

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER The Blossoms at Woodland Hills Rehab & Nursing Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 8701 Riley Drive Little Rock, AR 72205	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide nail care for one (Resident #6) of three residents reviewed for nail care, and to ensure staff answered one (Resident #8) of four resident ' s call lights in a timely manner.</p> <p>The findings include:</p> <p>1. A review of Resident #6 ' s Order Summary Report indicated the facility admitted the resident on 11/22/2024, with diagnosis which included type 2 diabetes mellitus without complications. Resident #6 ' s Order Summary Report also indicated the resident should be evaluated by a podiatrist and treated as needed.</p> <p>A review of Resident #6 ' s quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/30/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment.</p> <p>A review of Resident #6 ' s Care Plan initiated 12/03/2024, revealed the resident was independent with all activities of daily living, but required cueing at times. The Care Plan had interventions which included to check fingernails and toenails, trim as needed and to notify the nurse if the resident was a diabetic.</p> <p>During an interview on 06/26/2025 at 9:20 AM, Resident #6 indicated their toenails had not been cut since they were admitted on [DATE]. The resident stated when they took showers, the aides would tell the resident they used to cut toenails, but they did not anymore. Resident #6 indicated they were told by staff a week and a half ago they were going to cut the resident ' s nails.</p> <p>During an interview on 06/26/2025 at 9:20 AM, the Assistant Director of Nursing (ADON) indicated Resident #6 ' s toenails were clipped by the podiatrist, as needed.</p> <p>During an interview on 06/26/2025 at 9:46 AM, Licensed Practical Nurse (LPN) #1 stated the Certified Nursing Aides (CNAs) were responsible for cutting Resident #6's toenails, because the resident was not an active blood sugar check.</p> <p>During an observation on 06/26/2025 at 9:47 AM, CNA #3 removed both of Resident #6's socks. The resident ' s toenails were approximately 1/2 to 1 inch long. Some of the resident ' s toenails were curved and had sharp points on them. Resident #6's feet were dry with white flakes. CNA #3 stated the aides did not cut Resident #6's toenails, because the resident was diabetic.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 045259	If continuation sheet Page 1 of 3

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/26/2025 at 9:48 AM, Resident #6 stated their toenails were sharp, and that they could only wear open-toed shoes because their toenails were too long to wear regular shoes.</p> <p>During a concurrent interview and observation on 06/26/2025 at 10:03 AM, the Administrator verified that the nurse or the podiatrist were responsible for cutting Resident #6's toenails. The Administrator confirmed Resident #6's toenails were long, curved, and needed to be clipped.</p> <p>During an interview on 06/26/2025 at 10:06 AM, the ADON revealed Resident #6 did not have any records on file indicating that the resident had seen the podiatrist since admission.</p> <p>During a concurrent interview and observation on 06/26/2025 at 1:29 PM, the Director of Nursing (DON) stated she did not know how often the staff provided nail care for Resident #6. The DON verified Resident #6's toenails were too thick for staff to cut them, and the resident needed to see a podiatrist.</p> <p>2. During an observation on 06/18/2025 from 11:15 AM to 11:40 AM, this surveyor observed that Resident #8's call light was on.</p> <p>During an observation on 06/18/2025 at 12:15 PM, this surveyor observed that Resident #8's call light was on, and Licensed Practical Nurse (LPN) #1 was sitting at the nurse's desk.</p> <p>A review of Resident #8 ' s Order Summary Report indicated the facility re-admitted the resident on 09/02/2022, with diagnoses which included type 2 diabetes mellitus without complications.</p> <p>A review of Resident #8 ' s quarterly MDS with an ARD of 04/11/2025, revealed the resident had a BIMS score of 12, which indicated moderate cognitive impairment.</p> <p>A review of Resident # 8 ' s Care Plan, initiated 02/08/2022, revealed the resident was at risk for falls related to balance and unsteady gait. The Care Plan included interventions to ensure the call light was within reach and to encourage the resident to use the call light for assistance as they needed. Staff were to respond promptly to all requests for assistance from the resident.</p> <p>During an interview on 06/25/2025 at 11:58 AM, Resident #8 stated their call light had been on for 30 minutes. The resident indicated they told CNA #2 they were hurting, and CNA #2 told Resident #8 she could not put them in bed until after lunch.</p> <p>During an interview on 06/25/2025 at 12:24 PM, CNA #2 stated she could not answer Resident #8's call light, because she was on her lunch break. CNA #2 indicated she informed LPN #1 she was going on break. CNA #2 confirmed Resident #8 told her they wanted to get in bed, and CNA #2 asked the resident to wait until she returned from lunch.</p> <p>During an interview on 06/25/2025 at 1:07 PM, LPN #1 verified that CNA #2 told Resident #8 she was going on break. LPN #1 stated she did not realize Resident #8's call light had been going off for 30 minutes. LPN #1 indicated she was completing a medication pass on the C Hall, and did not realize there were no staff on the A Hall.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 06/26/2025 at 9:24 AM, Resident #8 stated it took staff a long time to answer the call lights. The resident indicated that sometimes the call lights never got answered, especially at night.</p> <p>During an interview on 06/26/2025 at 1:30 PM, the DON confirmed resident call lights should be answered immediately.</p> <p>During an interview on 06/26/2025 at 2:41 PM, the Administrator stated staff should not tell a resident to wait until they come back from break to be put in bed. The Administrator indicated the facility did not have a policy on call lights.</p>		