STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045379	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Bluff Transitional Care	6810 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews, record review, and facility policy review, the facility failed to ensure residents on the secure unit were free from abuse and failed to develop and implement an effective plan to ensure a resident (Resident #6), with a history of aggressive behaviors, did not initiate altercations with other residents on the secure unit. This resulted in multiple altercations, putting all residents on the secure unit at risk for serious harm, serious injury, serious impairment, or death. The Immediate Jeopardy (IJ) began on 04/09/2025 at 07:15 PM, when it was discovered that Resident #6 did not have adequate measures or interventions in place to protect the other residents on the secure unit from altercations. The IJ template was presented to the Administrator on 04/09/2025 at 07:15 PM by the survey team. The findings are: 1) Resident #6's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 02/16/2025 had Staff Assessment for Mental Status (SAMS) with a score of 3, indicating resident was severely mentally impaired. Other diagnoses on the MDS included seizure disorder or epilepsy, traumatic brain injury, psychotic disorder, and schizophrenia. In addition, the MDS had a score of 3 on the Behavioral Symptoms assessment (E0200), indicating Resident #6 exhibited daily physical behavioral symptoms (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and a wandering score of 3 (E0900), indicating the wandering behavior occurred daily. 2) A review of Resident #6's records indicated the following incidents: a. Per an Incident Note on 10/27/2024 at 06:43 PM, Resident #6 initiated an altercation by hitting an unknown resident and knocking them down in the hallway on the secure unit. Resident #6 was placed on 1:1 monitoring in Resident #6's room with a Certified Nurse ' s Aide (CNA). The Administrator, APRN (Advanced Practice Registered Nurse), and DON (Director of Nursing) notified - and no other interventions documented. There was no documentation of an assessment and status for the recipient of the altercation. b. Per an Incident and Accident report completed 12/29/2024 at 09:45 AM, Resident #6 initiated an altercation on an unknown resident by hitting them on the back of the right shoulder, while in the hallway of the secure unit. No interventions were documented. No notification to the provider was noted. No documentation of an assessment and status for the recipient of the altercation. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Per an Incident and Accident report completed 02/26/2025 at 04:33 AM, Resident #6 initiated an altercation by wandering into Resident #13's room and hitting Resident #13. The location on the resident's body, where Resident #13 was hit, was not disclosed in the medical record. Resident #6 was assisted to Resident #6's room and was offered fluid/snacks and the television turned on to soft music. There was no documentation to indicate the provider was contacted. d. Per an Incident and Accident report 03/04/2025 at 12:00 PM, Resident #6 initiated an altercation by wandering into Resident #12's room and jumping on Resident #12 while in bed. Resident #6 was assisted to Resident #6's room. The resident's Progress Note indicated the resident was started on a new medication for aggressive behavior. 3) On 04/07/2025 at 11:30 AM, Resident #6 was observed wandering into Resident #20's room. Resident #20 was backing up and reaching out to grab Resident #6's wrist as Resident #6 was approaching. CNA #3 was notified to intervene. The CNA indicated that when an aide was working alone on the secure unit and must provide personal care/hygiene to another resident, privacy must be provided by closing the door and pulling the curtain. The result was Resident #6 being left unattended. 4) During an interview on 04/09/2025 at 02:00 PM, CNA #4 indicated that if the survey staff saw Resident #6 you may want to duck, because of Resident #6's potential to hit others. CNA #4 also claimed to have witnessed Resident #6 hit another resident and staff member in December 2024. 5) On 04/09/2025, after concluding the interview with CNA #4 referenced above, Resident #6 was observed to wander into a resident's room that did not have Resident #6's name on the placard. 6) A review of the document titled Protection of Residents During Abuse Investigation, revised April 2017, stated that if the alleged abuse involves another resident, the Attending Physician will be informed of the alleged abuse incident. There was no notification to the provider in Resident #6's medical record for the occurrence of 12/29/2024 and 02/26/2025. 7) A review of the document titled Resident-to-Resident Altercations, revised December 2016, stated if two residents are involved in an altercation, staff will document in the resident's clinical record all interventions and their effectiveness. No interventions were listed for the occurrence on 12/29/2024. 8) During an interview on 04/16/2025 at 09:45 AM, CNA #1 described Resident #6's behaviors to include tantrums, approaching other residents and staff with unpredictable intentions, hitting others and wandering into other residents' rooms. 9) During an interview on 04/16/2025 at 10:10 AM, Licensed Practical Nurse (LPN) #2 for the secure unit, described Resident #6's behaviors as including hitting, elbowing, kicking, and yelling. LPN #2 was able to recall a recent incident on 04/08/2025 where the resident elbowed the night shift nurse in the face. LPN #2 indicated Resident #6 had a recent altercation with Resident #20 on 03/20/2025 at 01:54 PM. LPN #2 stated the resident was redirected by staff offering snacks. LPN #2 stated to have worked in the secure unit for about two months. LPN #2 also stated they notified the provider after each altercation initially. However, during the month of March 2025, the provider instructed LPN #2 to not call for each incident and instead make a note in the medical record and use standing orders. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	10) On 04/16/2025 at 02:45 PM, LPN #2 provided a copy of the Standing Orders reference above, dated October 8, 2024. After a review of the orders, no medications or interventions included addressed agitation or aggression. 11) During an interview on 04/16/2025 at 03:45 PM, the DON verified that there was no notification to the provider regarding the incident on 12/29/2024 with Resident #6 and no interventions listed. The DON indicated that it would be important to notify the provider with aggressive episodes because ultimately the physician was responsible for the medication and the follow-ups with the regimens for treatment. 12) During an interview with the Administrator on 04/17/2025 at 02:37 PM, it was indicated that process after Resident-to-Resident altercations included contacting the attending physician or primary care provider because they need to rule out signs/symptoms of a head injury, brain bleed, fracture(s), and decide if the behaviors determine the resident needs to be sent out of the facility for treatment. 13) During an interview with the Medical Director on 04/16/2025 at 05:15 PM, it was indicated that Resident #6 needed a Behavioral Health evaluation. It was originally entered by the provider on 01/28/2025, but because of leadership turnover, staff, and resources, it had not occurred. The Medical Director verified that instructions had been given to staff to make a note regarding the resident's behavior to be reviewed at a later date by the provider, after a Resident-to-Resident altercation. Removal Plan Onsite Verification: Onsite verification of the Removal Plan began on 04/17/2025, after the Plan of Removal was approved. The IJ was removed on 04/18/2025 at 01:45 PM after the survey team performed onsite verification and validated that the Removal Plan had been implemented, after a review of the evidence listed below. On 04/10/2025 an in-service was initiated for direct and indirect approaches for appropriate care/interventions with Resident #6 and other residents in the secure unit. On 04/17/2025 at 05:00 PM CNAs #10 and #11 were interviewed and indicated that they had received the in-service information, and demonstrated they were documenting behaviors of Resident #6. It was also verified that Resident #6 was on 1:1 observation with a CNA when he was awake and out of the bed by observation and interview with CNAs #10 and #11. On 04/17/2025 documentation was provided that indicated the Social Worker offered the cognitive resident on the secure unit to move, but the resident declined. On 04/17/2025 documentation was provided that indicated the Social Worker contacted the resident representatives of the residents on the secure unit, that were not cognitively intact. Two resident representatives agreed to have the resident moved to another location outside of the secure unit. On 04/17/2025 documentation was provided to demonstrate the CNA staff members were documenting any verbal/physical aggression behaviors or other behaviors including pacing, fidgeting, and withdrawal - and alerting the change nurse of the behaviors. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/17/2025 documentation was provided that a Behavior Management and Impulse Control in-service was completed. On 04/17/2025 documentation was provided that indicated an Interdisciplinary Team (IDT) meeting was held to determine the facility was not to place additional residents on the secure unit. On 04/17/2025 documentation was provided for the weekly behavioral meetings implemented by the IDT. On 04/17/2025 documentation was provided for body audits that were completed on 04/16/2025 for the secure unit residents provided. 0n 04/17/2025 psychosocial assessments for the Secure unit provided. On 04/17/2025 an activity calendar was provided.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, record review, and interview, the facility failed to report to the State Survey Agency an elopement for 1 (Resident #3) of 3 sample residents reviewed for elopement risk and failed to report altercations between residents that resulted in injury or had the potential to result in injury for 4 (Resident #1, #6, #12, #13) of 7 sample residents reviewed for abuse. The findings are: 1. A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/21/2025, indicated Resident #1 had a diagnosis of non-Alzheimer's dementia, anxiety disorder, and psychotic disorder, score of 3 (indicating severe impairment) on the Staff Interview for Mental Status (SAMS), and had physical behavior symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, or grabbing.) a. A review of the Care Plan with a revision date of 12/17/2024, indicated Resident #1 had the potential to be physically aggressive related to dementia and history of combativeness. The goal of the resident's care was the resident would not harm self or others. b. A review of an Incident Audit Report dated 12/17/2024 at 6:50 PM, indicated Resident #1 was standing in the hallway against the wall when another resident punched Resident #1 in the face. The report indicated Resident #1 was placed in a room and assessed. A body audit revealed the resident had a busted lip that resulted from the incident. c. On 04/07/2025 at 11:50AM, Resident #1 was sitting on the bed in their room. The resident was able to respond to name but did not answer any other questions. d. During an interview on 04/08/2025 at 1:30 PM, the Administrator indicated that she would have to look at the incident involving Resident #1 on 12/17/24, to determine who the other resident was that was involved. e. During an interview on 04/08/25 at 3:50 PM, the Administrator stated that she had identified the other resident involved in the incident on 12/17/2025, with Resident #1. The Administrator stated there was an incident report for that date on another resident that occurred about the same time. The Administrator stated the incident between the two residents was not reported to the state agency. f. A review of a policy titled Abuse Investigating and Reporting revised July 2017, indicated all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injury of unknown source (abuse) shall be reported immediately but no later than 2 hours if the allegation is abuse to local, state, federal agencies (as indicated by current regulations). g. A review of the policy Resident-to-Resident Altercations revision December 2016, indicated resident-to-resident altercations shall be reported to the Administrator and reported incidents, findings and corrective measures reported to appropriate agencies as outlined in the facilities abuse reporting policy. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of the quarterly MDS with an ARD of 03/14/2025, revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. Resident #3 had delusional behaviors, a potential indicator for psychosis. a. A review of the Care Plan Report revision date 02/03/2025, revealed Resident #3 was identified to be at risk for wandering/elopement. Resident #3 ' s Care Plan Report revision date 12/24/2024, revealed Resident #3 was at risk for behavior problems related to unspecified dementia and moderate agitation. b. A review of the Elopement Risk Evaluation dated 04/07/2025, revealed that Resident #3 had a history of attempting to leave the facility without informing staff and a history of wandering. c. According to a Behavior Note dated 04/04/2025 at 9:22 PM, Resident #3 got upset and exited the facility. Due to Resident #3 ' s wander guard, the automatic door locked, but the resident was able to pull the door apart. Resident #3 was accompanied by a staff member upon exiting the facility, and there was a second staff member outside of the facility. The two staff members walked with Resident #3 in the parking lot trying to encourage Resident #3 to come back into the facility, but Resident #3 did not comply. Resident #3 was able to get away from the two staff members and enter the woods. d. According to a Behavior Note dated 04/05/2025 at 6:48 AM, Resident #3 exited the facility and was off the facility's premises. Law enforcement was called to help with search for Resident #3 requiring the assistance of search dogs. Resident #3 was located by the dogs sitting on the patio chair between the facility, and the assisted living facility next door. e. On 04/08/25 at 1:45 PM, during an interview, Registered Nurse (RN) #7 stated Resident #3 had gotten upset, pulled the doors open, and exited the facility. The van driver and RN #7 were walking with Resident #3 until the resident broke away and proceeded into the woods. The facility was informed by the Police Department not to enter the woods behind the resident, because it would throw off the scent trail for the dogs. f. On 04/18/25 at 11:00 AM, during an interview, the Administrator voiced that the incident that occurred on 04/04/25 involving Resident #3 was not reported to the state. 3. Resident #6's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/16/2025, indicated the resident had a Staff Assessment for Mental Status (SAMS) with a score of 3, indicating Resident #6 was severely mentally impaired. Other diagnoses on the MDS included seizure disorder or epilepsy, traumatic brain injury, psychotic disorder, and schizophrenia. The MDS indicated the resident had a score of 3 on the Behavioral Symptoms assessment, indicating Resident #3 daily exhibited behaviors of physical behavioral symptoms (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and a Wandering score of 3, indicating that wandering behavior occurred daily. 4. Resident #12's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/06/2025, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 5, indicating Resident #12 was severely cognitively impaired. Other diagnoses and conditions listed included delusions, non-Alzheimer's dementia, and muscle weakness. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Resident #13's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/27/2025, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating Resident #13 was cognitively intact. 6. A review of the following records revealed the following incidents. a. The Incident Note on 10/27/2024 at 6:43 PM, indicated Resident #6 initiated an altercation by hitting an unknown resident and knocking them down in the hallway on the secure unit. No injuries recorded. b. The Incident and Accident report (I&A) for 12/29/2024 at 9:45 AM, indicated Resident #6 initiated an altercation on an unknown resident by hitting them on the back of the right shoulder, in the hall. No injuries recorded. c. The I&A report for 02/26/2025 at 4:33 AM, indicated Resident #6 initiated an altercation by wandering into Resident #13's room and hitting Resident #13. The location on the resident's body, where Resident #13 was hit was not disclosed in the record. No injuries recorded. d. The I&A report for 03/04/2025 at 12:00 PM, indicated Resident #6 initiated an altercation by wandering into Resident #12's room and jumping on Resident #12 while in bed. No injuries recorded. e. The resident-to-resident altercations listed above were not reported to the State Survey Agency. f. A review of a policy titled Resident-to-Resident Altercations, revised December 2016, stated report incidents, findings, and corrective measure to appropriate agencies as outlined in our facility's abuse reporting policy. g. During an interview on 04/17/2025 at 2:37 PM, the Administrator indicated that a Facility-Reportable Incident (FRI) would include any incidence of resident-to-resident verbal or physical altercation and would be reported to the State Survey Agency. h. During the Exit conference on 04/18/2025 at 1:30 PM, the facility was given the opportunity to provide additional documentation - none was provided.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure that physician's orders for wound care were followed for 2 (Resident #17, Resident #18) of 2 sampled residents reviewed for facility acquired pressure ulcer/injuries. The findings include: 1. A review of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/03/2025, revealed Resident #17 had a Brief Interview of Mental Status (BIMS) score of 10 which indicated moderate impaired cognition. Resident #17 was at risk for developing a pressure ulcer/injury, but Resident #17 did not currently have one or more unhealed pressure ulcer/injuries. a. A review of the Care Plan Report revision date 01/30/2024, revealed Resident #17 had diabetes mellitus type 2 with interventions to inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness. b. A review of the most recent Skin Only Evaluation dated 03/06/2025, revealed Resident #17 did not have current skin issues. c. A review of the Visit Note from the Family Medicine Podiatry encounter date 04/10/2025, indicated ulcer #1 was noted to left great toe, wound measured 1.5 centimeters (cm) in length, 1.5 cm in width, and 0.5 cm in depth and was a [NAME] stage 3 pressure ulcer, meaning it displayed full thickness tissue loss with involvement of tendon, ligaments, joints, and even bone. Escar (dying tissue) was absent, and slough (yellow grainy tissue) was present in the wound. d. A review of the Order Summary Report revealed there was an order which indicated monitor right great toe for intact dressing and sign/symptoms of infection. Notify treatment nurse if here of the need for new dressing or apply a new dressing. See TAR for orders. Every day and night shift related to pressure ulcer of other site, stage 4. e. A review of the Treatment Administration Record (TAR) revealed an order which indicated cleanse right great toe with normal saline, pay dry, apply betadine, apply dry dressing and tape; apply clean sock to help keep dressing in place. Every day shift for wound care until 04/14/2025 11:59 PM, start date 04/12/2025 at 700 AM. There was no indication that any dress changes had been completed. This surveyor noted that the Skin Only Evaluation prior to October indicated Resident #17 had an open area on the left great toe not the right. f. On 04/14/2025 at 12:50 PM, this surveyor observed Resident #17 sitting in wheelchair in room eating noon meal. This surveyor noted Resident #17 had a black shoe on the right foot and a yellow sock on the left foot. The dressing to the left foot was visible through the yellow sock. g. On 04/14/2025 at 12:51 PM, during an interview with Resident #17 the resident stated, there was an open wound on the foot, because someone stepped on the foot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	h. On 04/17/25 at 4:00 PM, during an interview Medication Administration Certified (MAC) #5 expressed that the facility's staff documented wound care orders on the TAR after completion, but if it was not documented on the TAR, it was likely not done. MAC #5 indicated that Skin Only Evaluations were completed weekly by a nurse on every resident regardless of the presence or absence of a wound. MAC #5 confirmed after record review that there were no signed completions on the TAR for Resident #17 since the order was entered on 4/11/25, and the most recent Skin Only Assessment was completed on 03/06/2025. 2. A review of the annual MDS with an ARD of 12/17/2024, revealed that Resident #18 had a BIMS score of 11, indicating moderately impaired cognition. Resident #18 was at risk for developing pressure ulcer/injuries, and Resident #18 had two stage 4 pressure ulcers. a. A review of the Care Plan Report Revised 03/27/2025, revealed that Resident #18 had actual pressure sores, a stage 4 to the right scrotum fold and stage 4 to scrum-coccyx area. b. A review of the March TAR revealed that there was an order which indicated Stage 4 to sacrum - coccyx area and scrotum: Clean with wound cleanser, pat dry with 4x4, apply calcium alginate to rule slough out of wound. Cover with silicone dressing every day apply abdominal pad and secure with tape every day shift. This surveyor noted 16 of 31 days signed as completed. c. A review of the April TAR , print date 04/14/2025, revealed there was an order which indicated Stage 4 to sacrum - coccyx area and scrotum: Clean with wound cleanser, pat dry with 4x4 apply calcium alginate to rule sloth out of wound. Cover with silicone dressing every day apply abdominal pad and secure with tape every day shift. This surveyor noted 7 of 14 days signed as completed. d. On 04/17/2025 at 4:20 PM, during an interview, Registered Nurse (RN) #6 expressed that the facility's staff documented wound care orders on the TAR after completion, but if it was not documented on the TAR, it was likely not done. RN #6 signified that Skin Only Evaluations were completed weekly by the treatment nurse if she is available, if not the floor nurse assigned the resident was responsible. According to RN #6 Resident #18 had treatment orders to be completed daily. After review of the TAR, RN #6 stated the treatments were not completed daily as ordered per the physician. e. On 04/17/2025 at 4:23 PM, this surveyor requested Director of Nursing (DON) review Resident #17 ' s visit note on 04/10/2025 and examination of ulcer #1. The DON indicated the note revealed the wound had progressed to a [NAME] stage 3 pressure ulcer, meaning it displayed full thickness tissue loss with involvement of tendon, ligaments, joints, and even bone. DON stated necrosis. On 04/18/25 at 9:13 AM, during an interview the Administrator voiced that inadequate staffing was the root cause for the TAR being incomplete potentially indicating wound care was not provided and the Skin Only Evaluations were not up to date. There was no pertinent information in the policies provided by the facility to support the deficient practice.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review the facility failed to ensure entrance/exit doors to the secured unit were functioning properly to safeguard residents on the secured unit and prevent resident on the secured unit from eloping from the facility. The facility to ensure Resident #3 had a wander guard in place at all times, as part of the facility plan to safeguard the resident from eloping from the facility without staff knowledge. The facility failed to ensure Resident #3 did not elope from the facility. These findings have been determined to have resulted in Immediate Jeopardy as defined at 42 CFR §488.301. The Administrator was informed of the Immediate Jeopardy on 04/09/2025 at 11:25 AM. The facility provided a plan of removal on 04/09/2025 and was approved on 04/17/2025 at 03:05 PM. The finding include: A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference ARD date of 03/14/2025 revealed that Resident #3 had a Brief Interview for Mental Status (BIMS) score of 13, indicating the resident was cognitively intact. It also revealed Resident #3 had delusional behaviors. A review of the Care Plan Report (revision date 02/03/2025) revealed that Resident #3 was at risk for wandering/elopement. Resident #3 (revision date 12/24/2024) was at risk for behavior problems related to unspecified dementia and moderate agitation. Interventions mentioned were to identify if there are triggers for wandering/eloping, identify if there is a certain time of day wandering/elopement attempts occur, and placement of a wander guard (an electronic wander management device). A review of the Order Summary Report (start date 03/27/2025) revealed that there was a physician's order for a wander guard to be placed on Resident #3 ' s left ankle to alert staff of unassisted exits from the facility, with every day and night shift checking for placement and proper working condition. A review of the Elopement Risk Evaluation (dated 12/12/2024) revealed that Resident #3 verbally expressed the desire to go home, packed belongings to go home or stayed near an exit door, wandered, exhibited wandering behavior that was a pattern and goal-directed, and which could affect the privacy of others. Resident #3 score was 2 and categorized as being at risk for elopement. A review of the Elopement Risk Evaluation (02/04/2025) revealed that Resident #3 had a history of attempting to leave the facility without informing staff and wandering. Resident #3 score was 1 and categorized as being at risk for elopement. A review of the Elopement Risk Evaluation (04/07/2025) revealed that Resident #3 had a history of eloping/attempting to elope while at home, history attempting to leave the facility without informing staff, wandering, exhibited wandering behavior that was a pattern and goal-directed, which could affect the safety/well-being and/or privacy of others. Resident #3 score was 4 and categorized as being at risk for elopement. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Bluff Transitional Care	6810 South Hazel Street Pine Bluff, AR 71603

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to a Behavior Note dated 02/01/2025 at 6:51 PM, Resident #3 exited the facility through a window. Staff were unable to locate the resident, so 911 was called. According to a Health Status Note dated 03/20/2025 at 04:20 PM (late entry), Resident #3 exited the front door, never leaving the sight of the nurse. Staff were able to encourage the resident to come back into the facility. According to a Behavior Note date 03/23/2025 at 03:45 PM, Resident #3 exited the facility and three nurse went after the resident. Resident #3 refused to enter the facility after encouragement. Resident #3 was administered an antianxiety medication, after which Resident #3 re-entered the facility. Resident #3 stated to staff, I am getting out of here. According to a Social Services note dated 03/26/2025 at 08:34 AM, Resident #3 was walking outside with Social Services and Resident #3 mentioned hitting the woods so that no could find. According to a Social Services note dated 03/28/2025 at 07:28 AM, Resident #3 was moved off the secured unit to room [ROOM NUMBER] bed B, because of the dislike to go on the secured unit to go to bed. According to a Behavior Note date 04/05/2025 at 06:48am Resident #3 exited the facility and was off the facility's premises. Law enforcement was called to help with search for Resident #3 requiring the assistance of the dogs. Resident #3 was located by the dogs sitting on the patio chair between the facility and the assisted living facility next door. According to Administrative Note dated 04/06/2025 at 4:29 PM Resident #3 did not have a wander guard in place and had not had one in place since elopement on 04/04. Resident #3 had a wander guard in place upon exit from the facility, but the resident did not have the wander guard in place upon return. There were no wander guards available to replace the missing wander guard. On 04/07/2025 at 11:30 AM, during initial rounds the Surveyor noted a piece of white paper with gate code 0000 written on it posted next to the exit door on 300 hall. On 04/07/2025 at 12:17 PM, the Surveyor observed Resident #3 sitting in the dining room at the table alone. On 04/07/2025 at 2:40 PM, the Surveyor noted the facility had multiple potholes in parking lot that posed a fall hazard, and the facility had a large wooded area bordering the parking lot. The Surveyor noted that most of the exit doors had push until alarm sounds door can be opened in 15 seconds written in red, and the front door was double sliding glass doors that automatically opened when approached. On 04/07/2025 at 03:20 PM, the Surveyor observed the Maintenance Director complete an inspection of all the facility's door to ensure that the alarm system was functioning properly. According to the Maintenance Director, the front door is the only door that alarms when a wonder guard is near. The results of the inspections were: 1. Front Door alarmed and did not automatically open when the Maintenance Director placed a wander guard near the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The Maintenance Director pushed on the handle to the exit door near the kitchen for 15 seconds and the alarm went off. 3. The Maintenance Director pushed on the handle to exit door at the end of 500 hall for 15 seconds, the alarm went off, Maintenance Director was unable to turn the alarm off. The Maintenance Director stated, the panel needs to be replaced the alarm won ' t go off. 4. The Maintenance Director pushed on the handle to the employee exit door and the alarm went off. 5. The Maintenance Director pushed on the handle to the exit door at the end of 400 hall and the alarm did not sound at the panel. There was a faint sound coming from the nurse's station, the sound level was very low. The Maintenance Director stated we have to replace this panel too, because the alarm is not sounding at the panel, it is going off at the nurse station though. 6. The Maintenance Director pushed on the handle to the exit door at the end of 300 hall and the alarm went off. The Surveyor asked the Maintenance Director about the piece of white paper posted next to the 300 hall exit door. The Maintenance Director stated, oh that's the gate code. The Maintenance Director then snatched the paper down and stated, Maybe that don't need to be up there because we do have one resident back here smart enough to read it. On 04/08/2025 at 09:30 AM, during an interview with Certified Nursing Assistant (CNA) #9 expressed that the entrance/exit door was broken by Resident #3. On 04/08/25 at 09:40 AM, the Surveyor observed Resident #3 push the entrance/exit door open and exit the secured unit. The Surveyor observed the only aide working the secured unit walk off the hall in pursuit of Resident #3. The aide returned shortly after with Resident #3. On 04/08/25 at 11:14 AM, during an interview Licensed Practical Nurse (LPN) #2 expressed that Resident #3 had escaped from the facility twice to her knowledge in the two months she has been employed with the facility. LPN #2 stated Resident #6 had opened the entrance/exit door to the secured unit about a month ago and the alarm did not sound at all. LPN #2 stated that she was able to get the resident back inside the secure unit despite the resident exhibiting aggressive behavior. LPN #2 stated the facility leadership was informed that the door was not functioning properly. LPN #2 voiced that there was a white piece of paper posted next to the exit door at the end of 300 hall and the gate code was written on it. LPN #2 confirmed that the piece of paper had been posted there since her hire date. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 04/08/2025 at 11:48 AM, during an interview the Maintenance Director expressed that after Resident #3 went out the window in February they screwed the windows down far enough to allow ventilation, (but not egress). There were magnetic alarms placed on all windows in the secured unit. The Maintenance Director stated he did not know who posted the gate code next to the exit door, but he informed the other maintenance personnel that staff would have to remember the code it could not be posted. The Maintenance Director stated that he was unsure how Resident #3 was able to get out the sliding automatic door at the front with the wander guard in place. He assumed that Resident #3 pulled the doors apart. The Maintenance Director stated that Resident #3 was able to get off the secured unit today, because Resident #3 broke the doors over the weekend. The Maintenance Director stated that he has been in contact with someone about repairs to the door, but at this time the doors are not functioning properly. The Maintenance Director stated that he was under the impression that someone would be monitoring the doors until repair were made but confirmed that there was no one monitoring the doors at the time of interview. The surveyor video recorded the Maintenance Director opening the entrance/exit doors to the secured unit to show the malfunction. On 04/08/25 at O1:05 PM, during an interview Resident #3 voiced history of hearing issues, but verbalized the ability to read. Resident #3 stated they had eloped from the facility twice, one time through the window and another into the woods. On 04/08/25 at 01:45 PM, during an interview with Registered Nurse #7 stated Resident #3 had gotten upset, pulled the doors open, and exited the facility. The van driver and I were walking with him until the resident snatched away and proceeded into the woods. We were instructed by the Police Department not to enter the woods behind the resident, because it would throw off the scent trail for the dogs. RN #7 stated Resident #3 had a history of elopement, but for some reason someone thought it was a good idea to move the resident off the secured unit. RN #7 stated we have complained about the resident's behavior so many times, but the behaviors were rewarded with moving the resident to the 400 hall. On 04/09/25 at 08:35 AM, during an interview the Administrator stated honestly the facility did not have an effective intervention in place to prevent Resident #3 from eloping from the facility. There was no pertinent information in the policy provided to support the deficient practice. The IJ was removed on 04/18/2025 at 02:00 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 04/17/2025, when elopement risk interventions were not implemented to safeguard the residents on the secured unit and prevent the elopement of Resident #3. 1. On 04/17/2025 the survey team verified that the facility had completed every 15 minutes rounds on the door to the secured unit. The documentation noted the 15 minutes rounds began on 04/08/2025 at 10:30 and ended on 04/11/2025 at 03:15 PM. 2. On 04/17/2025 the survey team verified there were repairs done to the doors on the secured unit. 3. On 04/17/2025 the survey team verified that 30 minutes round were completed on Resident #3. The documentation noted the 30 minutes were completed on 04/08/2025 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4. On 04/18/2025 the survey team verified in- services were completed for behaviors and elopement. The documentation noted that the in-service for behavior was completed on 04/17/2025 and the in-service for elopement was completed 04/11/2025, 04/15/2025. 5. On 04/18/2025 the survey team verified that the wander guard check was added to the controlled medication log. The documentation noted it was added on 04/16/2025. 6. On 04/18/2025 the survey team verified that the 300 hall secured unit door check was added to the controlled medication log to check function every shift. The documentation noted it was added to the controlled medication log on 04/10/2025. 7. On 04/18/2025 the survey team check to verify that elopement risk assessment were completed on all residents in the secured unit. The documentation noted that this was completed on 04/16/2025.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interviews, record review, and facility policy review the facility failed to ensure that the facility was sufficiently staffed to ensure residents residing in the facility received quality of care. This failed practice had the potential to affect every resident residing in the facility. The finding include: A review of the facility assessment and after an interview with the Administrator it was brought to our attention that the facility staff plan was for a full-time Director of Nursing (DON) and Assistant Director of Nursing (ADON), 2-3 charge nurses for each shift LPN/RN, 15 staff members on the day shift 7a-3p, 9 Certified Nursing Assistants only on the evening shift, and 8 staff members on the night shift. A review of the Daily Staffing Log for 01/04/2025 indicated that the facility had a census of 67 with 10 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 9.5 staff members during these hours. A review of the Daily Staffing Log for 01/04/2025 indicated that the facility had a census of 67 with 10 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 5 aides, during these hours. A review of the Daily Staffing Log for 01/04/2025 indicated that the facility had a census of 67 of with 8 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 7 staff members, which included 5 aides, during these hours. A review of the Daily Staffing Log for 01/04/2025 indicated that the facility had a census of 67 of with 5 staff members for the hours 11 PM-7 AM. Which was an accurate number. A review of the Daily Staffing Log for 01/05/2025, indicated that the facility had a census of 67 with 10 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 8 members during these hours. A review of the Daily Staffing Log for 01/05/2025 indicated that the facility had census of 67 with 6 staff members, which included 3 aides, for the hours 3 PM-7 PM. Which was accurate. A review of the Daily Staffing Log for 01/05/2025, indicated that the facility had a census of 67 with 5 staff members for the hours 7 PM-11 PM, which included four (4) aides, one (1) aide from agency that came in at 7pm. However, after a review of the time sheet provided, it was indicated there were 6 staff members during these hours. A review of the Daily Staffing Log for 01/05/2025, indicated that the facility had a census of 67 with 4 staff members for the hours 11 PM-7 AM. However, after a review of the time sheet provided, it was indicated there were 4.5 staff members during these hours. A review of the Daily Staffing Log for 01/11/2025 indicated that the facility had a census of 64 with 10 staff members for the hours 7 AM-3 PM which was accurate. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Daily Staffing Log for 01/11/2025 indicated that the facility had a census of 64 with 11 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members, which included 5 aides, during these hours. A review of the Daily Staffing Log for 01/11/2025 indicated that the facility had a census of 64 with 11 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8.5 staff members, which included one agency nurse and 5 aides, 6 total, aide came in after 9 PM, during these hours. A review of the Daily Staffing Log for 01/11/2025 indicated that the facility had a census of 64 with 8 staff members which included one agency nurse, for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 01/12/2025 indicated that the facility had a census of 67 with 10 staff members for the hours 7 AM-3 PM, which was accurate. A review of the Daily Staffing Log for 01/12/2025 indicated that the facility had a census of 67 with 11 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 01/12/2025 indicated that the facility had a census of 67 with 11 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 7 aides, one aide came in at 7pm, during these hours. A review of the Daily Staffing Log for 01/12/2025, indicated that the facility had a census of 67 with 7 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 01/18/2025 indicated that the facility had a census of 67 with 13 staff members for the hours 7 AM-3 PM, which was accurate. A review of the Daily Staffing Log for 01/18/2025 indicated that the facility had a census of 67 with 14 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 12 staff members, which included 7 aides, during these hours. A review of the Daily Staffing Log for 01/18/2025 indicated that the facility had a census of 67 with 14 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 10 staff members, which included 7 aides, during these hours. A review of the Daily Staffing Log for 01/18/2025, indicated that the facility had a census of 67 with 8 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 01/19/2025 indicated that the facility had a census of 67 with 13 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 11 staff members during these hours. A review of the Daily Staffing Log for 01/19/2025 indicated that the facility had a census of 67 with 11 staff members, which included 6 aides for the hours 3 PM-7 PM, which was accurate. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Daily Staffing Log for 01/19/2025 indicated that the facility had a census of 67 with 11 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members, which include 6 aides, during these hours. A review of the Daily Staffing Log for 01/19/2025, indicated that the facility had a census of 67 with 5 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 01/25/2025 indicated that the facility had a census of 68 with 12 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 10.25 staff members during these hours. A review of the Daily Staffing Log for 01/25/2025 indicated that the facility had a census of 68 with 4 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 01/25/2025 indicated that the facility had a census of 68 of with 4 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, they indicated there were 9 staff members which included 7aides, one aide came in at 7pm, during these hours. A review of the Daily Staffing Log for 01/25/2025, indicated that the facility had a census of 68 with 5 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 01/26/2025 indicated that the facility had a census of 67 with 12 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 11 staff members during these hours. A review of the Daily Staffing Log for 01/26/2025 indicated that the facility had a census of 67 with 10 staff members, which included 6 aides, for the hours 3 PM-7 PM, which was accurate. A review of the Daily Staffing Log for 01/26/2025 indicated that the facility had a census of 67 with 10 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 01/26/2025 indicated that the facility had a census of 67 with 7 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 02/01/2025 indicated that the facility had a census of 67 with 13 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 9.25 staff members during these hours. A review of the Daily Staffing Log for 02/01/2025 indicated that the facility had a census of 67 with 13 after a review of the hours 3p-7 PM. However, after review sheet provided, it was indicated there were 10 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 02/01/2025 indicated that the facility had a census of 67 with 13 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8.25 staff members, which included 6 aides, during these hours. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Daily Staffing Log for 02/01/2025 indicated that the facility had a census of 67 with 5 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 02/02/2025 indicated that the facility had a census of 68 with 11 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 12 staff members during these hours. A review of the Daily Staffing Log for 02/02/2025 indicated that the facility had a census of 68 with 11 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 8.25 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 02/02/2025 indicated that the facility had a census of 68 with 11 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 02/02/2025, indicated that the facility had a census of 68 with 7 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 02/08/2025, indicated that the facility had a census of 67 with 11 staff members for the hours 7 AM-3 PM, which was accurate. A review of the Daily Staffing Log for 02/08/2025 indicated that the facility had a census of 67 with 10 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members, which included 5 aides during these hours. A review of the Daily Staffing Log for 02/08/2025 indicated that the facility had a census of 67 with 10 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members which included 6 aides, one came in at 7 PM, during these hours. A review of the Daily Staffing Log for 02/08/2025, indicated that the facility had a census of 67 with 5 staff members for the hours 11 PM-7 AM. However, after a review of the time sheet provided, it was indicated there were 6 staff members during these hours. A review of the Daily Staffing Log for 02/09/2025, indicated that the facility had a census of 67 with 14 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 11 staff members during these hours. A review of the Daily Staffing Log for 02/09/2025, indicated that the facility had a census of 67 with 10 staff members which included 6 aides, for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 02/09/2025 indicated that the facility had a census of 67 with 10 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members which included 7 aides, one aide came in at 7 PM and 1 nurse stayed until 11 PM, during these hours. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Daily Staffing Log for 02/09/2025 indicated that the facility had a census of 67 with 5 staff members for the hours 11 PM-7 AM. However, after a review of the time sheet provided, it was indicated there were 4.5 staff members during these hours. A review of the Daily Staffing Log for 02/15/2025 indicated that the facility had a census of 62 with 14 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 11 staff members during these hours. A review of the Daily Staffing Log for 02/15/2025 indicated that the facility had a census of 62 with 10 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 6 aides during these hours. A review of the Daily Staffing Log for 02/15/2025, indicated that the facility had a census of 62 with 10 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 7 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 02/15/2025, indicated that the facility had a census of 62 with 6 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 02/16/2025, indicated that the facility had a census of 63 with 8 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 10 staff members, which included two (2) agency nurses, during these hours. A review of the Daily Staffing Log for 02/16/2025 indicated that the facility had a census of 63 with 6 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 02/16/2025, indicated that the facility had a census of 63 with 6 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 02/16/2025, indicated that the facility had a census of 63 with 6 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 02/22/2025 indicated that the facility had a census of 66 with 11 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 12 staff members during these hours. A review of the Daily Staffing Log for 02/22/2025, indicated that the facility had a census of 66 with 9 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members, which included 5 aides, during these hours. A review of the Daily Staffing Log for 02/22/2025 indicated that the facility had a census of 66 with 9 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members, which included 5 aides during these hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045379	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Bluff Transitional Care	6810 South Hazel Street Pine Bluff, AR 71603

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Daily Staffing Log for 02/22/2025, indicated that the facility had a census of 66 with 4 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 02/23/2025, indicated that the facility had a census of 66 with 10 staff members for the hours 7 AM-3 PM, which was accurate. A review of the Daily Staffing Log for 02/23/2025, indicated that the facility had a census of 66 with 8 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 7 staff members, which included 4 aides, during these hours. A review of the Daily Staffing Log for 02/23/2025 indicated that the facility had a census of 66 with 8 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 7 staff members, which included 5 aides, one aide came in at 7 PM, during these hours. A review of the Daily Staffing Log for 02/23/2025 indicated that the facility had a census of 66 with 7 staff members for the hours 11 PM-7 AM. However, after a review of the time sheet provided, it was indicated there were 6 staff members during these hours A review of the Daily Staffing Log for 03/01/2025 indicated that the facility had a census unknown with 12 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 13 staff members during these hours. A review of the Daily Staffing Log for 03/01/2025 indicated that the facility had a census unknown with 10 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 03/01/2025 indicated that the facility had a census unknown with 10 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members, which included 6 aides, during these hours. A review of the Daily Staffing Log for 03/01/2025 indicated that the facility had a census unknown with 5 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 03/02/2025, indicated that the facility had a census unknown with 11 staff members for the hours 7 AM-3 PM, which was accurate. A review of the Daily Staffing Log for 03/02/2025 indicated that the facility had a census unknown with 10 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 6 aides during these hours. A review of the Daily Staffing Log for 03/02/2025 indicated that the facility had a census of 66 with 8 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 7 staff members, which included 5 aides during these hours. A review of the Daily Staffing Log for 03/02/2025 indicated that the facility had a census of 65 with 5 staff members for the hours 11 PM-7 AM, which was accurate. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Bluff Transitional Care	6810 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Daily Staffing Log for 03/08/2025, indicated that the facility had a census of 65 with 11 staff members for the hours 7 AM-3 PM, which was accurate. A review of the Daily Staffing Log for 03/08/2025 indicated that the facility had a census of 65 with 8 staff members which included 5 aides for the hours 3 PM-7 PM, which was accurate. A review of the Daily Staffing Log for 03/08/2025 indicated that the facility had a census of 65 with 8 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 5 staff members, which included 4 aides during these hours. A review of the Daily Staffing Log for 03/08/2025, indicated that the facility had a census of 65 with 7 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 03/09/2025 indicated that the facility had a census unknown with 10 staff members for the hours 7 AM-3 PM, which was accurate. A review of the Daily Staffing Log for 03/09/2025 indicated that the facility had a census unknown with 8 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 6 aides during these hours. A review of the Daily Staffing Log for 03/09/2025 indicated that the facility had a census of 65 with 8 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members, which included 5 aides during these hours. A review of the Daily Staffing Log for 03/09/2025indicated that the facility had a census of 65 with 7 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 03/15/2025 indicated that the facility had a census of 65 with 11 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 8.5 staff members during these hours. A review of the Daily Staffing Log for 03/15/2025 indicated that the facility had a census of 65 with 9 staff members which included 5 aides for the hours 3 PM-7 PM, which was accurate. A review of the Daily Staffing Log for 03/15/2025 indicated that the facility had a census of 64 with 9 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 6 aides, one aide came in at 7 PM, during these hours. A review of the Daily Staffing Log for 03/15/2025 indicated that the facility had a census of 64 with 6 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 03/16/2025 indicated that the facility had a census of 64 with 8 staff members for the hours 7 AM-3 PM, which was accurate. A review of the Daily Staffing Log for 03/16/2025 indicated that the facility had a census of 64 with 9 staff members which included 6 aides for the hours 3 PM-7 PM, which was accurate. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pine Bluff Transitional Care	6810 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Daily Staffing Log for 03/16/2025 indicated that the facility had a census of 64 with 9 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8staff members which included 6 aides, one aide came in at & PM, during these hours. A review of the Daily Staffing Log for 03/16/2025 indicated that the facility had a census of 64 with 7 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 03/22/2025 indicated that the facility had a census of 64 with 8 staff members for the hours 7 AM-3 PM, which was accurate. A review of the Daily Staffing Log for 03/22/2025 indicated that the facility had a census of 64 with 9 staff members, which included 6 aides for the hours 3 PM-7 PM, which was accurate. A review of the Daily Staffing Log for 03/22/2025, indicated that the facility had a census of 64 with 9 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 8 staff members which included 6 aides, one aide came in at 7 PM, during these hours. A review of the Daily Staffing Log for 03/22/2025 indicated that the facility had a census of 64 with 11 staff members for the hours 11 PM-7 AM, which was accurate. However, after a review of the time sheet provided, it was indicated there were 10.75 staff members during these hours. A review of the Daily Staffing Log for 03/23/2025 indicated that the facility had a census of 64 with 8 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 9.5 staff members during these hours. A review of the Daily Staffing Log for 03/23/2025 indicated that the facility had a census of 64 with 7 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 7 staff members, which included 4 aides, during these hours. A review of the Daily Staffing Log for 03/23/2025 indicated that the facility had a census of 64 with 7 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, they indicated there were 6 staff members, which included 4 aides, during these hours. A review of the Daily Staffing Log for 03/23/2025, indicated that the facility had a census of 64 with 7 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 03/29/2025 indicated that the facility had a census of 66 with 14 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 12 staff members during these hours. A review of the Daily Staffing Log for 03/29/2025, indicated that the facility had a census of 66 with 10 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 11 staff members, which included 8 aides, during these hours. (continued on next page)

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Daily Staffing Log for 03/29/2025, indicated that the facility had a census of 66 with 10 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 8 aides, during these hours. A review of the Daily Staffing Log for 03/29/2025 indicated that the facility had a census of 66 with 5 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 03/30/2025 indicated that the facility had a census of 66 with 9 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 9.5 staff members during these hours. A review of the Daily Staffing Log for 03/30/2025 indicated that the facility had a census of 66 with 12 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 10 staff members, which included 7 aides, during these hours. A review of the Daily Staffing Log for 03/30/2025, indicated that the facility had a census of 66 with 12 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 7 aides, during these hours. A review of the Daily Staffing Log for 03/30/2025 indicated that the facility had a census of 66 with 6 staff members for the hours 11 PM-7 AM, which was accurate. A review of the Daily Staffing Log for 04/06/2025 indicated that the facility had a census of 66 with 8 staff members for the hours 7 AM-3 PM. However, after a review of the time sheet provided, it was indicated there were 12 staff members during these hours. A review of the Daily Staffing Log for 04/06/2025 indicated that the facility had a census of 66 with 10 staff members for the hours 3 PM-7 PM. However, after a review of the time sheet provided, it was indicated there were 11 staff members, which included 8 aides, during these hours. A review of the Daily Staffing Log for 04/06/2025 indicated that the facility had a census of 66 with 10 staff members for the hours 7 PM-11 PM. However, after a review of the time sheet provided, it was indicated there were 9 staff members, which included 8 aides, during these hours. A review of the Daily Staffing Log for 04/06/2025 indicated that the facility had a census of 66 with 5 staff members for the hours 11 PM-7 AM, which was accurate. On 04/07/2025 at 11:30 Certified Nursing Assistant (CNA) #3 stated she was working the hall alone due to a call in. CNA #3 stated she does not provide shower when she works alone. CNA #3 stated she works alone 3-4 times a month. On 04/08/2025 at 2:30 PM, during an interview the Administrator stated, the facility did not have a Director of Nursing (DON) at the current time. According to the Administrator, the DON was expected to start on 04/09/2025. The Administrator stated, I know we just got a tag for it; I am just as frustrated as you are. According to the Administrator the facility has been without a DON since March 14, 2025. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/08/2025 at 9:30 AM, during an interview Certified Nursing Assistant (CNA) #9 stated, she was working alone on the hall, which she does often. CNA #9 stated when she was providing care there was no one on the hall to watch the other residents to ensure their safety. On 04/08/25 at 11:14 AM, during an interview Licensed Practical Nurse (LPN) #2 stated, she was responsible for working 2 halls, plus providing wound care to those residents scheduled. On 04/08/2025 at 11:48 AM, during an interview the Maintenance Director stated, he felt there should be two staff members on the secured unit at all time. On 04/09/2025 at 1:10 PM, during an interview with CNA #1 stated, she was working the hall alone. CNA #1 stated when there was one aide on the hall a bed bath can be done but not showers. CNA #1 stated, she was unable to give everyone a bed bath today that was scheduled for a shower. On 04/09/2025 at 2:20 PM, during an interview CNA #4 warned this Surveyor to be cautious due to a resident being aggressive. CNA #4 stated she was working alone and that if she was providing care to another resident, she could not ensure that the aggressive resident would not hit another resident in her absence. On 04/14/2025 at 11:45 AM, during an interview the Administrator explained the staffing plan noted on the facility assessment. The Administrator stated, I will have a full-time Director of Nursing (DON), an RN/LPN as ADON, 15 staff members on day shift, 9 on evening, and 8 on nights. The Administrator stated it was the facility plan to have one to two additional staff members in addition to the minimum. The Administrator stated the numbers listed on the facility ' s assessment were minimum staffing. On 04/18/25 at 9:13 AM, during an interview, the Administrator stated she does not feel that the facility had enough staff. The Administrator indicated that staffing was the root cause analysis to elopements, treatments not being completed, and showers not being completed. A review of policy titled Staffing , revised October 2017, indicated our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services to all residents.