STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045216	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Rivers Rehabilitation and Healthcare Center	3021 Twin Rivers Drive Arkadelphia, AR 71923

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to ensure residents were free of harm due to improper transferring of residents with a mechanical lift for one (Resident #1) of one resident reviewed for transfers. Resident #1 had a negative outcome which resulted in a right distal third spiral femur fracture (a spiral fracture line caused by twisting forces). The findings include: Review of an “admission Record,” indicated the facility admitted Resident #1 on 07/03/2012 with diagnoses which included brain damage due to lack of oxygen, blocked blood flow to the brain, anxiety disorder, sudden burst of electrical activity in the brain (seizures), weakened bones, cognitive communication deficit, contracture of left hand, brain disorder that affects memory and behavior, high blood pressure, and type 2 diabetes. Review of an “Annual Minimum Data Set” (MDS) with Assessment Reference Date (ARD) of 09/25/2024 and a review of a “Quarterly MDS” with an ARD 06/24/2025, indicated Resident #1 had a Staff Assessment for Mental Status (SAMS) score of 3, which indicated the resident had severe cognitive impairment and had long and short-term memory problems. Resident #1 was severely impaired for daily decision making, and no behaviors were exhibited. The residents’ functional abilities were dependent; the helper performed all the effort. Resident #1 was incontinent with bowel and bladder, and a mechanical lift was required. Review of a “Discharge MDS”, with an ARD of 01/02/2025, revealed Resident #1 had a SAMS score of 3, which indicated the resident was severely cognitively impaired for their daily decision making. The MDS also revealed that Resident #1 was dependent on Activities of Daily Living (ADL’s) such as eating, hygiene, transfers, bed mobility, bathing, and dressing. Review of “ADL Transferring” dated 07/31/2025, indicated Resident #1 required total dependence for transferring and was dependent on “full staff performance.” Review of Resident #1’s “Comprehensive Care Plan” dated 06/30/2025, indicated Resident #1 was at risk for fracture due to diagnosis of weakened bones and staff was to provide gentle care while assisting the resident with ADLs. Resident #1 required non-weight bearing assistance with ADLs due to cognitive impairment, required total care and was dependent on two-person assistance with bed mobility, dressing, shower or bathing self, toileting and transfers required two staff with use of a mechanical lift with a green sling. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of an “Incident by Incident Type” dated March 2025 indicated Resident #1 had an ‘other’ incident on 03/15/2025 at 10:30 PM. A review of a “Progress Note” dated 03/15/2025 at 8:46 PM, indicated Resident #1 had a swollen right knee that was not present the day before and an x-ray was ordered. A review of a “Progress Note” dated 03/16/2025 at 12:09 AM, indicated Resident #1 had a displaced fracture of the right femur. Resident #1 was sent to the emergency room via ambulance. A review of Resident #1’s “Hospital records” revealed Resident #1 obtained a distal third spiral right femur from the pre-operative and post-operative diagnosis. Resident #1 received surgical fixation and stabilization of stated fracture. During an interview on 08/25/2025 at 5:45 PM, Resident #1’s family member stated they arrived to visit the resident on 03/15/2025 when CNA #10 informed them of a swollen knee. When the family member asked the Licensed Practical Nurse (LPN) #4 about the swollen knee and what happened, the LPN asked, “Well what do you want me to do about it?” The family member stated all they wanted to know was what happened and when the nurse “had an attitude,” it upset them without knowing what happened. After the X-ray was completed and it showed a fracture the Administrator was asked by the family member what happened, and the Administrator informed them that “the employee that hurt Resident #1 had been terminated.” When the resident was taken to the hospital for surgery, the hospital personnel came out and wanted to know how the resident got a spiral fracture. The family member stated, “You will have to ask the nursing home because that was where it happened.” The family member stated they had reported concerns about the care that was provided to Resident #1 and the facility had not done anything about their concerns. The family member stated that there were two employees that did not provide good, quality care and it worried them when they were working. The family member stated one was CNA #7 and they did not know the other one’s name. During a telephone interview on 08/25/2025 7:52 PM, CNA #10 stated the reason for her termination was due to improper use of a mechanical lift. She stated she noticed Resident #1 had a swollen knee the morning of 03/15/2025 and she alerted LPN #4. Resident #1 was already up to the Geri-chair when she got to work at 8:00 AM on 03/15/2025. The resident sat in the chair until around 2:30 PM on 03/15/2025. “We had previously been told by the Administrator that we had to do the best we could do when we were working short-staffed and as long as the second staff member was outside the door of the room they counted that as the second staff assist.” CNA #10 stated Resident #1 was like family to her and she did not drop or hit the leg on anything. When she told LPN #4 about the leg and asked if she would come look at it, LPN #4 stated, “Well, you know how the [Resident #1] is.” CNA #10 stated she told LPN #4, “No, something was wrong, the leg was flopping when I turned the resident.” When the family member came to visit the resident she informed them of the knee and that was what started the process for the X-ray. CNA #10 stated she took accountability and admitted she used the mechanical lift by herself. The Administrator informed the CNA that the fracture had happened between Friday 03/14/2025 and Saturday 03/15/2025. CNA #10 stated she did not work on that Friday night and came in on Saturday morning and the knee was already swollen. CNA #10 stated “upper management covered up for someone and I took the fall for it.” (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 08/26/2025 9:46 AM, CNA #1 stated she looked at the Kardex to know how to care for Resident #1. She stated if a resident had a change of condition, she informed the nurse. CNA #1 stated to operate a lift, you had to push it under the bed, lock the wheels and open the legs of the lift, hook up the sling, then the resident would be moved. She stated, “We are required to always use two staff to operate the mechanical lift.” She stated Resident #1 was totally dependent and required two or three staff members to move the resident. CNA #1 stated, “I had seen the lift being used by one person and the last time I saw it was a week ago on the 4-12 shift and it was CNA #7.” During an interview on 08/26/2025 10:01 AM, CNA #2 stated she had never worked the mechanical lift by herself. CNA #2 stated to work the lift, you had to push it under the bed, lock the wheels, hook the sling up and lift the resident up and you had to use a second staff member to help. CNA #2 stated Resident #1 was a total care resident. She stated she had recently seen staff work the lift with just one person on the 12-8 shift. During an interview on 08/26/2025 10:27 AM, CNA #3 stated you had to look every morning at the Kardex to see what you had to do for Resident #1. To work the mechanical lift, you had to get another CNA, get the right size sling, open the legs of the lift and make sure the legs are locked. You had to make sure the legs were opened to balance the resident. When this surveyor asked the reason the incident with Resident #1’s fractured leg occurred, CNA #1 stated “Someone used the mechanical lift by themselves. ” During an interview on 08/26/2025 10:43 AM, Licensed Practical Nurse (LPN) #4 stated she had “worked the lift by herself a few months ago due to low staffing.” LPN #4 stated she had received mechanical lift training “a very long time ago.” She stated she was at work the day CNA #10 called her to Resident #1’s room to assess the swollen knee. A family member of the resident walked in, and LPN #4 asked the family member if they wanted me to call the doctor. LPN #4 notified the provider and received an order for a stat x-ray. LPN #4 stated Resident #1’s knee was not swollen on 03/14/2025 and was on 03/15/2025. She stated she felt the incident happened “when they put the resident to bed the night of 03/14/2025 or when they got Resident #1 up early the morning of 03/15/2025.” She also stated, “I do not believe the CNA they terminated was the one that hurt the resident.” During an interview on 08/26/2025 11:31 AM, the CNA Supervisor stated there were ‘always’ to be two staff operating the mechanical lift. If a staff member used the lift by themselves, they would be terminated immediately. The CNA Supervisor stated, “I always made sure there was sufficient staffing, the reason Resident #1 got a fracture was due to an employee that used the lift without assistance and that was why they were terminated.” During an interview on 08/26/2025 2:01 PM, the Advance Practical Registered Nurse (APRN) stated for a resident to get a spiral fracture, there had to be some type of twisting movement. She stated if the lift was not properly used, it could result in a fracture. During an interview on 08/26/2025 2:39 PM, the Medical Director (MD) stated “I would not think a sling would cause this type of injury.” He stated the staff always called to inform him of incidents that happened at the facility. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 08/26/2025 3:01 PM, the Maintenance Director stated to operate the mechanical lift, you had to roll the lift under the bed, open the legs of the lift, lock the legs, hook the sling up to the lift, then proceed to lift the resident. He also stated, “if a person did not open the legs of the lift and did not lock the wheels, it affected the balance of the lift and resident.” During an interview on 08/26/2025 3:19 PM, LPN #5 stated “you had to look at the care plan to know how to care for a resident.” She stated two staff were required to operate the mechanical lift. LPN #5 stated she worked with Resident #1 on 03/14/2025 and the resident did not appear to be in pain. LPN #5 stated the CNAs that were working had gotten the resident up to the Geri-chair and that was where the resident was when she gave medications. The skin on Resident #1’s legs were not discolored. LPN #5 stated, “when day shift staff came on the next morning 08/15/2025, we noticed the knee was swollen, so the injury had to have happened the night before or early that morning and I do not believe it was done by the employee that got terminated even if that person was operating the lift by themselves.” She stated she had not seen an employee use the lift by themselves. During an interview on 08/26/2025 3:55 PM, CNA #6 stated the process to operating a mechanical lift was to get another staff member to help, open and lock the legs of the lift, lift the resident up, unlock the wheelchair to move it under the lift and to get the right size sling you had to look on the Kardex to see which color to get. CNA #6 stated “I heard Resident #1’s leg was hurt from someone that used the lift wrong, and the resident’s leg was dangling.” During an interview on 08/26/2025 4:25 PM, CNA #7 stated the “online care kiosk told us how to care for a resident, it gives us the care plan.” He stated to operate the mechanical lift “you had to make sure your partner was with you, the resident was placed flat on their back, the sling was placed under the resident, then you rolled the lift under the bed, spread the legs of the lift open, clamp the sling to the lift, work with your partner to move the chair.” He stated that Resident #1 required total, full care. CNA #7 stated he worked on 03/14/2025 on the 4-12 shift. When this surveyor asked if he had worked the lift by himself he responded, “not by myself, or let me say this…the other employee would peek around the door or would stand at the door to watch to make sure everything was okay while lifting the resident but that was when we were shorthanded to get the residents up to dinner.” When the question was reworded by this surveyor, CNA #7 stated he would be the only one that worked the lift, and the nurse would stand in the doorway and looked into the room.” CNA #7 stated “the reason residents were still in bed at that moment was due to being short-staffed tonight (08/26/2025) so he would feed the residents in bed and not get the residents up to a chair to eat.” During an interview on 08/27/2025 6:40 AM, CNA #9 stated she had not used a lift without having another aid helping even when they were short-staffed and that, “you would get terminated if you used it without two staff.” On 08/27/ 8:10 AM, this surveyor called and spoke to an employee with the company that serviced the mechanical lifts at this facility. He stated they checked them every 30-45 days and made sure they worked and did not have broken rubber strips or parts. He stated the facility had not had an issue with batteries not charging. He stated he would email this surveyor the manufacturer guidelines to operate the lift. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a “Invacare Reliant 450_600 Patient Lift Manual,” revealed Invacare does not recommend locking the rear casters of the patient lift when lifting an individual. Doing so could cause the lift to tip and endanger the patient and assistants. Invacare does recommend that the rear casters be left unlocked during lifting procedures to allow the patient lift to stabilize when the patient is initially lifted from a chair, bed or any stationary object. During an interview on 08/27/2025 at 9:49 AM, the CNA Supervisor revealed that care plans would indicate two people assist with any mechanical lift. During an interview on 08/27/2025 at 10:38 AM, the Radiologist Medical Director (RMD) indicated the x-ray on 03/15/2025 revealed that Resident #1 had a spiral fracture that did not appear to be pathological. RMD revealed that the type of fracture Resident #1 had does not typically come from osteoporosis (weakened bones). He revealed that this type of fracture could have resulted from a fall or body weight movement. He stated, “It takes a fair amount of force to break a femur. Whatever broke it took some weight behind it. I expect a body weight movement for this type of fracture.” During an interview on 08/27/2025 at 1:24 PM, LPN #11 revealed in reference to the morning of 03/15/2025, that the lift was locked prior to raising Resident #1 off the bed and when lowering the resident to the chair. LPN#11 stated, “We are supposed to lock the lift prior to lifting or lowering the lift.” During an interview on 08/27/2025 at 1:35 PM, CNA #3 verified that the lift was supposed to be locked when raising or lowering a resident. She stated, “It was so the lift wouldn’t tip over.” CNA #3 explained that the last in-service regarding the mechanical lift was 3-4 months ago. During an interview on 08/27/2025 at 1:37 PM, CNA #1 revealed that the mechanical lift was supposed to be locked when raising and lowering a resident. CNA #1 stated, “So the resident isn’t moving around when in the lift.” CNA #1 explained that the last in-service regarding the mechanical lift was 2-3 months ago. During an interview on 08/27/2025 1:45 PM, ADON (Assistant Director of Nursing) revealed that staff would know how to care for a resident by utilizing the care plan which was also reflected on the Kardex. She explained that interventions are determined based on resident cognition and the residents’ fall risk. The ADON explained that the Kardex will tell the staff how many staff would be required, as well as the sling color to use for each resident. The ADON revealed that the facilities’ last training regarding use of the mechanical lifts indicated to lock the wheels with transfers. She referred to the patients’ sling book, stating that the “wheels do not have to be locked.” She stated, “I was always trained to lock the mechanical lift.” This surveyor asked the ADON to read the passage on “Invacare Reliant 450_600 Patient Lift Manual”. After reading the passage, the ADON stated that the staff are “not locking the wheels.” (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 08/27/2025 at 2:15 PM, the Director of Nursing (DON) revealed that the CNA’s and Nurses would know how to care for a resident based upon the care plan and Kardex. The DON revealed the care plan was reviewed every three months. The DON revealed that she was taught to lock the wheels on a mechanical lift when in use but said she was recently taught not to lock the wheels and if a resident swung on the lift pad the mechanical lift could tip over. The DON revealed there was one staff member who admitted to using a mechanical lift by themselves. The time frame CNA #10 used the lift by themselves was in March of 2025. The DON revealed that what she remembers regarding Resident #1’s fracture was that the family member was there, and the family member noticed the resident’s knee was a little swollen. The doctor ordered an x-ray, and the results revealed a fracture and Resident #1 was sent to the hospital. A review of a facility policy titled, “Accident Hazards Prevention”, indicated, “An effective way for the facility to avoid accidents is to develop a culture of safety and commit to implementing systems that address risk and environmental hazards to minimize the likelihood of accidents. A facility with a commitment to safety: 6. Demonstrates a commitment to at all levels of the organization.”