STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045441	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLCREST HOME	1111 MAPLEWOOD RD HARRISON, AR 72601

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident and the resident's representative were notified in writing of a transfer to the hospital for 1 (Resident (R) #65) of 4 (R #29, R #65, R #75, and R #89) sampled residents who were transferred to the hospital in the last 180 days. This failed practice had the potential to affect 9 total residents who were transferred, according to a list provided by the Admissions Coordinator on 7/09/2020 at 2:59 PM. The findings are: 1. Resident #65 had [DIAGNOSES REDACTED]. a. The MDS assessment dated [DATE] documented a Discharge Return Anticipated on 5/29/2020 and an Entry on 6/02/2020. b. On 07/09/2020 at 10:40 AM, the Admissions Coordinator was asked if the resident and the resident's representative were notified in writing of the transfer and the bed hold and he stated, We do that for the rehab residents but we don't for the long term care residents because they would panic thinking we were not going to hold their bed for them. So, no we are not completely compliant with that. Then he was asked, so am I understanding you correctly, you did not send the written notification of the hospitalization transfer and bed hold for Resident #65? He stated, No. We did not. c. On 7/10/2020 at 8:15 AM, a copy of the written notification of transfer was requested from the facility, the Admissions Coordinator stated that he didn't believe there was one.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident and the resident's representative were provided a bed hold policy prior to a transfer to the hospital for 1 (Resident (R) #65) of 4 (R #29, R #65, R #75, and R #89) sampled residents who were transferred to the hospital in the last 180 days. This failed practice had the potential to affect 9 residents who were transferred, according to a list provided by the Admissions Coordinator on 7/09/2020 at 2:59 PM. The findings are: 1. Resident #65 had [DIAGNOSES REDACTED]. a. The MDS assessment dated [DATE] documented a Discharge Return Anticipated on 5/29/2020 and an Entry on 6/02/2020. b. On 07/09/2020 at 10:40 AM, the Admissions Coordinator he was asked if the resident and the resident's representative were notified in writing of the transfer and the bed hold and he stated, We do that for the rehab residents but we don't for the long term care residents because they would panic thinking we were not going to hold their bed for them. So, no we are not completely compliant with that. Then he was asked so am I understanding you correctly, you did not send the written notification of the hospitalization transfer and bed hold for Resident #65? He stated, No. We did not. c. On 7/10/2020 at 8:27 AM, a copy of the bed hold notification on transfer policy and procedure was received from the Admissions Coordinator. It documented, .In the event of an emergency transfers of a resident, Hillcrest Home will provide within 24 hours written notice of the facility's bed -hold policies, as stipulated in each state's plan . d. On 7/10/2020 at 8:45 AM, during an interview with the Admissions Coordinator he was asked if the resident's transferred from the list were given written notification of bed-hold and he stated, A copy was sent with them to the hospital but there is no guarantee that it was actually given to the resident and representative, since it is given to the hospital personnel.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments were coded accurately for 3 (Residents #47 #83 and #94) of 20 (Residents #64, #89, #94, #59, #73, #57, #11, #83, #42, #77, #75, #47, #28, #31, #60, #65, #52, #63, #1, and #24) sampled residents whose MDS assessments were reviewed. This failed practice had the potential to affect all 94 residents who resided in the facility, according to the Resident Census and Conditions of Residents form dated 7/7/2020. The findings are: 1. Resident #83 had [DIAGNOSES REDACTED]. The Quarterly MDS with an Assessment reference Date (ARD) of 6/17/2020 documented the resident scored 12 (8 - 12 indicates moderately intact) on a Brief Interview for Mental Status (BIMS); received an anticoagulant 7 days on the 7 day look back period. a. On 07/07/2020 at 09:52 AM, Resident #83's record review was completed with no anticoagulant found in physicians orders, or history. b. On 07/09/2020 at 02:06 PM, the Assistant Director of Nursing (ADON) was asked to provide documentation for Resident #83's anticoagulant. She stated, .I was unable to find any in the record . c. On 07/09/2020 at 02:19 PM, the last three MDSs with ARDs of 6/17/2020 (Quarterly), 5/22/2020 (Significant change), and 3/18/2020 (Annual) were reviewed, and all documented anticoagulant as being taken for the last 7 days. 2. Resident #47 had [DIAGNOSES REDACTED]. The MDS with an ARD of 5/20/2020 documented the resident's Brief Interview for Mental Status (BIMS) as not assessed, the Staff Assessment for Mental Status (SAMS) documented long and short term memory issues, and the Mood (PHQ-9) was documented as not assessed, staff completed with a score of 04 (1-4 indicates minimal depression), and Restraints used less than daily. a. The Care Plan dated 5/24/2020 didn't reference a restraint. b. Physician order [REDACTED]. No restraint assessment was found in the record. c. On 07/06/2020 at 1:55 PM, the resident was observed on a low bed. There was a fall mat at the bed side. d. On 07/08/2020 at 10:05 AM, Registered Nurse (RN) # 2 was asked if the resident had a restraint. She stated, No, I don't think so. He's on a low bed. But he is unable to walk. e. On 07/08/2020 at 10:40 AM, RN #2 stated, The MDS was incorrect . f. On 07/09/20 at 8:18 AM, CNA #1 was identified as the individual who completed the mental status and mood assessment and was asked, why was R#47 Quarterly MDS dated [DATE] BIMS & PHQ-9 marked as not assessed? CNA #1 stated, I really don't know why. Have you been trained on MDS completion? CNA #1 stated, Yes, by the person who's place I took. What are your job duties? The CNA stated, As house coordinator, I check rooms, check care, assist with families. So MDS' are last? CNA #1 stated Yes. g. At 2:00 PM, the Social Service Designee was asked what kind of training was provided for CNA#1? The Social Service Designee stated, I provided the initial training and recommended U-Tube training video. I trained him to always interview, it has to be offered. 3. Resident #94's Medicare 5 day/DRNA(Discharge Return Not Anticipated)/End of PPS (Prospective Payment System) Part A stay MDS with an ARD of 5/12/2020 documented discharge to acute care. a. The MDS progress note completed 5/19/2020 at 10:27 AM documented, (Name) entered (Name) on 5/6/2020 . (Name) discharged from (Name) to the community on 5/12/2020 and was completed by RN#1. b. On 7/9/2020 at 9:00 AM, RN#1 was asked to reference R#94's MDS note from 5/16/2020, and was asked, where does it say she was discharged to? RN #1 stated, community. When asked to review the discharge return not anticipated MDS with an ARD of 5/12/2020 to see where it identified she was sent, the RN stated, Oh, oops.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.**

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.

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F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure physician orders [REDACTED].#33) of 4 residents who had a physician order [REDACTED]. The findings are: 1. On 7/2/2020 the July 2020 Medication Administration Record [REDACTED]. **See orders for other directions** However, the blood sugar on 7/1/2020 was 65, the correct dosage should have been 38 units. b. On 7/3/2020 the [MEDICATION NAME] Solution 100 unit/ml (milliliter) inject 40 units subcutaneously in the morning the signature and the units were omitted the blood sugar from 7/2/2020 was 77. c. On 7/4/2020 the [MEDICATION NAME] Solution 100 unit/ml inject 42 units subcutaneously in the morning the signature and the units were omitted the blood sugar from 7/3/2020 was 54. d. On 7/6/2020 the MAR indicated [REDACTED]**See orders for other directions**. d. On 7/08/2020 at 7:24 PM, while completing the reconciliation of resident #33 orders, an order written [REDACTED]. e. On 7/09/2020 at 8:22 AM, Registered Nurse (RN) #2 was asked, How long had she been the unit manager? She stated, 2 weeks. She was asked, Do you review MAR's for omissions or errors? She hesitantly stated, Yes. She was asked, Are you aware of any insulin issues? She stated, Yes. She was asked, When were you made aware? She stated, This morning. She was asked, By whom? She stated, The DON. She was asked, Was it because of the request for the July 2020 MAR's? She stated, Yes. She was asked to provide any documentation related to the significant medication errors. f. On 7/9/2020 at 4:00 p.m., a review of the Medication Administration Policy and Procedure documented .Review MAR indicated [REDACTED].) to verify resident name, medication name, form, dose, route, and time. Sign MAR indicated [REDACTED]