Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLII Bear Creek Healthcare LLC	ER	STREET ADDRESS, CITY, STATE, ZI 322 West Collin Raye Drive DE Queen, AR 71832	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG			on)
F 0607  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	me's plan to correct this deficiency, please contact the nursing home or the state survey agency.  SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)  Develop and implement policies and procedures to prevent abuse, neglect, and theft.  46319  Based on record review and interview, the facility failed to ensure the facility abuse policies and procedur were implemented, as evidenced by failure to ensure an injury of unknown origin and an unwitnessed fall resulting in a fracture for 1 (Resident #16) was immediately reported to the Administrator, thoroughly investigated, evidence gathered, and findings reported to the state agency to rule out the posibility of ab and or neglect. The failed practice resulted in Immediate Jeopardy (IJ). On 10/19/22 at 1:50 pm, the facilit Owner and the DON were notified of the IJ. The findings are:  An Abuse/Neglect Policy provided by the Director of Nursing (DON) on 10/17/22 at 10:30 am, page 7 Identification, Unexplained bruising, skin tears. Shall be reported to the appropriate staff and investigated determine any possible abuse, neglect. Page 8-9 An Incident and Accident form will be completed along with the state form DMS-7794. The Medician Director, Director of Nursing, Administrator, Director Police Department, and the resident's Family will be notified immediately. The Administrator, Director of Nursing designee will complete a thorough investigation.  Resident #16 had diagnoses of Anemia, Hypertension, Renal Insufficiency, Non-Alzheimer's Dementia, Depression (Other than Bipolar) and a Brief Interview for Mental Status (BIMS) documented a score of 5 Severe Cognitive Impairment) according to the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 7/25/22.  a. During a record review on 10/19/22 at 9:20 am, a Nurses Note dated 4/11/22 stated, Hematoma note to L (left) outer shin, approx (approximately) 4cm (centimeters) X 4 1/2 cm. No known injuries/accidents we reported. No c/o (com		lity abuse policies and procedures in origin and an unwitnessed fall e Administrator, thoroughly by to rule out the possibility of abuse in 10/19/22 at 1:50 pm, the facility of 20/17/22 at 10:30 am, page 7 perpopriate staff and investigated to out form will be completed along Administrator, Local Police diministrator, Director of Nursing, or one of the complete of

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

FORM CMS-2567 (02/99) Event ID:
Previous Versions Obsolete

Facility ID: 045287

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Printed: 11/24/2024 Form Approved OMB No. 0938-0391

	55. 1.655		No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLIER  Bear Creek Healthcare LLC		STREET ADDRESS, CITY, STATE, ZI 322 West Collin Raye Drive DE Queen, AR 71832	P CODE
For information on the nursing home's pl	lan to correct this deficiency, please cont	act the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	IENCIES full regulatory or LSC identifying informati	on)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	d. A Physician's Order dated 6/18/2 Resident sent to emergency room f Emergency Report states, .you hav headache. No Poorly controlled hea Left wrist pain. Fall .  e. On 10/19/22 at 9:40 am, The Sur report for the injury of unknown orig fall that resulted in a fracture for Re facility report these two incidents to started.  f. On 10/19/22 at 10:18 am, the DO injury. Referring to the injury of unk report for the unwitnessed fall that of went to the ER (emergency room). stated, Well her Brief Interview Mer this happened and all I could find is DON stated, Depends on if it's witne think it might be a reportable, I cons g. On 10/19/22 at 10:45 am, The Sir R #16 stated, I don't remember eve wrong. The Surveyor asked R #16, eat? The Surveyor asked, You arer h. On 10/19/22 at 12:30 PM, the Su Administrator was out for the day. T for the Administrator. The facility ov Administrator. The Surveyor asked 4/11/22? The Owner stated, No. Th resulting in a fracture on 6/18/22? T	2 stated, send resident to [facility] for e	eval (evaluation) d/t (due to) fall addition (s): Acute post traumatic all fracture of the distal left radius.  DON) If there was a facility incident sident #16 and for the unwitnessed k. The Surveyor asked, Did the will see because that was before I dent and Accident Report) for this for a copy of the facility incident There is no reportable. She (R#16) ou what happened? The DON converse. I started in August after hould it have been reported? The a fracture. I can tell you that if I consultant.  I had a fall during your time here? eally bad but I'm not sure what was 6 stated, I'm not sure., When do we stated, I'm sure hungry.  Trator and was informed that the he staff member that was sitting in stating she was filling in for the ad an injury of unknown origin on R #16 had an unwitnessed fall ministrator is available to talk to

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 045287

If continuation sheet Page 2 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022	
NAME OF PROVIDER OR SUPPLI	FR	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Bear Creek Healthcare LLC		322 West Collin Raye Drive DE Queen, AR 71832	. 6682	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0607  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	i. On 10/19/22 at 12:45 PM, the Surveyor spoke to the Administrator via cellular phone. The Surveyor asked the Administrator, Are you aware the R #16 had an injury of unknown origin on 4/11/22? The Administrator stated, No. The Surveyor asked, Are you aware that R #16 had an unwitnessed fall resulting in a fracture on 6/18/22? The Administrator stated, No. The Surveyor asked, , Should an incident report and an investigation be completed for an injury of unknown origin? The Administrator stated, Yes, because if it isn't known what happened and the resident can't tell you what happened then it would be considered a state reportable. The Surveyor asked, Should an incident report and an investigation be completed for an unwitnessed fall resulting in a fracture? The Administrator stated, Yes, if the resident is not able to tell what happened. The Surveyor asked, Should both of these incidents have been reported to the state agency? The Administrator stated, Yes and if I would have been aware of these, I would have reported them.			
	Bear Creek Plan of Removal on 10	/19/2022 states:		
	1. On 10/19/2022 the DON immedi	ately on notification initiated a report to	the OLTC for each	
	finding related to the resident affect	ted: the injury of unknown origin on 4/1	1/2022 and the	
	unwitnessed fall with fracture on 6/	18/2022.		
	a. On 10/19/2022 the DON supervi	sed the head to-toe assessment of the	identified resident for	
	further signs of injury of unknown origin.			
	b. On 10/19/2022 the DON reviews	ed the identified resident's incident and	accident reports for the	
	past 6 months to identify any further	er incidents or accidents that need inve	stigated and reported	
	to OLTC.			
	2. On 10/19/2022 the DON initiated	I the review of residents with the poten	tial to be affected	
	incident and accident reports in the	past 6 months including the identified	resident, making	
	corrections as necessary.			
	3. On 10/19/2022the DON began in	n-service with current nursing staff on a	abuse and neglect,	
	reporting of unwitnessed falls with	fracture and injury of unknown origin to	the Administrator	
	, -	injuries of unknown origin can be prop		
		e nurses before taking assigned duties		
		istrator in-serviced the Director of Nurs		
		e OLTC and promptly starting an inves		
	(continued on next page)		J	
	(Sommada on Hoxt page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLIER  Bear Creek Healthcare LLC		STREET ADDRESS, CITY, STATE, ZI 322 West Collin Raye Drive	P CODE
		DE Queen, AR 71832	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0607	5. DON/designee using a monitoring	ng tool will review nursing documentation	on and incident &
Level of Harm - Immediate jeopardy to resident health or	accident reports to ensure injury of	unknown origin and unwitnessed falls	with fracture are
safety		to OLTC 5x weeks weeks, making corr	rections as necessary
Residents Affected - Some	and reporting negative findings to t		
		ve findings to the QAPI committee mon	nthly for review and
	recommendations		

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	10/20/2022	
		D. Willig		
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES		
	(Each deficiency must be preceded by	full regulatory or LSC identifying informati	on)	
F 0609	Timely report suspected abuse, ne	glect, or theft and report the results of t	the investigation to proper	
Level of Harm - Immediate	authorities.			
jeopardy to resident health or safety	46319			
•		ew, the facility failed to ensure that an		
Residents Affected - Some		fice of Long Term Care (OLTC) and otl s to provide any necessary oversight of	S .	
	l ·	t #16 of 5 residents sampled (Residents ouse/neglect. This failed practice result		
	Resident #16 and had the potentia	I to affect all 50 residents who resided i	in the facility according to the	
	Owner and the DON notified of IJ (	Residents Form dated 10/17/22. On 10 Immediate Jeopardy).	of 19/22 at 1:50 pm, the facility	
	The findings are:			
	,	by the DON on10/17/22 at 10:30 am, p		
	bruising, skin tears .Shall be reported to the appropriate staff and investigated to determine any possible abuse, neglect . Page 8-9 An Incident and Accident form will be completed along with the state form DMS-7734 .The Administrator, Director of Nursing, or designee will complete a thorough investigation .			
		emia, Hypertension, Renal Insufficienc ad a Brief Interview for Mental Status (B		
		ording to the quarterly Minimum Data S		
		2 at 9:20 am, a nurses note dated 4/11/ ely) 4cm (centimeters) X 4 1/2 cm. No	· · · · · · · · · · · · · · · · · · ·	
	reported. No c/o (complaints of) pa	in . A nurses note dated 6/18/22 at 10:	30 pm stated, Res (resident) was	
		Nursing Assistant (CNA). Resident was a knot on R (right) side of head with brued of) pain in her L (left) wrist.		
	A Physician's Order dated 6/18/22	stated, send resident to [facility] for eva	al (evaluation) d/t (due to) fall	
	Resident sent to emergency room	for evaluation.		
	Emergency Report states, .you have been evaluated .for the following condition (s): Acute post traumatic headache. No Poorly controlled headache. Closed nondisplaced segmental fracture of the distal left radius. Left wrist pain. Fall .			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022	
NAME OF PROVIDER OR SUPPLIER Bear Creek Healthcare LLC		STREET ADDRESS, CITY, STATE, ZI 322 West Collin Raye Drive DE Queen, AR 71832	P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)	
F 0609  Level of Harm - Immediate jeopardy to resident health or safety	a. On 10/19/22 at 9:40, The Surveyor asked the Director of Nursing (DON) If there was a facility incident report for the injury of unknown origin for the hematoma to the shin for resident #16 and for the unwitnessed fall that resulted in a fracture for resident #16? The DON stated, I will look. The Surveyor asked, Did the facility report these two incidents to the state agency? The DON stated, I will see because that was before I started.			
Residents Affected - Some	b. On 10/19/22 at 10:18 am, the DON stated, There is not an I and A (Incident and Accident Report) for this injury. Referring to the injury of unknown origin but did provide the surveyor a copy of the facility incident report for the unwitnessed fall that occurred on 6/18/22. The DON stated, There is no reportable. She (R#16) went to the ER (emergency room). The Surveyor asked, Can R #16 tell you what happened? The DON stated, Well her BIMS is low, but she can converse. I started in August after this happened and all I could find is this I and A. The Surveyor asked, Should it have been reported? The DON stated, Depends on if it's witnessed or unwitnessed, if it resulted in a fracture. I can tell you that if I think it might be a reportable, I consult with the Administrator and Nurse Consultant.  c. On 10/19/22 at 10:45, The Surveyor asked Resident #16, Have you had a fall during your time here? R #16 stated, I don't remember ever falling. The Surveyor asked, Have you ever hurt your arm or wrist? R #16 stated, Oh yes, it hurt really bad but I'm not sure what was wrong. The Surveyor asked, You aren't sure how			
	you hurt your wrist? R #16 stated, I'm sure hungry.  d. On 10/19/22 at 12:30 PM, the Surveyor asked to speak to the Administrator and was informed that the Administrator was out for the day. The Surveyor requested to speak with the staff member that was sitting in for the Administrator. The facility owner came to speak with the surveyor stating she was filling in for the Administrator. The Surveyor asked the owner, Are you aware the R #16 had an injury of unknown origin on 4/11/22? The Owner stated, No. The Surveyor asked, Are you aware that R #16 had an unwitnessed fall resulting in a fracture on 6/18/22? The Owner stated, Let me see if the Administrator is available to talk to you by phone. She will be able to answer those questions better than I can.			
	e. On 10/19/22 at 12:45 PM, The Surveyor spoke to the Administrator via cellular phone. The Surveyor asked, Are you aware the R #16 had an injury of unknown origin on 4/11/22? The Administrator stated, No. The Surveyor asked, Are you aware that R #16 had an unwitnessed fall resulting in a fracture on 6/18/22? The Administrator stated, No. The Surveyor asked, Should an incident report and an investigation be completed for an injury of unknown origin? The Administrator stated, Yes, because if it isn't known what happened and the resident can't tell you what happened then it would be considered a state reportable. The Surveyor asked, Should an incident report and an investigation be completed for an unwitnessed fall resulting in a fracture? The Administrator stated, Yes, if the resident is not able to tell what happened. The Surveyor asked, Should both of these incidents have been reported to the state agency? The Administrator stated, Yes and if I would have been aware of these, I would have reported them.			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022	
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDED OF SUPPLIED		P CODE	
Bear Creek Healthcare LLC	- ^	STREET ADDRESS, CITY, STATE, ZI 322 West Collin Raye Drive DE Queen, AR 71832	1 6052	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)	
F 0609  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	were implemented, as evidenced by resulting in a fracture for 1 (Reside investigated, evidence gathered, and and or neglect. The failed practice facility Owner and the DON were not an Abuse/Neglect Policy provided Identification, Unexplained bruising determine any possible abuse, negwith the state form DMS-7734. The	ew and interview, the facility failed to ensure the facility abuse policies and procedures is evidenced by failure to ensure an injury of unknown origin and an unwitnessed fall of for 1 (Resident #16) was immediately reported to the Administrator, thoroughly be gathered, and findings reported to the state agency to rule out the possibility of abuse ailed practice resulted in past Immediate Jeopardy (IJ). On 10/19/22 at 1:50 pm, the e DON were notified of the past IJ. The findings are:  Dictionally provided by the Director of Nursing (DON) on 10/17/22 at 10:30 am, page 7 lained bruising, skin tears .Shall be reported to the appropriate staff and investigated to ble abuse, neglect . Page 8-9 An Incident and Accident form will be completed along MS-7734. The Medical Director, Director of Nursing, Administrator, Local Police		
	Department, and the resident's Family will be notified immediately .The Administrator, Director of Nursing, or designee will complete a thorough investigation .  Resident #16 had diagnoses of Anemia, Hypertension, Renal Insufficiency, Non-Alzheimer's Dementia, Depression (Other than Bipolar) and a Brief Interview for Mental Status (BIMS) documented a score of 5 (0-Severe Cognitive Impairment) according to the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 7/25/22.			
	a. During a record review on 10/19/22 at 9:20 am, a Nurses Note dated 4/11/22 stated, Hematoma noted to L (left) outer shin, approx (approximately) 4cm (centimeters) X 4 1/2 cm. No known injuries/accidents were reported. No c/o (complaints of) pain . A Nurses Note dated 6/18/22 at 10:30 pm stated, Res (resident) was found lying on the floor by Certified Nursing Assistant (CNA). Resident was trying to go to the bathroom floor was wet @ (at) this time. Resident had a knot on R (right) side of head with bruising present, redness noted to R side of face and Resident c/o (complained of) pain in her L (left) wrist .			
		/22 at 10:28 AM, a Nursing Note dated imately) 4cm (centimeters) X 4 1/2 cm. in . LPN		
		/22 at 10:28 AM, a Nursing Note dated he left wrist and a hematoma to the rightion.		
	d. A Physician's Order dated 6/18/2	22 stated, send resident to [facility] for e	eval (evaluation) d/t (due to) fall	
	Resident sent to emergency room	for evaluation.		
	Emergency Report states, .you have been evaluated .for the following condition (s): Acute post traumatic headache. No Poorly controlled headache. Closed nondisplaced segmental fracture of the distal left radius. Left wrist pain. Fall .			
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FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 045287

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building	(X3) DATE SURVEY COMPLETED 10/20/2022	
NAME OF PROMISES OF SUPPLIE		B. Wing		
NAME OF PROVIDER OR SUPPLI	EK	STREET ADDRESS, CITY, STATE, ZI  322 West Collin Raye Drive  DE Queen, AR 71832	PCODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)	
F 0609  Level of Harm - Immediate jeopardy to resident health or safety	e. On 10/19/22 at 9:40 am, The Surveyor asked the Director of Nursing (DON) If there was a facility incident report for the injury of unknown origin for the hematoma to the shin for Resident #16 and for the unwitnessed fall that resulted in a fracture for Resident #16? The DON stated, I will look. The Surveyor asked, Did the facility report these two incidents to the state agency? The DON stated, I will see because that was before I started.			
Residents Affected - Some	f. On 10/19/22 at 10:18 am, the DON stated, There is not an I and A (Incident and Accident Report) for this injury. Referring to the injury of unknown origin but did provide the surveyor a copy of the facility incident report for the unwitnessed fall that occurred on 6/18/22. The DON stated, There is no reportable. She (R#16) went to the ER (emergency room). The Surveyor asked, Can R #16 tell you what happened? The DON stated, Well her Brief Interview Mental Status (BIMS) is low, but she can converse. I started in August after this happened and all I could find is this I and A. The Surveyor asked, , Should it have been reported? The DON stated, Depends on if it's witnessed or unwitnessed, if it resulted in a fracture. I can tell you that if I think it might be a reportable, I consult with the Administrator and Nurse Consultant.  g. On 10/19/22 at 10:45 am, The Surveyor asked Resident #16, Have you had a fall during your time here? R #16 stated, I don't remember ever falling. R #16 stated, Oh yes, it hurt really bad but I'm not sure what was wrong. The Surveyor asked R #16, Can you tell me how you hurt it? R #16 stated, I'm not sure., When do we			
	eat? The Surveyor asked, You aren't sure how you hurt your wrist? R #16 stated, I'm sure hungry.  h. On 10/19/22 at 12:30 PM, the Surveyor asked to speak to the Administrator and was informed that the Administrator was out for the day. The Surveyor requested to speak with the staff member that was sitting in for the Administrator. The facility owner came to speak with the Surveyor stating she was filling in for the Administrator. The Surveyor asked the owner, Are you aware the R #16 had an injury of unknown origin on 4/11/22? The Owner stated, No. The Surveyor asked, Are you aware that R #16 had an unwitnessed fall resulting in a fracture on 6/18/22? The Owner stated, Let me see if the Administrator is available to talk to you by phone. She will be able to answer those questions better than I can.			
	i. On 10/19/22 at 12:45 PM, the Surveyor spoke to the Administrator via cellular phone. The Surveyor asked the Administrator, Are you aware the R #16 had an injury of unknown origin on 4/11/22? The Administrator stated, No. The Surveyor asked, Are you aware that R #16 had an unwitnessed fall resulting in a fracture or 6/18/22? The Administrator stated, No. The Surveyor asked, , Should an incident report and an investigation be completed for an injury of unknown origin? The Administrator stated, Yes, because if it isn't known what happened and the resident can't tell you what happened then it would be considered a state reportable. The Surveyor asked, Should an incident report and an investigation be completed for an unwitnessed fall resulting in a fracture? The Administrator stated, Yes, if the resident is not able to tell what happened. The Surveyor asked, Should both of these incidents have been reported to the state agency? The Administrator stated, Yes and if I would have been aware of these, I would have reported them.			
	Bear Creek Plan of Removal on 10/19/2022 states:			
	1. On 10/19/2022 the DON immedi	ately on notification initiated a report to	the OLTC for each	
	finding related to the resident affect	ted: the injury of unknown origin on 4/1	1/2022 and the	
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER Bear Creek Healthcare LLC  STREET ADDRESS, CITY, STATE, ZIP CODE 322 West Collin Rays Drive DE Queen, AR 7.1832  For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey spency.  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (Sech deficiency must be preceded by full regulatory or LSC identifying information)  FD 6609  Level of Harm - Immediate please by the correct this deficiency must be preceded by full regulatory or LSC identifying information)  Unwitnessed fall with fracture on 6/18/2022. a. On 10/19/2022 the DON supervised the head to-toe assessment of the identified resident for further signs of injury of unknown origin. b. On 10/19/2022 the DON reviewed the identified resident's incident and accident reports for the past 6 months to identify any further incidents or accidents that need investigated and reported to OLTC. 2. On 10/19/2022 the DON initiated the review of residents with the potential to be affected incident and accident reports in the past 6 months including the identified resident, making corrections as necessary.  3. On 10/19/2022 the DON began in-service with current nursing staff on abuse and neglect, reporting of unwitnessed falls with fracture and injury of unknown origin to the Administrator or DON so that prompt reporting of injuries of unknown origin can be properly investigated and reported to OLTC and will in-service nurses before a investigation. 5. DON/designee using a monitoring tool will review nursing documentation and incident & accident reports to ensure injury of unknown origin and unwitnessed falls with fracture are proporly investigated and reported to OLTC Sx weeks weeks, making corrections as necessary and reporting negative findings to the administrator. 6. DON/designee will report negative findings to the QAPI committee monthly for review and recommendations	eriters for Medicare & Medic	ald Services		No. 0938-0391
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)  Level of Harm - Immediate jeopardy to resident health or safety  Level of Harm - Immediate jeopardy to resident health or safety  Do no 10/19/2022 the DON supervised the head to-toe assessment of the identified resident for further signs of injury of unknown origin.  Do no 10/19/2022 the DON reviewed the identified resident's incident and accident reports for the past 6 months to identify any further incidents or accidents that need investigated and reported to OLTC.  2. On 10/19/2022 the DON initiated the review of residents with the potential to be affected incident and accident reports in the past 6 months including the identified resident, making corrections as necessary.  3. On 10/19/2022 the DON began in-service with current nursing staff on abuse and neglect, reporting of unwitnessed falls with fracture and injury of unknown origin can be properly investigated and reported to OLTC and will in-service nurses before taking assigned duties on the floor.  4. On 10/19/2022 the acting administrator in-serviced the Director of Nursing on reporting unwitnessed falls with fracture to the OLTC and promptly starting an investigation.  5. DON/designee using a monitoring tool will review nursing documentation and incident & accident reports to ensure injury of unknown origin and unwitnessed falls with fracture are properly investigated and reported to OLTC 5x weeks weeks, making corrections as necessary and reporting negative findings to the administrator.  6. DON/designee will report negative findings to the OAPI committee monthly for review and		IDENTIFICATION NUMBER:	A. Building	COMPLETED
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			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLIE  Bear Creek Healthcare LLC	ER	STREET ADDRESS, CITY, STATE, ZI 322 West Collin Raye Drive DE Queen, AR 71832	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0610  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Respond appropriately to all allege 46319  Based on observation, record revie procedures were implemented, as an unwitnessed fall resulting in a fr in accordance with state law and fa abuse or neglect occurred for 1 of Immediate Jeopardy (IJ) for 1 (Resfacility according to the list provided the facility Owner and the DON we The findings are:  An Abuse/Neglect Policy provided bruising, skin tears .Shall be report abuse, neglect . Page 8-9 An Incid DMS-7734. The Medical Director, I resident's Family will be notified im complete a thorough investigation .  Resident #16 had diagnoses of An Depression (Other than Bipolar) an severe cognitive impairment) accor Reference Date (ARD) date of 7/25 (left) outer shin, aprox (approximate reported. No c/o (complaints of) papm stated, Res (resident) was fount to go to the bathroom floor was we bruising present, redness noted to A Physician's Order dated 6/18/22 Resident sent to emergency room in Emergency Report states, .you have	d violations.  ew, and interview, the facility failed to elevidenced by failure to immediately repacture to the Office of Long Term Care allure to ensure an investigation was im 1 (Resident #16) the sampled case mixident #16) and the potential to affect 50 d by the Director of Nursing (DON) on renotified of IJ.  by the DON on 10/17/22 at 1030am, paged to the appropriate staff and investigent and Accident form will be complete Director of Nursing, Administrator, Local mediately. The Administrator, Director and a Brief Interview for Mental Status (Ending to the quarterly Minimum Data Section 12.  2 at 9:20 am, a nurses note dated 4/11/ely) 4cm (centimeters) X 4 1/2 cm. Note in Licensed Practical Nurse (LPN). A resident had a knot Resident	Insure their abuse policies and port an injury of unknown origin and (OLTC) and other state agencies mediately initiated to determine if at. This failed practice resulted in 0 residents who were living in the 10/17/22. On 10/19/22 at 1:50 pm, age 7 Identification, Unexplained ated to determine any possible datong with the state form all Police Department, and the of Nursing, or designee will by, Non-Alzheimer's Dementia, at (MDS) with an Assessment at (MDS) with an Assessment at (CNA). Res was trying on R (right) side of head with dof) pain in her L (left) wrist and (evaluation) d/t (due to) fall andition (s): Acute post traumatic

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F 0610  Level of Harm - Immediate jeopardy to resident health or safety	a. On 10/19/22 at 9:40, The Surveyor asked the Director of Nursing (DON) if there was a facility incident report for the injury of unknown origin for the hematoma to the shin for resident #16 and for the unwitnessed fall that resulted in a fracture for resident #16? The DON stated, I will look. The Surveyor asked, Did the facility report these two incidents to the state agency? The DON stated, I will see because that was before I started.		
Residents Affected - Some	b. On 10/19/22 at 10:18 am, the DON stated, There is not an I and A (Incident and Accident Report) for this injury. Referring to the injury of unknown origin but did provide the surveyor a copy of the facility incident report for the unwitnessed fall that occurred on 6/18/22. The DON stated, There is no reportable. She (R#16) went to the ER (emergency room). The Surveyor asked, Can R#16 tell you what happened? The DON stated, Well her BIMS is low, but she can converse. I started in August after this happened and all I could find is this I and A. The Surveyor asked, Should it have been reported? The DON stated, Depends on if it's witnessed or unwitnessed, if it resulted in a fracture. I can tell you that if I think it might be a reportable, I consult with the Administrator and Nurse Consultant.  c. On 10/19/22 at 10:45 am, The Surveyor asked Resident #16, Have you had a fall during your time here? R#16 stated, I don't remember ever falling. The Surveyor asked R #16, Have you ever hurt your arm or wrist? R #16 stated, Oh yes, it hurt really bad but I'm not sure what was wrong. The Surveyor asked R #16, Can you tell me how you hurt it? R #16 stated, I'm not sure. When do we eat? The Surveyor asked, You		
	aren't sure how you hurt your wrist? R #16 stated, I'm sure hungry.  d. On 10/19/22 at 12:30 pm, The Surveyor asked to speak to the Administrator and was informed that the Administrator was out for the day. The Surveyor requested to speak with the staff member that was sitting in for the Administrator. The facility owner came to speak with the surveyor stating she was filling in for the Administrator. The Surveyor asked the owner, Are you aware the R #16 had an injury of unknown origin on 4/11/22? The Owner stated, No. The Surveyor, Are you aware that R #16 had an unwitnessed fall resulting in a fracture on 6/18/22? The Owner stated, Let me see if the Administrator is available to talk to you by phone. She will be able to answer those questions better than I can.		
	e. On 10/19/22 at 12:45 PM, The Surveyor spoke to the Administrator via cellular phone. The Surveyor asked, Are you aware the R #16 had an injury of unknown origin on 4/11/22? The Administrator stated, No. The Surveyor asked, Are you aware that R #16 had an unwitnessed fall resulting in a fracture on 6/18/22? The Administrator stated, No. The Surveyor asked, Should an incident report and an investigation be completed for an injury of unknown origin? The Administrator stated, Yes, because if it isn't known what happened and the resident can't tell you what happened then it would be considered a state reportable. The Surveyor asked, Should an incident report and an investigation be completed for an unwitnessed fall resulting in a fracture? The Administrator stated, Yes, if the resident is not able to tell what happened. The Surveyor asked, , Should both of these incidents have been reported to the state agency? The Administrator stated, Yes and if I would have been aware of these, I would have reported them.		
	f. On 10/19/22 at 1:50 pm, the facil (continued on next page)	ity Owner and the DON were notified o	f IJ (Immediate Jeopardy).

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045287	A. Building B. Wing	10/20/2022
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F 0610  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Based on record review and interview, the facility failed to ensure that an injury of unknown origin was investigated and reported to the Office of Long Term Care (OLTC) and other agencies in accordance with state law, to enable those agencies to provide any necessary oversight of the facility's investigations and protective measures for 1 Resident #16 of 5 residents sampled (Residents #16, #30, #33, #36 and #255) of residents who were reviewed for abuse/neglect. This failed practice resulted in past Immediate Jeopardy for Resident #16 and had the potential to affect all 50 residents who resided in the facility according to the Resident Census and Condition of Residents Form dated 10/17/22. On 10/19/22 at 1:50 pm, the facility Owner and the DON notified of IJ (Immediate Jeopardy).		
	The findings are:		
	An Abuse/Neglect Policy provided by the DON on10/17/22 at 10:30 am, page 7 Identification, Unexplained bruising, skin tears .Shall be reported to the appropriate staff and investigated to determine any possible abuse, neglect . Page 8-9 An Incident and Accident form will be completed along with the state form DMS-7734 .The Administrator, Director of Nursing, or designee will complete a thorough investigation .		
	Resident #16 had diagnoses of Anemia, Hypertension, Renal Insufficiency, Non-Alzheimer's Dementia, Depression (Other than Bipolar) and a Brief Interview for Mental Status (BIMS) documented a score of 5 (0 Severe Cognitive Impairment) according to the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 7/25/22.		
	During a record review on 10/19/22 at 9:20 am, a nurses note dated 4/11/22 stated, Hematoma noted to L (left) outer shin, aprox (approximately) 4cm (centimeters) X 4 1/2 cm. No known injuries/accidents were reported. No c/o (complaints of) pain . A nurses note dated 6/18/22 at 10:30 pm stated, Res (resident) was found lying on the floor by Certified Nursing Assistant (CNA). Resident was trying to go to the bathroom floor was wet @ (at) this time. Res had a knot on R (right) side of head with bruising present, redness noted to R side of face and Res c/o (complained of) pain in her L (left) wrist .		
	A Physician's Order dated 6/18/22	stated, send resident to [facility] for eva	al (evaluation) d/t (due to) fall
	Resident sent to emergency room	for evaluation.	
		ve been evaluated .for the following cor adache. Closed nondisplaced segment	
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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
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F 0610  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	b. On 10/19/22 at 10:18 am, the Doinjury. Referring to the injury of unk report for the unwitnessed fall that went to the ER (emergency room) stated, Well her BIMS is low, but stifind is this I and A. The Surveyor awitnessed or unwitnessed, if it resuconsult with the Administrator and c. On 10/19/22 at 10:45, The Surve #16 stated, I don't remember event stated, Oh yes, it hurt really bad but me how you hurt it? R #16 stated, I you hurt your wrist? R #16 stated, I don't remember event stated, Oh yes, it hurt really bad but me how you hurt it? R #16 stated, I don't remember event stated, Oh yes, it hurt really bad but me how you hurt it? R #16 stated, I don't really bad but me how you hurt it? R #16 stated, I don't you hurt your wrist? R #16 stated, I don't he day. The Surveyor asked did in a fracture on 6/18/22? You by phone. She will be able to a e. On 10/19/22 at 12:45 PM, The Sasked, Are you aware the R #16 has The Surveyor asked, Are you aware the R #16 has The Surveyor asked, Are you aware the R #16 has The Surveyor asked, Should an inciden resulting in a fracture? The Administrator stated, No. The surveyor asked, Should both of the stated, Yes and if I would have been Based on record review and interviewer implemented, as evidenced by resulting in a fracture for 1 (Reside investigated, evidence gathered, and or neglect. The failed practice	ON stated, There is not an I and A (Incitation origin but did provide the survey occurred on 6/18/22. The DON stated, The Surveyor asked, Can R #16 tell you can converse. I started in August affisked, Should it have been reported? The lited in a fracture. I can tell you that if I Nurse Consultant.  Beyor asked Resident #16, Have you have falling. The Surveyor asked, Have you tell i'm not sure what was wrong. The Sultim not sure. When do we eat? The Sultim occurred on the surveyor do we sure.	dent and Accident Report) for this or a copy of the facility incident. There is no reportable. She (R#16) ou what happened? The DON er this happened and all I could ne DON stated, Depends on if it's think it might be a reportable, I did a fall during your time here? Rever hurt your arm or wrist? R #16 reveyor asked R #16, Can you tell reveyor asked, You aren't sure how the staff member that was sitting in stating she was filling in for the ad an injury of unknown origin on R #16 had an unwitnessed fall liministrator is available to talk to n.  cellular phone. The Surveyor 22? The Administrator stated, No. esulting in a fracture on 6/18/22? Boot and an investigation be because if it isn't known what considered a state reportable. The eted for an unwitnessed fall able to tell what happened. The estate agency? The Administrator is dithem.  ity abuse policies and procedures in origin and an unwitnessed fall the Administrator, thoroughly yet or rule out the possibility of abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZI	P CODE
Bear Creek Healthcare LLC		322 West Collin Raye Drive	PCODE
Deal Creek Healthcare LLC		DE Queen, AR 71832	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0610  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	Identification, Unexplained bruising determine any possible abuse, neg with the state form DMS-7734. The Department, and the resident's Far designee will complete a thorough	by the Director of Nursing (DON) on 10, skin tears .Shall be reported to the applect . Page 8-9 An Incident and Accide Medical Director, Director of Nursing, mily will be notified immediately .The Acinvestigation .  emia, Hypertension, Renal Insufficiency	opropriate staff and investigated to nt form will be completed along Administrator, Local Police dministrator, Director of Nursing, or
	Depression (Other than Bipolar) an	d a Brief Interview for Mental Status (Bording to the quarterly Minimum Data S	IMS) documented a score of 5 (0-7
	L (left) outer shin, approx (approxin reported. No c/o (complaints of) pa found lying on the floor by Certified was wet @ (at) this time. Resident	/22 at 9:20 am, a Nurses Note dated 4/ nately) 4cm (centimeters) X 4 1/2 cm. N in . A Nurses Note dated 6/18/22 at 10 Nursing Assistant (CNA). Resident wa had a knot on R (right) side of head wit (complained of) pain in her L (left) wrist	No known injuries/accidents were :30 pm stated, Res (resident) was as trying to go to the bathroom floor th bruising present, redness noted
		/22 at 10:28 AM, a Nursing Note dated imately) 4cm (centimeters) X 4 1/2 cm. in . LPN	
		/22 at 10:28 AM, a Nursing Note dated he left wrist and a hematoma to the rightion.	
	d. A Physician's Order dated 6/18/2	22 stated, send resident to [facility] for e	eval (evaluation) d/t (due to) fall
	Resident sent to emergency room to	for evaluation.	
	,	re been evaluated .for the following cor adache. Closed nondisplaced segment	•
	report for the injury of unknown original that resulted in a fracture for Re	rveyor asked the Director of Nursing (Director of Nursing (Director) for the hematoma to the shin for Resident #16? The DON stated, I will look the state agency? The DON stated, I will look the state agency?	sident #16 and for the unwitnessed k. The Surveyor asked, Did the
	(continued on next page)		

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLI Bear Creek Healthcare LLC	ER	STREET ADDRESS, CITY, STATE, ZI 322 West Collin Raye Drive DE Queen, AR 71832	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0610  Level of Harm - Immediate jeopardy to resident health or safety  Residents Affected - Some	injury. Referring to the injury of unk report for the unwitnessed fall that went to the ER (emergency room) stated, Well her Brief Interview Methis happened and all I could find is DON stated, Depends on if it's witn think it might be a reportable, I cong. On 10/19/22 at 10:45 am, The SR #16 stated, I don't remember everong. The Surveyor asked R #16, eat? The Surveyor asked, You are h. On 10/19/22 at 12:30 PM, the Stadministrator was out for the day. For the Administrator. The Surveyor asked 4/11/22? The Owner stated, No. The resulting in a fracture on 6/18/22? You by phone. She will be able to a i. On 10/19/22 at 12:45 PM, the Su the Administrator, Are you aware the stated, No. The Surveyor asked, A 6/18/22? The Administrator stated, be completed for an injury of unknown happened and the resident can't te Surveyor asked, Should an incident resulting in a fracture? The Administrator, Yes and if I would have been bear Creek Plan of Removal on 10. 1. On 10/19/2022 the DON immedifinding related to the resident affect unwitnessed fall with fracture on 6/18/22.	ately on notification initiated a report to ted: the injury of unknown origin on 4/1 18/2022.  sed the head to-toe assessment of the	or a copy of the facility incident There is no reportable. She (R#16) ou what happened? The DON converse. I started in August after nould it have been reported? The a fracture. I can tell you that if I consultant.  I had a fall during your time here? really bad but I'm not sure what was 6 stated, I'm sure hungry.  rator and was informed that the the staff member that was sitting in stating she was filling in for the rad an injury of unknown origin on R #16 had an unwitnessed fall Iministrator is available to talk to n.  ellular phone. The Surveyor asked in on 4/11/22? The Administrator ressed fall resulting in a fracture on resident report and an investigation res, because if it isn't known what considered a state reportable. The reted for an unwitnessed fall that able to tell what happened. The restate agency? The Administrator red them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0610	b. On 10/19/2022 the DON reviewe	ed the identified resident's incident and	accident reports for the
Level of Harm - Immediate jeopardy to resident health or	past 6 months to identify any furthe	er incidents or accidents that need inve	stigated and reported
safety	to OLTC.		
Residents Affected - Some	2. On 10/19/2022 the DON initiated	the review of residents with the poten	tial to be affected
	incident and accident reports in the	past 6 months including the identified	resident, making
	corrections as necessary.		
	3. On 10/19/2022 the DON began i	n-service with current nursing staff on	abuse and neglect,
	reporting of unwitnessed falls with f	fracture and injury of unknown origin to	the Administrator
	or DON so that prompt reporting of	injuries of unknown origin can be prop	erly investigated and
	reported to OLTC and will in-service	e nurses before taking assigned duties	on the floor.
	4. On 10/19/2022 the acting administrator in-serviced the Director of Nursing on reporting		
	unwitnessed falls with fracture to the OLTC and promptly starting an investigation.		
	5. DON/designee using a monitorin	ng tool will review nursing documentation	on and incident &
	accident reports to ensure injury of	unknown origin and unwitnessed falls	with fracture are
	properly investigated and reported	to OLTC 5x weeks weeks, making con	rections as necessary
	and reporting negative findings to the	he administrator.	
	6. DON/designee will report negative	ve findings to the QAPI committee mor	nthly for review and
	recommendations		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  DESTRICTION NUMBER: D45287  NAME OF PROVIDER OR SUPPLIER Bear Creek Healthcare LLC  STREET ADDRESS, CITY, STATE, ZIP CODE 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 0844  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some  Residents Affected - Some  Residents Affected - Some  Residents Affected and the mental health in the state survey agency.  Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.  42965  Based on record review, and interview the facility failed to obtain the completed Preadmission Assessment Agency in a review (PASARR) level II evaluation from the State Agency in order in order incorporate the recommendations from the PASARR Level II evaluation from the				NO. 0936-0391
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)  Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some  Based on record review, and interview the facility failed to obtain the completed Preadmission Assessmen and Record Review (PASARR) level II evaluation report into the Residents Assessment. Care Plan and Transition of Care for 2 (Resident #20 and RW39) or 21 (Resident #7, #12, #13, #16, #20, #22,#23, #30,#31, #33, #34, #36, #36,#41 #42, #46, #49, #30/#51, #255) sampled residents that were admitted to I facility and had mental health diagnosis. The failed practice had the potential to affect 24 residents that he mental health diagnosis according to a list provided by the Medical Records/Infection Prevention Nurse o 10/20/22 at 10/45 AM. The findings are:  Resident #20 had diagnoses of Anxiety Disorder, and Bipolar Disorder. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Data (ARD) of 77/27/20/22 documented the resident source of 13 (13-indicates Cognitively interact) on the Brief Interview for Mental Slatus (BMS), required extensive assistance with dressing, limited assistance with transfers, tolleting, walking, personal hygiene, independent with mobility and eating and received Antianskey medications for 7 days out for 7 day look back period.  a. On 10/18/22 at 02:20 PM, a letter dated June 30, 2021 provided by the Director of Nursing documente Re: (Resident #20) Has been approved *for nursing home plateagent by OLTC (Office of Long Term Cranding and Record Review) evaluation.  b. On 10/18/22 at 02:30 PM, The Surveyor asked the Director of Nursin		IDENTIFICATION NUMBER:	A. Building	COMPLETED
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES  (Each deficiency must be preceded by full regulatory or LSC identifying information)  Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.  42965  Based on record review, and interview the facility failed to obtain the completed Preadmission Assessment and Record Review (PASARR) level II evaluation from the State Agency in order in order incorporate the recommendations from the PASARR Level II evaluation report into the Residents Assessment, Care Plan and Transition of Care for 2 (Resident #20 and R#33) or 21 (Resident #7, #12, #13, #16, #20, #22,#23, #83,#31, #33, #34, #34, #34, #34, #34, #34, #46, #44, #86,#565, #325) samples residents that were admitted to I facility and had mental health diagnosis. The failed practice had the potential to affect 24 residents that he mental health diagnosis according to a list provided by the Medical Records/Infection Prevention Nurse o 10/20/22 at 10.45 AM. The findings are:  Resident #20 had diagnoses of Anxiety Disorder, and Bipolar Disorder. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/27/20/22 documented the resident score 13 (13-i indicates Cognitively Intact) on the Brief Interview for Mental Status (BIMS), required extensive assistance with trassing, limited assistance with transfers, loileling, walking, personal hygiene, independent with be mobility and eating and received Antianxiety medications for 7 days out of the 7 day look back period.  a. On 10/18/22 at 02:20 PM, a letter dated June 30, 20/21 provided by the Director of Nursing documente Re: (Resident #20) has been approved for nursing home placement QU-TIC (Office of Long Temc Car and may enter the nursing home of his/her choice. ATTENTION NURSING FACILITIES: You MUST cont Inamed agencyl with the clients admitted in order to receive your client's completed PASRR (Preadmissic Screening and Record Review) evaluation.  b. On 10/18/22 at 02:30 PM, The S		ER	322 West Collin Raye Drive	P CODE
Each deficiency must be preceded by full regulatory or LSC identifying information	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some  Based on record review, and interview the facility failed to obtain the completed Preadmission Assessment and Record Review (PASARR) level II evaluation from the State Agency in order in order incorporate the recommendations from the PASARR Level II evaluation report to the Residents Assessment, Care Plan and Transition of Care for 2 (Resident #20 and R#38) or 21 (Resident #7, #12, #13, #16, #20, #22,#32, # #33,#31, #33, #34, #36, #38,# 41 #42, #46, #49, #50#51,#255) sampled residents that were admitted to 1 facility and had mental health diagnosis. The failed practice had the potential to affect 24 residents that he mental health diagnosis according to a list provided by the Medical Records/Infection Prevention Nurse o 10/20/22 at 10:45 AM. The findings are:  Resident #20 had diagnoses of Anxiety Disorder, and Bipolar Disorder. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/27/2022 documented the resident scored 13 (13-indicates Cognitively Intact) on the Brief Interview for Mental Status (BIMS), required extensive assistance with transfers, tolleting, walking, personal hygiene, independent with bernobility and eating and received Antianxiety medications for 7 days out of the 7 day look back period.  a. On 10/18/22 at 02:20 PM, a letter dated June 30, 2021 provided by the Director of Nursing documenter Re: (Resident #20) Has been approved* for nursing home placement by OLTC (Office of Long Term Car and may enter the nursing home of his/her choice. ATTENTION NURSING FACILTIES: You MUST cont [named agency] with the clients admitted in order to receive your client's complete PASRR (Preadmissis Screening and Record Review) evaluation.  b. On 10/18/22 at 03:15 PM, The Surveyor asked the Medical Records/Infection Prevention Nurse for a coffice of the complete PASRR packet on Resident #20.  c. On 10/19/22 at 03:15 PM, The Surveyor asked the Director of Nursing (DON). Were you able to get a coffice	(X4) ID PREFIX TAG			on)
	Level of Harm - Minimal harm or potential for actual harm	Coordinate assessments with the pservices as needed.  42965  Based on record review, and intervand Record Review (PASARR) lev recommendations from the PASAR and Transition of Care for 2 (Resid #30,#31, #33, #34, #36, #38,# 41 # facility and had mental health diagromental health diagnosis according 10/20/22 at 10:45 AM. The findings Resident #20 had diagnoses of An. (MDS) with an Assessment Refere indicates Cognitively Intact) on the with dressing, limited assistance with mobility and eating and received Ata. On 10/18/22 at 02:20 PM, a letter Re.: (Resident #20) Has been approand may enter the nursing home of [named agency] with the clients ad Screening and Record Review) evants of the complete PASARR packet on c. On 10/19/22 at 03:15 PM, The Store the facility have any mental health services? The DON a resident at another facility in (name got a copy of the PASARR from the State Designated Professional Assistance of the company of the PASARR from the State Designated Professional Assistance and interviews and the professional Assistance on the professional Assistance on the passion of the passional Assistance on the passion of the passion of the passional Assistance on the passion of the passional Assistance on the passion of	iew the facility failed to obtain the compel II evaluation from the State Agency in the Research of the Research of Research o	ceview program; and referring for solution of the program; and referring for solution of the program of the pro

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLII	FD	STREET ADDRESS, CITY, STATE, ZI	P CODE
Bear Creek Healthcare LLC		322 West Collin Raye Drive	r cobe
Boar Grook Hoalthoard EEG		DE Queen, AR 71832	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 10/20/22 at 09:39 AM, The S Does (Resident #20) have a Menta The MR/IP Nurse stated, Yes she of the completed Preadmission Scree review when (R#20) admitted to the The Surveyor asked the MR/IP Nurse stated, Our MDS coo MR/IP nurse, Is she here today? TI MR/IP Nurse, Why is it important the copy of the complete PASARR pack Nurse stated, So that we know how the MR/IP Nurse When (Resident #20 completed PASARR packet from the Yes, we should.  e. On 10/20/22 at 10:45 AM, the post Services (04/01/06) provided by the Need Assessments: Each Medical for nursing home services. A thorowho do not require nursing home services (04/01/06) provided by the Need Assessments: Each Medical for nursing home services. A thorowho do not require nursing home services of Antipolical Screening Retardation)/DD (Developmental Determine whether they need spectom most appropriate placement for the Resident #38 had diagnoses of Antipolical Antipolical Screening Activity of the resident scored 9 (8-12 indicate was dependent for bed mobility, traind received Antipsychotic, Antiantipolical Screening Activity of the Pasker (Resident #38) Long Term Care) and may enter the You MUST contact (named agency PASRR (Preadmission Screening and the Complete PASRR packet on (Resident #38)?	Rurveyor asked the Medical Record/ infall Health diagnosis that might impact he does. The Surveyor asked the MR/IP Number and Record Review Packet from the facility? The MR/IP Number stated, Nourse, Who at the facility is responsible redinator is responsible for getting that in the MR/IP Number stated, No she is out she may be a stated and the manufacture of the manufactu	ection Prevention (MR/IP) Nurse er care while she is in the facility? lurse, Did facility staff get a copy of the state agency completing the we did not get it when she admitted for obtaining that information? The information. The Surveyor asked the sick today. The Surveyor asked the all health diagnosis that you get a ted the evaluation? The MR/IP test they need. The Surveyor asked ity staff have gotten a copy of her alluation? The MR/IP Nurse stated.  of Medical Need for Nursing Home in Nurse documented, . 1. Medical each nursing home applicant's need conducted to ensure the individuals facility . I PRE-ADMISSION N/DEVELOPMENTAL DISABILITY (Mental Illness)/MR (Mental or a full psychosocial evaluation to whether a nursing facility is the left, and Schizophrenia. The (ARD) of 8/24/22 documented that interview for Mental Status (BIMS), iene and independent for eating for 7 days out of the 7-day look of the Director of Nursing is placement by OLTC (Office of ENTION NURSING FACILTIES: receive your client's completed fection Prevention Nurse for a copy were you able find the complete members to work on that for me. I

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 045287

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLIE Bear Creek Healthcare LLC	R	STREET ADDRESS, CITY, STATE, ZI 322 West Collin Raye Drive DE Queen, AR 71832	P CODE
For information on the nursing home's p	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	IENCIES full regulatory or LSC identifying informati	on)
F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(Resident #38) have Mental Health MR/IP Nurse stated, Yes Ma'am, significant The Surveyor asked the MR/IP Nurse and Record Review Packet from the facility? the MR/IP Nurse stated you asked me about it, and they sa guess we did not get because it is radmitted to the facility should facility state agency that completed the event continuation of care. I called the States.	urveyor asked the Medical Records/Inf Diagnosis that might impact her care was to does.  se Did facility staff get a copy of the consensus of the state agency completing the review was to be state agency completing the review was to be state agency completing the review was to be state agency completing the review was that they sent one, but I cannot find not here. The Surveyor asked the MR/I by staff have gotten a copy of her compaluation? The MR/IP Nurse stated, Yes at Designated Professional Associate we mailed a check so that they will sent they will	while she is in the facility? The impleted Preadmission Screening when (Resident #38) admitted to sional Associates on that the day one anywhere. So technically, I P Nurse, When (Resident #38) leted PASARR packet from the state of the stat

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	10/20/2022
		D. Willig	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0656	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.		
Level of Harm - Minimal harm or potential for actual harm	42965		
Residents Affected - Few	Based on record review, observation, and interview the facility failed to ensure the Comprehensive Care PI contained the necessary information to fully provide and coordinate care and services for a resident with Physician's Orders for Anticoagulant Medication for 1 (Resident #36) of 3 (Resident #20, #33 and #36) sampled residents with orders for Anticoagulant Medications. The failed practice had the potential to affect residents that had orders for Anticoagulant Medication according to a list provided by the Medical Records/Infection Prevention Nurse on 10/20/22 at 10:45 AM. The findings are:		
	Resident #36 had a diagnosis of Atrial Fibrillation with Dysthymias, Coronary Artery Disease, and Heart Failure. The Admission Minimum Data Set (MDS) with an Assessment Reference (ARD) of 8/11/22 documented that the resident scored 10 (8-12 indicates moderately impaired) on the Brief Interview for Mental Status (BIMS), was independent with all activities of daily living and received Anticoagulant medication for 7 days out of the 7-day look back period.		
	A Physicians' Order dated 8/3/2022 documented, . ELIQUIS 2.5 MG (Milligram) TAB (Tablet) 1 BID (twice Daily) . Unspecified Combined Congestive Heart Failure .		
	3. A Physician's Order dated 10/3/22 documented, . Eliquis 2.5mg 1 PO (By Mouth) daily .		
		Surveyor reviewed Resident # 36's Care ne resident takes an Anticoagulant Med	
	with (Resident #36's) Care? The Al #36) take an Anticoagulant Medica Surveyor asked the ADON, How lo the medical record and stated, She asked the ADON, Does (Resident) The ADON stated, It is not on her or residents care plan addresses that	Surveyor asked the Assistant Director of DON stated, Yes I am. The Surveyor astion? The ADON stated, Yes she takes ing has she received an Anticoagulant I has been on it since she admitted on a #36's) care plan address that she receivare plan. The Surveyor asked the ADO she that she is receiving an Anticoagular for medication side effects, adverse recognitions.	sked the ADON, Does (Resident the anticoagulant Eliquis. The Medication? The ADON looked in August the 4th. The Surveyor ves an Anticoagulant medication? DN, Why is it important that the lant Medication? The ADON stated,
	by the Medical Records/Infection P comprehensive care plan that inclu nursing, mental and psychological Implementation: 5. Care plan intervibetween the residents problem are	olicy titled Care Plan - Comprehensive ( prevention Nurse documented, . Policy sides measurable objectives and timetal needs is developed for each resident . prentions are designed after careful consum as and their causes . 7. The resident's completion of the resident's comprehe	Statement: An individualized, ples to meet the resident's medical, Policy Interpretation and sideration of the relationship comprehensive care plan is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLII Bear Creek Healthcare LLC	ER	STREET ADDRESS, CITY, STATE, ZIP CODE  322 West Collin Raye Drive DE Queen, AR 71832	
For information on the nursing home's	plan to correct this deficiency, please con	Lact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0695  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed.  42076  Based on observation, record review, and interview, the facility failed to ensure oxygen tubing was properly labeled for 1 (Resident #30) sample mix resident, failed to ensure oxygen tubing, nebulizer mask and tubing were properly stored when not in use for 2 residents (Residents #30 and #49) to prevent potential contamination that could result in respiratory infection for 7 (Residents #20, #23, #30, #31, #34, #46, and #49) sampled residents who had Physician Orders for oxygen therapy and nebulizer treatments. The finding are:  1.Resident #30 had diagnoses of Chronic Obstructive Pulmonary Disease, Restless Leg Syndrome, Unspecified Dementia with behavioral disturbances. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 8/10/22 and a Brief Interview for Mental Status (BIMS) of 03 (0-7 Severe Cognitive Impairment).  a. On 10/17/22 at 12:00 PM, Resident #30 was not in the room. A nebulizer machine was on the nightstand with the mask lying on the edge of the nightstand not stored in a protective bag. The oxygen tubing was attached to a concentrator that was dated 10/10/22.  b. On 10/18/22 at 8:45 AM, a nebulizer machine was on the nightstand with the mask lying on the edge of the nightstand not stored in a protective bag. The oxygen tubing was attached to a concentrator that was dated 10/10/22.  c. On 10/18/22 at 3:40 PM, a nebulizer machine was on the nightstand with the mask lying on the edge of the nightstand not stored in a protective bag. The oxygen tubing was attached to a concentrator that was dated 10/10/22.		
	Oxygen 2L (liters)/M(minute) via na (oxygen saturation) above 92%.  d. During record review on 10/18/2 documented, .Breathing Difficulty .l	2 at 1:15 PM, a Physician's Order date isal cannula PRN (as needed) SOB (she at 1:15 PM, a Care Plan with a proble Resident has potential for difficulty breat treatments .Oxygen .Keep oxygen tub	nortness of breath) to keep SPO2 em date of 12/21/2021 athing related to chronic condition

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0695  Level of Harm - Minimal harm or potential for actual harm	tubing and nebulizer masks and tul	rveyor asked Licensed Practical Nurse bing be stored when not in use? She st oxygen/nebulizer tubing/masks be cha	ated, In a plastic bag. The
Residents Affected - Some	oxygen tubing and nebulizer masks	urveyor asked the Assistant Director of s and tubing be stored when not in use oxygen/nebulizer tubing/masks be cha	? She stated, In a plastic bag. The
	and nebulizer masks and tubing be	Surveyor asked Licensed Practical Nursestored when not in use? She stated, I oxygen/nebulizer tubing/masks be cha	n a bag in the resident's room. The
	6. A facility policy received on 10/1	9/22 at 11:30 AM from the Assistant Di locuments .Oxygen tubing will be chan	<b>O</b> ( ,
	Administering Medications through policy is to administer aerosolized policy is to administer aerosolized policy in the second policy in the second policy is the second policy in the second policy in the second policy is the second policy in the second policy in the second policy is the second policy in the second policy in the second policy is the second policy in the second policy in the second policy is the second policy in the second policy in the second policy in the second policy in the second policy is the second policy in the second policy policy in the second policy in the second policy in the second p	9/22 at 11:30 AM from the ADON titled a Small Volume (Handheld) Nebulizer particles of medication safely and asep store in a plastic bag with the resident	documents .The purpose of this tically into the resident's airway .
	46319		

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			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045287	(X2) MULTIPLE CONSTRUCTION  A. Building  B. Wing	(X3) DATE SURVEY COMPLETED 10/20/2022
NAME OF PROVIDER OR SUPPLIE	- -p	STREET ADDRESS, CITY, STATE, Z	P 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 con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informat	ion)
F 0908	Keep all essential equipment worki	ng safely.	
Level of Harm - Minimal harm or	42569		
potential for actual harm  Residents Affected - Few	free of lint build up to decrease the This failed practice had the potentic form provided by the Director of Nu a. On 10/17/22 at 2:22 pm, two ele Assistant (LA) #1 opened the lint tr Dryer #1, on the lint trap, and wirin loosely from the frame. The Survey the lint trap screen is torn. The Sur them after every two loads, I check happen if there is an excessive am b. On 10/19/22 at 1:05 pm, Laundr observed a buildup of lint in the boil lint trap screen was torn and hangi what you see? LA #2 stated, Do yo happened, but it's been a while. Whafter it was fixed, we started using month, our supervisor has ordered the lint filter being torn cause a pro often are the lint traps cleaned? LA them. We just do it after every two on the lint trap been torn? The HSh not sure how long the lint trap has	w the facility failed to ensure 1 of 2 corpotential for fire and loss of laundry seal to affect 50 residents according to thursing (DON) on 10/17/22 at 10:30 am. Appendix of Dryer #1. The Surveyor observed go for the dryer thermostat, the lint traptor asked LA #1, Can you tell me what veyor asked, How often are the lint traptor on the dryer because it scares me. To ount of lint build up? LA #1 stated, It can you say the same of Dryer #1, on the lint trap, and with most of Dryer #1, on the lint trap, and with gloosely from the frame. The Surveyou mean the part hanging down? The life haven't been using that dryer because it again. We have been using that dryer a new one, but it hasn't come in yet. The life haven't been with the surveyou loads, we do loads.  Begin and the Housekeeping Supervity (Stated, The dryer was down for 2 year been torn. I told the person that fixed it the Surveyor asked, Should the dryer the surveyor asked.	ervices for 1 of 1 Laundry Room. The findings are:  The Surveyor asked, Lint, and the screen was torn and hanging you see? LA #1 stated, Lint, and the screen was torn and hanging you see? LA #1 stated, I clean the Surveyor asked, What can are cause a fire.  The Surveyor asked, What can are cause a fire.  The filter in the filter thermostat, the filter is torn. I don't know when it we it broke, and we couldn't use it. Filter with the filter torn for about a the Surveyor asked LA #2, Could are a fire. The Surveyor asked, How when't have a schedule for cleaning the sor (HSK), How long has the screen are, and they recently fixed it. I am about the screen, but he keeps
		Survey asked, What can happen if the	

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Facility ID: 045287

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