STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045449	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK MARIANNA, L L C	700 WEST CHESTNUT MARIANNA, AR 72360

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure call lights were placed within reach and available for residents use to enable the resident to call for assistance to accommodate the residents' care needs and to prevent possible injury for 2 (Residents #4 and #41) sampled residents who were able to use a call light. The findings are: 1. Resident # 4 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/2020 documented the resident scored 9 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS), was independent for most activity of daily living (ADL's) tasks, and was always continent of bowel and of bladder. a. On [DATE] at 2:14 p.m., Resident #4 was lying in bed. The resident's call light was approximately 4 feet out of the reach of the resident. The call light was in the floor behind Resident #4's nightstand. b. On 3/4/2020 at 12:05 p.m., Resident #4 was lying in bed. The resident's call light was approximately 4 feet out of the reach of the resident. The call light was in the floor behind Resident #4's nightstand. 2. Resident #41 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/2020 documented the resident scored 00 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS), required supervision of 1 person for bed mobility and transfer, required extensive assistance for dressing and toilet use, and was occasionally incontinent of bowel and of bladder. a. On [DATE] at 2:18 p.m., Resident #41 was lying in bed. The resident's call light was draped over the bedside table and was approximately 4 feet out of the reach of the resident. Resident #41 was asked, Do you need help to get into bed? Resident #41 shook her head up and down, indicating, Yes. b. On [DATE] at 2:57 p.m., Resident #41 was lying in bed. The resident's call light was draped over the bedside table and was approximately 4 feet out of the reach of the resident. c. On 3/3/2020 at 2:40 p.m., Resident #41 was lying in bed. The resident's call light was draped over the bedside table and was approximately 4 feet out of the reach of the resident. Resident #41 was asked, Can you get out of bed by yourself? Resident #41 shook her head, indicating, No. Resident #41 was asked, Do you need help to get out of bed? Resident #41 shook her head up and down, indicating, Yes. d. On 3/4/2020 at 12:07 p.m., Certified Nursing Assistant (CNA) #2 was asked, Should call lights be in reach of residents? CNA #2 stated, Yes. CNA #2 was asked, Who is responsible for ensuring residents have their call lights? CNA #2 stated, Everybody. e. On 3/4/2020 at 1:00 p.m., Licensed Practical Nurse (LPN) #1 was asked, Should call lights be in reach of residents? LPN #1 stated, Yes. LPN #1 was asked, Who is responsible for ensuring residents have their call lights? LPN #1 stated, Staff. f. On 3/4/2020 at 1:32 p.m., the Director of Nursing (DON) was asked, Should call lights be in reach of the residents? The DON stated, Yes. The DON was asked, Who is responsible for ensuring residents have their call lights? The DON stated, The CNAs. g. On 3/4/2020 at 1:41 p.m., the Administrator was asked, Should call lights be in reach of residents? The Administrator stated, Yes. The Administrator was asked, Who is responsible for ensuring residents have their call lights? The Administrator stated, All nursing staff, all of us. h. On 3/4/2020 at 3:33 p.m., the Director of Nursing (DON) was asked, Do you have a call light policy? The DON stated, We don't have any policies on call lights; just keep the call light in reach.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the residents' environment and equipment was kept in good repair, as evidenced by: failure to ensure wheelchair cushions were free of rips and torn surfaces for 2 (Residents #5 and #54) sampled residents; a sofa in the Day Room area was free of detached upholstery with tacks exposed; and failed to ensure rusty brackets were not on the sink for 1 (Resident #105) sampled resident. The findings are: 1. On [DATE] at 12:46 p.m., the upholstery on a sofa in the Day Room area on the right lower section close to the right front leg was loose and had 2 tacks exposed at approximately calf to knee height. (The Surveyor took a photograph of the sofa at this time.) a. On [DATE] at 12:59 p.m., Registered Nurse (RN) #2 was asked if she was aware of the exposed tacks. She looked at the sofa and stated, No. She asked another nurse that was close by to watch and make sure no one came near the sofa. b. On [DATE] a 1:02 p.m., the Housekeeping Supervisor came to the sofa and hammered the tacks back in place. c. On 3/5/2020 at 10:29 a.m., the Director of Nursing (DON) was asked if the sofa should have tacks exposed. She stated, No. It should be fixed. It could cause skin tears. 2. Resident #5 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set Assessment with an Assessment Reference Date of 2/19/2020 documented the resident was cognitively impaired, required extensive assistance of one person for locomotion, and required a wheelchair for mobility. a. The Plan of Care dated 11/20/19 documented, .Needs assistance with . transfer . assist (assistance) with ambulation and transfers as needed . risk for skin breakdown . cushion in . chair . b. On [DATE] at 2:52 p.m., Resident #5 was lying in bed. Her wheelchair was sitting in the hallway outside of her room. The wheelchair cushion cover was torn. (The Surveyor took a photograph of the wheelchair cushion at this time.) c. On 3/5/2020 at10:26 p.m., Licensed Practical Nurse #1 (LPN) was asked if the resident's wheelchair cushion should be ripped or torn. She stated, The ones getting her up needed to report that so we could get another cushion. We have plenty of cushions. d. On 3/5/2020 at 10:29 a.m., Director of Nursing (DON) was asked, Should the resident's wheelchair cushion cover be torn? She stated, No. 3. Resident #54 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set with an Assessment Reference Date of 2/11/20 documented the resident was cognitively impaired, used a wheelchair for mobility, and required supervision for locomotion. a. On [DATE] at 11:53 a.m., Resident #54 was lying in bed. A high back wheelchair was in her room. The cover on the head rest cushion on back of the wheelchair was ripped and torn. (The Surveyor took a photograph of the wheelchair head rest cushion at this time.) b. On 3/5/2020 at 10:23 a.m., LPN #1 was asked, Should the head rest cushion cover on (Resident #54's) wheelchair be ripped or torn? She stated, I think it needs fixed or a new chair. c. On 3/5/2020 at 10:29 a.m., the DON was asked, Should (Resident #54's) wheelchair cushion cover be ripped or torn? She stated, No. 4. Resident #105 had [DIAGNOSES REDACTED]. The resident was admitted on [DATE] and no comprehensive assessment (MDS) was available at this time. a. The Baseline Care Plan with an implementation date of 2/28/2020 documented, .Resident is alert and oriented times 2 . confused at times . requires total dependence for transfers . 1-person assist (assistance) with bed mobility, personal hygiene and bathing and continent of bladder with a [MEDICAL CONDITION] . b. On [DATE] at 2:15 p.m., the sink in Resident 105's room had four rusty metal brackets, approximately 2 inches long with sharp edges around the top of the sink. c. On 3/5/2020 at 6:55 a.m., the sink located inside Resident 105's room had four rusty metal brackets approximately 2 inches long, with sharp protruding edges on each of the brackets around the top of the sink. (The Surveyor took a photograph of the metal brackets at this time.) d. On 3/5/2020 at 6:57 a.m., Resident #105 was asked, Do you use the sink? Resident #105 stated, Yes, to wash my hands a little bit. He was asked, Have your arms or any part of

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045449	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK MARIANNA, L L C	700 WEST CHESTNUT MARIANNA, AR 72360

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) your skin gotten cut on the sink from those brackets with sharp edges? Resident #105 stated, No, I watch out for that. e. On 3/5/2020 at 8:57 a.m., the Director or Nursing (DON) was asked for a policy for potential accidents / hazards. She stated, We in-service to keep everything potentially hazardous put up. f. On 3/5/2020 at 8:58 a.m., the DON was asked, Should a resident's sink have metal brackets with sharp, protruding edges around the top of the sink? She stated, We shouldn't have sharp, protruding edges. She was asked, What is the potential hazard of sharp, protruding edges around the top of the sink? She stated, Skin tears. g. A facility policy titled Maintenance provided by the DON on 3/5/2020 at 3:29 p.m. documented, .Maintenance . (Facility) tries to make sure all our equipment, furniture, chairs, tables, etc (et cetera) are in proper working order .
F 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from the wrongful use of the resident's belongings or money.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the necessary efforts were made to ensure a resident's allegation of missing money was immediately reported as suspected misappropriation of property to the State agency and other officials in accordance with State law, and failure to immediately initiate an investigation and protective measures to prevent further potential misappropriation for 1 (Resident #39) of 1 sampled resident who had an allegation of misappropriation of property. The findings are: 1. Resident #39 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/2020 documented the resident scored 7 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS and required total assistance of one to two-person assistance with activities of daily living (ADLs). a. On 3/3/2020 at 10:11 a.m., the resident was asked if she had anything missing? She stated, Oh yes. $70.00. They got in my purse and took it. She was asked, Did you tell someone? She stated, Yes. She was asked, Who did you tell? She stated, My Certified Nursing Assistant (CNA). I have a hard time keeping up with names. She was asked, What did the facility do about it? She stated, Nothing. She was asked, How long ago did this happen? She stated, About a month ago. She was asked, Where did you have it (money)? She stated, In the purse beside the bed. b. On 3/4/2020 at 10:44 a.m., the Administrator was notified of (Resident #39's) concern related to missing money. She stated, 'No, her husband doesn't usually leave her any money. She was asked, Did anyone report to you that she allegedly had money missing? She stated, No one reported anything to me. I was just in her room and was not aware she had any money missing. I will call him now. c. The resident's Nurses Notes dated 2/4/2020 documented, .Left for appt (appointment) at 8:50 a.m.2/4/20 at 2:15 p.m. Instructed by R (resident) to look and see how much money was in black and grey pouch . Observed a five-dollar bill and one-dollar bill .Informed husband. Husband stated it should be more .Don't worry about it, I'll find it . d. On 3/4/2020 at 2:30 p.m., the Administrator faxed an Incident and Accident Report, Division of Medical Services (DMS) form 7734 to the Office of Long Term Care (OLTC). The Incident and Accident Report documented, .Type of Incident . Misappropriation of Property . Personal Property Notification . Family, Law Enforcement, Doctor and Administrator . Summary of Incident . 'Patient reported to surveyor on 3/4/2020 that she had $70.00 missing . On 2/4/2020 patient told 2 CNAs that took her to the doctor that she had money missing. Patient on 2/4/2020 contacted her husband and he wasn't aware she had that much money at that time and told her to not worry about it that he would look for it when he came to the nursing home and that it was probably in her other case at the nursing home. Staff contacted facility to get them to go look and patient did have $56.00 in her phone case, and $4.00 in her purse. Nothing was ever reported after that from patient or Husband, so facility thought that all money had been found . On 3/4/2020 Surveyor came to Administrator to ask if she was aware of the missing money and I, the Administrator, told her, 'No.' I then started the investigation to find out that on 2/4/2020 it was reported to the DON and facility hadn't heard anything more from Patient or husband about money missing and facility thought it had been found. When I, Adm (Administrator) went and asked her had the money been found, she (the resident) stated, 'No.' I asked patient if she knew who might have taken it, and she stated, 'No.' When I explained to her that facility was going to replace it, she said, 'No, she didn't want us to do that.' . On February 4, 2020, resident was taken to the doctor's office in (location) by 2 CNAs. It was reported by staff that resident stated she had money taken from her.Resident's husband had told her that the money could be in the case in the room . Checked case in her room and there was $6 in her phone case. Resident was informed that the money was in the case in her room. Husband was contacted by Charge Nurse .He stated that it is probably scattered . (DON's signature) . e. An OLTC Witness Statement Form dated 2/4/2020 and signed by Certified Nursing Assistant (CNA) #5 documented, .took (Resident #39) to doctor .searched in her purse and pulled out $4.00 . stated she had $60 .called her husband .asked if she had $60.00 .he didn't know how much .in her room .called (CNA #6) to look . She had $6.00 . f. An OLTC Witness Statement Form dated 2/4/2020 and signed by CNA #7 documented, .Resident stated she had money missing .called husband .He stated the money might be in pouch in room . (CNA #6) found $6.00 in pouch . g. On 3/5/2020 at 9:24 a.m., CNA #5 was asked, Did you have knowledge of (Resident #39's) missing money? If so, describe. She stated, Yes, I was the one who took her to her doctor appointment. The nursing home gave us money for lunch. (Resident's name), and she said she was going to pay for the lunch for us. I told her 'No.' She then looked into her purse and says she had money, she had $4.00. She stated she had $60.00 dollars. I then called the facility and talked to (CNA #6) and asked if (Resident's name) had $60.00 dollars on her, and (CNA #6) said, 'I don't know. I just gave her her purse.' I asked (Resident's name) do you remember when she last saw it. She said, 'I don't remember.' She then called her husband and told him, 'My money is gone. I had $60.00.' He said, 'Calm down.' She then handed me the phone. I asked (Husband's name, 'Did you give (Resident's name) any money?' and he told me he did give her some money and that it was at the facility. I asked him where it was, and I called the facility to look where he said, and (CNA #6) looked and she found $6.00. I told (Resident's name) they found $6.00. (Husband name) told the resident not to worry, he was going to look into it. CNA #5 was asked, What actions, if any, did you take in response to the allegation? She stated, I called the facility for (CNA #6) to look for it. The CNA was asked, Did you report the alleged abuse to any supervisors / administration? Who did you report it to? What was their response? She stated, I told one of the evening Charge Nurses, I don't remember who, when I got back around 4:00 (p.m.) or 5:00 (p.m.) o'clock and that nurse stated, 'I'm going to chart it.' h. On 3/5/2020 at 9:47 a.m., CNA #6 was asked, Did you have knowledge of (Resident #39's) missing money? If so, describe. She stated, The only thing I heard was she went out to the doctor. (CNA #7) called me and asked if I knew anything about (Resident's name) money, and I replied I do not. And she asked to go and check in her room in a black pouch. I took the nurse, (Registered Nurse (RN) #2) and another CNA, and we went into the room and to look and we found $6.00. I then informed (CNA #7) about the $6.00 we found. (CNA #7) stated that (Resident's name) said she had $70.00 dollars (I think). The nurse then went and called the husband. She was asked, What actions, if any, did you take in response to the allegation? She stated, I reported it to (RN #2) and she went into the room with us to look for the money. The CNA was asked, Did you report the alleged abuse to any supervisors / administration? Who did you report it to? What was their response? She stated, No. (RN #2) that was working. She stated she was going to look into it and called the residents husband. i. On 3/5/20 at 10:05 a.m., CNA #7 was asked, Do you have knowledge of (Resident #39's) missing money? If so, describe. She stated, Yes. I was one of the ones who took her to the doctor, and we were sitting around waiting for the doctor to come in and we made a comment that we were hungry and asked her what she wanted to eat. She made the statement she wanted to buy us lunch. We told her, 'No. The company provided money to buy her a meal.' She said she had money in her billfold. She got her billfold out and she stated she had $4.00. Then I made the statement that that's not enough to buy her lunch. (Resident's name) then stated she had $60.00. (CNA #5) looked into the billfold along with (Resident's name) and there wasn't any more money. (Resident's name) asked me if she could call her husband. She got him on the phone and told him her money was missing, and he told her not to cry, because she was crying and that it was just money and not to worry. Then (CNA #5) got the phone and was talking to (Husband's name) and she told him, (Resident's name) said she had $60.00 dollars missing. (Husband's name) said if her money is not in the billfold it's in her room in a case or box and he didn't know how much money she had. We called to speak with (CNA #6) and asked her to go to the resident's room to see how money she had in that case. (CNA #6) stated she had $6.00 dollar. After we told (Resident's name) how much was in there, she said, 'Ok.' CNA #7 was asked, What actions, if any, did you take in response to the allegation? CNA #7 stated, I called the facility at the time it happened and talked to (CNA #6). I told the nurses, (LPN (Licensed Practical Nurse) #2) and (RN #2) when we got back to the facility, around 5:00 p.m. And I mentioned it to the DON (Director of Nursing). She was asked, Did you report the alleged abuse to any supervisors / administration? Who did you report it to? What was their response? She stated, The Charge Nurses and DON when I got back to the facility. (RN #2) charted in her Nurses Notes and she was going to contact her husband. I don't recall how the DON responded. j. On 3/5/2020 at 10:37 a.m., RN #2 was asked, When a resident's is missing money / personal property, is that considered a type of abuse? She stated, Yes. She was asked, If so, would you do a reportable? And when. She stated, Yes, report it immediately. RN #2 was asked, Do you have knowledge of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045449	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK MARIANNA, L L C	700 WEST CHESTNUT MARIANNA, AR 72360

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 0602 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) (Resident #39's) missing money? If so, describe. She stated, Yes, I was at the Nurses Station when I heard. (CNA #6) approached me and asked me to go the resident's room and I asked her what was going on and she stated the resident has some money in her room and she needed to see how much. And she wanted me to go with her and look, and I asked her what was going on. She said that the resident had money in a pouch and how much. There was a pouch on the bedside table, and it had approximately 3 to 5 ones (one-dollar bills). I charted a note on it and then I called the husband and I notified the DON. The husband stated to me when I was on the phone with him, 'I think there is more than that. It might be scattered,' and for me not to worry about. She was asked, When and by whom were you notified of the alleged abuse? She stated. (CNA #6) told me. I don't remember when. RN #2 was asked, Did you interview the alleged victim? What interventions were provided, if any? She stated, No. She was gone to her appointment. I gave report to the Charge Nurse, (LPN #2). She was asked, Did you report the alleged abuse to the DON / Administration? Who did you report it to? What was their response? Did you report the alleged abuse to anyone else (e.g., resident representative, attending practitioner)? She stated, Yes, to the DON. I don't recall her response. No. She was asked, Were any external entities (e.g., APS (Adult Protective Services) or law enforcement) contacted? If so, who made the report, to whom, and when? She stated, Not to my knowledge, She was asked, Did you do a reportable on (Resident #39's) missing money? She stated, No. She was asked, When should you report misappropriation of property? RN#2 stated, Immediately. k. On 3/5/2020 at 10:52 a.m., LPN #2 was asked, When a resident is missing money / personal property, is that considered a type of abuse? LPN #2 stated, Yes. She was asked, If so, would you do a reportable? And when. She stated, Yes, as soon as they tell us. She was asked, Do you have knowledge of (Resident #39) missing money? If so, describe. LPN #2 stated, Yes, I heard about the conversation. I was here when (CNA #5) called and she asked (CNA #6) to go to the resident's room to look for her money, to see if she left her money in another purse. And (CNA #6) asked another CNA to go in with her. (RN #2) went in there with the CNAs. I don't know if they found any money. (RN #2) told the DON, and (RN #2) called the husband. She was asked, When and by whom were you notified of the alleged abuse? LPN #2 stated, I heard a conversation at the desk. I don't recall when. She was asked, Did you interview the alleged victim? What interventions were provided, if any? She stated, No, none. She was asked, Do you know if the alleged victim's representative and attending practitioner were notified of the alleged abuse? If so, when and what were the responses? LPN #2 stated, (RN #2) called the husband. She was asked, Did you report the alleged abuse to the DON / Administration? Who did you report it to? What was their response? Did you report the alleged abuse to anyone else (e.g., resident representative, attending practitioner)? She stated, No, I didn't. No. She was asked, Were any external entities (e.g., APS or law enforcement) contacted? LPN #2 stated, I don't remember. She was asked, Did you do a reportable on (Resident #39's) missing money? She stated, No. She was asked, When should you report misappropriation of property? She stated, Immediately. l. On 3/5/2020 at 11:07 a.m., the DON, was asked, When a resident's is missing money / personal property is that considered a type of abuse? She stated, Yes, misappropriation of resident property. She was asked, If so, would you do a reportable? And when? She stated, Yes, Immediately. She was asked, Do you have knowledge of (Resident#39) missing money? If so, describe.' She stated, Yes. I did know that staff called the facility to see if her money was in her room. And there was money in her room. I was under the understanding it was all good. She was asked, Were you told that she was missing $60.00 to $70.00 dollars? She stated, No, not until yesterday. She was asked, When and by whom were you notified of the alleged abuse? She stated, I knew that (Resident #39) said she had money to buy the staff lunch and then when they called to see if her money was here, they found $6.00 and called the husband to ask him how much money she had, and I was told the husband did not know how much money she had and would come look for it. That was the last this money was mentioned until yesterday. She was asked, Did you interview the alleged victim? What interventions were provided, if any? She stated, I did not, but the Administrator did yesterday. She was asked, Do you know if the alleged victim's representative and attending practitioner were notified of the alleged abuse? If so, when and what were the responses? She stated, The husband was notified by (RN #2). She was asked, Did you report the alleged abuse to the Administrator? She stated, No, I did not. She was out with family for medical reasons. She was asked, Were any external entities (e.g., APS or law enforcement) contacted? She stated, No. She was asked, Did you do a reportable on (Resident #39's) missing money? She stated, No. She was asked, When should you report misappropriation of property? She stated, Immediately.' m. On 3/5/2020 at 1:09 p.m., a telephone Interview was conducted with the Administrator. She was asked, When (date and time) were you notified of (Resident #39's) missing money and by whom? She stated, Yesterday, by the Surveyor. I don't remember what time it was. She was asked, What information was reported to you related to the alleged abuse? She stated, That the resident had money missing, $70.00, for a month and the resident told an CNA, and she remembers the CNAs name. She was asked, When and what actions were taken to protect the alleged victim from further abuse while the investigation was in process? She stated, Her husband is going to keep her money. She was asked, What steps were taken to investigate the allegation? Can you provide me a timeline of events that occurred? She stated, Interviewed other residents. Had witness statements taken. We are going to interview other residents. We are just getting started. She was asked, When (Resident #39's) money was reported missing in February, should a reportable have been done? And an investigation started? If so when? She stated, Probably so. It should have been done on the 4th of February (2/4/2020). She was asked, Was a reportable started at the time of the alleged misappropriation of property? She stated, No. She was asked, When should a reportable of abuse and neglect be submitted to the OLTC? She stated, Within 2 hours. She was asked, When should a reportable of misappropriation of property be submitted to the OLTC? She stated, By 11:00 (a.m.) o'clock the next day, 24 hours. n. The facility policy titled Abuse provided by the Administrator on 3/2/20 at 12:12 p.m., documented, .It is the policy of (Facility name) to take appropriate steps to prevent the occurrence of abuse, (verbal, mental, physical, sexual, involuntary seclusion), neglect, injuries of unknown source and misappropriation of resident property and to ensure that all alleged violations of Federal or State Laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property (alleged violation), are reported immediately to the Administrator of the facility . Such violations will also be reported to State agencies in accordance with existing State Law . The facility will investigate each such alleged violation thoroughly and report the results of all investigations to the Administrator or his / her designee, as well as to State agencies as required by State and Federal Law.Reporting . Any employee who suspects an alleged violation shall immediately notify the Administrator or his / her designee. The Administrator / designee shall also notify the appropriate State and Local agencies immediately but not later than . 2 hours if the alleged violation involves abuse or results in serious bodily injury or . 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury. The results of all investigations must be reported to the Administrator or his / her designee and to the appropriate State agency, as required by State Law, within five (5) working days of the alleged violation.The DON, or his / her designee, shall notify the resident's representative that an investigation has been initiated and the appropriate actions will be taken. The contact shall be documented. (Facility name) will analyze any findings of abuse and determine if any changes need to be made in any policies and procedures to prevent further occurrences.Investigation . All investigations shall be conducted by the Administrator or DON . In the event an alleged violation occurs when neither of these people is in the Facility, the Charge Nurse is responsible for initiating the investigation Procedure . The investigation shall include interviews of employees, visitors or residents who may have knowledge of the alleged incident.Corrective Action . The Facility shall make reasonable efforts to determine the cause of the alleged violation and take corrective actions consistent with the investigation findings and to eliminate any ongoing dangers to the resident .
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an allegation of missing money from a resident was immediately reported to the Administrator, which resulted in delays in initiating an investigation to rule out possible abuse / neglect and in reporting the allegation of suspected misappropriation of property to the State agency and other officials in accordance with State law for 1 (Resident #39) of 1 sampled resident who had an allegation of misappropriation of property. The findings are: 1. Resident #39 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/2020 documented the resident scored 7 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS and required total assistance of one to two-person assistance with activities of daily living (ADLs). a. On 3/3/2020 at 10:11 a.m., the resident was asked if she had anything missing? She stated, Oh yes. $70.00. They got in my purse and took it. She was asked, Did you tell someone? She stated, Yes. She was asked, Who did you

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045449	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK MARIANNA, L L C	700 WEST CHESTNUT MARIANNA, AR 72360

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	(continued... from page 3) tell? She stated, My Certified Nursing Assistant (CNA). I have a hard time keeping up with names. She was asked, What did the facility do about it? She stated, Nothing. She was asked, How long ago did this happen? She stated, About a month ago. She was asked, Where did you have it (money)? She stated, In the purse beside the bed. b. On 3/4/2020 at 10:44 a.m., the Administrator was notified of the resident's voiced concern related to the $70.00 missing. She was asked if she knew about (Resident #39's) concern related to missing money. She stated, 'No, her husband doesn't usually leave her any money. She was asked, Did anyone report to you that she allegedly had money missing? She stated, No one reported anything to me. I was just in her room and was not aware she had any money missing. I will call him now. c. The resident's Nurses Notes dated 2/4/2020 documented, .Left for appt (appointment) at 8:50 a.m.2/4/20 at 2:15 p.m. Instructed by R (resident) to look and see how much money was in black and grey pouch . Observed a five-dollar bill and one-dollar bill .Informed husband. Husband stated it should be more .Don't worry about it, I'll find it . d. On 3/4/2020 at 2:30 p.m., the Administrator faxed an Incident and Accident Report, Division of Medical Services (DMS) form 7734 to the Office of Long Term Care (OLTC). The Incident and Accident Report documented, .Type of Incident . Misappropriation of Property . Personal Property Notification . Family, Law Enforcement, Doctor and Administrator . Summary of Incident . 'Patient reported to surveyor on 3/4/2020 that she had $70.00 missing . On 2/4/2020 patient told 2 CNAs that took her to the doctor that she had money missing. Patient on 2/4/2020 contacted her husband and he wasn't aware she had that much money at that time and told her to not worry about it that he would look for it when he came to the nursing home and that it was probably in her other case at the nursing home. Staff contacted facility to get them to go look and patient did have $56.00 in her phone case, and $4.00 in her purse. Nothing was ever reported after that from patient or Husband, so facility thought that all money had been found . On 3/4/2020 Surveyor came to Administrator to ask if she was aware of the missing money and I, the Administrator, told her, 'No.' I then started the investigation to find out that on 2/4/2020 it was reported to the DON and facility hadn't heard anything more from Patient or husband about money missing and facility thought it had been found. When I, Adm (Administrator) went and asked her had the money been found, she (the resident) stated, 'No.' I asked patient if she knew who might have taken it, and she stated, 'No.' When I explained to her that facility was going to replace it, she said, 'No, she didn't want us to do that.' . On February 4, 2020, resident was taken to the doctor's office in (location) by 2 CNAs. It was reported by staff that resident stated she had money taken from her.Resident's husband had told her that the money could be in the case in the room . Checked case in her room and there was $6 in her phone case. Resident was informed that the money was in the case in her room. Husband was contacted by Charge Nurse .He stated that it is probably scattered . (DON's signature) . e. An OLTC Witness Statement Form dated 2/4/2020 and signed by Certified Nursing Assistant (CNA) #5 documented, .took (Resident #39) to doctor .searched in her purse and pulled out $4.00 . stated she had $60 .called her husband .asked if she had $60.00 .he didn't know how much .in her room .called (CNA #6) to look . She had $6.00 . f. On 3/5/2020 at 9:24 a.m., CNA #5 was asked, Did you have knowledge of (Resident #39's) missing money? If so, describe. She stated, Yes, I was the one who took her to her doctor appointment. The nursing home gave us money for lunch. (Resident's name), and she said she was going to pay for the lunch for us. I told her 'No.' She then looked into her purse and says she had money, she had $4.00. She stated she had $60.00 dollars. I then called the facility and talked to (CNA #6) and asked if (Resident's name) had $60.00 dollars on her, and (CNA #6) said, 'I don't know. I just gave her her purse.' I asked (Resident's name) do you remember when she last saw it. She said, 'I don't remember.' She then called her husband and told him, 'My money is gone. I had $60.00.' He said, 'Calm down.' She then handed me the phone. I asked (Husband's name, 'Did you give (Resident's name) any money?' and he told me he did give her some money and that it was at the facility. I asked him where it was, and I called the facility to look where he said, and (CNA #6) looked and she found $6.00. I told (Resident's name) they found $6.00. (Husband name) told the resident not to worry, he was going to look into it. CNA #5 was asked, What actions, if any, did you take in response to the allegation? She stated, I called the facility for (CNA #6) to look for it. The CNA was asked, Did you report the alleged abuse to any supervisors / administration? Who did you report it to? What was their response? She stated, I told one of the evening Charge Nurses, I don't remember who, when I got back around 4:00 (p.m.) or 5:00 (p.m.) o'clock and that nurse stated, 'I'm going to chart it.' g. On 3/5/2020 at 9:47 a.m., CNA #6 was asked, Did you have knowledge of (Resident #39's) missing money? If so, describe. She stated, The only thing I heard was she went out to the doctor. (CNA #7) called me and asked if I knew anything about (Resident's name) money, and I replied I do not. And she asked to go and check in her room in a black pouch. I took the nurse, (Registered Nurse (RN) #2) and another CNA, and we went into the room and to look and we found $6.00. I then informed (CNA #7) about the $6.00 we found. (CNA #7) stated that (Resident's name) said she had $70.00 dollars (I think). The nurse then went and called the husband. She was asked, What actions, if any, did you take in response to the allegation? She stated, I reported it to (RN #2) and she went into the room with us to look for the money. The CNA was asked, Did you report the alleged abuse to any supervisors / administration? Who did you report it to? What was their response? She stated, No. (RN #2) that was working. She stated she was going to look into it and called the residents husband. h. On 3/5/20 at 10:05 a.m., CNA #7 was asked, Do you have knowledge of (Resident #39's) missing money? If so, describe. She stated, Yes. I was one of the ones who took her to the doctor, and we were sitting around waiting for the doctor to come in and we made a comment that we were hungry and asked her what she wanted to eat. She made the statement she wanted to buy us lunch. We told her, 'No. The company provided money to buy her a meal.' She said she had money in her billfold. She got her billfold out and she stated she had $4.00. Then I made the statement that that's not enough to buy her lunch. (Resident's name) then stated she had $60.00. (CNA #5) looked into the billfold along with (Resident's name) and there wasn't any more money. (Resident's name) asked me if she could call her husband. She got him on the phone and told him her money was missing, and he told her not to cry, because she was crying and that it was just money and not to worry. Then (CNA #5) got the phone and was talking to (Husband's name) and she told him, (Resident's name) said she had $60.00 dollars missing. (Husband's name) said if her money is not in the billfold it's in her room in a case or box and he didn't know how much money she had. We called to speak with (CNA #6) and asked her to go to the resident's room to see how money she had in that case. (CNA #6) stated she had $6.00 dollar. After we told (Resident's name) how much was in there, she said, 'Ok.' CNA #7 was asked, What actions, if any, did you take in response to the allegation? CNA #7 stated, I called the facility at the time it happened and talked to (CNA #6). I told the nurses, (LPN (Licensed Practical Nurse) #2) and (RN #2) when we got back to the facility, around 5:00 p.m. And I mentioned it to the DON (Director of Nursing). She was asked, Did you report the alleged abuse to any supervisors / administration? Who did you report it to? What was their response? She stated, The Charge Nurses and DON when I got back to the facility. (RN #2) charted in her Nurses Notes and she was going to contact her husband. I don't recall how the DON responded. i. On 3/5/2020 at 10:37 a.m., RN #2 was asked, When a resident's is missing money / personal property, is that considered a type of abuse? She stated, Yes. She was asked, If so, would you do a reportable? And when. She stated, Yes, report it immediately. RN #2 was asked, Do you have knowledge of (Resident #39's) missing money? If so, describe. She stated, Yes, I was at the Nurses Station when I heard. (CNA #6) approached me and asked me to go the resident's room and I asked her what was going on and she stated the resident has some money in her room and she needed to see how much. And she wanted me to go with her and look, and I asked her what was going on. She said that the resident had money in a pouch and how much. There was a pouch on the bedside table, and it had approximately 3 to 5 ones (one-dollar bills). I charted a note on it and then I called the husband and I notified the DON. The husband stated to me when I was on the phone with him, 'I think there is more than that. It might be scattered,' and for me not to worry about. She was asked, When and by whom were you notified of the alleged abuse? She stated. (CNA #6) told me. I don't remember when. RN #2 was asked, Did you interview the alleged victim? What interventions were provided, if any? She stated, No. She was gone to her appointment. I gave report to the Charge Nurse, (LPN #2). She was asked, Did you report the alleged abuse to the DON / Administration? Who did you report it to? What was their response? Did you report the alleged abuse to anyone else (e.g., resident representative, attending practitioner)? She stated, Yes, to the DON. I don't recall her response. No. She was asked, Were any external entities (e.g., APS (Adult Protective Services) or law enforcement) contacted? If so, who made the report, to whom, and when? She stated, Not to my knowledge, She was asked, Did you do a reportable on (Resident #39's) missing money? She stated, No. She was asked, When should you report misappropriation of property? RN#2 stated, Immediately. j. On 3/5/2020 at 10:52 a.m., LPN #2 was asked, When a resident is missing money / personal property, is that considered a type of abuse? LPN #2 stated, Yes. She was asked, If so, would you do a reportable? And when. She stated, Yes, as soon as they tell us. She was asked, Do you have knowledge of (Resident #39) missing money? If so, describe. LPN #2 stated, Yes, I heard about the conversation. I was here when (CNA #5) called and she asked (CNA #6) to go to the resident's room to look for her money, to see if she left her money in another purse. And (CNA #6) asked another CNA to go in with her. (RN #2) went in there with the CNAs. I don't know if they found any money. (RN #2) told the DON, and (RN #2) called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045449	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK MARIANNA, L L C	700 WEST CHESTNUT MARIANNA, AR 72360

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	(continued... from page 4) the husband. She was asked, When and by whom were you notified of the alleged abuse? LPN #2 stated, I heard a conversation at the desk. I don't recall when. She was asked, Did you interview the alleged victim? What interventions were provided, if any? She stated, No, none. She was asked, Do you know if the alleged victim's representative and attending practitioner were notified of the alleged abuse? If so, when and what were the responses? LPN #2 stated, (RN #2) called the husband. She was asked, Did you report the alleged abuse to the DON / Administration? Who did you report it to? What was their response? Did you report the alleged abuse to anyone else (e.g., resident representative, attending practitioner)? She stated, No, I didn't. No. She was asked, Were any external entities (e.g., APS or law enforcement) contacted? LPN #2 stated, I don't remember. She was asked, Did you do a reportable on (Resident #39's) missing money? She stated, No. She was asked, When should you report misappropriation of property? She stated, Immediately. k. On 3/5/2020 at 11:07 a.m., the DON, was asked, When a resident's is missing money / personal property is that considered a type of abuse? She stated, Yes, misappropriation of resident property. She was asked, If so, would you do a reportable? And when? She stated, Yes, Immediately. She was asked, Do you have knowledge of (Resident#39) missing money? If so, describe.' She stated, Yes. I did know that staff called the facility to see if her money was in her room. And there was money in her room. I was under the understanding it was all good. She was asked, Were you told that she was missing $60.00 to $70.00 dollars? She stated, No, not until yesterday. She was asked, When and by whom were you notified of the alleged abuse? She stated, I knew that (Resident #39) said she had money to buy the staff lunch and then when they called to see if her money was here, they found $6.00 and called the husband to ask him how much money she had, and I was told the husband did not know how much money she had and would come look for it. That was the last this money was mentioned until yesterday. She was asked, Did you interview the alleged victim? What interventions were provided, if any? She stated, I did not, but the Administrator did yesterday. She was asked, Do you know if the alleged victim's representative and attending practitioner were notified of the alleged abuse? If so, when and what were the responses? She stated, The husband was notified by (RN #2). She was asked, Did you report the alleged abuse to the Administrator? She stated, No, I did not. She was out with family for medical reasons. She was asked, Were any external entities (e.g., APS or law enforcement) contacted? She stated, No. She was asked, Did you do a reportable on (Resident #39's) missing money? She stated, No. She was asked, When should you report misappropriation of property? She stated, Immediately. l. On 3/5/2020 at 1:09 p.m., a telephone Interview was conducted with the Administrator. She was asked, When (date and time) were you notified of (Resident #39's) missing money and by whom? She stated, Yesterday, by the Surveyor. I don't remember what time it was. She was asked, What information was reported to you related to the alleged abuse? She stated, That the resident had money missing, $70.00, for a month and the resident told an CNA, and she remembers the CNAs name. She was asked, When and what actions were taken to protect the alleged victim from further abuse while the investigation was in process? She stated, Her husband is going to keep her money. She was asked, What steps were taken to investigate the allegation? Can you provide me a timeline of events that occurred? She stated, Interviewed other residents. Had witness statements taken. We are going to interview other residents. We are just getting started. She was asked, When (Resident #39's) money was reported missing in February, should a reportable have been done? And an investigation started? If so when? She stated, Probably so. It should have been done on the 4th of February (2/4/2020). She was asked, Was a reportable started at the time of the alleged misappropriation of property? She stated, No. She was asked, When should a reportable of abuse and neglect be submitted to the OLTC? She stated, Within 2 hours. She was asked, When should a reportable of misappropriation of property be submitted to the OLTC? She stated, By 11:00 (a.m.) o'clock the next day, 24 hours. m. The facility policy titled Abuse provided by the Administrator on 3/2/20 at 12:12 p.m., documented, .It is the policy of (Facility name) to take appropriate steps to prevent the occurrence of abuse, (verbal, mental, physical, sexual, involuntary seclusion), neglect, injuries of unknown source and misappropriation of resident property and to ensure that all alleged violations of Federal or State Laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property (alleged violation), are reported immediately to the Administrator of the facility . Such violations will also be reported to State agencies in accordance with existing State Law . The facility will investigate each such alleged violation thoroughly and report the results of all investigations to the Administrator or his / her designee, as well as to State agencies as required by State and Federal Law.Reporting . Any employee who suspects an alleged violation shall immediately notify the Administrator or his / her designee. The Administrator / designee shall also notify the appropriate State and Local agencies immediately but not later than . 2 hours if the alleged violation involves abuse or results in serious bodily injury or . 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury. The results of all investigations must be reported to the Administrator or his / her designee and to the appropriate State agency, as required by State Law, within five (5) working days of the alleged violation.The DON, or his / her designee, shall notify the resident's representative that an investigation has been initiated and the appropriate actions will be taken. The contact shall be documented. (Facility name) will analyze any findings of abuse and determine if any changes need to be made in any policies and procedures to prevent further occurrences.Investigation . All investigations shall be conducted by the Administrator or DON . In the event an alleged violation occurs when neither of these people is in the Facility, the Charge Nurse is responsible for initiating the investigation Procedure . The investigation shall include interviews of employees, visitors or residents who may have knowledge of the alleged incident.Corrective Action . The Facility shall make reasonable efforts to determine the cause of the alleged violation and take corrective actions consistent with the investigation findings and to eliminate any ongoing dangers to the resident .
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure an allegation of possible misappropriation of property was thoroughly investigated and protective measures were immediately implemented to rule out potential misappropriation of resident's property and prevent further potential abuse for 1 (Resident #39) of 1 sampled resident who had an allegation of misappropriation of property. The findings are: 1. Resident #39 had [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/2020 documented the resident scored 7 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS and required total assistance of one to two-person assistance with activities of daily living (ADLs). a. On 3/3/2020 at 10:11 a.m., the resident was asked if she had anything missing? She stated, Oh yes. $70.00. They got in my purse and took it. She was asked, Did you tell someone? She stated, Yes. She was asked, Who did you tell? She stated, My Certified Nursing Assistant (CNA). I have a hard time keeping up with names. She was asked, What did the facility do about it? She stated, Nothing. She was asked, How long ago did this happen? She stated, About a month ago. She was asked, Where did you have it (money)? She stated, In the purse beside the bed. b. On 3/4/2020 at 10:44 a.m., the Administrator was notified of the resident's voiced concern related to the $70.00 missing. She was asked if she knew about (Resident #39's) concern related to missing money. She stated, 'No, her husband doesn't usually leave her any money. She was asked, Did anyone report to you that she allegedly had money missing? She stated, No one reported anything to me. I was just in her room and was not aware she had any money missing. I will call him now. c. The resident's Nurses Notes dated 2/4/2020 documented, .Left for appt (appointment) at 8:50 a.m.2/4/20 at 2:15 p.m. Instructed by R (resident) to look and see how much money was in black and grey pouch . Observed a five-dollar bill and one-dollar bill .Informed husband. Husband stated it should be more .Don't worry about it, I'll find it . d. On 3/4/2020 at 2:30 p.m., the Administrator faxed an Incident and Accident Report, Division of Medical Services (DMS) form 7734 to the Office of Long Term Care (OLTC). The Incident and Accident Report documented, .Type of Incident . Misappropriation of Property . Personal Property Notification . Family, Law Enforcement, Doctor and Administrator . Summary of Incident . 'Patient reported to surveyor on 3/4/2020 that she had $70.00 missing . On 2/4/2020 patient told 2 CNAs that took her to the doctor that she had money missing. Patient on 2/4/2020 contacted her husband and he wasn't aware she had that much money at that time and told her to not worry about it that he would look for it when he came to the nursing home and that it was probably in her other case at the nursing home. Staff contacted facility to get them to go look and patient did have $56.00 in her phone case, and $4.00 in her purse. Nothing was ever reported after that from patient or Husband, so facility thought that all money had been found . On 3/4/2020 Surveyor came to Administrator to ask if she was aware of the missing money and I, the Administrator, told her, 'No.' I then started the investigation to find out that on 2/4/2020 it was reported to the DON and facility hadn't heard anything more from Patient or husband about money missing and facility thought it had been found. When I, Adm (Administrator) went and asked her had the money been found, she (the resident) stated, 'No.' I asked patient if she knew who might have taken it, and she stated, 'No.' When I explained to her that facility was going to replace it, she said, 'No, she didn't want us to do that.' . On February 4, 2020, resident was taken to the doctor's office in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045449	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK MARIANNA, L L C	700 WEST CHESTNUT MARIANNA, AR 72360

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) (location) by 2 CNAs. It was reported by staff that resident stated she had money taken from her.Resident's husband had told her that the money could be in the case in the room . Checked case in her room and there was $6 in her phone case. Resident was informed that the money was in the case in her room. Husband was contacted by Charge Nurse .He stated that it is probably scattered . (DON's signature) . e. An OLTC Witness Statement Form dated 2/4/2020 and signed by Certified Nursing Assistant (CNA) #5 documented, .took (Resident #39) to doctor .searched in her purse and pulled out $4.00 . stated she had $60 .called her husband .asked if she had $60.00 .he didn't know how much .in her room .called (CNA #6) to look . She had $6.00 . f. On 3/5/2020 at 9:24 a.m., CNA #5 was asked, Did you have knowledge of (Resident #39's) missing money? If so, describe. She stated, Yes, I was the one who took her to her doctor appointment. The nursing home gave us money for lunch. (Resident's name), and she said she was going to pay for the lunch for us. I told her 'No.' She then looked into her purse and says she had money, she had $4.00. She stated she had $60.00 dollars. I then called the facility and talked to (CNA #6) and asked if (Resident's name) had $60.00 dollars on her, and (CNA #6) said, 'I don't know. I just gave her her purse.' I asked (Resident's name) do you remember when she last saw it. She said, 'I don't remember.' She then called her husband and told him, 'My money is gone. I had $60.00.' He said, 'Calm down.' She then handed me the phone. I asked (Husband's name, 'Did you give (Resident's name) any money?' and he told me he did give her some money and that it was at the facility. I asked him where it was, and I called the facility to look where he said, and (CNA #6) looked and she found $6.00. I told (Resident's name) they found $6.00. (Husband name) told the resident not to worry, he was going to look into it. CNA #5 was asked, What actions, if any, did you take in response to the allegation? She stated, I called the facility for (CNA #6) to look for it. The CNA was asked, Did you report the alleged abuse to any supervisors / administration? Who did you report it to? What was their response? She stated, I told one of the evening Charge Nurses, I don't remember who, when I got back around 4:00 (p.m.) or 5:00 (p.m.) o'clock and that nurse stated, 'I'm going to chart it.' g. On 3/5/2020 at 9:47 a.m., CNA #6 was asked, Did you have knowledge of (Resident #39's) missing money? If so, describe. She stated, The only thing I heard was she went out to the doctor. (CNA #7) called me and asked if I knew anything about (Resident's name) money, and I replied I do not. And she asked to go and check in her room in a black pouch. I took the nurse, (Registered Nurse (RN) #2) and another CNA, and we went into the room and to look and we found $6.00. I then informed (CNA #7) about the $6.00 we found. (CNA #7) stated that (Resident's name) said she had $70 dollars (I think). The nurse then went and called the husband. She was asked, What actions, if any, did you take in response to the allegation? She stated, I reported it to (RN #2) and she went into the room with us to look for the money. The CNA was asked, Did you report the alleged abuse to any supervisors / administration? Who did you report it to? What was their response? She stated, No. (RN #2) that was working. She stated she was going to look into it and called the residents husband. h. On 3/5/20 at 10:05 a.m., CNA #7 was asked, Do you have knowledge of (Resident #39's) missing money? If so, describe. She stated, Yes. I was one of the ones who took her to the doctor, and we were sitting around waiting for the doctor to come in and we made a comment that we were hungry and asked her what she wanted to eat. She made the statement she wanted to buy us lunch. We told her, 'No. The company provided money to buy her a meal.' She said she had money in her billfold. She got her billfold out and she stated she had $4.00. Then I made the statement that that's not enough to buy her lunch. (Resident's name) then stated she had $60.00. (CNA #5) looked into the billfold along with (Resident's name) and there wasn't any more money. (Resident's name) asked me if she could call her husband. She got him on the phone and told him her money was missing, and he told her not to cry, because she was crying and that it was just money and not to worry. Then (CNA #5) got the phone and was talking to (Husband's name) and she told him, (Resident's name) said she had $60.00 dollars missing. (Husband's name) said if her money is not in the billfold it's in her room in a case or box and he didn't know how much money she had. We called to speak with (CNA #6) and asked her to go to the resident's room to see how money she had in that case. (CNA #6) stated she had $6.00 dollar. After we told (Resident's name) how much was in there, she said, 'Ok.' CNA #7 was asked, What actions, if any, did you take in response to the allegation? CNA #7 stated, I called the facility at the time it happened and talked to (CNA #6). I told the nurses, (LPN (Licensed Practical Nurse) #2) and (RN #2) when we got back to the facility, around 5:00 p.m. And I mentioned it to the DON (Director of Nursing). She was asked, Did you report the alleged abuse to any supervisors / administration? Who did you report it to? What was their response? She stated, The Charge Nurses and DON when I got back to the facility. (RN #2) charted in her Nurses Notes and she was going to contact her husband. I don't recall how the DON responded. i. On 3/5/2020 at 10:37 a.m., RN #2 was asked, When a resident's is missing money / personal property, is that considered a type of abuse? She stated, Yes. She was asked, If so, would you do a reportable? And when. She stated, Yes, report it immediately. RN #2 was asked, Do you have knowledge of (Resident #39's) missing money? If so, describe. She stated, Yes, I was at the Nurses Station when I heard. (CNA #6) approached me and asked me to go the resident's room and I asked her what was going on and she stated the resident has some money in her room and she needed to see how much. And she wanted me to go with her and look, and I asked her what was going on. She said that the resident had money in a pouch and how much. There was a pouch on the bedside table, and it had approximately 3 to 5 ones (one-dollar bills). I charted a note on it and then I called the husband and I notified the DON. The husband stated to me when I was on the phone with him, 'I think there is more than that. It might be scattered,' and for me not to worry about. She was asked, When and by whom were you notified of the alleged abuse? She stated. (CNA #6) told me. I don't remember when. RN #2 was asked, Did you interview the alleged victim? What interventions were provided, if any? She stated, No. She was gone to her appointment. I gave report to the Charge Nurse, (LPN #2). She was asked, Did you report the alleged abuse to the DON / Administration? Who did you report it to? What was their response? Did you report the alleged abuse to anyone else (e.g., resident representative, attending practitioner)? She stated, Yes, to the DON. I don't recall her response. No. She was asked, Were any external entities (e.g., APS (Adult Protective Services) or law enforcement) contacted? If so, who made the report, to whom, and when? She stated, Not to my knowledge, She was asked, Did you do a reportable on (Resident #39's) missing money? She stated, No. She was asked, When should you report misappropriation of property? RN#2 stated, Immediately. j. On 3/5/2020 at 10:52 a.m., LPN #2 was asked, When a resident is missing money / personal property, is that considered a type of abuse? LPN #2 stated, Yes. She was asked, If so, would you do a reportable? And when. She stated, Yes, as soon as they tell us. She was asked, Do you have knowledge of (Resident #39) missing money? If so, describe. LPN #2 stated, Yes, I heard about the conversation. I was here when (CNA #5) called and she asked (CNA #6) to go to the resident's room to look for her money, to see if she left her money in another purse. And (CNA #6) asked another CNA to go in with her. (RN #2) went in there with the CNAs. I don't know if they found any money. (RN #2) told the DON, and (RN #2) called the husband. She was asked, When and by whom were you notified of the alleged abuse? LPN #2 stated, I heard a conversation at the desk. I don't recall when. She was asked, Did you interview the alleged victim? What interventions were provided, if any? She stated, No, none. She was asked, Do you know if the alleged victim's representative and attending practitioner were notified of the alleged abuse? If so, when and what were the responses? LPN #2 stated, (RN #2) called the husband. She was asked, Did you report the alleged abuse to the DON / Administration? Who did you report it to? What was their response? Did you report the alleged abuse to anyone else (e.g., resident representative, attending practitioner)? She stated, No, I didn't. No. She was asked, Were any external entities (e.g., APS or law enforcement) contacted? LPN #2 stated, I don't remember. She was asked, Did you do a reportable on (Resident #39's) missing money? She stated, No. She was asked, When should you report misappropriation of property? She stated, Immediately. k. On 3/5/2020 at 11:07 a.m., the DON, was asked, When a resident's is missing money / personal property is that considered a type of abuse? She stated, Yes, misappropriation of resident property. She was asked, If so, would you do a reportable? And when? She stated, Yes, Immediately. She was asked, Do you have knowledge of (Resident#39) missing money? If so, describe.' She stated, Yes. I did know that staff called the facility to see if her money was in her room. And there was money in her room. I was under the understanding it was all good. She was asked, Were you told that she was missing $60.00 to $70.00 dollars? She stated, No, not until yesterday. She was asked, When and by whom were you notified of the alleged abuse? She stated, I knew that (Resident #39) said she had money to buy the staff lunch and then when they called to see if her money was here, they found $6.00 and called the husband to ask him how much money she had, and I was told the husband did not know how much money she had and would come look for it. That was the last this money was mentioned until yesterday. She was asked, Did you interview the alleged victim? What interventions were provided, if any? She stated, I did not, but the Administrator did yesterday. She was asked, Do you know if the alleged victim's representative and attending practitioner were notified of the alleged abuse? If so, when and what were the responses? She stated, The husband was notified by (RN #2). She was asked, Did you report the alleged abuse to the Administrator? She stated, No, I did not. She was out with family for medical reasons. She was asked, Were any external entities (e.g., APS or law enforcement) contacted? She stated, No. She was asked, Did you do a reportable on (Resident #39's) missing money? She stated, No. She was asked, When should you report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045449	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK MARIANNA, L L C	700 WEST CHESTNUT MARIANNA, AR 72360

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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) misappropriation of property? She stated, Immediately. l. On 3/5/2020 at 1:09 p.m., a telephone Interview was conducted with the Administrator. She was asked, When (date and time) were you notified of (Resident #39's) missing money and by whom? She stated, Yesterday, by the Surveyor. I don't remember what time it was. She was asked, What information was reported to you related to the alleged abuse? She stated, That the resident had money missing, $70.00, for a month and the resident told an CNA, and she remembers the CNAs name. She was asked, When and what actions were taken to protect the alleged victim from further abuse while the investigation was in process? She stated, Her husband is going to keep her money. She was asked, What steps were taken to investigate the allegation? Can you provide me a timeline of events that occurred? She stated, Interviewed other residents. Had witness statements taken. We are going to interview other residents. We are just getting started. She was asked, When (Resident #39's) money was reported missing in February, should a reportable have been done? And an investigation started? If so when? She stated, Probably so. It should have been done on the 4th of February (2/4/2020). She was asked, Was a reportable started at the time of the alleged misappropriation of property? She stated, No. She was asked, When should a reportable of abuse and neglect be submitted to the OLTC? She stated, Within 2 hours. She was asked, When should a reportable of misappropriation of property be submitted to the OLTC? She stated, By 11:00 (a.m.) o'clock the next day, 24 hours. m. The facility policy titled Abuse provided by the Administrator on 3/2/20 at 12:12 p.m., documented, .It is the policy of (Facility name) to take appropriate steps to prevent the occurrence of abuse, (verbal, mental, physical, sexual, involuntary seclusion), neglect, injuries of unknown source and misappropriation of resident property and to ensure that all alleged violations of Federal or State Laws which involve mistreatment, neglect, abuse, injuries of unknown source and misappropriation of resident property (alleged violation), are reported immediately to the Administrator of the facility . Such violations will also be reported to State agencies in accordance with existing State Law . The facility will investigate each such alleged violation thoroughly and report the results of all investigations to the Administrator or his / her designee, as well as to State agencies as required by State and Federal Law.Reporting . Any employee who suspects an alleged violation shall immediately notify the Administrator or his / her designee. The Administrator / designee shall also notify the appropriate State and Local agencies immediately but not later than . 2 hours if the alleged violation involves abuse or results in serious bodily injury or . 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury. The results of all investigations must be reported to the Administrator or his / her designee and to the appropriate State agency, as required by State Law, within five (5) working days of the alleged violation.The DON, or his / her designee, shall notify the resident's representative that an investigation has been initiated and the appropriate actions will be taken. The contact shall be documented. (Facility name) will analyze any findings of abuse and determine if any changes need to be made in any policies and procedures to prevent further occurrences.Investigation . All investigations shall be conducted by the Administrator or DON . In the event an alleged violation occurs when neither of these people is in the Facility, the Charge Nurse is responsible for initiating the investigation Procedure . The investigation shall include interviews of employees, visitors or residents who may have knowledge of the alleged incident.Corrective Action . The Facility shall make reasonable efforts to determine the cause of the alleged violation and take corrective actions consistent with the investigation findings and to eliminate any ongoing dangers to the resident .
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the comprehensive Care Plans were accurate and complete and addressed the resident's current care needs for hand mitts to prevent the resident from scratching self and prevent potential infection and skin issues for 1 (Resident#20) sampled resident who had physician's orders [REDACTED].#20 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 12/12/19 documented the resident was severely impaired in cognitive skills for daily decision making and required total assistance of one person for personal hygiene. a. A physician's orders [REDACTED].Hand mitts (mittens) every shift to prevent scratching . Restraint documentation every shift . Check restraint every 30 minutes and release every 2 hr (hours) with ROM (range of motion) (times) 10 min (minutes) . b. As of [DATE] at 12:00 p.m., the residents Plan of Care contained no documentation related to the use of hand mittens. c. On [DATE] at 12:02 p.m., Resident #20 was lying in bed. The resident had padded mittens on both hands. d. On 3/3/2020 at 9:12 a.m., Resident #20 was lying in bed. The resident's right hand was not in a mitten; the left hand was covered by a padded hand mitten. e. On 3/5/2020 at 10:19 a.m., Licensed Practical Nurse (LPN) #1 was asked to come to the resident's room. The resident's left hand was covered with a padded mitten; the right hand was exposed. LPN #1 was asked why the resident has the mittens. She stated, He scratches himself. She stated, He takes the mittens off all the time. It's on the MAR (Medication Administration Record). We check them every 30 minutes, make sure his hands are clean, and do range of motion, and leave them off for a while. f. On 3/5/2020 at 10:29 a.m., the Director of Nursing (DON) was asked, Why does (Resident #20) have hand mittens? She stated, It's to prevent him from scratching, because he digs. She was asked, Should the use of the mittens be included in his Plan of Care? She stated, Yes.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure oral care was routinely and consistently provided to promote good personal hygiene for 1 (Residents #10) sampled resident who was dependent for oral care; and failed to ensure fingernails were clean and trimmed to promote good personal hygiene and prevent possible skin infections and injury for 1 (Resident #20) sampled resident who was dependent for nail care. The findings are: 1. Resident #10 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/1/19 documented the resident scored 00 (0-7 indicates severely impaired), on a Brief Interview for Mental Status (BIMS), was totally dependent for all activities of daily living (ADL's), was always incontinent of bowel and of bladder, and had a Percutaneous Endoscopic Gastrostomy (PEG) tube. a. A physician's orders [REDACTED].NPO (nothing by mouth) status . b. A Care Plan dated 3/1/2019 documented, .Resident is at risk for fluid volume deficit related to diuretic use and tube feeding . Provide oral care Q (every) shift and PRN (as needed) . c. On [DATE] at 2:59 p.m., Resident #10 was lying in bed. The resident's mouth was dry with a white, dry substance on the resident's lips and on the resident's tongue. d. On 3/3/2020 at 2:42 p.m., Resident #10 was lying in bed. The resident's mouth was gaped open. There was a white substance on the resident tongue. There was a thick yellow substance from the roof of the resident's mouth to the tongue. e. On 3/4/2020 at 12:07 p.m., Certified Nursing Assistant (CNA) #2 was asked, When is oral care performed on the residents? CNA #2 stated, In the morning, after meals, and as needed. CNA #2 was asked, Should residents have dry cracked lips with thick white substances on their tongues? CNA #2 stated, No. CNA #2 was asked, Who is responsible for ensuring oral care is done on residents? CNA #2 stated, The aides and the nurses. f. On 3/4/2020 at 1:00 p.m., Licensed Practical Nurse (LPN) #1 was asked, When is oral care done on residents? LPN #1 stated, Daily and as needed. LPN #1 was asked, Should residents have dry cracked lips with a thick white substance on their tongues? LPN #1 stated, No. LPN #1 was asked, Who is responsible for ensuring oral care is done on residents? LPN #1 stated, The Certified Nursing Assistant (CNA) does the task, and the nurse should make sure they are doing it. g. On 3/4/2020 at 1:32 p.m., the Director of Nursing (DON) was asked, When is oral care done on residents? The DON stated, At least twice a day, morning and evening. The DON was asked, Should residents have dry, cracked lips with a thick white substance on their tongues? The DON stated, No. The DON was asked, Who is responsible for ensuring oral care is done on residents? The DON stated, The CNAs are supposed to do it, and the Charge Nurse is supposed to make sure it's done. h. On 3/4/2020 at 1:41 p.m., the Administrator was asked, When is oral care done on residents? The Administrator stated, Daily and as needed. The Administrator was asked, Should residents have dry, cracked lips with a thick white substance on their tongues? The Administrator stated, No. The Administrator was asked, Who is responsible for ensuring oral care is done on residents? The Administrator stated, Nursing staff. i. A facility policy titled Oral Care provided by the Director of Nursing on 3/5/2020 at 3:29 p.m. documented, .CNAs are to provide the following care for residents . oral care must be done at least twice a day .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045449	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK MARIANNA, L L C	700 WEST CHESTNUT MARIANNA, AR 72360

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) 2. Resident #20 had a [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 12/12/19 documented the resident was severely impaired in cognitive skills and required total assistance of one person for personal hygiene. a. The Plan of Care dated 3/14/19 documented, .Resident will be groomed and dressed by staff QD (every day) . staff to provide all ADL (activities of daily living) care to ensure daily needs are met . b. The physician's orders [REDACTED].hand mitts (mittens) every shift to prevent scratching .' c. On 3/3/2020 at 9:12 a.m., Resident #20 was lying in bed. The resident's fingernails of his right hand were approximately 1/4 inch in length, with a dark substance under the nails. (The Surveyor took a photograph of the resident's fingernails at this time.) d. On 3/5/2020 at 10:19 a.m., Licensed Practical Nurse #1 (LPN) was asked to come to (Resident #20's) room. She was asked to look at his exposed right hand and was asked, When are his (the resident's) fingernails cleaned and trimmed? She stated, They are supposed to be cleaned when his is bathed. They are not supposed to be that long. She was asked how long are they, about 1/4 inch? She stated, Yes. He gets a bed bath every day. They should be cleaned and trimmed then. e. On 3/5/2020 at 10:29 a.m., the Director of Nursing (DON) was asked, Should (Resident #20's) fingernails be 1/4 in length with a dark brown substance underneath? She stated, No. f. A facility care list titled CNAs Care Provider List provided by the Director of Nursing on 3/5/2020 documented, .Nail care on bath days and PRN (as needed) .
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the environment was as free of accident hazards as possible, as evidenced by failure to ensure tobacco and lighting materials were secured to prevent potential burn injuries for 1 (Resident #4) of 1 sampled resident who smoked; and a blanket cradle (bed cradle) was properly applied to the bed to prevent potential injury for 1 (Resident #46) of 1 sampled resident who had a bed cradle in place. The findings are: 1. Resident # 4 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/26/2020 documented the resident scored 9 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS), was independent for most activities of daily living (ADLs), and was always continent of bowel and of bladder, and did not contain documentation indicating the resident was a smoker or used tobacco. a. A Smoking assessment dated [DATE] documented, .The resident is able to verbalize . No lighting materials are to be kept in resident's possession . The resident is able to store smoking materials to prevent access by other residents . b. A Care Plan dated 8/26/2019 documented, . (Resident #4) wishes to smoke his pipe and is designated as safe smoker . No lighting material is to be kept in resident's possession . c. On [DATE] at 12:10 p.m., Resident #4 was walking into the facility from outside carrying a rolled-up bag of loose tobacco. d. On [DATE] at 1:06 p.m., Resident #4 was walking in the facility to the Nurses Station. The resident was carrying a rolled-up bag of loose tobacco in his left hand throughout the facility. Resident #4 was asked by the Director of Nursing (DON), What do you need? Resident #4 stated, A lighter. The DON stated, I'll have to get you one. The DON handed a lighter to another staff member. Resident #4 pulled a brown smoking pipe from his right jacket pocket and went outside with the staff member with a lighter. e. On [DATE] at 2:16 p.m., Resident #4 was lying in bed. A tobacco pipe and a bag of tobacco were on the resident's nightstand out in the open. f. On 3/4/2020 at 12:07 p.m., Certified Nursing Assistant (CNA) #2 was asked, Should tobacco and lighters be left out in the open? CNA #2 stated, No. CNA #2 was asked, What could happen if a cognitively impaired resident were to obtain the tobacco and the lighters? CNA #2 stated, They could eat the tobacco and start a fire. CNA #2 was asked, Would this be considered a potential hazard? CNA #2 stated, Yes. g. On 3/4/2020 at 1:00 p.m., Licensed Practical Nurse (LPN) #1 was asked, When are smoking assessments done? LPN #1 stated, Upon admission, quarterly, and yearly. LPN #1 was asked, Should tobacco and lighters be left out in the open? LPN #1 stated, No. LPN #1 was asked, What could happen if a cognitively impaired resident were to obtain the tobacco and lighter? LPN #1 stated, They may chew the tobacco and burn themselves. LPN #1 was asked, Would this be considered a potential hazard? LPN #1 stated, Yes. h. On 3/4/2020 at 1:32 p.m., the Director of Nursing (DON) was asked, When are smoking assessments done? The DON stated, Upon admission and quarterly. The DON was asked, Should tobacco and lighters be left out in the open? The DON stated, Tobacco makes him secure, but the lighter no. The DON was asked, What could happen if a cognitively impaired resident were to obtain the tobacco and lighter? The DON stated, If they are impaired, I don't think they could start a fire. The DON was asked, Would this be considered a potential for hazard? The DON stated, Yes. i. On 3/4/2020 at 1:33 p.m., the Minimum Data Set (MDS) Coordinator was asked, When are smoking assessments done? The MDS Coordinator stated, We need to do them quarterly. j. On 3/4/2020 at 1:41 p.m., the Administrator was asked, When are smoking assessments done? The Administrator stated, On admission and as needed. The Administrator was asked, Should tobacco and lighters be left out in the open? The Administrator stated, No. The Administrator was asked, What could happen if a cognitively impaired resident were to obtain the tobacco and lighter? The Administrator stated, They could start a fire. The Administrator was asked, Would this be considered a potential hazard? The Administrator stated, Yes. k. On 3/5/2020 at 1:06 p.m., Resident #4 was outside at the designated smoking area by himself smoking a tobacco pipe. l. On 3/5/2020 at 1:53 p.m., Resident #4 was outside at the designated smoking area by himself smoking a tobacco pipe. m. A facility policy titled Smoking provided by the Administrator on 3/5/2020 documented, .Resident will not be allowed to keep lighting materials or cigarettes in their possession . Confused and disoriented residents shall not be allowed to smoke unattended . 2. Resident #46 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/3/2020 documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS), required extensive assistance of 1 person for bed mobility, dressing, toilet use, and personal hygiene, required total assistance of 2 persons for transfer, and was always incontinent of bowel and of bladder. a. On [DATE] at 2:27 p.m., Resident #46 was lying in bed. A blanket cradle was at the end of the resident's bed and was not connected to the top part, leaving a round metal bar protruding 2 inches above the bed mattress. b. On 3/3/2020 at 1:30 p.m., Resident #46 was lying in bed. The blanket cradle at the foot of Resident #46's bed was protruding out 3 inches above the bed mattress. c. On 3/4/2020 at 1:24 p.m., Certified Nursing Assistant (CNA) #3 was asked, Can you tell me what this metal bar is and what it is used for? CNA #3 stated, It's to keep the blankets off the resident's feet. There's another bar that is supposed to be on it. CNA #3 was asked, Can you describe the top of the metal bar to me? CNA #3 stated, It's hard, it has sharp edges, it could cause a skin tear. CNA #3 was asked, Would this be considered a hazard? CNA #3 stated, Yes. d. On 3/4/2020 at 1:28 p.m., Certified Nursing Assistant (CNA) #4 was asked, Can you tell me what this metal bar is and what it is used for? CNA #4 stated, It's to keep the sheets and covers off the resident's feet. CNA #4 was asked, Can you describe the top of the metal bar to me? CNA #4 stated, It's sharp and rough and has sharp edges. CNA #4 was asked, Would this be considered a hazard? CNA #4 stated, Yes. e. On 3/4/2020 at 1:32 p.m., the Director of Nursing (DON) was asked, Can you tell me what this metal bar is and what it is used for? The DON stated, Another part of it keeps the blanket off her feet. It's a blanket cradle. The DON was asked, Can you describe the top of the metal bar to me? The DON stated, It's a metal piece, it's small, and it could puncture. The DON was asked, Would it be considered a hazard? The DON stated, Yes. f. On 3/4/2020 at 1:41 p.m., the Administrator was asked, Can you tell me what this metal bar is and what it is used for? The Administrator stated, Normally it's used to keep the blanket off the feet. The Administrator was asked, Can you describe the top of the metal bar to me? The Administrator stated, It's metal, it's kind-a smooth. The Administrator was asked, Would it be considered a hazard? The Administrator stated, Yes.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure oxygen was consistently administered at the flow rate ordered by the physician, to minimize the potential for [MEDICAL CONDITION] or other respiratory complications for 2 (Residents #205 and #39) sampled residents who had physician's orders [REDACTED]. The findings are: 1. Resident #205 had [DIAGNOSES REDACTED]. urinary catheter, and required oxygen therapy. a. A Physician order [REDACTED].Oxygen .PRN (as needed) 2l/m (liters per minute) via N/C (nasal cannula) for SOB (shortness of breath) . b. A Care Plan dated [DATE]20 documented, .Oxygen as prescribed . c. On [DATE] at 11:44 a.m., Resident #205 was lying in bed with oxygen on. The oxygen flow rate was set at 3.5 to 4 liters per minute via nasal cannula. d. On [DATE] at 2:48 p.m., Resident #205 was lying in bed with oxygen on. The oxygen flow rate was set at 4 liters per minute via nasal cannula. e. On 3/3/2020 at 8:42 a.m., Resident #205 was lying in bed with oxygen on. The oxygen flow rate was set at 4 liters per

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045449	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK MARIANNA, L L C	700 WEST CHESTNUT MARIANNA, AR 72360

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 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) minute via nasal cannula. f. On 3/4/2020 at 12:07 p.m., Certified Nursing Assistant (CNA) #2 was asked, Who is responsible for ensuring residents' oxygen is running per physician's orders [REDACTED].#2 stated, Nurses. g. On 3/4/2020 at 1:00 p.m., Licensed Practical Nurse (LPN) #1 was asked, Who is responsible for ensuring residents' oxygen is running per physician's orders [REDACTED].#1 stated, The nurse. LPN #1 was asked, Should physician's orders [REDACTED].#1 stated, Yes. LPN #1 was asked, Should Care Plans be followed? LPN #1 stated, Yes. h. On 3/4/2020 at 1:32 p.m., the Director of Nursing (DON) was asked, Who is responsible for ensuring residents' oxygen is running per physician's orders [REDACTED]. The DON was asked, Should the physician's orders [REDACTED]. The DON was asked, Should Care Plans be followed? The DON stated, Yes. i. On 3/4/2020 at 1:41 p.m., the Administrator was asked, Who is responsible for ensuring residents' oxygen is running per physician's orders [REDACTED]. The Administrator was asked, Should physician's orders [REDACTED]. The Administrator was asked, Should Care Plans be followed? The Administrator stated, Yes. j. On 3/4/2020 at 3:33 p.m., the Director of Nursing (DON) was asked, Do you have a policy for Oxygen Administration? The DON stated, We don't have any policies for oxygen. We follow the physician's orders [REDACTED]. 2. Resident #39 has [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/26/2020 documented the resident scored 07 (0-7 indicates severely impaired) on a Brief Interview for Mental Status (BIMS), required one-person physical assistance with bed mobility and dressing, and required two-plus person physical assistance with transfers and toilet use. a. A physician's orders [REDACTED].Oxygen . prn (as needed) 3 L/M (liters per minute) per N/C (nasal cannula) for SOB (shortness of breath) . b. The Care Plan with a revised date of 1/28/2020 documented, .Breathing Difficulty . Resident has potential for difficulty breathing related to Shortness of Breath . Approaches . Oxygen at 3 L/M (liters per minute) PRN (as needed) for Shortness of Breath . c. On [DATE] at 1:55 p.m., the resident was lying in bed with oxygen via nasal cannula at 2 liters per minute (L/M). d. On 3/3/2020 at 10:27 a.m., the resident was lying in bed with oxygen via nasal cannula at 2 L/M. e. On 3/4/2020 at 12:11 p.m., the resident was lying in bed with oxygen via nasal cannula at 2 L/M. Registered Nurse (RN) # 1 was asked, What is (Resident 39's) oxygen set at? She stated, 2 liters per minute. She was asked, Do you know what it is supposed to be set at? She stated, It is supposed to be at 3 liters per minute. They just switched it out, that's probably what happened.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** Based on record review, the facility failed to ensure 4 (2 on 2-Wing, 2 on 3-Wing) of 4 fire barrier door assemblies were inspected annually in accordance with National Fire Prevention Association (NFPA) 80, Standard for Fire Doors and Other Opening Protectives, in order to ensure the door assemblies would function properly to prevent the spread of smoke / fire from one smoke compartment to another and provide a safe path of egress in the event of a fire. The failed practice had the potential to affect all 62 residents who resided in the facility, according to the Room-Bed List provided by the Director of Nursing (DON) on [DATE]. The findings are: On 3/4/2020 at 1:40 p.m., while reviewing the Life Safety Log, a document titled, Fire Doors Monthly Check contained no documentation to indicate all fire door assemblies were inspected appropriately, and by persons trained to inspect the fire door assemblies.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation and interview, the facility failed to ensure regular and pureed foods were prepared by methods that preserved their and nutritional value, flavor, and appearance to encourage adequate nutritional intake for 1 of 1 meal observed. These failed practices had the potential to affect 3 residents who received a pureed diet, and 57 residents who received a regular diet, according to a Room-Bed list provided by the Director of Nursing (DON) on 3/6/2020. The findings are: 1. On [DATE] at 11:48 a.m., the following observations were made on the steam table: a. A silver pan of broccoli and cauliflower mixture had black, burnt edges. 2. On [DATE] at 11:56 a.m., the following observations were made on the steam table: a. The lunch menu item, pureed chicken and dumplings, appeared runny with a watery consistency. b. The lunch menu item, pureed broccoli and cauliflower, appeared runny with a watery consistency. 3. On 3/3/2020 at 11:18 a.m., Dietary Employee #1 placed English peas in the Robo Coupe bowl, pureed the mixture, and poured the pureed peas in a silver pan. The pureed English peas appeared runny with a watery consistency. Dietary Employee #1 was asked, Do you think the peas looked too watery? She stated, Might be just a little, but not real soupy. Dietary Employee #1 placed the pureed English peas on the steam table to serve to the residents for the lunch meal. 4. On 3/5/20 at 8:59 a.m., the Director of Nursing (DON) was asked, Should pureed food served to residents have a runny and watery consistency? She stated, No. She was asked, Should broccoli and cauliflower served to the residents have burnt edges? She stated, No, ma'am.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure food items were used or promptly discarded on or before the expiration date or use by dates; foods stored in the storage area and refrigerator / freezer were covered, sealed, and labeled/dated to maintain freshness and prevent potential cross-contamination; failed to ensure dietary employees washed their hands between dirty and clean tasks and before handling clean equipment or food items; failed to ensure food preparation equipment was maintained in a clean condition; failed to ensure clean food preparation pans were covered or inverted; and failed to follow manufacturer's instructions for safe dishwashing temperatures / sanitizing solution to prevent the potential for food-borne illness for residents who received meals from 1 of 1 kitchen. These failed practices had the potential to affect 57 (total census: 62) residents who received meals from the kitchen, according to a Room-Bed List provided by Director of Nursing (DON) on 3/6/2020. The findings are: 1. On [DATE] at 11:48 a.m., the following observations were made in the kitchen: a. On [DATE] at 11:48 a.m., one loaf of whole wheat bread was stored on a shelf in the dry storage area. The loaf of bread documented, best if used by date of (NAME)1 ([DATE]). b. On [DATE] at 11:49 a.m., a loaf of sandwich white bread was stored on a shelf in the dry storage area. The loaf of bread was open and contained no date. 2. On [DATE] at 11:53 a.m., Dietary Employee #1 placed a thermometer in a pan of broccoli and cauliflower. Dietary Employee #1 touched the left side of her face, close to her mouth, with her left hand. Without washing her hands, she walked to a cart containing the lunch menu item peach cobbler and checked the temperature of the cobbler. a. On [DATE] at 11: 56 a.m., Dietary Employee #1 walked to the 3-compartment sink, washed the Robot Coupe bowl, lid, and blade with a rag, rinsed it with water, and sanitized it. The Robot Coupe lid still contained a yellow food substance. Dietary Employee #1 placed in 3 (6 ounce) ladles of chicken and dumplings into the Robot Coupe bowl, pureed the mixture, and poured the mixture into a silver pan. She placed the pan of chicken and dumplings on the steam table to serve to residents for the lunch meal service. b. On [DATE] at 12:13 p.m., Dietary Employee #1 washed, rinsed and sanitized the Robot Coupe bowl, lid, and blade in the 3-compartment sink. She took the food preparation items to the preparation area with soap on her right hand and forearm and on the Robot Coupe lid. Dietary Employee #1 walked to the stove, turned a knob on the stove, and without washing her hands, walked back to preparation counter where the Robot Coupe was. She placed 3 (4 ounce) servings of broccoli and cauliflower mixture in the Robot Coupe bowl, retrieved a pan from the pan rack, and sat the pan on the stove. With her left hand, she picked up a red lighter and lit the stove. Without washing her hands, she picked up the pan from the stove and took the pan to the preparation counter where the Robot Coupe was. Dietary Employee #1 poured (2) pints of whole milk into the Robot Coupe, pureed the broccoli and cauliflower mixture, and poured the mixture into a silver pan. 3. On [DATE] at 12:16 p.m., one gallon of Almond milk was stored on a shelf in the reach-in refrigerator. The milk contained a best if used by date of [DATE] ([DATE]). a. On [DATE] at 12:18 p.m., six 4-ounce containers of unsweetened applesauce with strawberry puree were stored on a shelf in the reach-in refrigerator. The containers of applesauce contained no date. b. On [DATE] at 12:19 p.m., one opened 5-pound container of yellow cheese was stored on a shelf in the reach-in refrigerator. The opened container of cheese contained no opened date. c. On [DATE] at 12:21 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045449	A. BUILDING _____ B. WING _____	03/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTPARK MARIANNA, L L C	700 WEST CHESTNUT MARIANNA, AR 72360

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 9) one clear bag of a circular meat substance was stored on a shelf in the reach-in freezer. The bag of meat substance was open and was not sealed. d. On 3/3/2020 at 11:15 a.m., five silver pans were in the kitchen, lying underneath a commercial mixer. The pans were not covered or inverted. 4. On 3/3/2020 at 11:24 a.m., Dietary Employee #1 washed, rinsed with water, and used sanitizer to clean the Robot Coupe bowl, blade and lid, in the 3-compartment sink. She brought the items back to the preparation area. The Robot Coupe bowl still contained a green substance and was not clean. a. On 3/3/2020 at 1:09 p.m., Dietary Employee #2 was in the dishwashing room, dumping food from plates and cups, and putting the eating utensils into tubs of a liquid substance. Dietary Employee #2 filled a tray sitting on the dishwashing preparation area with dirty cups and pushed the cups into the dishwasher and turned the dishwashing machine on. Dietary Employee #2 ran the dishwasher through the wash cycle. The dishwashing temperature on the wash cycle was 110 degrees Fahrenheit and the rinse cycle was 119 degrees Fahrenheit. Dietary Employee #2 was asked to test the sanitizing solution in the dishwashing machine as the dishwasher was running. Dietary Employee #2 reached to where the test strips were located on the machine and there were no test strips in the container to test the chemical sanitizing solution. Dietary Employee #2 was asked if they had any more dishwasher sanitizing solution test strips. She stated, No, we get the from the supervisor. The Administrator was notified that Dietary Employee #2 could not find the chemical sanitizing solution test strips. b. On 3/3/2020 at 1:35 p.m., the Administrator stated, We have the test strips now (chemical sanitizing solution test strips) and we are going to rewash all those dishes (the cups Dietary Employee #2 washed in the machine when the temperature was not per manufacturer's instruction and the sanitizing solution was not tested). Dietary Employee #2 tested the sanitizing solution which registered on the test strip at 0 Parts Per Million (PPM). 5. On 3/5/2020 at 8:54 a.m., the Director of Nursing (DON) was asked, Should food items be within 'use by' date and labeled / dated? She stated, Yes. She was asked, Should an employee touch the side of her face and then check temperatures on the steam table without washing her hands? She stated, No, ma'am. She was asked, Should kitchen utensils / preparation equipment be clean? She stated, Yes. She was asked, Should employees wash their hands between dirty and clean tasks? She stated, Yes. She was asked, Should dishes / utensils be washed / sanitized in the dishwasher per the manufacturer's instructions? She stated, Yes. 6. The manufacturer's instructions for the dishwashing machine provided by the Director of Nursing on 3/5/20 at 11:05 a.m. documented, .compare strip with chart on vial . Minimum 50-00 p.p.m (parts per million) is required . 7. A facility policy titled Dietary Food Safety and Sanitation In-Service provided by the Acting Administrator on 3/5/2020 at 8:20 a.m. documented, .2. Make sure all foods are labeled and dated . 3. Make sure all food in fridge (refrigerator) is labeled and dated . 8. A facility policy titled Handwashing Procedure for Dietary When Are You Required to Hand Wash provided by the Acting Administrator on 3/5/20 at 8:20 a.m. documented, .3. Between dirty and clean tasks . Food stored in freezer, refrigerator, and dry storage must be . 1. Dated, covered, and tightly sealed .