Printed: 03/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045177	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Dewitt, LLC	1325 Liberty Drive DE Witt, AR 72042

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. Based on interview and record review, the facility failed to ensure residents with a trust account had access to their personal funds after business hours and on weekends for 1 (Residents #20) sampled resident. The findings are: On 10/02/24 at 10:30 AM, the Surveyor asked Resident #20 who handled the residents' money. Resident #20 indicated that the facility handles the residents' money. Resident #20 was asked if the resident was able to access funds on the weekend. Resident #20 indicated no; you must get your money from the business office by Friday if you want money for the weekend. On 10/03/24 at 9:55 AM, the Surveyor asked the Business Office Manager (BOM) if the residents have access to their money on weekends. The BOM indicated the residents come to the BOM office by Friday and get a check to get funds, or they will tell a nurse on the weekend and the nurse will call the BOM and she will come up here and get the funds for the resident. The BOM was asked when the last time she had to come up to the facility on the weekend to get funds for a resident. The BOM indicated she could not remember; it had been a long time. The Surveyor asked the BOM if the new residents had been informed of how to acquire funds on the weekend, either by getting funds before Friday or asking a nurse to call the BOM. The BOM indicated she was not sure. On 10/03/2024 at 2:30 PM, the Administrator indicated that they did not have a personal funds policy.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Dewitt, LLC	1325 Liberty Drive DE Witt, AR 72042

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interviews, record review, and facility document review, it was determined the facility failed to coordinate with the state designated office to get a Preadmission Screening and Resident Review (PASARR) evaluation for a resident to ensure the resident received designated services for 1 (Resident #19) of 1 sampled resident. Findings include: A review of the electronic health records indicated the facility admitted Resident #19 on 02/28/2023 with diagnoses that included psychotic disorder with delusions due to known psychotic disorder; bipolar disorder, current episode depressed, mild; anxiety disorder, unspecified. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/06/2023, revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 7 which indicates the resident had sever cognitive impairment, and had diagnoses of anxiety disorder, bipolar disorder, psychotic disorder (other than schizophrenia). A review of Resident #19's Resident Plan of Care, revised 06/26/2024, revealed the resident had the potential regarding Bipolar Disorder, Psychotic Disorder) Other Than Schizophrenia). Interventions included Observe for any S/S [signs/symptoms] of drug related: (if noted report to nurse), hypotension, gait disturbance, cognitive impairment, behavioral impairment, ADL [Activities of Daily Living] decline, decline in appetite. Report to physicians any negative outcomes associated with use of drug. Administer medication as prescribed by the physician. Educate resident/family on potential risk/benefits of psychotropic drug use. Monitor for effectiveness of psychotropic drug(s) and review for changes at psychotropic committee meeting. During an interview on 10/03/2024 at 2:42 PM, the Director of Nursing (DON) indicated that she was the one responsible for ensuring admission PASARRs were completed and sent to the State Designated Professional Associate. The DON indicated that they did not have a PASARR for Resident #19. The DON indicated that they completed an initial assessment on Resident #19 before admission. The DON indicated that they did not realize they had to do a PASARR after admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure nail care was provided to toenails for 1 (Resident #20) sampled resident reviewed for nail care. The findings are: On 09/30/2024 at 12:25 PM, Resident #20 was observed lying in bed awake with feet exposed. The resident's great toenails on both feet were greater than a quarter inch (1/4) in length and thick. Resident #20's Physician's Orders were reviewed and indicated diagnoses of a long-term lung disease that causes difficulty breathing (chronic obstructive pulmonary disease) and lack of coordination. A physician's order dated 12/13/2016 indicated the resident may be seen by a podiatrist as needed. An annual Minimum Data Set with an Assessment Reference Date of 07/09/2024 was reviewed and indicated Resident #20 had a Brief Interview for Mental Status score of 15, which indicated cognitively intact and required partial/moderate assistance with personal hygiene. A Resident Plan of Care, dated as reviewed 07/19/2024, was reviewed and indicated Resident #20 had a self-care deficit in activities of daily living (ADLs) and required staff assistance of one person with personal hygiene. The Daily Whirlpool/Bath List sheets, provided by the Director of Nursing (DON) on 10/03/2024, were reviewed and indicated the following for Resident #20: received baths on 09/12/2024, 09/19/2024, 9/21/2024, 9/26/24, 10/1/2024; refused baths on 09/07/2024, 09/14/2024, 09/24/2024; on 09/05/2024, 3:32 Stop was documented. Resident #20's Nurse's Notes, dated 03/26/2024 through 09/28/2024, were reviewed and there was no indication nail care was refused. On 10/03/2024 at 1:33 PM, Certified Nursing Assistant (CNA) #7 was interviewed and asked when Resident #20 received a bath/shower. She stated on Tuesdays, Thursdays, and Saturdays on the evening shift, but Resident #20 had received baths on the day shift when requested. She stated the resident could bathe self, but staff washed the resident's hair and back as needed. She was asked who was responsible for nail care to the resident's hands and feet. She stated diabetic nail care was provided by the nurse, and non-diabetic nail care was provided by the CNAs. She stated CNAs did not document nail care, but they could write on the side of the bath sheet when nail care was done for residents. On 10/03/2024 at 1:24 PM, Resident #20 was observed lying in bed awake. The resident was asked if the staff provided nail care to the resident's toes. The resident stated a lady comes to the facility, but she did not do the resident's toenails. Sometimes the resident needed to go to the podiatrist because the resident has calluses on the bottom of the feet and sometimes the resident's feet hurt. On 10/03/2024 at 3:45 PM, the DON provided a typed statement which was reviewed and indicated, Nail care is provided by CNA on bath days and PRN [as needed). Diabetic nails are trimmed by license personnel only.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 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. Based on observation and interview, the facility failed to ensure potential hazardous chemicals were secured and stored behind a locked door. The findings are: On 09/30/2024 at 11:26 AM, this surveyor approached the beginning of hall 600. The door to the whirlpool room was observed open. This surveyor entered the whirlpool room and observed a 1-gallon jug of [brand name] surface disinfectant cleaner, 2 spray bottles of [brand name] surface disinfectant cleaner on an over bed table to the right of the whirlpool. There was a 1-gallon jug of tearless shampoo and body wash, 1 blue razor sitting directly on the whirlpool and 2 blue razors inside a purple basket with holes sitting directly on top of the whirlpool. On 09/30/2024 at 11:30 AM, Certified Nursing Assistant (CNA) #1 was observed passing by the whirlpool room on hall 600. She was asked if the door to the whirlpool was supposed to be open. She stated, As far as I know it's supposed to be shut. She stated CNA #4 was responsible for providing whirlpool baths to the residents on this day. On 10/03/2024 at 9:18 AM, CNA #4 was interviewed and asked who had access to the whirlpool room. She stated herself, housekeeping, maintenance, and all the CNAs. She confirmed the door to the whirlpool room should be closed and locked when not in use. She stated there were chemicals, soap, shampoo and conditioner in the whirlpool room. She stated the cleaner for the whirlpool room was a chemical used to clean the chair and whirlpool and they could be harmful to the residents. On 10/03/2024 at 3:40 PM, the Director of Nursing (DON) provided the Material Safety Data Sheet, not dated, for [brand name] surface disinfectant cleaner. The document was reviewed and indicated the chemical could cause moderate skin irritation, could be harmful if swallowed and to seek medical attention if ingested. On 10/03/2024 at 3:40 PM, the DON provided a typed statement which was reviewed but did not address if the facility had a policy on accidents and hazards and no policy was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure oxygen was administered at the physician's ordered rate for 1 (Resident #20) sampled resident reviewed for oxygen (O2) use and failed to provide a policy and procedure for respiratory care and services according to professional standards of practice. The findings are: Resident #20's Physician's Orders, were reviewed and indicated a diagnosis of a long-term lung disease that causes difficulty breathing (chronic obstructive pulmonary disease). A physician's order dated 09/23/2024 indicated oxygen 2 to 4 (2-4) liters (L) nasal cannula (NC) to keep O2 saturation (sat) above 93 percent (%). An annual Minimum Data Set with an Assessment Reference Date of 07/09/2024 was reviewed and indicated Resident #20 had a Brief Interview for Mental Status score of 15, which indicated cognitively intact, and the resident had shortness of breath/trouble breathing. A Resident Plan of Care, dated as reviewed 07/19/2024, was reviewed and indicated Resident #20 required oxygen by way of a NC at a rate of 2 to 4 liters to keep the O2 saturation greater than 93%. On 09/30/2024 at 12:25 PM, Resident #20 was lying in bed awake with nasal cannula prongs in the nose. The nasal cannula was attached to a humidifier bottle dated 09/29/2024. The oxygen concentrator was on and set at 4.5 liters per minute. On 10/01/2024 at 12:46 PM, Resident #20 was lying in bed with eyes closed with NC prongs in the nose. The nasal cannula was attached to a humidifier bottle dated 09/29/2024. The oxygen concentrator was on and set at 4.5 liters per minute. On 10/03/2024 at 1:26 PM, Registered Nurse (RN) #6 was interviewed with concurrent observation. She was asked to look at Resident #20's O2 and she confirmed the rate was at 4.5 liters per minute. She stated the resident's physician ordered oxygen rate was 2, but no more than 4 liters per minute. She stated the nurses set the rate on the O2 concentrator and this should be checked every shift. She stated the O2 setting should be checked to make sure the physician's orders were followed. She stated for a resident with COPD, if the O2 setting was too high, the resident could retain carbon dioxide (CO2) (a gas which stimulates breathing). On 10/03/2024, the Director of Nursing (DON) was asked to provide a policy for oxygen administration. At 3:45 PM, the DON provided a typed statement which was reviewed and indicated, The policy for oxygen is to administer oxygen per physician's orders and to change tubing and storage bag every week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review, and interview, the facility failed to accurately account for a controlled liquid narcotic, Lorazepam, after narcotic being administered to 1 (Resident #5) sampled resident who was reviewed for pharmaceutical services. The findings are: On 10/02/2024 at 3:33 PM, this surveyor and Registered Nurse (RN) #2 entered the medication storage rooms. RN #2 unlocked a small refrigerator, in which the contents were observed, and a box that contained a bottle of Lorazepam 2 milligrams/milliliters (mg/ml) liquid was inside. The liquid inside the bottle was approximately at the 20 ml black line on the bottle. The manufacturer's guidelines on the bottle indicated to discard an opened bottle 90 days after being opened. There was no date on the box or bottle. On 10/01/2024 at 4:06 PM, a narcotic log was reviewed and indicated on page 92, a 30 ml bottle of Lorazepam liquid was received from the pharmacy. On 03/18/2024 at 1215 (12:15 PM), a 0.5 (ml) dose of Lorazepam was signed out of the log but was added to the balance, instead of subtracted and the balance indicated 29.75 (ml) remaining, instead of 29.25 ml. On 05/23/2024 at 1600 (4:00 PM), the balance indicated 25.25 [ml] of Lorazepam remaining in the bottle. A second narcotic log was reviewed and indicated page 32 was started on 05/28/2024, with a balance-forward of 25.25 (ml) of Lorazepam. On 09/26/2024 at 1420 (2:20 PM), the balance indicated 22.25 (ml) of Lorazepam should be in the bottle (a 2.25 ml discrepancy). On 10/01/2024 at 4:55 PM, this surveyor informed the Director of Nursing (DON) of a discrepancy in the liquid Lorazepam remaining count. She was informed the bottle indicated about 20 ml remained, and the narcotic log indicated 22.25 ml remained which was a 2.25 ml difference. She stated she would review the concern. Resident #5's Physician's Orders were reviewed and indicated a diagnosis of anxiety. An order dated 05/07/2024 indicated Lorazepam 2 mg/ml and give 0.25 ml sublingual (SL) as needed every 6 hours. Resident #5's quarterly Minimum Data Set with an Assessment Reference Date of 07/23/2024, was reviewed and indicated the resident had a Staff Assessment of Mental Status score of 3, which indicated the resident was severely cognitively impaired. On 10/02/2024 at 10:10 AM, an in-service training report on medication administration, dated 06/10/2024 and conducted by the DON, was reviewed and indicated if any discrepancies were found, the DON was to be notified. On 10/02/2024 at 11:38 AM, the DON provided a typed statement, which was reviewed and indicated during calculation of a dose in the narcotic log on 03/18/2024, a dose was added, instead of subtracted from the count and the correct remaining balance was 21.25 ml [a 1.25 ml discrepancy]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/2024 at 1:39 PM, the DON stated the pharmacy consultant did not conduct narcotic audits but audited if the narcotic log matched the medications the nurses signed on the MAR as administered. She stated the pharmacist comes monthly but only does random narcotic counts. She stated the facility did not have a process on how the nurses performed narcotic counts, but the nurses counted the narcotics every shift. On 10/02/2024, the DON provided a copy of the Controlled Drug Count narcotic log from 03/18/2024 to 10/02/2024. The count was performed 430 times by licensed nurses during this period. There were 29 occurrences where one signature was observed instead of two signatures of licensed nurses for a shift count. On 10/02/2024 at 5:55 PM, this surveyor observed RN #2 and Licensed Practical Nurse (LPN) #3 perform a change of shift narcotic count of the medication cart used to administer medications to the 300 Hall in the medication storage room, with the DON present. During the count, LPN #3 observed the bottle of Lorazepam from the refrigerator and stated there were approximately 19 ml in the bottle. RN #2 stated the bottle was over 20 ml. LPN #3 requested to measure the contents of the bottle manually. The DON stated the contents had been measured earlier with 3 people observing the process. LPN #3 accepted the DON and RN #2's account of the amount in the Lorazepam bottle and the count continued. After the narcotic count was complete, both nurses signed the narcotic log and LPN #3 accepted the keys to the medication cart. On 10/03/2024, the DON provided a list of all the nurses who counted the bottle of Lorazepam after the discrepancy occurred on 03/18/2024 and 14 licensed nurses were listed. The Lorazepam insert, provided by the DON on 10/03/2024, was reviewed and indicated in the dosage and administration section to use only the calibrated dropper provided with the product.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on record review and interview, the facility failed to ensure an as needed psychotropic medication, Lorazepam, was not continued past 14 days without a physician's documented rationale and duration for 1 (Resident #30) sampled resident reviewed for as needed (PRN) psychotropic medication. The findings are: Resident #30's Physician's Orders were reviewed and indicated a diagnosis of anxiety. An order dated 02/22/2024 indicated Ativan 1 milligram (mg) per tube every 8 hours as needed for anxiety. An annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/02/2024, was reviewed and indicated the resident had a Staff Assessment for Mental Status score of 2, which indicated the resident was moderately cognitively impaired and received an antianxiety medication. A Consultation Report dated 04/01/2024 was reviewed and indicated the resident had a PRN order for an anxiolytic, Ativan, without a stop date. The recommendation indicated if the medication could not be discontinued at the time, the documentation had to include 3 items: 1. an indication for use, 2. the anticipated or expected duration of therapy, which the provider left blank, and 3. the rationale for the extended time period, which the provider left blank. On 10/03/2024 at 2:03 PM, the Director of Nursing (DON) was interviewed and asked how and when the provider received the gradual dose reduction forms from the pharmacist for review. She stated she provided the forms to the doctors when they came every month. She stated the medical director looked at his on the second Wednesday of every month during his visits. She stated she followed up with the providers to ensure all areas of the GDR were completed. She was asked if she reached out to the provider if something was missing on the form. She stated no. She was asked if she knew the length of time a resident could take a PRN psychotropic. She said 14 days. On 10/03/2024, the DON provided a typed statement which was reviewed and indicated the facility did not have a written policy concerning GDRs. The statement indicated that after the pharmacist provided the facility with the recommendation, the doctor reviewed the information and was responsible for filling out the form and providing a rationale for the declination. The statement indicated psychotropic medications were administered per the physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, record review, and facility policy review, the facility failed to maintain a medication error rate of less than 5% to prevent complications for 2 (Residents #10 and #15) sampled residents observed during medication pass resulting in medication errors. The findings include: 1. A review of the Physician's Orders, revealed Resident #10 had an order for Digoxin 125 microgram (MCG), and to hold the medication if pulse is less than 60 beats per minute (BPM) listen to pulse for one full minute. a. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/17/2024 revealed on the Brief Interview for Mental Status (BIMS) that Resident #10 scored 11 indicating moderate cognitive impairment and had the diagnoses of heart failure and the presence of a heart assistive device. b. On 10/01/2024 at 04:21 PM, the Surveyor observed Registered Nurse (RN) #2 did not check the heart rate of Resident #10 prior to administering the medication Digoxin 125 MCG to Resident #10. c. On 10/01/2024 at 04:25 PM, during an interview RN #2 stated she had forgotten to check the resident's heart rate prior to administering the medication. 2. A review of the Physician's Orders revealed Resident #15 had an order for Renvela (a medication for chronic disease) 800 milligrams (MG) at 7:00 AM, 12:00 PM and 5:00 PM and to give with meals and Tylenol 650 mg give 2 tablets twice a day. a. Review of the quarterly MDS with an ARD of 7/23/2024 revealed on the BIMS that Resident #15 scored 15 indicating the resident was cognitively intact, and had diagnoses of renal insufficiency, renal failure, and end stage renal disease (ESRD). b. A review of the Resident Plan Of Care, for Resident #15 (problem date 5/06/2023) revealed Resident #15 was receiving hemodialysis. c. On 10/01/24 at 04:09 PM, the Surveyor observed RN #2 administer medications to Resident #15 while the resident sat in the common area not eating. d. On 10/02/24 at 2:23 PM, during an interview RN #2 stated Resident #15 was not eating at the time the Renvela was administered and she forgot to give Resident #15 the Tylenol. e. On 10/03/24 at 09:00 AM, during an interview the Director of Nursing (DON) stated that according to the Physician's Orders Renvela was to be given with food, evening meal was served starting at 5:00 PM, and an acceptable time to administer the medication would have been 30 minutes prior to mealtime. f. A policy titled, Administering Medication, noted medications must be administered in accordance with the physician's orders, including any required time frame. Medications must be administered within one hour of their prescribed time, unless otherwise specified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to ensure the nurse checked the heart rate for 1 (Resident #10) sampled resident prior to the administration of a medication used to treat a heart condition by slowing down the heart rate and making sure the heart beats stronger resulting in a significant medication error. The findings include: A review of the Physician's Orders, revealed Resident #10 had an order for Digoxin 125 microgram (MCG), and to hold the medication if pulse is less than 60 beats per minute (BPM) listen to pulse for one full minute. Review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/17/2024 revealed on the Brief Interview for Mental Status (BIMS) that Resident #10 scored 11 indicating moderate cognitive impairment and had the diagnoses of heart failure and the presence of a heart assistive device. On 10/01/2024 at 04:21 PM, the Surveyor observed Registered Nurse (RN) #2 did not check the heart rate of Resident #10 prior to administering the medication Digoxin 125 MCG to Resident #10. On 10/01/2024 at 04:25 PM, during an interview RN #2 stated she had forgotten to check the resident's heart rate prior to administering the medication. On 10/03/24 at 09:00 AM, during an interview the Director of Nursing (DON) stated that according to the Physician's Orders the nurse should have checked the heart rate prior to administering the medication and the medication should have been held if the heart rate was less than 60 BPM. The DON stated administering the medication without knowing the heart rate could potentially have a negative outcome on the resident by causing a low heart rate, which is serious. A policy titled, Administering Medication, noted that medications must be administered in accordance with the physician's orders and vital signs must be checked if necessary prior to administering the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 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 observation, record review, and interview, the facility failed to consistently implement a system to accurately reconcile and dispose of a controlled liquid narcotic, Lorazepam, 90 days after the bottle was opened, according to the manufacturer's instructions on the bottle for 1 (Resident #5) sampled resident who was reviewed for disposition of Lorazepam. The findings are: On 10/01/2024 at 3:33 PM, this surveyor and Registered Nurse (RN) #2 entered the medication storage room. RN #2 unlocked a small refrigerator, in which the contents were observed, and a box with a bottle of Lorazepam 2 milligrams/milliliters (mg/ml) liquid was inside for Resident #5. The liquid inside the bottle was approximately at the 20 ml black line on the bottle. The manufacturer's guidelines on the bottle indicated to discard the bottle 90 days after being opened. There was no date on the box or bottle. On 10/01/2024 at 4:06 PM, a narcotic log was reviewed and indicated on page 92 that Resident #5 received a 30 ml bottle of Lorazepam liquid from the pharmacy. On 03/03/2024 at 0730 (7:30 AM), 0.25 ml of Lorazepam was signed out of the narcotic log, leaving a balance of 29.75 [ml]. A second narcotic log was reviewed and indicated page 32 was started on 05/28/2024 and indicated a balance forward of 25.25 [ml] of Lorazepam. On 09/26/2024 at 1420 (2:20 PM), 0.5 [ml] of Lorazepam was signed out of the narcotic log. Resident #5's Physician's Orders were reviewed and indicated an order dated 05/07/2024 for Lorazepam 2 mg/ml and give 0.25 ml sublingual (SL) as needed every 6 hours. Resident #5's quarterly Minimum Data Set with an Assessment Reference Date of 07/23/2024, was reviewed and indicated the resident had a Staff Assessment of Mental Status score of 3, which indicated the resident was severely cognitively impaired, and had special treatments from hospice care. On 10/03/2024 at 3:45 PM, the Director of Nursing (DON) was interviewed and asked what the facility's process was for removing and returning narcotics for destruction. She stated the narcotic medications were logged on a form and the nurse working on the medication cart where the medications were removed was the witness. She stated liquid medications were measured and placed in a [name brand] bag. She stated the logs were rubber banded around the medication, placed in a sealed box and sent by way of certified mail to be destroyed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and facility policy review, the facility failed to ensure a staff's hair was contained while preparing and serving food, and staff used proper hand hygiene while preparing and/or serving a meal. The findings include: On 10/02/24 at 9:30 AM, the Surveyor observed the Dietary [NAME] (DC) with gloved hands stop cutting raw meat, without removing the gloves and washing her hands, she grabbed a can of cooking spray and then sprayed the cooking spray on a baking pan. The Dietary [NAME] then returned to cutting raw meat without removing the gloves and washing her hands. On 10/02/24 at 9:40 AM, the Surveyor observed the Dietary Helper's hair out of the bonnet while mixing the ingredients of a pie. On 10/02/24 at 11:30 PM, the Surveyor observed the Dietary Helper's hair out of the bonnet while serving staff. On 10/02/24 at 9:50 AM, during an interview, the Dietary Manger stated the Dietary Helper was given permission to wear a hair bonnet rather than a hair net because she had a lot of hair. On 10/02/24 at 10:12 AM, during an interview, the Dietary [NAME] stated she handled raw meat, grabbed the cooking spray, and returned to handling raw meat. On 10/03/24 at 9:17 AM, during an interview, the Dietary Manger stated the Dietary [NAME] cross contaminated when she grabbed the cooking spray between handling raw meat, and when the Dietary Helper's hair was out while prepping and/or serving food she could have gotten hair in the food. A policy titled, Rules of Sanitation, noted, wear a hairnet or cap while on duty and keep your hands clean, washing them frequently.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and interview, the facility failed to ensure the facility assessment included pertinent information to assure the necessary care and resources were allocated to meet the needs of the residents in 1 of 1 facility. This deficient practice had the potential to affect all residents of the facility. The total census was 36 residents. The findings are: A review of the Facility Assessment Tool, dated 09/12/2024, did not contain the following required information: a. Name of the governing body representative involved in the completion of the facility assessment. b. Plan to recruit and retain enough medical personnel who are adequately trained and knowledgeable in the care of residents and/or how management expectations of medical personnel. c. The facility's resources which included supplies, equipment, or other services necessary to provide for the needs of residents. d. An evaluation of any contracts, memorandums of understanding including third-party agreements for the provision of goods, services or equipment to the facility during both normal operations and emergencies. e. Heath information technology resources for managing resident records and sharing information with other organizations. f. Evaluation of the physical environment necessary to meet the needs of the residents. g. No reference to the facility-based and community-based risk assessment, utilizing an all-hazards approach/emergency preparedness plan. On 10/03/2024 at 2:42 PM, the Administrator and Administrative Assistant (AA) were interviewed with the concurrent observation concerning the facility assessment. The AA was asked who the governing body member was who was involved in completing the facility assessment. The Administrator stated, I'm the governing body. This surveyor stated to the Administrator the governing body would be someone over her. The AA stated another name of an owner of the facility as the governing body. The AA stated portions of the facility assessment were missing because they did not answer the items appropriately. The AA stated the Quality Assurance and Assessment (QAA) committee was responsible for completing the facility assessment. The Administrator stated she reviewed the facility assessment to ensure that all necessary components were in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Crestpark Dewitt, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Liberty Drive DE Witt, AR 72042	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to maintain Legionella surveillance for 1 of 1 water management plan. Findings include: A review of the facility's water management plan with an Annual Review Date of 09/13/2024, titled Water Management Plan, indicated Legionella was a bacteria common in water systems that causes a severe pneumonia called a serious type of pneumonia called Legionnaires Disease (LD). Legionella surveillance is one component of the facility's water management plan for reduction risk of bacteria in the facility's water system. Legionella grows best in water which is stagnate or does not have enough disinfectant and at temperatures above 59 degrees Fahrenheit or below 131 degrees Fahrenheit. Temperature control measures included hot water shall be stored at above 160 degrees Fahrenheit and progressively flushing the system for a minimum of 5 minutes. A review of a facility Water Management Plan, with an annual review date of 09/13/2024, Management Team are responsible for the implementation and oversight of the Water Management Program. They must include employees with knowledge of building water systems and how those systems relate to Legionellosis. The diagram of the facility in the Water Management Plan, does not show where water is received into the building, it does not show cold water distribution, heating, hot water distribution, and waste. Second, the map did not identify areas which encourage growth and spread of Legionella and other waterborne bacteria like storage tanks, water heaters, filters, aerators, showerheads/hoses, humidifiers, hot tubs, fountains, and medical devices Third, map did not identify situations such as presence of biofilm, sediment, water temperatures fluctuations, water pressure changes, water stagnation, and inadequate disinfection. Lastly, the diagram of where control measures are applied and a system to monitor control limits and effectiveness. During an interview on 10/02/2024 at 2:20 PM, the Maintenance Supervisor (MS) was asked to test the water temperature in room [ROOM NUMBER]. The MS tested the water temperature, and it took 8 minutes for the water temperature to reach 107 degrees Fahrenheit. The MS indicated on halls 200 and 600 the water is very slow to heat up.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045177	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Dewitt, LLC	1325 Liberty Drive DE Witt, AR 72042

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interviews and record review, it was determined that the facility failed to provide a pneumonia vaccine for 2 (Residents #1 and #20) of 5 residents reviewed for immunizations. Findings include: A review of Resident #1's Immunizations on the resident's face sheet in the paper chart did not have information entered that the pneumonia vaccine was received. A review of Resident #20's Immunizations on the resident's face sheet in the paper chart did not have information entered that the pneumonia vaccine was received. On 10/03/2024 at 9:35 AM, the Infection Control Preventionist (IPC) was asked to provide information on the administration of the pneumococcal vaccine to Resident #1 and Resident #20. During an interview on 10/03/2024 at 12:18 PM, the IPC stated Resident #1 and Resident #20 never received the pneumococcal vaccine. The IPC provided both of the resident's shot records.