

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2026
NAME OF PROVIDER OR SUPPLIER  The Blossoms at Berryville Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  500 Hammons Avenue Berryville, AR 72616	
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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to ensure significant medication errors did not occur for two (Resident #1 and Resident #5) of five residents reviewed for medication administration.</p> <p>The findings include:</p> <p>Resident #1</p> <p>Review of Resident #1's admission Record, indicated the facility admitted Resident #1 on 03/09/2026 with diagnoses that included pneumonia, chronic obstructive pulmonary disease (COPD), cognitive communication deficit, congestive heart failure, atrial fibrillation, pulmonary hypertension, peripheral vascular disease, chronic kidney disease stage 3, hypertension, hyperlipidemia, and aortic valve stenosis.</p> <p>Review of Resident #1's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2026, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS also revealed Resident #1 was on medications that included a hypnotic, anticoagulant, antibiotic, diuretic, and antiplatelet.</p> <p>Review of the March 2026 Medication Administration Record (MAR), revealed Resident #1 was administered a scheduled cholesterol lower medication, four diuretic medications, two prostate medications, an anticoagulant, a medication to lower blood sugar, potassium electrolyte replacement, a medication to reduce heart rate, antihypertensive, magnesium electrolyte replacement, a medication to treat a nervous system disorder, antibiotic, a sleeping pill, and was on two liters (L) of oxygen on 03/23/2026.</p> <p>Review of a Medication Error Report dated 03/23/2026 at 4:00 PM stated Resident #1 was mistakenly given another resident's medication at approximately 4:02 PM which was discovered between 45 minutes to one hour later. The four incorrect medications given were for blood sugar lowering, an antidepressant, a medication to lower uric acid levels, and an antihypertensive with side effects of low blood sugar and increased levels of potassium. The antihypertensive medication has label warnings for diabetic medications. Monitoring of vitals at 8:00 PM and 10:00 PM revealed minimal hypotension. At 12:00 AM on 03/24/2026, Resident #1's blood pressure was 60/40 and blood sugar was 46. The provider on call was contacted and notified of the earlier medication error; new order was received to send the resident to the emergency room.</p> <p>Review of the Hospital Records revealed Resident #1 was treated for diagnoses of a medication error, hypotension, hypoglycemia, elevated heart enzymes, and acute kidney injury. Blood pressure on arrival was 64/38 and stated that Resident #1 reported, I feel like I am dying. Documentation stated (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
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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>the facility staff reported the resident had been hypotensive for two hours. The electrocardiogram (EKG) revealed no acute Myocardial Infarct (MI), lab results showed elevated heart enzymes and fluid levels consistent with stress on the heart, and a normal white cell count. Resident #1 was subsequently airlifted to another hospital for a higher level of care.</p> <p>Review of Resident #1's vital sign revealed a blood pressure of 98/78 at 8:28 PM and 93/56 at 9:59 PM, then 60/40 at 12:00AM prior to hospitalization. No other hypotensive blood pressure had been recorded since the resident's admission.</p> <p>During an interview on 04/21/2026 at 2:43 PM, Licensed Practical Nurse (LPN) #1 stated, 03/23/2026 was her very first day on the job and she had never worked in a long-term care facility before. LPN #1 stated she had Registered Nurse (RN) #2 training her from 6am-10am prior to RN #2 clocking out for the day and was trained on how the residents took their medications and who had swallowing issues. LPN #1 stated she was trying to help and give medications when she pulled and gave Resident #6's medications to Resident #1. It did not register it was the wrong person; I didn't know the person. The Unit Manager (UM) arrived to help LPN #1. UM instructed me to pull Resident #1's medications, when LPN #1 went to administer them, she realized that the person she gave Resident #6's medications to was actually Resident #1. LPN #1 immediately reported her mistake to the UM. The Director of Nursing (DON) and Nurse Practitioner (NP) were notified. LPN #1 was given one on one education by the Assistant Director of Nursing (ADON) on the five rights of medication administration. LPN #1 stated she had been a nurse for 24 years and was upset. Resident #1 was put on blood pressure monitoring every two hours. LPN #1 stated, I didn't even know how to put orders into the computer at that time. It was a new computer program for me. LPN #1 stated, the residents had pictures loaded in the computer system, but they were so small on the screen and being new people, unless you knew the residents, they look like each other. LPN #1 was told to verify with an aide or someone more familiar with the resident or administration if the aide did not know. LPN #1 stated, I was over stimulated, I could have slowed down. I was trying to do something on my own.</p> <p>During an interview on 04/22/2026 at 2:23 PM, the UM stated, on 03/23/2026 she worked performing wound care, and also worked as the UM and serving as preceptor at the same time. The UM reported that LPN #1 stated she thought she had it and was ok prior to the UM leaving her alone to administer medication. LPN #1 was on her own for about 30 minutes when the UM went to check on her and LPN #1 reported there was a lot going on. So, I asked where she was at, she said [Resident #6], then she looked at the cards, pulled the meds, and went in the room. The UM indicated that LPN #1 reported I made a mistake I gave [Resident #6's] medications to [Resident #1]. The UM and LPN #1 went back down to the cart and went over the photo on the computer chart and had an in-service on five rights to ensure you were giving the right meds to the right person. LPN #1 did not have any long-term care experience. The UM stated, I don't know when the competency checklist should be completed. Somebody should not complete a task alone before they have been checked off. The UM stated the nursing part of the competency check list was checked off that day by RN #2 and then she (UM) worked on a couple as well. I did not do the medication portion I did not look at it. The UM stated she left LPN #1 as she had been through morning medication pass and said she felt comfortable. The UM stated RN #2 did not pass off or give a report to her and she did not see LPN #1 pass any medications before leaving her alone.</p> <p>During an interview on 04/23/2026 at 10:40 AM, RN #2 stated it was LPN #1's first day and LPN #1 had observed RN #2 that morning. RN #2 stated, I don't like them to go hands on when they don't know my residents. [LPN #1] just watched me. RN #2 reported LPN #1 had not performed any task on her own before RN #2 clocked out. I had not checked her off to administer medications by herself. She (continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>was not ready to work by herself on the cart. RN #4 stated there was no training provided to her by the facility before she started training new employees.</p> <p>During an interview on 04/22/2026 at 12:36 PM, the Pharmacist stated after reviewing Resident #1's scheduled medications and the medications given in error, she would have monitored for low blood pressure, low blood sugar and over sedation. She stated there were five different medications that would have contributed to the effects but no drug-to-drug interactions and no specific allergic reactions to consider.</p> <p>During an interview on 04/23/2026 at 9:00 AM, the NP stated she received an afterhours call from the ADON reporting Resident #1 had received their roommate's medications by error. She ordered all of Resident #1's medication to be held until the next morning until she could assess Resident #1, blood pressure to be checked every 2 hours, and blood sugar to be checked twice a day. The NP reported she had seen Resident #1 the day before and completed an assessment including the resident's lungs. There had been no change in the Care Plan at that time. Resident #1 had a lot going on with pneumonia and kidney function. The NP stated, It is hard to say if the medication error caused the event or not, it could have gone either way.</p> <p>During an interview on 04/23/2026 at 12:10 PM, the ADON stated LPN #1 misidentified Resident #1 and administered the wrong medications. The NP was notified and Resident #1 was monitored. Resident #1 was later sent out to the emergency room for treatment. The expectations for nurses were to have the right resident and the right medications. LPN #1 was provided one on one education. The UM was assigned to LPN #1 on the cart after RN #2 left but there was a moment LPN #1 wanted to pass medications and the UM stepped away and the incident occurred.</p> <p>During an interview on 04/23/2026 at 12:39 PM, the Administrator stated, it was an unfortunate medication error and no policy, procedure, or training lead up to the error. It was human error. The Administrator was unsure how much training LPN #1 had before she was allowed to complete medication administration alone. The Administrator stated that the UM also did wound care and he was unaware if she was doing both jobs while she was assigned to precept LPN #1. The Administrator stated, The med error is a med error, but [Resident #1] was very sick when [they] got here. Because of the med error [Resident #1] was monitored more and so they caught the change more quickly and sent [Resident #1] out, seven hours after the meds were given. \</p> <p>During an interview on 04/22/2026 at 10:38 AM, Resident #1's representative stated the facility called at 2:30 AM to report they were life fighting [Resident #1] to a larger hospital because the resident's blood pressure dropped to nothing. The Representative stated, Resident #1 was sent to the emergency room then spent two days in critical care because [Resident] was given someone else's medications. The representative stated he had been at the facility before when medications were passed, and staff never identified Resident #1 by name when they gave medications. Resident #1's Representative stated the doctor stated, if I was you, I would seek legal advice.</p> <p>Resident #5</p> <p>Review of Resident #5's admission Record revealed, the facility admitted Resident #5 on 02/04/2026 with diagnoses that included critical illness myopathy, metabolic encephalopathy, cerebral edema, diabetes, morbid obesity, respiratory failure with hypoxia and hypercapnia, obstructive sleep apnea, cognitive communication deficit, dysphagia, hyperlipidemia, bipolar disorder, hypertension, and chronic kidney disease. (continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of Resident #5's admission MDS, with an ARD of 02/08/2026, revealed Resident #5 had a BIMS score of 15 which indicated the resident was cognitively intact. The MDS also revealed Resident #5 was on medications that included an antipsychotic, antidepressant, anticoagulant, antibiotic, diuretic, opioid, and hypoglycemic.</p> <p>Review of the March 2026 MAR revealed, Resident #5 was administered a scheduled antihistamine, a vitamin supplement, a sleeping pill, two antidepressants, antipsychotic, potassium electrolyte replacement, a medication for gastric reflux, steroids, a cholesterol reducing medication, two stool softeners, two diuretics, anticoagulant, magnesium electrolyte replacement, antihypertensive which also lowers heart rate, narcotic pain medication, and supplemental oxygen three L on 03/26/2026.</p> <p>Review of a Medication Error Report dated 03/27/2026 at 5:30 AM, revealed Resident #5 was accidentally given two sleeping pills instead of two pain pills. The on call NP was notified and ordered staff to monitor Resident #5. Other information noted was, resident had no predisposing situations involved.</p> <p>During an interview on 04/22/2026 at 3:18 PM, LPN #3 stated she was in training and both she and her preceptor LPN #4 were both pulling medications from the same cart. LPN #3 stated she was pulling the non-controlled medications and LPN #4 was pulling the narcotics. LPN #3 took the pills in and administered them to Resident #5. The nurses found out later that Resident #5 was administered the wrong pills. LPN #3 stated she believed the mistake was discovered later when they were counting the controlled medications. Resident #5 had asked for a pain pill and was given sleeping pills instead. We called the on-call NP and she said to just monitor the resident. There were no adverse reactions, we just kept an eye on [Resident #5]. The sleeping pill was a controlled medication, and it was in the narcotic box along with all the other controlled medications. LPN #3 stated, LPN #4 punched it from the wrong card. They are both small white pills and she did not pay attention; we were trying to hurry of course. LPN #3 stated she didn't remember any particular competency check offs at all, they just checked her license. I don't know if the preceptor checked off anything or not. It was just that we were both in the cart and that is how the error happened.</p> <p>This Surveyor attempted to contact LPN #4 multiple times and LPN #4 did not return calls for an interview.</p> <p>During an interview on 04/21/2026 at 11:11 AM, Resident #5 stated they had knowledge of a medication error with their pain medication or sleeping medication, but did not remember details of the event.</p> <p>During an interview on 04/22/2026 at 12:36 PM, the Pharmacist stated, the dose of the sleeping medication Resident #5 received was above the recommended daily dose and would definitely increase sedation. The medication specifically could cause amnesia and central nervous system depression. If Resident #5 did not wear a pressurized mask while sleeping it could cause a break in breathing. The medication could also cause episodes of sleep walking.</p> <p>During an interview on 04/23/2026 at 9:00 AM, the NP stated, she saw Resident #5 after the medication error and there were no adverse side effects.</p> <p>During an interview on 04/23/2026 at 12:10 PM, the ADON indicated that LPN #3 stated the wrong medication card was pulled, and two sleeping pills were pulled instead of two pain pills. The expectation for nurses was to have the right resident and the right medications. (continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 04/23/2026 at 12:39 PM, the Administrator stated that the medication error with Resident #5 was caught pretty quickly. It was not a medical emergency. [Resident #5] had a good sleep, but it wasn't as critical, not a massive change in condition.</p> <p>Review of a facility policy titled, Medication Administration dated 11/25/2022 revealed, Medication must be administered in accordance with orders. The individual administering medications must verify the resident's identity before giving the resident his/her medication. Methods of identifying the resident include checking photographs attached to the medical record or verifying resident identification with other facility personnel. The individual administering the medication must check the label three times to verify the right resident, right medication, right dose, and right method (route) of administration before giving the medication. The individual administering the medication must initial the resident's MAR [Medication Administration Record] on the appropriate line after giving each medication and before administering the next ones. Medications ordered for a particular resident may not be administered to another resident, unless permitted by state law and facility policy, and approved by the Director of Nursing (DON) Services. New personnel authorized to administer medications will not be permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility. The Charge Nurse must accompany new nursing personnel on their medication rounds for a minimum of three days to ensure established procedures are followed and proper resident identification methods are learned.</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>Based on interviews, record review and facility policy review, it was determined that the facility failed to implement effective nurse training to ensure education of new nursing staff for two (LPN #1 and LPN #3) of two nurses reviewed.</p> <p>The findings include:</p> <p>Review of a facility undated New Trainee Folder provided by the Assistant Director of Nursing (ADON) contained the following: -Licensed Nurse Competency Skills Check-off-Gait Belt Technique, Mechanical Lift Technique-Nurse Report Sheet blank-24-Hour Report Sheet-Standing Orders-Incontinent &amp; Catheter Care Observation Checklist-Fluid Restriction Instruction Sheet-Med-Pass Best Practices MAR (Medication Administration Record) Marker-Med-Pass Quick References-Fall Intervention Strategies-Shift Trade Agreement-On-call Process &amp; Contact Information-Physician Order Sheet blank-Falling Leave Fall Prevention-Welcome letter -Policy and Procedures including: Resident Rights, Abuse/Neglect/Exploitation, and Elopements.</p> <p>Review of the undated Licensed Nurse Competency Skills Check-off revealed the preceptor should initial and signify the trainee had met the training requirements for unit safety, professional communication, infection control, provided nursing care, emergency procedures, units rounds &amp; documentation, equipment, medication administration, pain management, discharge process, resident advocacy, professional accountability, quality improvement/risk management, abuse, dementia, effective communication, Quality Assurance and Performance Improvement (QAPI), resident rights, person centered care, cultural competency, and Health Insurance Portability and Accountability Act (HIPPA).</p> <p>Review of the Director of Nursing (DON) Job Description revealed the DON had authority, responsibility, and accountability for the functions, activities, and training of the nursing services staff. The DON ensures that a sufficient number of qualified supervisory and supportive nursing personnel were assigned for each unit to meet the residents' needs. Participation as assigned in the orientation of new staff.</p> <p>Review of the Assistant Director of Nursing (ADON) Job Description revealed the ADON was to assist the DON with the management and training of the nursing services staff. The ADON was responsible for ensuring that Nursing staff were aware of their job duties and the facility's expectation of resident care. Participation as assigned in the orientation of new staff.</p> <p>Review of the Licensed Practical Nurse (LPN) Job Description, revealed responsibilities to participate in developing, conducting, and in-service training classes that provide instruction on 'how to do the job,' and ensures a well-educated nursing services department. Implement and maintain an effective orientation program that orients the new employee to their shift, its policies &amp; procedures, and to the job position and duties.</p> <p>Review of a facility policy titled, Medication Administration dated 11/25/2022, revealed New personnel authorized to administer medications will not be permitted to prepare or administer medications until they have been oriented to the medication administration system used by the facility. The Charge Nurse must accompany new nursing personnel on their medication rounds for a minimum of three days to ensure established procedures are followed and proper resident (continued on next page)</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>identification methods are learned.</p> <p>During an interview on 04/22/2026 at 12:08 PM, the Human Resources (HR) personnel stated that when a new LPN started, she printed off the competency check-off list and placed it in the front of the staffing binder kept at the front nurses' station. HR stated the preceptor should complete it with the new hire over their first three days. When it was completed, it went in a basket in the DON's office so the Unit Manager (UM), DON, or ADON could sign off on it.</p> <p>LPN #1</p> <p>During an interview on 04/22/2026 at 12:20 PM the UM stated, the facility competency checklist created for LPN #1 was put in folder created for her, but the LPN quit before it was completed and took it with her.</p> <p>Review of a Medication Error Report dated 03/23/2026 at 4:00 PM, stated Resident #1 was mistakenly given another resident's medication at approximately 4:02 PM which was discovered between 45 minutes to one hour later. The four incorrect medications given were for lowering blood sugar, an antidepressant, a medication to lower uric acid levels, and an antihypertensive with side effects of low blood sugar and increased levels of potassium.</p> <p>During an interview on 04/21/2026 at 2:43 PM, Licensed Practical Nurse (LPN) #1 stated, 03/23/2026 was her very first day on the job and she had never worked in a long-term care facility before. LPN #1 stated she had Registered Nurse (RN) #2 training her from 6 AM-10 AM prior to RN #2 clocking out for the day and was trained on how the residents took their medications and who had swallowing issues. LPN #1 stated she was trying to help and give medications when she pulled and gave Resident #6's medications to Resident #1. It did not register it was the wrong person; I didn't know the person. The Unit Manager (UM) arrived to help LPN #1. The UM instructed LPN #1 to pull Resident #1's medications, when LPN #1 went to administer them, she realized that the person she gave Resident #6's medications to was actually Resident #1. LPN #1 immediately reported her mistake to the UM. The DON and Nurse Practitioner (NP) were notified. LPN #1 was given one on one education by the ADON on the five rights of medication administration. LPN #1 stated she had been a nurse for 24 years and was upset. LPN #1 stated, I didn't even know how to put orders into the computer at that time. It was a new computer program for me. I was over stimulated, I could have slowed down, I was trying to do something on my own.</p> <p>During an interview on 04/22/2026 at 12:31 PM, LPN #1 stated that the competency checklist was given to her, but it was not completed. RN #2 talked to me about the checklist that morning, but she said we were going to complete the med pass first and look at it later. LPN #1 worked at the facility for three weeks.</p> <p>During an interview on 04/23/2026 at 10:40 AM, RN #2 stated, it was LPN #1's first day and LPN #1 had observed RN #2 that morning. RN #2 stated, I don't like them to go hands on when they don't know my residents. [LPN #1] just watched me. RN #2 reported LPN #1 had not performed any task on her own before RN #2 clocked out. I had not checked her off to administer medications by herself. She was not ready to work by herself on the cart. RN #4 stated there was no training provided for her by the facility before she started training new employees.</p> <p>During an interview on 04/22/2026 at 2:23 PM, the UM stated, on 03/23/2026 she worked performing wound care and worked as the UM at the same time. The UM reported that LPN #1 stated she thought (continued on next page)</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>she had it and was ok prior to the UM leaving her alone to administer medication. LPN #1 was on her own for about 30 minutes when the UM went to check on her and LPN #1 reported there was a lot going on. So, I asked where she was at, she said [Resident #6] she looked at the cards and pulled the meds and went in the room. The UM indicated that LPN #1 reported I made a mistake I gave [Resident #6's] medications to [Resident #1]. The UM stated that LPN #1 did not have any long-term care experience. The UM stated, I don't know when the competency checklist should be completed. Somebody should not complete a task alone before they have been checked off. The UM stated the nursing part of the competency check list was checked off that day by RN #2 and then she worked on a couple as well. The UM stated, I did not do the medication portion, I did not look at it. The UM stated she left LPN #1 as she had been through morning medication pass and said she felt comfortable. The UM stated RN #2 did not pass off or give a report to her and she did not see LPN #1 pass any medications before leaving her alone.</p> <p>Review of LPN #1's Employee File revealed an on boarding date of 03/01/2026. Disciplinary action was given on 03/26/2026 for the 03/23/2026 medication error incident, part of the action was LPN #1 was given oversight on the cart for the rest of that day to ensure the nurse understood the five rights of medication administration. The disciplinary action was signed by the UM and ADON. No Licensed Nurse Competency Skills Check-off was completed as of 04/23/2026.</p> <p>LPN #3</p> <p>Review of a Medication Error Report dated 03/27/2026 at 5:30 AM, revealed Resident #5 was accidentally given two sleeping pills instead of two pain pills.</p> <p>During an interview on 04/22/2026 at 3:18 PM, LPN #3 stated she was in training and both she and her preceptor LPN #4 were both pulling medications from the same cart. LPN #3 stated she was pulling the non-controlled medications, and LPN #4 was pulling the narcotics. LPN #3 took the pills in and administered them to Resident #5. The nurses found out later that Resident #5 was administered the wrong pills. LPN #3 stated she believed the mistake was discovered later when they were counting the controlled medications. Resident #5 had asked for a pain pill and was given sleeping pills instead. The sleeping pill was a controlled medication, and it was in the narcotic box along with all the other controlled medications. LPN #3 stated, LPN #4 punched it from the wrong card. They are both small white pills and she did not pay attention; we were trying to hurry of course. LPN #3 stated she didn't remember any particular competency check offs being done, they just checked her license. I don't know if the preceptor checked off anything or not. It was just that we were both in the cart and that is how the error happened.</p> <p>This Surveyor attempted to contact LPN #4 multiple times and LPN #4 did not return calls for an interview.</p> <p>During an interview on 04/22/2026 at 2:23 PM, the UM stated that LPN #3 was a new nurse and was in training with LPN #4 as a preceptor. Trainees usually had three days of orientation, if they don't feel confident the orientation would be extended until they do. The UM stated the preceptor should be helping them the way they were taught, the right way with the five rights, getting to know the residents, and the computer system. The way that I teach and the way other people teach is different, I always follow up with nurses to see if they feel like they understand something, sometimes I have them walk me through the process after to confirm they do know it. The UM stated there was no training for the preceptor prior to becoming a preceptor. They are just the nurse on the floor that has been working those shifts.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045295	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/23/2026
NAME OF PROVIDER OR SUPPLIER  The Blossoms at Berryville Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  500 Hammons Avenue Berryville, AR 72616	
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 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of LPN #3's Employee File revealed an onboarding date of 03/18/2026. No Licensed Nurse Competency Skills Check-off was completed as of 04/23/2026. LPN #3 was still currently employed at the facility.</p> <p>During an interview on 04/23/2026 at 9:00 AM, the Nurse Practitioner (NP) stated she would like to see the facility follow up and change. We have all been nurses, we have been there. We deserve our orientation, to have that person there to ask our questions.</p> <p>During an interview on 04/23/2026 at 12:10 PM, the ADON stated LPN #1 had 18 years of experience, but none in Long-Term Care. The ADON stated she did not recall how much training LPN #1 had prior to the medication error and did not know if it was her first day. The ADON stated that the preceptor was just one of the floor nurses. The nurses were promoted to preceptor if they had been at the facility longer and knew the residents well. There is no rule, maybe six months. There was no preceptor training prior to training others. The current training program just started in March 2026 prior to the two medication errors. The ADON stated, all new hires get a folder of information.</p> <p>During an interview on 04/23/2026 at 12:39 PM, the Administrator stated he determined there was no policy, procedure, or training issue which led up to the medication errors, it was human error. For training, the facility typically started with three days of training, if the trainee needed additional time they could get it. Some trainees were not comfortable and they got extra training. I'm not sure how much training [LPN #1] had before she was turned loose, she was mid-way and was starting to turn loose. I don't remember when her start date was to be honest. After the medication error LPN #1 was put back into training with a trainer immediately. LPN #1 had been a nurse for a long time but none in Long-Term Care. The Administrator stated, [UM] is the unit manager; I think she is also wound care. I don't know for a fact if she was both the day she was also precepting. The facility will be discussing the medication errors in depth during the April 2026 QAPI meeting. The Administrator stated he would suggest improving the training process and addressing the five rights of medication administration with all nurses.</p>		