STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045199	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HEARTLAND REHABILITATION AND CARE CENTER	**19701 INTERSTATE 30 BENTON, AR 72015**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Complaint (AR 382) was substantiated, all or in part, with these findings: Based on record review and interviews, the facility failed to ensure staff did not yelling at another staff member in front of a resident to maintain respectfulness for 1 (Resident (R) #2) of 1 sampled resident. This failed practice had the potential to affect 1 (Resident #2) resident. The findings are: 1. Resident #2 had an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/02/2020 documented the resident scored 9 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); a. On 4/13/2020 at 9:36 a.m., via (by way of) telephone, R #2 was asked, Can you tell me about the staff yelling, cursing, and being rude? R #2 stated, Everything happened on the weekend. We were on the Rehab (Rehabilitation) part of the building, and it was time for our smoke break. b. On 4/14/2020 at 2:51 p.m., Certified Nursing Assistant (CNA) #1 was telephoned by this Surveyor and was asked, Has a nurse or other staff ever yelled at you for asking to bring 4 x (by) 4 (dressing) to change a residents dressing? CNA #1 stated, Yes. I think it was Licensed Practical Nurse (LPN) #1. I was trying to get a dressing for the resident I think the nurse was overwhelmed. She was mainly yelling at me. I think R 2 was upset for hearing and seeing this. But it was in front of the resident it made her mad more than anything. CNA #1 was asked, Was it reported to anyone? CNA #2 stated, I don't know. I know about abuse and reporting but it wasn't directed toward the resident. c. On 4/15/2020 at 9:58 a.m., the Director of Nursing (DON) was asked, Should staff be yelling at other staff in front of the residents? She stated, No. They should not. She was asked, If a resident becomes upset after hearing and witnessing staff yelling at another staff member, should that be reported? She stated, It would depend on the tone of voice, were they loud. It should be reported if it's an all-out brawl. I don't want anyone yelling at someone with a resident present. I would have liked for the staff to have reported this. It would be inappropriate. I think it would fall under resident dignity. It could make feel that it was directed at them. I wish they had reported it at the time. d. On 4/9/2020 at 9:00 a.m., the Administrator was asked should staff be yelling at other staff in front of the residents? He stated, No. He was asked, If a resident becomes upset after hearing and witnessing staff yelling at another staff member, should that be reported? He stated, Yes. Anytime a resident is upset, it should be reported. e. On 7/22/2020 at 10:18 a.m., a review of the schedules for April 2020, May 2020, June 2020, and July 2020 did not identify LPN #1 on the schedule. f. On 7/22/2020 at 11:10 a.m., the DON was asked, What happened to LPN #1, her name isn't on the schedules? She stated, She quit. March 18, 2020 was her last shift. This Surveyor asked for LPN #1's time sheet. g. On 7/22/2020 at 11:13 a.m., the Administrator provided a time sheet dated 3/5/2020 - 3/18/2020 which identified LPN worked from 3:00 p.m. to 11:05 p.m. on 3/11/2020, 3/12/2020, 3/13/2020, and 3/18/2020. h. On 7/22/2020 at 11:14 a.m., the Administrator was asked, When were you made aware of the complaint? He stated, When the first surveyor called. He was asked, Did you report it to the Office of Long Term Care? He stated, We didn't report it. The resident had left, and the employee was no longer here. And it was employee to employee.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure a mechanical lift transfer was performed according to the manufacturer's guidelines to prevent potential injury and the wheelchair locks were operational for 1 (Resident #1) of 1 sampled resident who required a mechanical lift transfer and used a wheelchair. This failed practice had the potential to affect 19 residents who are transferred with the mechanical lift and used a wheelchair, based on the list provided by the Director of Nurses (DON) on 7/23/2020. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/15/2020 documented the resident scored 0 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS); and required extensive assistance of two persons for transfers. a. The Care Plan dated 3/19/2020 documented a problem as (Resident #1) has an ADL (activities of daily living) self-care performance deficit r/t (related to) cognitive impairment and debility. A goal documented resident will be clean and well-groomed daily throughout review interventions documented transfers: Resident requires 2 person assist with transfers using a sling lift. 5-1-20 Do not use lift pad that criss crosses through thighs. Date Initiated: 03/06/2020 Revision on: 05/04/2020. b. On 7/22/2020 at 10:20 a.m., Certified Nursing Assistant (CNA) #2 and CNA #3 used the mechanical lift to transfer R #1 from the bed to the wheelchair for a bath. The legs of the lift were not opened. They were moved under the bed. The lift pad was secured, and the lift was initiated. The lift was backed out and turned 90 degrees at 10:26 a.m. CNA #2 stated to CNA #1 Let me get behind the wheelchair the locks don't work. CNA #3 opened the lift legs and pushed the lift over the wheelchair with CNA #2 guiding the resident in the lift pad and securing the wheelchair. R #1 was lowered into the wheelchair without incident and the lift was removed. CNA #2 was asked how long the wheelchair locks haven't worked? CNA #2 stated, As long as I've been here. CNA #2 was asked, How long have you been here? CNA #2 stated, Since March (2020). CNA #2 was asked, Have you to told anyone? CNA #2 stated, Yes. The maintenance man quite a few times. CNA #3 was asked, How long have you worked here? CNA #3 stated, This is my second day. c. On 7/22/2020 at 10:41a.m., the Maintenance man was asked, Has anyone reported a wheelchair that's breaks won't lock? He stated, Weekly. He was asked, Has anyone reported (R #1) wheelchair? He stated, No ma'am. No one reported it. d. On 7/22/2020 at 10:55 a.m., a review of the Mechanical Lift User Manual documented, transferring to a wheelchair Ensure the legs of the lift with patient in the sling are in the open position. Press the legs open button until in maximum open position. Move the wheelchair into position. Engage the rear wheel locks of the wheelchair to prevent movement of the chair. Warning DO NOT place the patient in the wheelchair if the locks are not engaged. The wheelchair wheel locks MUST be in a locked potion before lowering the patient into the wheelchair for transport. Otherwise, injury may result. e. On 7/22/2020 at 1:06 p.m., the Administrator was asked, What is the process for notifying maintenance that there is a problem with a wheelchair? He stated, We have forms at the nurses station the staff are supposed to fill out.

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.