STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	305061	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTWOOD CENTER	**40 CROSBY STREET MILFORD, NH 03055**

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** Based on interview, record review and policy review, it was determined that the facility failed to ensure that all alleged violations involving abuse were reported to the administrator immediately for 2 residents out of 4 residents reviewed with allegations of abuse. (Resident identifiers are #1 and #7) Findings include: Resident #1 Review on 7/28/20 of Facility Reported Incident dated 4/17/20 revealed an allegation of 2 LNA's (Licensed Nursing Assistant) (Staff A and Staff D) cut Resident #1's hair without Resident #1's permission on 4/10/20. An anonymous staff reported this incident through the facility hotline on 4/17/20. Review on 7/29/20 of the facility staffing from 4/10/20 thru 4/17/20 revealed that Staff A worked the following shifts: 4/10/20 - 7 a.m. to 3 p.m. 4/11/20 - 7 a.m. to 3 p.m. 4/12/20 - 7 a.m. to 11 a.m. 4/13/20 - 6 a.m. to 2 p.m. 4/14/20 - 7 a.m. to 3 p.m. 4/15/20 - 7 a.m. to 3 p.m. 4/16/20 - 3 p.m. to 9 p.m. 4/17/20 - 7 a.m. to 3 p.m. Interview on 7/28/20 at approximately 11:15 a.m. with Staff E (Unit Manager) revealed that there had been an allegation against Staff A for rough handling of a resident reported to Staff E. Staff E revealed this allegation was prior to the incident that occurred on 4/10/20. Staff E could not recall the date of the allegation. Staff E stated, I didn't think that (pronoun omitted) would do that, so I talked to (pronoun omitted) myself. Staff E did not inform management of the allegation. There was no investigation done of the allegation. Staff E revealed that if other staff members tell Staff E of allegations, Staff E would tell them to report the allegation to management themselves. Interview on 7/28/20 at approximately 11:32 a.m. with Staff B (LNA) revealed that Staff B had heard from another LNA that Staff A (LNA) had been rough with residents during care. Staff B stated that Staff B knew it had been happening for months. Staff B did not know exact dates and descriptions of when Staff A was rough with residents. Staff B stated that they reported to Staff E that they had heard from other LNA's that Staff A was rough with residents. Staff B did not know what happened after they reported this to Staff E. Review on 7/28/20 of the written statement from an anonymous staff dated 3/4/20 revealed that the anonymous staff stated that .About a year ago I spoke with the DON (Director of Nursing) myself about how a resident told me that (Staff B name omitted) and the other aides were too rough with (pronoun omitted). I went straight to the DON about the situation, yet I see it occur frequently . Interview on 7/28/20 at approximately 8:10 a.m. with Staff I (Ditector of Nursing) revealed that Staff I provided abuse re-education to all staff in response to the 4/10/20 allegation. Staff I was not able to provide any documentation of the re-education provided to staff. Resident #7 Review on 7/28/20 of the grievance log for the past year revealed a grievance was filed on 2/17/20 by Resident #7 with allegations against Staff A. The allegations was that Staff A was rough with Resident #7 and Staff A took Resident #7's wheelchair into the hallway. This allegation was not reported to the State Agency. Review on 7/28/20 of Staff A's employee file revealed that there were no abuse re-education or discipline in regards to allegations of roughness with residents prior to the incident on 4/10/20. Interview on 7/28/20 at approximately 12:35 p.m. with Staff I (Director of Nurses) revealed that there was no evidence of an investigation about Staff A taking Resident #7's wheelchair and putting it in the hallway. Review on 7/29/20 of the the facility policy and procedure titled, OPS300 Abuse Prohibition, with a revision date of 7/1/19 revealed: .Purpose To ensure that Center staff are doing all that is within their control to prevent occurrences of abuse, mistreatment, neglect, exploitation, involuntary seclusion, injuries of unknown source, and misappropriation of property for all patients 6. Staff will identify events - such as suspicious bruising of patients, occurrences, patterns, and trends that may constitute abuse - and determine the direction of the investigation 6.1 Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately. 6.1.1 The notified supervisor will report the suspected abuse immediately to the Center Executive Director or designee and other officials in accordance with state law. 6.1.2 The employee alleged to have committed the act of abuse will be immediately removed from duty, pending investigation 7.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than 2 hours after the allegation is made 7.7 Initiate an investigation within 24 hours of an allegation of abuse that focuses on: 7.7.1 whether abuse or neglect occurred and to what extent; 7.7.2 clinical examination for signs of injuries, if indicated; 7.7.3 causative factors; and 7.7.4 interventions to prevent further injury

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.