STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045221	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Helena, LLC	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Number of residents sampled: Number of residents cited: Based on observation, interview and facility policy review, it was determined that the facility failed to provide and maintain a safe and sanitary environment to help prevent the development and transmission of communicable disease and infections for three of three meal services observed. The findings include: Review of a facility policy titled Handwashing/Hand Hygiene revised in April 2010, indicated that the facility considers hand hygiene the primary means to prevent the spread of infections. The policy also indicated that employees must wash hands for at least fifteen seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: before and after eating or handling food; before and after assisting a resident with meals. During an observation of the Lunch Meal served in the dining room on 09/02/2025 at 11:44 AM, Certified Nursing Assistant (CNA)# 5 and CNA #7 did not sanitize their hands before getting meal trays from the facility kitchen serving window and handing trays to the residents. During an observation of the Lunch Meal served in the dining room on 09/03/2025 at 11:40 AM, CNA # 11 and CNA # 9 did not sanitize their hands before getting meal trays from the facility kitchen serving window and handing trays to the resident. CNA # 8 did not sanitize their hands after sitting down to assist a resident with their meal. During an observation of the Lunch Meal served on 200 Hall on 09/03/2025 at 11:47 AM, CNA # 12 did not sanitize their hands before handing trays to residents in rooms or when coming out of rooms after serving trays to the residents. No hand sanitizer dispenser was observed in the rooms or in the hallway. During an observation of the Lunch Meal served on 100 Hall on 09/03/2025 at 11:55 AM, CNA # 5 did not sanitize their hands before handing out trays in rooms. During one observation CNA touched bedside table to move the table closer to the resident then opened items on the tray without sanitizing their hands. No hand sanitizer dispenser was observed in the room or in the hallway. During observation of the Dinner Meal served on 09/03/2025 at 4:35 PM, CNA # 3, CNA # 2 and CNA # 10 did not sanitize their hands before getting meal trays out of the facility kitchen serving window or before opening items on dinner trays. CNA # 9 was observed holding a baked potato with their bare hand while cutting the potato open to put butter on it. (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
	045221	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Helena, LLC	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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA #5 on 09/05/2025 at 9:42 AM, CNA #5 indicated that their hands were to be sanitized before getting trays out of the serving window. During the setup of trays on halls, their hands were to be sanitized before picking up trays from the cart and before leaving the residents' rooms. If a bedside table was touched, then their hands were to be sanitized before opening items on the tray. CNA #5 also indicated that the outcome of not sanitizing hands was that cross contamination from hands to resident can occur and the resident may get sick. During an interview with Registered Nurse (RN) #6 on 09/03/2025 at 10:21 AM, RN #6 indicated that staff were to sanitize their hands before getting trays out of the serving window, after any care of a resident and before going to the next resident. The resident can get sick, or an infection can occur if hands were not washed or sanitized before serving trays or doing any type of care for a resident. During an interview with Director of Nursing (DON) on 09/05/2025 at 10:54 AM, DON indicated that CNAs are trained on hand washing and hands are to be sanitized before getting trays out of the serving window to give to residents. Hands are to be sanitized before serving trays to residents in their rooms and before the CNA comes out of a resident room. During an interview with the Administrator on 09/05/2025 at 11:35 AM, Administrator indicated that CNAs were to sanitize their hands before getting meal trays out of the kitchen serving window. Administrator also indicated that hand washing in-service was done at least once a year and more if needs are seen. During an interview with the Assistant Director of Nursing (ADON) on 09/05/2025 at 12:26 PM, ADON indicated that CNAs were trained on hand washing after being hired. ADON indicated that spot checks and Hand washing check offs are also done sporadically. ADON also revealed that there have not been any infectious stomach issues with residents per tracking and trending.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045221	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Helena, LLC	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Number of residents sampled: Number of residents cited: Based on record review and interview, it was determined that the facility failed to monitor the continued need for an as needed (PRN) medication order for psychotropic drugs after 14 days, per the regulation, for one (Resident #9) of one resident reviewed for unnecessary drug administration. The findings include: Review of an annual Minimum Data Sheet (MDS) with an Assessment Reference Data of 03/12/2025, indicated Resident #9 had a Brief Interview for Mental Status score of two, which indicated the resident had severe cognitive impairment. The MDS also indicated that the resident had diagnoses which included major depressive disorder; loss of memory, language and reasoning with agitation; loss of memory, language and reasoning with behaviors. Review of a Care Plan indicated Resident #9 was at risk for wandering behaviors and exhibited aggression with staff at times. Interventions included administering medications as prescribed, assessing the effectiveness of the medications given, assess for side effects of medications as ordered. Review of Physician Order's, indicated Resident #9 had a psychotropic medication ordered that was to be used PRN for agitation. Review of a Nurses Note dated 07/09/2025 at 2:30PM, stated Resident #9 cursed at the nurse. A Physician's Order was given to start psychotropic medication every eight hours PRN for agitation. Review of a Medication Record for Resident #9 indicated that a PRN psychotropic medication was ordered for the resident from 07/09/2025 to 09/02/2025. Review of a Medication Regimen Review (MRR) dated 08/11/2025, indicated the MRR was completed without addressing PRN psychotropic drugs, and did not contain a rationale for extending the order for the PRN psychotropic medication past 14 days. During an interview with the Director of Nursing on 09/05/2025 at 9:36 am, the DON indicated PRN medication orders used for behaviors are received from the Physician, and are to be given as the Physician prescribed. During an interview with a Pharmacy Consultant on 09/05/2025 at 9: 49 AM, the Pharmacy Consultant indicated last month's Gradual Dose Reduction did not address the psychotropic drug due to the Pharmacy Consultant being unaware Resident #9 was currently on psychotropic medication. During an interview with the Medical Director (MD) on 09/05/2025 at 12:15 PM, the MD indicated the duration or end date was not indicated on the medication order for the psychotropic medication. The MD also indicated that he was not aware of the regulation requiring PRN psychotropic medications be limited to 14 days. The MD indicated that the Pharmacy Consultant comes out monthly. The MD (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045221	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Helena, LLC	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)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed Pharmacy Consultants review the PRN psychotropic medication order and the Pharmacy Consultant suggests if the medication needs an end date or a decrease in the medication. The MD indicated that the suggestions of the Pharmacy Consultant are followed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045221	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Helena, LLC	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)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, it was determined the facility failed to ensure maintenance services were provided for a safe, clean, comfortable and homelike environment, to maintain the quality of life for the residents by reviewing the water temperature for one of three bathroom sinks tested. The findings include: During an observation and concurrent interview on 09/03/2025 at 8:37 AM, the hot water temperature in the bathroom sink that was shared by rooms [ROOM NUMBERS], was obtained by an infrared thermometer, registered 120.9 degrees Fahrenheit. The resident in room [ROOM NUMBER] stated that the water available in the sink was very hot. During an observation with the Administrator (AD) on 09/03/2025 at 10:30 AM, the hot water temperature in the bathroom sink that was shared by rooms [ROOM NUMBERS] registered 122.9 degrees Fahrenheit, the temperature being verified by the Administrator using the facility's thermometer. During an interview with the AD on 09/03/2025 at 10:45 AM, the AD indicated that the maximum temperature of hot water was to be no more than 110 degrees Fahrenheit. During an interview with a Plumber on 09/03/2025 at 11:45 AM, the Plumber stated that it was unknown why the hot water in some rooms was hotter than other rooms and that the temperature of hot water coming from the tank should be the same throughout the building. During an interview with Certified Nursing Assistants (CNA) #5 on 9/05/2025 at 10:54 AM, CNA #5 indicated that water that was too hot could burn a resident that was able to get to and use the water. During an Interview with RN #6 on 09/05/2025 at 11:09 AM, RN#6 indicated that hot water that was not the right temperature could cause burns to a resident's skin. During an Interview with the Director of Nursing (DON) on 09/05/2025 at 11:16 AM, the DON indicated that CNAs are advised to notify Administration if they feel hot water was too hot for a resident. During an interview with the AD on 09/05/2025 at 11:18 AM, the AD indicated that water temperatures were checked once a week and kept in a log. The AD that a Plumber was notified of any issues with water temperatures. AD also stated that the outcome of hot water temperatures being too high was that it could result in a burn to a resident's skin. AD also stated they did not have a facility policy related to water temperatures and review of a policy titled Resident Rights revealed this policy did not include maintaining a safe, clean, comfortable and homelike environment, to maintain the quality of life for the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045221	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Helena, LLC	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)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Number of residents sampled: Number of residents cited: Based on observation and interviews, the facility failed to ensure that daily staffing was posted in a prominent place readily accessible to residents, staff, and visitors. The findings include: On 09/03/25 at 2:20 PM, the Daily Staffing Log was observed in a copier room off the main dining area. No signage directing visitors to look in the copier room for staffing assignments was observed. On 09/03/25 at 2:32 PM, Certified Nursing Assistant #1 (CNA#1) indicated that visitors were not allowed to enter the copier room. CNA#1 also stated that visitors would have no reason to go into the copier room. CNA#1 stated the way visitors would know if certain staff members were working would be by the staff telling them. On 09/03/25 at 2:38 PM, CNA#2 indicated that visitors were not allowed to enter the copier room where the Daily Staffing Log was posted. CNA #2 stated if visitors wanted to know if a certain staff member were working they could ask one of the other CNA's and they would direct them to where the staff member was working. On 09/03/25 at 2:43 PM, CNA#3 indicated that visitors were not allowed to enter the copier room where the Daily Staffing Log was posted. CNA#3 stated that visitors could ask staff members who was working. On 09/03/25 at 2:56 PM, Licensed Practical Nurse (LPN #4) indicated that visitors were not allowed to enter the copier room where the Daily Staffing Log was posted. LPN #4 stated that visitors could stop at the front office and ask if certain staff were working if anyone was still in the offices when the visitors came into the facility. LPN #4 stated that she had visitors ask her about who was working, and she would provide the information to them. On 09/03/25 at 3:07 PM, the Director of Nursing (DON) indicated that visitors were not allowed to enter the copier room. The DON stated the facility does not give out information to visitors relating to which staff members were working, or what area they were assigned to. The DON stated that visitors should not be allowed to look at the Daily Staffing Logs. The DON stated that the CNA's schedule was posted at each of the nurse's station if visitors wanted to see that. On 09/03/25 at 3:11 PM, the Assistant Director of Nursing (ADON) indicated that she was responsible for posting the Daily Staffing Log and visitors were not allowed to enter the copier room. The ADON stated that she posts the CNA schedule at each nurse's station and if visitors had a question they could look there. The ADON stated that she was not sure if visitors knew the schedule was posted there. On 09/03/25 at 3:35 PM, the Administrator indicated that visitors were not allowed to enter the copier room where the Daily Staffing Log was posted. The Administrator said that the Daily Staffing Log should be posted in an area that was easily accessible to visitors, but they could ask one of the staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045221	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Helena, LLC	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)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	who was working. On 09/03/25 at 3:56 PM, the Daily Staffing log was observed posted at the nurse's station at the end of 100 Hall. The date on the schedule read 08/11/25 through 08/17/25. No nurse's schedule was observed. On 09/03/25 at 4:00 PM, the Daily Staffing log was observed posted behind the nurse's station at the end of 200 Hall. The date on the schedule read 08/18/25 through 08/25/25. No nurse's schedule was observed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045221	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Helena, LLC	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)
F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Number of residents sampled: Number of residents cited: Based on record review, interview and facility policy review, it was determined the facility failed to ensure Minimum Data Set (MDS) information was transmitted electronically within 14 days after completion of the assessment for two (Residents #16 and #30) of two resident assessments reviewed. The findings include: Resident #16 Review of Resident #16's Medical Record revealed an admission MDS with an Assessment Reference Date (ARD) of 08/18/2025. Review of a discharge, return not anticipated (DRNA) MDS with an ARD of 06/13/2025 provided by the Administrator on 09/04/2025 at 3:31 PM, indicated that the date of completion of 06/13/2025 was handwritten on the form. Review of an MDS Transmission Form provided by the ADON on 09/05/2025 indicated Resident #16's DRNA MDS with an ARD of 06/13/2025 was transmitted on 07/03/2025, which was six days past the required timeframe of submission of 06/27/025. During an interview on 09/04/2025 at 5:50 PM, the Assistant Director of Nursing (ADON) reviewed Resident #16's DRNA MDS with an ARD of 06/13/2025. ADON acknowledged signing the DRNA MDS when it was completed by the MDS Coordinator and stated the MDS Coordinator inputs the information into the computer system including the date of completion. ADON denied entering MDS data into the computer system. Resident #30 A review of an MDS Transmission Form provided by the ADON on 09/05/2025 indicated Resident #30's quarterly MDS, with an ARD of 06/10/2025, was transmitted on 07/03/2025. A review of Resident #30's quarterly MDS with an ARD of 06/10/2025 indicated the date of completion was 06/11/2025. This MDS should have been transmitted by 06/25/2025 and was transmitted 8 days past this date on 07/03/2025. During a telephone interview with the MDS Coordinator on 09/05/2025 at 10:40 AM, she stated the Resident Assessment Instrument (RAI) manual located in the facility's computer system was used and she did not know the version of the manual. She stated an MDS should be transmitted 2 weeks after completion. She stated [ADON's first name] signs the MDS for completion and she transmit them. She stated she may have worked the floor during the month of June 2025, and this may be the reason several MDS forms were submitted on 07/03/2025. She stated there was no certain date that she submitted the MDS information [in the facility's MDS information system], but she knew the MDS (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045221	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crestpark Helena, LLC	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)
F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	information was supposed to be transmitted within two weeks of completion. Review of a policy titled, Electronic Transmission of the MDS, with a revision date of October 2010, indicated all MDS assessments, such as an admission, annual, significant change, quarterly, discharge and entry records would be completed and electronically put in a coded form into the facility's MDS information system and transmitted to the Centers for Medicare and Medicaid (CMS) system by the current OBRA [Omnibus Budget Reconciliation Act] regulations governing the transmission of MDS data. Review of a policy titled, MDS Completion and Submission Timeframes dated October 2010, indicated the transmission date for a DRNA MDS was the MDS completion date plus (+) 14 calendar days. The transmission date for a quarterly MDS was the MDS completion date + 14 calendar days.