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	01/22/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure a resident received prescribed and requested pain medication for one (Resident #1) of one resident reviewed. The findings include: A review of an OLTC [Office of Long-Term Care] Incident and Accident [I&A] report with a discovery date of 01/09/2025 at 8:30 AM, and a submitted date of 01/11/2025 at 1:23 PM, revealed the type of incident as abuse and neglect for Resident #1 and the status of alleged perpetrator was a facility employee. This I&A report indicated Resident #1 was sent out to the hospital after a fall. Upon the resident's return to the facility, Resident #1 requested pain medication twice and no medication was provided. A review of Resident #1's admission Record indicated the facility admitted the resident on 01/30/2024, with diagnoses which included bipolar disorder, current episode manic severe with psychotic features. Resident #1's admission Record also revealed a discharge date of 02/06/2025 at 12:51 PM, to a nursing home unknown/to be determined. A review of Resident #1's quarterly Minimum Data Set with an Assessment Reference Date of 11/15/2024, revealed a Brief Interview for Mental Status score of 10, which indicated moderate cognitive impairment. Resident #1's MDS also revealed the resident had verbal behavioral symptoms directed toward others, was dependent for toileting/personal hygiene, received PRN (as needed) pain medications or was offered and declined, had two falls with no injury and two falls with injury (except major), and took high risk meds in the categories of antianxiety, antidepressant, opioids, and anticonvulsants. A review of Resident #1's Care Plan, with a revision date of 02/27/2025, indicated the resident had a behavior problem of agitation related to communication, and Resident #1 threw self on the floor purposely if any demand the resident verbalized was not instantly met. Resident #1's Care Plan also indicated the resident had a risk for pain and took pain medication, date initiated was 12/27/2024. An intervention included anticipating the resident's need for pain relief and responding immediately to any complaint of pain. A review of Resident #1's January 2025 electronic Medication Administration Record (eMAR) revealed a pain medication with instruction to give one tablet orally every four hours, as needed for pain with a start date of 05/13/2024, and a discontinue date of 04/01/2025. The January 2025 eMAR revealed the pain medication was administered to Resident #1 on January 6th, January 9th through January 11th, January 13th-14th, January 16th-20th, January 22nd-23rd, and January 27th-28th. The January 2025 eMAR indicated pain monitoring-assess for pain every shift for pain monitoring with a start date of 10/02/2024 and a discontinue date of 04/01/2025. There was no documentation for the night box on the 8th. A review of a witness statement for Certified Nursing Assistant (CNA) #1 indicated Resident #1 returned to the facility on [DATE] around 10:30 PM, from the hospital. After being put to bed, Resident #1 requested pain medication. CNA #1's witness statement revealed she informed Licensed Practical Nurse (LPN) #4 of Resident #1's request for pain medication. CNA #1's witness statement indicated around 12:30 AM, she went to the nurse again because Resident #1 was yet calling out for help, stating they were in pain. CNA #1 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER: Pine Bluff Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the resident kept refusing personal care. CNA #1's witness statement indicated around 5:00 AM, CNA #1 checked on Resident #1 and the resident was yet awake and still asking for medication for their head pain. CNA #1 went to LPN #4 again, and LPN #4 refused to give pain meds to Resident #1 because LPN #5, [who was not present in the building during this time] allegedly had agreed to pass the medications on the hall Resident #1 resided. A review of a witness statement from LPN #4 dated 01/09/2025 at 9:30 AM, indicated LPN #4 came to work on 01/08/2025 at 7:00 PM, and was informed the other nurse [LPN #5] was running late, but would arrive soon. LPN #4's witness statement indicated LPN #4 counted all the medication carts, passed meds on the 200 and 500 halls, and that LPN #4 was responsible for the 200 and 500 halls. LPN #4's statement indicated LPN #4 signed for Resident #1's return [from a local hospital] at 9:11 PM, and their un-named co-worker handled all meds for the hall on which Resident #1 resided. LPN #4's witness statement indicated they rarely made an appearance on Resident #1's hall. A review of an In-Service sign-in sheet dated 01/09/2025, titled Abuse/Neglect/Falls and was conducted by Administrator (Admin) #6, had multiple different names and titles listed, including LPN #4. A review of a Counseling Notice for LPN #4, located in the OLTC I&A report and dated 01/13/2025, revealed an unnamed resident accused LPN #4 of not providing medications and the employee was suspended pending investigation and later terminated. LPN #4's last day worked was indicated as 01/10/2025. A review of LPN #4's timecard revealed on 01/08/2025 an in-punch time of 6:52 PM and an out-punch time of 12:00 AM. On 01/09/2025 there was an in-punch of 12:00 AM, an out punch of 7:07 AM, another in-punch of 6:28 PM, and an out punch at 12:00 AM. On 01/10/2025, there was an in-punch at 12:00 AM and an out-punch at 07:11 AM. The timecard indicated the employee returned to work the night of 01/09/2025, after the allegation of neglect had been made known to the Administrator at that time (Admin #6). A review of LPN #5's timecard revealed an in-punch on 01/05/2025 at 7:15 PM, and a final out-punch on 01/06/2025 at 11:32 AM. The were no in or out punches after 01/06/2025 for LPN #5. A review of the daily staffing log dated 01/08/2025, revealed the name for LPN #4 in the sign and print name column and there was no other LPN name listed on the log. On 01/21/2026 at 1:54 PM, this surveyor telephoned the number on file for LPN #4, but a voicemail intercepted the call, and this surveyor did request a call back and contact information was provided. As of 01/22/2026 at 4:00 PM, LPN #4 had not returned this surveyor's call. During an interview on 01/21/2026 at 4:17 PM, Social Services stated they did go to Resident #1's room the morning of 01/09/2025, after coming to work, and observed Resident #1 laying on their mat on the floor. Social Services stated Resident #1 did not voice any complaints of pain but voiced being mad. Resident #1 did not give any information regarding why they were mad. Social Services stated they informed Admin #6 of the incident the morning of 01/09/2025, but no specific time was stated. During a telephone interview on 01/22/2026 at 8:40 AM, CNA #1 stated while trying to get Resident #1 situated in bed on the night of 01/09/2025, Resident #1 stated they were having pain in their head. CNA #1 stated they went to LPN #4, because LPN #4 had LPN #5's keys [to the medication cart]. CNA #1 stated LPN #4 stated LPN #5 had stepped out [of the facility] and would be back, and therefore LPN #4 continued passing medications to others. CNA #1 stated LPN #4 stated that if LPN #5 had not returned by the time LPN #4 was done passing medications to others, LPN #4 would give Resident #1 something [medication for pain]. CNA #1 stated LPN #4 did not come to the hall Resident #1 resided on and around 12:00 AM, LPN #5 had not made it back to the facility and Resident #1 began to act out. CNA #1 stated around this time, LPN #4 was again asked to give Resident #1 pain medication since LPN #4 was sitting at the nursing station at this time. CNA #1 stated LPN #4 stated again, LPN #5 was supposed to be there and LPN #4 did not give Resident #1 any medication for pain during this time. CNA #1 stated they went to LPN #4 again and stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045379	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was acting out and was in pain, however LPN #4 did not go to Resident #1 or provide Resident #1 with any pain medication. CNA #1 stated their lead CNA was informed by text message of the matter but was unable to provide an exact time on 01/09/2025 when the text was sent. CNA #1 stated LPN #4 did not go to Resident #1's room at all during their shift. During a telephone interview on 01/22/2026 at 9:25 AM, Admin #6 stated Social Services informed them on 01/09/2025, of a matter concerning Resident #1, although Admin #6 could not recall the exact place and time they were informed. Admin #6 stated they immediately began an investigation into what happened with Resident #1 on 01/09/2025 but did not give a time. Admin #6 stated they had no written communication from LPN #4 to indicate what was going on in Resident #1's room and LPN #4 did not always communicate back with Admin #6. Admin #6 stated during their investigation, Resident #1's MAR was reviewed, and the conclusion was LPN #4 did not give Resident #1 any medications for pain. During an interview on 01/22/2026 at 11:30 AM, LPN #7 stated the nurse who accepted the keys to all medication carts, would be responsible for taking care of a resident's request for any type of medication. LPN #7 stated if a resident requested medication for pain, they [all staff] would check if the resident asking had an order for medication and then administer the medication to the resident. LPN #7 stated if the resident requesting pain medication did not have an order for pain medication, they would call the doctor. LPN #7 stated neglect was a type of abuse and they would immediately report any suspicion or knowledge of neglect to the Director of Nursing (DON). During an interview on 01/22/2026 at 11:53 AM, Admin #10 stated their expectations regarding the staff for suspected abuse and neglect was If you see something, say something. Admin #10 stated an investigation would be started, staff and resident interviews would be performed, and staff would be educated on abuse and neglect. During an interview on 01/22/2026 at 3:50 PM, the DON stated if a nurse had accepted the keys to all the medication carts and was the only nurse in the building, that nurse was responsible for taking care of any resident's requests for pain medication. A review of an Administering Medications policy, with a revision date of December 2012, indicated medications shall be administered in a safe and timely manner, and as prescribed. This policy also indicated only persons licensed or permitted by this state to prepare, administrated and document the administration of medications may do so. A review of the Abuse Prevention Program policy revealed as part of the resident abuse prevention, the administration would protect residents from abuse by anyone including but not necessarily limited to staff and other residents etcetera, develop and implement policies and procedures to aid the facility in preventing abuse, neglect, or mistreatment of residents, and protect residents during abuse investigations.The Administrator provided documentation of corrective actions performed by the facility following the incident:01/22/2025 - all staff had been in-serviced on neglect, medication administration.01/22/2025 - Administration had identified 15 additional residents with BIMS of less than 8, who were unable to verbalize allegations of mistreatment. Identified residents assessed and electronic health records reviewed, with no negative findings .DON/Designee monitored all residents twice weekly for four months, once weekly for 4 weeks.Facility alleged compliance achieved 08/29/2025.