STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045277	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Pine Bluff	6301 South Hazel Street Pine Bluff, AR 71603

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident and resident representative were included in care planning meetings for one (Resident #63) of one resident, reviewed for care plan meetings and failed to ensure a care plan was revised to reflect the code status of Do Not Resuscitate (DNR) for a resident under hospice care for one (Resident #63) of one resident reviewed for hospice care. The findings include: A review of Resident #63 ' s modified quarterly Minimum Data Set (MDS), with an Assessment Reference Date of [DATE], revealed the facility re-admitted the resident on [DATE] with a Staff Assessment for Mental Status score of 03, which indicated the resident was severely impaired and never/rarely made decisions. The MDS also revealed the resident was to receive special services from hospice care. A review of Resident #63 ' s Order Summary Report revealed the resident was admitted to local hospice services as of [DATE], and had a code status of DNR, with a start date of [DATE]. The Order Summary Report also indicated Resident #63 had diagnoses which included type 2 diabetes mellitus, paranoid schizophrenia, and Alzheimer's disease. A review of Resident #63 ' s Care Plan Report, last reviewed [DATE], revealed the resident had requested that cardiopulmonary resuscitation (CPR) measures be performed, and that the resident was a full code. The Care Plan revealed an intervention, with an initiation date of [DATE], that directed staff to initiate CPR if found pulseless and breathless and to continue CPR until emergency personnel arrived to take over. The Care Plan also revealed Resident #63 had elected for hospice services. During a phone interview on [DATE] at 2:13 PM, Resident #63 ' s family member stated the facility had not performed a care plan meeting with them since March of 2024, and the last care plan meeting was over the telephone. During a concurrent observation and interview on [DATE] at 3:50 PM, the Director of Nursing (DON) stated the MDS Coordinator was responsible for conducting care plan meetings and updating the residents' care plans. She stated Resident #63's care plan should have been updated to reflect the resident was no longer a full code. The DON reviewed the resident's Electronic Health Record (EHR) and stated there was a DNR order for [DATE]. She reviewed the resident's care plan and stated it reflected, I am a full code. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on [DATE] at 9:52 AM, the MDS Coordinator stated she was responsible for updating residents' care plans. She stated the care plans were updated per a review schedule, or if she received new orders. She stated the nurse consultant prepared the review schedule for her. The MDS Coordinator revealed she gathered information for updating care plans from the DON, and the aides, or the DON would give her a list of new orders daily. She stated if a resident's full code status was changed to DNR, this should have been reflected on the care plan. The MDS Coordinator stated she completed care plan meetings with the resident, or the resident ' s representative, and the schedule was triggered , alerting her when the meetings were due. The MDS Coordinator provided a copy of the schedule and Resident #63's name was not listed. She stated she sent letters to the resident and resident ' s representative with information regarding when the meeting was scheduled, but sometimes she performed the care plan meetings by phone, due to family not showing up. The MDS Coordinator reviewed the information in the resident's EHR and stated she did not see any documentation to indicate the last care plan meeting had been done. The MDS Coordinator reviewed her current care plan meeting schedule and stated she did not see the resident's name on the list. She stated in the past three months she had not called the family member to provide updates on the resident's care. There were no progress notes in the resident ' s EHR detailing why the care plan meetings were not held. A review of a Care Plans, Comprehensive Person-Centered policy, revised 03/2022, revealed the following: - the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. -the resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. -if the participation of the resident and his/her representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record and should include the steps taken to include the resident or representative in the process. -assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and facility policy review, the facility failed to ensure nail care was provided for one (Resident #5) of one resident reviewed for nail care and failed to ensure a bath or shower was provided for one (Resident #386) of one resident reviewed for baths/showers. The findings include: Resident #5 During an observation on 06/17/2025 at 9:01 AM, this surveyor observed Resident #5 lying in bed awake. The resident ' s fingernails, on both hands, were past the tips of the fingers and a dark substance was underneath the nail beds. Resident #5 stated not remembering the last time their fingernails were trimmed. During an observation on 06/18/2025 at 2:41 PM, this surveyor observed Resident #5 sitting up in a Geri-chair in their room, awake. The resident ' s fingernails, on both hands, were past the tips of the fingers and a dark substance was underneath the nail beds During a concurrent observation and interview on 06/19/2025 at 12:12 PM, Certified Nursing Assistant (CNA) #12 stated she had worked at the facility for 19 years. She looked at Resident #5's fingernails and stated the nails were medium length and had stuff underneath their nail beds, which was brown in color. She stated the nurses performed nail care for residents who were diabetic. During a concurrent observation and interview on 06/19/2025 at 2:57 PM, Licensed Practical Nurse (LPN) #13 described Resident #5's fingernails on both hands as too long, brown in color with what appeared to be feces and dirt. LPN #13 stated nail care was randomly provided by the aides, and the Director of Nursing (DON) also provided nail care to residents sometimes. She stated she did not know if residents received nail care on bath days and that Resident #5 had not refused baths. LPN #13 stated CNAs did not provide nail care for residents who had diabetes. A review of Resident #5 ' s admission Record revealed the facility admitted the resident on 12/12/2024, with diagnoses which included diabetes mellitus. A review of Resident #5 ' s Order Summary Report revealed the resident may see a podiatrist, a doctor who treats the foot, ankles and lower legs, every 90 days, and as needed. The Order Summary Report revealed Resident #5 had no orders for weekly nail care. A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/09/2025, revealed Resident #5 had a Brief Interview for Mental Status of 07, which indicated severe cognitive impairment. The MDS also revealed Resident #5 had no behaviors, no rejection of care, required moderate assistance with oral and toileting hygiene, and was dependent upon staff for bathing themself and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #5 ' s Care Plan Report, revised 05/19/2025, revealed the resident had an activities of daily living (ADL) self-care performance deficit. The Care Plan included an intervention that directed staff to check nail length, trim, and clean, as necessary. The resident did not express any preference regarding bathing schedule. The Care Plan report also revealed the resident had diabetes mellitus, which included an intervention of diabetic toenail care to be provided by licensed staff. There was not an intervention listed on Resident #5 ' s Care Plan Report for weekly nail care by a licensed staff member. A review of Resident #5 ' s ADL Nail Care Task revealed nail care was last completed on 06/15/2025. A review of Resident #5 ' s ADL Task Bath type revealed the resident ' s bath days were Tuesdays, Thursdays, and Saturdays. According to the ADL Task Bath type, the resident received a shower on 06/14/2025 and a sponge bath on 06/17/2025 and 06/19/2025. A review of the 06/2025 electronic Medication Administration Record (eMAR) for Resident #5 did not indicate an order for nail care. A review of Resident #5 ' s Treatment Record for 06/2025 did not reveal a treatment order for nail care. A review of Resident #5 ' s Progress Notes from 06/01/2025 to 06/19/2025 did not indicate the resident had refused nail care and included documentation of the resident feeding self on 06/14/2025, 06/08/2025, 06/07/2025 and 06/01/2025. During an interview on 06/19/2025 at 3:31 PM, the DON stated any licensed nursing staff could provide nail care to residents who were diabetic, but the facility preferred that CNAs not clean diabetic resident ' s fingernails. She stated Resident #5 was on a schedule to have nails trimmed weekly, and this should have been on the resident's eMAR. The DON stated a licensed nurse needed to clean the residents' fingernails through the week. The DON continued that residents' fingernails should be trimmed and cleaned, because residents eat their food with their hands and so residents did not scratch themselves. A review of a Fingernails/Toenails, Care of policy, revised 02/2018 revealed nail care includes daily cleaning and regular trimming and unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments, and trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. The policy indicated the supervisor should be notified if the resident refuses the care. Resident #386 During an interview on 06/16/2025 at 1:23 PM, Resident #386 indicated they had not had a bath since being admitted . A review of Resident #386 ' s ADL/bath record indicated that their showers were scheduled for Monday ' s, Wednesday ' s, and Friday ' s. The ADL/bath record did not indicate that Resident #386 had been given a shower since being admitted . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #386 ' s admission Record revealed the facility admitted the resident on 06/10/2025 with a history of falls and a brain bleed. During an observation on 06/16/2025 at 1:25 PM, Lead CNA #8 was heard telling Resident #386 that she would give the resident a shower. A review of Resident #386 Care Plan, initiated 06/10/2025, revealed the resident did not express any bathing preferences, but did require limited assistance with bathing. During an interview on 06/18/2025 at 10:50 AM, CNA #9 indicated that Resident #386 received a shower every week, and the resident had not been informed about their shower days yet. CNA #9 indicated new admissions received their showers as soon as they were admitted . CNA #9 confirmed Resident #386 was admitted on e to two weeks ago. CNA #9 revealed the CNAs were responsible for giving the residents a shower, if there was not a shower aide scheduled. CNA #9 stated he did not know why Resident #386 had not received a shower before yesterday. During an interview on 06/18/2025 at 2:11 PM, Resident #386 indicated only having had three showers since being admitted . The resident indicated they had a shower on 06/16/2025, 06/17/2025, and 06/18/2025, but missed their shower on 06/11/2025, and 06/13/2025. During an interview on 06/18/2025 at 2:17 PM, Lead CNA #8 indicated showers should be documented by the staff after completion, but before the shift was over. Lead CNA #8 stated Resident #386 was cognitive and informed her on Monday that they had not received a shower. Lead CNA #8 indicated that she gave Resident #386 a shower on Monday 06/16/2025. During an interview on 06/19/2025 at 10:40 AM, the DON indicated if a new admit came in after hours, the CNA may not put their task in the computer. The DON stated most of the time, the next morning the department heads made sure the tasks were completed. The DON stated she was not here the week Resident #386 was admitted , and she did not get a chance to look at the task. The DON revealed Resident #386 should have received a bath before 06/16/2025. The DON confirmed Resident #386 received baths on Mondays, Wednesdays, and Fridays. During an interview on 06/19/25 at 2:32 PM, the Administrator stated a new admission should receive a shower whenever they want one, but at least by the next day. She revealed she did not know Resident #386 had not received a shower. A review of a policy titled, Bath, Shower/Tub indicated the purpose of a bath/shower is to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin.

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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. Based on observation, record review, interview, and facility policy review, the facility failed to ensure the necessary care and services were provided to a resident with a non-pressure related skin issue for one (Resident #1) of two residents reviewed for non-pressure related skin issues. The findings include: During a concurrent observation and interview, on 06/17/2025 at 12:34 PM, this surveyor observed Resident #1 lying in bed on their right side, with a wedge behind their back. There were scabs and bruises, reddish in color, observed on the resident's left arm. When asked what happened, Resident #1 stated the resident and somebody's sister were play scratching and she scratched the resident's arm. The resident was unable to state who the sister was or when this incident happened. The resident's hands were not visible at this time. During an observation on 06/18/2025 at 9:50 AM, this surveyor observed Resident #1 sitting at the dining room table dressed, with both arms covered. During an observation on 06/19/2025 at 11:59 AM, this surveyor observed Resident #1 lying in bed on their right side with eyes closed and their left arm exposed. The left arm was observed with purplish bruising and scabbed over areas. A review of Resident #1 ' s admission record revealed the facility admitted the resident on 06/07/2024, with diagnoses which included dementia, and moderate protein calorie malnutrition. A review of Resident #1 ' s Order Summary Report revealed an order for a left lower leg wound cleanse, with a start date of 06/03/2025. Staff were to apply a dressing to the wound bed, cover with gauze, and secure with tape every shift and as needed (PRN). The Order Summary report also revealed Resident #1 was to receive a low dose delayed release Aspirin tablet one time a day for high blood pressure. A review of Resident #1 Progress Notes from 05/16/2025 to 06/17/2025, did not reveal any documentation of bruising, scabs, or redness to the resident ' s left arm. A review of Resident #1 ' s significant change Minimum Data Set (MDS), with an Assessment Reference Date of 04/23/2025, revealed the resident had a Brief Interview for Mental Status score of 03, which indicated the resident had severely impaired cognition. The MDS also revealed Resident #1 was dependent on staff for oral, personal and toileting hygiene, and transfers. The MDS indicated that the resident had no unhealed pressure ulcers/injuries. A review of Resident #1 ' s Care Plan Report, with a review date of 05/05/2025, indicated the resident had an Activities of Daily Living (ADL) self-care performance deficit with interventions, that directed staff to check nail length, trim, and clean as necessary. Another intervention on Resident #1 ' s Care Plan Report directed staff to inspect skin weekly and PRN, and to observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. A review of a Skin Check dated 06/11/2025, revealed Resident #1's skin condition was not clear, and no comments were documented on the form to indicate what the skin condition was. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1 ' s ADL Task Skin Condition revealed from 05/29/2025 to 06/17/2025, no new skin issues were documented. For question two, skin observation, the sections for scratched, red area, discoloration, skin tear, and open area, for 05/29/2025 to 06/17/2025, indicated response not required. For question 3, location of skin concerns, the form indicated response not required. A review of Resident #1 ' s ADL Task - Bathing indicated the residents bath days were Tuesdays, Thursdays, and Saturdays on day shift. The ADL Task Bath Type revealed the resident received a shower on the following days: 06/03/2025 and 06/14/2025, and a sponge bath on 05/31/2025, 06/04/2025, 06/05/2025, 06/07/2025, 06/12/2025, and 06/17/2025. A review of Resident #1 ' s 05/2025 Treatment Record did not indicate any treatment orders for skin issues to the resident ' s left arm. A review of Resident #1 ' s 06/2025 Treatment Record did not indicate any treatment orders for skin issues to the resident ' s left arm. During an interview on 06/18/2025 at 3:58 PM, Licensed Practical Nurse (LPN) #2 stated if she saw a skin issue on a resident such as a laceration, cut, scrape, or bruise that was not there on a previous round, she would have put the observation on an Incident and Accident (I&A) form and would have gotten a treatment order from the provider. LPN #2 stated the family, the Director of Nursing (DON), and Administrator were notified of any I&As completed. During an interview on 06/19/2025 at 10:22 AM, Certified Nursing Assistant (CNA) #17 stated if she saw a skin issue on a resident such as a laceration, cut, scrape, or bruise that was not there on a previous round, she would have gotten the nurse and documented on the chart [the electronic health record]. During an interview on 06/19/2025 at 12:21 PM, CNA #12 stated if she saw a skin issue on a resident such as a laceration, cut, scrape, or bruise that was not there on a previous round, she would have gotten her charge nurse and stated the resident had a cut or bruise. During a concurrent interview and observation on 06/19/2025 at 3:04 PM, LPN #13 stated if she noticed a bruise, scratch, skin tear, sore, open area or scab on a resident's skin that was not previously observed, she would notify the DON, the Assistant Director of Nursing (ADON), and the treatment nurse. She stated she would complete a progress note, if needed. LPN #13 was asked to look at Resident #1's left arm. She described what she observed as old and new bruising on intact skin, some old wounds that were scabbed, healed, and not dressed. She stated there could be old blood on the skin tears. LPN #13 stated she did not know when the resident's left arm became bruised or scabbed. If the CNAs saw bruising or scabs on the resident's skin, they were supposed to let the nurse know. During an interview on 06/19/2025 at 3:41 PM, the DON stated if the CNAs saw any skin issues, they were to notify the charge nurse immediately. She stated it was everyone's responsibility to notify the charge nurse, and the charge nurse would notify the treatment nurse. She stated skin tears were addressed, and CNAs checked the resident's skin every time a resident was checked. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Prevention of Pressure Injuries policy, dated as revised 04/2020, indicated to inspect the skin on a daily basis when performing or assisting with personal care or ADLs and to evaluate, report and document potential changes in the skin. The DON was asked to provide a policy on skin issues and did not provide the policy indicated above instead.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on interviews and record review the facility failed to ensure one (Resident #62) of five residents reviewed for medications did not receive an unnecessary medication. The findings include: A review of Resident #62 ' s admission Record indicated the facility admitted the resident on 09/18/2023 with diagnoses that included type 2 diabetes mellitus, without complications. A review of Resident #62 ' s quarterly Minimum Data Set, with an Assessment Reference Date of 05/26/2025, revealed the resident had a Brief Interview for Mental Status score of 07, which indicated severe cognitive impairment. A review of Resident #62 ' s Care Plan, initiated 12/05/2024, revealed the resident had desired to lose weight with a goal weight of 145 pounds (lbs). A review of Resident #62 ' s Order Summary Report revealed Resident #62 had an order for an antidepressant to be given one time a day related to abnormal weight loss ordered on 02/06/2025. The Order Summary Report also revealed the resident had a desire to lose weight with a goal weight of 145 lbs. A review of Resident #62 ' s Weight Summary revealed a weight of 155lbs on 09/02/2024, 148lbs on 12/05/2024, 148lbs on 02/05/2025, 148lbs on 03/04/2025, and 153lbs on 06/02/2025. A review of Resident #62 ' s Weekly Weight Note, dated 09/20/2024 indicated the resident ate what they wanted and was losing weight for their spouse. A review of Resident #62 ' sWeekly Weight Note, dated 09/27/2024, indicated the resident wanted to lose weight. A review of Resident #62 ' s Weekly Weight Note, dated 12/03/2024, indicated orders were received from the Medical Doctor (MD) to start Resident #62 on an anti-depressant medication at bedtime, related to weight loss. During an interview on 06/19/2025 at 9:43 AM, Resident #62 indicated they lost a little weight, and desired to lose a little more. The resident stated they did not eat much at all, because of their desired weight loss. Resident #62 indicated they had not been informed of taking an anti-depressant to gain weight. During an interview on 06/19/2025 at 10:45 AM, the Director of Nursing (DON) confirmed Resident #62 was trying to lose weight. The DON stated Resident #62 informed the Psych Nurse this morning [06/19/2025] that they were too big. The DON indicated that Resident #62 came to her about a year ago and told her they wanted to lose weight. The DON then went to the Care Plan Coordinator and informed her that Resident #62 desired to lose weight and had a goal weight of 145lbs. The DON indicated that she informed Resident # 62 that today the resident had met their weight loss goal. The DON stated Resident #62 received the anti-depressant because they had started losing weight. The DON indicated she would have to check if the anti-depressant was something that the Registered Dietician recommended, and the MD (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/19/2025 at 11:02 AM, the MD indicated Resident #62 was receiving an anti-depressant for depression. The MD stated he could not remember if Resident #62 had a diagnosis of depression. The MD indicated he monitored for symptoms and changes, to determine if the anti-depressant was effective. He indicated that side effects and symptoms were monitored to evaluate whether medications should be initiated, continued, reduced, discontinued, or otherwise modified. The MD revealed he was not sure if there was a reason why a gradual dose reduction had not been attempted and could not remember Resident #62 telling him anything concerning their weight. During an interview on 06/19/2025 at 2:34 PM, the Administrator indicated she was not aware Resident #62 wanted to lose weight. A review of a policy titled, Medication Therapy indicated medication use shall be consistent with an individual's condition, prognosis, values, wishes, and responses to treatment.

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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 policy review, the facility failed to ensure that the kitchen air vent was cleaned; the kitchen floor was free of chips, debris, dirt, rust, and stains, and floor tiles were replaced; food items stored in the freezer were covered or sealed; the ice machine was maintained in a clean and sanitary condition in one of one kitchen, and dietary staff washed their hands before handling clean equipment or food items for two of two meals observed. The findings include: During a tour of the kitchen on 06/16/2025 at 8:52 AM, this surveyor observed the following: a. A cabinet below the deep fryer had four gas pilot valves, with grease on them. The bottom of the cabinet had a mixture of grease and greasy food crumbs. The Dietary Manager (DM) was asked how often she cleaned the deep fryer and the gas pilot valves, she stated she cleaned them every week, but they had not been cleaned for about a month. b. The ceiling air vent by the steam table, and one by the food preparation counter, had water condensation, rust, and gray stains. The DM stated the vent was sweating and had gray and black residue on them. During an interview on 06/19/2025 at 2:05 PM, the Maintenance Director was asked how often he cleaned the ceiling air vent in the kitchen, and he stated he tried to clean it once a week. During an observation on 06/16/2025 at 9:26 AM, this surveyor observed Dietary [NAME] (DC) #1, without gloves, remove a box of dinner rolls from the freezer and place it on the counter, which contaminated her hands. She then placed gloves on her hands, which contaminated the gloves in the process. Without changing her gloves or washing her hands, DC #1 used her contaminated gloved hands to remove dinner rolls from the bag and place them on the pan to be baked and served for lunch. DC #1 was asked what she should have done after touching dirty objects and before handling food items. She stated she should have washed her hands. During an observation on 06/16/2025 at 10:02 AM, this surveyor observed an opened bag of fish breading on a rack in the storage room. The bag was not sealed, which exposed it to air. The DM confirmed leaving the bag open would allow something to crawl into it. During a concurrent observation and interview on 06/16/2025 at 10:04 AM, the ice machine located in a room facing the dining room, which lead to the 300 Hall, had an accumulation of wet brown residue on the panel and on the area where ice traveled down to the ice collector. There was a wet accumulation of black residue on the inside body of the ice machine that could have fallen onto the ice. The DM stated she cleaned the ice machine once a week. She also verified that the Certified Nursing Assistants used the ice for the water pitchers in the residents' rooms and that it was used to fill beverages served to the residents at mealtimes. The DM confirmed the ice machine was dirty with brown color. During an interview on 06/17/2025 at 10:30 AM, the Maintenance Director stated he cleaned the ice machine weekly, but residue built up fast. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045277	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs of Pine Bluff	6301 South Hazel Street Pine Bluff, AR 71603

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 06/16/2025 at 11:58 PM, this surveyor observed Dietary Aide (DA) #4 turn on the three-compartment sink faucet to wash the blender bowl, blade, and lid. After sanitizing the equipment, he turned off the faucet with his bare hand, which contaminated his hand. Without washing his hands, he picked up a clean blade and attached it to the blender to puree food items to be served to the residents, who required pureed diets, for lunch. DA #4 was asked what he should have done after touching dirty objects and before handling clean equipment. He stated he should have washed his hands. During an observation on 06/16/2025 at 12:17 PM, this surveyor observed DC #1 turn on the hand washing sink faucet and wash her hands. After washing her hands, she turned off the faucet with tissue paper, contaminating the tissue. Then, she used the same contaminated tissue to dry her hands. Without rewashing her hands, DC #1 removed slices of cheese from a plastic bag and placed them on a cutting board. DC #1 was asked what she should have done after touching dirty objects and before handling clean equipment. She stated she should have washed her hands. During a concurrent observation and interview on 06/17/2025 at 11:40 AM, this surveyor observed DC #5 use an empty bread bag to push slices of bread into a blender to be pureed and served to the residents, on pureed diets, for lunch. DC #5 was asked the reason he used a bread bag to push slices of bread into the blender. He stated he should have used a tong. A review of a facility policy titled, Safe Storage of Food indicated all foods would be stored, wrapped, or in covered containers. A review of a facility policy titled, Quick Resource Tool: QRT Handwashing indicated hands should be washed as often as possible, and that it was important to wash hands before starting to work with food, as often as needed during food preparation, and when changing tasks. A review of a facility policy titled Sanitation of Ice Machine indicated the ice machine should be sanitized twice monthly by dietary.

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The Springs of Pine Bluff	6301 South Hazel Street Pine Bluff, AR 71603

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure required vaccinations were administered to three (Resident #6, #52, and #63) of five sampled residents reviewed for immunizations. The findings include: A review of Resident #6's Immunization Screen, within the resident ' s Electronic Health Record (EHR), revealed the pneumococcal vaccine was refused, but did not indicate a refusal date. A review of Resident #6's Allergies Screen within the resident ' s EHR indicated the resident had an allergy to penicillin. A review of Resident #6 ' s Order Summary Report revealed the pneumococcal vaccine would be offered, as needed unless contraindicated per the Centers for Disease Control (CDC) guidelines, with an order date of 05/23/2025. A review of Resident #6 ' s significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/27/2025, revealed the facility admitted the resident on 12/11/2024 and re-entered to the facility on [DATE], and had a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. During an interview on 06/19/2025, the Assistant Director of Nursing (ADON), who was also the Infection Preventionist, provided a Release-Pneumococcal Vaccines form, dated 12/11/2024. The Release-Pneumococcal Vaccines form was reviewed and indicated the responsible party signed consenting to Resident #6 ' s receipt of the pneumococcal vaccine. The ADON stated when the nurse attempted to give Resident #6 the vaccine, the resident refused. The ADON stated she could not find documentation of staff informing the Adult Protective Service (APS) worker, who was Resident #6 ' s responsible party, about the resident's refusal of the vaccine or if any education on risks/benefits was provided to Resident #6, or the APS worker. A review of Resident #52's Immunization Screen, within the resident ' s EHR, revealed the pneumococcal vaccine was refused, but did not indicate a refusal date. A review of Resident #52 ' s Order Summary Report revealed the pneumococcal vaccine would be offered per CDC guidelines, with an order date of 11/17/2022. A review of Resident #52 ' s quarterly MDS, with an ARD of 05/07/2025, revealed the facility admitted the resident on 11/17/2022. The MDS also revealed Resident #52 had a BIMS score of 06, which indicated severe cognitive impairment. During an interview on 06/19/2025, the ADON provided a Resident Vaccination Record for Resident #52 which revealed the pneumococcal vaccine was declined on 11/17/2022, but did not specify if any education on the risks/benefits was provided to the resident/responsible party. As of 06/20/2025, the ADON had not provided any further documentation for Resident #52. (continued on next page)

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The Springs of Pine Bluff	6301 South Hazel Street Pine Bluff, AR 71603

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F 0883 Level of Harm - Potential for minimal harm Residents Affected - Some	A review of Resident #63's Immunization Screen, in the resident ' s EHR, revealed the pneumococcal vaccine was refused, but did not indicate a refusal date. A review of Resident #63 ' s Order Summary Report in the resident ' s EHR, revealed the resident had diagnoses which included type 2 diabetes mellitus, paranoid schizophrenia, and Alzheimer's disease. A review of Resident #63 ' s modified quarterly MDS, with an ARD of 03/14/2025, revealed a Staff Assessment for Mental Status score of 03, which indicated the resident was severely impaired and never/rarely made decisions. On 06/19/2025, the ADON provided a copy of an untitled document, dated 12/12/2024 at 9:58 AM, which listed Resident #63's medications. There was an order for pneumococcal vaccine to be given intramuscularly once, with an order date of 12/09/2024, and a discontinue date of 12/09/2025. There was no documentation on this form verifying if Resident #63 received the vaccine. As of 06/20/2025, the ADON had not provided the vaccine information for Resident #63. During an interview on 06/20/2025 at 11:59 AM, the ADON stated she followed up after a resident was admitted to the facility to verify if the resident accepted or declined vaccines. She stated if the resident or resident representative declined vaccines, she would normally put refused but had learned this week to put a note in the EHR. The ADON stated going forward, she would notify the responsible party that the resident declined the vaccine and provide education regarding the risks versus benefits. A review of a Pneumococcal Vaccine policy, dated as revised March 2020, indicated all residents are offered the pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The policy specified before or on admission, residents were assessed for eligibility to receive the pneumococcal vaccine series and when indicated, offered the vaccine series within 30 days of admission to the facility unless medically contraindicated or had already been vaccinated. The policy indicated residents/representatives had the right to refuse vaccination and appropriate information was documented in the resident's medical record indicating the date of the refusal of the vaccine.