Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number** 04L103	**(X3) Date Survey Completed** 06/04/2019
Name of Provider or Supplier Habilitation Center, Llc	**Street Address, City, State** 1810 Industrial Drive, Fordyce, AR	

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

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
E0000	Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The facility was in compliance with Emergency Preparedness of Psychiatric Residential Treatment Center.
N0000	A Validation and complaint survey was conducted from 5/23/19 to 5/24/19. Complaint AR00022948 was substantiated, all or in part, with deficiencies cited at N128 and N196 The facility was not in compliance with §483, Subpart G - Conditions of Participation for Psychiatric Residential Treatment Center
N0128	PROTECTION OF RESIDENTS CFR(s): 483.356(a)(3) Restraint or seclusion must not result in harm or injury to the resident and must be used only- This ELEMENT is not met as evidenced by: Complaint AR00022948 was substantiated, all or in part, in these findings. Based on record review and interview, the facility failed to ensure an Emergency

	Safety Intervention (ESI) did not result in an injury for 1 of 1 (Resident #1) who was involved in an ESI. The findings are: Resident #1 had diagnoses of Disruptive Mood Dysregulation and Attention-Deficit /Hyperactivity Disorder. a. An "Emergency Safety Intervention and Debriefing" documented an ESI was initiated on 4/26/19 at 8:20 p.m. involving Resident #1. The resident was placed into a physical restraint in released from the physical restraint at 8:34 p.m. The form documented a physical assessment was completed by Registered Nurse (RN) #1 on 4 /26/19 at 8:34 p.m. The assessment documented Resident #1 had an injury during restraints: "c/o [complained of] left knee pain-good ROM [range of motion] [no] swelling... First aid applied: Ibuprofen 400 mg [milligrams] po [orally]-refused ice pack. Medial Services, Describe: None Pain scale (0-10) [0 being no pain, 10 being the worst pain]: 5/10. Location of Pain Left knee..." b. An OLTC (Office of Long Term Care) Incident and Accident Report (I&A) documented, " ...Date of I&A 4/26/19 Time: 2020 [8:20 p.m.]... Summary of Incident... [Resident #1] refused all directives multiple times. She was eventually placed into a physical restraint for safety...Nursing evaluation: Complained of left knee pain, 5/10 [pain scale]. On 4/27/19, had a limp and complained of knee pain 8 /10. [Resident #1] was evaluated by the doctor on 5/3/19. The doctor recommended [Resident #1] she an orthopedic doctor. The patient stated her knee went inward as she was taken down... " c. A Witness Statement completed RN #1 dated 5/13/19 documented, " ...On 4/26/19 called to [cottage] due to patient being aggressive [with] staff. Pt [Patient] placed in physical restraint due to continued ongoing aggressive behaviors... Pt continued to be aggressive while in physical restraint fighting against staff. When pt was calm released from physical restraint. Pt had good ROM in all extremities other than soreness in left knee. Pt walks to room. When assess pain level 5/10 Ibuprofen given. Pt got in bed. Reassessed one hour later pain 2/10. Went back down hall about an hour later pt in bed [with] eyes closed. [No] further complaints of pain. " d. On 5/23/19 at 12:19 p.m., the Director of Risk Management was asked "Did you get to see the video of the incident?" He stated, "No Ma'am. By the time I was told about it on the 10th, I went to look at the video, but it had been recorded over. The video had been reviewed by the patient advocate, as it shows on the restraint log I gave you." He was asked, "What did the patient advocate say about the restraint when you talked to her?" He stated, "She said she didn't see anything, but didn't really remember, said she didn't remember any details." He was asked "When was the staff suspended that was involved?' He stated, "On the 10th after I found out about the incident."
N0196	MEDICAL TREATMENT FOR INJURIES CFR(s): 483.372(a) Staff must immediately obtain medical treatment from qualified medical personnel for a resident injured as a result of an emergency safety intervention. This STANDARD is not met as evidenced by: Complaint AR00022948 was substantiated, all or in part, in these findings.

Based on interview and record review, the facility failed to ensure prompt medical treatment was obtained to prevent further potential complications for a 1 of 1 (Resident #1) sampled client who sustained an injury during an emergency safety intervention. The findings are:

Resident #1 had diagnoses of Disruptive Mood Dysregulation and Attention-Deficit /Hyperactivity Disorder.

a. An "Emergency Safety Intervention and Debriefing" documented an ESI was initiated on 4/26/19 at 8:20 p.m. involving Resident #1. The resident was placed into a physical restraint in released from the physical restraint at 8:34 p.m. The form documented a physical assessment was completed by Registered Nurse (RN) #1 on 4 /26/19 at 8:34 p.m. The assessment documented Resident #1 had an injury during restraints: "c/o [complained of] left knee pain-good ROM [range of motion] [no] swelling... First aid applied: Ibuprofen 400 mg [milligrams] po [orally]-refused ice pack. Medial Services, Describe: None Pain scale (0-10) [0 being no pain, 10 being the worst pain]: 5/10. Location of Pain Left knee..."

b. An OLTC (Office of Long Term Care) Incident and Accident Report (I&A) documented, " ...Date of I&A 4/26/19 Time: 2020 [8:20 p.m.]... Summary of Incident... [Resident #1] refused all directives multiple times. She was eventually placed into a physical restraint for safety...Nursing evaluation: Complained of left knee pain, 5/10 [pain scale]. On 4/27/19, had a limp and complained of knee pain 8 /10. [Resident #1] was evaluated by the doctor on 5/3/19. The doctor recommended [Resident #1] she an orthopedic doctor. The patient stated her knee went inward as she was taken down... "

c. Nurse ' s Note dated 4/26/19 at 8:20 p.m. documented, " ... [8:34 p.m.] pt released [from restraint] due to contracts to be calm and go to bed. [8:35 p.m.]. Pt complains of left knee pain 5/10 [pain scale]. Ibuprofen 400 mg given. Pt walking on knee complains ' it feels sore ' ... Will continue to watch it closely. "

d. A Nurse ' s Note dated 4/27/19 at 7:15 p.m. documented, " Pt ambulates to nurse ' s station for HS [bed time] meds [medications]... Noticeable limp. Pt. c/o pain 8/10 to [left] knee. States injury occurred while in restraint. Requests to see MD [medical doctor]... Upon assessment pedal pulses present & [and] equal. [No] edema. [No] s/s [signs or symptoms] inflammation noted. Medicated [with Ibuprofen 600 mg po. Instructed to go lay down & nurse would check [after] med pass. Upon ambulation back to unit, pt noted with only slight limp. Will continue to monitor. "

e. Nurse ' s notes dated 4/2719 at 8:45 p.m. until 5/6/19 did not document any monitoring of knee pain.

f. Nurse ' s Note dated 5/6/19 at 6:45 a.m. documented, " Pt c/o 8/10 [pain scale] [left] knee pain... to schedule appt [appointment] [with] orthopedist this am [morning]. Medicated [with] Ibuprofen 600 mg [at] this time... "

g. A Consultation Form dated 5/3/19 and signed by the Advanced Practice Nurse documented, " ...Nurse ' s Note: C/O knee pain...HPI [history of previous illness]; Reports [left] knee pain. Fell to ground reports knee went inward & foot outward... Schedule [with] [orthopedic doctor... "

	h. A Consultation Form dated 5/20/19 and signed by the Orthopedic physician documented, " ... Results of Examination: Effusion, medial joint tenderness + [plus] McMurray sign Diagnosis: Possible left medial meniscus tear... "