STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045287	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Creek Healthcare LLC	322 West Collin Raye Drive DE Queen, AR 71832

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50505 Based on interviews, record review, and facility document review, it was determined that the facility failed to ensure care plans were updated to include interventions for incidents for (Resident #16, Resident # 18, Resident # 27) 3 residents reviewed for incidents with care plan revisions and updates. Findings include: 1. On 10/24/2024 at 11:00 AM, the Director of Nursing (DON) stated, the facility did not have a policy for care plans or care plan revisions. 2. A review of Resident #16's Face Sheet indicated, the facility admitted Resident #16 with diagnoses that included congestive heart failure, Type 2 Diabetes Mellitus, chronic obstructive pulmonary disease, vascular dementia with behavioral disturbance, cerebral infarction and polyneuropathy. a. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/12/2024, revealed, Resident #16 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. b. A review of the Incident/Accident report revealed, Resident #16, on 07/09/2024 at 5:00 PM, was observed to have a bruise to their right great toe. The resident stated the toe was smashed between the wheelchair and the doorframe. According to the report, the additional step taken to prevent recurrence was to encourage Resident #16 to be mindful of feet when wheeling the wheelchair through doorways. c. A review of the Incident/Accident report revealed, Resident #16, on 08/22/2024 at 8:00 AM, was leaning on the right side of the bed attempting to eat and fell from the side of the bed onto the floor. According to the report, the additional step taken to prevent recurrence was to encourage Resident #16 to be out of bed for all meals. d. A review of the Nurse Aide's Information Sheet for Resident #16 had no interventions for the incident that occurred on 07/09/2024 and no interventions for the incident that occurred on 08/22/2024. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. A review of Resident #16's Care Plan, dated 04/23/2024 and updated 07/23/2024, revealed Resident #16 had a risk for abnormal bleeding or hemorrhage because of antiplatelet usage and a risk for injury related to falls; due to unsteady balance and history of fall. The bruise and intervention that occurred on 07/09/2024, and the fall that occurred on 08/22/2024, were not included in the care plan. 3. A review of Resident #18's Face Sheet indicated, the facility admitted Resident #18 with diagnoses of Dementia with Lewy Bodies, Parkinson's disease and soft tissue infection. a. The quarterly MDS with an ARD of 09/16/2024 revealed Resident #18 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. A review of the Incident/Accident report revealed Resident #18, on 10/11/2024, complained of pain to the right forefinger with swelling and redness noted, with no open lesion. Additional comments noted on the reports stated, the physician prescribed an antibiotic and wound care to be provided. Resident #18 was assessed and there was no indication that the area to the forefinger was caused by an injury. A review of Physician's Orders for Resident #18 revealed the resident had an order, initiated on 10/11/24, to clean lesion to right index finger with wound cleanser; apply antibiotic ointment and cover with bandage every day until healed and as needed and to start antibiotic, 1 pill every day for 7 days. A review of Resident #18's Care Plan, updated 09/24/2024, revealed Resident #18 had a risk for abnormal bleeding or hemorrhage due to daily antiplatelet use; a risk for unrelieved pain related to Parkinson's disease and cognitive deficit with limited memory; and a risk for skin breakdown related to decreased mobility and frequent episodes of incontinence of bowel and bladder. The care plan had not been updated to include the incident/infection or the antibiotic and treatment order that occurred on 10/11/2024. A review of Resident #27's Face Sheet indicated the facility admitted Resident #27 with diagnoses of anxiety disorder, muscle spasm, and bipolar disorder. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/22/2024, revealed Resident #27 had a Staff Interview for Mental Status (SAMS) which indicated the resident was severely impaired for daily decision making. A review of the Incident/Accident report revealed that Resident #27, on 09/29/2024, received a skin tear to their left hand while pulling hand out of the side of the wheelchair when the hand caught on the bottom of the arm rest. Additional comment/steps taken to prevent recurrence indicated, treatment order for the skin tear and a larger, more comfortable and safer chair was requested from hospice. A review of the Nurse Aide's Information Sheet for Resident #27 had no interventions for the incident that occurred on 09/29/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Physician Orders for Resident #27 revealed, resident had an order, initiated on 09/29/2024, to cleanse skin tear to left hand with wound cleanser. Pat dry. Apply strip closures and cover with dry dressing. Monitor strip closures every day and as needed. Keep covered with dry dressing until healed. A review of Resident #27's Care Plan, dated 06/18/2024, revealed Resident #27 had a terminal illness and the family had opted for hospice care for the diagnosis of senile degeneration of the brain and resident was at risk for further decline in overall condition as disease progresses. The request for a larger, more comfortable, and safer chair from hospice had not been added to the care plan. There was no care plan added to include the skin tear Resident #27 received on 09/29/2024. During an interview on 10/16/2024 at 2:20 PM, the MDS Coordinator confirmed there were no updates or interventions added to Resident #16's care plan for the incident that occurred on 07/09/2024 and no updates or interventions were added for the incident that occurred on 08/22/2024. MDS coordinator confirmed that the care plan for Resident #18 had not been updated to include the incident/accident, the treatment or the infection for the right index finger. MDS coordinator confirmed, the care plan for Resident #27's skin tear and the intervention for a larger, more comfortable and safer chair request had not been added to the resident's care plan. MDS coordinator indicated, the care plan should be updated as soon as the incident/accident happens or as soon as possible and the reason for that would be to prevent it from happening again. When asked how the staff would know what interventions were put into place, the MDS Coordinator stated the staff have ADL books but, they were being worked on and for now the staff would be told. During an interview on 10/16/2024 at 2:30 PM, the DON stated each morning Incidents/Accidents and infections were reviewed in the morning stand up meetings and the registered nurse (RN) was supposed to be updating the care plan with the information and interventions. The DON confirmed that care plans should be updated within 24 hours after an incident occurred. DON explained the importance of making sure care plans are updated was to prevent it from happening again. The DON indicated the ADL books that the staff use are supposed to be updated by the MDS Coordinator. During an interview on 10/17/2024 at 9:10 AM, RN stated there had been a misunderstanding, but now the incidents/accidents would be care planned. RN stated the incident/accident reports had been given to the MDS Coordinator thinking that the interventions would be care planned, not realizing that they were to be care planned by the RN.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50505 Based on interviews, record review, facility document review it was determined that the facility failed to ensure that physician orders were followed as written on telephone order for 1 (Resident #27) reviewed for physician order accuracy. Findings include: On 10/24/2024 at 11:00 AM, the Director of Nursing (DON) stated the facility did not have a policy for physician's orders or the processing of physician's orders. A review of a Face Sheet indicated the facility admitted Resident #27 with diagnoses of anxiety disorder, muscle spasm, and bipolar disorder. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/22/2024, revealed Resident #27 was severely impaired for daily decision making. The MDS indicated Resident #27 had an indication for use of a high-risk drug, an anti-anxiety medication. A review of a Physician's Telephone Order dated 09/12/2024, for Resident #27 indicated a new order for (name brand) anti-anxiety medication 0.5 mg (milligram) give 1 tablet by mouth twice a day and was signed by the physician on 10/03/2024. A review of October 2024 Physician's Orders, signed by the physician on 10/03/2024, for Resident #27 revealed an order for (name brand) Anti-anxiety medication 0.5 mg 1 tablet by mouth three times a day for anxiety disorder that had been updated on 09/12/2024. A review of Resident #27's Care Plan, dated on 06/18/2024, revealed the resident was at risk for adverse effects of psychotropic medications. Interventions included: observe for adverse effects of - (name brand) Anti-anxiety medication and report to physician if occurs, sedation, discoordination, unsteady balance, increased agitation, headache, nausea, and hallucination. A review of the Medication Administration Record (MAR) for September 2024 revealed, on 09/12/2024, an order had been added. (Name brand) Anti-anxiety medication 0.5 mg 1 tablet by mouth three times a day (TID). The original twice a day (BID) was marked out with one line through the BID with error written above the word. A review of the MAR for October 2024 revealed, an order for -(name brand) Anti-anxiety medication 0.5 mg 1 tablet by mouth TID. On 10/16/2024 at 9:49 AM, the DON confirmed the Physician's Telephone Order and the printed October Physician's Orders did not match. During an interview on 10/17/2024 at 9:20 AM, the LPN stated, that the order should have been clarified when the BID had been crossed out on the MAR. Confirmation was given by LPN that the telephone order had not been reviewed and the order had not been clarified for the (name brand) Anti-anxiety medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/24 at 9:00 AM, the DON indicated, the process of processing physician's orders was for the nurse to write the order, tear the top copy of the telephone order off, and fax to the pharmacy then to call the family. Once completed, the telephone order would go in a basket and would be picked up each morning. The order would then be entered into the electronic physician's orders. The DON revealed, it was important to ensure orders are transferred correctly and with any order that was unclear, that the order should be clarified.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49981 Based on observation, record review, and interview, it was determined that the facility failed to follow the recipe for pureed foods to maintain nutritional value for 4 (Resident # 8, #9, #25, and #38) residents receiving pureed foods from the facility kitchen. The findings are: On 10/15/2024 at 10:16 AM, during an observation the [NAME] prepared and pureed food items for lunch. The [NAME] pureed chicken fried steak and thinned food mixture using a total of 3 cups of hot water. On 10/15/2024 at 10:33 AM, the [NAME] pureed rolls and thinned the bread mixture with a total of 2 cups of hot water. On 10/16/2024, a list of residents with puree diets was provided by the Dietary Supervisor (DS), along with guidelines for pureeing foods, and recipes for pureed chicken fried steak and pureed rolls. The recipes for pureed foods were reviewed and the recipe for pureed chicken fried steak indicated at Step #2, add liquid if needed [ex. reserved liquid, broth, milk, gravy, or sauce] to assist with pureeing and a note that indicated, water should not be used as a liquid to puree foods. The recipe for pureed rolls indicated at Step #2, add liquid if needed [ex. reserved liquid, broth, milk, gravy, or sauce] to assist with pureeing, and a note that indicated water should not be used as a liquid to puree foods. On 10/16/2024 at 10:27 AM, the [NAME] was asked during an interview to read over the recipe. The [NAME] read the recipe and confirmed water should not have been used to thin the food mixtures. The [NAME] stated adding water takes away from the nutritional value and flavor of the foods. On 10/16/2024 at 10:33AM, the DS was asked to read over the recipe and confirmed water should not have been used to thin pureed foods. Broth, gravy, or milk would have been a better option. The DS said when water is used, it reduces the nutritional value and flavor of foods. If broth, milk, or gravy would have been used, it would have added nutrition and more flavor.