

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Windcrest Health and Rehab Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2455 Lowell Road Springdale, AR 72764	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and facility document review, the facility failed to ensure that the food preparation equipment and environment were maintained in a clean and sanitary condition to prevent contamination and potential development of foodborne pathogens, one of one kitchens and one meal service observed. The findings include:Ice Machine During the initial tour of the kitchen on 06/08/2026 at 11:03 AM this surveyor asked the Dietary Consultant to perform a swipe test on the ice machine where the ice comes from the dispenser with a white paper towel. The Dietary Consultant described what came off on the white paper towel as brown and black specks. During an interview on 06/08/2026 at 11:15 AM, the [NAME] stated the ice machine was cleaned once a week. Review of the kitchen cleaning schedule on 06/09/2026 2:56 PM, revealed the ice machine was marked as cleaned on 06/02/2026 and 06/09/2026. Refrigerator During an observation of the left refrigerator on 06/08/2026 at 11:06 AM this surveyor observed a pork roast in a shallow pan in the bottom of the refrigerator labeled 06/01/2026. The Dietary Consultant informed this surveyor the date marked was the date the roast was pulled from the freezer. During a second observation of the left refrigerator on 06/08/2026 at 11:17 AM the pork loin was no longer observed in the refrigerator. The Dietary Consultant stated it had been thrown out due to being held to long. During an interview on 06/08/2026 at 11:20 AM, the Dietary Manager indicated that the pork loin have been in the refrigerator since it was pulled June first and should have been cooked yesterday for today's lunch (06/08/2026). Food Preparation Equipment During an observation on 06/09/2026 at 11:11 AM the [NAME] indicated a large cooking pot on the (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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and facility document review, the facility failed to ensure that the waste was properly contained in the dumpsters, and the area was free from debris. The findings include: During on observation of the dumpsters behind the facility, on 06/08/2026 at 11:10 AM, this surveyor observed the following behind and around the facility dumpsters: pieces of metal a broken bed side table top, one glove, behind the dumpster, two gloves at the front of the dumpster in the ground, and on the right side of the dumpster were four additional gloves on the ground. white plastic grocery bag various scraps of paper. an aluminum can, a Styrofoam cup. During a continuation of the observation behind the facility building this surveyor observed the following: - The commercial grease trap behind the building had two plastic chairs leaning on it, a plastic wheeled dolly was lying on top of the commercial grease trap along with a cooking thermometer. -A large tin can full of water and cigarette butts sat on the ground. -The top of the commercial grease trap had a thick black substance on the top of it. -The commercial grease trap was 104 inches from the back door and approximately six inches from the back of the building. During a second and third observation on 06/09/2026 at 7:45 AM and 06/10/2026 at 11:10 AM, this surveyor again observed the following behind and around the facility dumpsters: pieces of metal a broken bed side table top, one glove, behind the dumpster, two gloves at the front of the dumpster on the ground, and on the right side of the dumpster were four additional gloves on the ground. white plastic grocery bag (continued on next page)		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	various scraps of paper. an aluminum can, a Styrofoam cup. During interview on 06/10/2026 at 3:48 PM, the Maintenance Director confirmed the dumpster findings and stated, everyone pitches in and picks up the trash on a daily basis. It mostly blows in from other areas like the apartments next door. The gloves are facility trash. The Maintenance Director stated, I am responsible for the area around the dumpster and pick it up on a daily basis. The Maintenance Director confirmed and observed the commercial grease trap. The Maintenance Director stated the kitchen staff are responsible for this area, the facility has a company that empties the grease trap every couple of months. During an interview on 06/10/2026 at 3:07 PM, the Dietary Manager stated the cooks were responsible for taking out kitchen trash, and the dietary aides were responsible for taking out dish room trash. The Dietary Manager stated the whole facility uses the dumpsters, and everybody was responsible for keeping the area around the dumpster clean. The Dietary Manager went on to add that the kitchen staff had not been told they are solely responsible for the dumpster. When asked about the commercial grease trap, the Dietary Manager stated that maintenance cleans around the building, if the oil gets spilt on the container the person dumping the oil should clean it up. During an interview on 06/11/2026 at 12:53 PM, the Administrator stated staff need to follow the policy on the grounds and pick up trash on a daily basis depending on the weather. The Administrator stated, I drive around the building about three times a week to monitor the trash. This week I drove around on Tuesday, Wednesday, and today (Thursday). The Administrator indicated she did not document when she drove around the building, and the Maintenance Director did not document when he picked up trash on the grounds. Review of a facility policy titled, Sanitation with a revision date of October 2008, revealed kitchen wastes that are not disposed of by mechanical means shall be kept in clean, leakproof, nonabsorbent, tightly closed containers and shall be disposed of daily.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain a safe, clean, homelike environment. Specifically, the facility failed to replace missing window blinds that compromised resident privacy during dressing; and failed to replace heavily soiled, stained bed linens and pillows that were left unchanged for multiple days in the resident rooms. The findings include: During an observation of room [ROOM NUMBER]-A on 06/08/2026 at 11:45 AM this surveyor observed a bed made with a bare pillow missing its pillowcase. The pillow itself was heavily soiled with a large, dark brown stain measuring approximately 8 inches in diameter across the center. During an observation on 06/09/2026 at 8:10 AM of room [ROOM NUMBER]-A, the surveyor observed that the bed linens at the foot of the bed were heavily soiled with a reddish-brown substance. Additionally, the floor fan was missing its protective safety cover, leaving the fan blades completely exposed to resident contact. During a follow-up observation of room [ROOM NUMBER]-A on 06/10/2026 at 9:21 AM this surveyor observed that the soiled bed sheets that had been noted on the previous days had still not been changed or laundered. During a concurrent observation of Resident #26's room and interview on 06/09/2026 at 9:02 AM, this surveyor noted there were no blinds on the room window to enhance privacy. Resident #26 stated that due to the missing window blinds they changed clothing in the corner. During an interview on 06/10/2026 at 8:55 AM, Certified Nursing Assistant (CNA) #11 stated they had not noticed the missing window blinds in Resident #26's room but noted that the resident was independent with dressing. CNA #11 observed the pillow in 401-B at this surveyor's request and stated the pillow was nasty and coved in brown stains. CNA #11 immediately discarded the pillow into the trash. During an interview on 06/10/2026 at 9:56 AM, Licensed Practical Nurse (LPN) #13 stated that bed sheets must be changed immediately anytime they become soiled. LPN #13 stated they were unaware that the window blinds were missing in Resident #26's room. During a follow up interview on 06/11/2026 at 11:11 AM, CNA #11 indicated that staff were supposed to report broken items by writing them down in the maintenance book or by verbally telling the maintenance department. During an interview on 06/11/2026 at 12:39 PM, the Director of Nursing (DON) revealed that broken items should be logged by staff in the maintenance book or reported by the CNAs to the charge nurse to notify maintenance. The DON stated that missing blinds should be reported immediately and (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verified that resident bed linens [NAME] be changed daily, or as needed if they become soiled. During an interview on 06/11/2026 at 11:16 AM, Charge Nurse LPN #14 revealed that all maintenance requests must be written in the facility maintenance log and stated that none of these specific environmental issues had been reported to them. During a follow-up interview on 06/11/2026 at 11:16 AM, the Maintenance Director indicated that they go from one work order to the next based on what staff write in the log or tell them verbally. The Maintenance Director stated they check the building every morning to ensure items are in working order but explicitly stated that nobody had reported the broken/missing blinds in room [ROOM NUMBER] to them.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, record review, interview and facility policy review, the facility failed to ensure residents environment remained free form smoking hazards as evidence by two (Residents #29 and #41) of four resident observed had with cigarettes and lighters in their possession during smoke breaks. The findings include: Resident #41 On 06/08/2026 during the 2:00 PM smoke break, this surveyor observed Resident #41 with a lighter. An unidentified female staff member took the lighter from Resident #41. Resident #41 was observed again by a surveyor removing a second lighter from a personal bag observed on the resident when they were observed in the smoking area. The resident placed the second lighter back in their bag, and it was not given to the staff member to place in the container before the resident went back into the facility. On 06/08/2026, Resident #41 had a sign on the door which indicated surveyors were not allowed in the room. On 06/10/2026 at 2:08 PM, this surveyor was seated in a room facing windows to the smoking area. Resident #41 was observed entering the smoking area wearing a smoking apron with a black and pink pouch hanging on the right side of a wheelchair. Resident #41 opened the black and pink pouch, pulled out a green and white carton of cigarettes, opened the top, removed one cigarette placing the cigarette between their lips, and put the green and white carton inside the black and pick pouch. Resident #41 removed a small lighter from the same pouch and lit their cigarette and placed the lighter inside the black and pink pouch. This surveyor observed smoke coming from the cigarette and the resident's mouth. There was a female staff CNA, later identified as CNA #5, in the area handing cigarettes to other residents and lighting the other residents' cigarettes. CNA #5 did not give Resident #41 a cigarette or lighter during this smoke break. Resident #41 did not give the black and pink pouch to CNA #5 after leaving the smoking area. Resident #41 was observed later in the day on 06/10/2026 with the black and pink pouch hanging on the side of their wheelchair in the hallway as surveyor was walking to the conference room. Review of an admission record revealed Resident #41 admitted to the facility on [DATE] with diagnoses which included epilepsy and primary open-angle glaucoma in right eye, moderate stage and left eye, severe stage. Review of the Order Summary Report for Resident #41 revealed an order dated 05/19/2025 to admit to long term care. There was no order indicating Resident #41 had approval to keep smoking items in their possession. A review of Resident #41's Care Plan, with a review date of 05/13/2026, revealed Resident #41 was a (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	smoker. Interventions included that Resident #41's smoking supplies were stored at the nurses' station. Interventions also include that Resident #41 required a smoking apron and supervision while smoking. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date of 05/07/2026 for Resident #41 revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS also included that Resident #41 was a current tobacco user. A review of Resident #41's nursing smoking safety screen and care plan form dated 05/04/2026 indicated the resident's cigarettes and lighter were kept at the nurses' station. During an interview on 06/10/2026 at 2:45 PM, Certified Nursing Assistant (CNA) #5 stated residents were not allowed to have their own cigarettes and lighters on their person, such as in a bag. She stated, But I will tell you that this has been an issue. There have been times that I have confiscated them on smoke break, put them in a box, come back the next day and they [residents] have them again. She stated the residents' smoking items are to be stored at the nursing station in a drawer. CNA #5 stated she did not give Resident #41 a cigarette or light Resident #41's cigarette during the 2 PM smoke break. She also stated Resident #29 was not supposed to have a lighter on their person. During an interview on 06/11/2026 at 10:45 AM with the Advance Practice Registered Nurse (APRN), she stated residents were not allowed to have their individual smoking paraphernalia. She stated for residents to receive consent to have smoking paraphernalia on them, providers would have to screen them. She stated she has not approved any residents to smoking paraphernalia in their possession. During an interview on 06/11/2026 at 1:45 PM, the Director of Nursing (DON) stated Resident #41 was not allowed to have smoking items on their person. He stated he was made aware on 06/11/2026 around 2:30 PM by the CNA who was scheduled for the smoke break [CNA #5] that Resident #41 had cigarettes and a lighter in their possession. During an observation and concurrent interview on 06/11/2026 at 5:15 PM, Licensed Practical Nurse (LPN) #6 she stated the smoking items were stored in the drawer and pointed this surveyor to an unlocked drawer in the nursing station. This surveyor opened the drawer and observed a clear container with white top with the word smokers' written in blue on the top. The container was not locked. There was no black and pink pouch observed in the drawer that contained smoking container. LPN #6 stated nurses and CNAs had access to the drawer with the smoking items. She stated it was important to keep cigarettes/lighters out of the hands of the residents, so they don't burn each other and for oxygen precautions. Resident #29 During an observation on 06/10/2026 at 2:10 PM during the 2:00 PM smoking break at the outdoor smoking area visible from the surveyor conference room window, Resident #29 was observed removing an oblong package from a black case on their lap. Resident #29 was observed removing a cigarette from this oblong box, then placed it in their mouth. Resident #29 removed a lighter from the same black case and lit the cigarette independently. Resident #29 replaced the cigarette pack and lighter into the black bag on their lap. Staff were present and walking around assisting the other residents with their smoking material. A review of the admission Record indicated that Resident #29 (continued on next page)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** [NAME] SmithBased on observation, record review, interview, and facility policy review, the facility failed to recognize and/or assess risk factors that placed a resident at risk for receiving possible sexually inappropriate behaviors, and to implement guidance to maintain separation of affected residents, for one (Resident #40) of one resident reviewed.The findings include:A review of a reportable for Resident #40, dated 06/02/2026, indicated the Administrator received a report that Resident #50 had inappropriately touched Resident #40 during smoke break time.A review of a witness statement included in the reportable from Certified Nursing Assistant (CNA) #6 dated 06/01/2026 at 21:25 (9:25 PM) indicated [Resident #40] mentioned that [Resident #50] had touched them in the chest area while both residents were out on a smoke break. The witness statement indicated Resident #40 was very displeased and uncomfortable at the incident.A review of a witness statement included in the reportable from Licensed Practical Nurse (LPN) #8 dated 06/01/2026 indicated Resident #40 was brought to her by a CNA (not named) to report an incident from the smoke break. The witness statement indicated Resident #50 had touched Resident #40 inappropriately on the breast and other residents in the smoking area. There were no other residents named, or dates or times listed for the other incidents with the other residents.A review of in-services on types of abuse dated 06/02/2026, conducted by the Administrator with nursing, housekeeping, laundry, dietary and other staff members, revealed several names and titles. The in-service indicated sexual abuse was a non-consensual sexual act of any kind with an elderly person. The in-service also revealed if abuse is witnessed or reported to a staff member, the staff must report this to the Administrator/DON (Director of Nursing) immediately.A review of the Office of Long-Term Care (OLTC) Incident and Accident Report (I&A) 762-Findings and actions taken dated 6/9/2026 and completed by the Administrator indicated staff was instructed to keep Residents #40 and #50 separated during smoke times.A review of the admission record for Resident #40 indicated the facility admitted the resident on 02/23/2026 with diagnoses that included dementia and cognitive communication deficit.A review of the Order Summary Report for Resident #40 indicated admit to long term care with an order date of 02/23/2026.A review of the quarterly Minimum Data Set, with an Assessment Reference Date of 05/25/2026, for Resident #40 revealed a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS also indicated that Resident #40 did not use a mobility device.A review of Resident #40's care plan, with a reviewed date of 05/25/2026, revealed Resident #40 was a smoker and required supervision while smoking.A review of Resident #50's Order Summary Report revealed diagnoses of vascular dementia and other sexual disorders. An injectable medication, with a start date of 06/07/2026, related to the diagnosis of other sexual dysfunction, was to be given intramuscularly one time a day starting on the seventh and ending on the eighth of every month.A review of Resident #50's care plan, initiated 05/28/2026, revealed Resident #50 exhibits indicators of hypersexual behaviors: grabbing the CNAs (Certified Nursing Assistants) inappropriately and making sexually inappropriate comments. An intervention initiated on 06/10/2026 included an injectable medication.A review of Resident #50's admission MDS with an ARD of 06/02/2026 revealed a BIMS score of 15, which indicated the resident was cognitively intact. The MDS also indicated Resident #50 used a wheelchair for mobility.During an interview on 06/08/2026 at 2:30 PM, Resident #40 stated Resident #50 touched them, pointing to their chest area, while outside during a smoke break. Resident #40 asked if Resident #50 was going to jail and this surveyor stated they would have to refer to what was done by the facility.On 06/08/2026 at 3:13 PM, Resident #50 was lying awake in bed. During an (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045367	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2026
NAME OF PROVIDER OR SUPPLIER Windcrest Health and Rehab Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 2455 Lowell Road Springdale, AR 72764	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview, Resident #50 stated, I have not touched anyone period. Resident #50 stated they were spoken to by other staff members at the facility about this and was taken out to smoke at different times with no other residents present for a while but did not state how long this occurred of them smoking separately from other residents. During an observation on 06/10/2026 at 11:13 AM, this surveyor was seated in the room with other surveyors and looked out the window to observe the residents on smoke break. This surveyor observed Resident #50 seated to the immediate left of Resident #40 in the smoking area where the initial incident was alleged to have transpired. The residents were not speaking to each other. Resident #40 was looking straight across the area and did look down at one point. This surveyor went to Licensed Practical Nurse (LPN) #7 for assistance but she was not able to assist surveyor with an observation at the time. This surveyor then asked Certified Nursing Assistant (CNA) #2 for assistance identifying Resident #40. CNA #2 looked out the glass door to the smoking area and stated Resident #40 was in a blue shirt, seated on the left side of Resident #50. At 11:21 LPN #7 came to the area and stated those two residents were not to be seated next to each other. She called CNA #3 to the door and informed her of the situation. CNA #3 then moved Resident #50 to a different area. During an interview on 06/10/2026 at 11:55 AM, Resident #40 stated she was not happy that Resident #50 had been seated next to them. Resident #40 asked this surveyor if Resident #50 was going to jail, and this surveyor told Resident #40 the Administrator would have to speak to them about the concern of Resident #50 and jail. During an interview on 06/10/2026 at 12:15 PM, CNA #3 was interviewed and state she did not place the residents out in the smoking area for the 11 AM smoke break because she was on lunch break. She stated she was unaware that Residents #40 and #50 were seated next to each other. CNA #3 stated the Director or Nursing (DON), Assistant Director of Nursing (ADON) or Administrator had not informed her that Residents #40 and #50 were not to sit next to each other. CNA #3 stated she had been given the information by a coworker but could not recall who it was nor the date she had been told. During an interview on 06/10/2026 at 12:24 PM, CNA #4 stated she had placed Resident #50 to the right of Resident #40 during the 11 AM smoke break. She stated another CNA did tell her that these two residents were not to be seated next to each other, but she could not recall the date. She stated she placed Resident #50 by Resident #40 because, that was the only spot to put [Resident #50]. She stated that she forgot Resident #40 was sitting there and she was just helping out by bringing [the residents] out there. She stated she had not been told by the DON, ADON, or Administrator to keep Residents #40 and #50 separated. During a telephone interview on 06/11/2026 at 10:45 AM, the Advanced Practice Registered Nurse (APRN) stated she was made aware of the alleged incident on 06/02/2026 between Resident #40 and #50. She stated she was made aware that Residents #40 and #50 were to be separated and not sit together. During an interview on 06/11/2026 at 1:54 PM, the DON stated they did not have findings that gave them certainty of the occurrence [Resident #50 touching Resident #40]. He stated he believed keeping Residents #40 and #50 from sitting next to each other was the appropriate intervention. During an interview on 06/11/2026 at 2:21 PM, the Administrator stated he received a telephone call on his way to work on 06/02/2026 and was made aware of the allegations that Resident #50 had inappropriately touched Resident #40 during a smoke break. He stated after this incident, the residents were to be kept separate at all times. The Administrator stated it was not acceptable to place Resident #40 and #50 next to each other. He stated the DON or designee should have immediately instructed the nurses and CNAs to keep Resident #40 and #50 separated. A review of an Abuse Prevention Program policy, with a revision date of December 2016, indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy indicated that the administration will protect their resident from abuse by anyone including but not limited to other residents.		