STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045459	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAPPY VALLEY NURSING & REHABILITATION	**955 DIVISION STREET MALVERN, AR 72104**

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 273) was substantiated, all or in part, with these findings: Based on observation, record review, and interview the facility failed to ensure prompt incontinent care was provided to prevent the potential for skin breakdown and failed to ensure a resident was free of odors for 1 (Resident (R) #2) of 1 sampled resident who was dependent on staff for incontinent care. The findings are: Resident #2 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 2/12/2020 documented resident scored 10 (8 - 12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); and required extensive assist of one person for personal hygiene. a. The Plan of Care dated 02/12/2020 documented, resident requires assistance with ADL (activities of daily living) functioning. The goal .clean, well-groomed and free of odor . b. On 3/11/2020 at 8:15 AM, the resident was sitting in a Geri chair in the common area in front of the television (tv). c. On 3/11/2020 at 10:50 AM, the resident was taken from the common area to the activity room. The resident was observed by the surveyor to the time of 8:15 AM to 10:50 AM and never left the common area until now. d. On 3/11/2020 at 11:05 AM and at 11:30 AM, the resident was still in the activity room. e. On 3/11/2020 at 11:42 AM, the resident was taken from the activity room to the dining room and set at a table. f. On 3/11/2020 at 12:00 PM, the resident was taken from the dining room by Certified Nursing Assistant (CNA) #1. This surveyor followed CNA #1 and CNA #2 and ask them what they were doing. CNA #1 stated, We are going to check her and change her. CNA #2 was in the room to help change the resident. The resident used a Hoyer lift and was lifted to the bed with no concerns. CNA #2 was asked, How often are residents to be checked and or changed? CNA#2 stated, Every two hours. CNA #2 was asked, When was the last time the resident was checked? CNA#2 stated, Around breakfast I guess. The resident was soaked through to her clothes and the lift pad under her was wet.

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