

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/06/2024
NAME OF PROVIDER OR SUPPLIER  Crestpark Helena, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  116 November Drive Helena, AR 72342	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>49596</p> <p>Based on record review, interview, and observations, the facility failed to ensure the bedside commode in a resident 's room was emptied in a timely manner for 1 (Resident #187) of 1 resident with a bedside commode and failed to ensure care plan interventions were followed regarding seizure precautions by installing padded bedrails for 1 (Resident #1) of 1 sample mix resident.</p> <p>The findings are:</p> <p>1. On 06/03/2024 at 12:21 PM, the Surveyor observed the bedside commode sitting beside Resident #187's bed and in front of the resident who was sitting in the recliner. The commode was lined with a trash bag. The commode had 3 sets of used gloves folded together and tossed in the commode. Solid and liquid waste was observed in the commode. The Surveyor asked when the resident had used the bedside commode. The resident stated, I used the bedside commode at 8:00 AM and again at 10:15 AM.</p> <p>a. On 06/03/2024 at 03:34 PM, the Surveyor observed the bedside commode had three pairs of used gloves and solid/liquid waste inside the trash bag lined bucket.</p> <p>b. On 06/03/2024 at 04:01 PM, the Surveyor observed the bedside commode still contained gloves and solid/liquid waste. The Surveyor asked the resident if the staff had been in and emptied the commode. The resident stated, I don't think so. The Surveyor then asked Resident #187 if the resident had used the toilet since the Surveyor was in last. The resident stated, No, but I'm about to.</p> <p>c. On 06/04/2024 at 08:39 AM, the Surveyor observed the beside commode sitting beside the resident who was receiving therapy. When the therapist left the room, the Surveyor looked inside the toilet which contained a black trash bag with used gloves and liquid waste in the commode bucket.</p> <p>d. On 06/04/2024 at 03:26 PM, the Surveyor observed Resident #187 sitting in the recliner. The bedside commode was sitting beside the resident and contained the same gloves and liquid waste.</p> <p>e. On 06/05/2024 at 08:35 AM, Resident #187 was observed in bed. The bedside commode was observed beside the bed. The bedside commode contained a black trash bag lining the bucket, with liquid waste and gloves tossed inside. The Surveyor asked the resident if she had been up this morning. Resident #187 stated No, I have not been up to toilet this morning.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>f. On 06/04/2024 at 04:30 PM, Resident #187 was asked about the waste remaining in the bedside commode and stated, Well, one or two pees don't bother me so bad, but when it goes this long, by the end of the day it is embarrassing and nasty. It is unsanitary. It bothers me more that it is not a big deal to the CNAs [Certified Nursing Assistants]. They should want to empty it every time.</p> <p>g. A Facility Policy on Personal Care titled, Bedside Commode, Offering/Removing, provided by the Administrator on 06/05/2024 at 2:05 PM, provided instructions for cleaning the bedside commode once it has been used, .27. Wipe the portable commode clean. Store it in its designated storage area. 28. Discard soiled towels, wash cloth, etc., in the soiled laundry container. 29. Discard disposable items into designated containers. 30. Remove gloves and discard into designated container. Wash and dry your hands thoroughly. 31. Clean wash basin and return to designated storage area. 32. Clean the bedside stand. 33. Wash and dry your hands thoroughly. 34. If the resident desires, return the door and curtains to the open position and if visitors are waiting, tell them that they may now enter the room .</p> <p>h. Resident #187's Care Plan identified the resident to be incontinent, with a goal to maintain resident's dignity, and that the resident utilizes a bedside commode.</p> <p>50923</p> <p>2. Review of Resident #1's Care Plan revealed diagnoses of a seizure disorder, osteoporosis, and fracture of femur. The care plan had a Disease Diagnosis section that indicated the resident was at risk for complications related to possible seizure activity. Approaches included, Keep side rails up and padded to reduce risk of injury.</p> <p>a. On 06/03/2024 at 11:29 AM, the Surveyor observed Resident #1 lying in bed, metal side rails up times two without padding installed, none visualized in room.</p> <p>b. On 06/04/2024 at 9:35 AM, the Surveyor observed Resident #1 lying in bed, metal side rails up times two, no padding noted, none visualized in any location in the resident's room.</p> <p>c. On 06/05/2024 throughout the day starting at 8:35 AM, ending at 5:05 PM, the Surveyor observed Resident #1 lying in bed with metal side rails up times two without padding installed, and none visualized in any location in resident's room.</p> <p>d. On 06/06/2024 at 11:00 AM, the Surveyor interviewed Licensed Practical Nurse (LPN) #1 and asked if she was familiar with Resident #1's care plan and medical diagnoses. LPN #1 stated, Yes. When asked what the policy for seizure precautions regarding bedrails instructs, LPN #1 answered, [Resident #1] should have padded bedrails. The Surveyor walked with LPN #1 to Resident #1's room and asked if the resident had padded bedrails in place. LPN #1 stated, No she doesn't. (None were observed on the bed or in the room).</p> <p>e. On 06/06/2024 at 11:26 AM, the Surveyor interviewed the MDS Coordinator and asked if she was familiar with Resident #1's care plan and medical history. The MDS Coordinator stated, Yes I am familiar. When asked what the policy for seizure precautions regarding bedrails instructs, the MDS Coordinator answered, Padded bedrails. The Surveyor walked with the MDS Coordinator to Resident #1's room and asked if the resident had padded bedrails in place. The MDS Coordinator stated, No. (none were observed on the resident's bed or in the room).</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>50923</p> <p>Based on observation, record review, and interview, the facility failed to ensure a comprehensive assessment was completed to provide the resident with the proper type of call light to accommodate the physical limitations of 1 (Resident #1) of 1 sampled resident. This failed practice had the potential to negatively impact resident care and safety due to the inability of the resident to alert staff.</p> <p>The findings are:</p> <p>Resident #1 had severe contractures to both left and right hands with hand contracture pads noted in both hands. Resident #1 is known to be non-verbal per staff and family member.</p> <p>The Minimum Data Set (MDS) with an Assessment Reference Date of 03/18/2024 addresses in section GG the physical limitations of the resident (impairment on both sides, mobility device in use) and bilateral contractures.</p> <p>On 06/03/2024 at 12:32 PM, the Surveyor observed Resident #1 in bed with a standard call light draped across the resident's chest over the blanket.</p> <p>On 06/06/2024 at 11:04 AM, the Surveyor interviewed Licensed Practical Nurse (LPN) #1 regarding the call light for Resident #1. LPN #1 was questioned about her knowledge of the limitations of range of motion and finger dexterity of Resident #1 due to severe contractures to bilateral hands. She confirmed Resident #1 does not have the ability to grip and/or press a standard call light to alert staff of a need, stating No, [Resident #1] couldn't grip it and push the button. The Surveyor asked, what other types of call lights are available? LPN #1 stated, The kind you apply pressure. The Surveyor walked with LPN #1 to Resident #1's room and asked what type of call light was observed in Resident #1's room. LPN #1 answered, The regular one with a button.</p> <p>On 06/06/2024 at 11:32 AM, the Surveyor interviewed the MDS Coordinator regarding the call light for Resident #1. The MDS Coordinator was asked to explain the process of assessing the resident for the proper call light. The MDS Coordinator stated, Can they push the call light, if not, we give them the one they can use. The Surveyor asked the MDS Coordinator about her knowledge of the limitations of range of motion and finger dexterity of Resident #1 due to severe contractures to both hands. She stated, Due to the contractures in [Resident #1's] hands, [the resident] wouldn't have the ability to use the standard call light. The Surveyor walked with the MDS Coordinator to Resident #1's room, and asked what type of call light was observed in Resident #1's room. The MDS Coordinator answered, A standard call light.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Administrator stated they do not have a policy or procedure specific to assessments or the determination of equipment matching the resident ' s needs. On 06/06/2024, the Surveyor discussed the process of assessments and determining the proper equipment for the residents with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON). When asked the process of assessing and determining which equipment would be needed, the Administrator stated, Once the assessments are completed, the nurse decides what is needed based on the assessment. The DON and ADON both agreed this is the facility's process.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925</b></p> <p>Based on observation, record review, and interview, the facility failed to ensure the medication error rate was less than 5 percent (%) during the medication administration observation of 3 (Residents #10, #27 and #32) of 5 (Residents #7, #8, #27, #29 and #32) residents who received medications from 3 Licensed Practical Nurses (LPNs).</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. Resident #32 had physician's orders for Lasix 20 milligrams (mg) and Omeprazole 40 mg to be administered at the 8:00 AM medication pass.             <ol style="list-style-type: none"> <li>a. On [DATE] at 8:31 AM, LPN #4 gathered Resident #32's medications and stated she was holding the Lasix because it was to be held if the resident's blood pressure was low. At 8:35 AM, she gave the resident the medications with water, but did not give Lasix 20 mg or Omeprazole 40 mg at this time.</li> <li>b. On [DATE] at 2:38 PM, LPN #4 was asked if she recalled administering Omeprazole to Resident #32 during the 8:00 AM medication pass and she stated, I think I did. She was asked to check the cart to see if the resident had a medication card for the medication in question. LPN #4 checked the medication cart and when she pulled out the resident's cards, there was no card of Omeprazole. She checked the as needed section of the cart, and it was not there. The evening nurse came out of a resident's room and stated the medication was in a packet. She opened the top drawer and removed a clear plastic bag that had foil bubble packets of Omeprazole for this resident. LPN #4 stated, Let me go back to the MAR (medication administration record) and circle that because Resident #32 missed that dose. She was asked if Resident #32 had a physician's order to hold the Lasix because no order was located in the resident's paper chart. She stated she thought she saw an order to hold it if the systolic (top number) blood pressure was less than 110 and the diastolic (bottom number) was less than 60. She was unable to provide an order to hold the Lasix prior to leaving her shift.</li> </ol> </li> <li>2. Resident #27 had physician's order for Potassium Chloride 10 Meq (milliequivalents) and Meloxicam 7.5 mg, both to be given with food.             <ol style="list-style-type: none"> <li>a. On [DATE] at 8:42 AM, LPN #4 gathered Resident #27's 8:00 AM medications and at 8:51 AM, she gave the Resident #27 the scheduled medications, but there was no food on the resident's bedside table, or any applesauce or pudding given with the medications. The facility kitchen served breakfast at 6:45 AM.</li> <li>b. On [DATE] at 2:38 PM, LPN #4 confirmed Resident #27 did not have any food during the morning medication pass.</li> </ol> </li> <li>3. Resident #10 had a physician's order for Eliquis 5 mg to be held times 3 days starting [DATE] at 2:00 PM. There were no further orders to hold the medication past this date, the order was not clarified with the provider to resume the medication after this time. On [DATE] at 8 AM, Resident #10's order to hold the medication had expired.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. On [DATE] at 4:13 PM, LPN #6 stated Resident #10's Eliquis was on hold and she did not administer the medication at the 4:00 PM medication pass.</p> <p>b. On [DATE] at 12:28 PM, the Director of Nursing (DON) confirmed there was no order in the record to continue to hold the Eliquis and stated, She's [the nurse] calling the doctor now.</p> <p>c. An Administering Medications policy provided by the Business Office Manager on [DATE] specified, . Medications shall be administered in a safe and timely manner, and as prescribed .</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925</b></p> <p>Based on observation, record review, and interview, the facility failed to ensure the facility remained free of a significant medication error for 1 (Resident #10) of 5 (Residents #7, #8, #10, #27 and #32) residents observed during the medication administration observation.</p> <p>The findings are:</p> <p>Resident #10 had a physician's order for Eliquis 5 milligrams (an anticoagulant medication used to treat and prevent blood clots and strokes) to be held times 3 days starting [DATE] at 2:00 PM. There were no further orders to hold the medication past this date and the order was not clarified with the provider to resume the medication after this time. On [DATE] at 8:00 AM, Resident #10's order to hold the medication had expired.</p> <p>a. On [DATE] at 4:13 PM, Licensed Practical Nurse (LPN) #6 stated Resident #10's Eliquis was on hold, and she did not administer the medication at the 4:00 PM medication pass.</p> <p>b. On [DATE] at 12:28 PM, the Director of Nursing (DON) confirmed there was no order in the record to continue to hold the Eliquis and stated, She's [the nurse] calling the doctor now.</p> <p>c. The [DATE] Medication Administration Record (MAR) reflected the Eliquis was held on [DATE] through [DATE] for the 8:00 AM and 4:00 PM times. The order was written on [DATE] at 2:00 PM to hold Eliquis x (times) 3 days. There was no documentation in the 8:00 AM or 4:00 PM box for [DATE] and [DATE] and the 8:00 AM box for [DATE] was blank. As of [DATE] at 1:00 PM, Resident #10 had missed 8 doses of Eliquis.</p> <p>d. An Administering Medications policy, provided by the Business Office Manager on [DATE] specified, . Medications shall be administered in a safe and timely manner, and as prescribed . The DON confirmed on [DATE] the facility did not have a policy covering significant medication errors.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49596</p> <p>Based on observations and interviews, the facility failed to ensure the container used to store controlled substances was permanently affixed in Medication room [ROOM NUMBER].</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>On 06/05/2024 at 2:42 PM, the Surveyor observed the black box used to store controlled substances was not permanently affixed. The box contained 2 vials of 2 mg/ml (milligram/milliliter) of Ativan. The Surveyor asked Licensed Practical Nurse (LPN) #2 if the box was permanently affixed. LPN #2 stated, No, it is not attached to anything. It is locked and the refrigerator is locked but it is not affixed to anything.</li> <li>On 06/05/2024 at 3:45 PM, the Surveyor asked the Director of Nursing (DON) if the black narcotic box in the refrigerator in Medication room [ROOM NUMBER] containing controlled substances should be permanently affixed. The DON stated I don't know about it being permanently affixed we never have it affixed. Is it supposed to be affixed? The Administrator and DON then went to the medication room to look at the box, both stated they did not know it should be affixed but would get it affixed.</li> <li>The facility policy titled Storage of Medications did not contain relevant information.</li> </ol>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37925</p> <p>Based on observation and interview, the facility failed to ensure dietary staff performed hand hygiene during the preparation of a meal and during the meal service, and failed to ensure food was properly stored and labeled after it was opened in 1 of 1 kitchen (Census 36). This had the potential to affect 33 residents who received meals from the kitchen.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>On 06/05/2024 at 1:40 PM, the Cook brought a box of frozen dinner roll dough and placed it in on the workstation. Without washing his hands, he donned a pair of clean gloves and a took a can of oil out of the cabinet, removed the top with his left hand and held the can with his right hand and sprayed a metal pan. Without washing his hands or changing gloves, he used the same gloves, and he reached in the box and removed some frozen dinner rolls and placed them on the metal pan. He removed the gloves and took the pan to the counter and pulled some clear plastic wrap over it and then placed the pan on top of the upright oven. He retrieved a second metal pan and without washing his hands, put on a pair of clean gloves, removed the top with his left hand, held the can of oil and sprayed the pan using his right gloved hand. He sat the pan on the counter, discarded the gloves and pulled a piece of clear plastic wrap over the pan and placed it on top of the upright oven. He re-taped the box, and at 1:45 PM he left the kitchen with it.</li> <li>At 1:47 PM, the Cook returned to the kitchen with a bag of frozen vegetables, and a 10 pound box of pulled white turkey. He then retrieved a 49 ounce can of chicken broth. At 1:50 PM, he took a 3rd pan and placed it on the workstation, reached in the upper cabinet and gathered a few plastic bottles of seasonings and sat them on the workstation. With his bare hands, he removed the top and sprayed the pan with oil. He then put on oven mitts and checked the items in the upright oven, removed the oven mitts and without washing his hands, donned a pair of clean gloves and opened a plastic bag of the turkey meat and poured it in a prepared pan. He opened a second bag of turkey meat and poured a small amount into the pan with the other turkey meat. He removed his gloves, took the bag or remaining turkey meat, wrapped it with clear plastic wrap, returned it to the box.</li> <li>At 2:29 PM, the Cook took another metal pan, sprayed it with oil and opened the box of dough sheets using his bare hands. He put on a clean pair of gloves without washing his hands and removed a sheet of the frozen dough and placed it in the pan. He took a second sheet of frozen dough and filled the open areas on the pan. He took a scoop and removed some of the meat and vegetables and layered it over the dough and continued this process of layering with the sheets of dough and then the meat mixture.</li> <li>At 2:34 PM, the Cook changed his gloves without sanitizing his hands and took a sheet of frozen dough and placed it over the meat mixture x 2 sheets. He removed his gloves and placed the prepared turkey pot pie in the over.</li> </ol> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5. At 4:38 PM, the first tray was served through the kitchen window. During this observation, the Dietary Helper was assisting with placing utensils, condiments, and other items on the tray before it was passed to the cook with her bare hands. She was asked to retrieve some bread for a resident that received an alternate meal. She left the area and returned to the counter by the sink, holding a bag of bread from the dry storage area. With her bare hands she untied the bag. Without washing her hands, she put a glove on her right hand, and held the bag with her left hand, and reached in the bag with her gloved right hand and removed two slices of bread and placed them on a piece of foil, folded the foil over the bread and passed the foil of bread to the cook. The Surveyor left the kitchen at this time.</p> <p>6. On 06/06/2024 at 1:08 PM, there were 3 reach in freezers, side by side and the third freezer had a clear plastic bag that was tied off and not properly sealed and there was no date or time noted on the bag.</p> <p>7. On 06/06/2024 at 1:11 PM, the Cook was asked, Are you familiar with the handwashing policy? The Cook stated, Yes. He was asked, Tell me when should you wash your hands? He stated, Whenever you enter the kitchen, or touch a trash bag. I usually wash my hands after I spray something in the dish or touch items with my bare hands. He confirmed that he should have changed his gloves after he touched a box or can of spray with gloves on. He confirmed on the food that had been opened, it should have been wrapped in [name brand] wrap, put in a [name brand] bag, and labeled with what it was and the date. He added that depending on the items, it might need the expiration date. At 1:15 PM, he was asked to look in the reach in freezer on the right and look at a plastic bag and describe what was in the bag. He looked at the bag and confirmed they were dinner rolls and he confirmed that the bag was not labeled.</p> <p>8. On 06/06/2024 at 1:18 PM, the Dietary Helper confirmed she should have washed her hands after she touched a non-food item, such as the outer part of a bread sack with her bare hands. She confirmed she should have washed her hands before putting on gloves. She was asked, Before touching the bread with a gloved hand that was used to touch the outer part of a bread sack, what should you do before removing the bread from the inside of the sack? She stated, I should have taken it off and changed my glove.</p> <p>9. A Handwashing Procedure policy provided by the Dietary Manager on 06/06/2024 contained the procedure when washing the hands but did not contain information regarding when or how often the hands should be washed in the kitchen. A Food Facts sheet by the FDA (United States Food and Drug Administration) revealed, .Clean wash your hands and surfaces often . Wash your hands . before and after handling food .</p> <p>10. A Storage policy provided by the Dietary Manager on 06/06/2024 revealed, .Correct storage procedures will be followed, and storerooms, refrigerators, and freezers will be kept clean and orderly .Frozen foods are stored at 0 degrees Fahrenheit or below. All foods to be frozen are well wrapped, labeled, and dated before freezing .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/06/2024
NAME OF PROVIDER OR SUPPLIER  Crestpark Helena, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  116 November Drive Helena, AR 72342	

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)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>49596</p> <p>Based on observations and interviews, the facility failed (1) to ensure the ceiling was in good repair in 1 (Resident #9) resident's room, (2) to ensure the two sofas and a chair in the dayroom were in good repair, free of tears, cracks, and holes, and (3) to ensure the tables, benches, and seating on the patio were in good repair without holes, tears and cracks in the seats.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. On 06/03/2024 at 12:02 PM, the Surveyor observed the ceiling falling/hanging down over Resident #9's dresser. The falling ceiling had 9 nails/screws attempting to hold it in place, with several split areas of ceiling tile hanging down. Resident #9 asked the Surveyor to look at his/her ceiling Resident #9 stated, It has been that way about a month and a half.               <ol style="list-style-type: none"> <li>a. On 06/04/2024 at 3:31 PM, the ceiling over Resident #9's dresser remained damaged.</li> <li>b. On 06/05/2024 at 8:36 AM, the ceiling over Resident #9's dresser remained damaged.</li> <li>c. On 06/06/2024 at 9:15 AM, as the Administrator and Surveyor approached Resident #9's room the Administrator stated, If you are talking about [Resident #9's] ceiling, I have contacted the contractor about it. The Surveyor asked when the contractor was contacted. The Administrator stated, Two weeks ago and then I texted him yesterday. The Administrator was asked if she had proof of the contact made two weeks ago. The Administrator stated, No. The Administrator was asked if she had any work order for the repair. The Administrator stated, No, we just call someone or fix the issue. The Administrator was asked if she had a Repair or Replacement policy. The Administrator stated, No.</li> </ol> </li> <li>2. On 06/03/2024 at 1:25 AM, the Surveyor observed a long sofa and a loveseat in the front day room had multiple tears and cracks in the coverings, a chair was torn from one arm to the other arm across the front of the seat. These areas had the potential to cause skin tears to anyone who might sit in them.               <ol style="list-style-type: none"> <li>a. On 06/06/2024 at 9:15 AM, the Administrator stated the tears in the upholstery could cause a skin tear.</li> </ol> </li> <li>3. On 06/03/2024 at 1:00 PM, the Surveyor observed the resident smoking area had a pink chair with a tear along the front of the chair exposing the foam cushion, cracks in the fabric covering the entire seat of the chair, two blue chairs with holes and cracks in the seats of both chairs, a mauve colored chair with the back broken, a mauve colored chair with cracks and a large split in the fabric exposing the foam cushion, and a wooden bench with a dry cracking wood seat and back. These items have the potential to cause skin tears to residents who smoke or sit outside in this area.               <ol style="list-style-type: none"> <li>a. On 06/04/2023 at 10:00 AM, the damage to the chairs and bench was observed to remain.</li> <li>b. On 06/04/2024 at 3:43 PM, the damage to the chairs and bench was observed to remain.</li> </ol> </li> </ol> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/06/2024
NAME OF PROVIDER OR SUPPLIER  Crestpark Helena, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  116 November Drive Helena, AR 72342	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>c. On 06/06/2024 at 9:00 AM, the damage to the chairs and bench was observed to remain.</p> <p>d. On 06/06/2024 at 9:15 AM, the Surveyor asked the Administrator to join the Surveyor in the patio area. Upon arriving at the patio area, the Surveyor asked do you have any concerns here. The Administrator stated, Yes, and I hadn't been out here or seen this. The Surveyor asked what could happen if a resident sat at one of the tables or chairs. The Administrator said, They could get a skin tear.</p>		