

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025
NAME OF PROVIDER OR SUPPLIER Hillcrest Home		STREET ADDRESS, CITY, STATE, ZIP CODE 1111 Maplewood Rd Harrison, AR 72601	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observations, interviews, record review, document review, and facility policy review, the facility failed to ensure adequate supervision was provided, and the alert alarm system was monitored and tested per manufacturer's recommendation to prevent elopement for 1 (Resident #55) of 3 sampled residents reviewed for accidents/supervision.</p> <p>The findings are:</p> <p>An admission Record was reviewed and revealed Resident #55 had diagnoses that included Alzheimer's disease, dementia with behavioral disturbances, and anxiety.</p> <p>A quarterly Minimum Data Set [MDS] with an Assessment Reference Date [ARD] of April 23, 2025, was reviewed and revealed resident #55 had a Brief Interview for Mental Status [BIMS] of 02 [indicated severely cognitively impaired]. Section GG indicated the resident was able to walk at least 150 feet independently.</p> <p>An undated Care Plan Report was reviewed and indicated that Resident #55 was a high risk for wandering, identified 01/17/2023. Care plan interventions included engagement with purposeful activities (1/17/2023), supervised walks (11/05/2024), pet therapy (3/06/2025), looking out windows, outside with supervision (3/10/2025), independent ambulation but is an elopement risk (3/05/2024), loud noises can be a trigger for the resident, supervise during and after a fire drill (2/27/2024), provide care in a calm reassuring manner, clear simple instructions, [brand name] watch (1/27/2023).</p> <p>A Wander Risk Assessment for Resident #55 dated 1/21/2025 was reviewed and indicated that Resident #55 was a moderate risk for wandering.</p> <p>An Office of Long-Term Care incident document with a submitted date of 3/01/2025 at 8:50 AM was reviewed and revealed that during the facility staff video review, on 2/28/2025 at 5:18 PM, Resident #55 was observed standing by the front entrance door. Resident #55 wore a safety device that automatically locked the door when Resident #55 approached the door. A visitor attempted to open the door from the outside, activating the alarm. After the 15 second wait time, the door lock deactivated and the visitor who was standing on the other side of the door then opened the door and let Resident #55 outside. At 5:20 PM the review indicated a visitor was seen on the video, coming to the front door, then returned to the parking lot, then the visitor was observed returning to the building with Resident #55 without difficulty.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Progress notes dated for a late entry 2/28/2025 were reviewed and revealed while Resident #55 was standing at the front door of the facility, a pharmacy delivery driver approached the door. The door was locked due to the resident guard bracelet setting the door alarm. Once the door alarmed for 15 seconds, the door released, the driver held the door open for Resident #55 to exit the facility. Resident #55 was placed on 30-minute checks and the pharmacy was notified regarding the door alarm system and residents safety.</p> <p>Progress notes dated 7/26/2024 were reviewed and revealed that during a care plan meeting Resident #55 had one elopement within the look back period where Resident #55 made it outside. A Behavior Progress note dated 7/21/2025 was reviewed and revealed a follow-up from an elopement from 7/20/2025. A progress note dated 7/20/2024 was reviewed and indicated that Resident #55 was found outside of the facility in a grassy area by the Administrator and returned to the facility.</p> <p>Progress notes dated 9/29/2024 were reviewed and revealed Resident #55 was observed out of the facility with the door alarm activated. Resident #55 made it out of the facility to the parking lot past the first row of cars, more than 40 feet from the front entrance.</p> <p>During an interview on 5/06/2025 at 8:47 AM, the Information Technology [IT] #1 staff was interviewed and indicated that the IT department was responsible for setting up the alert alarm system, the units are provided after setting up to the nursing staff to place on the residents person. IT #1 denied routinely checking the door alarm system to determine if it was performing as expected, indicating the system was only checked when a new bracelet was being set up. IT #1 stated that if the door wasn't working then someone would notice when it didn't lock when a resident wearing a bracelet got close to the doors, and it didn't lock, confirming that unless a staff member was with the resident when a resident with a guard bracelet on their person went close to the door, if the door wasn't functioning properly, the resident could exit the facility without staff being aware. IT #1 was asked what the manufacturers recommendations for routine monitoring of the alarm system were. IT #1 denied any knowledge of the manufacturing recommendations for monitoring the system. IT #1 confirmed that the last time the alert alarm system was checked was a month or two ago. IT #1 confirmed that there was not any alert to IT if the system wasn't functioning properly. IT #1 confirmed that the facility would not know there was an issue with the system until a resident got out the doors. IT #1 denied having any knowledge of the facility performing any drill for elopement for the system. IT #1 confirmed that the installation company doesn't provide routine onsite checks, only when the facility requests a check of the system. IT #1 remarked that the last time the installation company checked the system was the end of last year, November or December, due to an issue with the door not functioning properly after a resident was able to get the door open part of the way and the alarm not activating. IT #1 stated that after facility staff reviewed the video, Resident #55 was observed pushing the door open partway and the alarm didn't activate. The installation company was notified and when they checked the system, it was determined that a sensor wasn't functioning properly and the wiring had to be reworked.</p> <p>On 05/06/2025 at 8:57 AM, the facility door downstairs at Brookside was activated with a tag provided by IT #1, the door locked, and the alarm sounded, 6 staff members responded to the alarm within 42 seconds, and no phone alerts were received by the staff.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/06/2025 at 9:36 AM, the facility front entry door was tested with a tag provided by IT #1, when the door was approached within 5 feet the door locks were activated, the door handle was depressed once and the alarm sounded, after the 15 second wait time, the door locks released and the surveyor was able to get out of the door and stand in the portico prior to the first employee on the scene. The first unit staff approached the door at 1 minute and 22 seconds after the initial activation of the guard system.</p> <p>During an interview with the Administrator on 5/06/2025 at 1:00 PM, it was revealed that the residents are assessed for elopement on admission and quarterly. The Administrator confirmed that the facility had a door alarm system, staff education, elopement policies and care planning intervention for residents who are high elopement risks. The Administrator confirmed that the staff were in-serviced annually for elopement and thought the drills were conducted annually with the skills fair. When asked if Resident #55 had eloped prior to the elopement in February 2025, the Administrator confirmed that the resident had eloped in July of 2024. The Administrator was asked how Resident #55 exited the facility on 2/28/2025, he confirmed that an outside vendor delivery person held the door open for Resident #55 allowing the resident to exit the facility. The Administrator confirmed that the door alarm system was a [name brand] guard. Explaining that when the system detects the guard bracelet, the door automatically locks, but if the resident pushes on the door an alarm sounds and the phone alerts go out to staff who are expected to respond immediately and redirect the resident. If the door alarm sounds for 15 seconds, then the door lock releases, allowing the door to be opened.</p> <p>During an interview on 05/06/2025 with the visitor who returned the resident to the facility, it was confirmed that on 2/28/2025 between 5:00pm and 5:30pm they observed the resident outside the facility. When the visitor arrived, they recognized a person walking in the parking lot as a resident that resides at the facility. The visitor confirmed that they approached the resident, the resident happily took their hand, and they walked back inside the facility.</p> <p>An undated vendor letter included with the facility reported incident was reviewed and revealed the facility requesting assistance from the vendors to please wait for staff assistance if the alarm had been activated and not allow anyone to exit prior to checking with staff.</p> <p>A System Maintenance and Testing instruction sheet for the electronic elopement/monitoring system was reviewed and revealed the recommendation was system testing at least monthly and periodic testing of these critical performance functions could help prevent undetected security system failures. For a properly functioning system, when a guard tag approaches a monitored door zone equipped with locks, the lock should engage. Test results should be written down and kept in a log.</p> <p>The Elopement-Prevention and Search policy was reviewed and revealed the alarm systems must be maintained and monitored for accurate operation. The vendors and staff should be educated annually on the elopement policy. When the door alarm had been activated, step outside and scan the area for residents or identify the reason for the alarm.</p>		