

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER The Blossoms at Eureka Springs Rehab & Nursing Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 235 Huntsville Road Eureka Springs, AR 72632	

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)
<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>50924</p> <p>Based on observations, interviews, record review, and facility document review, the facility failed to allow the resident to receive and open their packages for 1 (Resident #12) of 1 resident reviewed for privacy of communication by mail.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Resident Rights, revised on 11/01/2022 and signed by Resident #12 and the facilities representative on 08/24/2023, indicated residents have the right to communicate by mail in privacy.</p> <p>A review of the Admission Record indicated the facility admitted Resident #12 with diagnoses that included major depressive disorder with a single episode, post-traumatic stress disorder, anxiety, and bipolar disorder.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/06/2024, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.</p> <p>A review of Resident #12's Care Plan, undated, revealed the resident had behavior problems. Interventions included the facility would open her packages related to history of drug abuse.</p> <p>A review of a progress report dated 06/10/2024 at 7:33 AM revealed Resident #12 had received packages in the mail. The Director of Nursing (DON), witnessed by another staff member, opened the packages to inspect the contents. When Resident #12 was informed, Resident #12 became upset about the violation of rights and stated the DON was breaking the law.</p> <p>During an interview on 08/28/2024 at 12:03 PM, Resident #12 reported to this surveyor packages were delivered to the facility and then opened by the DON with the Administrator's approval. Resident #12 felt this was disrespectful and stated it's a dignity issue and illegal.</p> <p>During an interview on 08/29/2024 at 10:45 AM, the Administrator stated they opened all packages addressed to Resident #12 to inspect what items she had ordered. The Administrator reported Resident #12 had a history of ordering unauthorized items for his/her room in the past.</p> <p>(continued on next page)</p>

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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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/29/2024 at 11:00 PM, the DON stated she opened all packages addressed to Resident #12. The DON stated all items were added to one of two inventory lists as the packages were opened and inspected. The first list is approved items that were then turned over to the resident. The second list were unapproved items the DON kept locked in the office in a file cabinet accessible by the DON.</p> <p>During a concurrent observation and interview on 08/29/2024 at 12:17 PM, the DON opened three packages addressed to Resident #12. The first package was a box that contained 6 cans of baked beans, the second, a plastic shipping bag, contained a small black box with two blue stoned rings, and the third, a plastic shipping bag, contained a bag of flavored sunflower seeds. The DON stated she was entering all items on Resident #12 inventory list and would then deliver the approved items.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>50924</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, the facility failed to maintain limited access to special care residents in 2 of 2 units reviewed for resident comfort and safety.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Resident Rights, revised on 11/01/2022, indicated residents have a right to live in a safe and environment.</p> <p>A review of a facility policy titled, Special Care Unit, revised on 02/15/2022, indicated the facility would maintain a safe environment for residents who were an elopement risk, at risk due to cognitive impairment, and/or occurrences of behavior symptoms. The Interdisciplinary Team (IDT) reviewed appropriate placement for residents quarterly.</p> <p>A review of the document titled, Consent for Admission to Special Care Unit, dated 02/2022, indicated the Special Care Unit provides a quieter living environment for those whose physical, mental, and/or psychosocial diagnoses require protection from external stressors to promote enhanced function and improved quality of life by decreasing anxiety and agitation. The Special Care Unit is maintained by locked doors to support these residents' enhanced environment which allows for reduction in psychiatric medications.</p> <p>During an interview and observation on 08/28/2024 at 8:27 AM, Maintenance Worker (MW) #1 was seen leaving the 300 Hall Special Care Unit and monitoring the door close. The sign posted on the door stated, Please use other door the magnet is tricky. MW #1 stated he was unaware of the sign on the door. The Director of Nursing (DON) approached and put the code in the keypad. Both doors were pushed open and allowed to shut, waited two minutes, the alarm blared, and the doors could be pushed open. The DON and MW #1 both attempted to instruct this surveyor how to use only one door so it would lock. During a second attempt, the code was entered into the keypad and both doors were pushed open. The doors were allowed to close without interference and the magnetic click on the door was heard engaging. Attempted to open the right door only and it was not secured, and the door was opened. No alarm sounded with the second attempt.</p> <p>During a concurrent observation and interview on 08/28/2024 at 8:38 AM, all 300 Hall residents were ambulating in the hallway directly inside the secure doors. Certified Nursing Assistant (CNA) #2 stated the tricky sign was on the 300 Hall secure doors on 08/20/2024 at 8:40 AM when CNA #2 arrived at work.</p> <p>During a concurrent observation and interview on 08/28/2024 at 8:48 AM, the 500 Hall Special Care Unit secure doors were found to have one door not closed and was not secure. Nursing Assistant (NA) #5 stated the secure doors had been broken for about a week.</p> <p>During an interview on 08/28/2024 at 9:10 AM, MW #1 stated technicians had been called and would be out tomorrow to fix the 300 Hall secure doors.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a phone interview on 08/28/2024 at 2:03 PM, the Ombudsman reported secured unit doors propped open with a chair to one of the Special Care Units and at the other Special Care Unit two unidentified staff holding secure doors shut, due to non-functioning secure doors, while exit seeking residents were exhibiting aggressive behavior.</p> <p>During an interview on 08/29/2024 at 10:52 AM, the Maintenance Director stated the issues with the 300 Hall Special Care Unit door was the hinge on the top of the left door when entering. It was an old door and too heavy for the current hinge which was bending under the weight. The Maintenance Director stated he planned to install a heavier hinge to allow the magnetic lock to engage.</p> <p>During a concurrent observation and interview on 08/29/2024 at 12:40 PM, CNA #4 entered the code to the 300 Hall Special Care Unit secure doors, three people walked through the doors and the doors were allowed to shut without interference. Both doors shut completely without issue. The sound of the magnetic click was heard engaging and the light over the doors turned red to indicate they were locked. The doors were able to be pushed open. CNA #4 stated the door did not lock and was not secure.</p> <p>During an interview on 08/29/2024 at 12:52 PM, the Administrator stated the doors were locked, but not locking. The Administrator stated no knowledge that a hinge was needed. The Administrator stated the unit was secure and stated the surveyors seemed to be the only ones having issues. Administration was informed it was CNA #4 who entered the code.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016</p> <p>Based on observations, interviews, record review, facility document review and facility policy review, it was determined the facility failed to identify abuse to ensure a calm, safe and injury free environment for 4 (Resident #6, Resident #7, Resident #8, and R #10) of 4 residents reviewed for abuse.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Policies and Procedures .Abuse, Neglect, and Exploitation, with a reviewed date of 07/2023, indicated, Policy Statement .the resident has the right to be free from .physical .abuse .uses the general term abuse to specify all .Policy Interpretation and Implementation .4. Identify events and occurrences that may constitute .abuse .5. Investigation of all allegations of abuse, neglect, or mistreatment . 7. Reporting/Response - assurance that incidents are reported, corrective actions are taken, and preventative measures are put into place .Reporting .1. All personnel must immediately report suspected cases of abuse to the Administrator. In the Administrator's absence, suspected abuse should be reported to the Director of Nursing [DON] and immediate supervisor .3. The facility will report all alleged violations involving .abuse to the Office of Long-Term Care, Family, Police, and MD [Medical Director]. Suspicion of allegation of abuse shall be reported immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury .Investigation .5. All incidents involving abuse will be analyzed to determine root cause and identify ways to prevent recurrence .Definitions .Abuse - the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .</p> <p>A review of Resident #6's Consent for Admission to Special Care Unit, indicated risks of residing on the special care may include, incidents of resident-to-resident altercations. Residents may wander into the personal space of others .</p> <p>A review of the Admission Record indicated the facility admitted Resident #6 on 05/26/2024 with diagnoses that included vascular dementia, depression, and anxiety.</p> <p>The quarterly Minimum Data Set [MDS] with an Assessment Reference Date [ARD] of 08/19/2024 revealed Resident #6 had a Brief Interview for Mental Status [BIMS] score of 3, which indicated resident had severe cognitive impairment. Resident #6 had a mood score of 1 indicating resident had little interest or pleasure in doing things and scored 1 on feeling down and hopeless 2 to 6 days. Resident #6 did not exhibit behaviors. Resident #6 was independent with toileting and required setup or clean up assistance with eating, oral hygiene, showering, dressing, and personal hygiene. Resident #6 was independent with ambulation and did not require an assistive device.</p> <p>A review of a Care Plan, with an initiation date of 05/30/2024, revealed Resident #6 had a history of self-harm and self-mutilation ideation related to severe mental illness. Interventions included a stop sign placed across the room door to deter wandering and uninvited residents out of the room; conduct random room safety checks and personal wellness checks, and behavior monitoring.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a Behavioral assessment dated [DATE], revealed Resident #6's behaviors as cursing, yelling, agitation, and aggression/combativeness. The interdisciplinary team [IDT] recommendation was continuation on Special Care Unit.</p> <p>A review of the Incident Note dated 07/23/2024 at 5:55 PM, revealed Resident #6 became upset when another resident entered Resident #6's room and attempted to lay down on the bed. Aggressor was placed 1:1 [one-on-one meaning one staff member was assigned to aggressor for observation]. Eureka Springs Police Department was notified.</p> <p>A review of the local Police Department Offense/Incident Report, dated 07/23/2024 at 5:30 PM, revealed the type of incident as an Information Report with a complaint number of 24-000344. The report revealed Licensed Practical Nurse [LPN] #7 contacted the police department to report an altercation involving Resident #6 and the progress notes from the nurses were attached to the report. The attached report indicated it was privileged and confidential. The report revealed the incident #1702 Physical Aggression Initiated, listed impulsive as a predisposing factor. The incident was described as Resident #6 sitting in his room when another resident entered and attempted to lay on the bed. Resident #6 hit the other resident on the arm and Resident #6 was struck back in their arm. No visible marks present. Notification was made to the Administrator, Police Department, Family, Physician, and Director of Nursing (DON). The report was completed by LPN #10. The attached incident note dated 07/25/2024 at 11:25 AM, revealed Resident #6 was placed 1:1 supervision for safety and a stop was placed across Resident #6's door, family member and APRN [Advance Practice Registered Nurse]/MD [Medical Director] were notified.</p> <p>Review of Resident #6's progress notes did not reveal the other resident involved in this incident. A review of the Incidents by Incident Type dated 08/28/2024, under the subheading of Physical Aggression Initiated Incidents, revealed Resident #6 listed with the date of 07/23/2024 at 5:00 PM, and under the subheading of Physical Aggression Received Incidents, Resident #7 listed with a date of 07/23/2024 at 5:00 PM.</p> <p>During interview on 08/29/2024 at 1:11 PM, Licensed Practical Nurse (LPN) #10 stated Resident #7 wandered into Resident #6's room and has a history of wandering. The staff intervened in an altercation between the two of them. Resident #7 went in and laid in Resident #6's bed. Staff heard yelling and LPN #10 was notified and intervened to keep it from becoming physical. Staff also notified LPN #7. LPN #10 stated 1:1 is standard intervention for the aggressor, usually for 24 hours, and the DON will follow up to determine if the situation will occur again.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/29/2024 at 5:58 PM, the DON stated she was notified and was familiar with the Resident-to-Resident incident involving Resident #6 and Resident #7 on 07/23/2024. The DON notified the Administrator via a social communication platform at 9:40 AM. The DON described the procedure for staff to follow, stating the nurses call the physician and then they call the family and the police department. The incident did occur, and an incident number was requested. The physician was notified at 9:40 AM, the police department was notified at 9:47 AM, and the responsible party was notified at 10:02 AM. The nurse did the body audit, and the aggressor was placed on one on one. Resident #7 was sent to the geri-psych unit as an intervention. No facility report was done, and the state was not notified. The DON stated the incident did not involve malice because there were no injuries and the resident's BIMS scores were low. The DON believes no notification to the Office of Long-Term Care was necessary because no malice was involved. The DON stated she received the information regarding malice from a CMS in-service on electronic reporting and could not recall when the in-service was attended.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #7 on 05/28/2024 with diagnoses that included a brain disorder caused by a chemical imbalance in the blood, Alzheimer's Disease, and anxiety disorder.</p> <p>A review of the admission MDS, with an ARD of 06/02/2024, revealed Resident #7 had a BIMS score of 2, which indicated Resident #7 had severe cognitive impairment. Resident #7 required supervision with eating; partial to moderate assistance with oral hygiene and dressing; substantial to maximum assistance with personal hygiene and was dependent on staff for toileting and showering; and required partial to moderate assistance from sitting to lying, lying to sitting, and sitting to standing, and utilizes a manual wheelchair for ambulation.</p> <p>A review of the Incident Note dated 07/23/2024 at 5:48 PM, revealed Resident #7 entered another resident's room attempting to lay in another resident's bed, the resident became upset and hit Resident #7 in the arm. Resident #7 in turn, hit the other resident on the arm. Notification was made to the local Police Department, APRN, and resident representative.</p> <p>A review of the eINTERACT SBAR Summary for Providers note, dated 07/23/2024 at 5:49 PM, revealed the situation as an Other change in condition. The primary care provider recommended monitoring.</p> <p>A review of the Incident Note, dated 07/25/2024 at 11:10 AM, revealed an investigation was conducted and showed staff heard a resident yell out and upon arrival to Resident #6's room, Resident #7 was getting into Resident #6's bed, and Resident #6 hit Resident #7 on the arm and Resident #7 hit Resident #6 back on the arm.</p> <p>A review of the Behavior Note, dated 07/25/2024 at 6:45 PM, revealed Resident #7 exhibiting aggressive behaviors toward staff and went for an unnamed Certified Nursing Assistant's [CNA's] hair and throat. Resident #7 placed on 1:1 supervision, notifications made to Assistant Director of Nursing [ADON], and physician. The physician gave order for geri-psych [geriatric psychiatry] transfer.</p> <p>A review of the Behavior Note, dated 07/25/2024 at 9:47 PM, revealed geri-psych did not have a bed available.</p> <p>A review of the Behavior Note, dated 07/27/2024 at 03:50 AM, revealed Resident #7 was aggressive toward staff earlier in the shift.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Behavior Note, dated 07/31/2024 at 07:33 AM, revealed Resident #7 had episodes of agitation related to a failed gradual dose reduction [GDR - reducing the amount of a medication being given to determine the lowest effective dose of the medication]. The medication was not identified.</p> <p>A review of the Nursing Progress Note, dated 08/03/2024 at 6:00 PM, revealed Resident #7 became aggressive with staff and residents and began coming at nurse with a butter knife, and stated, I'm going to cripple you. Resident #7 was kicking and hitting other residents. Residents were not identified in the note. Resident #7's responsible party was notified.</p> <p>A review of the Nursing Progress Note, dated 08/05/2024 at 5:11 AM, revealed the DON was notified of the incident on 08/03/2024 and Resident #7 is scheduled to see psychiatrist on the 9th.</p> <p>A review of the Behavior Note, dated 08/16/2024 at 1:34 PM revealed resident continuing to be aggressive with residents and staff. Resident #7 cannot be redirected. The physician ordered medication for depression to be restarted.</p> <p>A review of an Incident Note, dated 08/19/2024 at 09:35 AM, revealed Resident #7 was placed 1:1 supervision for safety, after staff reported hearing screams and observed Resident #7 trying to use the call light to choke a resident and kneeling the other resident in the chest Notification was made to Eureka Springs Police Department, Power of Attorney [POA], DON, Administrator and physician. Police incident number issued was 24-00416.</p> <p>A review of the local Police Department Offense/Incident Report, complaint number 24-000416, dated 08/19/2024 at 09:58 AM, and an incident type listed as Battery-3rd. The report indicated the incident occurred on 08/19/2024 at The Blossoms Rehab & Nursing Center. The victim is listed as Resident #8, and the suspect is listed as Resident #7. The Offense/Incident Narrative indicated the office spoke with the DON who revealed two residents were involved in an altercation with no injuries and requested the incident be documented, and that both had issues to where they did not fully understand what they were doing. Resident #8 entered Resident #7's room to watch television and Resident #8 became angry and attempted to choke Resident #7 with a cord and was unsuccessful. Resident #8 also kneeed Resident #7 in the chest a couple of times.</p> <p>A review of an Incident Note, dated 08/21/2024 at 6:40 AM, revealed Resident #7 had unpredictable behaviors. An unidentified CNA heard screaming and observed Resident #7 using the call light to choke another resident while putting their knee in the other resident's chest. Staff separated the residents immediately before [Resident #7] could get the cord completely around the resident. Resident #7 was sent for a geri-psych consult.</p> <p>A review of the Admission Record indicated Resident #8 was admitted on [DATE] with diagnoses that included age related macular degeneration, bipolar disorder, anxiety disorder, traumatic brain injury, alcohol-induced persisting dementia, somnolence [excessive sleepiness with known causes that included anxiety, medication, depression or stress], altered mental status and delusional disorders.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The significant change MDS with an ARD of 08/04/2024 revealed Resident #8 had a BIMS score of 2, which indicated the resident had severe cognitive impairment. Resident #8 had a mood score of 1 which indicated resident had little interest or pleasure in doing things 2-6 days. Behaviors toward others occurred 1 to 3 days a week and included physical and verbal symptoms. Resident #8 required assistance eating and was dependent on staff for oral hygiene, toileting dressing, and personal hygiene and required supervision walking and moderate assistance sitting, standing from seated position, and transfers from chair to bed and bed to chair, and use an assistive device for ambulation was not indicated.</p> <p>A review of SBAR [Situation Background Appearance Review and Notify] Communication Form, dated 08/19/2024, indicated Resident #8's change in condition was skin wound, other change in condition: receiver of physical aggression. Notification of the primary care was listed as 9:35 AM with recommendation to monitor.</p> <p>A review of eINTERACT Change in Condition evaluation V5, dated 08/19/2024 at 09:35 AM, revealed, the change in condition was a skin wound or ulcer and other change in condition listed as receiver of physical aggression on 08/19/2024. The skin evaluation status indicated Resident #8 had an abrasion and the site indicated was on the face, with a description of bridge of nose. Response to evaluation for pain status was listed as Not clinically applicable to the change in condition being reported. Additional pertinent diagnosis was marked as dementia. Notification of resident representative was listed as case worker notified on 08/19/2024 at 09:35.</p> <p>A review of Resident #8's Incident Note dated 08/19/2024 at 09:35 AM revealed, the CNA heard screaming and observed another resident with their knee in Resident #8's chest while trying to choke Resident #8 with a call light. Resident #8's body audit revealed an abrasion on the bridge of the nose. The aggressor was placed on 1:1 supervision for safety. The local police department, the POA, the DON, the Administrator, and MD were notified.</p> <p>A Health Status note, dated 08/20/2024 at 3:24 PM, revealed Resident #8 remained on follow up for previous altercation and had no complaints of pain or discomfort.</p> <p>An Incident Note, dated 08/21/2024 at 07:03 AM indicated Resident #8 had not been sleeping at night, staff reported screaming and upon investigation found a resident trying to use the call light to choke [Resident #8's first name] while kneeling [Resident #8 gender pronoun] in the chest. Staff separated residents before resident could get cord completely around [Resident #8] neck to choke [Resident #8 gender identity]. Investigation was conducted and revealed Resident #8 entered another resident's room and was sitting on a roommate's bed watching television [TV]. A small abrasion on the bridge of nose was noted and Resident #8 states does not know where it [the abrasion] came from.</p> <p>During an interview on 08/29/2024 at 12:20 PM, LPN #7 stated Resident #8 was watching TV visiting with Resident #11 when Resident #7 attempted to choke Resident #8. Resident #7 lifted their leg to Resident #8's chest and began hitting Resident #8 with their knee. The CNA was sent to report to the DON. Resident #7 was placed 1:1, and the doctor was notified. Resident #7 remained 1:1 until they were sent to behavioral health. Resident #8 usually did not show emotion and there were no signs or symptoms of pain.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Blossoms at Eureka Springs Rehab & Nursing Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 235 Huntsville Road Eureka Springs, AR 72632	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/29/2024 at 5:58 PM, the DON stated they were notified of the incident on 08/19/2024 involving Resident #7 and Resident #8 and Resident #8 had an abrasion on the nose from the incident, and indicated the bridge of the nose, the DON placed the right index finger on upper part of the nose between the eyes. The DON stated CNAs were interviewed and the call light was in front of Resident #8's face, but not touching the body. The DON was asked if the documentation in the EHR [electronic health record] was accurate and stated, The nurse put on the I & A [incident and accident report] what she was told. The DON then demonstrated using hands, palms with fingers curled as if holding an object, facing away from their shoulders, even with their jaw line/chin on either side of their neck. The DON was asked to demonstrate with a charging cord, the DON pulled the cord with the right hand, straight out away from their right shoulder, and began to drape the cord to the opposite side of the body, then let the cord drop along the right side and stated the cord was pulled and still attached to the wall in one of Resident #7's hands and was not close to Resident #8's neck, the rest of it was laying on the bed next to him.</p> <p>A review of the Admission Record revealed Resident #10 was admitted to the facility on [DATE], with diagnoses that included blood clot formation in the brain after injury, loss of brain function caused by toxins in the blood due to liver damage, and anxiety.</p> <p>The admission MDS, with an ARD of 06/02/2024, revealed Resident #10 had a BIMS score of 6, which indicated resident had severe cognitive impairment. Resident #10 mood score was 1 feeling down, depressed, or hopeless 2-6 days. Resident #10 was independent eating, toileting and oral hygiene; required set up/cleanup assistance with dressing; and required supervision with showering and personal hygiene. Resident #10 was independent with transfers and walking. Resident #10 did not have behaviors.</p> <p>A review of a Behavior Note, dated 08/27/2024 at 12:45 AM revealed, Resident #10 was in another resident's room and was stuck on the left cheekbone causing swelling and hematoma [abnormal collection of blood in the tissues outside of the blood vessel].</p> <p>A review of a Health Status, note dated 08/27/2024 at 10:36 AM, indicated Resident #10's cheekbone continues to have swelling and labs were drawn for increased confusion.</p> <p>A review of an Order Note, dated 08/27/2024 at 2:53 PM, indicated Resident #10 had vomiting and received an order for medication to relieve nausea and vomiting to be given every 8 hours.</p> <p>A review of a Health Status, note dated 08/29/2024 at 2:52 PM indicated Resident #10 continues to have confusion and swelling to left cheekbone.</p> <p>A review of the local Police Department Offense/Incident Report, dated 08/27/2024 at 1:24 AM, revealed the complaint number was 24-000439 and the incident was listed as Battery 3rd. Resident #10 was identified as the victim, and Resident #11 was identified as the suspect. The narrative indicated a CNA heard cursing and went to the room, Resident #11 was angry and began hitting Resident 10 in the chest and face. The CNA left the room to seek a nurse and upon return, Resident #10 had blood in his mouth and a black eye. Resident #11 had a scratch to the hand. The police report contained photos of the injuries.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 08/29/2024 at 3:54 PM, LPN #9 stated they are employed by an online staffing platform and was working 6:00 PM to 6:00 AM shift. Resident #10 was wandering all night and went into Resident #11's room, through the bathroom. Resident #10 was confused and had a hematoma on their left cheek when LPN #9 entered the room. Notification was made to the DON, who notified the Administrator, the Physician, and Resident #10's responsible party. LPN #9 notified LPN #7 who called to make a police report. Both residents were assessed. Resident #11 had previously exhibited behaviors that included throwing things and hitting people.</p> <p>During an interview on 08/29/2024 at 5:58 PM, the DON stated being notified of the incident on 08/27/2024 involving Resident #10 and Resident #11 and that Resident #10 was turned around leaving the bathroom and got into Resident #11's bed. When staff arrived in the room, Resident #11 had already hit Resident #10. Staff removed Resident #10 from the room and did a body audit. Resident #10 had redness or signs of pain. The DON stated the assessment did not show any injuries and no treatment was needed because there was no swelling or bruising to Resident #10's face. The DON stated the vomiting was related to Resident #10's elevated potassium level and when Resident #10 was admitted, the level was over 300. [normal range for potassium in adults is 3.5 to 5.2 mEq/L (milliEquivalent per liter)] The DON did not observe any swelling or bruising when they assessed Resident #10 and states there was no swelling or bruising on reassessment.</p> <p>On 08/29/2024 at 6:30 PM, the DON stopped the interview stating they needed to get a copy of the In-service.</p> <p>On 08/29/2024 at 6:37 PM, the Administrator entered the conference room and stated residents are not responsible for their actions and the incident was resident to resident and not required to be reported if there were no injuries. The Administrator stated he had never seen anything in the regulations that says we don't have to report, and it is based on resident to resident.</p> <p>The Administrator stated he was made aware of the incident involving Resident #6 by the DON and that residents were assessed according to the facility's process. The Administrator stated the facility does all the steps as if it was to be reported to the state and notifications to the physician, police department, and family are made. The Administrator stated it was Always told from surveyors, that resident-to-resident are not responsible for their actions and does not need to be reported. The Administrator stated he could not tell the names of everyone that told him and he could not recall what the regulation says. The Administrator stated the facility had two hours, per the requirement, to report. It was not done, not reported to the state, and stated the reason was [AGE] years ago the person doing the intake at the state said it was not reportable. The Administrator stated it was only major injuries that needed to be reported and stated a major injury, I assume it is a broken bone.</p> <p>The Administrator could not recall the incident with Resident #7 and Resident #8. The Administrator stated the incident was not reported to the state, he believes it was serious, and there was intervention by staff and the process was taken care of. The putting an extra report on that to the state was an unnecessary thing.</p> <p>The Administrator stated Resident #10 and Resident #11 incident was not reported and the fact considering the diagnoses and the hematoma on Resident #10's cheek from being struck by Resident #11 was a resident-to-resident altercation and was not reportable.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 08/29/2024 at 6:52 PM, the DON returned to the conference room to resume the interview. The DON stated there was no report made to the Office of Long-Term Care for the incident involving Resident #7 and Resident #8 or the incident involving Resident #10 and Resident #11. We did all the steps but no, it was not reported.</p> <p>On 08/29/2024 at 7:19 PM, the Nurse Consultant entered the conference room and provided additional information via email to the surveyor. The document was titled, RCF [Residential Care Facility] Incident Reporting, and is not a regulation for a Skilled Nursing or Nursing Facility.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016</p> <p>Based on record review, facility document review and interviews, it was determined the facility failed to report alleged abuse for 4 (Resident #6, #7, #8, and #10) residents of 4 resident reviewed for abuse.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Policies and Procedures, with a subject of Abuse, Neglect, and Exploitation, with a reviewed date of 07/2023, specified Reporting: .All complaints, concerns, or suspicions of abuse should be immediately reported to the Administrator .3. The facility will report all alleged violations involving . abuse to the Office of Long-Term Care .shall be reported immediately, but not later than 2 hours after forming the suspicion .or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.</p> <p>A review of the Admission Record indicated the facility admitted Resident #6 on 05/26/2024 with diagnoses that included vascular dementia, depression, and anxiety.</p> <p>The quarterly Minimum Data Set [MDS], with an Assessment Reference Date [ARD] of 08/19/2024 revealed Resident #6 had a Brief Interview for Mental Status [BIMS] score of 3, which indicated resident had severe cognitive impairment. Resident #6 was independent with toileting and required setup or clean up assistance with eating, oral hygiene, showering, dressing, and personal hygiene. Resident #6 was independent with ambulation and did not require an assistive device.</p> <p>A review of a Care Plan, with an initiation date of 05/30/2024, revealed Resident #6 had a history of self-harm and self-mutilation ideation related to severe mental illness. Interventions included a stop sign placed across the room door to deter wandering and uninvited residents out of the room; conduct random room safety checks and personal wellness checks, and behavior monitoring.</p> <p>A review of the Incident Note, dated 07/23/2024 at 5:55 PM, revealed Resident #6 became upset when another resident entered Resident #6's room and attempted to lay down on the bed. Aggressor was placed 1:1 supervision [one-on-one meaning one staff member was assigned to aggressor for observation]. Local Police Department was notified.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #7 on 05/28/2024 with diagnoses that included a brain disorder caused by a chemical imbalance in the blood, Alzheimer's Disease, and anxiety disorder.</p> <p>A review of the admission MDS, with an ARD of 06/02/2024, revealed Resident #7 had a BIMS score of 2, which indicated Resident #7 had severe cognitive impairment. Resident #7 required supervision with eating; partial to moderate assistance with oral hygiene and dressing; substantial to maximum assistance with personal hygiene and was dependent on staff for toileting and showering; and required partial to moderate assistance from sitting to lying, lying to sitting, and sitting to standing, and utilizes a manual wheelchair for ambulation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Incident Note, dated 07/23/2024 at 5:48 PM, revealed Resident #7 entered another resident's room attempting lay in another resident's bed, the resident became upset and hit Resident #7 in the arm. Resident #7 in turn, hit the other resident in the arm. Notification was made to the local Police Department, APRN[Advance Practice Registered Nurse] , and resident representative.</p> <p>A review of the Incident Note, dated 07/25/2024 at 11:10 AM, revealed an investigation was conducted and showed staff heard a resident yell out and upon arrival to Resident #6's room, Resident #7 was getting into Resident #6's bed, and Resident #6 hit Resident #7 in the arm and Resident #7 hit Resident #6 back in the arm.</p> <p>A review of the local Police Department Offense/Incident Report, dated 07/23/2024 at 5:30 PM, revealed the type of incident as an Information Report. The report revealed Licensed Practical Nurse (LPN) #7 contacted the police department to report an altercation involving Resident #6 and the progress notes from the nurses were attached to the report. The attached report indicated it was privileged and confidential. The report revealed physical aggression initiated, listed impulsive as a predisposing factor. The incident was described as Resident #6 sitting in his room when another resident entered and attempted to lay on the bed. Resident #6 hit the other resident on the arm and Resident #6 was struck back in their arm. No visible marks present. Notification was made to the Administrator, Police Department, Family, Physician, and Director of Nursing (DON). The report was completed by LPN #10. The attached incident note dated 07/25/2024 at 11:25 AM, revealed Resident #6 was placed 1:1 supervision for safety and a stop was placed across Resident #6's door, wife and APRN MD [Medical Director] were notified.</p> <p>During an interview on 08/29/2024 at 5:58 PM, the DON stated she was notified and was familiar with the Resident-to-Resident incident involving Resident #6 and Resident #7 on 07/23/2024. The DON notified the Administrator via social communication at 09:40 AM. The incident did occur, and an incident number was requested. No facility report was done, and the Office of Long-Term Care was not notified.</p> <p>A review of an Incident Note, dated 08/19/2024 at 9:35 AM, revealed Resident #7 was placed 1:1 supervision for safety, after staff reported hearing screams and observed Resident #7 trying to us the call light to choke a resident and kneeling the other resident in the chest Notification was made to local Police Department, POA (Power of Attorney), DON, Administrator and physician. Police incident number issued was issued</p> <p>A review of the Admission Record, indicated Resident #8 was admitted on [DATE] with diagnoses that included age related macular degeneration, bipolar disorder, anxiety disorder, traumatic brain injury, alcohol-induced persisting dementia, somnolence [excessive sleepiness with known causes that included anxiety, medication, depression or stress], altered mental status and delusional disorders.</p> <p>The significant change MDS, with an ARD of 08/04/2024, revealed Resident #8 had a BIMS score of 2 which indicated the resident had severe cognitive impairment. Resident #8 had a Mood score of 1 which indicated resident had little interest or pleasure in doing things 2-6 days. Behaviors toward others occurred 1 to 3 days a week and included physical and verbal symptoms. Resident #8 required assistance eating and was dependent on staff for oral hygiene, toileting dressing, and personal hygiene and required supervision walking and moderate assistance sitting, standing from seated position, and transfers from chair to bed and bed to chair, and use an assistive device for ambulation was not indicated.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of SBAR [Situation Background Appearance Review and Notify] Communication Form, dated 08/19/2024, indicated Resident #8's change in condition was skin wound, other change in condition: receiver of physical aggression. Notification of the primary care was listed as 9:35 AM with recommendation to monitor.</p> <p>A review of Resident #8's Progress Notes New type Incident Note dated 08/19/2024 at 9:35 AM revealed, the Certified Nursing Assistant [CNA] heard screaming and observed another resident with their knee in Resident #8's chest while trying to choke Resident #8 with a call light. Resident #8's body audit revealed an abrasion on the bridge of the nose. The aggressor was placed on 1:1 for safety. Eureka Springs police department, the POA, DON, Administrator and MD were notified.</p> <p>An Incident Note, dated 08/21/2024 at 07:03 AM indicated Resident #8 had not been sleeping at night, staff reported screaming and upon investigation found a resident trying to use the call light to choke [Resident #8's first name] while kneeling [Resident #8 gender pronoun] in the chest. Staff separated residents before resident could get cord completely around [Resident #8] neck to choke [Resident #8 gender identity].</p> <p>During an interview on 08/29/2024 at 12:20 PM, LPN #7 stated Resident #8 was watching television [TV] and visiting with Resident #11 when Resident #7 attempted to choke Resident #8. Resident #7 lifted their leg to Resident #8's chest and began hitting Resident #8 with their knee. The CNA was sent to report to the DON. Resident #7 was placed 1:1, and the doctor was notified. Resident #7 remained 1:1 until they were sent to behavioral health. Resident #8 usually did not show emotion and there were no signs or symptoms of pain.</p> <p>During an interview on 08/29/2024 at 5:58 PM, the DON stated she was notified of the incident on 08/19/2024 involving Resident #7 and Resident #8 and that Resident #8 had an abrasion on their nose from the incident, and indicated the bridge of the nose, the DON placed their right index finger on upper part of the nose between their eyes.</p> <p>A review of the local Police Department Offense/Incident Report,, dated 08/19/2024 at 9:58 AM, and an incident type listed as Battery-3rd. The report indicated the incident occurred on 08/19/2024 at facility. The victim is listed as Resident #8, and the suspect is listed as Resident #7. The Offense/Incident Narrative indicated the office spoke with the DON who revealed two residents were involved in an altercation with no injuries and requested the incident be documented, and that both had issues to where they did not fully understand what they were doing. Resident #8 entered Resident #7's room to watch television and Resident #8 became angry and attempted to choke Resident #7 with a cord and was unsuccessful. Resident #8 also kneed Resident #7 in the chest a couple of times.</p> <p>A review of the Admission Record revealed Resident #10 was admitted to the facility on [DATE], with diagnoses that included blood clot formation in the brain after injury, loss of brain function caused by toxins in the blood due to liver damage, and anxiety.</p> <p>The admission MDS with an ARD of 06/02/2024 revealed Resident #10 had a BIMS score of 6, which indicated resident had severe cognitive impairment. Resident #10 Mood score was 1 feeling down, depressed, or hopeless 2-6 days. Resident #10 was independent eating, toileting and oral hygiene; required set up/cleanup assistance with dressing; and required supervision with showering and personal hygiene. Resident #10 was independent with transfers and walking. Resident #10 did not have behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of a Behavior Note, dated 08/27/2024 at 12:45 AM revealed, Resident #10 was in another resident's room and was stuck on the left cheekbone causing swelling and hematoma [abnormal collection of blood in the tissues outside of the blood vessel].</p> <p>A review of the local Police Department Offense/Incident Report, dated 08/27/2024 at 1:24 AM, revealed the complaint and the incident was listed as Battery 3rd. Resident #10 was identified as the victim, and Resident #11 was identified as the suspect. The narrative indicated a CNA heard cursing and went to the room, Resident #11 was angry and began hitting Resident #10 in the chest and face. The CNA left the room to seek a nurse and upon return, Resident #10 had blood in his/her mouth and a black eye. Resident #11 had a scratch to their hand. The police report contained photos of the injuries.</p> <p>During an interview on 08/29/2024 at 3:54 PM, LPN #9 stated they are employed by online staffing platform and was working 6:00 PM to 6:00 AM shift. Resident #10 was wandering all night and went into Resident #11's room, through the bathroom. Resident #10 was confused and had a hematoma on their left cheek when LPN #9 entered room. Notification was made to the DON, who notified the Administrator, the Physician, and Resident #10's responsible party. LPN #9 notified LPN #7 who called to make a police report.</p> <p>During an interview on 08/29/2024 at 5:58 PM, the DON stated they were notified of the incident on 08/27/2024 involving Resident #10 and Resident #11.</p> <p>On 08/29/2024 at 6:37 PM, the Administrator stated residents are not responsible for their actions and the incident was resident to resident and not required to be reported if there were no injuries. The Administrator stated he had never seen anything in the regulations that says they don't have to report based on resident to resident. The Administrator stated the facility had two hours, per the requirement, to report. It was not done, not reported to the state.</p> <p>The Administrator could not recall the incident with Resident #7 and Resident #8. The Administrator stated the incident was not reported to the state, he believes it was serious, and there was intervention by staff and the process was taken care of. Putting an extra report on that to the state was an unnecessary thing.</p> <p>The Administrator stated Resident #10 and Resident #11 incident was not reported and the fact considering the diagnoses and the hematoma on Resident #10's cheek from being struck by Resident #11 was a resident-to-resident altercation and was not reportable.</p> <p>On 08/29/2024 at 6:52 PM, the DON stated there was no report made to the Office of Long-Term Care for the incident involving Resident #7 and Resident #8 or the incident involving Resident #10 and Resident #11. We did all the steps but no, it was not reported.</p>		