STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045232	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Stamps Rehab & Nursing Center	826 North Street Stamps, AR 71860

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47916 Based on observation, record review, interview, and facility policy review it was determined the facility failed to ensure the rear casters or wheels of the mechanical lift were left unlocked when lifting and lowering residents affecting 1 sampled (Resident #211) resident, and to ensure medications were not left unattended in a resident's room to prevent misappropriation, accidents, or injuries for 1 sampled (Resident #51) of 2 sampled reviewed for accidents and injuries. Findings include: 1. A review of Medical Diagnosis, revealed Resident #211 with a diagnosis of dementia, heart attack, and anemia. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/04/2024, with a Brief Interview for Mental Status (BIMS) score of 00 (0-6 indicates cognitively impaired). Section GG0130 indicated Resident #211 is dependent on total care. a. On 10/15/2024 at 2:15 PM, a review of an in-service for Certified Nursing Assistants (CNA)s and nursing staff including a policy titled Mechanical Lift Procedure, revised, 09/29/2023 revealed the purpose is to establish a safe mechanical lift policy. The policy does not address locking the rear casters or wheels. b. Review of a Care Plan for Resident #211, revised 09/13/2024, revealed Resident #211 requires 1-2 staff members to use a mechanical lift for transfers. c. On 10/15/2024 at 6:53 AM, CNA #1 and #2 were observed using the mechanical lift with rear casters in the locked position when raising Resident #211 from the bed, and when lowering Resident #211 to a specialty chair. When asked the purpose of locking the rear casters or wheels when lifting and lowering residents, CNA #2 stated locking the rear wheels keeps the lift from moving, and the lift stays stationary. CNA #1 agreed and revealed it was a safety issue. d. During an interview with Director of Nursing (DON) on 10/15/2024 at 1:00 PM, the DON was asked the procedure staff were expected to follow when lifting and lowering residents with a mechanical lift. DON stated the legs of the left should be kept straight, and the wheels locked so that the lift stays in place. We want the wheels locked to make sure that the lift is stable. The DON was asked to provide mechanical lift policy, procedures, and any in-service documentation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 10/15/2024 at 07:25 AM, A review of the Battery Operated Patient Lift Manual, stated to maintain mechanical lift legs spread open to the widest position, and ensure the casters are unlocked with lifting or lowering a resident except when lifting a resident from the floor. 2. A review of Medical Diagnosis, revealed Resident #51 with diagnosis of schizophrenia, bipolar, and Parkinson's. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/31/2024, with a Brief Interview for Mental Status (BIMS) score of 13 (13-15 indicates cognitively intact). a. A review of Physician orders dated 07/31/2024 revealed: Antidepressant 60 milligrams 1 capsule in the morning by mouth for chronic pain. A blood pressure medication, 2.5 MG give 1 tablet by mouth in the morning for high blood pressure. Stool softener 8.6 MG, give 1 tablet by mouth every morning and at bedtime for stool softener Vitamin D3 Oral Tablet 25 micrograms 1 tablet by mouth in the morning for supplement A Physicians Order, dated 09/12/2024 revealed, Antipsychotic 2 MG, give 1 tablet by mouth every morning and at bedtime related to suicidal ideation. b. A review of an In-service titled Medication Administration Skills, dated 10/10/2024 given to nursing staff along with a policy titled Medication Administration, revised 11/25/2022, revealed medications must be given in a safe manner, and the medication cart must be clearly visible to the nurse administering medications, and the outward sides of the medication cart should be inaccessible to residents or other people passing by c. On 10/15/2024 at 8:00 AM, Resident #51 asked to take medications with applesauce and the Surveyor observed Licensed Practical Nurse (LPN) #3 set down a medication cup containing an antidepressant, antihypertensive, stool softener, antipsychotic, and a vitamin down in front of Resident #51 and walk out of the Resident's room and out of sight to a medication cart resting against the wall in the hallway. d. On 10/15/2024 at 8:04 AM, LPN #3 was asked if medications should have been left at Resident #51's bedside when retrieving applesauce from the medication cart, and LPN #3 stated the medications should not have been left at the bedside because another resident could have wandered in, or Resident #51 could have done something with the pills and she would not have known. e. During an interview on 10/15/2024 at 1:00 PM, the DON was asked the process nursing is expected to follow if they return to the medication cart before administering medications. The DON stated the nurse should take the medications with them when they return to the cart because another resident could get the medicine, or they could be knocked to the floor.

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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. 47916 Based on observation, record review, interview, and facility policy review, the facility failed to ensure gloves were removed after touching a trash can, and appropriate hand hygiene was performed during medication pass to prevent cross contamination, and the risk of infection for 1 (Resident #51) sampled resident reviewed for infection control risk. Findings include: 1. A review of Medical Diagnosis, revealed Resident #51 had diagnoses of schizophrenia, bipolar, and type II diabetes. a. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/31/2024 revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of 13 (13-15 indicates cognitively intact). b. A review of a policy titled Hand Hygiene, dated 03/2020, revealed hand hygiene prevents the spread of infection, and all staff are expected to follow hand hygiene procedures to prevent the spread of infection to others. Gloves do not replace handwashing or hand hygiene. c. Review of a policy titled Medication Administration, revised 11/25/22, reveal staff should follow infection control procedures including handwashing and gloves for administering medications. d. A review of Physician Order, dated 07/31/2024 revealed, Lantus 30 units subcutaneously every morning and at bedtime for diabetes. (Lantus is a long acting insulin.) e. On 10/15/24 at 7:45 AM, Licensed Practical Nurse (LPN) #3 was observed putting on gloves, and holding a syringe in the left hand while wiping the top of a bottle of insulin with an alcohol pad. LPN #3 reached down with the right hand and opened the lid of the garbage can on the medication cart, then drew up insulin for Resident #51 in the syringe without sanitizing hands. e. On 10/15/24 at 7:59 AM, the Surveyor asked LPN #3 what process should be followed when administering medications after touching the trash can on the medication cart. LPN #3 stated she probably should have sanitized her hands because there are germs on the lid of the trash can. f. During an interview with Director of Nursing (DON) on 10/15/24 at 1:05 PM, the DON confirmed nursing should remove gloves after touching a trash can and sanitize hands because there could be a hole in the gloves, and it is an infection control issue.