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	03/06/2026

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on record review, interviews, and facility policy review, the facility failed to ensure the residents' orders and other electronic health records accurately and consistently reflected the resident's advanced directive decision that documented the resident did not want Cardiopulmonary Resuscitation (CPR) for one (Resident #17) of eight residents whose clinical records were reviewed for advanced directive information. The findings include: Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE], revealed Resident #17 had diagnoses which included non-Alzheimer's dementia, anxiety, and depression. The MDS also revealed a Staff Assessment for Mental Status (SAMS) score of 2 which indicated Resident #17 had moderate impairment for decision making and received hospice services. Review of a Durable Power of Attorney (POA) with Health Care [NAME] signed by Resident #17 on [DATE], revealed Resident #17 chose to have CPR withheld. Review of a form titled Living Will Declaration, signed [DATE] by Resident #17's Durable Power of Attorney (DPOA) revealed, if I should have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment I direct my physician to withhold Cardiac Resuscitation to include CPR. Review of a Resuscitate/Do Not Resuscitate Order dated [DATE] signed by Residents #17's DPOA and Physician, revealed the resident had a Do Not Resuscitate (DNR) Order. Review of a Physician's Order revealed the facility admitted Resident #17 on [DATE]. An order dated [DATE] indicated the resident was a full code. Review of a Medical Doctor (MD) Progress Note dated [DATE], revealed Resident #17 was a DNR patient. Review of a Care Plan with a review date of [DATE], revealed Resident #17 had the following Advanced Directives on record; a Living Will, a Durable Power of Attorney for Health Care and a DNR order with the goal of Resident #17's Advanced Directives are in effect, and the residents wishes and (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	directives will be carried out. Review of a MD Progress Note dated [DATE], revealed Resident #17 was a full code. Review of a Physician's Orders revealed Resident #17 had an order dated [DATE] to be admitted to hospice services with diagnosis of senile degeneration of the brain and an order dated [DATE] revealed the resident was a full code. Review of a Medication Administration Record (MAR) dated [DATE] to [DATE], revealed Resident #17 was a full code. Review of the Face Sheet for Resident #17 indicated the resident had an advanced directive for no CPR. During an interview on [DATE] at 9:33 AM, Registered Nurse (RN) #1 indicated Resident #17 was receiving hospice services for dementia. RN #1 indicated that Resident #17's Advanced Directives consisted of a POA, DNR order and a Living Will. RN #1 indicated Resident #17's Living Will indicated the resident did not want CPR. RN #1 indicated a resident's code status was documented on the Face Sheet, MAR, and Advanced Directive. RN #1 was asked if the residents' code status was included in Physician Orders and RN #1 stated that the code status was verified by looking in the medical record that Resident #17's current Physician Orders indicated the resident was a full code. RN #1 stated that Physicians' Orders should reflect the residents Advanced Directives regarding code status and after further review of Resident #17's medical record, RN #1 stated the Physicians' Orders from [DATE] to [DATE] when the facility admitted Resident #17 also showed that the resident was a full code. RN #1 stated that Resident #17's Medical Record and orders needed to be updated to reflect the resident's wishes as outlined in the residents Advanced Directive since someone could look at the record and do CPR when that is not what the resident wants. RN #1 stated, We would not want anyone to make that mistake. During an interview on [DATE] at 9:50 AM, Licensed Practical Nurse (LPN) #3 indicated Advanced Directives were kept in the resident's Medical Record and the code status was written on the MAR and on the Face Sheet. LPN #3 was asked where she would look for a resident's code status if the residents' heart stopped and she stated that if she was at the nurse's station she would look in the Medical Record and if she was on the hall she would look at the MAR. LPN #3 was asked what Resident #17's MAR indicated as the code status and LPN #3 stated that it indicated a full code. LPN #3 was asked to review Resident #17's medical record and verify what the resident's code status was in the medical record. LPN #3 reviewed Resident #17's medical record and stated the residents code status was DNR. LPN #3 stated the resident had a DNR order and a Living Will stating no chest compressions. LPN #3 was asked what the residents' current orders indicated regarding code status and LPN #3 stated the residents' current orders stated full code. LPN #3 was asked why it was important that the resident record accurately reflected the resident's Advanced Directives and code status, and LPN #3 stated, it was important so that staff know the resident's wishes and that Resident #17 did not want CPR. During an interview on [DATE] at 10:15 AM, the Assistant Director of Nursing (ADON) was asked who ensured the order for code status was correct when a resident was first admitted to the facility. The ADON stated the code status form was in the admission packet, and at the time of admission, the admissions staff member asked the resident and/or family if they have any Advanced Directives such as a living will. The ADON stated Resident #17's family chose a DNR order and the order was signed (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by the resident's family member. The ADON stated that the admissions staff member would put the initial information in the computer and print out the Face Sheet. The resuscitate/do not resuscitate order was brought to the nursing department and taken to the MD for signature. When the signed resuscitate/do not resuscitate order came back from the MD, the ADON would go into the computer and put the DNR code status into the orders. The ADON was asked what Resident #17's orders should say regarding the code status and the ADON stated it should say Resident #17 was a DNR. The DON was asked where she would look for code status if a resident's heart was to stop and she stated she would look at the resuscitate/do not resuscitate order because she would want to know if it had been signed by the physician or not. The ADON was asked to look at Residents #17's Physician Orders regarding the resident's code status and the ADON stated the residents face sheets stated no CPR, but Physician Orders stated full code and that was not correct. The ADON was asked why it was important that a resident's Advanced Directives and orders were correct in the Medical Record and the ADON stated it was important, so we know the resident's and resident family's wishes and know whether to start CPR. The ADON stated, If I start CPR, I cannot stop until a physician tells me to stop. This needs to be clarified immediately. During an interview on [DATE] at 10:30 AM, the Director of Nursing (DON) verified Resident #17 was on hospice services for dementia. The DON was asked if Resident #17 had an Advanced Directive and the DON stated that she believed the resident had an Advanced Directive stating DNR and no Intravenous (IV) therapy. The DON was asked where the code status was documented and she stated it was documented in the Advanced Directives, on the Face Sheet and on the MAR. The DON acknowledged that the MAR was not correct and stated, she was getting that corrected now. The DON was asked why it was important that the resident's Advanced Directives were known and the DON stated it was important so that staff know what to do. Staff should check the actual advanced directives to see what the resident's wishes are. That is what I would do. The surveyor showed the DON the MD Progress Note dated [DATE] that indicated the resident was a full code and the DON stated, I will call the doctor and clarify this with him. During an interview on [DATE] at 10:55 AM, The Administrator stated Resident #17 was on hospice services. The Administrator was asked if Resident #17 had an Advanced Directive and the Administrator stated Resident #17 was a DNR. The Administrator was asked if she was aware that Resident #17's Physicians Orders indicated the resident was a full code and the Administrator stated, she had just been made aware of that. The Administrator was asked why it was important that the resident's Medical Record accurately reflected their Advanced Directives and the Administrator stated, so that staff can carry out the wishes of the resident in case of an emergency. The Administrator stated, we are correcting it right now by reviewing all the residents' Advanced Directives and orders. Review of a facility policy titled Advanced Directives with a reviewed date 01/2024, revealed advanced directives will be respected in accordance with state law and facility policy. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advanced directive and the Director of Nursing or designee will notify the attending physician of advanced directives so that appropriate orders can be documented in the resident's medical record and plan of care.