STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045295	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Berryville Rehab & Nursing Center	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)
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. Based on observation, interview, and facility document review, the facility failed to ensure that the food preparation equipment and environment were maintained in a clean and sanitary condition to prevent contamination and the potential development of foodborne pathogens, specifically, not cleaning the drip pans and fish fryer. The findings include: During an observation on 12/01/2025 at 11:20 AM, during the initial tour of the facility's kitchen, this surveyor observed the drip pans were covered with aluminum foil, approximately two feet long, by two feet wide. The foil was completely covered in a brown and black substance, with visible charred curly noodles. During an observation on 12/01/2025 at 11:23 AM, this surveyor observed the grease in the fish fryer to be mostly covered with a layer of floating brown particles. The grease that was visible through the floating debris was cloudy. During an interview on 12/01/2025 at 11:20 AM, Dietary Manager (DM) #2 confirmed that the drip pans had not been cleaned or checked by her personally, since she started her employment in September. DM #2 then said the kitchen staff used the fish fryer a couple times a week and it was cleaned once every two weeks. During an interview on 12/03/2025 at 11:32 AM, [NAME] #3 was asked to verbalize the tasks involved in keeping the kitchen's food preparation areas clean and sanitary, and referenced cleaning the steam table and dishes as a daily task, but there was no mention of cleaning the stove, drip pans, or fish fryer. During an interview on 12/03/2025 at 11:36 AM, DM #2 stated that staff were in-serviced at least once a month on pureeing foods, tray cards, glove use, safe food handling, and kitchen cleaning. During an interview on 12/03/2025 at 11:40 AM, Regional Dietary Manager #1 confirmed that during random weekly visits, sanitation audits were done, in-service recommendations were made to the DM, and competency check offs were performed with staff. During an interview on 12/03/2025 at 11:45 AM, Dietary Aide (DA) #4 stated that doing dishes, making desserts, and pureeing foods were part of the day-to-day job duties. DA #4 did not mention any cleaning tasks other than dishwashing and could not recall when the last in-service was or what it was on. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/04/2025 at 9:36 AM, the Administrator took responsibility of overseeing the kitchen and stated he made frequent visits in the kitchen every day. Spot checks were conducted, along with sampling food, checking in-service training, and checking temperatures of the walk-in refrigerator and freezer. The Administrator confirmed that the drip pans not being cleaned frequently could create a potential hazard of foodborne pathogens. A review of the facility's Policy and Procedure Kitchen Cleaning stated, The food and nutrition services staff will maintain the cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. A review of the facility's Kitchen Cleaning Schedule indicated that the fish fryer was to be cleaned once per week, and the drip pans every day. According to this cleaning schedule, the drip pans had not been cleaned since 11/28/2025, and the fish fryer had not been cleaned since the week of 11/24/2025-11/30/2025.

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, interview, record review, and facility document review, the facility failed to ensure adequate staffing levels to meet residents' needs for timely assistance, call-light response, and water pass for one (Resident #3) of one resident reviewed, according to the facility assessment. The findings include: A review of the facility assessment revised 07/11//2025, documented required direct-care staffing levels for an average daily census of 64 residents as follows: Dayshift- 6 Certified Nursing Assistants (CNAs)/3 nursesEvening shift- 4 CNAs/3 nursesNightshift- 4 CNAs/2 nurses. A review of facility daily staffing records from 04/05/2025 through 11/23/2025, revealed multiple dates in which the required staffing levels were not met across day, evening, and night shifts, which included: -04/05/2025 with day shift staffing of 6 CNAs/1 nurse and night shift staffing of 3 CNAs/2 nurses for a census of 64 residents-04/12/2025 with day shift staffing of 4 CNAs/2 nurses for a census of 65 residents-04/19/2025 with day shift staffing of 4 CNAs/3 nurses for a census of 66 residents-05/17/2025 with day shift staffing of 6 CNAs/2 nurses and evening shift staffing of 5.5 CNAs/2 nurses for a census of 64 residents-05/24/2025 with evening shift staffing of 6.5 CNAs/2 nurses and night shift staffing of 3.5 CNAs/1 nurse for a census of 66 residents-06/01/2025 with evening shift staffing of 6.5 CNAs/2 nurses for a census of 66 residents-07/06/2025 with day shift staffing of 4 CNAs/3 nurses for a census of 62 residents-08/23/2025 with census of 57 residents and day shift staffing of 5 CNAs/3 nurses with evening shift staffing of 4 CNAs/3 nurses-09/06/2025 with day shift staffing of 5 CNAs/3 nurses and evening staffing of 4.5 CNAs/3 nurses for a census of 56 residents-10/18/2025 with day shift staffing of 4 CNAs/3 nurses for a census of 56 residents-11/02/2025 with night shift staffing of 2 CNAs/2 nurses for a census of 61 residentsThese and additional dates reflected staffing levels below those required in the facility assessment. A review of the facility grievance logs revealed on the following dates, call lights were not answered by staff in a timely manner: 01/30/2025, 03/27/2025, 04/30/2025, 06/03/2025, 06/11/2025, 07/02/2025, 09/25/2025, 09/26/2025, 10/30/2025, 11/01/2025, 11/10/2025, 11/24/2025, and 12/01/2025. A review of the facility's resident council meeting minutes revealed that residents complained their call lights were not answered in a timely manner on 04/24/2025, 05/27/2025, and 07/31/2025. During an observation on 12/01/2025 at 11:30 AM, while rounding and screening residents, this surveyor observed multiple stripped bare, unmade beds in different rooms throughout the facility. During an observation on 12/01/2025 at 12:27 PM, the Administrator, the Activity Director (AD), and Social Director were observed in the facility dining room passing out resident meal trays, and the Administrator was observed assisting with feeding the residents. During an observation on 12/01/2025 at 1:25 PM, this surveyor observed Resident #3's call light lit and sounding, with several staff members walking by the room in the hallway without stopping. Resident #3 was yelling out, Hey when they saw someone pass by the door, several staff members responded Hey, without stopping to check on the needs of the resident. This occurred while this surveyor was in the resident room with them. Resident #3 was sitting up at beside in a wheelchair, their bed was stripped with folded linen lying in a chair in the room. During an interview on 12/01/2025 at 1:56 PM, Resident #3 reported to this surveyor they wanted their bed made and to be assisted to bed. The resident then reported the facility was always shorthanded. During an interview on 12/04/2025 at 11:15 AM, the Administrator indicated he frequently assisted with passing trays and feeding residents at mealtimes. During an interview on 12/04/2025 at 10:15 AM, the AD revealed that assistance in passing meal trays was provided during periods of short staffing, including a report of assisting on Monday 12/01/2025, to ensure trays were distributed on time. During an interview on 12/04/2025 at 9:32 AM, the Administrator reported no known concerns from residents or families about weekend staffing levels and indicated no awareness of residents waiting extended periods for assistance. The Administrator (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	acknowledged that a grievance regarding call-light response time had occurred and stated it was addressed by the Director of Nursing (DON) and the Assistant Director of Nursing through scheduling and staffing adjustments and follow-up with involved staff.During an interview on 12/04/2025 at 9:23 AM, the Administrator stated facility expectations were for beds to be made by 10:00 AM, water to be passed around at 10:00 AM, and at least twice daily, and call lights were to be answered within five minutes. The Administrator reported tasks were monitored through assignment sheets and periodic spot checks conducted by nurses and unit managers. The Administrator then stated there were sufficient staff in the facility. During an interview on 12/04/2025 at 12:03 PM, CNA #13 reported that staffing was not adequate and identified lunchtime as one of the busiest periods of the day. The CNA stated that the front hall had no hot water for approximately one week, which resulted in some residents being unable to be taken to the back hall for showers, due to not having time to complete. CNA #13 stated there was not always enough time to complete required tasks and that concerns had been reported up the chain of command, without improvement. CNA #13 stated that having no water at the bedside was neglect and indicated call lights should be answered within two to three minutes. CNA #13 also noted that scheduled showers were not completed on weekends, due to insufficient staffing. During an interview on 12/04/2025 at 12:14 PM, CNA #10 stated there was not always enough staff to complete assigned tasks. The CNA reported that back-hall staff were responsible for residents located around a corner that was difficult to observe and that call lights were not always answered timely during busy morning care periods. The CNA stated these concerns had been reported to nursing management and assistance was only sometimes provided. During an interview on 12/04/2025 at 12:03 PM, CNA #13 stated there was frequently not enough staff and that this had been reported to the DON, who indicated attempts were being made to hire more staff. The CNA stated water was sometimes not passed as needed due to workload, and tasks could not always be completed. CNA #13 reported call-light wait times of up to ten minutes. The CNA then stated that during a recent weekend shift, daytime staffing consisted of only three CNAs and that it was not sufficient staff to assist residents with breakfast or lunch on weekends. During an interview on 12/04/2025 at 12:33 PM, CNA #5 reported the shower aide was responsible for 20 to 28 scheduled showers a day, as well as nail care, shaving, lotion, and application of skin protectants for residents. CNA #5 then stated frequent re-assignment of the shower aide from shower duties to floor coverage resulted in an incomplete shower schedule. The CNA also reported that residents became upset when shower services were delayed and that concerns had been verbally reported to the DON and additional supervisory staff. CNA #5 stated there was no designated shower aide on weekends. During an interview on 12/04/2025, the DON confirmed the facility had no policy in regard to resident hygiene of answering call lights.