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	06/16/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, interview, and facility policy review, the facility failed to ensure an allegation of physical abuse was reported to the State Survey Agency within the required timeframe of two hours for 1 (Resident #15) of 2 residents reviewed for physical abuse allegations. The findings are: A review of a Progress Note, dated 06/05/2025 at 2:20 PM, indicated Certified Nursing Assistant (CNA) #2 reported to Licensed Practical Nurse (LPN) #1 at 10:30 AM that Resident #15 was emotional about an incident that happened on 06/04/2025. Resident #15 alleged being punched in the genital area by a night shift staff member identified as CNA #3. The progress note indicated LPN #1 asked Resident #15 later [in the shift] what happened last night [06/04/2025] with CNA #3, and the resident reported the same information. The progress note indicated LPN #1 checked the resident and Resident #15 reported soreness with palpation. The progress note indicated LPN #1 reported the incident to the Interim Administrator for further investigation. There was no documentation to indicate the State Survey Agency, medical provider, family, or law enforcement were notified of the allegation by Resident #15 of being hit in the genital area by CNA #3. A review of Resident #15 ' s admission Record revealed the facility admitted the resident on 01/03/2025. The resident was admitted with diagnoses which included schizophrenia, major depressive disorder, anxiety, and intellectual disabilities. A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 01/07/2025, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 04, which indicated the resident had severe cognitive impairment. The MDS also revealed the resident exhibited no behaviors, no rejection of care, or wandering. The MDS indicated Resident #15 required substantial/maximal assistance with toileting, personal hygiene, and shower/bathe self and was dependent for chair/bed-to-chair, toilet, and tub/shower transfer. A review of Resident #15 ' s Care Plan report, with a review date of 03/15/2025, revealed impaired cognitive function related to schizophrenia. Interventions included to incorporate cues, reorientation, and supervision as needed. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/2025 at 12:47 PM, the [NAME] President (VP) of Operations, who was Interim Administrator during the time of the alleged incident, stated she was notified by LPN #1 of an allegation of Resident #15 being punched in the genital area by CNA #3. The VP of Operations stated she spoke with CNA #1 and LPN #1, and that she and the Social Worker went to speak with Resident #15. The VP of Operations stated Resident #15 ' s storyline kept changing and the resident could not provide a name for the CNA in question. The VP of Operations stated she spoke with CNA #3 when she came to work that night, 06/05/2025, and CNA #3 stated the resident was confused. The VP of Operations stated after speaking with CNA #3, she, LPN #1, and CNA #3 went to Resident #15's room and the VP of Operations asked the resident if it was okay for CNA #3 to care for the resident and the resident stated, Well of course. The VP of Operations stated she did not report this allegation, because the facility was unable to prove anything. The VP of Operations stated she spoke with Resident #15 and the staff [CNAs and nurses] about Resident #15 ' s allegation, which was her investigation and had a folder that she was trying to locate with staff witness statements. The VP of Operations stated she did not involve Resident #15 ' s family member, because she did not know if the resident had family. On 06/11/2025, the VP of Operations provided a folder with an Office of Long-Term Incident and Accident Report (I&A) form, not dated, which only had the facility ' s name, area code, and address on it. All the other areas were blank. Page 2 of the I&A report indicated Resident [#15] reported multiple different stories to a variety of staff about getting hit in the [genital area]. The resident was a poor historian with a history of making false accusations at their previous place of residency. Resident #15 had a BIMS of 6 and a diagnosis of schizophrenia, with hallucinations and a history of behavior and accusatory behavior with staff and other residents. After conducting an investigation, it was found that the residents' allegations were unfounded. Staff were educated to have two people present during personal care. The MDS Coordinator was informed to care plan Resident #15 for history of false allegations. The VP of Operations stated she was familiar with the facility's abuse policy and the policy indicated all allegations of abuse were to be reported to the state agency, but she did not state the time frames when reporting allegations. A review of the Abuse Prevention Program policy, revised 12/2016, revealed the residents had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This included physical abuse. The policy revealed the administration would do the following: protect the residents from abuse by anyone, develop and implement policies and procedures to aid the facility in preventing abuse, neglect or mistreatment of the residents, identify and assess all possible incidents of abuse, and investigate and report any allegations of abuse in the timeframes as required by federal requirements and protect residents during abuse investigations. The facility did not provide any further documentation on reporting abuse.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to ensure the facility had a full-time Director of Nursing (DON) to promote effective leadership and nursing care oversite, with the potential to affect all 60 residents. The findings include: A review of the Facility Assessment, dated 06/2025, revealed the DON position was documented as vacant. During an interview on 06/10/2025 at 1:20 PM, the Administrator said, we do not have a DON. The Administrator also stated they were not sure when the DON left the facility, and that nobody was working in the role as the DON at this time. The Administrator revealed there were no nursing waivers. During an interview on 06/10/2025 at 2:00 PM, the Administrator provided documentation which revealed a posting for the DON position began on 05/06/2025. During an interview on 06/11/2025 at 6:25 AM, the [NAME] President (VP) of Operations provided documentation which revealed the former DON was employed from 03/27/2025 to 05/06/2025. They also stated the facility had not had a DON in about a month. The VP of Operations confirmed employing a DON was a regulation requirement, and needed to provide clinical leadership to staff. During an interview on 06/11/2025 at 10:30 AM, the Medical Records (MR) Nurse indicated not having a DON had broken the chain of command for the nursing staff working the floor. The MR Nurse revealed the Administrator started at the facility on Friday, 06/06/2025. During an interview on 06/11/2025 at 11:13 AM, Licensed Practical Nurse #1 said, not having a DON has been terrible and makes it stressful when I do not know something. A review of the DON Job Description indicated the primary purpose of the DON position was to direct Nursing Services in planning and organizing according to state, federal, and local laws. In the absence of the Medical Director, the DON was to carry out the resident care policies, as well as administrative functions including care planning, safety, sanitation, equipment and supplies, education, budgeting, and resident rights.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and facility policy review, the facility failed to ensure hand hygiene was performed to prevent cross contamination and the risk for infection during incontinence care for one (Resident #15) of one resident reviewed. The findings include: During an observation on 06/12/2025 at 2:07 PM, this surveyor observed Certified Nursing Assistant (CNA) #2 perform hand hygiene, put on gloves, and then assist Resident #15 in rolling side to side, to remove the resident ' s wet brief. Licensed Practical Nurse (LPN) #7 entered Resident #15 's room and instructed CNA #2 to put cream on the resident ' s perineal area. With their soiled gloves, CNA #2 first looked in Resident #15 's bedside drawer, then went to a dresser across from the foot of the bed and removed a white tube of cream. CNA #2 placed a clean brief on Resident #15 and was observed applying cream to the perineal area while still wearing the same contaminated gloves. CNA #2 then repositioned the resident onto their right side, and pulled up the linens, without changing gloves or performing hand hygiene. A review of Resident #15 ' s quarterly Minimum Data Set (MDS), with an Assessment Reference Date, of 04/09/2025 revealed a Brief Interview for Mental Status score of 06, which indicated severe cognitive impairment. The MDS revealed Resident #15 was dependent on staff for toileting, dressing, bathing, and personal care. The MDS confirmed Resident #15 was always incontinent of bowel and bladder. During an interview with CNA #2 and LPN #7 on 06/12/2025 at 2:17 PM, CNA #2 stated, we wash hands before and after perineal care, and wear gloves during perineal care. CNA #2 confirmed her dirty gloves should have been changed before going from dirty body sites to clean body sites and touching Resident #15 ' s environment, to prevent the transferring of germs around the room. LPN #7 confirmed hand hygiene should have been performed during Resident #15 ' s perineal care, to prevent cross contamination. During an interview on 06/12/2025 at 2:40 PM, with the [NAME] President (VP) of Operations and the Administrator, the VP of Operations stated, the Infection Preventionist (IP) did competencies and perineal care check offs with all the CNAs. The VP of Operations stated, I know the IP provided education for peri-care to protect the resident from infections. The Administrator revealed it was not appropriate to go from dirty to clean without changing gloves, due to cross contamination, and staff were expected to perform hand hygiene. A review of an undated Perineal Care Protocol revealed staff should not touch anything with soiled gloves after providing perineal care including clean linens, rails, or call light. A review of a policy titled Employee Training on Infection Control, revised 01/2012, revealed all staff were oriented and received training on preventing the transmission of healthcare acquired infections. Infection control training involved hand hygiene and included preventative and monitoring measures. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a policy titled Handwashing/Hand Hygiene, revised 08/2015, revealed hand hygiene was the primary means to prevent the spread of infection. Staff were in-serviced regularly on hand hygiene and were to follow procedures to prevent the spread of infection. Staff were expected to perform hand hygiene when moving from a contaminated body site to a clean body site during personal care. In-service on hand hygiene was requested.