STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045212	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Rogers Rehab & Nursing Center	1513 South Dixieland Rd Rogers, AR 72758

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 - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review, interview, facility document review, and facility policy review, the facility failed to ensure Physician's Orders were transcribed without error and consistently administered and followed for two (Resident #7 and Resident #26) of five sampled residents, reviewed for medications. The findings include: Resident #7 A review of Resident #7's admission Record revealed the facility admitted Resident #7 on 10/21/2025 with diagnoses which included type two diabetes mellitus and acquired absence of left great toe. A review of Resident #7's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/03/2025, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #7's MDS also revealed the resident was a diabetic and received insulin injections daily. A review of Resident #7's Physician's Orders, initiated 11/21/2025, for December 2025 and January 2026, revealed orders for a [fast acting] insulin injection solution 100 UNIT/ML [milliliter] inject as per sliding scale: if 0 - 150 = 0; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10. Resident #7's Physician's Orders also revealed, <60 or >400, notify MD [medical doctor], subcutaneously with meals related to type two diabetes mellitus. A review of Resident #7's Care Plan Report, with an initiated date of 11/11/2025, revealed Resident #7 had a diagnosis of diabetes mellitus and had a potential for complications, due to elevated blood sugar. Resident #7's Care Plan Report included interventions, which directed staff to provide medication as ordered. Resident #7's Care Plan Report revealed the resident was also at risk for skin breakdown, related to diabetes mellitus. A review of Resident #7's Lab Report dated 11/04/2025, revealed a HbA1C (A blood test showing an average blood sugar over 2-3 months) result of 11.0 (normal was below 5.7%). Resident #7's Lab Report also revealed a Glucose (the sugar level of the blood) result of 307 (74-109 was normal). A review of Resident #7's Medication Administration Record (MAR) dated from 12/01/2025 through 12/31/2025, revealed on 12/11/2025 at 7:00 AM, the result of Resident #7's blood sugar test was documented as 469. During an interview on 01/07/2026 at 10:40 AM, the Director of Nursing (DON) reported after requesting documentation for Resident #7 that the provider had been contacted as ordered on 11/21/2025, for the out of parameter blood sugar result of 469. The DON remarked, I'm having trouble (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	getting them [nursing staff] to document findings. During an interview on 01/07/2026 at 10:46 AM, Medication Aide-Certified (MA-C) #1 confirmed they were the person working that day [12/11/2025] and who took Resident #7's blood sugar reading. MA-C #1 also confirmed that the elevated blood sugar reading of 469 was reported to the charge nurse, Licensed Practical Nurse (LPN) #2. MA-C #1 did not recall if LPN #2 contacted the provider. During a phone interview on 01/07/2026 at 11:04 AM, the Medical Director (MD) reported that usually the Physician's Assistant (PA) would have been notified initially, of the resulted blood sugar reading that was out of parameters and given orders. The MD then said that the Physician would be notified if the facility could not contact the PA. The MD did not recall being contacted for the out of parameter blood sugar reading of 469 for Resident #7. During an interview on 01/07/2026 at 12:06 PM, the PA reviewed their phone messages received from the facility on 12/11/2025, and Resident #7's electronic medical record. The PA reported there was no evidence of being contacted for the reported out of parameter blood sugar reading of 469, by anyone at the facility on that date. The PA reported that if they had been contacted, an order for an increased insulin dose would have been given at that time for Resident #7. During an interview on 01/07/2026 at 12:32 PM, the DON confirmed the nursing staff were expected to follow facility policies and Physician's Orders. If the order was written to notify the Physician for a blood sugar reading of over 400, and the reading was 469 for Resident #7, then the Physician or the PA should have been notified. During an interview on 01/08/2026 at 8:36 AM, LPN #2 confirmed being notified of the out of parameter blood sugar reading for Resident #7 of 469 on 12/11/2025. LPN #2 indicated the provider had been notified but did not recall if the notification was documented. LPN #2 confirmed having medication administration training and was knowledgeable of contacting the provider when there was a change in the resident or following an order that indicated the provider should be contacted. A review of Resident #7's Progress Notes did not reveal documentation of the provider notification for the resident's blood sugar reading of 469, on 12/11/2025. A review of a Licensed Nurse Competency Skills Check-Off dated 11/07/2025, with LPN #2's name at the top, revealed under performance objectives, LPN #2's initials. Competency #5 indicated the purpose was to provide nursing care based on scientific principles and sound theoretical knowledge. 3. able to recognize a change in a resident's acuity. 4. the ability to report pertinent information in a timely manner to the appropriate person. A second Competency #5 indicated the demonstration of the knowledge of nursing documentation. 5 b. Notification of the provider and appropriate documentation. Competency #6 revealed the ability to administer medications according to the policy and procedures. Competency #10 indicated a responsibility for one's own actions. This competency report was signed on the last page with LPN #2's name. During an interview on 01/08/2026 at 10:08 AM, Registered Nurse (RN) #4 confirmed they completed the medication administration competencies with the facility and the expectation of reporting changes with a resident, out of parameter findings, or missed doses to the provider. RN #4 reported that any time a provider was contacted, the conversations should be documented in the Progress Notes. RN #4 indicated a missed medication dose would be a medication error, the provider should be contacted, and it should be documented in the Progress Notes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/2026 at 10:13 AM, LPN #5 confirmed they had completed the medication administration competencies (training). LPN #5 reported following Physician's Orders was expected and if there was a problem with an order, the orders would be clarified. LPN #5 then stated, if an order specifically required the provider to be contacted with an out of parameter result, then the provider should have been contacted, and the conversation documented. During an interview 01/08/2026 at 10:27 AM, the Assistant Director or Nursing (ADON) confirmed completing the nursing competency for medication administration. The ADON reported that if a Physician's Order specifically directed nursing staff to contact the provider with out of parameter results, then the provider should have been contacted and the conversation documented. During an interview on 01/08/2026 at 11:03 AM, MA-C #3 did not recall the specific situation that occurred on 12/11/2025 but reported generally if a blood glucose reading was out of the parameters set by the provider, the charge nurse would have been notified. Then, the charge nurse would contact the provider and get new orders, if any. MA-C #3 confirmed the initials on the MAR were their initials and would indicate for 12/11/2025, they had taken the blood sugar reading and documented the results for Resident #7, although MA-C #3 was unable to recall the specific situation. MA-C #3 confirmed they completed Medication Assistant competencies. A review of a Medication Assistant -Certified Skills Check-Off document dated 12/04/2025, read in part, Blood Glucose Monitoring demonstrated the ability to notify nurse if blood sugar was outside of the parameter set by the provider. This section had the initials of MA-C #3 and was dated 12/09/2025. Resident #26 A review of Resident #26's Face Sheet revealed the facility admitted the resident on 10/17/2025, with ulcers on both heels, and the resident's left toes. Resident #26 had medical diagnoses, which included atherosclerosis of native arteries of extremities with intermittent claudication, left leg, type two diabetes mellitus, traumatic subcutaneous emphysema, peripheral vascular disease, and chronic kidney disease. A review of Resident #26's Transfer admission Orders, received from another facility, revealed the resident was to have two antibiotics per day for seven days. The medication was entered on Resident #26's MAR at this facility as, patient is to have 1 tablet twice a day every 7 days. A review of Resident #26's MAR revealed the patient received the initial dose of medication on the day admitted to the facility, 10/17/2025, and did not receive another dose until 10/20/2025, when the DON caught the error and cancelled the incorrect order and re-entered the correct dosage. At that time, Resident #26 began receiving the correct dosage. During an interview on 01/07/2025 at 10:57 AM, the MD confirmed that the facility nursing staff made a transcription error when entering Resident #26's orders. This error caused the resident to miss two days of antibiotics. During an interview on 01/07/2026 at 12:32 PM, the DON stated that facility staff were expected to follow medication administration policies and Physician Orders. If a medication error was made, then the physician should have been notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/08/2026 at 10:26 AM, the ADON confirmed that, if a Physician's Order was not clear, they [nursing staff] should contact that Physician to get the order clarified. If a medication error was made, the Physician would be contacted and documentation needed to be made on the residents' MAR. During an interview on 01/08/2026 at 10:54 AM, RN #6 did not recall entering Physician's Orders into the electronic record system for Resident #26. RN #6 did confirm that when a medication error was made the Physician and DON should be notified, and documentation should be done on the resident's MAR, along with a nurse's Progress Note. During an interview on 01/08/2026 at 12:23 PM, the Administrator stated that facility staff were expected to follow medication administration orders. The Administrator confirmed that the DON monitored Physician's Orders that were entered into the resident's electronic medical records and would notify the Physician of any errors. During an interview on 01/08/2026 at 12:41 PM, the PA indicated that Resident #26's medication error was made prior to her employment with the facility but expected to be notified when an error was made. The PA said that medication administration policies and procedures should be followed, as well as any Physician's Orders that were given. A review of the Medication Administration Policy with a reviewed date of 11/25/2024, indicated medications must be administered in accordance with the orders, including any required timeframe. The policy also indicated, if a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.