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