

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 08/08/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>42016</p> <p>Based on observations, interviews, and record review, the facility failed to ensure residents were treated with dignity during meal service for 3 (Resident #15, #34, and #55) residents of 13 residents observed during meal service.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Resident Assistance with Meals, with an effective date of April 2021, indicated residents would be assisted with dignity and without staff standing over them while providing dining assistance.</p> <p>A review of a document titled, The Blossoms Employee Handbook, indicated the care of facility residents was guided by respect and dignity of human life.</p> <p>A review of the Admission Record indicated the facility admitted Resident #15 with diagnoses that included difficulty swallowing, muscle weakness, and lack of coordination.</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/03/2024, revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated the resident had sever cognitive impairment and required assistance with eating.</p> <p>A review of Resident #15's Care Plan, dated 06/13/2024, revealed the resident had an activity of daily living (ADL) self-care performance deficit related to weakness and cognitive impairment related to dementia. Interventions included set up and supervision during meals, providing orientation focusing on abilities, and promoting meaningful interaction.</p> <p>A review of the Admission Record indicated the facility admitted Resident #34 with a central nervous system disorder affecting movement.</p> <p>The signification change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/15/2024, revealed Resident #34 had a BIMS score of 9, which indicated the resident had moderate cognitive impairment and required assistance with eating.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #34's Care Plan, initiated 07/17/2024, revealed the resident had central nervous system disorder affecting movement. Interventions included monitoring for ADLs, signs and symptoms of choking, and difficulty swallowing.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #55 with diagnoses that included movement disorder and progressive disease-causing impairment of memory and mental functions.</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/03/2024, revealed Resident #55 had a BIMs score of 0, which indicated the resident had severe cognitive impairment and was dependent on staff for eating.</p> <p>A review of Resident #55's Care Plan, initiated 06/11/2024, revealed the resident was at risk for altered nutritional and hydration and required extensive assistance with eating. Interventions included assisting the resident with meals.</p> <p>During an observation on 08/05/2024 at 1:01 PM, Resident #55 was sitting in a reclining wheelchair, on the far-right side of the first half round table, in the assisted dining room. LPN #4 was standing on the right side of Resident #55, spoon feeding the resident pureed chicken and dumplings. LPN #4 then walked to Resident #34, sitting at the second table on the right side of the dining room, stood on the right side of the resident and spoon fed Resident #34 chicken and dumplings. LPN # 4 then walked to the center dining room table where Resident # 15 was sitting in a wheelchair. LPN #4 stood on the right of Resident #15 and spoon fed resident one bite of chicken and dumplings. LPN # 4 returned to the right side of Resident #55 and spoon fed the resident another bite of food.</p> <p>During an interview on 08/05/2024 at 1:15 PM, Certified Nursing Assistant (CNA) #3 stated staff should be at the same level as residents, not standing when assisting with meals, to prevent intimidating residents.</p> <p>During an interview on 08/05/2024 at 1:30 PM, LPN #4 stated aides sit to assist residents, but the nurse is not required to sit due to the need to move from table to table to assist residents.</p> <p>During an interview on 08/07/2024 at 1:00 PM, the Director of Nursing (DON) stated all staff should be sitting at eye level with residents while providing assistance. There is no exception for nurses, they must provide dignity, so the residents do not feel someone is hovering or intimidating them.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>42016</p> <p>Based on observations, interviews, record review, and policy review, it was determined the facility failed to ensure a bath or shower for 1 (Resident #65) of 1 resident reviewed for activities of daily living.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Showering Residents, dated April 2021, indicated the purpose was to promote resident cleanliness and included a procedure only and did not address missed bathing or showers.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #65 with diagnoses that included a disorder that affected a person's ability to think, a mood disorder, anxiety disorder, pain, and dizziness.</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/12/2024, revealed Resident #65 had Brief Interview for Mental Status (BIMS) a score of 10 which indicated the resident had moderate cognitive impairment and an assessment to determine resident's ability to shower/bathe themselves was not attempted. The accompanying Care Area Assessment (CAA) Worksheet indicated the resident may have care needs or problems with cognitive loss, mood disorder impacting loss of cognition, pain, and functional abilities.</p> <p>The Admission Nursing Evaluation, dated 07/12/2024, indicated Resident #65's functional status for ability to transfer required 1 person to assist, a bathing preference of a shower, and required bathing assistance of 1 person.</p> <p>A review of Resident #65's Care Plan, initiated 07/22/2024, revealed the resident had an activity of daily living (ADL) self-care deficit related to fatigue, impaired balance, limited mobility and pain; a cognitive function or impaired thought process related to making decisions. Interventions included using simple instructions to promote independence, cue, reorient and supervise, keep the resident's routine consistent to decrease confusion. The Care Plan did not indicate Resident #65's preferences or number of staff required for assistance.</p> <p>A review of Order Summary, revealed Resident #65 had a disorder that affected a person's ability to think, a mood disorder, anxiety disorder, pain, and dizziness.</p> <p>During an interview on 08/05/2024 at 10:50 AM, Resident #65 stated it had been over a week since their last shower.</p> <p>During an interview on 08/05/2024 at 11:09 AM, Licensed Practical Nurse (LPN) #14, stated the Assistant Director of Nursing (ADON), the Director of Nursing (DON), and the floor nurse were responsible to ensure residents receive showers. The ADON was on maternity leave, they were running at a bare minimum and care was being provided.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Medication Administration Record, for July and August 2024 revealed Resident #54 had behavior monitoring, that included refusal of care every shift. There was no documentation of Resident #65 refusing care.</p> <p>A review of an Activity of Daily living (ADL) task titled, Shower/Bathe Self, revealed Resident #65 had a shower on 07/20/2024 at 12:55 PM and a shower on 07/30/2024 at 2:29 PM in the last 30 days. A shower sheet provided with the ADL sheet titled, Daily Shower Sheet, documented Resident #65 received a shower on 07/15/2024. Instructions at the bottom of the Daily Shower Sheet indicated the shower aides were to notify the nurse if the resident refused and all showers on the roster were to be accounted for. The Nurse on Duty was to ensure nurse assistants were completing the assigned showers. If a resident refused, the nurse was to encourage the resident and if the resident continued to refuse, staff were to initial the page as a refusal and place a note in the electronic health record as a 'Behavior Note'. The Daily Shower Sheet was provided by the Director of Nursing (DON) on 08/07/2024 at 10:05 AM. The DON stated the Daily Shower Sheet was provided to the shower aides daily and listed residents who were to receive showers on that date and was used to document who received showers and who refused. Initials on the left of the name was the nurse acknowledging a resident refused and initials on the right indicated the aide who provided the care. An R on the right indicated a resident refused.</p> <p>A review of the Tub/Shower Transfer tasks from 07/12/2024 through 08/06/2024, indicated Resident #65 was independent with transfer on 08/02/2024. Not Applicable was documented daily on all other dates during this time.</p> <p>A review of Progress Notes revealed Resident #65 refused a shower on 08/05/2024. No follow-up documentation was found. On 08/06/2024 at 3:34 PM, Resident #65 agreed to be shaved and refused a shower. Follow up documentation at 3:44 PM, the resident agreed to and received a shower.</p> <p>During an interview on 08/07/2024 at 12:57 PM, the DON stated Not Applicable indicated the resident refused a bath or shower and did not know why CNAs would mark Not Applicable when they can mark refused.</p> <p>During an interview on 08/08/2024 at 8:05 AM, CNA #15 stated when aides arrived for their shift, they receive a list of residents who are to receive showers. If a resident refused, the nurse was notified and would go speak with the resident. If the resident still refused it was documented in the electronic health record for bath/shower as refused. Not Applicable was used if staff did not get to the shower for that resident. The nurse was notified if the showers were not done. Residents' usual schedule is twice a week on days chosen by the resident.</p> <p>During an interview on 08/08/2024 at 8:17 AM, CNA #16 stated a list of residents was received at the beginning of the shift. Residents were asked if they wanted their shower or bath and if they refused, the nurse was notified. The nurse would then speak with the resident and if the resident refused, it was documented as a refusal in the computer. Not applicable was used if the CNA did not speak with the resident and the resident did not receive a bath or shower. The nurse received the list of residents for showers.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49866</p> <p>Based on observations, interviews, facility document review, and facility policy review, the facility failed to ensure the following: foods stored in walk in refrigerator was stored off the ground for 1 of 1 kitchen, that beneath the dishwasher was clean for 1 of 1 kitchen, standing water in front of the refrigerator in kitchen and in walk in refrigerator with towels/sheet in floor absorbing water in 1 of 1 kitchen, drinks in the unit refrigerator was labeled, dated and covered for 1 of 3 dining rooms, foods on the unit was dated and used by expiration/best by date 1 of 3 dining rooms, resident's and employee foods not stored in the same refrigerator in 1 of 3 dining rooms and the refrigerator was clean and in sanitary condition for 1 of 3 dining rooms in order to prevent cross contamination and foodborne illnesses. These failed practices have the potential to affect 72 residents who received meals from 1 of 1 kitchen and potential to affect 72 residents who reside in facility and potential to have food in unit refrigerator.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. The Surveyor observed on [DATE] at 10:35 AM, the walk-in refrigerator had water on the floor with towels on top of the refrigerator. There was also water standing without covering of towel on the floor. 2. The Surveyor observed on [DATE] at 10:37 AM, a box of uncovered potatoes sitting on the floor in the pantry room. 3. The Surveyor observed on [DATE] at 10:42 AM, the Surveyor observed underneath the dishwasher to be damp with dark brown areas observed in numerous places on the floor. It also had dark brown areas on the sheetrock. Dietary Manager (DM) #10 stated that the dishwasher was leaking, and the maintenance man fixed it the day before on [DATE]. 4. The surveyor observed a refrigerator in the small dining room on 300 Hall on [DATE] at 7:30 AM. The refrigerator had a brown sticky substance at the bottom underneath crisper drawers. The following were observed in refrigerator: <p>Two cups with fluid without lids. No name or dates observed.</p> <p>16-ounce (oz) hazelnut creamer- no open date and expired ,d+[DATE]</p> <p>28 oz of barbeque sauce with no open date</p> <p>24 oz sweet relish expired [DATE] with no open date.</p> <p>20 oz mustard with no open date.</p> <p>22 oz strawberry syrup with no open date</p> <p>20 oz jar of cowboy candy with open date of [DATE]</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>20 oz salad dressing with no open date and expired [DATE].</p> <p>20 oz salad dressing with no open date and expired [DATE].</p> <p>13 oz whipped topping with no lid and no open date</p> <p>8 oz mustard with no open date and expired [DATE].</p> <p>24 oz salad dressing with no open date and expired [DATE].</p> <p>16 oz salad dressing with no open date expired [DATE].</p> <p>9 oz green cookie icing with no open date, unable to find expiration date. No lid on the bottle.</p> <p>10 oz dill relish no open date.</p> <p>18 oz barbeque sauce no open date no expiration date seen on bottle.</p> <p>8.4 oz sesame dipping sauce no open date expiration date unreadable ink rubbed off.</p> <p>9 oz red cooking icing bottle with no lid. no open date no expiration date seen.</p> <p>15 oz soy sauce with no open date and no expiration date seen.</p> <p>32 oz jar of jalapeno slices no open dates, expired [DATE].</p> <p>1 package of mozzarella cheese no open date.</p> <p>9 oz package of turkey with open date of [DATE] with sell by date of [DATE].</p> <p>22 oz bottle of mayonnaise no open date and expired on [DATE].</p> <p>1 package of cheese no open date and unable to locate expiration date.</p> <p>16 oz potato salad with no open date.</p> <p>Half of cantaloupe with no date.</p> <p>Package of croutons package open and no sealed with no open date.</p> <p>64 oz of cranberry grape bottle with no open date.</p> <p>1 apple with white fuzz on one side not bagged.</p> <p>24 oz container of sour cream no open date and expired [DATE].</p> <p>Container pasta salad container sealed- expired [DATE].</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>12 count container of eggs with no open date with best by date [DATE].</p> <p>6 count container of eggs with no open date with best by date of [DATE].</p> <p>6 count container of eggs with no open date with best by date [DATE].</p> <p>18 count container of eggs with no open date with best by date of [DATE].</p> <p>24 count container of eggs with no open date with best by date of [DATE].</p> <p>1 bottle of 64 oz of hummingbird nectar.</p> <p>1 cup of dark brown fluid with saran wrap on it with no date.</p> <p>1 turquoise fabric lunch bag.</p> <p>16 oz of hazelnut creamer with no open date expired ,d+[DATE].</p> <p>28 oz of barbeque sauce with no open date.</p> <p>24 oz sweet relish with no open date expired [DATE].</p> <p>20 oz container of mustard no open date.</p> <p>22 oz container of strawberry syrup with no open date.</p> <p>20 oz jar of cowboy candy with date on lid [DATE].</p> <p>20 oz bottle of salad dressing with no open date and expiration date of [DATE].</p> <p>20 oz bottle of salad dressing with no open date and expiration date of [DATE].</p> <p>Container of potato salad with no open date.</p> <p>Bag of mozzarella cheese with no open date.</p> <p>Container of salad no open date.</p> <p>Half of cantaloupe with no date.</p> <p>Container of sour cream with no open date and expired on [DATE].</p> <p>The freezer contained:</p> <p>A box of frozen waffles with no open date.</p> <p>2 boxes of popsicles with no open date.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>2 containers of ice cream with no open date.</p> <p>1 bag of min ice cups with no open date.</p> <p>1 cup of dark purple frozen fluid with saran wrap on top with no label or open date.</p> <p>5. On [DATE] at 10:55 AM, the surveyor observed a sheet/thin blanket lying on the floor in the walk in refrigerator.</p> <p>6. During an interview on [DATE] at 10:35 AM, DM #10 informed the surveyor the water on the floor in front of the refrigerator in kitchen and the one in walk in refrigerator, was from a leak and the maintenance man had not fixed it yet, and it had been that way since she started, which was ninety days. Also reported that the Maintenance Director was aware of it. Also stated the dishwasher was leaking, and the Maintenance Director had just fixed it the day before.</p> <p>7. During an interview on [DATE] at 10:55 AM, DM #10 revealed the sheet/thin blanket in the walk-in refrigerator was there to absorb the water that leaks from the top of the refrigerator and reported that Maintenance Director #9 came in on [DATE] and stated that the water is from condensation leaks. DM #10 stated the floor underneath and on the wall beneath the dishwasher was not good and was old, stained, and rusted. DM #10 stated they mop every day, but the floor remains that color. DM #10 stated that it needed to be retiled. Below the dishwasher clean table needs new tiles and it was brown in color. Reported no food should be placed on the floor and it should have been put in the container bins instead.</p> <p>8. During an interview on [DATE] at 11:10 AM, Maintenance Director #9 revealed the floor beneath the dishwasher was concrete, plain, and dark in color, and that the wall underneath was dirty. Maintenance Director #9 reported there were no missing tiles and the floor was made that way it was just the floor exposed from being dug up over eight years ago when there was a problem there before. Reported that in the walk-in refrigerator the water was coming from the re-circulation fan. It blows the water at times and lands on the floor and is the reason the water is on the floor. Maintenance Director #9 stated they go outside every day and turns it off for about five minutes and it stops it. Maintenance Director #9 reported not being sure if this is done on the weekends and that's why it probably was like that Monday because it had not been done yet. Maintenance Director #9 stated that in the refrigerator there is a tray in the back that fills up, and that it does it more when it is humid. Reported that it is drained every two days to keep it from leaking.</p> <p>On [DATE] at 7:42 AM, the Director of Nursing (DON) stated that the refrigerator in the small dining room on the 300 Hall was used by the residents and staff. The staff is not supposed to use it, but they do. The DON observed the food in the refrigerator and reported the foods did not have open dates on them and were not labeled. The DON observed the turkey lunch meat at bottom of the refrigerator and acknowledged it was expired, and no open date was on it; observed the two cups with no lids on them and stated they had no coverings and was not labeled or have open date on them. The DON reported that the housekeeping department was responsible for cleaning it every day, that the bottom of the refrigerator had spilled brown fluid and appeared sticky, and she was uncertain whose food was whose. At 10:20 AM, was shown the hummingbird nectar in the refrigerator and DON stated she was unsure what it was for, it was a non-food item and should not be in that refrigerator.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview with Housekeeping Supervisor (HSKSP) #11 on [DATE] at 9:00 AM, HSKSP #11 reported that as a housekeeper on that hall and had never cleaned the refrigerator in the small dining room. At 10:32 AM, observed the hummingbird nectar bottle in the refrigerator and stated that they do not know why it was in the refrigerator or what it is for, but it should not be in that refrigerator. The bottle was removed by HSKSP #11.</p> <p>A review of a facility document titled, Housekeeping List, undated but received by Administrator dated [DATE], did not indicate any cleaning duty of the refrigerator in the small dining room on the 300 Hall.</p> <p>A review of facility document titled Daytime Dishwasher Duties, undated but received on [DATE] at 11:43 AM, indicated that dishwasher employees are to clean door walls and floor.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>42016</p> <p>49866</p> <p>50924</p> <p>Based on observations, interviews, record review, and facility policy review, the facility failed to ensure staff performed hand hygiene while serving meals and providing assistance to 6 (Resident #11, #15, #25, #28, #34, and #55) of 13 residents observed, specifically, staff moved from one resident to the next while feeding the residents, and touching other high contact areas, without performing hand hygiene; and failed to ensure that enhanced barrier precautions (EBP) were worn while performing indwelling catheter care to 1(Resident #31) of 3 sampled residents who had orders for indwelling catheter.</p> <p>Findings include:</p> <p>1. A review of a facility policy titled, Hand Hygiene, dated April 2021, indicated hand hygiene was considered the primary means in preventing the spread of infections and staff should follow handwashing and hand hygiene procedures to prevent the spread of infections to residents.</p> <p>a. A review of a facility policy titled, Resident Assistance with Meals, dated April 2021, indicated residents who were unable to feed themselves would be fed with attention to safety.</p> <p>b. During an observation on 8/05/2024 at 12:52 PM, Certified Nursing Assistant (CNA) #3 used a spoon and placed food in Resident #28's mouth. CNA #3 moved hands below the table, rubbed hands on thighs, and folded their hands on their lap. CNA #3 moved hands above the table, picked up resident's spoon and placed food in resident's mouth. No hand hygiene was performed during this observation.</p> <p>c. During an observation on 08/05/2024 at 12:54 PM, CNA #3 used their hand and wiped the right side of their face, scratched side of their nose, picked up a spoon and placed food in Resident # 25's mouth. CNA #3 then placed the spoon on the table, raised their hands and adjusted their glasses, and picked up the spoon and placed food in Resident # 28's mouth. This observation occurred twice. After placing food in Resident #25's mouth, CNA #3 touched their face, picked up a cup and provided Resident #55 with a drink. No hand hygiene was performed. CNA #3 wiped their fingers on Resident # 28's napkin, picked up a spoon and placed food in Resident #28's mouth. No hand hygiene was performed during the entire observation.</p> <p>d. During an observation on 08/05/2024 at 12:56 PM, Nursing Assistant (NA) #5 and spoon fed Resident #11 chicken and dumplings, laid spoon down, and placed their hands below the table and resided them on their lap, palms down. NA raised their hands above the table, picked up the spoon and fed Resident #11 chicken and dumplings. No hand hygiene was performed during the observation.</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 08/08/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e. During an observation on 08/05/2024 at 1:01 PM, Licensed Practical Nurse (LPN) LPN #4 was standing on the right side of Resident #55, spoon feeding the resident. LPN #4 then walked to Resident #34, and spoon fed Resident #34. LPN # 4 then walked to the center dining room table where Resident # 15 was sitting in a wheelchair, and spoon fed the resident. LPN # 4 returned to Resident #55 and spoon fed the resident. No hand hygiene was performed between feeding each resident.</p> <p>f. During an interview on 08/05/2024 at 1:15 PM, CNA #3 stated hand hygiene should be done when moving between residents, and after touching clothing, their face, or nose to ensure germs were not spread to the residents. CNA #3 did not sanitize because no sanitizer was available. Sanitizer was observed on the top shelf of the resident's meal cart, brought into the dining room at 12:23 PM.</p> <p>g. During an interview on 08/05/2024 at 1:17 PM, NA #5 stated hands should be sanitized before assisting the resident, after touching their uniform, because residents' immune systems are not like mine so they could get my germs and be ill.</p> <p>h. During an interview on 08/05/2024 at 1:30 PM, LPN #4 stated hand hygiene should probably be done but constantly assisting residents prohibits it.</p> <p>i. During an interview on 08/07/2024 at 1:00 PM, the Director of Nursing (DON) stated staff should sanitize or wash their hands between each resident when passing trays or when feeding residents, to prevent the spread of germs or bacteria that are on their hands, which could result in infection to residents.</p> <p>2. A review of the Admission Record, dated 12/27/2023, indicated the facility admitted Resident #31 with diagnoses that included infection and inflammatory reaction due to indwelling urethral catheter and neuromuscular disfunction of the bladder.</p> <p>a. During an observation of Resident #31 on 08/05/24 at 3:42 PM, Licensed Practical Nurse (LPN) #8 removed a urinary catheter and inserted a new urinary catheter without putting on a gown for EBP.</p> <p>b. During a subsequential interview on 08/05/24 at 4:02 PM, LPN #8 confirmed Resident #31 was on EBP, but they did not utilize a gown during the urinary catheter insertion and care per policy.</p> <p>c. A review of a facility policy titled, Enhanced Barrier Precautions, dated 09/21/2022, indicated, For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities. Activities listed as devise care or use including urinary catheter.</p>		

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NAME OF PROVIDER OR SUPPLIER The Blossoms at Berryville Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Hammons Avenue Berryville, AR 72616	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>49866</p> <p>Based on observations, document review and interviews the facility failed to ensure bleach wipes and disinfectant wipes were not left at bedside for 1 (Resident #42) of 1 sampled resident.</p> <p>The findings are:</p> <p>A review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/26/2024 showed Resident #42 had a Brief Interview of Mental Status (BIMS) score of 12, which suggests moderate cognitive impairment.</p> <p>On 08/05/2024 at 1:24 PM, the surveyor observed a container of bleach wet wipes and disinfectant wipes sitting on Resident #42's table next to bed.</p> <p>On 08/05/2024 at 3:26 the surveyor observed a container of bleach wet wipes and a container of disinfectant wet wipes on Resident #42's table next to bed.</p> <p>On 08/06/2024 at 10:17 AM, the surveyor observed a container of bleach wet wipes and a container of disinfectant wet wipes on Resident #42's table next to bed.</p> <p>On 08/07/2024 at 2:09 PM, the surveyor observed a container of bleach wipes and a container of disinfectant wet wipes on Resident #42's table next to bed.</p> <p>On 08/07/2024 at 2:09 PM, an interview with Certified Nursing Assistant (CNA) #13 was conducted. CNA #13 opened the bleach wipe container and verified that there were wipes in the container, then opened the disinfectant wipe container and verified that there were wipes in that container as well. When asked what type of wipes these containers were, CNA #13 reported they were bleach wipes and sanitizer wipes, and that neither of the wipes should have been left in Resident #42's room. CNA #13 revealed the wipes are hazardous, and the housekeepers store them in their carts.</p> <p>On 08/07/2024 at 2:15 PM, an interview with Registered Nurse (RN) # 12 was conducted. RN #12 revealed that the two containers in the room were bleach wipes and disinfectant wipes and should not be in the resident's room, because they could get mixed up and used as personal wipes or mixed up and used with food. RN #12 reported they should be locked up in cabinets so residents cannot get to them.</p> <p>On 08/08/2024 at 2:20 PM, an interview with Director of Nurses (DON) was conducted. The DON revealed that the wipe containers in Resident #42's room were bleach wipes and disinfectant wipes, and indicated the wipes are a hazard and should not be left where a resident has access to them. They should be stored where a resident cannot have access to them such as the med cart or locked up somewhere else.</p>		