STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045259	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Woodland Hills Rehab & Nursing Cen	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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect the residents' right to be free from neglect. Specifically, the facility failed to obtain a urine sample in a timely manner to rule out a Urinary Tract Infection (UTI) for Resident #1 and failure to order an antibiotic in a timely manner for Resident #1 to treat a UTIIt was determined the facility's noncompliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The immediate Jeopardy (IJ) was related to eCFR S483.12(Freedom from Abuse, Neglect, and Exploitation) at a scope and severity of K.The IJ began on [DATE] at 6:02 PM, when Resident #1 had a written physician order to obtain a Urinary Analysis (UA) to rule out a UTI. On [DATE] at 6:06 PM, according to a lab report, resident's urine sample was obtained. On [DATE] at 11:46 AM, the lab report contained a critical result which required antibiotic treatment that was not received. The Administrator and Director of Nursing (DON) were notified of IJ on [DATE] at 1:14 PM. A removal plan was requested. The removal plan was accepted by the State Agency on [DATE] at 7:23 PM.The findings include: Review of an admission Record revealed Resident #1 was admitted on [DATE] with diagnoses which included dementia, encephalopathy, urinary incontinence, bipolar disorder, anxiety, and painful micturition [urination]. Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed Resident #1 had a Staff Assessment of Mental Status (SAMS), which indicated the resident was moderately impaired for decision making. The MDS also included that Resident #1 was frequently incontinent with urine, and occasionally incontinent with bowel. Review of Resident #1's Care Plan, initiated on [DATE], revealed the medical doctor should be called as needed for agitation, confusion, and change in eating habits. Review of a Physician Order dated [DATE] indicated to obtain a Urine Analysis (UA) [urine test] to rule out UTI and treat if indicated. The order was signed as being entered by Assistant Director of Nursing (ADON) #1 and dated [DATE]. Review of a Lab Results Report with a collection date of [DATE] revealed Resident #'s1 lab results indicated positive for a UTI and was flagged as a critical result. Review of an Order Note dated [DATE] revealed an order for an antibiotic to be given one capsule by mouth four times a day for UTI for five days. The medication order was created by Assistant Director of Nursing (ADON) #2. Review of the Medication Administration Record (MAR) with a start date of [DATE] revealed a Physician Order for an antibiotic to be given four times a day for five days. Review of Progress Notes dated [DATE] at 12:35 PM and [DATE] at 6:38 PM electronically signed by LPN #2 revealed a note text indicating med not available. Review of a Progress Note dated [DATE] at 1:25 AM and electronically signed by LPN #5 revealed a note text indicating could not locate med.Review of a Visit Note dated [DATE] revealed Advanced Practice Registered Nurse (APRN) #2 indicated the reason for the visit was to follow up on lab. The note indicated that Resident #1 did not interact much and was not eating and drinking on their own. The note indicated that Resident #1 was on antibiotics for a UTI, and labs for chloride, calcium, and lithium were elevated. The note indicated to send Resident #1 to the emergency room if the resident was not willing to take in more fluids. Review of Resident #1's Hospital Records dated [DATE] indicated that Resident #1 was admitted to the (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Intensive Care Unit on [DATE]. The Hospital Records indicated that Resident #1 was admitted with a diagnosis of septic shock (a life-threatening infection), respiratory failure, strep pneumonia (bacterial infection), acute kidney failure, leukocytosis (high white blood cell count), and metabolic acidosis (results from kidney failure). The hospital records also indicated that Resident #1 was pronounced deceased on [DATE] at 1:33 AM. During a phone interview on [DATE] at 10:32 PM, a visitor for Resident #1 indicated she came to visit Resident #1 on [DATE] and Resident #1 was not their normal self. The visitor indicated that Resident #1 was usually walking around and talking, and on [DATE] the resident was in bed moaning, scratching their skin, and appeared to be in pain. The visitor indicated that she was informed by Licensed Practical Nurse (LPN) #2 that Resident #1 had not had anything to eat or drink in a couple of days. The visitor indicated that LPN #2 stated, Resident #1 needed an Intravenous (IV) antibiotic, but he was scared she would pull it out. The visitor indicated that she asked LPN #2 to send Resident #1 to the hospital. The visitor indicated that Resident #1 was sent to the hospital and the visitor had received report that Resident #1's UTI had become septic (a life-threatening medical emergency), and that Resident #1 was in organ failure, had pneumonia, and strep. This information was verified by surveyor review of the hospital records. The visitor stated that she felt the facility was neglectful in caring for Resident #1. During an interview on [DATE] at 11:15 AM, Certified Nursing Assistant (CNA) #13 indicated that she had been employed for one and a half years at the facility. CNA #13 indicated that Resident #1 was walking when the resident was first admitted to the facility. CNA #13 indicated that she had reported to the nurses that Resident #1 was hurting a lot but that she did not remember what nurses she informed. During an interview on [DATE] at 12:40 PM, ADON #2 indicated that she had been employed at the facility for two weeks. ADON #2 indicated that the APRN would write orders on a handwritten physician order note and would give the nurses and ADON #2 a copy of the orders. ADON #2 indicated that she would put the orders in the electronic system if the nurses did not put the order in. ADON #2 indicated that ADON #1 had put the urine lab order in the system for Resident #1. ADON #2 indicated that ADON #1's last day had been on [DATE]. ADON #2 indicated that when lab orders were received, they go directly on the MAR. ADON #2 indicated that lab orders fall off the MAR within 24-48 hours after they were placed on the MAR. ADON #2 indicated that if the nurse could not obtain a urine specimen, then the oncoming nurse should be informed until the urine specimen was obtained. During a phone interview on [DATE] at 1:39 PM staff at [the local Pharmacy] indicated that her records indicated that facility staff did not pull an antibiotic from the [Name Brand] emergency medication dispensing cabinet. During a phone interview on [DATE] at 1:58 PM, the account manager from [the local Pharmacy] indicated that there were no medications pulled from the [Name Brand] emergency medication dispensing cabinet for Resident #1 while a resident at this facility. During a phone interview on [DATE] at 2:34 PM, with a staff member at [the local Pharmacy] she indicated that she received a call from an unknown staff member at the facility on [DATE] at 11:30 AM with a request to order an antibiotic for Resident #1. She indicated that she reviewed all of Resident #1's records and there was not a request for this medication prior to [DATE]. During an interview on [DATE] at 2:45 PM, ADON #2 indicated that she faxed the order for Resident #1's antibiotic to the pharmacy on [DATE]. She indicated that she never received the confirmation report that the pharmacy received the order. ADON #2 indicated that the administrator also faxed orders. ADON #2 indicated that if the nurses had an order for an antibiotic, they should get it from the emergency kit within two hours. ADON #2 indicated that the antibiotic ordered for Resident #1 should have been in the emergency kit. ADON #2 indicated that if the antibiotic was not in the emergency kit, the nurses should call the pharmacy so that the medication could be delivered the same day. During an interview on [DATE] at 3:20 PM, the DON indicated that Adult Protective Services called the administrator and requested that Resident #1 be sent to the hospital on [DATE]. The DON indicated she had not completed an assessment on Resident #1, that the ambulance had already picked Resident #1 up to go to the hospital when she made it to the residents' room to perform an assessment. During a phone interview on [DATE] at 3:25 PM, ADON# 1 indicated that she (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	wanted to obtain a UA on Resident #1 because the resident was not acting normally. ADON #1 indicated that she put the order in the computer for the urine sample on [DATE]. ADON #1 indicated that the floor nurses were responsible for obtaining the urine samples. ADON #1 indicated that she did not contact the doctor when she was not able to get the urine sample. ADON #1 indicated that she gave Resident #1 more water and informed LPN #12 that a urine sample was needed for Resident #1. During an interview on [DATE] at 3:35 PM, LPN #2 indicated that if medication was not available the number 9 was put in a box on the medication record indicating the medication was not available. LPN #2 indicated that the pharmacy should be called if a medication was not available. LPN #2 indicated that he called the pharmacy informing them that the antibiotic was needed for Resident #1. LPN #2 indicated that he did not recall what day he contacted the pharmacy. LPN #2 indicated that he was not sure if he checked the emergency stock for the medication. LPN #2 indicated that when medication was not available the pharmacy would usually bring the medication the evening the mediation was ordered. LPN #2 indicated that the nurses inform the oncoming nurse in report if a urine sample was needed. LPN #2 indicated that the information was passed to each nurse, on every shift until the urine sample was obtained. LPN #2 indicated that he was never informed that a urine sample was needed for Resident #1. During a phone interview on [DATE] at 12:24 AM, LPN #5 indicated that she saw Resident #1 once before the resident went to the hospital. LPN #5 indicated that it was at night when she saw Resident #1 and the resident was OK. LPN #5 indicated that she could not remember if she ordered the antibiotic for Resident #1. LPN #5 indicated that the floor nurses were responsible for getting the urine samples. LPN #5 indicated that she was never informed that Resident #1 needed a urine sample. During an interview on [DATE] at 8:53 AM, the DON indicated that the lab staff (an outside vendor) were not responsible for collecting urine samples, the facility staff collect the urine samples, and the lab staff pick up the samples. During an interview on [DATE] at 9:05 AM, LPN #12 indicated that she had been employed at the facility over a year on an as needed basis. LPN #12 indicated that Resident #1 walked around and required prompting to take medications. LPN #12 indicated the APRN would give the floor nurse, DON, and ADON a copy of all orders. LPN #12 indicated that the nurses were responsible for putting the orders in the electronic system. LPN #12 indicated that the orders will show up on the medication record after they were put in the electronic system. LPN #12 indicated that the lab (outside vendor) picked up urine samples after it was collected by the nurses. LPN #12 indicated that she was informed to attempt to collect urine on Resident #1. LPN #12 indicated that ADON #1 informed her that she could not do an in and out catheter on Resident #1. LPN #12 indicated that Registered Nurse (RN) #11 obtained the urine sample for Resident #1 but was not sure what day the urine sample was obtained. LPN #12 indicated that a requisition was printed off and placed on the tubing. LPN #12 indicated that if the lab order to obtain a urine specimen was on the medication record, then the nurse should sign it indicating that it was completed. During a phone interview on [DATE] at 9:33 AM, APRN #2 indicated that when an order was given for a urine culture, it was expected to be collected that day. APRN #2 indicated that the nurses should call one of the APRN's or the doctor if they were not able to collect the urine sample. APRN #2 indicated that she was not contacted about staff not being able to get a urine sample for Resident #1. APRN #2 indicated that she expected the nurses to give antibiotics the same day they were ordered. APRN #2 indicated that the pharmacy usually delivered antibiotics the evening they were ordered. APRN #2 indicated that she was not notified that the antibiotic was not available for Resident #1. APRN #2 indicated that a UTI should not be left untreated. APRN #2 indicated that she assumed the antibiotic was being given as ordered. During a phone interview on [DATE] at 9:57 AM, the Medical Director (MD) indicated that he expected urine to be collected the same day for lab orders. The MD indicated that urine should be collected within 24-48 hours after a UA was ordered to rule out a UTI. The MD indicated that he expected the nurses to contact him or the APRN'S if they could not get the specimen, and if the lab results were out of range. The MD indicated that he was not aware of any delays staff experienced obtaining the urine specimen for Resident #1. The MD indicated (continued on next page)

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Staff are trained upon hire, during orientation, then annually, on the policy regarding reporting abuse, the types of abuse, detecting abuse, and the recognition of signs and symptoms of abuse which include, but are not limited to, the following: unexplained crying, sudden change in mood or behaviors, suspiciousness, suspicious behaviors on the part of family or caregivers. Review of a facility policy titled, Resident Rights revealed that residents have the right to equal access to quality of care. Review of a facility policy titled, Medication Administration revealed that the Director of Nursing Services will supervise and direct all nursing personnel who administer medications. Medications must be administered according to orders, including required time frames. The individual administering the medication will record in the resident's medical record the signature and title of the person administering the medication. Review of a facility in-service form titled, In-service Education Report revealed an in-service was conducted on abuse and neglect on [DATE]. The form had 13 signatures on it.Removal Plan:On [DATE] immediately on notification DON initiated in-service with nurses working on the floor to ensure nurses were doing the following: -putting lab orders in the computer as Physician Ordered,- collecting lab specimens based on urgency, facility workflow, and lab access, with routine being collected within 24 hours and stat collected as soon as possible on the same day while respecting resident rights to participate in the lab collection, -notifying Physicians of problems obtaining labs -notifying Physician of critical results to be completed immediately, for residents that currently reside in the facility and newly admitted . Resident #1 no longer resides in the facility. On [DATE] immediately on notification the DON initiated in-services with nurses currently working on the following: -ordering medication based on urgency, facility workflow, and pharmacy access. - Routine medication will be ordered the same day, new meds needed soon but not stat will be ordered immediately after the order was written, or stat should be ordered immediately for current residents and newly admitted , Resident #1 no longer resides in the facility. On [DATE], 101 residents have the potential to be affected that reside in the facility according to the census.On [DATE], DON/Unit Manager initiated match back with Physician Orders and lab requisition for the past month to ensure nurses were:- putting lab orders in the computer as Physician Ordered,- collecting lab specimens based on urgency, facility workflow, and lab access, with routine [orders] being collected within 24 hours and stat collected as soon as possible on the same day while respecting resident rights to participate in the lab collection, -notifying Physicians of problems obtaining labs and -notifying Physician of critical results immediately, for current residents, with no negative findings.On [DATE], DON/Unit Manager interviewed nurses on duty, for current residents, to ensure Physicians have been notified of problems obtaining lab and critical labs have been reported, with no negative findings. On [DATE], DON/Unit Manager initiated match back with Physician Orders and medications for the past month for current residents to ensure the facility ordered medication in a based on urgency, facility workflow, and pharmacy access. Routine medication will be ordered the same day, new meds that were needed soon but not stat would be ordered immediately after the order was written, or stat should be ordered immediately for residents with the potential to be affected. The facility completed all medication reviews on [DATE] for current residents, last 30 days, with no negative findings. On [DATE] DON/Unit manager began re-education of all nurses currently working and DON/Designee would provide 1:1 education with all nurses, using an employee nurse roster, either in-person or via phone prior to starting their next shift to ensure nurses were putting lab orders (continued on next page)

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Beginning [DATE] DON/Unit Manager during clinical start-up will complete a clinical start up sheet to document the match back with Physician Orders and lab requisition using a log to ensure nurses were putting lab orders in the computer as Physician Ordered, collecting lab specimens based on urgency, facility workflow, and lab access, with routine being collected within 24 hours and stat collected as soon as possible same day while respecting resident rights to participate in the lab collection, notifying Physicians of problems obtaining labs and notifying Physician of critical results would be done immediately, to prevent re-occurrence. Beginning [DATE] DON/Unit Manager during clinical start-up would complete a clinical start up sheet to document match back Physician Orders and medications to ensure the facility ordered the medication based on urgency, facility workflow, and pharmacy access. Routine medication will be ordered the same day, new meds needed soon but not stat will be ordered immediately after the order was written, or stat should be ordered immediately to prevent re-occurrence. DON/designee using a start-up form will observe lab orders, Physician Orders, 24-hour communication sheets, and lab floor to ensure nurses were putting lab orders in the computer as Physician Ordered, collecting labs specimen based on urgency, facility workflow, and lab access, with routine being collected within 24 hours and stat collected as soon as possible same day while respecting resident rights to participate in the lab collection, notifying physician of problems obtaining labs and notifying Physician or critical results would be done immediately. Monitoring would be three times a week for eight weeks, making corrections as necessary and reporting negative findings to the administrator.DON/designee using a monitoring log will observe Physician Orders and medications to ensure medications were ordered based on urgency, facility workflow, and pharmacy access. Routine medication would be ordered the same day, new meds needed soon but not stat will be ordered immediately after the order was written, or stat should be ordered immediately this would be monitored for three times a week for eight weeks, making corrections as necessary and reporting negative findings to the administrator.DON/designee will report negative findings to the QAPI committee for review and recommendations. Onsite verification of the Removal Plan began on [DATE] at 11:25 AM, The IJ was removed on [DATE] at 12:35 PM after the survey team performed onsite verification that the Removal Plan had been implemented. when on [DATE], at 1:14 PM, it was determined that the following occurred on [DATE] at 6:02 PM:Element 1: Resident #1 had a written Physician Order to obtain a urinary analysis (UA) to rule out a urinary tract infection. On [DATE] at 6:06 PM, according to a lab report, resident's urine sample was obtained. On [DATE] at 11:46 AM, the lab report contained a critical result. Facility immediately began in-services, with nurses on the floor, for entering physician orders into the computer, collecting lab specimens based on urgency, lab access with routine being collected within 24 hours and stat collected as soon as possible, same day, physician notification of issues obtaining labs and notifying physician of critical results. In-services with nurses currently working on ordering medication based on urgency, facility workflow and pharmacy access. Routine medications ordered the same day, new medications needed soon, not stat, ordered immediately after the order is written or stat should be ordered immediately for current residents and newly admitted residents. Element 2: The Director of Nurses initiated a match back of lab requisitions with physician orders for the past month. Interviewed nurses on duty for current residents to ensure physicians have been notified of problems obtaining lab and (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	critical labs have been reported. A match back of medications with physician orders for the past month. Element 3: DON/Unit manager began 1:1 re-education of all nurses currently working using nurse roster, in person or via telephone prior to starting the next shift, on putting lab orders into the computer, collecting lab specimens, lab access and notification of physician with problems obtaining specimens and critical lab results. DON/Unit manager began 1:1 re-education on medication ordering. Element 4: DON/Unit Manager during clinical start-up will complete start up sheet to document match back with physician orders and lab requisition using log to ensure nurses are putting lab orders in the computer, physician ordered collecting lab specimens and lab access, notifying physician of problems obtaining labs and notifying physician of critical results. Complete clinical start-up sheet to document match back physician orders and medications. Element 3: DON/designee using start up form will observe lab orders, physician orders I the computer as physician ordered, collecting lab specimens, notifying physician of problems obtaining labs and notifying physician of critical results will be done immediately, three times a week for 8 weeks. Using monitoring log will observe physician orders and medications to ensure mediations are ordered based on urgency 3 times a week for 8 weeks. DON/designee will report negative findings to the QAPI committee for review and recommendations. A total of 11 staff interviews were conducted with staff from all shifts to verify training had been completed. The staff interviewed included Administrator, Director of Nursing, Registered Nurses, Licensed Practical Nurses, and Certified Medication Tech (CMT). The staff interviewed verified they had been trained on how to take and enter a physician order for medications into the computer, how to notify the pharmacy of the order, routine medication versus stat order, checking the emergency kit, reordering medication, identifying sexual abuse, how to report, and who to report to. How to enter lab orders into the computer, how to notify the laboratory, collect routine and stat labs, obtaining results, notifying physicians of problems obtaining labs and notifying physician of critical labs results. During an interview, the DON explained the match back process and reporting of findings. A review of in-service sheets provided indicated 24 of 37 staff in-serviced were provided training. Those staff who were not physically present to receive the 1:1 in-services were provided with the 1:1 by telephone or in-service prior to the start of their next shift. 13 of the 37 were PRN who had not worked and were terminated. A review of CMT, LPN and RN statements indicated physicians were notified of problems obtaining lab and critical labs were provided to physicians. A review of the QAPI meeting indicated 8 members in attendance for Ad Hoc meeting on deficiency findings. A review of match back documents provided by DON indicated all medication orders and lab orders were reviewed with no negative findings.