STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045308	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE LIVING CENTER	**1175 MORNINGSIDE DRIVE CONWAY, AR 72034**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 463) was substantiated, all or in part, with a deficiency cited with these findings: Based on record review and interview, the facility failed to ensure their Abuse Investigation Protocol was followed by not submitting to the State agency, in the required time frame, an incident of alleged physical abuse from one resident to another resident which resulted in one resident receiving a major injury for 1 (Resident #2) of 1 sampled resident who received a major injury after allegedly being pushed by another resident. The failed practice had the potential to affect 129 residents, as documented on the Resident Census and Condition of Residents dated 4/6/2020. The findings are: Resident #2 had [DIAGNOSES REDACTED]. An Admission Minimum Data Set with an Assessment Reference Date of 04/05/20 documented the resident scored 3 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS), had no behavioral symptoms or wandering in the 7 day look back period, and required two-plus person extensive assistance for mobility, transfer, walking in room and in corridor and one person extensive assistance for locomotion on and off unit. 1. A Care Plan, last revised on 04/08/20, documented, . The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) Dementia And Recent Right [MEDICAL CONDITION] . The resident has limited physical mobility r/t Dementia And Recent Right [MEDICAL CONDITION] . The resident is an elopement risk / (and or) wanderer r/t Dementia . The resident has a [MEDICAL CONDITION] r/t fall after an altercation with another resident . 2. Resident #2's Progress Notes documented the following: a. Effective Date: 3/25/2020 13:39 (1:39 pm) . New admit has been ambulating up and down the halls . Able to redirect with ease when needed . b. Effective Date: 3/26/2020 13:36 (1:36 pm) . New Admit has been ambulating up and down the halls . Able to redirect with ease when needed . c. Effective Date: 3/27/2020 10:52 (10:52 am) . New Admit has been ambulating up and down the halls . Able to redirect with ease when needed . d. Effective Date: 3/29/20 at 08:55 (8:55 am) . During rounds floor nurse asked if the incident (physical aggression one being receiver (Resident #2) and one being aggressor) between residents needed to be reported and if the cops needed to be called. This nurse contacted the Administrator explained the situation regarding resident to resident contact. Asked if this needed to be reported. This nurse was informed that it was not reportable, to follow protocol. This nurse verbalized to floor nurse to complete I&A (Incident and Accident), notify doctor and treat it as we would normally. e. Effective Date: 3/29/2020 08:59 (8:59 am) . I & A Note . Incident Description: CNA (Certified Nursing Assistant) reported to this nurse two residents were in the floor. Upon entry into room both residents were found on the floor. The resident that occupies this room stated (Resident #1) was in her restroom and was exiting the restroom when (Resident #2) came into room. She stated, She felt in danger and pushed this resident to the floor. Immediate Intervention: Resident was assessed for injury right hip pain noted during transfers and movement. Resident has knot on forehead and back of head noted. No bleeding noted. Resident was assisted to another room to separate residents. She c/o (complained of) pain and asked to go to ER (emergency room) for evaluation. Responsible party called family requested resident be sent to ER for evaluation. Resident was then sent to ER for evaluation. In-service provided to CNA's to keep eye on resident's whereabouts that initiated aggression to prevent further confrontation . f. Effective Date: 3/29/2020 14:19 (2:19 pm) Type: *Physician Communication . Conversation: (Licensed Practical Nurse (LPN) #1) Sent: 03/29/2020 8:54 AM, I&A completed resident was pushed by another resident after exiting other resident's restroom. She fell and is c/o right hip pain has knot on head from fall. Do you want me to send this resident out for evaluation to hospital or order x-ray? . (LPN #1) Sent: 03/29/2020 2:19 PM FYI (For Your Information) (Hospital) admitted resident for fracture to right femur and possible GI (Gastro-Intestinal) bleed . 3. An Imaging Services report dated 03/29/20 documented, . PROCEDURE: Single Lateral View Right Hip Date: 3/29/2020 HISTORY: Fall, pain . IMPRESSION: Displaced Impacted right femoral fracture . 4. An Incident & Accident Next Day Reporting Form, dated as submitted 03/31/2020, documented, . Date & time of Discovery: 03/30/2020 1030 (10:30 am) . Date of I & A: 03/29/2020 Time: 1:30 . (x) PM . Status of Alleged Perpetrator: . (x) Other . Type of Incident: . Abuse: . Physical (x) . SUMMARY OF INCIDENT . On 3/29/20 CNA (CNA #1) found residents (Resident #2 and #1) in the floor of (Resident #1)'s room. When staff asked (Resident #1) what happened she stated that the lady came in her room and was in her bathroom and I pushed her, and she fell . (Resident #2) was sent to (hospital) ER for evaluation. Upon notification of injury of right femur fracture due to resident to resident incident (Resident #1) was interviewed by Assistant Administrator . 5. An Operative Report, dated 03/31/20, documented . PREOPERATIVE [DIAGNOSES REDACTED]. The patient was identified in preoperative holding, was then again identified in the operative suite. . The procedure was then begun . The final implant was opened and impacted into place . The patient was woken and transferred to PACU (Post Anesthesia Care Unit) in stable condition . 6. On 4/10/20 at 9:58 am, CNA #2 was asked, Are you familiar with the care of (Resident #2)? She stated, A little bit. She was asked, Did this resident have any falls, altercations, / (and or) accidents that you were aware of in the past 3 months? She stated, No ma'am. She was asked, Have you had any training on how to care for residents with Dementia or Aggressive Behaviors? She stated, Yes. She was asked, When? She stated, I do not remember. She was asked, What do you do if a resident is aggressive with another resident? She stated, I would separate them immediately to protect them both and I would let the nurse know. She was asked, When do you report this? She stated, Immediately. She was asked, Name 3 types of abuse? She stated, Verbal, sexual and physical. She was asked, If you suspect a resident has been abused in any way, for example physical abuse, what would you do? She stated, I would immediately let my DON (Director of Nursing) or Administrator or my nurse know. She was asked, For the resident's safety, what would you do? She stated, I would stay with the resident. 7. On 4/10/20 at 12:06 PM, Licensed Practical Nurse (LPN) #1 was asked, . Were you aware of the incident between (Resident #1 and #2)? She stated, Yes ma'am. A CNA came and reported to me that both residents were in the floor and upon entering the room both residents were found on the floor. The resident that occupied the room, which was (Resident #1), stated that (Resident #2) was in her restroom and was exiting the restroom whenever she came in the room and she felt like she was in danger and pushed the resident to the floor. None of this was witnessed. That's just what (Resident #1) said when I asked her what happened. (Resident #2) could not tell me what happened. She was asked, Did (Resident #2) sustain an injury? She stated, Yes ma'am. She was asked, I read in the notes that she had a knot on her forehead and the back of head. Did she have a knot on the back of her head as well? She stated, Yes, she had a knot on the front and back of her head. She was asked, When did the hospital notify the facility of (Resident #2)'s injury? She stated, I called them to get an update on her and they told me they were admitting her due to the right femur fracture and her hemoglobin being low and she needed a blood transfusion. They said it was a possible GI (Gastrointestinal) bleed but they weren't sure. She was asked, When you were told about the fracture, did you report this to anyone? She stated, Yes. I reported it to (DON) and I also reported it to my supervisor, who was (Registered Nurse #1), the weekend RN Supervisor. She was asked, So, this happened on the weekend? She stated, Yes. I'm not sure if it was a Saturday or a Sunday. She was asked, Have you had any training on how to care for residents with Dementia or Aggressive Behaviors and If so, when? She stated,

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) During our in-service about Dementia patients, Hand in Hand. She was asked, What do you do if a resident is aggressive with another resident? She stated, You separate them and protect and monitor them. She was asked, Who do you report this too and when? She stated, Your supervisor and DON and Administrator and immediately, as soon as possible. 8. On 4/10/20 at 1:33 pm, the Administrator was asked if CNA #1 and RN #1 were available and at this time she stated CNA #1 worked PRN (as needed) and was not currently at work and RN #1 was not working at this time due to she works full time at a hospital. The Administrator was asked, Tell me when and what was reported to you regarding the incident with (Resident #1 and #2)? She stated, We did do a reportable on her. I know on 3/29/20 is when both residents were found to be in the floor, it was un-witnessed by staff, and their BIMS are a 4 and the other one is lower than a 4 so we knew that we did have two falls. I did not know the origin of those. Later, I did hear that she was positive for a fracture, that Monday (30th). It appeared that I had two residents that had a fall, one with an injury and one did not. We decided the intervention would be a room change. We had (Resident #2) at one point say that she pushed her, so we still didn't know what was going on. I just took the extra step in doing the reportable. We have never had that before, so we took the separate step to report and monitored it and in serviced staff. We also had (Doctor's Name) evaluate (Resident #2) and we did a UA (urinalysis) on her because it was physical aggression and because we had not witnessed that of her. She was asked, What is the time frame that you should have done a reportable? She stated, Had I known that it was an injury, immediately. She was asked, So, you were not told that (Resident #1) stated that she pushed (Resident #2)? She stated, I was told that. I was told the two sides of the story. She was asked, Were you notified of (Resident #2)'s injury the same day that she sustained a fracture? She stated, No. I was not notified until the next morning (30th). She was asked, Has your staff had any training on how to care for residents with Dementia or Aggressive Behaviors? If so, when? She stated, I don't have the in-service book in front of me, but we have been doing that Hand in Hand series. We also do like a fair, where we do all annual in-services during that time. We have (Name) Hospice do that in-service for our staff. All of that Dementia training, re-directing and things to offer if a resident is combative or refusal of care. She was asked, Has the facility provided in-services on Abuse to the staff? If so, when and to whom? She stated, It's a part of our orientation. They start off by watching the videos, and they take a test on it. We print off the form the 8 types of abuse to the size of their name tags that has the 8 types of abuse, and it's placed on the back of their badges. We have yearly in-services. Anytime there is a reportable, we do an in-service on abuse and neglect at that time. 9. An Abuse Investigation Protocol Policy Statement, provided by the Administrator on 4/7/20, documented, All reports of resident abuse, neglect, injuries of an unknown source, resident-to-resident abuse and resident-to-staff abuse are promptly and thoroughly investigated by facility management . Policy Interpretation and Implementation 1. Should an incident or suspected incident or resident abuse, neglect, injury of an unknown source, resident-to-resident abuse and / or resident-to-staff abuse be reported, the administrator, or his / her designee, will appoint an individual to investigate the incident . 11. The facility will ensure that all allegations of abuse, neglect, exploitation, mistreatment, including injuries of unknown origin and misappropriation or suspicion of a crime against a resident are reported immediately; the administrator or designee will make an initial report to the local police department as applicable and to the state licensing agency not more than 2 hours after the allegation is made if the events that caused the allegation involve abuse or result in serious bodily injury . Reporting Abuse Policy Statement . Policy Interpretation and Implementation . 6. To assist one in recognizing incidents of abuse, the following definitions of abuse are provided: . d. Physical abuse is defined as hitting, slapping, pinching, kicking, etc. (etcetera). It also includes controlling behavior through corporal punishment .