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	04/03/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49689 Based on observations, record review, and interviews, the facility failed to ensure that residents were living a dignified existence for two residents (Resident #6 and Resident #67) of two sampled residents reviewed for dignity. The findings include: A review of the facility policy Resident Dignity effective on 04/2021, indicated that Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. A review of the facility policy Resident Rights effective on 04/2021, indicated that, These rights include the resident's right to a dignified existence. 1. A review of an Admission Record indicated that Resident #67 was admitted with diagnoses that included stroke, cognitive communication deficit, and mood disorder. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/20/2025, revealed Resident #67 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated resident had severe cognitive impairment. A review of the Care Plan initiated on 01/29/2025, indicated Resident #67 takes clothes off and wears hospital gown. A review of Progress Notes revealed on 02/9/2025 at 11:47 AM, Care Plan Note: Resident #67 refuses to keep clothes or briefs on. Resident #67 lifts leg and places it on the wall. Resident #67 hits themselves and cries out and is unable to be redirected. Staff keep privacy curtain partially pulled to provide privacy and dignity to Resident #67. On 03/31/2025 at 8:30 AM, this surveyor observed staff passing trays on Unit D. Resident #67's door was open. This surveyor observed Resident #67 in bed, with the hospital gown removed, a blanket against the wall, and the resident was exposed to the hallway. No privacy curtain was observed to be hanging in the room. This surveyor attempted to interview Resident #67 who was not able to answer questions. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/31/2025 at 10:45 AM, this surveyor observed Resident #67 exposed from doorway of room with hospital gown removed and underneath [pronoun] head. No blanket was observed in the bed at this time. No privacy curtain was observed to be hanging in the room. On 04/01/2025 at 9:43 AM, this surveyor observed Resident #67 lying in bed, hospital gown removed, exposed from doorway of the room. A blanket was observed by the resident's feet in the bed. A full lift pad was observed underneath the resident from shoulders to the back of their knees. A male housekeeper cleaning the rooms on the unit walked past the room, with Resident #67 unclothed in clear view. No privacy curtain was observed to be hanging in the room. On 04/01/2025 at 2:20 PM, this surveyor observed Resident #67 exposed from the doorway of the room with hospital gown removed and lying in the bed, by the wall. A blanket was observed at the foot of bed. A full lift pad was observed underneath the resident from shoulders to the back of their knees and the resident ' s brief was pulled down, exposing the genital region. On 04/02/2025 at 9:40 AM, this surveyor observed Resident #67 exposed from the doorway of the room with hospital gown removed and lying underneath the resident ' s head. A pillow was in the floor, a blanket was observed at the foot of the bed, and the resident ' s brief was pulled down exposing the genital region. No privacy curtain was observed hanging in the room. A male housekeeper was observed to be cleaning rooms on the unit. 2. A review of an Admission Record indicated Resident #6 was admitted to the facility with diagnoses that included type 2 diabetes, dementia, depressive disorder, and heart failure. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of March 10, 2025, indicated that Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8, which indicates moderate cognitive impairment. A review of the Care Plan initiated on 03/24/2025, indicated Resident #6 required cuing and supervision with all activities of daily living related to cognitive loss, an intervention indicated they were able to choose clothing for the day and to assist/cue as needed. A review of the Document Survey Report indicated for Resident #6, was marked as independent or supervision on the lower body dressing task, for the month of March. On 04/01/2025 at 2:00 PM, during a concurrent interview and observation, Resident #6 was observed walking up and down the hallway on Unit D with a t-shirt on and a hospital gown over it. Resident #6 was not wearing pants. The resident ' s lower body and brief were exposed. Resident #6 asking Where are my pants? and attempted to cover [pronoun] exposed lower half by holding gown closed in the back while walking. Certified Nursing Assistant (CNA) #3 stated they were waiting on laundry to bring more pants. CNA #3 stated Resident #6 would take clothes off and on in their room making a mess of them. CNA #3 stated the night aide did not tell her in report that the resident was low on clothes. CNA #3 also stated when laundry delivered the resident ' s clothes she planned to dress the resident. CNA #3 stated she was not aware of any extra clothes in the laundry room to get for Resident #6. CNA #3 stated Resident #6 had been uncomfortable. On 04/01/25 at 2:15 PM, Resident #6 was observed walking up and down hallway with lower half exposed, using left hand to hold the back of the hospital gown closed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/2025 at 2:20 PM, Resident #6 was observed knocking on the window of the unit doors, asking Where are my pants? Resident #6 was holding the back of the hospital gown and then sat in a chair. On 04/01/2025 at 2:30 PM, Resident #6 got out of the chair, held the back of the gown, and was observed knocking on the unit window again asking, Where are my pants? Resident #6 remained in this position for a few minutes before returning to the chair. This surveyor attempted to interview the resident, but the resident was not able to be directed. On 04/01/2025 at 2:30 PM, Resident #6 rose out of chair, held the back of the gown and knocked on the unit window asking about laundry. CNA #3 tied the second string on the back of the gown the resident was wearing. Resident #6 sat down in the chair. On 04/01/25 at 3:05 PM, during an interview, CNA #3 stated she was familiar with the residents on the secure unit. CNA #3 stated Resident #67 had not had a privacy curtain for a while. CNA #3 stated that they place the lift pad under Resident #67 to use when repositioning the resident. CNA #3 stated the resident had a full lift pad under them because the CNA could not leave to get a green pad to put under the resident due to CNA #3 was the only staff member on the unit. CNA #3 stated this was to help me pull [the resident] up for lunch when the restorative aide came back here for a minute. CNA #3 stated the negative outcome for the resident taking clothes off with no privacy curtain was dignity because it exposed the resident unknowingly to staff and other residents that walked by. CNA #3 stated the negative outcome for Resident #6 was that the resident was wandering around exposed, and that would be embarrassing. It was a dignity issue. CNA #3 stated, I did notice [the resident] trying to cover [pronoun] bottom. CNA #3 stated that she was going to get the nurse ' s attention to go to the laundry for Resident #6 and that the resident had been wearing a hospital gown since eleven that morning. On 04/02/2025 at 2:34 PM, during an interview, LPN #2 stated that Resident #67 was exposed from the doorway, and that could be embarrassing. LPN #2 stated there was no privacy curtain hanging in the resident ' s room. LPN #2 stated a resident should wear clothes to prevent them from being embarrassed, and for dignity. On 04/03/2025 at 12:15 PM, the Minimum Data Set Coordinator stated that Resident #67's behaviors of stripping off clothes could be a dignity issue if they were exposed from the doorway and a privacy curtain would be an intervention that could be added into the Care Plan to help. On 04/03/2025 at 12:30 PM, the Director of Nursing (DON) stated residents should not be exposed to other residents or staff and it could make them uncomfortable or embarrassed. The DON stated Resident #67 should have a privacy curtain hanging in the room to ensure that the resident did not expose themself related to behavior.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 49689 Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADL) care such as facial hair removal, and nail care were completed for two (Resident #6 and Resident #67) of five sampled residents reviewed for ADL care. The findings include: 1. A review of the Admission Record indicated Resident #6 was admitted with diagnoses that included type 2 diabetes, dementia, depressive disorder, and heart failure. A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of March 10, 2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated moderate cognitive impairment. A review of a Care Plan initiated on 03/24/2025, indicated that Resident #6 required cuing and supervision with all activities of daily living related to cognitive loss. Interventions indicated the resident was able to choose clothing for the day and to assist/cue as needed. A review of the Document Survey Report used to track behaviors, indicated Resident #6, for the month of March had one documented day for refusal of care on night shift on 3/11/2025, and for bath, given on Tuesday, Thursday, and Saturday; one refusal charted on 3/8/2025, was blank for 3/15/2024, and 3/29/2024, charted not applicable on 3/22/2025, and the rest were given. On 03/31/2025 at 9:00 AM, this surveyor observed Resident #6 wandering up and down the hallway on Unit D. The resident had facial hair across their upper lip that connected with facial hair that covered the length and width of Resident #6's chin. On 03/31/2025 at 1:00 PM, this surveyor observed Resident #6 wandering the hallway with no changes in facial hair. On 04/01/2025 at 9:00 AM, this surveyor observed Resident #6 wandering the hallway with no changes in facial hair. On 04/01/2025 at 2:30 PM, this surveyor observed Resident #6 wandering the hallway with no changes in facial hair. On 04/02/2025 at 9:30 AM, this surveyor observed Resident #6 wandering the hallway with no changes in facial hair. 2. A review of the Admission Record indicated Resident #67 was admitted with diagnoses that included stroke, cognitive communication deficit, and mood disorder. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/20/2025, revealed Resident #67 had a Brief Interview for Mental Status (BIMS) revealed a score of 0, which indicated the resident had severe cognitive impairment. Section GG revealed Resident #67 was dependent on staff for activities of daily living care. A review of the Care Plan, initiated on 2/5/2025, indicated Resident #67 required extensive assist x 2 staff with bed mobility, transfer, dressing, toileting, personal hygiene, bathing and required extensive assist x 1 staff with eating and locomotion; Interventions include: Please check my fingernail and toenail length and trim as needed unless I am diabetic. Please notify my nurse if I need my toenails trimmed and please give me my shower/bath as per my bath schedule and if needed give me a sponge bath on non-shower days. A review of the Documentation Survey Report used to track behaviors, indicated Resident #67's bath days were on Monday, Wednesday, and Friday and in March all days were marked not applicable except March 5th,10th, 26th, and 28th, which were marked as given. On 03/31/2025 at 8:30 AM, this surveyor observed Resident #67 hit themselves in the chest and abdomen and hit the side rails. Resident #67 ' s fingernails on the left hand were short, broken, and jagged, with all having sharp edges/points and matter that appeared to be food under them. On the right hand, nails were observed to be long, and jagged, having sharp edges and points and what appeared to be food matter underneath them. This surveyor observed Resident #67 eating food with their hands with staff supervising. On 03/31/2025 at 10:45 AM, this surveyor observed Resident #67 rubbing their facing, hitting themselves in the arms and on side rails. No changes to fingernails were observed. On 04/01/2025 at 9:40 AM, this surveyor observed Resident #67 using their left hand to scratch their right arm and chest, then started to hit the side rails, and crying out. No changes to fingernails were observed. On 04/01/2025 at 12:30 PM, this surveyor observed Resident #67 feeding themselves lunch with their hands, with staff supervising. On 04/02/2025 at 9:20 AM, this surveyor observed Resident #67 flailing their left hand back and forth hitting the side rails frantically. The resident was observed scratching themselves and crying out. No changes to fingernails were observed. On 04/02/2025 at 2:30 PM, this surveyor observed Resident #67 hitting themselves in the abdomen and scratching themselves. No changes to fingernails were observed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/2025 at 9:32 AM, during an interview, Certified Nursing Assistant (CNA) #3 stated that activities of daily living care should be performed daily, as needed, and on bath days. CNA #3 stated the negative outcome for unkempt facial hair was hygiene, confidence and dignity. CNA #3 stated that the negative outcome for uncut nails was germs and hygiene. CNA #3 stated that it could affect confidence, for nails to be uncut and for facial hair to be not shaved. CNA #3 stated that Resident #6 and Resident #67 do not refuse bath days or trims for facial hair and nails. CNA #3 described Resident #6's facial hair as a goatee that needed to be shaved. CNA #3 described Resident #67's nails as long, broken, and uneven, with sharp edges or points, and food matter under them. CNA #3 continued stating Resident #67 hits themselves all the time, nails like this could cause them to hurt themselves. CNA #3 stated baths were usually done on Monday, Wednesday and Friday on the unit, and they should have been done yesterday. On 04/02/2025 at 2:30 PM, during an interview Licensed Practical Nurse (LPN #2) stated she was with an agency and had been back here the last two days. LPN #2 described Resident #6's facial hair as a goatee, and it needed trimmed. LPN #2 described Resident #67's nails as jagged, long, with sharp points, and needed trimmed. LPN #2 stated unkempt facial hair could be seen as embarrassing definitely a dignity issue. LPN #2 stated that nails were to be trimmed for hygiene and to prevent skin breakdown. LPN #2 stated that facial hair and nail care should be done as needed and on bath days. LPN#2 stated that uncut nails can cause skin breakdown, and facial hair could be seen as unkempt. On 04/02/2025 at 2:40 PM, during a concurrent interview and observation, CNA #3 stated that baths were not completed because CNA #3 was the only staff member on the unit. CNA #3 stated they planned to attempt to do baths tonight while floating until 7:00. This surveyor observed Resident #6 sitting in a chair with facial hair and no changes. On 04/03/2025 at 12:30 PM the Director of Nursing (DON) stated activities of daily living care such as nails and facial hair should be done on an as needed basis and on shower days. The DON stated negative outcomes for uncut nails could be hygiene or even scratching themselves. The DON stated negative outcomes for unkempt facial hair could be that it's embarrassing for residents. The DON stated that it could be seen as a dignity issue for facial hair to not be shaved. The DON stated activity of daily living care helped meet the needs of the resident.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 49981 Based on observation, record review, and interview, the facility failed to ensure cigarettes and lighters were properly stored, to prevent residents from having and using cigarettes and lighters without staff knowledge, on 1 of 1 observation, to prevent accidental burns and injury. This failed practice had the potential to affect 4 (Resident #29, #40, #61, and #84) of 18 sampled residents, reviewed for smoking tobacco or nicotine use to ensure safe interventions were in place. The facility also failed to ensure 1 resident (Resident #59) of 1 sampled resident was not in the smoking area with cigarettes and lighter stored in a personal cigarette case to prevent possible injury. The findings include: Review of Medical Diagnosis revealed Resident #84 had diagnoses that included seizure disorder and aphasia. Review of Resident #84 ' s admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Resident #84 was observed sitting in a specialty chair in the courtyard smoking area. Review of Medical Diagnosis revealed Resident #61 had diagnoses that included Huntington's disease and anxiety. Review of admission MDS dated [DATE], revealed Resident #61 had a BIMS of 15, which indicated no cognitive impairment. Resident #61 was observed sitting on the right side of the courtyard smoking area. Review of Care Plan revealed interventions for Resident #61 included storing smoking materials, including cigarettes and lighters, in the Administrator ' s office. Review of Medical Diagnosis revealed Resident #29 had diagnoses that included schizophrenia, stroke, and seizure disorder. Review of Resident #29 ' s quarterly MDS dated [DATE], revealed a BIMS of 11, which indicated moderate cognitive impairment. Resident #29 was observed sitting on the left side in the courtyard smoking area. Review of Care plan revealed interventions include must wear an apron to smoke and storing smoking materials including cigarettes and lighter, in a locked area of the Administrator ' s office, and the nurse's station. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Smoking Policy, dated 02/2024, revealed smoking privileges and restrictions should be documented in the care plan. All residents will require monitoring, and residents cannot keep smoking materials including cigarettes, tobacco, etcetera. The facility stores all smoking material and retains the right to confiscate smoking articles from residents not adhering to policy. Review of an in-service titled Resident Smoke Break, dated 1/20/25, revealed residents need to be timely for their assigned smoke breaks, but did not address storage of smoking materials. On 03/31/2025 at 1:14PM, the Activity Director (AD) was observed placing smoke aprons on residents. The AD was asked what the process was and how residents who wore a smoking apron were identified. The AD stated all residents were to wear an apron, and the residents were not given more than two (2) cigarettes at a time. On 03/31/25 at 1:24 PM, Resident #84 lifted [pronoun] right leg and a pack of [brand name] cigarettes was observed to be resting under Resident #84's upper thigh. Resident #69 said Resident #84 has had cigarettes on their person before and they were always smashed flat under [pronoun] leg. Certified Nursing Assistant (CNA) #3 and CNA #8 removed the cigarettes from the resident ' s possession and revealed 12 cigarettes were in the pack. On 03/31/2025 at 1:25 PM, during an interview, CNA #3 was asked to describe the events that just occurred. CNA #3 said she suspects a friend or relative brought Resident #84 cigarettes. CNA #8 stated residents were only given 2 cigarettes at a time with each smoke break. CNA #3 stated she did not have a concern with residents having cigarettes, but knowing they were bringing them in [the building] was a concern. CNA #3 said CNA #8 had a lighter and would light them. CNA #8 confirmed nobody was supposed to light their own cigarette. Resident #61 was observed reaching in the left pocket of the resident ' s jacket, pulled out a lighter, and lit a cigarette, after throwing aside the smoker's apron. This surveyor looked to the left and observed Resident #29 and Resident #84 lighting their own cigarettes. On 03/31/2025 at 1:26 PM, CNA #3, CNA #8, and the AD were observed talking to Residents #29, Resident #61, and Resident #84 while CNA #8 attempted to confiscate three (3) lighters. On 03/31/2025 at 1:27 PM, the Administrator was asked what concerns they had about residents having lighters and cigarettes on their person. The Administrator stated smokers had all signed a contract and should not have cigarettes or lighters. CNA #8 took possession of all the lighters and placed three (3) lighters in the Administrator ' s hand. The Administrator stated the facility and staff needed to monitor residents' cigarettes but also make sure residents smoke safely. The Administrator revealed that smoking materials were locked in her office, and the AD put cigarettes in a plastic bag for the day. The bags are locked up at the nurse ' s station and used during smoke breaks. On 03/31/2025 at 2:02 PM, review of a list titled, Residents Who Smoke revealed Resident #29, Resident #61, and Resident #84 were included. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/01/25 at 9:28 AM, Resident #84 revealed that [pronoun] saw an opportunity one (1) day ago to pick up a lighter while smoking outside and grabbed it. My brother chewed me out because I was going through lighters that he gave me and cigarettes. Resident #84 revealed family and friends gave [pronoun] cigarettes and lighters. The resident said [pronoun] did not remember being told [pronoun] could not keep cigarettes and lighters. On 04/01/25 at 9:38 AM, the MDS Nurse stated she was the C Hall nurse today and Resident #61 constantly comes back with stuff not allowed like fingernail clippers, cigarettes and lighters after going on family leave. Resident #61 did not like anyone in their room or space and got very mad when questioned. Resident #61 would sometimes slam doors. The MDS Nurse stated Resident #84's family does the same thing and puts things in drawers. The MDS Nurse stated she sometimes would ask about items and try to get things out that residents should not have like lighters and cigarettes. We have educated both families about this. On 04/01/2025 at 11:20 AM, the Medical Director said he was aware from time-to-time residents got cigarettes and lighters from family and friends. They are here for a reason, and confusion plays a part in their understanding. The Medical Director was not aware of any recent incidents and stated it was the facility policy that residents did not keep cigarettes or lighters. On 04/01/25 at 12:15 PM, during an interview, the Director of Nursing (DON) stated educating residents and families on not bringing in cigarettes and lighters was an ongoing battle. The facility had provided education during resident council, smoking contracts, and re-educated when they suspected a resident was smoking. The DON was asked when Resident #84 was assessed last for smoking and provided an Admission/Readmission Nursing Evaluations Packet, dated 12/19/24, that revealed in VI. evaluation indicated Resident #84 was not a smoker. The DON stated she remembered that Resident #84 changed their mind about smoking after admission, and said Resident #84 should have been reassessed. The DON said she would like everyone to wear a smoker's apron and has ordered more of them. On 04/01/2025 at 12:38 AM, review of Resident #61 ' s Admission/Readmission Nursing Evaluations Packet, dated 01/08/2025, revealed Resident #61 smoked and required supervision, and a smoker ' s apron. On 04/1/2025 at 2:40 PM, the [NAME] Director of Operations (RDO) said that smoking assessments were done quarterly. On 04/02/25 at 1:50 PM, this surveyor observed a yellow chair resting against the wall outside Resident #40's room. This Surveyor asked the RDO if Resident #40 was on 1:1, and if so, could she explain why. The RDO revealed that Resident #40 had been caught smoking in their personal room this morning, and the resident ' s father had been contacted for a 30-day discharge. The facility called the resident ' s dad because he was responsible for all the resident ' s decisions and had already been working on a place for Resident #40 to go. On 04/02/25 at 2:00 PM, the RDO provided a copy of a letter titled 30-Day Discharge Notice, dated 04/02/2025, which informed Resident #40 that due to smoking in their room on April 2, 2025, they were considered a danger to self and others and the decision was made to discharge Resident #40 from the facility. The facility had offered to assist in finding placement. Appeal information was included. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/02/25 at 3:35 PM, the Administrator provided evidence regarding the smoking area incident. Residents observed had BIMS of 11-15, and residents have rights. The Administrator provided additional evidence and stated that witness statements were taken from staff and residents, and residents said after smoking they planned to turn their lighters into the staff. The Administrator stated her evidence included the smoking in-service, employee handbook and resident rights policy, because residents have rights, and staff cannot search residents and their belongings without infringing on the resident's rights. On 04/03/25 at 9:15 AM, CNA #7 said most of the time she found things in resident rooms when she was getting their underwear from a drawer or something like that. CNA #8 stated that she looked at what was out in the room but did not look through personal belongings. On 04/03/25 at 9:25 AM, during smoke break, [a food delivery service] brought a [Brand name coffee shop] bag to Resident #40. CNA #8 observed cigarettes resting under the frozen [Brand name coffee shop] drink. CNA #8 confiscated cigarettes, and the Administrator was observed taking possession of the cigarettes. The Administrator confirmed residents were not allowed to have cigarettes or lighters on their person. On 04/01/2025 at 4:08 PM, in the facility's designated smoking area, Resident #59 was observed producing a small case approximately six (6) inches long, four (4) inches wide, and about two (2) inches thick. Resident #59 opened the case and pulled out a cigarette and lighter and proceeded to light and smoke the cigarette. On 04/01/2025 at 4:10 PM, the Administrator and RDO were notified of the incident. The Administrator and RDO were asked if they were aware Resident #59 had possession of the items. The Administrator stated that all residents were aware of the smoking policy and that no resident should be in possession of cigarettes or lighter. On 04/01/2025 at 4:28 PM, the Administrator confirmed that the resident agreed to give cigarettes and lighter over to be stored until designated smoking times.

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	045259	A. Building B. Wing	04/03/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47916 Based on observation, record review, and interview, the facility failed to ensure three (3) syringes of [Name Brand Anti-anxiety medication] were documented in a narcotic book to maintain receipt and accounting of a narcotic during 1 of 1 observation to prevent diversion for 1 (Resident #71) resident. The findings include: Review of Medical Diagnosis revealed Resident #71 had diagnoses of dementia, schizophrenia, and urinary retention. Review of Care Plan for Resident #71 dated 12/09/2024, indicated Resident #71 used antianxiety medication related to an agitation disorder. On 04/02/2025 3:15 PM, this surveyor accompanied the Unit Manager to the medication room outside the unit. The narcotic box was permanently affixed and contained antianxiety medication 2mg/ml (milligram/milliliter) x2 syringes and there was a bag labeled Resident #71 containing antianxiety medication 2mg/ml x3 syringes, dated 12/06/2024. The Unit Manager was asked to show where Resident #71's antianxiety medication was documented in the narcotic book. The Unit Manager was unable to locate the requested documentation. On 04/02/2025 at 3:20 PM, the Unit Manager walked to central supply where she was joined by the Director of Nursing (DON) in searching narcotic books for documentation on Resident #71's antianxiety medication. On 04/02/2025 at 3:30 PM, the DON stated Resident #71's antianxiety syringes were not documented in any of the narcotic books. The DON stated that when the medication was delivered nursing staff should have documented it right away. The DON stated it was unknown why the antianxiety medication was not in the narcotic books. The DON stated Resident #71 moved from C to E Hall and any narcotics should have been transferred from one narcotic book to another. The DON was accompanied back to the medication room where she removed Resident #71's antianxiety medication and stated that there was not a narcotic book page number written on the prescription label and it was never logged in. The DON stated it could have easily been diverted, because it was not documented in a narcotic book. On 04/03/2025 at 10:57 AM, the Administrator stated she was surprised to hear that Resident #71's antianxiety medication was not documented in a narcotic book. The administrator was asked for documentation that the antianxiety medication was signed for by a nursing staff member. This surveyor requested policies on medication storage, narcotics, and any nursing in-services on documenting medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/03/2025 at 11:59 AM, Licensed Practical Nurse (LPN) #6 was asked the process for receiving medications from the pharmacy. LPN #6 stated when the pharmacy brings medications, nursing staff look at the documentation to make sure it was the right medication dose and quantity. If the quantity was wrong that would be noted/corrected on the documentation, then the nurse that accepted it would write it in the narcotic book, if the medication was a narcotic. The medication would then be placed in locked storage. Review of a Pharmacy Manifest dated 12/6/2025, indicated Resident #71 received antianxiety medication 2mg/ml syringes x4. A review of Medication Administration Record for Resident #71 did not show a current order for antianxiety medication. Review of a policy titled Label/Store Drugs and Biologicals, dated 01/2024, revealed drugs and biologicals are to be stored in a safe, secure and sanitary manner. The policy did not address documentation of narcotics. Reviewed an in-service on Medication Storage, dated 4/2/25, revealed all narcotic medication was to be accurately logged in and stored according to policy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916 Based on observation, record review, and interview, the facility failed to ensure that medications were locked away and stored in a manner that prevented resident access for 1 of 1 observation of the central supply room. Specifically, a box of medications was found resting on a pallet in central supply and the doorknob was broken. The door was ajar and could not be closed. The facility failed to ensure 13 bottles of expired [name brand] supplemental feeding were removed from the supply shelf to prevent nursing staff from using them on residents with feeding tubes for 1 of 1 observation. The findings include: On [DATE] at 6:34 AM, the central supply door was observed as being propped open ,d+[DATE] inches by a broken inner doorknob. Paint outside the door appeared scuffed off in the area of the doorknob. In central supply an open box was observed resting on a pallet containing: a. Clear lax 17.9oz (ounce) bottles x5 b. Sleep aid 3mg (milligram) x3 250ct (count) c. Sleep aid 5mg x3 90ct d. Zinc 50mg x3 100ct e. Aspirin x1 36ct f. Acetaminophen 325mg x2 1000ct g. Vitamin D3 x3 25mcg 300ct h. Iron 325mg x2 200ct i. NSAID (nonsteroidal anti-inflammatory drugs) 200 mg x5 300ct j. Stool Softener 100mg x3 200ct k. Glucose Gel 15g (gram), 3 tubes l. Magnesium 400mg x1 120ct m. Antacid x2 750mg 96ct (1 bottle of antacid had been open) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 6:40 AM, the Administrator was asked to explain the process for storing the open box of medications. The Administrator identified the box of medications as over the counters and stated they should be stored locked at the nurse ' s station. The Administrator stated residents should not have access to this room with medications. The Administrator stated the damage to the wall outside central supply, at the inner doorknob level was new. The Administrator did not know the door could not be closed to central supply. The Administrator stated residents would have told nursing staff if they found the open box of medications. On [DATE] at 6:45 AM, the Director of Nursing (DON) was asked if the supplemental feeding, stored on the central supply room shelf, was in date for use. The DON confirmed that the supplemental feeding was available for use. The DON was asked about 13 bottles of [name brand] supplemental feeding. The DON confirmed an expiration date of ,d+[DATE] and said it should have been returned. The Administrator stated maintenance should have been called to fix the central supply doorknob. On [DATE] at 7:00 AM, Registered Nurse (RN) #1 was asked the process for storing drugs in the medication room. RN #1 revealed medications should be behind a locked door, and she did not notice that the door was not closed all the way during her 12-hour shift. RN #1 stated a resident could have taken any of the medications that were left out in the open. RN #1 was unable to confirm if any residents were receiving the expired supplemental feeding. On [DATE] at 10:33 AM, the Medical Director confirmed he did not know medications were being stored in an open box resting on a pallet in central supply. The Medical Director said the concern would be diversion of the mediations. Review of a policy titled Label/Store Drugs and Biologicals, dated ,d+[DATE], revealed drugs and biologicals are to be stored in a safe, secure and orderly manner. Drugs should be locked away when not in use, and out of date drugs should be returned to the pharmacy or destroyed. Review of an in-service titled Medication Storage, dated [DATE], revealed all narcotic medication is to be stored accurately, logged in and stored according to policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49689 Based on observations and interviews, the facility failed to ensure that cross contamination did not occur during lunch service for one of one kitchen observed. The findings include: On 04/02/2025 at 11:07 AM, this surveyor observed Dietary Aide (DA) #4 using bare hands to place four slices of cake in bags. DA #4 then placed the bagged cake slices in a stainless-steel bin. The Dietary Manager requested five (5) slices of cake for purees. With bare hands, DA #4 added 5 slices of cake to the stainless-steel container for puree. DA #4 was observed with cake coated on all ten fingertips. The Dietary Manager proceeded to use the cake for puree diets in the building. This surveyor observed the cake being served for all diets in the facility, during the lunch meal service. On 04/02/2025 at 11:10 AM, during an interview, DA #4 stated that this was their first time on days, and you do not touch food with bare hands. DA #4 stated they were unsure why. On 04/02/2025 at 11:45 AM, this surveyor observed the blade from the food processor fall into the pureed pasta. The Dietary Manager removed the blade and asked this surveyor if that could be cross contamination. On 04/02/2025 at 12:15 PM, this surveyor observed Dietary [NAME] (DC) #5 take three plates at a time out of the stack and place them on the line with bare hands. DC #5 then placed their whole ungloved hand in the middle of the plate. This surveyor observed this pattern throughout the lunch service while filling carts. On 04/03/2025 at 12:40 PM, during an interview, the Dietary Manager stated that touching food, touching plates, and a blade in puree was cross contamination which could cause foodborne illness in the residents. On 04/03/2025 at 1:05 PM, during an interview, DC #5 stated that the process was not to touch plates bare handed and to use the suction thing to prevent cross contamination. Then stated that a negative outcome could be sickness for the residents.