STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045219	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2024

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

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43409 Based on interviews, record review, facility document review, it was determined the facility failed to ensure the care plan was revised to accurately indicate wandering behaviors with interventions to prevent the potential for elopement for 2 (Resident #1 and Resident #3) of 3 residents reviewed for wandering behaviors. Findings include: On 06/12/2024 at 9:19 AM, the Administrator stated the facility did not have a policy for care plans. A review of the Face Sheet indicated the facility admitted Resident #1 with diagnoses that included unspecified dementia, unspecified fall, and pneumonia. The 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/07/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment. Section E regarding wandering and frequency of wandering indicated Resident #1 had wandering behavior of this type occurring 1 to 3 days. A review of the Initial Elopement and Wandering Risk Assessment for Resident #1 dated 01/03/2024 documented, Resident is at risk for elopement/wandering at this time. A care plan for wandering/elopement risk will be initiated identifying appropriate preventive interventions. A review of Resident #1's Baseline Care Plan on 01/03/2024, revealed the resident was a wanderer. The baseline care plan did not have any interventions documented. A review of Resident #1's undated Nursing Assistant Care Plan (Closet Care Plan) revealed the resident was an elopement risk. The closet care plan did not have any interventions documented. A review of the Face Sheet indicated the facility admitted Resident #3 with diagnoses that included unspecified dementia, Alzheimer's disease with late onset, and anxiety disorder. The Admission MDS with an ARD of 05/22/2024 revealed Resident #3 had a BIMS score of 9 which indicated the resident had moderate cognitive impairment. (continued on next page)

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Initial Elopement and Wandering Risk Assessment for Resident #3 dated 05/10/2024 documented, Resident is at risk for elopement/wandering at this time. A care plan for wandering/elopement risk will be initiated identifying appropriate preventive interventions. A review of Resident #3's Baseline Care Plan dated 05/10/2024, did not indicate wandering and elopement risks and no interventions were in place. A review of Resident's #3's Care Plan for 05/10/2024 through 05/09/2025 did not indicate wandering and elopement risks and no interventions were in place. During an interview on 06/11/2024 at 9:07 AM, the MDS Coordinator confirmed Resident #1 had a baseline care plan completed and did not have any interventions included. The MDS Coordinator confirmed Resident #1 was only admitted for 13 days and did not complete a comprehensive care plan.

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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. 43409 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to provide adequate supervision to prevent a resident with moderate cognitive impairment and exit seeking behaviors from exiting the facility unsupervised for 1 (Resident #1) of 3 residents reviewed for elopement. Findings include: A review of the facility's undated policy titled, Wandering Resident Policy indicated, In an effort to prevent resident from wandering away from the facility, [Facility name] has door alarm systems on all appropriate doors. This system is to help alert any unauthorized exits of residents who may try to wander outside the facility unsupervised .staff will monitor all residents and those who have been identified as wanderer's on an ongoing basis to ensure all resident safety and privacy. A review of the Face Sheet indicated the facility admitted Resident #1 with diagnoses that included unspecified dementia, unspecified fall, pneumonia, and chronic prostatitis. The 5-day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/07/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident had moderate cognitive impairment. Section E regarding wandering and frequency of wandering indicated Resident #1 had wandering behavior of this type occurring 1 to 3 days. A review of Resident #1's Baseline Care Plan on 01/03/2024, revealed the resident was a wanderer. The baseline care plan did not have any interventions documented. A review of Resident #1's undated Nursing Assistant Care Plan (Closet Care Plan) revealed the resident was an elopement risk. The closet care plan did not have any interventions documented. A review of Initial Elopement and Wandering Risk Assessment revealed Resident #1 was at risk for elopement/wandering at this time and a care plan for wandering/elopement risk will be initiated identified appropriate preventive interventions. A review of Progress Note dated 01/05/2024 on the 3:00 PM to 11:00 PM shift documented, .ambulatory in the hall with his belongings stating he's going home . A review of Progress Note dated 01/11/2024 at 10:20 PM documented, Resident found in another resident room with just a tee shirt on . A review of Progress Note dated 01/12/2024 on the 3:00 PM to 11:00 PM shift documented, Confused to location. Thinks he is at home. Wandered x2 into another resident room . A review of Progress Note dated 01/13/2024 on 7:00 AM to 1:00 p documented, .Ambulates with unsteady gait wandered in another resident's room . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Progress Note dated 01/14/2024 at 10:32 AM documented, Resident ambulating with walker. Resident ambulated to double doors and pushed on door causing door alarm to go off. CNA [Certified Nursing Assistant] and writer rushed to door and removed resident from area . A review of Progress Note dated 01/15/2024 at 10:50 AM documented, Admin [Administrator] informed resident not in room. Female resident informed staff she thought he was by the door. Upon looking outside of the doors, it is noted that 2 pairs of socks and glasses were on the ground outside the door. 1057 [10:57 AM] resident around side of building next to alternate exit approximately 60 feet from exit site. Resident states I was looking for my care. Resident brought back into facility . During a concurrent observation and interview on 06/10/2024 at 12:04 PM, the Administrator and Surveyor walked out the double doors the resident went through and walked to the area where the resident was found. Resident #1 was found approximately 60 from the exit. The Administrator verbalized Resident #1's room was next to the double doors the resident exited. The Administrator confirmed Resident #1 was out of the facility approximately seven minutes.