| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045441 | A. Building<br>B. Wing | 06/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hillcrest Home | 1111 Maplewood Rd<br>Harrison, AR 72601 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and facility policy review, the facility failed to ensure an allegation of abuse were reported to the Administrator and the State Survey Agency (SSA) within the required timeframe for one (Resident #2) of three residents reviewed for abuse. Specifically, the facility received a report of alleged abuse involving Resident #2 on 10/23/2025 (reported by LPN #10 to the Administrator) but did not report the allegation to the SA until 06/19/2026. Additionally, it was revealed by the Clinical Coordinator that the facility received a report of abuse for Resident #2 on 11/17/2025, which was reported to LPN #9, who failed to report the allegation to the Administrator until 11/18/2025.<br><br>The findings include:<br><br>Review of the undated facility policy titled, Abuse, Neglect and Exploitation revealed requirements for reporting all alleged violations to the Administrator, State Agency, Adult Protective Services, and to all other required agencies immediately, but not later than two hours after the allegations is made, if the events that caused the allegations involve abuse or result in serious bodily injury.<br><br>Review of a county law enforcement Dispatch Call Detail revealed that on 10/23/2025 at 2:19 PM the dispatch received a call from the facility. A narrative of the ensuing encounter revealed law enforcement was informed Resident #2 had reported being sexually assaulted by an employee of the facility, and that the facility was conducting an internal investigation.<br><br>Review of an OLTC (Office of Long-Term Care) Incident and Accident (I&A) Report for Resident #2, with a Date of I&A and Discovery Date of 10/23/2025 and a Submitted Date of 06/18/2026, revealed the resident alleged on 10/23/2025 at 11:15 AM that they had been sexually assaulted by a tall guy, and said they were kissed by the big, tall guy [this allegation was] reported to the Unit Manager.<br><br>Review of an OLTC I&A Report for Resident #2, with a Date of I&A of 11/17/2025 at 9:30 PM and a Submitted Date of 11/18/2025 at 3:02 PM, revealed Resident had made a second allegation of sexual assault by the tall guy.<br><br>Review the Advanced Practice Registered Nurse (APRN) progress note dated 10/23/2025 revealed Resident #1 was seen for a body audit due to an allegation of abuse with no negative findings.<br><br>Review of a progress note dated 11/17/205 and authored by LPN #9 indicated Resident #1 alleged being raped. No indication of reporting the allegation to the Administrator.<br><br>Review of the quarterly Minimum Data Set (MDS) dated [DATE] with an Assessment Reference Date<br>(continued on next page) |



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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045441 | A. Building<br>B. Wing | 06/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hillcrest Home | 1111 Maplewood Rd<br>Harrison, AR 72601 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of 10/15/2025 indicated Resident #2 had a Brief Interview of Mental Status score of 03, which indicated severe cognitive impairment.<br><br>Review of Resident #2's Care Plan revealed a focus, modified on 11/19/2025, that indicated the potential to demonstrate physical behaviors towards others, make accusations of spouse cheating and others raping me and occasional nightmares. Interventions for agitation, guide away from sources of distress, engage calmly in conversations, if response is aggressive [toward] staff to walk calmly away and approach later.<br><br>Review of an Order summery indicated resident was on palliative care, and was monitored for episodes of verbal outburst, disruptiveness, accusations of spouse having an affair, or saying other raped them.<br><br>During an interview on 06/16/2026 at 1:30 PM, the Clinical Coordinator indicated LPN #9 was unaware of the facility reporting requirements and did not report the allegation of sexual abuse. The Clinical Coordinator became aware of the sexual abuse allegation by reading the documentation from the night before, then immediately reporting it to the Administrator.<br><br>During an interview on 06/18/2026 at 11:33 AM, the Administrator confirmed the allegation of abuse alleged to have occurred on 10/23/2025 was not reported to the SSA, stating, Resident #2 did not identify the alleged perpetrator at this time, if we had identified the person, we would have suspended the alleged perpetrator.<br><br>During a follow-up interview on 06/16/226 at 12:25 PM, the Administrator indicated when completing the report to the State Agency for the 11/17/2025 incident, it was discovered that there was a gap in timely notifications to the required staff due to lack of a standard process and a checklist to ensure all items are done timely. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045441 | A. Building<br>B. Wing | 06/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hillcrest Home | 1111 Maplewood Rd<br>Harrison, AR 72601 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, facility documents, and policy review, it was determined that the facility failed to provide adequate supervision to prevent elopement for one (Resident #1) of three sample residents who were reviewed for accident and supervision. Specifically, facility staff failed to respond to an exit door alarm on a kitchen exit door, which allowed Resident #1, a cognitively impaired resident with a known history of wandering, to exit the facility unattended into an unsecured area without staff knowledge. The IJ began on 12/24/2025 at 6:14:PM, when Resident #1 eloped through the unsecure kitchen door without staff knowledge. The facility's failure to monitor alarmed exits and to supervise wandering, at-risk residents placed Resident #1 at immediate risk for serious bodily injury, harm, or death due to an altered mental status and exposure to external environmental hazards. The Immediate Jeopardy was removed on 12/26/2025 at 5:28 PM, prior to survey entry. This correction date was verified through a comprehensive review of the facilities plan of correction, including review of mandatory training logs regarding door alarm training protocols. Verification of monitoring logs, revision of policies and procedures, 15-minute check monitoring logs, visual verification of facility equipment changes and verification of retraining through staff interviews. Because the facility identified the deficiency, implemented systemic corrective actions, and achieved substantial compliance prior to the start of the current survey, the deficiency constitutes Past-Noncompliance at a Scope and Severity level of J.<br><br>The Administrator was notified of the Past Non-Compliance (PNC) Immediate Jeopardy on 6/17/2026 at 4:57 PM.^<br><br>The findings include:<br><br>A review of the admission Record for Resident #1 revealed the resident was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia, unsteadiness on feet, and difficulty in walking.^<br><br>A review of the quarterly Minimum Data Set [MDS] assessment with an Assessment Reference Date [ARD] of 10/22/2025 indicated Resident #1 had a Brief Interview for Mental Status [BIMS] of 00, indicating severe cognitive impairment.<br><br>A review of the annual MDS with an ARD of 04/15/2026 indicated Resident #1 had a Staff Assessment for Mental Status [SAMS] assessment of 3 which indicated the resident was severely impaired for daily decision making.<br><br>A review of the Care Plan Report for Resident #1 revealed the following: Resident #1 had impaired cognitive function (07/22/2023) and independent with ambulation (03/21/2024). Resident #1 was care planned as a high risk for wandering (initiated 01/17/2023). A corresponding entry reported Resident #1 liked to walk in the halls independently and all staff were aware of the risk of elopement (initiated 03/05/2024). Diversional Interventions included engagement in purposeful activities, 1:1 time, family visits, supervised walks outside, pet therapy and television (initiated 01/17/2023). Additional interventions included enjoying walks outside in the courtyard and offering walks outside when Resident #1 was restless (initiated 11/05/2024). Resident #1 had a wander alert bracelet device that was placed 01/27/2023.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045441 | A. Building<br>B. Wing | 06/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hillcrest Home | 1111 Maplewood Rd<br>Harrison, AR 72601 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | A review of an Order Summary Report for Resident #1 revealed a physician's order dated 03/10/2025 instructing staff to monitor the resident for episodes of rummaging, wandering, and pacing. A separate physician's order dated 02/13/2024 directed staff to monitor for side effects of antipsychotic medications, including tremors, rigidity, confusion, weakness, and sedation.^<br><br>A review of a facility Wandering Risk Assessment dated 10/21/2025 indicated Resident #1 was at high risk for wandering and had a documented history of wandering behaviors.^<br><br>An internet search of local historical weather data for the municipality on 12/24/2025 revealed the following environmental conditions at the time of the incident. At 5:53 PM the temperature was 69.1 degrees Fahrenheit with winds out of the south at 6.90 miles per hour and clear skies. At 6:53 PM the temperature dropped to 66.0 degrees Fahrenheit.<br><br>During an interview on 6/16/2025 at 1:44 PM, CNA [certified nursing assistant] #1 reported that they joined the search immediately upon completing care with another resident. CNA #1 reported they were informed a door to the kitchen had been propped open, that the door was usually closed and only assessable with a keypad. CNA #1 reported checking the specific door in the kitchen listed on the facility communication device and found it shut. CNA #1 investigated a knocking sound coming from the old dining room and visualized Resident #1 standing outside the back door of the room. ^CNA #1 entered the keycode into the electronic keypad, brought Resident #1 back into the facility, and escorted them back to their home unit. CNA #1 reported Resident #1 did not appear to have any injury and was ambulating as usual upon return. CNA #1 confirmed that when an alert was activated, the provided phones display photos of at-risk elopement residents along with their physical descriptions.<br><br>During an interview on 6/17/2026 at 10:14 AM, CNA #2 indicated that upon reporting for duty on 12/24/2025 at approximately 6:15 PM, the facility communication device was actively alarming. CNA #2 reported that the device had been sounding for approximately two minutes and indicated that the alarm originated from the big kitchen door. CNA #2 entered the kitchen through an interior door that required a keycode for entry and proceeded to the exterior door facing the parking lot that was found partially open. CNA #2 stood in the doorway, looked outside, and observed no one in the vicinity. CNA #2 then entered the keypad code to deactivate the alarm. CNA #2 reported that approximately three minutes later, upon re-entering the home unit of Crestview, they were notified Resident #1 was missing and a facility search was underway. CNA #2 further reported that following Resident #1's elopement on 12/24/2025, they received remedial training on abuse and elopement protocols. CNA #2 reported that the elopement training protocol was modified to require staff to conduct physical searches outside the facility until the precise cause of a door alarm was determined. CNA #2 also reported that the facility communication device dashboard was updated to include photographs of high-risk residents and to require more frequent checks by staff.^<br><br>During an interview on 6/17/2026 at 12:28 PM the Administrator's retrospective review of the facility's electronic alarm log verified that the alarm sounded in the main kitchen on 12/24/2025 at 6:14:47 PM, when Resident #1 eloped from the facility unattended. The Administrator reported that based on the facility's internal investigation, Resident #1 exited the kitchen door, traveled up the uneven ground to the parking lot, walked around the back of the kitchen across uneven pavement to a grassy area and re-entered the facility through the old dining room door. The Administrator reported that the path walked by Resident #1 was approximately 225 ft from the point of exit to the point of re-entry.^<br><br>A joint physical tour of the area occurred on 06/17/2026, observation of the outdoor path traveled by<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045441 | A. Building<br>B. Wing | 06/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hillcrest Home | 1111 Maplewood Rd<br>Harrison, AR 72601 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #1 during the elopement was conducted by the surveyor accompanied by the Administrator. The following environmental hazards were observed: -The designated area consisted of uneven, steep terrain covered in small, shallow pits.ˆ -The path sat approximately 90 feet from a frequently traveled public roadway.ˆ -The exterior entrance to the old dining room door required an individual to ascend three concrete steps to reach the door handle.ˆ<br><br>A review of an untimed OLTC [Office of Long-Term Care] Witness Statement Form dated 12/24/2025 and signed by CNA #3 revealed CNA #3 received a message regarding Resident #1 on 12/24/2025 at 6:16 (PM), at which time they initiated a physical search for the resident.ˆ<br><br>A review of an untimed OLTC [Office of Long-Term Care] Witness Statement Form dated 12/24/2025 and signed by CNA #1 revealed the following timeline:ˆ<br><br>-CNA #1 wrote they were informed Resident #1 was missing. They [CNA #1] were informed by CNA #2 they had cleared the active electronic door alarm.ˆ -CNA #1 conducted a physical search of the facility's interior hallways and returned to the kitchen area to continue the investigation.ˆ -Upon entering the kitchen, CNA #1 heard knocking sounds originating from the old dining room exterior door, proceeded to investigate, and observed Resident #1 standing outside the facility unattended. -CNA #1 immediately brought Resident #1 back into the facility and escorted the resident to their assigned home unit.ˆ<br><br>A review of an untimed OLTC [Office of Long-Term Care] Witness Statement Form dated 12/24/2025 and signed by CNA #2 revealed the following documented facts:ˆ -CNA #2 reported for duty on 12/24/2025 and observed that the Big Kitchen door was actively sounding. -CNA #2 proceeded to the kitchen area and cleared the active alarm.ˆ -CNA #2 explicitly documented that they deactivated the alarm system without checking the outside grounds or exterior perimeter of the door.<br><br>A review of a facility policy titled Elopements and Wandering Residents with a revised date of 12/21/2025 revealed the following operational mandates:ˆ<br><br>-The facility would ensure residents who exhibit wandering behavior or are at risk for elopement received adequate supervision. Residents would receive care according to their personalized plan of care that specifically addressed their unique behaviors contributing to a wandering or elopement risk.<br><br>-Every staff member would be responsible for the physical location of residents.ˆ Wandering was defined as a random or repetitive locomotion that may or not be goal directed.<br><br>- Elopement was defined as when a resident left the premises or safe area without the proper authorization or supervision.ˆ -Policy directives included utilization of door alarms, locking mechanisms, and wander alert devices to prevent elopements.ˆ<br><br>-The Policy mandated the ongoing monitoring of safety devices, monthly door alarm drills with response time audits, structured outside search protocols, and the utilization of internal communication systems. The policy explicitly required that the outside area of an alerting exit must be searched immediately. ˆ<br><br>Review of the facility's Action Plan following the elopement incident on 12/24/2025 revealed the following interventions had been enacted prior to the survey team entering the facility:<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 045441 | A. Building<br>B. Wing | 06/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hillcrest Home | 1111 Maplewood Rd<br>Harrison, AR 72601 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | -The removal of the doorstop from the kitchen door immediately to prevent it from being propped open, to avoid residents having unimpeded access to the kitchen.<br><br>-The facility placed highly visible signage on the kitchen door instructing staff and visitors to keep the door closed at all times.ˆ<br><br>-Increased monitoring through visual and electronic communication device and the facility placed Resident #1 on formal 15-minute safety checks daily. These checks begin at 4:00 PM and continue until the resident is safely in bed for the night.ˆ<br><br>-Resident #1's care plan was updated to mandate that staff-to-staff communication addressing Resident #1's specific location whenever they were away from their home unit.ˆ<br><br>-The intra-facility communication plan implemented a structured communication plan for staff to share real-time updates when wandering residents were observed in their respective areas, specifically identifying individuals designated as high wander risks.<br><br>-Alarm system auditing with scheduled monthly monitoring and testing of the electronic alarm system staff's reaction times.<br><br>-Mandated an immediate outside search protocol for any facility alarm that is activated without a known or obvious cause.ˆ<br><br>-Conducted a comprehensive facility assessment of residents for elopement risk, ensuring any resident assessed as an elopement risk was added to the intra-facility communication plan.<br><br>A review of an Elopement training document verified that mandatory staff training was initiated 12/26/2025. The education program provided targeted instruction on elopement procedures, execution of structured elopement drills and specific parameters for outdoor search methods.ˆ |