STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045219	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Forrest City, LLC	500 Kittle Rd Forrest City, AR 72335

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(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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, interviews, and review of the facility's policies and state requirements, the facility failed to ensure a safe and secure environment as evidenced by not adhering to the facility's policies and procedures after an accident/fall for 2 (Resident #48 and Resident #251) of 2 residents reviewed for a fall with serious injury. The findings are: On 08/06/2024 at 8:35 AM, observed Resident #48 during medication administration. Noticed extensive bruising to the resident's face. When asked what happened, Resident #48 stated, I rolled out of bed, and fell on the floor. I'm always doing that. When asked if she hurt herself, the resident stated, My left hip hurts. I'm afraid to get up and walk. On 08/06/2024 at 8:45 AM, during an interview Licensed Practical Nurse (LPN) #12 stated she received report this morning and was told Resident #48 fell out of bed, but no injuries were noted. LPN #12 stated [LPN #14] notified the family but did not notify hospice or the provider to determine need to have resident evaluated. Nurse initiated neuro checks but did not advise on coming nurse of the continuing neuro checks. When asked what the protocol is when residents fall, LPN #12 stated, Assess the resident, obtain vital signs, call provider and hospice is applicable. Notify family, complete I&A [Incident and Accident] report, notify Director of Nursing (DON), continue to monitor resident or follow orders from provider. Upon record review and interviews with Licensed Practical Nurse (LPN) #14, it was discovered resident fell two days prior as well on 08/04/2024. Hospice or the provider were not notified Resident #48 was not sent to the hospital for evaluation for either fall. On 08/06/2024 at 8:56 AM, during an interview with Licensed Practical Nurse (LPN) #14 regarding the fall on 08/06/2024 LPN #14 stated, I walked into the room to check on resident, found her on the floor beside her bed. I assessed her, took vital signs, I didn't see any injuries on the resident except scratches on the back. I notified the son of the accident. I didn't notify hospice or the doctor, but the nurse on dayshift said she would call them since I didn't. When asked what the protocol is for a fall. She stated, assess the resident, notify the doctor and hospice if they are hospice residents, call the family, send them out if needed. LPN #14 further stated, I was under impression, we don't call the doctor if they aren't hurt, so I didn't. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/6/2024 at 9:05 AM, during an interview with the Director of Nursing (DON) regarding the recent falls, she stated, I was unaware until about fifteen minutes ago that the resident had had falls. I don't know why this resident's provider or hospice was not notified per our policy. We will be providing follow up training to ensure everyone is on the same page.

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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 ensure refrigerated narcotics were stored in a permanently affixed storage box to prevent misappropriation of resident medications. The findings are: On 8/07/2024 at 9:30 AM, during an observation of the medication storage area, the surveyor observed the red controlled medication lockbox was not secured inside the refrigerator. The box contained controlled medication. On 8/07/2024 at 9:45 AM, during an interview with Licensed Practical Nurse (LPN) #13, when asked why it is important to secure the box inside the refrigerator, LPN #13 admitted it would be very easy to conceal the medication box due to the size and remove it from the facility. Reviewed the facility's undated policy (received on 8/07/2024 at 10:39 AM from the Administrator) titled, Controlled Medication (Schedule II, III, IV, &V) Receiving, Recording, Storage, Accountability, and Disposition Of stated under the section labeled Storage, that narcotics will be kept in a locked container affixed inside a locked cabinet, inside the medication room.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed. This failed practice had the potential to 3 affect residents who received regular diets from 1 of 1 kitchen according to a list provided by Dietary Manager #11 on 08/06/24 at 9:33 AM. The findings are: 1. On 08/05/24, the noon meal menu documented the residents who received regular diets were to receive 4 ounces of fried chicken. 2. On 08/05/24 at 12:16 PM, during the noon meal service Dietary [NAME] (DC) #1 served 2 fried chicken legs to 6 residents and 2 chicken wings to 5 residents. 3. On 08/05/24 at 12:36 PM, the surveyor asked Dietary Aide (DA) #4 to weigh the same amount of chicken legs served to the 6 residents for lunch, and the same amount of chicken wings served to the 5 residents for lunch. She did and the 2 legs weighed 2.5 ounces and the 2 wings weighed 1.2 ounces, instead of 4 ounces of fried chicken as per the menu. DA #4 stated, We should have given them more chicken.

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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, record review, and interview, the facility failed to ensure meals were served in a method that maintained the appearance of hot products and at temperatures that were acceptable to the residents to improve palatability and encourage good nutritional intake during 1 of 1 meal observed. This failed practice had the potential to affect 24 residents who received their meal trays in the dining room, 12 residents who received their meal trays in their rooms on the 100 Hall and 200 Halls, and 8 residents who received their meal trays in their room on the 700 Hall, as documented on a list provided by Dietary Manager #11 on 08/05/24 at 9:33 AM. The findings are: 1. On 08/05/24 at 11:34 AM, Resident #23 stated the food is cold by the time it gets to us. 2. On 08/05/24 at 12:30 PM, an unheated food cart that contained 17 lunch trays was delivered to the dining room by Dietary Aide (DA) #3. At 1:08 PM, immediately after the last residents received their trays in their rooms in the dining, the temperatures of food items on a test tray were checked and read by DA #4 with the following results: a. Vegetable blend - 97.7 degrees Fahrenheit. b. English peas - 92.4 degrees Fahrenheit. c. Ground fried chicken with no gravy - 92.6 degrees Fahrenheit. 3. On 08/06/24 at 7:29 AM, an unheated food cart that contained 12 breakfast trays for the 100 and 200 Halls were delivered to the 200 Hall by Certified Nursing Assistant (CNA) #6. At 7:35 AM, the food cart was pushed to the 100 Hall by CNA #8. At 7:49 AM, immediately after the last residents received their trays in their rooms on the 100 Hall, the temperatures of the food items on the trays used as test tray were checked and read by the CNA #8 with the following results: a. Milk - 46.9 degrees Fahrenheit. b. Sausage links - 91.9 degrees Fahrenheit. c. Scrambled eggs - 103.6 degrees Fahrenheit. d. Ground sausage - 84.5 degrees Fahrenheit. 4. On 08/06/24 at 7:30 AM, an unheated food cart that contained 8 breakfast trays was delivered to the 700 Hall by Certified nursing Assistant (CNA) #7. At 7:00 AM, immediately after the last residents received their trays in their rooms on the 700 Hall, the temperatures of food items on the trays used as test trays were checked and read by CNA #7 with the following results: a. Milk - 45.5 degrees Fahrenheit. b. Scrambled eggs - 106.6 degrees Fahrenheit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Ground sausage - 88.1 degrees Fahrenheit. 5. On 08/06/24 at 2:07 PM, Resident #23 stated the hot food was not hot at lunch today.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and facility policy review, the facility failed to ensure pureed food items were blended to a smooth, lump free consistency to minimize the risk of choking or other complications for those residents who required pureed diets for 2 of 2 meals observed. The failed practice had the potential to affect 2 residents who received pureed diets. The findings are. 1. On 08/05/24 at 10:30 AM, a bowl that contained pureed strawberry cake was observed on the counter. Dietary [NAME] (DC) #1 stated, That is pureed strawberry cake, she covered the bowl with a lid and placed it in refrigerator to be served to the residents who required pureed food items. The consistency was runny, lumpy, and not smooth. There were pieces of strawberries in the mixture. 2. On 08/05/24 at 11:37 AM, Dietary Aide (DA) #3, used a 4 ounce spoon to place 2 servings of English peas into a bowl with its juice from a pan on the steam table. 3. On 08/05/24 at 11:38 AM, DA #3 poured 2 servings of English peas into a blender and pureed. At 11:40 AM, DA #3 poured the pureed English peas into a bowl. The consistency of the pureed peas was running and not formed. 4. On 08/05/24 at 11:43 AM, Dietary Aide (DA) #3 used a 4 ounce spoon to place 2 servings of vegetable blend from a pan on the steam table into a bowl and poured it into a blender and pureed. At 11:44 AM, DA #3 poured the pureed vegetable blend into a bowl. The consistency of the pureed vegetable blend was running and not formed. There were pieces of carrots in the mixture. 4. On 08/05/24 at 11:47 AM, DA #3 poured 2 servings of deboned chicken breast into a blender, added chicken broth, and pureed. At 11:48 AM, DA #3 poured the pureed fried chicken into a pan and placed it on the steam table. The consistency of pureed fried chicken was gritty and not smooth. There were pieces of chicken visible in the mixture. 5. On 08/05/24 at 11:58 AM, a pan of pureed bread with milk was on the steam table. The consistency of the pureed bread was too thick. 6. On 08/05/25 at 12:38 PM, DA #5 was asked to describe the consistency of the pureed bread with milk, pureed vegetable blend, pureed peas, and pureed cake. DA #5 stated, Pureed meat was gritty and not smooth, pureed vegetable blend was runny and had piece of carrots in it, and pureed bread with milk was too thick. 7. On 08/05/24 at 8:00 AM, the pureed sausage served to the residents on pureed diets was gritty, not formed and was not smooth. There were pieces of meat in the mixture. 8. On 08/06/24 at 8:04 AM, the surveyor asked Certified Nursing Assistant #9 who was assisting residents in the dining room to describe the consistency of the pureed sausage served to the residents on pureed diets. She stated, It looks more like ground meat. It is supposed to be like pudding. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. On 08/06/24 at 8:08 AM, the surveyor asked Dietary Manager #11 to describe the consistency of the pureed sausage served to the residents on pureed diets. He stated, It looks more like mechanical soft meat. 10. On 08/06/24 at 8:09 AM, the surveyor asked DA #3 to describe the consistency of the pureed sausage served to the residents on pureed diets. DA #3 stated, It looks more like mechanical soft meat. 11. A facility policy titled, Consistency Alteration of Food & Fluid Mechanically Altered Foods & Thickened Liquids initiated 12/11/2010 indicated, .Pureed Consistency -Pureed items should be completely smooth without any pieces or chunks. -Mouth feel should be smooth and the consistency of PUDDING or MASHED POTATOES. -This texture requires very little to no effort to chew. -As presentation is important, gravy and smooth condiments should be added on top for visual appearance and taste, ex. ketchup/mustard on pureed hit dog with bun (to individual's preference). -When items are served, staff should always express to the patient what each food item is. -Refer to your facility spreadsheets/extension sheets for correct serving size .

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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 observation, interview, record review, and facility policy review, the facility failed to ensure 2 of 2 ice machines in the facility, one in the kitchen and one on the 400 Hall were maintained in clean and sanitary condition to prevent food and beverage contamination; dairy products stored in the refrigerator were sealed to minimize the potential for food borne illness for residents who received meals from 1 of 1 kitchen; expired dairy products and food items were promptly removed/discarded on or before the expiration or use by date to prevent the growth of bacteria; dietary staff washed their hands before handling clean equipment or food items to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen; kitchen ceiling tiles were cleaned to provide a sanitary environment for food preparation. The failed practices had the potential to affect 46 residents who received meals from the kitchen (total census: 48), as documented on a list provided by Dietary Manager #11 on 08/06/2024. The findings are: 1. On 08/05/2024 at 9:46 AM, the ice machine panel in the kitchen where ice touches before dropping into the ice collector had brown colors on it. Dietary Manager #11 was asked to wipe the area. The brown residue easily transferred to the tissue. Dietary Manager #11 was asked to describe what was observed on the panel. He stated, It was black and brown dirt. Dietary Manager #11 was asked, Who uses the ice from the ice machine and how often do you clean it? He stated, We clean weekly, and we use it in the kitchen to fill beverages served to the residents at mealtimes. 2. On 08/05/2024 at 9:48 AM, an opened zip top bag that contained slices of cheese, was on a shelf in the refrigerator. The bag was not sealed. 3. On 08/05/2024 at 9:55 AM, the following observations were made in the storage room. a. There were 5 bags of grits on a shelf in the storage room with an expiration date of 5/25/2024. b. There were 8 bags of cream of wheat with an expiration date of 1/23/2023. c. There were 3 containers of fajita marinade and seasoning with an expirations date of 7/23/2024. d. An opened box of salt, the box was not covered. e. A container of rubbed sage with an expiration date of 11/25/2023. f. Eight of 8 boxes of tea with an expiration date of 05/16/2024. g, Four of 4 bottles of lemon juice with an expiration 04/20/2024. h. An opened gallon of barbeque sauce, the manufacturer's specification on the gallon specified, refrigerate after opening. i. Two opened gallon containers of soy sauce, the manufacturer's specification on the gallon specified, refrigerate after opening. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. On 08/05/2024 at 10:35 AM, the following observations were made in the walk-in refrigerator in a room leading to the dining room and the kitchen: a. The ceiling tiles had an accumulation of black and grayish dust stuck on it. The surveyor asked Dietary Manager #11 to describe the condition of the ceiling tiles. He stated, That is an accumulation of black and gray dirt. b. A half-gallon of butter milk in a milk crate with an expiration date of 7/26/2024. c. An opened box of fresh buttery taste spread with an expiration date of 12/18/2023. Dietary Manager #11 stated, We don't use them. d. A box that contained 20 cartons of probiotic yogurts had an expiration date of 7/26/2024 5. On 08/05/2024 at 10:48 AM, the ice machine panel in the break room on the 100 Hall, where ice touches before dropping into the ice collector, had wet black and brown colors on it. Dietary Manager #11 was asked to wipe the area. The wet black and brown residue easily transferred to the tissue. Dietary Manager #11 was asked to describe what was observed on the panel of the ice machine. He stated, It was black and brown dirt. Dietary Manager #11 was asked, Who uses the ice from the ice machine and how often do they clean it? He stated, The maintenance man cleans it, and that's the ice the CNAs [Certified Nursing Assistants] use for the water pitchers in the residents' rooms. On 08/06/24 at 11:13 AM, the Maintenance Supervisor was asked how often they cleaned it. He stated, By-weekly. 6. On 08/05/2024 at 10:53 AM, Dietary [NAME] (DC) #2 pushed a food cart that contained a pan of fried chicken towards the food preparation area. Without washing her hands, she removed gloves from the glove box and placed them on her hands, contaminating the gloves. She then used her contaminated gloved hands to debone chicken to be ground and or pureed to serve the residents on mechanical soft diets and pureed diets. The surveyor asked what should have done after touching dirty objects and before handling food items and or handling clean equipment? She stated, Washed my hands. 7. On 08/05/2024 at 11:25 AM, Dietary Aide (DA) #3 turned on the hand washing sink faucet and washed her hands. After washing her hands, she turned off the sink faucet with her hands, contaminating her hands, she removed tissue paper and dried her hands. Without rewashing her hands, she picked up a clean blade and attached it to the base of the blender to be used in pureeing foods items to be served to the residents who required pureed diets. When DA #3 was about to pour food items into a blender to puree, the surveyor immediately stopped her and asked what should have been done after touching dirty objects and before handling clean equipment? She stated, I should have washed my hands. 8. On 08/05/2024 at 11:58 AM, the temperature of the broccoli with cheese when checked and read by Dietary Aide #4 on the steam table was 117 degrees Fahrenheit. The surveyor asked Dietary Aide #4 what should you do when food items are not hot enough to serve. DA #4 stated, Reheat it. 9. A facility policy titled, Handwashing and Glove Usage in Food service stated, When Food Handlers must wash their hands .Before starting work.After leaving and returning to the kitchen/prep area .After touching anything else such as dirty equipment, work surfaces or cloths.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to follow enhanced barrier precautions when flushing a feeding tube for 1 (Resident #3) of 1 sampled resident reviewed feeding tube care and on enhanced barrier precautions (EBP). The findings are: A review of Resident #3's Face Sheet revealed diagnoses to include Parkinson's, depression, and PEG (percutaneous endoscopic gastrostomy) tube management. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/27/2024 suggested a Brief Interview for Mental Status (BIMs) a score of 6 (0-7 indicates severe cognitive impairment). Section K0520B3 indicated Resident 3 had a feeding tube. a. During an interview with the Director of Nursing (DON) on 08/06/24 at 2:59 PM, the DON confirmed the facility does not have Enhanced Barrier Precaution (EBP) signage, but they place a small bedside dresser outside the room with personal protective equipment (PPE). The DON stated all staff know that a small dresser outside the room is a sign of EBP. It was confirmed Resident #3 was on EBP due to a feeding tube, and staff knew because there was a small dresser outside the door. b. Review of the Physician's Orders revealed there was not an order for Enhanced Barrier Precautions. c. On 08/07/2024 at 9:30 AM, during a concurrent observation and interview, Licensed Practical Nurse (LPN) #12 was observed checking Resident #3's feeding tube for residual tube feeding, throwing away the overnight feeding and tubing and then flushing the feeding tube with 30cc [cubic centimeters] of free water. LPN #12 was not wearing any Enhanced Barrier Precautions (EBP) other than gloves. The Surveyor asked if Resident #3 was on Enhanced Barrier Precautions and LPN #12 confirmed Resident #3 was not on EBP and confirmed that she cannot think of any reason to put on PPE. The Surveyor observed a small dresser outside the door. The bottom drawer was slightly open with blue gowns visible. d. During an interview with the Administrator on 08/07/2024 at 4:00 PM, she confirmed a drawer outside the resident rooms indicated EBP, staff have been in-serviced, and she confirmed staff were expected to wear PPE when flushing a feeding tube because microbes could be transferred to the resident. e. On 08/07/2024 at 4:13 PM, the Administrator provided a policy titled Gastrostomy Feedings that did not apply to EBP. f. On 08/07/2024 at 4:16 PM, review of an Inservice Training dated 07/26/2024 on Enhanced Barrier Precautions (EBP) and other topics revealed, EBP recommendations now include use of EBP for residents with feeding tubes during high-contact resident care activities regardless of their multidrug-resistant organism status. g. On 08/07/2024 at 4:20 PM, the Administrator provided a letter stating .[Facility Name] facility does not have a policy on Enhanced Barrier Precautions at this time .