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	06/24/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to report suspicion of sexual abuse within the two-hour allotted time frame per Center for Medicare and Medicaid Services (CMS) guidelines, for one (Resident #2) of one resident reviewed for allegations of sexual abuse discovered on 04/27/2026 at 10:15 AM and was reported on 04/28/2026 at 11:45 AM. The findings include: A review of an admission Record revealed that the facility admitted Resident #2 on 04/10/2025 with diagnoses that included muscle weakness, obesity, altered mental status, dementia, and hearing impairment. A review of a re-entry Minimum Data Set (MDS), with an Assessment Reference Date of 04/16/2026, revealed Resident #2 had a Brief Interview for Mental Status score of 3 which indicated the resident had severe cognitive impairment. The MDS revealed Resident #2 was dependent on staff for toileting, showering, and upper and lower body dressing. Resident #2 required supervision touch assistance with rolling from left to right. Other mobility skills such as sitting to lying, lying to sitting, sitting to standing, toilet and shower transfer were not attempted due to medical conditions or safety concerns. A review of Resident #2's Care Plan dated 04/13/2026 thru 06/23/2026, revealed the resident was unable to take self to activities, needed assistance with activities of daily living, had nightmares at times with yelling, had impaired cognitive skills and impaired communication, Interventions included to assist the resident to the activity, use a mechanical lift for all transfers, turn every two hours, out of bed in medical reclining chair, monitor frequency of nightmares and determine the underlying cause. A review of a Medication Administration Record and Treatment Administration Record (MAR-TAR) dated 06/01/2026, revealed Resident #2 had medications for dementia and nerve damage. A review of a facility document titled Reportable, revealed an allegation of rape with a discovery date of 04/27/2026 at 10:15 AM which was not reported to the State Agency until 04/28/2026 at 11:45 AM, by the Director of Nursing (DON). During an interview on 06/24/2026 at 9:55 AM, the DON indicated that the facility's policy should match the CMS guidelines. The DON indicated the report was started on 04/27/2026 and was completed within 24 hours unless it was a little late. The DON indicated that per the facility's policy she had 24 hours to report any abuse unless bodily injury was involved. The DON stated that the accusation of rape could be considered bodily harm. (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

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	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/24/2026 at 10:39 AM, the Business Office Manager indicated abuse should be reported immediately and We have to have the report to Office of Long-Term Care (OLTC) within the day, at least before we leave. During an interview on 06/24/2026 at 11:10 AM, the Administrator stated, We have about three to four hours to report abuse. A review of an undated facility policy titled Protecting Resident During a Suspected Abused revealed, If there is a suspected abuse an internal investigation will take place immediately. OLTC will be notified by 11:00 am next day.