STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045269	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Star City Rehab & Nursing Center	702 N Drew St Star City, AR 71667

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. 37925 Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to ensure privacy and dignity was provided for 1 (Resident #28) of 2 sampled residents reviewed for privacy and dignity. The findings are: A review of a facility policy titled, Resident Rights, dated 01/01/2024, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents ' right to: a. a dignified existence. b. be treated with respect, kindness, and dignity . A review of the Admission Record indicated the facility admitted Resident #28 with diagnoses that included chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, Asperger's syndrome, and bipolar disorder, current episode mixed, severe, with psychotic features. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/18/2024, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. A review of Resident #28's care plan revised on 12/10/2024, revealed the resident had an ADL self-care performance deficit related to muscle weakness, Asperger's syndrome, muscle wasting and atrophy, and unsteady gate. Interventions included personal hygiene: the resident required assistance by staff with personal care, and toilet use: the resident required assistance by staff for toileting. During an observation on 01/27/2025 at 3:33 PM, Certified Nursing Assistant (CNA) #9 changed Resident #28's brief while the resident was standing, exposing the resident's buttock to the roommate. CNA #9 wiped Resident #28's bottom with a wipe while Resident #28's roommate was sitting up in bed watching the care be provided. CNA #9 did not pull the privacy curtain between the residents' beds. During an observation on 01/28/2025 at 11:57 AM, Resident #28 was in their room, standing up with no pants or brief on while CNA #9 removed a dirty brief from the resident in the room. Resident #28 was standing exposing the resident's buttock to the roommate. CNA #9 wiped Resident #28's bottom with a wipe while the resident's roommate was lying in bed watching the care be provided. CNA #9 did not pull the privacy curtain between the residents' beds. (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	During an interview on 01/30/2025 at 10:26 AM, CNA #11 confirmed Resident #28 stood to have a brief change, and the privacy curtain should be pulled between the resident beds. During an interview on 01/30/2025 at 10:48 AM, Licensed Practical Nurse (LPN) #3 confirmed Resident #28 stood to have a brief change while holding onto the walker and the privacy curtain should be pulled between the resident beds. During an interview on 01/30/2025 at 12:41 PM, the Director of Nursing (DON) confirmed Resident #28 stood to have a brief change while holding onto the walker and the privacy curtain should be pulled between the resident beds. 43409

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 37925 Based on observations, interviews, and record reviews, the facility failed to accurately complete the care plan to address bipolar disorder and post-traumatic stress disorder (PTSD) (Resident #13) and contractures (Resident #44) for two (Resident #13 and Resident #44) of 23 sampled resident who were reviewed for care plan accuracy. The findings are: 1. Resident #13's Order Summary Report was reviewed and indicated diagnoses of a mental health condition caused by a traumatic event affecting one's ability to function daily (post-traumatic stress disorder) and a mental disorder characterized by periods of depression and periods of abnormal moods (bipolar disorder). [Antipsychotic medication name] 25 milligrams (mg) give 1 table by mouth at bedtime for post-traumatic stress disorder (PTSD) and [antipsychotic medication name] 2.5 mg give 1 tablet by mouth two times a day for bipolar disorder was ordered. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/24/2024 was reviewed and revealed Resident #13 had a Brief Interview for Mental Status (BIMS) of 7, which indicated severely cognitively impaired, and had active diagnoses of bipolar disorder and PTSD. A care plan, dated 12/16/2024, was reviewed and did not address Resident #13's PTSD or bipolar disorder. 2. Review of Resident #44's diagnosis sheet indicated the resident had diagnoses of cerebral infarction (stroke), pneumonia, dysphagia (swallowing difficulties), heart failure and muscle weakness. Resident #44's quarterly MDS with an ARD of 01/13/2025 revealed a Staff Assessment of for Mental Status (SAMS) that indicated severe cognitive impairment. The MDS indicated the resident had impairments to bilateral upper and lower extremities, was dependent on staff for activities of daily living, transfer, wheelchair ambulation and incontinence care. The restorative section of the MDS indicated Resident #44 received no range of motion, splints or braces for assistance. Review of Resident #44's care plan did not mention or address contractures of upper or lower extremities. Review of progress notes dated 12/30/2024 to 01/30/2025 did not indicate identification of contractures to musculoskeletal system. On 01/27/2025 at 10:28 AM, Resident #44 was observed lying in bed. The resident ' s left upper extremity was contracted into a forward bend at the wrist and hand into a semi fist, both legs were contracted to a near fetal position. No brace or hand roll was observed on the upper extremity, no pillows or positioning devices were observed to the lower extremities. Resident #44 was observed again on 01/28/2025 at 09:15 AM, 01/29/2025 at 8:47 AM and 3:36PM, and 01/30/2025 at 10:00 AM and 1:30 PM without any devices to the left upper extremity or bilateral lower extremities. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/30/2025 at 1:33 PM, Licensed Practical Nurse (LPN) #4/ MDS Coordinator was asked how she determines what was included in the resident's care plans. She related she uses the MDS, new orders, diagnoses and nurses notes to help guide her as to what is included in the resident's care plans. She said the care plan should be updated daily as needed related to the resident's condition as well as at least quarterly. The MDS Coordinator was asked if Bipolar, PTSD, and contractures were concerns that should be addressed on the care plan, to ensure proper interventions are used. She confirmed they should be. 46724

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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. 37925 43409 Based on observation, interview, record review, and facility policy review, the facility failed to ensure smoking paraphernalia was not stored in the resident rooms and failed to ensure residents with vape devices were assessed for safe usage for 2 (Residents #24 and #176) of 2 sampled residents reviewed for smoking. The findings are: On 01/27/2025 at 2:34 PM, Resident #24 was sitting up on the side of the bed awake and there was a small device on the overbed table. The resident was interviewed and when asked about the device, the resident picked up the device, placed it in the resident's mouth, inhaled and blew white smoke from the resident's mouth. The resident stated once the vape device was empty, it was refilled. The resident opened the top drawer on the nightstand and removed a glass bottle. The label on the bottle indicated the contents were a flavored liquid for vaping and contained nicotine. Resident #24's care plan, dated 01/16/2025, was reviewed and indicated the resident was a smoker and tobacco user and vaped and to instruct the resident about the facility policy on smoking/electronic smoking devices/smokeless tobacco. The care plan did not indicate if the resident required supervision or if the resident was safe to keep or use the vape device/refill bottle in the resident's room. The resident's IHCMA Quarterly/Annual/Significant Change Nursing Evaluation dated 01/17/2025 did not indicate if the resident was safe to use/store the vape device or refill bottle in the resident's room, or if the vaping paraphernalia was to remain with staff. Resident #24's Order Summary Report was reviewed and there was no indication the resident smoked. On 01/30/2025 at 12:20 PM, Licensed Practical Nurse (LPN) #2 was interviewed and stated the nurses assessed the residents on admission and quarterly for capabilities to hold/light a cigarette, and if he/she required supervision. She stated residents were not allowed to have smoking paraphernalia in their room. LPN #2 stated smoking paraphernalia, and vaping devices were locked in the medication room. At 12:28 PM, LPN #2 stated residents were not allowed to keep the refills for the vape devices in their rooms and those items were kept in the nursing station with other cigarette items. A Smoking Policy, dated as reviewed 02/2024, was reviewed and indicated the facility will establish and maintain safe resident smoking practices. The smoking policy indicated smoking was only permitted outside in designated smoking areas, was not allowed inside the facility under any circumstances and included tobacco and electronic cigarettes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Admission Record, indicated the facility admitted Resident #176 with diagnoses that included hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side, cerebral infarction, other seizures, nicotine dependence, unspecified and psychoactive substance abuse with other psychoactive substance induced disorder. A review of the Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/27/2025, was incomplete. A review of Resident #176's care plan initiated on 01/15/2025, revealed the resident had chosen to smoke and needed to be observed for safety. Interventions included the resident may need to wear a smoker's apron when smoking due to safety concerns, store all my smoking material, including lighters, matches, etc., in a safe place; remind the resident's family not to give smoking materials directly to the resident, show the resident the designated smoking areas and assist the resident to and from smoking area during smoking times. A review of the physician orders revealed Resident #176 was admitted to the male secure unit due to diagnosis of psychoactive substance abuse with other psychoactive substance induced disorder. A review of the Admission/Readmission Nursing Evaluation Packet, revealed Resident #176 had medications that affected awareness, judgement, and safety including medications with adverse reactions, a smoking related burn in the past 6 months and required supervision while smoking with additional comments which included needs assist/supervision. During an observation on 01/27/2025 at 1:38 PM, Resident #176 had a vape device lying on the nightstand and a vape device on the charger lying on the bed. During an observation on 01/28/2025 at 9:07 AM, Resident #176 was sitting in a wheelchair with vape device in the resident's hand. During an observation on 01/28/2025 at 12:03 PM, Resident #176 was lying in bed with a vape device in the resident's left hand and another vape device lying on the nightstand charging. During a concurrent observation and interview on 01/28/2025 at 2:48 PM, Resident #176 verbalized going outside to smoke and while in room using a vaping device. Resident #176 took two puffs from the vaping device during the interview.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46724 43409 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a glucometer was disinfected per disinfectant wipe directions for one of one glucometer disinfecting observed; failed to ensure infection prevention and control practices were implemented to prevent the development of communicable diseases and infections as evidenced by leaving a clean linen cart uncovered and placing used hangers with clean clothes on linen cart; failed to ensure infection prevention and control practices were implemented to prevent the development of communicable diseases and infections as evidenced by failure to keep dirty briefs and linen off of the floor in Resident #28 ' s room and failure to contain items during transport through the hallway. The findings are: 1. On 01/29/25 11:28 AM, Licensed Practical Nurse (LPN) #1 was observed walking up the North Hall with a glucometer in her hand, she unlocked her medication cart, removed a disinfectant wipe from the bottom drawer of the medication cart and wiped the glucometer once. She then laid the wiped glucometer on a tissue on the top of the medication cart. The glucometer was not visibly wet. At 11:29 AM, LPN #1 gathered supplies of gloves, alcohol swabs, one piece lancet and a bottle of glucose testing strips, then picked up the glucometer in the tissue and proceeded to room [ROOM NUMBER]-S-B. After performing a blood glucose test, LPN #1 wrapped the glucometer back in the tissue and placed it in a disposable plastic cup and took it back to the medication cart. At 11:30 AM, back at the medication cart, she removed a disinfectant wipe from the bottom drawer of her medication cart and wiped the glucometer once, then laid it on a clean tissue on top of the cart. The glucometer was not visibly wet. On 01/29/25 at 11:31 AM, LPN #1 was asked to describe her procedure for disinfecting the glucometer. She stated, after using it she wiped it with a disinfectant wipe and laid it on a tissue to air dry for 3-5 minutes for the disinfectant to be effective. After being asked to read the directions printed on disinfectant wipe container, she read the label and stated, It says two minutes. LPN #1 was then asked to read the directions for use on the label which indicated for disinfected areas to remain visibly wet for 2 minutes and allowed to air dry. LPN #1 was then asked if the surface of the glucometer had remained wet for 2 minutes, she replied, probably not. When asked what the outcome of improper disinfecting could be, she confirmed it could lead to cross contamination. The glucometer cleaning and disinfecting instructions indicated disinfecting was needed to prevent the transmission of bloodborne pathogens. The label for the disinfecting wipes indicated that the surface of the item to be disinfected should remain wet for 2 minutes for disinfection to be effective. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of a facility policy titled, Infection Prevention and Control Program, revised on 01/01/2024 indicated, 1. The infection prevention and control programs are a facility-wide effort involving all disciplines and individuals. 2. The elements of the infection prevention and control program consist of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety .policies and procedures a. policies and procedures are utilized as the standards of the infection prevention and control program .prevention of infection .educating staff and ensuring that they adhere to proper techniques and procedures. During an observation on 01/29/2025 at 12:48 PM, a clean linen cart with clean clothes hanging on the rod and linen setting inside the basket was uncovered on the 500 hallway. During an observation on 01/29/2025 at 12:49 PM, Laundry #12 walked out of a resident's room and placed hangers onto the rod with clean clothing. During a concurrent observation and interview on 01/29/2025 at 12:50 PM, Laundry #12 placed hangers laying in the basket on the rod with clean clothes and verbally confirmed the hangers in the basket were the hangers removed from the resident rooms while placing the resident's clean clothes into the closet. Laundry #12 confirmed the clean clothes, and linen should be covered while in the hallway to prevent contamination. Laundry #12 confirmed putting hangers from resident rooms on the rod with clean clothes and that it can cause cross contamination. During an interview on 01/30/2025 at 12:05 PM, LPN #10 confirmed clean clothing should be covered while on the clean linen cart in the hallways. LPN #10 confirmed hangers removed from resident rooms should not be placed on a rod with clean clothes due to contaminating the clean clothes. During an interview on 01/30/2025 at 12:25 PM, the Director of Nursing (DON) confirmed clean clothing on a linen cart should be covered while in the hallways and DON confirmed hangers removed from resident rooms should not be placed on a rod with the clean clothes due to cross contamination. 3. A review of the Admission Record, indicated the facility admitted Resident #28 with diagnoses that included chronic obstructive pulmonary disease (COPD) with (acute) exacerbation, Asperger's syndrome, bipolar disorder, current episode mixed, severe, with psychotic features. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/18/2024 revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. A review of Resident #28's care plan revised on 12/10/2024, revealed the resident had an ADL (activities of daily living) self-care performance deficit related to muscle weakness, Asperger's syndrome, muscle wasting and atrophy and unsteady gate. Interventions included personal hygiene: the resident requires assistance by staff with personal care, toilet use: the resident requires assistance by staff for toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 01/27/2025 at 3:33PM, Certified Nursing Assistant (CNA) #9 removed Resident #28 pants and dirty brief and threw the pants and dirty brief onto the floor. CNA #9 used wet wipes to clean Resident #28 and threw the wet wipes onto the floor. CNA #9 removed the wet linen off the bed and placed it on the floor. After Resident #28 was dressed, CNA #9 picked up all the items off the floor, opened the door, walked down the hallway and placed the items into a trash can and the soiled linen receptacle. During an observation on 01/28/2025 at 11:57 AM, CNA #9 placed Resident #28's brief and pants on. Lying on the floor was a dirty brief, used wipes, wet clothes, and wet bed linen. After Resident #28 was dressed, CNA #9 picked up the dirty brief and dirty wipes and placed them in the trash can with a trash liner. CNA #9 removed the trash liner and tied it in a knot. CNA #9 opened the door with dirty gloved hands, walked down the hallway and placed the trash liner with dirty items into the trash receptacle. CNA #9 returned to the room, picked up the dirty clothes and linens, walked down the hall with the wet items and placed them into the soiled linen receptacle. During an interview on 01/30/2025 at 10:26 AM, CNA #11 confirmed dirty briefs, used wipes, dirty clothes and wet linens should be placed into a trash bag and not on the floor. CNA #11 verbalized items should be in a bag to transport down the hallway due to possible contamination. During an interview on 01/30/2025 at 10:48 AM, the LPN #3 confirmed dirty briefs, used wipes, dirty clothes and wet linens should be placed into a trash bag and not on the floor due to possible spread of bacteria. LPN #3 verbalized items should be in a bag to transport down the hallway due to possible spread of bacteria. During an interview on 01/30/2025 at 12:10 PM, the LPN #10 confirmed dirty briefs, used wipes, dirty clothes and wet linens should be placed into a trash bag and not on the floor due to possible cross contamination. LPN #10 verbalized items should be in a bag to transport down the hallway due to possible cross contamination. During an interview on 01/31/2025 at 12:41 PM, the DON confirmed dirty briefs, used wipes, dirty clothes and wet linens should be placed into a container like a trash bag and not on the floor due to possible cross contamination. The DON verbalized items should be in a bag to transport down the hallway due to possible cross contamination.