CNA #6 stated, We had to go in there every 15 minutes and check on her. CNA # 6 was asked Were you doing 1 to 1 or every 15 minute checks? CNA #6 stated, Every 15 minute checks, not 1 to 1. CNA # 6 was asked, What day was that? CNA #6 reviewed the One on One Contact Forms for 9/8/15 through 9/10/15. CNA #6 stated, I don't recall when she said that but I did every 15 minute checks on 9/9/15 at 3:45 p.m., 4:00 p.m., 4:30 p.m., 4:45 p.m., 5:00 p.m. and 9:15 p.m. 2) On 10/21/15 at 3:50 p.m., CNA #7 was asked, Has any resident stated to you they were going to kill themselves? CNA #7 stated Yes. CNA #7 was asked, Who? CNA #7 stated, (Resident # 5). CNA # 7 was asked, When? CNA #7 stated, About 2 weeks before she tried to hang herself. CNA #7 was asked, What did she say? CNA # 7 stated, That she was tired of being here so she was just going to kill herself. CNA #7 was asked, What did you do? CNA #7 stated, I told the nurse, she said it numerous times. I know (LPN # 2) is usually the nurse. CNA #7 was asked, What did the nurse do? CNA # 7 stated, Started every 15 minute checks . CNA #7 was asked to review the One on One Contact Forms from 9/8/15 to 9/10/15. CNA #7 was asked, Can you put a check mark by when you did checks? CNA # 7 put 5 check marks on 9/8/15 at 9:30 p.m., 9:45 p.m., 10:30 p.m., 10:45 p.m. and 11:00 p.m. CNA #7 stated, It was me and (CNA # 13) who went and told (LPN # 2) about it, then she stopped saying it. 3) On 10/22/15 at 6:43 a.m., CNA # 13 was asked, Has any resident stated to you they were going to kill themselves? CNA #13

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	045192	A. BUILDING _____ B. WING _____	**10/23/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS OF HARRISON AT TIMS HEALTH AND REHABILIT	**202 TIMS AVENUE HARRISON, AR 72601**

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 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) stated, Yes, (Resident # 5). CNA #13 was asked, How often did she say that? CNA #13 stated, Once and I reported it to my nurse. CNA #13 was asked, Which nurse? CNA #13 stated, (LPN # 2). CNA #13 was asked, What did (LPN # 2) have you do? CNA #13 stated, We started on 1 to 1 and when she went to bed we did every 15 minute checks. I made sure her door was open and curtains pulled back so I could see her. CNA #13 was asked, Was that on 9/8/15? CNA # 13 reviewed the on One Contact Forms from 9/8/15 to 9/10/15. CNA # 13 stated, Yes, (initials) on here is me. CNA #13 initials were documented on 9/8/15 at 9:00 p.m., 9:15 p.m., 10:00 p.m. and 10:15 p.m. m. On 10/22/15 at 10:35 a.m. LPN # 4 stated she had been the Acting Assistant Director of Nurses (ADON) since August 2015. LPN # 4 was asked What do you know about (Resident # 5's) threats to kill herself? LPN # 4 stated I knew she had threatened to kill herself. LPN # 4 was asked What did the facility do to protect the resident? LPN # 4 stated Put resident 1 to 1 and I know (SSD) talked with her and I know someone from the hospital came in to talk with her. LPN # 4 was asked, When did the 1 to 1 end? LPN # 4 stated, I don't know when or why it was stopped. The Acting DON, (SSD) and Administrator were dealing with that. LPN # 4 was asked, When did you tell (APN # 1) that (Resident # 5) would not go to in-patient psych? LPN # 4 stated, That was after she'd tried to hang herself. n. On 10/22/15 at 12:27 p.m., the Administrator was asked, Did you know about the 9/8/15 happening documented by (LPN # 2) when (Resident # 5) threatened to hang herself? The Administrator stated, No. He told me she was crying and upset but not that she wanted to hang herself. The Administrator was asked, What was staff doing, monitoring (Resident # 5) 1 to 1 or every 15 minute checks? The Administrator stated I thought it was 1 to 1. This surveyor informed the Administrator that the 3:00 p.m. to 11:00 p.m. staff had stated they were doing every 15 minutes checks. The Administrator was asked, Is every 15 minute checks okay for a resident threatening to hang herself? The Administrator stated, No. The Administrator was asked, On 9/9/15 what did you know about this situation? The Administrator stated, That was when I told (SSD) she needed to talk with (APN # 1) about behavioral health and possible admit to geri-psych. The Administrator was asked, Geri-psych came on 9/10/15? The Administrator stated, Yes. The Administrator was asked, Did you know they recommended in-patient admission? The Administrator stated, Yes and that she had refused placement. The Administrator was asked, Why was the monitoring of (Resident # 5) stopped? The Administrator stated, Because she refused to go and the nurses did not see the geri-psych notes. The Administrator was asked, Who made the decision to stop the monitoring? Were you involved? The Administrator stated, No, I was not. The Administrator was asked, Who made the decision? The Administrator stated, I don't know. The Administrator was asked, Did anyone call you before they stopped it? The Administrator stated No. The Administrator was asked, Were you in the building on 9/10/15 and 9/11/15? The Administrator stated, Yes. The Administrator was asked, Who was in charge of nursing? The Administrator stated, (Acting DON # 1). The Administrator was asked, Were you informed on 9/12/15 when the resident attempted to hang herself? The Administrator stated, Yes. The Administrator was asked, What's been done since this to prevent re-occurrence? The Administrator stated, We did an in-service on reporting increased symptoms of depression. We started a behavior monitoring sheet. We started that this month and who the nurse needed to report increased behaviors to. The Administrator was asked, Why do in-services on reporting increased behaviors when they did that? There was no response from the Administrator. This surveyor requested copies of the in-services. 1) On 10/22/15 at 1:55 p.m., Acting DON # 1 stated she was the DON from August through 10/14/15. Acting DON # 1 was asked, Did (Resident # 5) threaten to kill herself? Acting DON # 1 stated, Yes. Acting DON #1 was asked, What were you doing to monitor the resident for suicide attempts? Acting DON # 1 stated, It was supposed to be 1 to 1 monitoring but maybe the CNAs got confused and only did every 15 minute checks. Acting DON # 1 was asked, Who made the decision to stop the 1 to 1 or every 15 minute monitoring? Acting DON # 1 stated, I don't know. Acting DON # 1 was asked, Were you working 9/10/15 and 9/11/15? Acting DON # 1 stated, Yes. Acting DON # 1 was asked, Did anyone ask you if they could stop monitoring (Resident # 5)? Acting DON # 1 stated, No. Acting DON #1 was asked, Did you know the monitoring was stopped with (Resident # 5) prior to psych seeing the resident? Acting DON # 1 stated, No. Acting DON # 1 was asked, Who did the CNA assignments? Acting DON # 1 stated, The charge nurses or (LPN # 5). 2) On 10/22/15 at 2:20 p.m., LPN #5 was asked, Do you complete the 7:00 a.m. to 3:00 p.m. assignment sheets? LPN # 5 stated, If I have time, sometimes the nurses do it. There is no one assigned to fill it out. LPN # 5 was asked, Did you know about (Resident # 5) threatening to hang herself on 9/8/15? LPN #5 stated, Yes. I was working that night on C and D halls and (LPN # 2) told me what happened and I told him he better call (Administrator) and see what to do. I filled out the 9/10/15 3:00 p.m. to 11:00 p.m. assignment sheet and I didn't know she was 1 to 1 and I didn't make her 1 to 1 on the 11th and I did the 9/12/15 assignments and I didn't assign 1 to 1. When the resident refused to go to psych I was under the impression it was over and I was never told she was 1 to 1. If she had been 1 to 1 there would be 1:1 with a CNAs name. I know in stand up (Administrator) said the psych person came and she refused to go and made her own decision so we are covered. There was nothing said about 1 to 1. That was on 9/11/15. LPN # 5 was asked to review the One on One Contact Forms and the assignment sheets from 9/8/15 through 9/12/15 for indications of 1 to 1 monitoring. LPN # 5 stated, There was no one assigned to do 1 to 1 from 9/8/15 through 9/12/15 and her monitoring stopped on 9/10/15 at 6:45 a.m. o. On 10/23/15 at 5:15 p.m. the Administrator was asked, Who should have ensured the monitoring was 1 to 1 for (Resident # 5) and that it was in place and stayed in place? The Administrator stated, The DON at that time and I should have made sure she was doing that. The Administrator was asked, Do you have any documented in-services that were done since (Resident # 5) attempted to hang herself on notification or suicidal ideation, (et cetera) prior to 10/22/15?' The Administrator stated, No. 2. Resident # 7 had [DIAGNOSES REDACTED]. The Departmental Note dated 8/5/15 at 9:24 a.m. documented, New order received per (Advanced Practice Nurse (APN) # 1) to decrease [MEDICATION NAME] (anti-depressant) to 5 (milligrams) (per mouth) at bedtime . The Quarterly MDS with an ARD of 8/28/15 documented the resident scored 14 (13 - 15 indicates cognitively intact) on the Brief Interview for Mental Status, had thoughts of better off dead on 12 - 14 days (nearly every day), had a safety notification completed, and scored 12 (10 - 14 indicates moderate depression) on a Patient Health Questionnaire . The Signature of Person Completing the Assessment documented the Social Service Director (SSD) completed Section D Mood of the MDS on 8/28/15. a. On 10/22/15 at 10:55 a.m., the SSD was asked, For the MDS done 8/28/15, you completed the Mood Section? The SSD stated, Yes. The SSD was asked, Did the resident state he was having thoughts of being better off dead and he said this occurred almost daily? The SSD stated, Yes. The SSD was asked, Did you do a safety notification? The SSD stated, I told the hall (charge) nurse. I know now that I need to tell (Administrator) and (DON) and (APN # 1). I learned that yesterday (10/21/15). The SSD was asked, Did he verbalize any plan for suicide? The SSD stated, No he said he was jealous of his roommate and could not understand why his wife did not visit him. The SSD was asked, Did you go back and monitor (Resident # 7) after 8/28/15? The SSD stated Yes but I didn't document it. b. The Departmental Notes dated 8/28/15 at 3:32 p.m. and electronically signed by LPN # 1 contained no documentation to indicate the resident stated he would be better off dead. c. The Care Plan dated 8/2/13, reviewed on 9/1/15, documented, I am at risk for side effects from antidepressant/antianxiety medication use for a history of depression . Approaches: . Observe and record my target behaviors . There was no updated Plan of Care to address the reported thoughts of better dead that occurred nearly every day. d. As of 10/20/15 at 3:19 p.m., there was no documentation in the Departmental Notes dated 8/28/15 through 10/16/15 of the resident ' s mood, monitoring for further statements that the resident would be better off dead or assessment to determine if the resident had thoughts of suicide or a plan for suicide. e. On 10/21/15 at 11:35 a.m., Advanced Practice Nurse (APN) # 1 was asked, Were you told (Resident # 7) had expressed feelings of being better off dead on 8/28/15? APN # 1 stated, I don't think so I would have done an intervention for that. I was asked on 8/31/15 to clarify his ICD 10 (International Statistical Classification of Diseases and Related Health Problems) [DIAGNOSES REDACTED]. I wasn't told anything about expression of better off dead. f. On 10/21/15 at 2:07 p.m., LPN # 1 was asked, Has any resident stated to you they were going to kill themselves? LPN # 1 stated, No, but (Resident # 7) says 'Sometimes I feel like I'd be better off dead'. LPN # 1 was asked, How long ago did he say that? LPN #1 stated, Several months ago. It was only once and I contacted Social and we monitored him for several days and he never said anything after that. LPN # 1 was asked, Where is it documented, the monitoring? LPN #1 stated, It's not. 3. The Immediate Jeopardy was removed and the scope/sev
F 0469 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.**

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F 0469 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 10) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 775) was substantiated (all or in part) in these findings. Based on observation, record review and interview, the facility failed to ensure roach, fly, spider, and gnat pest sightings were reported and treated in order to maintain an effective pest program to prevent possible microbe transport or possible allergic reactions for 92 residents who resided in the facility. The facility also failed to ensure screens were present on sliding glass doors in the dining rooms and resident rooms to reduce the number of pest in the facility. These failed practices had the potential to affect all 92 residents who resided in the facility according to the listing received from the Regional Minimum Data Set (MDS) Consultant on 10/23/15. The findings are: 1. On 10/20/15 at 2:50 p.m., Family Member # 1 reported that roaches were observed in the kitchen and dining room on 10/16/15. Family Member # 1 was asked, When did you see roaches on 10/16/15? Family Member # 1 stated, At lunch with my (Family Member). I didn't tell her because I didn't want to upset her. Family Member # 1 was asked, Where at in the dining room? Family Member #1 stated, By the menu at the serving area. I couldn't tell if it was one or more. I saw it going back and forth under the kitchen door. I couldn't tell if it was more than one going back and forth or not. You know where there is one you usually have an invasion. I showed it to one of the girls serving trays. 2. On 10/21/15 at 8:35 a.m., there was a gap of approximately 2 inches noted between the bottom of the kitchen door and the floor. No roaches were noted. There were 5 dead roaches to the left of the ice machine and wooden box structure next to the dirty window leading into the kitchen. 3. On 10/21/15 at 8:40 a.m., the Certified Dietary Manager (CDM) stated he had worked in the facility since November 2014. The CDM was asked, Any problems with roaches in the kitchen? The CDM took this surveyor to the dish area. The CDM pointed to the partial wall by the dish area. The CDM stated, See how the paneling is not attached to the wall and opened along the ceiling, roaches are all in there. I've been here for months and it was worse then than it is now. Last week we had the bug guy come and 2 weeks before that. It is not working, we still have roaches. The wall board on the divider wall was bowed outward a gap was noted of approximately 1/4 of an inch between the wall board and ceiling in places along the wall behind the dish washer. The CDM was asked, Is there anywhere else you see roaches? The CDM took this surveyor into the dining room. The CDM kicked the loose cove board between the kitchen door and serving window. The CDM stated, Roaches run out from the loose wall covering and cove board and come up to the serving window. The CDM was asked, Any complaints from residents about roaches? The CDM stated, No and the bug guy was here again on 10/19/15. This surveyor looked up and noted a live roach crawling along the ceiling in the dining room. This surveyor pointed to the roach and asked the CDM What's that? The CDM stated A roach. When I see them up there I get them down and kill them. 4. On 10/21/15 at 9:00 a.m., Dietary Staff # 1 was asked, Have you ever seen any roaches in the dining room? Dietary Staff # 1 stated, Yes. Dietary Staff # 1 was asked, When? Dietary Staff # 1 stated, Yesterday after the bug man had come the night before. They were all dead. Dietary Staff # 1 was asked, Where about? Dietary Staff # 1 stated, Over by the dirty window and ice machine, on the floor. Dietary Staff # 1 was asked, Ever see any roaches in the kitchen? Dietary Staff # 1 stated, Yes, mainly in the dish pit area and some on the walls around the steam table and yesterday morning they were all over the floor because they were dead. Dietary Staff # 1 was asked, How long have you seen roaches? Dietary Staff # 1 stated, Pretty bad over the last couple of years. He comes and sprays and fogs and it seems to kill several of them but they are still living in the walls. 5. On 10/21/15 at 9:07 a.m. , Dietary Staff # 2 was asked, Ever seen any roaches in the dining room? Dietary Staff # 2 stated, A few by the door, dirty window, ice machine and serving window. Dietary Staff # 2 was asked, When was the last time you saw them? Dietary Staff # 2 stated, Yesterday. Dietary Staff # 2 was asked, How long have you seen them? Dietary Staff # 2 stated, Months and months. Dietary Staff # 2 was asked, Is it any better after the bug man comes? Dietary Staff # 2 stated, We find them out in the floor and when you got to get them up, they scatter. They were laying there like they were stunned but they were not dead. What he's doing just does not work. Dietary Staff # 2 was asked, Seen any roaches in the kitchen? Dietary Staff # 2 stated, Yes, all over and they sometimes fall from the ceiling. Usually the dish pit is the worse, that's usually where you see them. 6. On 10/21/15 at 9:15 a.m., Dietary Staff # 3 was asked, Ever seen any roaches in the kitchen? Dietary Staff # 3 stated, Yes, around the dish pit. I see more when bug man is here because when he sprays they come out of the walls. Dietary Staff # 3 was asked, Are they dead or alive? Dietary Staff # 3 stated, They are kind of addled, dying. Dietary Staff # 3 was asked, Does it get better after he sprays? Dietary Staff # 3 stated, For a little while, for about 2 weeks then they are right back. 7. On 10/21/15 at 9:20 a.m., the CDM was asked, Do you have any pest sighting logs in the kitchen? The CDM stated No. I just call the pest guy when I see them and he comes right out. 8. On 10/21/15 at 9:25 a.m., the Maintenance Supervisor was asked, Do you have any pest sighting logs in the kitchen? The Maintenance Supervisor stated, No, only at the nursing station in the pest book. The Maintenance Supervisor and this surveyor reviewed the pest book. The Maintenance Supervisor was asked, Have there been any pest sightings documented in the facility since December 2014? The Maintenance Supervisor stated, No, it's mostly just word of mouth. I call him (pest company representative) and he comes out. Because of the age of the building and the condition it's hard to maintain. a. The (Name of Company) Sightings Log documented, Date/Time:12/29/14 at 1:10 p.m. Problem Pest: Roach. Area of Infestation: Nurse's station . Service Date/Time: 1/21/15 at 10:00 a.m. b. The (Company Name) Log Report dated 7/27/15 documented that Basic Pest Control and Fly Service were provided. There was no documentation of the parts of the facility that were treated. c. The (Company Name) Log Report dated 8/25/15 documented that Basic Pest Control and Fly Service were provided. There was no documentation of the parts of the facility that were treated. d. The (Company Name) Log Report dated 9/28/15 documented that Basic Pest Control and Fly Service and Exterior perimeter . spiders services were provided. e. The (Company Name) Log Report dated 9/30/15 documented, . Location and method of Application: Kitchen/aerosol (and) dust. Infestation Treated: Roach . Comments: Treated wall behind dish machine, killed a bunch, will do again in 2 weeks. f. The (Company Name) Log Report dated 10/13/15 documented, . Location and method of Application: Kitchen/aerosol (and) dust. Infestation Treated: Roach . Comments: Treated all walls, dish room window wall on dining side had bunch behind wall board. Will come again in 1 week. g. The (Company Name) Log Report dated 10/19/15 documented, . Location and method of Application: Kitchen/aerosol (and) dust. Infestation Treated: PA (Preventative Application) . Comments: fogged and dusted in walls again. Especially dish room was still infested. Numbers are down so maybe there won't be as many causing you problems. 9. On 10/21/15 at 9:35 a.m., this surveyor, the Maintenance Supervisor, and the CDM observed the dining room area. The Maintenance Supervisor was asked, Has (CDM) told you they see roaches coming from behind this metal wall board by the kitchen door in the dining room? The Maintenance Supervisor stated, No and it's not fastened right so it's loose. The Maintenance Supervisor was asked, How about this closed in wooden box by the ice machine, what's that for? The Maintenance Supervisor stated, It encloses the water pipes to the ice machine but I see what you are saying it would be a nesting area and there's a gap around it. The Maintenance Supervisor took a flashlight and put the end of the flashlight into the gap. The end of the flashlight was approximately the size of a quarter. The Maintenance Supervisor was asked, Did you know that the wall board on the partial divider wall next to the dish area is bowed out and the kitchen staff see roaches coming out from behind the wall board? The Maintenance Supervisor stated, No. I can reattach it and seal it and get the pest guy back out here and get with him about a combined plan to treat the roaches in the nesting areas. 10. On 10/21/15 at 1:50 p.m. Certified Nurse Assistant (CNA) # 1 was asked, Have you seen any roaches in the dining room? CNA # 1 stated, Yes and I've seen the exterminator two times in the last week. CNA # 1 was asked, When was the last time you saw roaches? CNA # 1 stated, Yesterday, it was on the ceiling and Wednesday last week I had a resident on E hall complain to me that he had a dead roach on his tray. CNA # 1 was asked, Who was the resident? CNA # 1 stated, (Resident # 10). We took the tray to his nurse and we took it to the kitchen and after that they notified (name) the Administrator. 11. On 10/21/15 at 2:07 p.m., Licensed Practical Nurse (LPN) # 1 was asked, Have you seen any roaches or other pest in resident rooms? LPN # 1 stated, Yes, a few spiders in the hallways. LPN # 1 was asked, When was the last time? LPN # 1 stated, A couple of weeks ago. LPN # 1 was asked, Did you document it on the sightings log? LPN # 1 stated, No, I told (Maintenance Supervisor) and the pest guy was here that day.

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F 0469 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 11) 12. On 10/21/15 at 2:30 p.m., CNA # 2 was asked, Have you seen any roaches in the dining room? CNA # 2 stated, I saw one by the coffee machine in the dining room just a couple of days ago and I told them and they said someone had just sprayed. CNA # 2 was asked, Them? CNA # 2 stated, The kitchen staff. CNA # 2 was asked, Have you seen any pest in the resident's rooms? CNA # 2 stated, Just a spider crawling down D hall. 13. On 10/21/15 at 2:40 p.m., CNA # 3 was asked, Have you seen any roaches in the dining room? CNA # 3 stated, Yes on the wall in the small dining room, by the ice machine, and the dirty window area. I've seen quite a few. CNA # 3 was asked, When? CNA # 3 stated, One to two weeks ago on the wall in the small dining room and last weekend in the large dining room. CNA # 3 was asked, What did you do? CNA # 3 stated, Told the other CNAs. CNA # 3 was asked, Did you tell anyone else? CNA # 3 stated, No. CNA # 3 was asked, Did you document the sighting? CNA # 3 stated, No, are we supposed to? 14. On 10/21/15 at 2:55 p.m., CNA # 4 was asked, Have you seen any roaches in resident rooms? CNA # 4 stated, Yes in (room number), (Resident # 11's) room, he hoards food and we clean it out. CNA # 4 was asked, Did you tell anyone or document it? CNA # 4 stated, It was Sunday or Monday and I told the nurse. I only saw the one roach. 15. On 10/21/15 at 3:12 p.m., CNA # 5 was asked, Have you seen any roaches in the dining room? CNA # 5 stated, Yes. CNA # 5 was asked, Where about? CNA # 5 stated, A resident told me that one crawled across the table and he killed it and now it was on the floor. I think that's the only one I saw. CNA # 5 was asked, Where was the resident sitting? CNA # 5 stated, In the back of the dining room by D hall (this is 4 tables away from the serving window according to the dining room seating chart provided by the Administrator on 10/21/15). CNA # 5 was asked Which resident? CNA # 5 stated (Resident # 6). CNA # 5 was asked, Did you see the roach? CNA # 5 stated, Yes. CNA # 5 was asked, When was that? CNA # 5 stated, I think it was last Friday (10/16/15). CNA # 5 was asked, Did you tell anyone or document it? CNA # 5 stated, No, they already knew about the roaches. 16. On 10/21/15 at 3:30 p.m., CNA # 6 was asked, Have you seen any roaches in the dining room? CNA # 6 stated, Yes. CNA # 6 was asked, Where at? CNA # 6 stated, I saw one on a resident's shoulder, (Resident # 13) . I brushed it off. He'd asked me to take him to his room. I saw it and I brushed it off and then I stepped on it. CNA # 6 was asked, When? CNA # 6 stated, With in the last week. CNA # 6 was asked, Have you seen any roaches in the resident's rooms? CNA # 6 stated, Yes. CNA # 6 was asked, Where? CNA # 6 stated, E hall (Resident # 14) room (number). CNA # 6 was asked, When? CNA # 6 stated Every night when you turn the lights on, one or so run around. I saw them first in the bathroom. They were so small I thought they were ants but now they are much bigger. CNA # 6 was asked, Have you told anyone? CNA # 6 stated, Yes. CNA # 6 was asked, Who? CNA # 6 stated, The nurse but I can't remember which one. CNA # 6 was asked, Did you document it as a pest sighting? CNA # 6 stated, No, I haven't. 17. On 10/21/15 at 3:50 p.m., CNA # 7 was asked, Have you seen any roaches in the resident rooms? CNA # 7 stated, No but (Resident # 10) told me he saw them in his room and in his food. CNA # 7 was asked When did he tell you that? CNA # 7 stated A week to 1 1/2 weeks ago . He never told me he had them in his room, other people said that. He only told me about them being in his food. 18. On 10/22/15 at 6:35 a.m. CNA # 8 was asked, Have you ever seen any roaches in the resident rooms? CNA # 8 stated, Yes. CNA # 8 was asked, What rooms? CNA # 8 stated (Resident # 14's) and (Resident # 10's) room E hall (room number) in bed with (Resident # 14) and on him, in the room, in drawers, crawling on the floor, and around the sink. On linen barrels in the hall, at the nurses station, and in the break room. CNA # 8 was asked, What did you do? CNA # 8 stated, I told 2 or 3 different nurses. CNA # 8 was asked, Did you know there is a pest sighting log and that you should document this on the pest sighting log? CNA # 8 stated, No. 19. On 10/22/15 at 8:02 a.m., Housekeeper # 1 was asked, Have you seen any roaches in the dining room? Housekeeper # 1 stated, Yes, we do have roaches in the dining room. Housekeeper # 1 was asked, How long have you seen them? Housekeeper # 1 stated, It's on and off within the last 3 months and after the bug man comes we sweep up the dead ones for 2 to 3 days after. It's like the spiders. We have them coming in and that's been within the last month. Housekeeper # 1 was asked, Are the spiders in the dining room? Housekeeper # 1 stated, No, mostly in the hallways. 20. On 10/22/15 at 8:12 a.m., Housekeeper # 2 was asked, Have you seen any roaches in resident rooms? Housekeeper # 2 stated, No but I've seen spiders. Housekeeper # 2 was asked, How long ago? Housekeeper # 2 stated, I usually kill about 2 or 3 a week. Housekeeper # 2 was asked, Are you documenting the pest sightings? Housekeeper # 2 stated, No. Housekeeper # 2 was asked, Are you telling anyone? Housekeeper # 2 stated, No, just my co-workers. 21. On 10/22/15 at 8:30 a.m., Housekeeper # 3 stated she had worked in the facility for 1 1/2 weeks. Housekeeper # 3 was asked, Have you seen any roaches in the dining room? Housekeeper # 3 stated, No, just spiders. We dust for spiders and kill them a lot. I saw some in the little dining room since I've been here. 22. On 10/23/15 at 9:20 a.m., Resident # 6 was asked, Do you eat in the dining room? Resident # 6 stated, Yes for lunch and supper. Resident # 6 was asked, Ever see any roaches in the dining room? Resident # 6 stated, Yes and I killed another one last night. 23. On 10/22/15 at 10:04 a.m., CNA # 9 was asked, Have you seen any roaches in the dining room? CNA # 9 stated, Yes. CNA # 9 was asked, Where about? CNA # 9 stated, Crawling along the serving window in the dining room and the floor along the wall with the serving window. CNA # 9 was asked, How often? CNA # 9 stated, Last time was 1 week ago and it's been going on for months now. CNA # 9 was asked, Have any resident's complained about roaches to you? CNA # 9 stated ,Yes, (Resident # 10). CNA # 9 was asked, Have you seen any roaches or other pest in the resident rooms? CNA # 9 stated, Gnats in resident rooms. (Resident # 16), (Resident # 15). (Resident # 16) hoards food. CNA # 9 was asked, Are they there all the time? CNA # 9 stated, Yes. CNA # 9 was asked, Have you told anyone? CNA # 9 stated, The nurses mainly. 24. On 10/22/15 at 10:28 a.m., CNA # 10 was asked, Have you seen any roaches in the dining room? CNA # 10 stated, Yes. CNA # 10 was asked, Where about? CNA # 10 stated, On a hall cart, in the floor by the serving window to the ice machine. CNA 10 was asked, How long has this been going on? CNA # 10 stated, The last week. CNA # 10 was asked, How many have you seen? CNA # 10 stated, One or two each time 25. On 10/22/15 at 2:05 p.m., Resident # 9 was asked, Do you eat in the dining room? Resident # 9 stated, Yes. Resident # 9 was asked, Have you seen roaches or any other pest in the dining room? Resident # 9 stated, Yes the other day one (roach) ran across the dining room table and I knocked it off onto the floor and I stepped on it. (Per the dining room seating chart received from the Administrator on 10/21/15 at 1:50 p.m., the table designated for Resident # 9 is 4 tables away from the serving window at the back of the dining room, by D hall.) 26. Resident # 3 had a [DIAGNOSES REDACTED]. a. On 10/19/15 at 11:01 a.m., the resident stated she was concerned with flies in her room. The resident's sliding glass door was opened approximately 6 inches. There was no sliding screen on the door. This surveyor counted 6 flies on the resident's bed. The resident stated, I brought some Velcro screens last week and (name), Maintenance is asking (Administrator) if he can put them up so the flies aren't so bad. b. On 10/19/15 at 3:20 p.m., there were two hanging screens attached with Velcro to the top of the outside of the sliding glass door. The screens were approximately 2 feet wide and did not attach to each other or to the door frame on the sides or on the bottom. Flies were still able to enter the resident's room. There were 4 flies in the room and 4 to 5 on the hanging screens. 27. On 10/23/15 at 8:30 a.m., this surveyor and the Maintenance Supervisor toured the outside of the facility. There were no sliding screen doors on any of the resident rooms or the dining room doors. There was one room that had temporary screens attached to the sliding glass door, Resident # 3's room.
F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # , (AR 720), and # (AR 768) were substantiated (all or in part) in these findings. A. Based on record review and interview, the facility Administration and Nursing Administration failed to ensure licensed nursing staff were knowledgeable regarding the criteria for meeting the needs of a resident who had shown a tendency for suicide or verbalized feelings of being better off dead for 1 of 1 (Resident #5) case mix resident who verbalized she was going to kill herself and 1 of 1 (Resident #7) case mix resident who voiced feeling of being better off dead. The failed practices resulted immediate jeopardy which caused or could have caused serious harm, injury or death for Resident #5, who attempted suicide, Resident #7 who verbalized feelings of being better off dead and had the potential to affect 2 residents who voiced an intent to kill themselves since 9/1/15 according to a list provided by the Minimum Data Set (MDS) Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045192	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS OF HARRISON AT TIMS HEALTH AND REHABILIT	202 TIMS AVENUE HARRISON, AR 72601

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

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 12) on 10/23/15 and 8 residents who voiced feeling of being better off dead since 8/1/15 according to a list provided by the Nurse Consultant dated 10/28/15. The facility was notified of the Immediate Jeopardy condition on 10/22/15 at 4:25 p.m. The findings are: 1. The Administrator Job Description and Performance Standards documented: . Authority is delegated to the individual in this position to: Develop, maintain and implement operational policies and procedures to meet residents' needs in compliance with federal, state and local requirements. Determine the personnel requirements of the facility and hire or arrange for sufficient staff to implement the facility policies and procedures. The primary functions and responsibilities of this position are as follows: . 3. Establish systems to enforce the facility policies and procedures . 8. Supervise all department supervisors and administrative staff . 10. Assume responsibility with department supervisors to implement effective policies and assure adequate staffing to meet facility needs . The Director of Nursing Services Job Description and Performance Standards documented: . Authority is delegated to individual in this position to: Assess resident needs and interview, hire and terminate adequate nursing personnel . Supervise and manage all aspects of the nursing department. Assess, direct and supervise resident's care needs . The primary functions and responsibilities of this position are as follows: . 3. Direct, evaluate and supervise all resident care and initiate corrective action as necessary. 4. Assess resident care needs and assist in the development of individualized plans of resident care . Direct and supervise scheduling of employees within established guidelines for allocation of nursing service personnel on duty . 2. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/2/15 documented the resident scored 10 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status;, had no signs or symptoms of [MEDICAL CONDITION]; had no thoughts of better off dead; and scored 2 (1 - 4 indicates minimal depression) on the Patient Health Questionnaire. a. The Care Plan dated 4/3/15 and updated on 9/8/15 documented, I have behaviors . 9/8/15 I have voiced [MEDICAL CONDITION] . Approaches: . 9/8/15 Notify MD/APN (Medical Doctor/Advanced Practice Nurse) of my [MEDICAL CONDITION] . b. The Departmental Notes dated 9/8/15 at 8:42 p.m. and signed by Licensed Practical Nurse (LPN #2) documented, Resident crying and verbally aggressive toward staff. This nurse sat and talked with resident for 20 (minutes) in order to get resident to take her medications that included (Klonopin(used to treat Panic Disorder). Resident stated to this nurse and other staff that she was 'going to hang herself because she could not get out of here'. Resident placed on 1 on 1 monitoring for suicidal ideation, and administrator notified. c. The Departmental Notes dated 9/9/15 at 1:25 p.m. and signed by the Social Services Director (SSD) documented, Earlier on this date, SSD spoke with the resident regarding her statement of wanting to hang herself made on 9/8/15. The resident stated she did say that to staff. SSD interviewed the resident to complete the Geriatric Depression Scale. The resident score was 9. Due to the client's answers and responses, the clients depression only appears to be situational and possibly attention seeking. Administrator and Nurse Practitioner were notified of the scores. Further analysis will take place. On 10/22/15 at 10:55 a.m., the SSD was asked, The 9/9/15 entry in the Departmental Notes, what had happened? The SSD stated, I was told about (LPN # 2's report) and was told to see her and I went to do the Geriatric Depression Scale. The SSD was asked, What did you tell the Nurse Practitioner? The SSD stated, Everything (Resident # 5) was saying - 'I'll do whatever it takes to get out of here, whether it's jump the fence or kill myself'. I did tell (APN # 1) I would feel more comfortable if we referred this over to (name of Behavioral Health). (APN # 1) said yes. The SSD was asked, Did (Name of Behavioral Health) come out? The SSD stated, Yes. I was in the room when she refused. The SSD was asked, Did you tell (APN # 1) that (Resident # 5) had refused admission to behavioral health? The SSD stated, No. d. A SOAP (Subjective, Objective, Assessment and Plan) note dated 9/9/15 and signed by Advanced Practice Nurse (APN) #1 documented, . Chief Complaint: Patient has told staff that she plans to kill herself, I have been asked to see her. I know her very well and I have taken care of her since she first admitted to LTC (Long Term Care). Today she is in her room with her son. She is defiant and irrational. She will not deny a desire to harm herself. She is fixated on 'leaving'. No specific reason. She is delusional - saying (she) has the ability to get on a plane or in a car and move to California, where her son says she lived [AGE] years ago. I can't redirect her. Her mood is labile. Active Diagnoses: [REDACTED]. Mood - her mood has always been labile, she is frequently anxious and gets only periodically, she is confused today which is worse than usual, she is wild and I am not able to redirect her, her son is not, she threatens to harm herself but does not have a plan in mind. Objective: . Mood - she is anxious, she is having delusional thoughts of driving to California, getting a job, she will not contract for safety with me or her son. Plan: Suicidal threat - she is more confused than usual today, more delusional than I am used to seeing her. I thought I would easily get her to contract for safety but I can't. Her son is here - we discussed the spot she has put herself in by telling staff that she would kill herself. Since she will not retract or clarify the statement then I think it's in her best interest to go to an (in-patient) psych unit. The son is in agreement. I spoke to the social worker and to the acting DON (Director of Nursing) and asked them to make the referral. I expect them to come out today. Case (discussed with) Dr. (name of resident's attending physician, who is also the facility's Medical Director) and he agrees with plan. e. The (Name) Behavioral Health Pre-Admission Screening form documented Date: 9/10/15. Time: 7:30 a.m. Responsible Party/Relationship: Self . Presenting Symptoms: . (Suicidal Ideation) . Depressed . Behavior: . Verbally aggressive . Summary: (Patient) has a history of Depression and Anxiety. (Patient) currently has passive death wish but no plan to commit suicide. (Nursing facility) reports suicidal statements . Physician Recommendations (and) Family/Guardian Response: . MSW (Medical Social Worker) recommends admission to (name of behavioral health), Dr. (name) has accepted (patient) . No Admission Indicated due to: (Patient) accepted for admission to (name of behavioral health) however (patient) is refusing to come and has no designee or family that will be surrogate . As of 10/19/15 at 1:35 p.m., there was no departmental note found in the clinical record that documented any family member had been contacted or that the Nurse Practitioner of Physician had been notified of the resident's refusal to be admitted to behavioral health unit on 9/10/14. f. A SOAP note dated 9/11/15 and signed by APN #1 documented, . Chief Complaint: Nurses tell me patient is still here, she is not saying she is going to kill herself but she is distressed, moody, anxious and delusional. She has been combative and refusing basic care. The nurse has asked me to review her meds and see what I can do to help her psychological distress. I did review her meds after taking to 3 nurses about her recent and current behaviors. See chart for order change . 1) A physician order [REDACTED]. 2) The One on One Contact Forms documented resident observations were started on 9/8/15 at 8:30 p.m. and resident observations stopped on 9/10/15 at 6:45 a.m. The CNA assignment sheets dated from 9/8/15 through 9/12/15 were reviewed. There was no staff member who was documented as providing 1 on 1 monitoring during this time. The assignment sheets for 9/12/15 for the 3:00 p.m. to 11:00 p.m. shift were reviewed. CNA #s 5, 11, and 12 were assigned to Resident # 5's hall on 9/12/15 for the 3:00 p.m. to 11:00 p.m. shift. There was no indication that any of these CNAs provided 1 on 1 monitoring of the resident during this time frame. g. The Departmental Notes dated 9/13/15 at 1:46 a.m. documented, This nurse was called to resident's room at 1715 (5:15 p.m. 9/12/15) by CNA (Certified Nurse Assistant). Upon entering the room, this nurse observed resident to be non-responsive with a cloth tied around her neck. This nurse immediately had another nurse call 911. We removed the cloth from around resident's neck and sternal rubbed her for about 4 minutes before getting her eyes to fluttering. Resident also noted to have a pair of scissors which later this nurse found that another resident had given them to her and assisted her in cutting the cloth. Resident came around and was fighting with CNAs to get cloth back to put back around her neck. CNAs kept a tight grip on cloth until EMTs (Emergency Medical Technicians) arrived. Ambulance arrived at 1725 (5:25 p.m.) along with (name of town Police Department) to do formal evaluation and reports. EMTs helped to get resident away from the closet when resident became very combative and cursing them. EMTs and officers asked resident multiple times if she wanted to harm herself and resident stated yes, she wanted to kill herself. EMT asked resident how she planned on doing this and resident stated that she was going to choke herself. EMTs took resident to ER after thorough investigation and report was done with resident. After the resident left the facility, this nurse had all staff on 3:00 p.m. to 11:00 p.m. do a witness statement whether they had contact with resident or not. After talking with some of the CNAs, they reported that this resident had been seen talking with another resident (Resident # 12). This nurse approached resident and asked if this resident had said anything to her about trying to kill herself. Resident stated that she was very emotional talking about wanting to get out

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	045192	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS OF HARRISON AT TIMS HEALTH AND REHABILIT	202 TIMS AVENUE HARRISON, AR 72601

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

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 13) of here. Resident also reported that she was talking about how her kids left her here to die and she would rather be dead. Resident also stated that (Resident # 5) had repeatedly mentioned that her husband had killed himself years ago by shooting himself in the head. When (Resident # 5) asked resident to cut the cloth, resident asked (Resident # 5) 'What are you going to do, hang yourself?' Resident said that (Resident # 5) began to cry even more. Resident did admit to helping (Resident # 5) cut the cloth but she said she had no idea why she wanted this done . Around 8:30 p.m. one of the nurses from (Behavioral health/geri-psych) called reported that resident had been admitted . 1) The (name) EMS (Emergency Medical Services) Patient Encounter form dated 9/12/15 documented, . Date: 9/12/15 . Reason for Transfer or Dispatch Reason: Attempted hanging . Time: 6:00 p.m. (Blood pressure) 163/96, (pulse) 100, (respirations) 20 . Chief Complaint: (Attempted) hanging. Edge of sheet around door knob and around neck, pushing back with legs in wheelchair . staff stated may have been (unresponsive) (prior to arrival) of EMS. Awake (and) alert (and) able to answer questions . 2) The (hospital) Emergency Department Record dated 9/12/15 at 6:04 p.m. documented, . Arrival Date/Time: 9/12/15 6:04 p.m . Stated Complaint: Attempted hanging . Physical Assessment . Glasgow Coma Scale . Eye opening: Spontaneous . Motor: Obeys commands . Verbal: Oriented . Per (Nursing Home), per EMS (Emergency Medical Services) (patient) tied cord of sheet around door knob, around neck and initially was pale and unresponsive. On arrival of EMS (patient) awake and alert, (patient) stated 'I want out of there', referring to (nursing home) . Patient Discharge or Departure: discharge date : 9/12/15. Discharge time: 8:22 p.m. Discharge order: Transfer to psych . 9/12/15 6:04 p.m. 5:57 p.m. actual arrival of (patient) . with alleged hanging from sheet at (nursing home) Per (nursing home) on their arrival (patient) was pale and unresponsive but on arrival of EMS, (patient) alert and awake. No visible signs of strangulation noted. No redness or marks visible. (Respirations) even and unlabored. (Patient) admits of intentionally attempted to hang self due to fact that she does not like the (nursing home) and does not want to reside there . 3) The Diagnostic Imaging Report documented . Visit Date: 9/12/15 . Exam: Cervical spine . Order (diagnosis): tried to hang self . Impression: . without evidence of hangman's fracture . h. The Resident Incident Report dated 9/12/15 at 5:15 p.m. documented, . Associate Involved: (CNA # 4) . This nurse was called to resident's room . Narrative of Investigation: . Upon investigation it was determined resident had attempted to hang herself utilizing cut up sheets where she place around her neck and tied to her closet door knob, where she then propped her lower extremities off the floor. Staff was previously in room [ROOM NUMBER] - 10 minutes before setting up dinner tray where resident got up from bed to eat dinner without any difficulties or irrational statements leading up to incident. Staff found resident unresponsive, called 911 immediately and removed sheets to arouse after noting she was not responding. Stayed with resident until EMS arrived. Resident had days before been assessed by a house visit from the Behavioral Health unit . Resident was a candidate for inpatient care due to previous behaviors and statements, but refused to go to receive treatment. Currently admitted to Behavioral unit. 6. New Intervention: In-service staff on [MEDICAL CONDITION] pending in-service from behavioral health representative with nurses on suicidal threats and interventions . On 10/21/15 at 2:55 p.m., CNA # 4 was asked, Have you ever worked with (Resident # 5)? CNA # 4 stated, Yes, that day she hung herself (9/12/15). I'm the one who found her that night. She was okay when she got her dinner and I was on call lights and found her. CNA #4 was asked, About what time was that? CNA # 4 stated, About 5:15 p.m. to 5:30 p.m., I walked past her room and I saw her in the corner by her dresser. She was between the closet door and her dresser. She had one end of the sheet tied around the closet door handle and the other end wrapped around her neck a couple of times. She had her feet pushing against the door and she was leaning back in the wheelchair with her head back and she was holding onto the sheet around her neck. CNA #4 was asked, She had a grip on the sheet when you found her? CNA # 4 stated, Yes and she didn't want to let it go. CNA #4 was asked, She had her legs straight and was pushing back from the door when you found her? CNA # 4 stated, Yes. CNA #4 was asked, Was she responsive? CNA #4 stated, No, it took 4 to 5 minutes for her to answer us. CNA #4 was asked, Was she still breathing and still had a pulse? CNA #4 stated, Yes. CNA #4 was asked, The only thing she wasn't doing was responding? CNA #4 stated, Yes and then she opened her eyes and said 'Leave me alone, I'm dying'. i. The Verification of Investigation form signed by the Administrator documented, . Date/Time of Occurrence: 9/12/15 7:00 p.m. Provided detailed description of event/allegation: Resident found hanging from a cut bed sheet on closet. Assessment of Resident/Describe Injury: Resident was found unresponsive with cut cloth around her neck. Causal/Contributing Factor and Observations: Resident asked another resident to cut the bed sheet and had expressed the desire to harm herself to the resident. Resident had been upset that her family had not been visiting as often as she thought they should have. She does not like living in Arkansas and wishes she had never came. Specific Recommendations/Interventions Taken to Prevent Reoccurrence: One on one with resident on alerting staff if a resident makes statements of self-harm. Offer the resident the opportunity to locate another facility if she chooses. Was Abuse/Neglect Substantiated? No. Provide Summary of Investigative Findings: Resident had been assessed by (name) Behavioral health on the 9th for placement for increased symptoms of depression. Placement was offered to resident but resident denied wanting placement. On 9/12/15, resident requested another resident cut a bed sheet for her and expressed an idea of wanting to die. Resident did not alert staff to (Resident # 5's) statement. Resident was found at 7:00 p.m. with material around her throat. Staff removed her from immediate harm and she remained one on one until EMS took over care for the resident. She was then taken to (hospital name) under a suicide hold. j. On 10/21/15 at 10:00 a.m., APN # 1 was asked, Was (Resident # 5) treated by you? APN stated, Yes. APN # 1 presented progress noted dated 9/9/15 and 9/11/15. APN # 1 was asked, Did you recommend that the resident was safe to stop the 1 to 1 monitoring? APN # 1 stated, No one asked me that. When I was there on 9/9/15 her family was there but no staff was present. She kept repeating she was going to kill herself and I recommended a psych referral. I told (Acting DON) and (SSD) that she needed an in-patient psych referral and someone did come out and they saw her. I did not know she was still in the building on Friday (9/11/15) until a nurse casually asked me to review her meds. I reviewed her meds and I didn't ask about the psych referral on Friday. APN # 1 was asked, Did you know the resident was not one on one on Friday, 9/11/15? APN # 1 stated, You are they first person to even ask me about one on one monitoring. No I was only asked to look at her meds. I was told she would not consent to the psych admit but I'm not sure if she (LPN # 4) said that on Friday (9/11/15) or Monday (9/14/15) after all that happened. The son had already consented and the resident was delusional so I don't know why she wasn't sent to the psych unit. On Monday (9/14/15) I was told by the nurses she had asked for scissors all day Saturday (9/12/15) and even got a resident to cut her sheets. She carried out a plan to commit suicide over the course of a day and that's very high level functioning. k. The Quality Assessment and Assurance Committee form dated 9/29/15, received from the Administrator on 10/22/15 at 3:00 p.m., documented, Topic: Note: Resident attempted suicide. Process Owner: All Departments. Summary of Analysis should include trends and root cause analysis: Improve documentation using the behavior monitoring sheets contained in MARs (Medication Administration Records). Review medical record for indications missed to show staff how to identify possible harm to resident before (it) gets to that point. Speak with (name) Behavioral (Health) on inservice to be conducted to include a better understanding of warning signs of suicidal thoughts in the elderly. Inservice with staff on more effective documentation in respect to resident behaviors and changes in condition. l. CNA interviews were conducted regarding one to one monitoring of Resident #5 from 9/8/15 - 9/12/15: 1) On 10/21/15 at 3:30 p.m., CNA # 6 was asked, Has any resident stated to you they were going to kill themselves? CNA # 6 stated Yes, just one. CNA #6 was asked, Who? CNA # 6 stated, (Resident # 5). We were at the nurses station and she said she wanted to go to California with her brother or son and then she said I'll just kill myself. CNA # 6 was asked, What happened after that? CNA #6 stated, We had to go in there every 15 minutes and check on her. CNA # 6 was asked Were you doing 1 to 1 or every 15 minute checks? CNA #6 stated, Every 15 minute checks, not 1 to 1. CNA # 6 was asked, What day was that? CNA #6 reviewed the One on One Contact Forms for 9/8/15 through 9/10/15. CNA #6 stated, I don't recall when she said that but I did every 15 minute checks on 9/9/15 at 3:45 p.m., 4:00 p.m., 4:30 p.m., 4:45 p.m., 5:00 p.m. and 9:15 p.m. 2) On 10/21/15 at 3:50 p.m., CNA #7 was asked, Has any resident stated to you they were going to kill themselves? CNA #7 stated Yes. CNA #7 was asked, Who? CNA #7 stated, (Resident # 5). CNA # 7 was asked, When? CNA #7 stated, About 2 weeks before she tried to hang herself. CNA #7 was asked, What did she say? CNA # 7 stated, That she was tired of being here so she was just going to kill herself. CNA #7 was asked, What did you do? CNA #7 stated, I told the nurse, she said it numerous times. I know (LPN # 2) is usually the nurse. CNA #7 was asked, What did the nurse do? CNA # 7 stated, Started every 15 minute checks . CNA #7 was asked to review the One on One Contact Forms from 9/8/15 to 9/10/15. CNA #7 was asked, Can you put a check mark by when you did checks? CNA # 7 put 5 check marks on 9/8/15 at 9:30 p.m., 9:45 p.m., 10:30 p.m., 10:45 p.m. and 11:00 p.m. CNA #7 stated, It was me and (CNA # 13) who went and told (LPN # 2) about it, then she stopped

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045192	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHLANDS OF HARRISON AT TIMS HEALTH AND REHABILIT	202 TIMS AVENUE HARRISON, AR 72601

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 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) saying it. 3) On 10/22/15 at 6:43 a.m., CNA # 13 was asked, Has any resident stated to you they were going to kill themselves? CNA #13 stated, Yes, (Resident # 5). CNA #13 was asked, How often did she say that? CNA #13 stated, Once and I reported it to my nurse. CNA #13 was asked, Which nurse? CNA #13 stated, (LPN # 2). CNA #13 was asked, What did (LPN # 2) have you do? CNA #13 stated, We started on 1 to 1 and when she went to bed we did every 15 minute checks. I made sure her door was open and curtains pulled back so I could see her. CNA #13 was asked, Was that on 9/8/15? CNA # 13 reviewed the on One Contact Forms from 9/8/15 to 9/10/15. CNA # 13 stated, Yes, (initials) on here is me. CNA #13 initials were documented on 9/8/15 at 9:00 p.m., 9:15 p.m., 10:00 p.m. and 10:15 p.m. m. On 10/22/15 at 10:35 a.m. LPN # 4 stated she had been the Acting Assistant Director of Nurses (ADON) since August 2015. LPN # 4 was asked What do you know about (Resident # 5's) threats to kill herself? LPN # 4 stated I knew she had threatened to kill herself. LPN # 4 was asked What did the facility do to protect the resident? LPN # 4 stated Put resident 1 to 1 and I know (SSD) talked with her and I know someone from the hospital came in to talk with her. LPN # 4 was asked, When did the 1 to 1 end? LPN # 4 stated, I don't know when or why it was stopped. The Acting DON, (SSD) and Administrator were dealing with that. LPN # 4 was asked, When did you tell (APN # 1) that (Resident # 5) would not go to in-patient psych? LPN # 4 stated, That was after she'd tried to hang herself. n. On 10/22/15 at 12:27 p.m., the Administrator was asked, Did you know about the 9/8/15 happening documented by (LPN # 2) when (Resident # 5) threatened to hang herself? The Administrator stated, No. He told me she was crying and upset but not that she wanted to hang herself. The Administrator was asked, What was staff doing, monitoring (Resident # 5) 1 to 1 or every 15 minute checks? The Administrator stated I thought it was 1 to 1. This surveyor informed the Administrator that the 3:00 p.m. to 11:00 p.m. staff had stated they were doing every 15 minutes checks. The Administrator was asked, Is every 15 minute checks okay for a resident threatening to hang herself? The Administrator stated, No. The Administrator was asked, On 9/9/15 what did you know about this situation? The Administrator stated, That was when I told (SSD) she needed to talk with (APN # 1) about behavioral health and possible admit to geri-psych. The Administrator was asked, Geri-psych came on 9/10/15? The Administrator stated, Yes. The Administrator was asked, Did you know they recommended in-patient admission? The Administrator stated, Yes and that she had refused placement. The Administrator was asked, Why was the monitoring of (Resident # 5) stopped? The Administrator stated, Because she refused to go and the nurses did not see the geri-psych notes. The Administrator was asked, Who made the decision to stop the monitoring? Were you involved? The Administrator stated, No, I was not. The Administrator was asked, Who made the decision? The Administrator stated, I don't know. The Administrator was asked, Did anyone call you before they stopped it? The Administrator stated No. The Administrator was asked, Were you in the building on 9/10/15 and 9/11/15? The Administrator stated, Yes. The Administrator was asked, Who was in charge of nursing? The Administrator stated, (Acting DON # 1). The Administrator was asked, Were you informed on 9/12/15 when the resident attempted to hang herself? The Administrator stated, Yes. The Administrator was asked, What's been done since this to prevent re-occurrence? The Administrator stated, We did an in-service on reporting increased symptoms of depression. We started a behavior monitoring sheet. We started that this month and who the nurse needed to report increased behaviors to. The Administrator was asked, Why do in-services on reporting increased behaviors when they did that? There was no response from the Administrator. This surveyor requested copies of the in-services. 1) On 10/22/15 at 1:55 p.m., Acting DON # 1 stated she was the DON from August through 10/14/15. Acting DON # 1 was asked, Did (Resident # 5) threaten to kill herself? Acting DON # 1 stated, Yes. Acting DON #1 was asked, What were you doing to monitor the resident for suicide attempts? Acting DON # 1 stated, It was supposed to be 1 to 1 monitoring but maybe the CNAs got confused and only did every 15 minute checks. Acting DON # 1 was asked, Who made the decision to stop the 1 to 1 or every 15 minute monitoring? Acting DON # 1 stated, I don't know. Acting DON # 1 was asked, Were you working 9/10/15 and 9/11/15? Acting DON # 1 stated, Yes. Acting DON # 1 was asked, Did anyone ask you if they could stop monitoring (Resident # 5)? Acting DON # 1 stated, No. Acting DON #1 was asked, Did you know the monitoring was stopped with (Resident # 5) prior to psych seeing the resident? Acting DON # 1 stated, No. Acting DON # 1 was asked, Who did the CNA assignments? Acting DON # 1 stated, The charge nurses or (LPN # 5). 2) On 10/22/15 at 2:20 p.m., LPN #5 was asked, Do you complete the 7:00 a.m. to 3:00 p.m. assignment sheets? LPN # 5 stated, If I have time, sometimes the nurses do it. There is no one assigned to fill it out. LPN # 5 was asked, Did you know about (Resident # 5) threatening to hang herself on 9/8/15? LPN #5 stated, Yes. I was working that night on C and D halls and (LPN # 2) told me what happened and I told him he better call (Administrator) and see what to do. I filled out the 9/10/15 3:00 p.m. to 11:00 p.m. assignment sheet and I didn't know she was 1 to 1 and I didn't make her 1 to 1 on the 11th and I did the 9/12/15 assignments and I didn't assign 1 to 1. When the resident refused to go to psych I was under the impression it was over and I was never told she was 1 to 1. If she had been 1 to 1 there would be 1:1 with a CNAs name. I know in stand up (Administrator) said the psych person came and she refused to go and made her own decision so we are covered. There was nothing said about 1 to 1. That was on 9/11/15. LPN # 5 was asked to review the One on One Contact Forms and the assignment sheets from 9/8/15 through 9/12/15 for indications of 1 to 1 monitoring. LPN # 5 stated, There was no one assigned to do 1 to 1 from 9/8/15 through 9/12/15 and her monitoring stopped on 9/10/15 at 6:45 a.m. o. On 10/23/15 at 5:15 p.m. the Administrator was asked, Who should have ensured the monitoring was 1 to 1 for (Resident # 5) and that it was in place and stayed in place? The Administrator stated, The DON at that time and I should have made sure she was doing that. The Administrator was asked, Do you have any documented in-services that were done since (Resident # 5) attempted to hang herself on notification or suicidal ideation, (et cetera) prior to 10/22/15?' The Administrator stated, No. 3. Resident # 7 had [DIAGNOSES REDACTED]. The Departmental Note dated 8/5/15 at 9:24 a.m. documented, New order received per (Advanced Practice Nurse (APN) # 1) to decrease [MEDICATION NAME] (anti-depressant) to 5 (milligrams) (per mouth) at bedtime . The Quarterly MDS with an ARD of 8/28/15 documented the resident scored 14 (13 - 15 indicates cognitively intact) on the Brief Interview for Mental Status, had thoughts of better off dead on 12 - 14 days (nearly every day), had a safety notification completed, and scored 12 (10 - 14 indicates moderate depression) on a Patient Health Questionnaire . The Signature of Person Completing the Assessment documented the Social Service Director (SSD) completed Section D Mood of the MDS on 8/28/15. a. On 10/22/15 at 10:55 a.m., the SSD was asked, For the MDS done 8/28/15, you completed the Mood Section? The SSD stated, Yes. The SSD was asked, Did the resident state he was having thoughts of being better off dead and he said this occurred almost daily? The SSD stated, Yes. The SSD was asked, Did you do a safety notification? The SSD stated, I told the hall (charge) nurse. I know now that I need to tell (Administrator) and (DON) and (APN # 1). I learned that yesterday (10/21/15). The SSD was asked, Did he verbalize any plan for suicide? The SSD stated, No he said he was jealous of his roommate and could not understand why his wife did not visit him. The SSD was asked, Did you go back and monitor (Resident # 7) after 8/28/15? The SSD stated Yes but I didn't document it. b. The Departmental Notes dated 8/28/15 at 3:32 p.m. and electronically signed by LPN # 1 contained no documentation to indicate the resident stated he would be better off dead. c. The Care Plan dated 8/2/13, reviewed on 9/1/15, documented, I am at risk for side effects from antidepressant/antianxiety medication use for a history of depression . Approaches: . Observe and record my target behaviors . There was no updated Plan of Care to address the reported thoughts of better dead that occurred nearly every day. d. As of 10/20/15 at 3:19 p.m., there was no documentation in the Departmental Notes dated 8/28/15 through 10/16/15 of the resident ' s mood, monitoring for further statements that the resident would be better off dead or assessment to determine if the resident had thoughts of suicide or a plan for suicide. e. On 10/21/15 at 11:35 a.m., Advanced Practice Nurse (APN) # 1 was asked, Were you told (Resident # 7) had expressed feelings of being better off dead on 8/28/15? APN # 1 stated, I don't think so I would have done an intervention for that. I was asked on 8/31/15 to clarify