

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2025
NAME OF PROVIDER OR SUPPLIER Pink Bud Home for the Golden Years		STREET ADDRESS, CITY, STATE, ZIP CODE 400 So Coker Greenwood, AR 72936	

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)
<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document review the facility failed to ensure an allegation of abuse was reported immediately to the appropriate authorities, which include the state agency, but not later than two hours after the allegation was made for two incidents with Resident #12. This failed practice had potential to affect all residents residing in the facility.</p> <p>It was determined the facility ' s non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) situation was related to State Operation Manual, Appendix PP, 483.12 at a scope and severity of L .</p> <p>The IJ began on 01/07/2025 after review of a record provided by the Administrator regarding Certified Nursing Assistant (CNA) #13 being rough with Resident #12. The Administrator presented the two-page record as her investigation into an allegation of a staff member being rough with Resident #12 as the complete investigation. This was never reported through the State Agency/Office Long Term Care (OLTC) reporting portal.</p> <p>The Administrator was notified of the Immediate Jeopardy (IJ) on 05/20/25 at 3:49 PM. A Removal Plan was requested. An IJ removal plan must include all the actions the facility has taken or will take to immediately address the noncompliance that resulted in or made serious injury, serious harm, serious impairment or death likely. On 05/21/25 at 5:20 PM an acceptable Immediate Jeopardy removal plan was accepted in accordance with Appendix Q.</p> <p>The findings are:</p> <p>A review of the facility ' s undated Abuse/Neglect Policy and Procedures presented to the surveyors on 04/21/2025 stated in section VII Reporting/Response Reports will be filed in all alleged violations and substantiated incidents to the state agency and all other agencies as required and take all necessary corrective action depending on the result of the investigation.</p> <p>A review of facility in-service training dated 02/15/2024 at 01:30 PM and 01/23/2025 at 01:30 PM, revealed staff, including the Administrator and Assistant Director of Nursing (ADON) were trained on Abuse and Neglect and Resident Rights. The Administrator and ADON signed the signature page to acknowledge their training. The in-service training included the types of abuse, identifying abuse, and prevention of abuse. Investigation of abuse and reporting the results to the proper authorities using the proper forms required by the state, and the protection of residents. The training instructed the suspected/alleged employee will be clocked out immediately and the Administrator, Director of</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Nursing (DON), family, and physician will be notified of the incident, and all reports will be filed in all alleged violations and substantiated incidents to the state agency and all other agencies as required.</p> <p>Resident #12 's Care Plan dated October 27, 2024, identified Resident #12 to need assistance of one staff with transfers with the sit to stand lift, dressing, toilet use, personal hygiene and bathing. Resident #12 is non-ambulatory with walking. Resident #12 's Care Plan did not identify the resident to make false allegations.</p> <p>Resident #12 's Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 01/28/2025, identified the resident to have a Brief Interview for Mental Status score of 14, which indicated Resident #12 had intact cognition.</p> <p>Resident #12 's Physician Orders dated 04/1/2025 thru 05/31/2025 revealed the resident to have diagnoses of Parkinsons Disease, chronic pain, anxiety disorder, atrial fibrillation, overactive bladder, depression, vitamin D deficiency, and dementia.</p> <p>During an interview on 04/24/25 at 7:33 AM, Resident #12 reported some girl beat the (explicit) out of me. Her name was something simple like [Certified Nurse Assistant (CNA) #2]. I told someone and [Registered Nurse (RN) #4] said she would not be in my room anymore.</p> <p>On 04/24/25 at 8:01 AM, RN #4 stated it was Resident #12 's preference CNA #2 did not return to Resident #12 's room because she was rough. RN #4 said she instructed CNA #2 not to go back into Resident #12 's room and she had reassigned CNA #2 to work on another hallway. RN #4 stated she reported the incident to the ADON because the DON was not working at the time. During a follow-up interview on 05/19/2025 at 3:52 PM, RN #4 said the incident happened on April 10, 2025.</p> <p>During review of a Nurse 's Note 7-3 PRN dated 04/10/2025, RN #4 documented Resident #12 was alert and orientated to person, place and time. The resident was able to voice needs. The resident transferred per staff with a sit to stand lift, was mobile in a wheelchair propelled by staff, preferred meals in their room, fed self, and had a fair appetite. The record did not contain a body audit or a resident interview concerning the report of the allegation.</p> <p>On 04/24/2025, at 9:09 AM, the ADON said Resident #12 stated CNA #2 got rough with the resident. The ADON stated she did not complete any paperwork because she was not at the facility. The ADON said she reported the allegation to the Administrator and DON the day following the allegation. The ADON said if a resident said staff had been rough with them, staff needed to do a body audit to make sure they don ' t have something wrong with them and the roughness didn ' t cause a problem. The ADON said she did not know if the allegation was reported.</p> <p>During an interview on 05/19/2025 at 4:16 PM, the DON told the survey team the ADON had a log-in for the state reporting portal for submission of allegations of abuse.</p> <p>During an interview on 05/20/2025 at 8:00 AM, the Administrator provided a list of those employees with access to the state reporting portal, which included the ADON.</p> <p>A review of the facility 's OLTC Incident and Accident Report (Form 7734) revealed the allegation was reported on 04/24/2025, fourteen days after the allegation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>During an interview on 04/24/2025 at 9:30 AM Certified Nursing Assistant Supervisor (CNA Supervisor) stated, she was unfamiliar with the incident involving Resident #12 and CNA #2 but was aware of an incident involving Resident #12 and CNA #13. CNA Supervisor removed CNA #13 from working with Resident #12 following an allegation of CNA #13 being rough with Resident #12. CNA #13 was reassigned by CNA Supervisor to work another hall, allowing her to work with other residents the same day. CNA Supervisor said Resident #12 did not want the CNA Supervisor to tell anyone the CNA had been rough with Resident #12. The CNA Supervisor said she did not know if she ever reported to her supervisor about the incident involving CNA #13. CNA Supervisor stated Resident #12 was a [NAME] about us telling what (Resident #12) had said because (Resident #12) feels somebody will be mean. The CNA Supervisor said CNA #13 should have been written up and the nurse should have investigated. CNA Supervisor stated, I don ' t think I wrote her up, I think I just moved her off that hall.</p> <p>On 05/19/2025 at 2:15 PM, the Administrator provided a two-page investigation of the incident involving CNA #13 and Resident #12. One page was a half-page statement made by the CNA Supervisor which stated CNA #13 had been rough with Resident #12. The other half of the page was a written statement made by the Administrator which stated Resident #12 did not remember anything about this and no CNAs had witnessed any abuse or roughness with the conclusion that no injury was noted. The second page of the record was an Employee Warning Record stating Verbally in-serviced (CNA #13) on not being rough with residents. (CNA #13) was told to not go into the room with (Resident #12) and she denied being rough. She was moved to North Hall but was told if she had to work East to not go in (Resident #12 ' s) room. The surveyor asked the Administrator if she had reported this allegation or had any other information regarding this incident. The Administrator said she had not reported the allegation of abuse to the mandatory authorities. The Administrator said the two pages she had given the surveyors were the full report she had done in this investigation. This had not been reported to any authorities or the State Agency/OLTC. No body audit or Nurse assessment was completed for Resident #12.</p> <p>A review of the facility undated Resident Rights document states Each and every resident in this facility has the right to: #12. Be free of verbal, mental, physical, and sexual abuse.</p> <p>Onsite Verification:</p> <p>The IJ was removed on 05/22/2025 at 11:00 AM, after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 05/22/2025 at 8:15 AM with no negative findings regarding the Removal Plan. The survey team verified the Plan of Removal in reviewing the facility in-service training for all staff on reporting abuse and neglect to the Administrator, the DON and Office of Long-Term Care, ensuring all incidents are reported properly and to ensure resident ' s safety. Of the fifty-five residents currently residing in the facility forty-three residents were interviewed regarding abuse, and eleven residents unable to verbalize abuse received body audits. One resident was out of the facility. The DON had been appointed to monitor, investigate and report allegations of abuse and the monitoring tool for documenting and reporting of allegations began on 05/20/2025. The DON was appointed as the Abuse and Neglect Coordinator with all corrections completed on 05/21/2025. A total of ten staff interviews were conducted with staff from all shifts to verify training had been completed. The staff interviewed included the Housekeeping Supervisor, a Housekeeper, a laundry worker, a Nursing Assistant, a Dietary cook, a Medication Assistant Coordinator, a Certified Nursing Assistant, a Licensed Practical Nurse, the Administrator and the Director of Nursing. The staff interviewed verified they had been trained on reporting of abuse. A review of in-service sheets provided indicated sixty-four of seventy-eight employees had been provided training. One staff member was in the hospital and the others are not allowed to return to work until they have been trained.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility document review, the facility failed to thoroughly investigate two allegations of abuse for Resident #12 and failed to prevent potential abuse or maltreatment of all residents by removing the alleged perpetrator during an on-going investigation. Specifically, no evidence of a resident statement, accused statement, assessment of the resident, bedside staff interviews, and a police report were completed for review and the accused was allowed to continue working with residents in the facility immediately following both allegations.</p> <p>It was determined the facility 's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) situation was related to State Operation Manual, Appendix PP, 483.12 at a scope and severity of L .</p> <p>The IJ began on 01/07/2025 after review of a record provided by the Administrator regarding Certified Nursing Assistant (CNA) #13 being rough with Resident #12. The Administrator presented the two-page record as her investigation into an allegation of a staff member being rough with Resident #12 as the complete investigation. This was never reported through the State Agency/Office Long Term Care (OLTC) reporting portal.</p> <p>The Administrator was notified of the IJ on 5/20/25 at 3:46 PM. A Removal Plan was requested. An IJ removal plan must include all the actions the facility has taken or will take to immediately address the noncompliance that resulted in or made serious injury, serious harm, serious impairment or death likely. On 05/21/2025 at 5:20 PM an acceptable Immediate Jeopardy removal plan was accepted in accordance with Appendix Q.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. A review of the facility 's undated Abuse/Neglect Policy and Procedures presented to the surveyors on 04/21/2025 stated in section V Investigation: The Administrator or Designee will investigate all types of incidents and identify the staff member responsible for the initial reporting of alleged violation(s) and a report of the results will be reported to the proper authorities using the proper forms required by the state. 2. A review of facility in-service training dated 02/15/2024 at 1:30 PM and 01/23/2025 at 1:30 PM, revealed staff, including the Administrator and Assistant Director of Nursing (ADON), were trained on Abuse and Neglect and Resident Rights. The Administrator and ADON signed the signature page to acknowledge their training. The in-service training included types of abuse, identifying abuse, and prevention of abuse. Investigation of abuse and reporting the results to the proper authorities using the proper forms required by the state, and the protection of residents. The training instructed the suspected/alleged employee will be clocked out immediately and the Administrator, Director of Nursing (DON), family and physician will be notified of the incident, and all reports will be filed in all alleged violations and substantiated incidents to the state agency and all other agencies as required. Section III of the training instructs staff to encourage family members, staff and residents to report concerns, incidents, and grievances without the fear of retribution. Supervision of staff will be on-going to identify inappropriate behavior, such as .rough handling, . 3. Resident #12 's Care Plan, dated October 27, 2024, identified Resident #12 needed assistance of <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>one staff with transfers with the sit to stand lift, dressing, toilet use, personal hygiene and bathing. Resident #12 was non-ambulatory with walking. Resident #12 ' s Care Plan did not identify the resident to make false allegations.</p> <p>4. Resident #12 ' s Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/28/2025, identified resident to have a Brief Interview for Mental Status of 14, which indicated Resident #12 had intact cognition.</p> <p>5. Resident #12 ' s Physician Orders dated 4/1/2025 thru 5/31/2025 identifies resident to have diagnoses of Parkinsons disease, chronic pain, anxiety disorder, atrial fibrillation, overactive bladder, depression, vitamin D deficiency, dementia.</p> <p>6. During an interview on 04/24/25 at 7:33 AM, Resident #12 reported some girl beat the (explicit) out of me. Her name was something simple like [Certified Nurse Assistant (CNA) #2]. I told someone and [Registered Nurse (RN) #4] said she would not be in my room anymore.</p> <p>a. On 04/24/25 at 8:01 AM, Registered Nurse (RN) #4 stated it was Resident #12 ' s preference CNA #2 did not return to Resident #12 ' s room because she was rough. RN #4 said she instructed CNA #2 not to go back into Resident #12 ' s room and she had reassigned CNA #2 to work on another hallway. RN #4 stated she reported the incident to the ADON because the DON was not working at the time. During a follow-up interview on 5/19/2025 at 3:52 PM, RN #4 said the incident happened on April 10, 2025.</p> <p>b. During record review of a Nurse ' s Note 7-3 PRN, dated 04/10/2025, RN #4 documented Resident #12 was alert and orientated to person, place and time. Resident #12 was able to voice their needs. Resident transferred per staff with a sit to stand lift, was mobile in a wheelchair, propelled by staff, preferred meals in room their room, fed self, and had a fair appetite. The record does not contain a body audit or a resident interview concerning the report of the allegation.</p> <p>c. During an interview on 05/19/2025 at 3:52 PM, RN #4 stated she reported the incident to her superior, the ADON. RN #4 stated she did not feel like due diligence was done. RN #4 stated she interviewed staff and other residents, since no one had a problem, she allowed CNA #2 to continue work. She stated she was not the abuse coordinator; she would let a superior complete them. It should have been brought to the Administrator and DON attention. The facility did not have any record of the investigation; there was not a body audit or assessment documented in the medical record.</p> <p>d. During an interview on 04/24/2025, at 9:09 AM, the ADON said Resident #12 stated CNA #2 got rough with Resident #12. The ADON stated she did not complete any paperwork because she was not at the facility. The ADON said she reported the allegation to the Administrator and DON the following day. The ADON said if a resident said staff had been rough with them, staff needed to do a body audit to make sure the resident don ' t have something wrong with them and the roughness didn ' t cause a problem. The ADON said she did not know if the allegation was investigated and she did not do a body audit, and one should have been conducted to make sure they don ' t have something wrong with them and the roughness didn ' t cause a problem</p> <p>e. A review of the facility ' s OLTC Incident and Accident Report (Form 7734) revealed the investigation was completed on 04/24/2025, fourteen days after the allegation on 04/10/2025.</p> <p>7. During an interview on 04/24/2025 at 9:30 AM, the Certified Nursing Assistant Supervisor (CNA Supervisor) stated, she was unfamiliar with the incident involving Resident #12 and CNA #2 but was</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>aware of an incident involving Resident #12 and CNA #13. The CNA Supervisor removed CNA #13 from working with Resident #12 following an allegation of CNA #13 being rough with Resident #12. CNA #13 was reassigned by the CNA Supervisor to work another hall, allowing her to work with other residents the same day. The CNA Supervisor said Resident #12 did not want the CNA Supervisor to tell anyone the CNA had been rough with Resident #12. The CNA Supervisor said she did not know if she ever reported to her supervisor about the incident involving CNA #13. The CNA Supervisor stated Resident #12 was a [NAME] about us telling what (Resident #12) has said because (Resident #12) feels somebody will be mean. The CNA Supervisor said CNA #13 should have been written up and the nurse should have investigated. CNA Supervisor stated, I don ' t think I wrote her up, I think I just moved her off that hall. This allegation was not investigated or reported to the appropriate authorities or the State Agency/OLTC.</p> <p>8. On 05/19/2025 at 2:15 PM, the Administrator provided a two-page investigation of the incident involving CNA #13 and Resident #12. One page was a statement made by the CNA Supervisor which stated CNA #13 had been rough with Resident #12. The other half of the page was a written statement by the Administrator stating Resident #12 did not remember anything about this and no CNAs had witnessed any abuse or roughness with the conclusion that no injury was noted. The second page of the record was an Employee Warning Record stating Verbally in-serviced (CNA #13) on not being rough with residents. (CNA #13) was told to not go into the room with (Resident #12) and she denied being rough. She was moved to North Hall but was told if she had to work East to not go in (Resident #12) room. The Administrator stated she had not reported this allegation or had any other documentation regarding this incident. The Administrator said she had not reported the allegation of abuse to the mandatory authorities. The Administrator said the two pages she had given the surveyors were the full report she had done in this investigation. This had not been thoroughly investigated or reported to any authorities or the State Agency/OLTC. There was no body audit or Nurse assessment completed for Resident #12.</p> <p>9. On 05/19/2025 at 4:16 PM, during an interview on 05/19/2025 at 4:16 PM the DON stated the ADON is who the staff reported incidents to when the DON was not in the building, but the ADON could have called her at any time. Resident #12 had never made any abuse accusation before, and accusation should be investigated when the report is made. The DON stated she goes to the source of the accusations, the staff being accused, and everyone including kitchen staff, CNAs, Nurses. The first step is to make sure the resident is ok. Separate the accused, they should go home until the investigation is done. The DON stated she usually does the reportables, but the ADON had a login. She used to be the DON here so she would have known the time frames. The DON stated ADON was one of the staff who have access to the State Reporting system and could have input the allegation of abuse.</p> <p>10. On 05/19/2025, at 4:55 PM, the Administrator stated the facility did not have an abuse coordinator, but the highest-ranking person in the building was responsible for the investigation.</p> <p>11. A review of the facility ' s undated Resident Rights document revealed, Each and every resident in this facility has the right to: #12. Be free of verbal, mental, physical, and sexual abuse.</p> <p>Onsite Verification:</p> <p>The IJ was removed on 05/22/2025 at 11:00 AM, after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 05/22/2025 at 8:15 AM with no negative findings regarding the Removal Plan. The survey team verified the Plan of Removal in reviewing the facility in-service training for all staff on reporting abuse and neglect to the Administrator, the DON and Office of Long-Term Care, ensuring all incidents are reported</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>properly and to ensure resident ' s safety. Of the Fifty-five residents currently residing in the facility forty-three residents were interviewed and the eleven residents were interviewed regarding abuse, and resident ' s unable to verbalize abuse received body audits. One resident was out of the facility. The DON had been appointed to monitor, investigate and report allegations of abuse and the monitoring tool for documenting and reporting of allegations began on 05/20/2025. The DON was appointed as the Abuse and Neglect Coordinator with all corrections completed on 05/21/2025. A total of ten staff interviews were conducted with staff from all shifts to verify training had been completed. The staff interviewed included the Housekeeping Supervisor, a Housekeeper, a laundry worker, a Nursing Assistant, a Dietary cook, a Medication Assistant Coordinator, a Certified Nursing Assistant, a Licensed Practical Nurse, the Administrator and the Director of Nursing. The staff interviewed verified they had been trained on reporting of abuse. A review of in-service sheets provided indicated sixty-four of seventy-eight employees had been provided training. One staff member was in the hospital and the others are not allowed to return to work until they have been trained.</p>		