STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045303	A. BUILDING _____ B. WING _____	04/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK STUTTGART, LLC	707 WEST 20TH STREET STUTTGART, AR 72160

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 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 360) was substantiated, all or in part, with these findings. Based on record review and interview, the facility failed to ensure a thorough investigation was completed on an allegation of staff to resident abuse and the staff was suspended during the investigations (per facility policy) to ensure residents were protected from further potential abuse for 1 (Resident #1) of 1 sampled resident. This failed practice had the potential to affect all 64 residents who reside at the facility according to a list provided by the Administrator on 3/31/20. The findings are: 1. The facilities Abuse policy provided by the Administrator documented, .Protecting Residents during suspected abuse . The employee suspected of the abuse will be suspended until the investigation has been completed . a. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 2/20/20 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BI[CONDITION]) and was independent with activities of daily living. b. The Plan of Care with a revised date of 2/21/20 did not document concerns related to the resident having history of making false allegations. c. On 04/2/20 at 8:35 AM, spoke with the Director of Nursing (DON) via telephone. She was asked, I am calling about (Resident #1) and the incident with the inhaler. Can you tell me when this happened? She stated, I believe it was the 6th when the replacement came from the pharmacy. What medication was missing? She stated, Her [MEDICATION NAME] inhaler. What times was the medication ordered for? She stated, BID (twice a day) 8AM and 8 PM. What day did it go missing? She stated, I saw it on the morning report on the 5th, I believe. Did the resident go without any doses of this medication? She stated, Yes, she didn't have it on the 5th. Was (Resident #1) questioned about the inhaler? She stated, Not by me, I don't do reportable, I just went in her room to see if I could see it lying on the floor or somewhere obvious. MAC (Medication Assistant Certified) volunteered to help us look. That is not her regular hall we were looking everywhere because it had just been filled at the first of the month. Did you stay in the room while MAC was looking? She stated, No. What was the resident's reaction to having her room searched? She stated, She was mad, she was yelling. The DON was asked, Did you stop? She stated, We were looking for the inhaler. She was asked, On the March Medication Administration Record [REDACTED]? She stated, You won't see her name, she passes meds on south hall, she was up here helping us look for the inhaler that's all. Did you interview any other residents that day to determine if they (MAC) had made them nervous or upset? She stated, No I didn't, she doesn't work that hall. She was asked, Was staff member sent home at any time during this investigation? She stated, No it was only 1 day, and you have to understand (Resident #1) has behaviors. d. On 4/2/20 at 9:40 AM, phone conversation was conducted with Medication Assistant Certified, who was asked, Did you go to (Resident #1) room to search for an inhaler in the month of March? She stated, Yes I did. She was asked, Where did you search? She stated, I knocked on her door and ask if I could look under her recliner to see if it had fallen and went under there. She sits in her recliner most of the time and she is very particular about her room. You don't touch anything unless she says its ok. I got down on my hands and knees and looked and it wasn't there. Did you look in her drawers or anywhere else? She stated, No ma'am I did not. What was her reaction to you looking in her room? She stated, She was fine she wasn't upset. The MAC was asked, Where you sent home at any time while they were investigating after she (Resident) said she was mistreated? She stated, No. e. On 4/2/20 at 10:15 AM, phone conversation was conducted with resident's daughter-in-law (first contact on contact sheet). She was asked, Did the facility contact you when the inhaler was missing? She stated, Yes, but did they ever find it? The surveyor stated, she had an inhaler. Did you observe any changes in her behavior since the inhaler incident? She stated, She has had behaviors for the past 6 to 8 months. She [MEDICAL CONDITION] that is up in her sinus close to her brain, maybe that is causing her behaviors. She also has [MEDICAL CONDITION] so who knows. I feel like the facility does all they can for her. If I felt like they were abusing her I would step in and say something. For the past 6 months she over- exaggerates things, she has changed. She has even tried to hit (Administrator) at one time. f. On 04/2/20 at 12:00 PM, a phone interview was conducted with the Administrator. She was asked about the call to their home office and stated she was calling to tell them about the inhaler and the shower being cold. She was asked, So, you were aware the day before the Office of Long-Term Care (OLTC) called that she was upset about the inhaler? She stated, Yes, the day before. Did you go speak with the resident? She stated, I did not personally, she looks at me as a person of authority and she doesn't like talking to me. With her [DIAGNOSES REDACTED]. I sent the Assistant Director of Nursing to speak with her. She was asked, On [DATE] OLTC contacted you about Resident #1's complaint. Did you suspend the staff member that she accused of abuse? She stated, No, she was on another hall and was told not to go into residents' room. The investigation lasted less than a day, so I didn't suspend her. She was asked, On your policy on the second page on number 4 it stated, 'If there is a suspected abuse, an internal investigation will take place immediately. All alleged violations will be reported to OLTC .' It also stated, 'The employee suspected of abuse will be suspended until the investigation is complete .' Did you suspend the staff member? She stated, No, it was just a matter of filling out the reportable. We knew that she was upset over the inhaler, but it was replaced, and she states that she is not angry. We got the doctor to see her regarding her recent medication changes and he increased her medication back because her being paranoid and she dwells on things.
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 360) was substantiated, all or in part, with these findings. Based on record review and interview, the facility failed to ensure physician orders [REDACTED].#1) of 1 sampled resident who had a physician order [REDACTED].#1 had [DIAGNOSES REDACTED]. a. The Physicians order dated for 6/27/18 documented, [MEDICATION NAME] HFA 115/21 MCG (microgram) inhalation 2 puffs 8 AM (morning) and 8 PM (evening). b. On 04/01/20 at 4:43 PM, received the Medication Administration Record [REDACTED]. c. On 04/02/20 at 8:35 AM, the Director of Nursing was contacted via phone and was asked, Looking at the MAR, I see that there are circles on March 5th for the day and evening shift and there was a circle on March 6th for the day shift only. She stated, Yes she did not have the medicine on the 5th that is when we were looking for it, I told (Administrator) we could not find it and she said order it. The medication arrived later in the day on the 6th, and I personally went and delivered it and told Resident #1 that it was there. She was asked, What does it mean for the initials circled on the MAR? She stated, The medication wasn't given. She was asked, Should there be an explanation on the back as to why it wasn't given? She stated, Yes. She was asked, Are you saying that she missed three doses then? She stated, Yes, she missed three doses. d. This medication error was significant based on the number of doses missed and the classification of the medication, [MEDICATION NAME][MEDICATION NAME].

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.