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	12/23/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, interview and facility policy review, it was determined the facility failed to report alleged violations involving abuse and misappropriation to the proper state agency within the allotted time frame for three (Resident #18, Resident #39, and Resident #43) of three residents reviewed. The findings include: Resident #18 Review of Resident #18's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/15/2025, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS also indicated no pain medication was received scheduled or as needed . No pain medications were listed on the MDS. Review of Resident #18's admission Record revealed the facility admitted the resident with diagnoses which included contracture of right knee, chondromalacia patellae (degeneration of the cartilage under the knee cap causing knee pain), and intentional self-harm by firearm discharge. Review of Page 73 of the Narcotic Book on 12/19/2025 at 12:40 PM, revealed on dates 09/29/2025, 10/01/2025, 10/03/2025, 10/06/2025, and 10/07/2025 there was documentation that pain medication was administered to Resident #18 by Registered Nurse (RN) #1. During an interview on 12/19/2025 at 12:40 PM, the Director of Nursing (DON) stated Resident #18 was interviewed about the dates of administration of narcotic pain medication and the resident denied requesting or receiving pain medication on those dates. During an interview on 12/19/2025 at 2:23 PM, Resident #18 stated pain medication had not been administered in a while and they take [over the counter pain medication] instead of [narcotic pain medication]. Resident #39 Review of a quarterly MDS with an ARD of 11/16/2025, revealed Resident #39 had a BIMS score of 15, which indicated the resident was cognitively intact. The MDS also indicated no scheduled pain medication was received but that Resident #39 had received as needed pain medication, and non-medication interventions. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission Record for Resident #39 revealed the facility admitted the resident with diagnoses which included chronic obstructive pulmonary disease (COPD), and a bladder infection without blood noted in the urine. Review of the Narcotic Book on 12/19/2025 at 12:40 PM, revealed on dates 10/02/2025, 10/03/2025, and 10/06/2025 there was documentation that pain medication was administered to Resident #39 by RN #1. During an interview on 12/19/2025 at 12:40 PM, the DON stated Resident #39 was interviewed about the dates of administration of narcotic pain medication and the resident denied requesting or receiving pain medication on those dates. During an interview on 12/19/2025 at 2:27 PM, Resident #39 stated they receive pain medication at times but seldom and that they just take regular [name brand over the counter pain medication] for their aches. During an interview on 12/19/2025 at 12:09 PM, the DON confirmed the two residents (Resident #18 and Resident #39) had narcotic diversions by the nurse in the reported allegation and the facility did not report it to the Office of Long-Term Care (OLTC). She stated, we investigated it, interviewed the residents, and terminated the employee. When asked about the documentation of the investigation, the DON stated there was not any documentation other than we flagged it in the narcotic book. The DON stated it was discussed in a nursing meeting and did not know if it was discussed at the Quality Assessment and Assurance (QAA) meeting. No QAA minutes were provided when requested from the DON by this surveyor. During an interview on 12/19/2025 at 2:44 PM, Licensed Practical Nurse (LPN) #2 revealed she was one of the nurses that reported the diverted medication of Resident #18 and Resident #39 to the DON. LPN #2 stated she was the Charge Nurse and saw on the medication administration record (MAR) that the residents had been administered pain medications only on the dates the alleged nurse was working the medication cart. LPN #2 stated she interviewed the residents to see if they had been having pain and both residents denied having pain. During an interview on 12/19/2025 at 3:20 PM, the Administrator revealed all drug diversions should be reported to the OLTC. He stated the department head and the administrator were responsible for investigating alleged abuse. If after the investigation the employee was proven to be guilty, that employee would be terminated. The Administrator stated all investigations were documented. Resident #43 Review of an admission Record, indicated the facility admitted Resident #43 with diagnoses that included type II diabetes, peripheral vascular disease (narrowing or blocked blood vessels), absence of right and left legs above the knee, osteomyelitis (inflammation of bone or bone marrow) and sepsis (the body's negative response to infection.) Review of an admission MDS with an ARD of 08/27/2025, revealed Resident #43 had a BIMS Score of 15, which indicated the resident was cognitively intact. The MDS also revealed the resident required partial to moderate assistance with toilet transfer and chair/bed-to-chair transfer. Review of a Facility Incident Report (FRI) dated 08/25/2025 at 9:35 AM, revealed Resident #43 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported to the DON that Certified Nurse Assistant (CNA) #8 had grabbed the resident's arm causing a bruise . Resident #43's report indicated CNA #8 stated that Resident #8 was disrespectful for not having shorts on, and that CNA #8 threw shorts at the resident and threw a trash can in the room. The FRI had a discovery date of 08/25/2025 at 9:30 AM and was submitted to the OLTC on 08/26/2025 at 9:34 AM. During an interview on 12/22/2025 at 2:00 PM, the DON stated the allegation was not called to her attention until the next morning on Monday,08/25/2025. She stated she reported the incident to the OLTC, contacted the police, physician and attempted to contact the family of Resident #43.The DON stated she started an investigation and suspended CNA #8 pending the investigation. The DON stated that Resident #43 reported the allegation to RN #6, the charge nurse for the shift on 8/24/2025 at 9:15 PM. RN #6 reassigned CNA #8 to another hallway to work with other residents. The DON stated, the RN should have called me, the administrator, and sent the CNA home, then started the process as a reportable. By not sending the CNA home, the RN put other residents and staff at risk. Review of a facility policy titled Protecting Residents during a suspected abuse indicated If there is a suspected abuse an internal investigation will take place immediately. Office of Long Term (OLTC) will be notified by 11:00 AM next day. Any willful act of abuse, neglect, involuntary seclusion, or misappropriation of resident's property will be subject to immediate termination and OLTC will be notified by 11:00 AM the next day. All written reports will be completed and faxed/mailed to OLTC according to Arkansas State Law.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review, interviews and facility policy review, the facility failed to ensure immediate protective measures were implemented and maintained until a thorough investigation was initiated. The facility also failed to immediately report to the Office of Long-Term Care (OLTC) to enable the state agency to provide the necessary oversight of the facility's efforts to investigate and protect residents from potential harm for one (Resident #43) of one resident reviewed. The findings include: Review of an admission Record, indicated the facility admitted Resident #43 with diagnoses that included type II diabetes, peripheral vascular disease (narrowing or blocked blood vessels), absence of right and left legs above the knee, osteomyelitis (inflammation of bone or bone marrow) and sepsis (the body's negative response to infection.) Review of an admission MDS with an ARD of 08/27/2025, revealed Resident #43 had a BIMS Score of 15, which indicated the resident was cognitively intact. The MDS also revealed the resident required partial to moderate assistance with toilet transfer and chair/bed-to-chair transfer. Review of a Facility Incident Report (FRI) dated 08/25/2025 at 9:35 AM, revealed Resident #43 reported to the Director of Nursing (DON) that Certified Nurse Assistant (CNA) #8 had grabbed the resident's arm causing a bruise. The report also indicated Resident #43 was told by CNA #8 that the resident was disrespectful for not having shorts on. Resident #43 reported that CNA #8 threw shorts at the resident and threw a trash can. The FRI had a discovery date of 08/25/2025 at 9:30 AM and was submitted to the OLTC on 08/26/2025 at 9:34 AM. Review of a Witness Statement dated 08/25/2025 at 2:30 PM, written by Registered Nurse (RN) #6, revealed on 08/24/2025 at 9:15 PM, RN #6 went into Resident #43's room to check an IV and the resident told her that CNA #8 had come in the night before and found resident naked. Resident #43 indicated CNA #8 told them that was indecent exposure. The Witness Statement indicated CNA #8 told the resident to put on clothes and threw some at Resident #43. Later that shift, another CNA, who the RN could not recall the name of, told RN #6 that the night before, a couple revealed Resident #43 told them, CNA #8 had grabbed the resident's left arm leaving redness on the arm. RN #6 went back to Resident #43's room and was told the same allegation by the resident. RN#6 then assigned Resident #43 to another CNA. RN #6 planned to report the allegation to the DON the next morning. A review of an Employee Detail Report for the night of 08/23/2025, revealed CNA #8 worked from 10:57 PM to 6:05 AM, then again for the night of 08/24/2025 from 9:55 PM to 6:00 AM, before being suspended on 08/25/2025 through 08/28/2025 pending investigation. During an interview on 12/22/2025 at 2:00 PM, the DON stated the allegation was not called to her attention until the next morning on Monday, 08/25/2025. She stated that she reported the incident to the OLTC, contacted the police, physician and attempted to contact the family of Resident #43. She stated that she started an investigation and suspended CNA #8 pending the investigation. The DON stated that Resident #43 reported the allegation to RN #6, the charge nurse for the shift, on 8/24/2025 at 9:15 PM. RN #6 reassigned CNA #8 to another hallway to work with other residents. The DON stated that the RN should have called me, the administrator, and sent the CNA home, then started the process as a reportable. By not sending the CNA home, the RN put other residents and staff at risk. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an undated facility policy titled Protecting Residents During a Suspected Abuse indicated If there is a suspected abuse and internal investigation will take place immediately. OLTC will be notified by 11:00 a.m. next day. Residents who have voiced an abuse complaint will be protected from any further harm during the period of investigation. This will be accomplished by QA (Quality Assurance) members appointing a supervisor or trusted employee to observe resident continually thru out the time period involved in this investigation. If possible, the resident would be moved to convenient area for continual observation.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined that the facility failed to ensure the Five Rights of Medication was performed by nursing staff before giving a resident's family/representative the incorrect medications upon discharge from the facility and failed to ensure the discharge instructions were confirmed with resident's family/representative upon discharge effecting two (Resident #42 and Resident #12) of two residents reviewed. The findings include: A review of Facility Reported Incident indicated on 05/01/2025 at 2:45 PM, it was discovered that Resident #12's medication that included medicine for hypertension, congestive heart failure, Dementia, high cholesterol and atrial fibrillation (rapid, irregular heartbeat) was given to a family/representative of Resident #42 upon Resident #42's discharge on [DATE]. The facility reported/submitted to the state Office of Long-Term Care (OLTC) on 05/06/2025 at 6:42 PM. The incident report indicated Resident #42's family/representative contacted the facility to question the discharge instructions and medicines issued at time of discharge on [DATE]. Resident #42's family/representative stated the charge nurse gave the medications, the discharge instructions and instructed family member to sign the discharge instruction form without going over the medications with the family/representative. The initial investigation revealed that the 3:00 PM -11:00 PM charge nurse (LPN #2) had prepared the discharge instruction paperwork and pulled the resident's medications. The medications pulled were the medications of another resident (Resident #12) and the medication regimen information on the discharge instruction form were those of the resident she had pulled the medications from. The 7:00 AM – 3:00 PM charge nurse (RN #5) admitted she did not review meds with resident's family. During an interview on 12/17/2025 at 1:30 PM Licensed Practical Nurse (LPN) #2 stated, she had been working with Resident #12 when she was told that another resident, Resident #42 was going home. She thought she would get Resident #42's things together before the resident discharged . She pulled the medication, counted and listed them, then placed them in a bag with the discharge instructions. LPN #2 stated the family/representative did not come to get Resident #42 during her shift, so she advised the oncoming nurse Registered Nurse (RN) #5 that the medications were ready to go. LPN #2 stated she was in a hurry but should have slowed down and paid better attention, but she was doing too many things at one time and got the residents mixed up. LPN #2 continued that protocol for discharging a resident was to verify that all medications are accounted for, to go over each medication with the family, educate the family, then ask if there were any questions. LPN #2 said after the incident, she was counselled and educated on the 5 Rights of Medication Administration, Medication Pass, Health Insurance Portability and Accountability (HIPPA) and proper discharge instructions. There were not any documented competencies on the 5 Rights of Medication Administration, Medication Pass, HIPPA and Discharge Instruction prior to incident. During a phone interview on 12/17/2025 at 2:45 PM, RN #5 said LPN #2 had bagged the medicine to send home with Resident #42's family before ending her shift, then told RN #5 that the medicine was ready to go. RN #5 stated she neglected to check the medications herself to ensure they were correct, and she should have checked the resident's name, date of birth (DOB) with the medication list, then compared the medication to the release/discharge form. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/18/2025 at 11:25 AM, the Director of Nursing (DON) stated Resident #12's medications were sent home with the wrong resident (Resident #42). RN #5 did not review the paperwork nor the resident's medication but handed the family/representative the medications. The family/representative asked RN #5 for instructions but was told by RN #5 that she did not have time to go over the medications. The DON indicated RN #5 had not reviewed the medications prior to giving them, nor took the time to go over the discharge instructions. The DON confirmed that it was important to go over discharge instructions and medications with residents or family/representatives and to ensure they know how to administer the medicine for continuity of care. The DON stated that an in service was done on 05/16/2025, covering the 5 Rights of Medication, Medication Pass, Proper discharge instructions, and HIPPA. A review of an in service titled Abuse/Neglect, the 5 Rights of Medication, Medication Administration & Storage, Med Pass, DC Instructions and HIPPA, initiated 05/01/2025 revealed 16 CNAs, 6 LPNs, 1 RN and various other staff signatures. The facility re-educated LPN #2 following the incident on 05/01/2025, on the 5 Rights of Medication Administration, Medication Pass, Health Insurance Portability and Accountability (HIPPA) and proper discharge instructions. Per an in-service initiated on 05/01/2025, all staff including LPN #2 and RN #5 were educated on abuse/neglect, the 5 rights of medication, medication administration and storage, medication pass, discharge instructions and HIPPA. These actions were performed before the survey team entered the facility, resulting in this finding being cited at past non-compliance.

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F 0602 Level of Harm - Potential for minimal harm Residents Affected - Many	Protect each resident from the wrongful use of the resident's belongings or money. Based on record review, interview, and facility policy review, it was determined the facility failed to ensure residents were free from misappropriation of resident property for three (Resident #19, #18, and #39) of three residents reviewed. The findings include: A review of Resident #18's quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) 09/15/2025, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS also indicated no pain medication was received by Resident #18, either scheduled or available as needed. There was no pain medication listed on the MDS. A review of Resident #19's annual MDS with ARD 11/17/2025, revealed Resident #19 had a BIMS score of 03, which indicated the resident was severely cognitively impaired. The MDS also indicated Resident #19 had no pain medication scheduled or available as needed. There was no pain medication listed on the MDS. A review of Resident #39's quarterly MDS with ARD 11/16/2025, revealed Resident #39 had a BIMS score of 15, indicated the resident was cognitively intact. The MDS indicated no scheduled pain medication was received by Resident #39. Resident #39 had received as needed pain medication and non-medication interventions. During an interview on 12/17/2025 at 1:30 PM, Licensed Practical Nurse (LPN #2) stated when narcotics were delivered by the pharmacy, they were double bagged, the name, and amount verified, and immediately logged in the narcotic book. Before the pharmacy delivery staff left, the medication was checked off with them, the invoice was signed by Registered Nurse (RN) #1 and signed again on the electronic device. The narcotic book was counted at the beginning and end of each shift. LPN #2 stated, the facility does not have a policy on pharmacy deliveries. She stated when the count was off, it was reported to the Director of Nursing (DON). LPN #2 stated when Resident #19's narcotic was taken by RN #1, and that the staff member was terminated. LPN #2 stated LPN #3 gave RN #1 the locked narcotic box key to place the narcotic in the lock box when she was not supposed to do that. During an interview on 12/17/2025 at 4:17 PM, the Director of Nursing (DON) indicated she was notified by LPN #3 of the incident with Resident #19's narcotic delivery and count. Resident #19 had not arrived from the hospital when the delivery was made, and the count was found to be incorrect. The DON stated the staff looked for the signed invoice and the plastic wrapping that was around the medication, and neither were found. The DON stated she received a copy of the invoice where RN #1 signed in the count of the narcotic as 20. The narcotic book had 19 logged with one of the pills punched out. The DON called in RN #1 and LPN #3 for a drug test. RN #1 was terminated for not following facility policy on pharmacy deliveries. The DON stated only certain staff can accept pharmacy deliveries. The DON stated she had provided an in-service for receiving medications from the pharmacy. The DON stated the facility did not have a policy on who could accept pharmacy deliveries, but staff had been in-serviced on this. During an interview with LPN #4 on 12/18/2025 at 9:09 AM, LPN #4 stated the only nurse to accept deliveries were the ones that were charge nurses for that shift. The charge nurse was the one that had the medication cart keys. She stated, You can't give those keys to anyone else, unless you are (continued on next page)

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F 0602 Level of Harm - Potential for minimal harm Residents Affected - Many	leaving your shift. A narcotic count was done with two nurses at the end and beginning of every shift. LPN #4 stated they received an in-service after the incident with Resident #19's drug diversion, specifically on how to accept medication from the pharmacy. During an interview on 12/18/2025 at 10:32 AM, LPN #3 stated she was the nurse that reported the diversion to the DON. LPN #3 stated she was in the middle of medication pass when pharmacy delivery arrived. She stated she informed the delivery staff she would be right there. When LPN #3 arrived to the Nurses' Station, RN#1 had already accepted the pharmacy delivery and signed the medications in. LPN #3 stated Resident #19 had not made it to the facility from the hospital at the time of delivery. LPN #3 stated I opened the narcotic box and RN #1 placed the drug card in the box and I locked it back. I didn't think anything about it. LPN #3 indicated during the middle of her shift, she decided to check the narcotics and noticed the count that was in Resident #19's book and card with one punched out. LPN #3 stated, I went to look for the invoice to see the count and could not find the invoice, nor the drug wrapping. I checked the shred box and trash. LPN #3 stated she called the DON, who wanted LPN #3 to send a picture of the card front and back. LPN #3 called the pharmacy to check with them on the count, and it was verified there were 20 tablets delivered, not the 19 which was signed in the narcotic book and count of the card. LPN #3 stated they had another in-service the day after it happened and was told that whoever had the medication cart key was the only one to get in the medication cart. During an interview with Owner/Consultant on 12/18/2025 at 11:16 AM, the owner/consultant revealed they did not have a policy on pharmacy deliveries of narcotics. She stated when narcotics were delivered, they were in a tamper resistant bag. It was double bagged. You had to cut the bag open and once you cut the outer bag, the narcotic was in another bag. The nurse receiving the medication signed the invoice as well as the mobile device accepting the medication and the count of the narcotic. The nurse that had the medication cart keys were supposed to be the only one with access to the narcotic box contents. LPN #3 was the nurse with the medication cart key and should have been the only one dealing with the narcotics. During an interview on 12/18/2025 at 12:14 PM, RN #1 stated sort of like a fill in nurse for whatever was needed. RN #1 stated on the day of the incident, LPN #3 was busy in medication pass, so she accepted the pharmacy delivery. She stated part of acceptance was signing the delivery slip. RN #1 stated, I was in the middle of checking multiple medications when the Charge Nurse (LPN #3) arrived to the Nurses' Station. The Charge Nurse stood right next to me while I finished the counts. LPN #3 watched while RN #1 completed the delivery acceptance. RN #1 stated, I reached over and got the narcotic book off the top of the med cart and started logging the counts. RN #1 stated LPN #3 picked up the invoice slip and reviewed all the medications to make sure we had everything. RN #1 stated LPN #3 unlocked the locked narcotic box and I placed the narcotic card for Resident #19 in. RN #1 stated, after we restocked the med cart it was the end of RN #1's shift. RN #1 stated the DON called her the following morning for a miscount on a narcotic. The DON informed RN #1 that she was suspended until further investigation. RN #1 stated she did the drug screen, and it was negative. RN #1 stated the DON informed her that she was the only one that was being disciplined for this matter even though the other nurse did not follow the rules. RN #1 stated the Charge Nurse could accept deliveries, and she had always helped the other nurses. During an interview with DON on 12/19/2025 at 12:09 PM, the DON revealed the process when controlled drugs were ordered was when the drug arrived to the facility, they were counted and entered into the narcotic book. They were reconciled with a slip that came with them. The DON stated, I found out the invoices are put in the shred box and have not been able to locate them. DON (continued on next page)

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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 0602 Level of Harm - Potential for minimal harm Residents Affected - Many	stated LPN #3 was responsible for the medication cart on the incident day of 10/15/2025. DON stated it was her understanding that LPN #3 opened the lock box and allowed RN #1 to put the card in there. The DON stated she did not ask LPN #3 why a narcotic count was not done with another nurse getting into the narcotic box. DON stated LPN #3 was not disciplined for not following policy by allowing another staff member to get in the medication cart and I can't give you an explanation for that. The DON stated a picture of LPN #3's controlled drug prescription bottle in the reportable, because if her drug test was positive, she would be covered. The DON did not know if LPN #3 took her controlled drugs before or during the time LPN #3 was working and did not know how it would affect her ability to function because it affected everyone differently. The DON stated the facility did not have a policy for nurses working while taking a controlled drug. The DON stated, everyone functions differently while taking narcotics and did not know if staff was working while taking narcotics even for the safety of the residents. The DON stated there were two other residents (Resident #18 and Resident 39) with drug diversion with RN #1 taking their narcotics. The DON stated these two investigations were not reported to the Office of Long-Term Care (OLTC). The DON revealed the investigation process consisted of resident interviews, nurses notes, review of the narcotic book, and the investigation was not documented anywhere. The DON stated we discussed narcotics in our nurses meeting and could not tell me if it was discussed at Quality Assessment and Assurance (QAA) meeting. During an interview with the Administrator on 12/19/2025 3:20 PM, the Administrator revealed he expected staff to be terminated if it was proven a drug diversion took place. The Administrator stated, the QAA committee would be notified of a drug diversion and may have input toward it but not have the final say as to what happens. I have the final say. The Administrator stated there are times staff may not get disciplined but may have a note placed in their personnel file. The Administrator stated, it was not appropriate for the charge nurse with the key to the narcotic box to open it and allow another nurse access to the contents and he/she should be reprimanded but there should be a count of the narcotic and be correct. The Administrator said all drug diversion should be reported to the state agency. A review of an undated facility policy titled, Protecting residents during a suspected abuse , indicated the facility will take appropriate steps to prevent the occurrence of abuse and misappropriation of resident property and to ensure that all alleged violations of Federal and State Laws which involve abuse and misappropriations of resident property are reported to the Administrator of the facility and to State agencies in accordance with existing state law. The facility shall take the following steps to prevent, detect, and report abuse, and misappropriation of resident property: screening, training, prevention, identification, protection, reporting, investigation, corrective action, and documentation.