

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/19/2025
NAME OF PROVIDER OR SUPPLIER The Blossoms at the Village Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1208 North Highway 7 Hot Springs, AR 71909	
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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on record review, observation, and interview, it was determined that the facility failed to serve three (Resident #56, #30, and #68) of three residents ordered fortified foods, reviewed for diet orders. The findings include: Resident #56 A review of Resident #56's admission Record indicated the facility admitted the resident on 06/28/2024, with diagnoses which included dementia. A review of Resident #56's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/03/2025, revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. A review of Resident #56's Care Plan revised on 07/14/2025, revealed the resident had a nutritional problem or potential nutritional problem related to a history of dysphagia and poor by mouth intake. Resident #56's Care Plan also included interventions, which directed staff to provide and serve diet as ordered. A review of Resident #56's Diet Type Report revealed the resident had a diet order for fortified food with lunch. A review of Resident #56's Order Summary revealed the resident had an order for regular texture, thin liquids consistency, fortified food with lunch, two tablespoon butter with breakfast, eight ounces of whole milk with breakfast, give ice cream two times a day with lunch and supper, for weight loss. Resident #30 A review of Resident #30's admission Record indicated the facility admitted the resident on 06/30/2021, with diagnoses which included Alzheimer's and anemia. A review of Resident #30's quarterly MDS with an ARD of 09/26/2025, revealed a BIMS score of 11, which indicated the resident had moderate cognitive impairment. A review of Resident #30's Care Plan, revised on 07/14/2025, revealed the resident had a nutritional problem or potential nutritional problem due to Alzheimer's. Resident #30's Care Plan also included interventions which directed staff to provide fortified foods at breakfast, large portions with breakfast. (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #30's Order Summary revealed regular fortified food diet, regular texture, thin liquids consistency, large portions at breakfast, and ice cream at lunch. A review of Resident #30's Diet Type Report revealed the resident had a diet order for regular fortified foods. Resident #68 A review of Resident #68's admission Record indicated the facility admitted the resident on 10/29/2020, with diagnoses which included late onset Alzheimer's disease. A review of Resident #68's annual MDS with an ARD of 10/23/2025, revealed a BIMS score of 12, which indicated the resident had moderate cognitive impairment. A review of Resident #68's Care Plan, revised on 04/28/2025, revealed the resident had a nutritional problem or potential nutritional problem due to Alzheimer's disease. Resident #68's Care Plan also included interventions, which directed staff to add fortified foods, weekly weights until stable. A review of Resident #68's Order Summary revealed regular fortified foods, regular texture, thin liquid consistency. A review of Resident #68's Diet Type Report indicated the resident had an order for regular fortified foods. During a concurrent observation and interview on 12/17/2025 at 12:00 PM, this surveyor observed [NAME] #2 with melted butter in a glass container and poured an unmeasured amount on top of the mashed potatoes for the residents that was ordered fortified foods. [NAME] #2 indicated, that is my fortified mashed potatoes. During an observation on 12/17/2025 at 12:27 PM, Resident #56's tray card indicated the resident liked mashed potatoes and required fortified foods. There were no mashed potatoes served to the resident. Resident #30 and Resident #68's tray cards indicated both residents required fortified foods. During an observation on 12/17/2025 at 1:39 PM, Resident #56 was served lunch, from the regular menu, in their room. Resident #56's lunch tray revealed only a biscuit with a soup-like substance on top of it, a bowl of salad, a cookie, and a drink. There were no fortified foods observed. During an observation on 12/17/2025 at 1:42 PM, Resident #30 was served from the alternate menu, which was an open-faced turkey sandwich, chips, and a cookie. The resident was only served the turkey sandwich and a drink. There were no chips, cookie, or fortified foods observed. This surveyor also observed that Resident #68 was served from the regular menu which was a biscuit with a soup-like substance on top of the biscuit, side salad and a cookie. The resident was served the regular menu with no fortified food observed. During an interview on 12/18/2025 at 10:38 AM, [NAME] #2 revealed, We had a fortified log before the last dietary manager. I don't know where it is. I just found it. I find something to put in the food like cream, butter, cheese, or whatever to make it high in calories. If the residents had pudding, I would probably put cream in it because it's fattening. I don't know if we have an updated one. This one is from 2019. I have not been making fortified foods by the menu. It is important to make sure the (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents are getting their calories they need. Not getting the fortified dish, it could cause weight loss which could cause health issues. During an interview on 12/18/2025 at 1:43 PM, with [NAME] #3 revealed, Residents that are required to receive fortified foods have it documented on their tray card. If there is a fortified menu, I don't know where it is. I still make fortified foods for the residents. I add milk, chicken stock, sour cream, and butter. I don't really measure it; I just add it in. It's important for the residents to get more protein to help with weight loss. During an interview on 12/18/2025 at 2:00 PM, the Regional Dietary Manager (RDM) indicated, The staff are supposed to be trained to know the fortified menus are in the back of the production book. [Cook #3] told me that the binder was pulled out earlier for you but couldn't find it at first. The importance of fortified foods is to make sure the residents are getting the extra calories they need for weight loss. The fortified menu ensures the appropriate amount of extra calories the residents need. The meal card indicates whether the resident is on fortified foods.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Number of residents sampled: Number of residents cited: Based on observations and interviews it was determined that the facility failed to post the required nurse staffing information for resident and visitor access. Specifically, the facility failed to post nurse staffing information on 12/17/2025 until 2:00 PM. The findings include: During an observation on 12/17/2025 at 2:00 PM, this surveyor observed the facility's common areas and discovered there was no nurse staffing information posted anywhere in the building for residents and visitors. Effort to locate the nurse staffing information was made at the front entrance area, at the entrance to every hall, in the common area, and the nurse's station. Upon request, the Human Resource Director went into his office and wrote the information on a sheet of paper and posted it on a glass window facing the common area close to the entrance of the facility. During an interview on 12/17/2025 at 2:12 PM, the Human Resources Director stated the daily posted staffing was not out and posted at the beginning of the shift as mandated, because he had been, working on updating it. The Human Resources Director stated today's information was not on there and he had been busy and not gotten to it today. During an interview on 12/19/2025 at 12:22 PM, the Director of Nursing (DON) stated the information was there for the facility's visitors and residents to know how many nurses and Certified Nursing Assistants (CNAs) were in the building. During an interview on 12/19/2025 at 12:28 PM, the Administrator stated she was aware that the daily nursing staff information was supposed to be posted, however she was not aware of the importance or purpose for the information. During a follow-up interview on 12/19/2025 at 12:35 PM, the Administrator stated the information regarding additional staffing information like names and assignments were on the facility's staffing sheets in a different area of the same room and all people had to do was ask for it and the staff would show it to them.		