STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Conway Rehab & Nursing Center	3501 College Avenue Conway, AR 72034

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 Based on record review and interview, it was determined the facility failed to ensure the comprehensive care plan addressed and individualized appropriate care and services for resident behaviors for 1 (Resident #4) of 1 sample mixed resident. The findings are: A review of an Admission Record, revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of alcohol abuse, altered mental status, encephalopathy, and cognitive communication deficit. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/5/2024 revealed Resident #4 scored a 02 (indicates cognitively moderately impaired for daily decision making) on a Staff Assessment for Mental Status (SAMS). A review of the nursing Progress Notes dated 8/17/2024 at 5:18 PM, revealed Resident #4 was in a wheelchair in the common area under staff supervision due to attempting to enter other resident's rooms. Resident #4 had multiple family members visiting throughout the day. A review of nursing Progress Notes dated 8/18/24 at 2:05 AM, revealed Resident #4 requiring frequent redirection and becoming angry and striking out. Resident #4 was assessed as an elopement risk and fall risk and required frequent observation for safety. A review of the nursing Progress Notes dated 8/18/24 at 6:01 PM, revealed Resident #4 was in the common area watching television. Signs and symptoms (S/S) of increased anxiety were observed and treated with Chlordiazepoxide (a medication used to relieve symptoms of anxiety, including nervousness or anxiety and may also be used to treat symptoms of alcohol withdrawal) 25 milligrams (mg) by mouth as needed (PRN) with mild effect. Resident #4 was impulsive with poor safety awareness, difficult to redirect at times, wandered and entered other resident rooms, and staff were to keep the resident within sight when not in bed. A review of a nursing Progress Notes dated 8/19/2024 at 6:42 PM, revealed Resident #4 began to have aggressive behaviors, which included verbally abusing staff when asked to go to the dining room, blocking the resident's bedroom door so staff could not enter, refusing medication and dinner. The Director of Nursing (DON) was present for all events. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a nursing Progress Note dated 8/19/2024 at 7:30 PM, revealed Resident #4 was having aggressive behaviors which included refusing medication, throwing furniture and water at staff, balling up fist, and expressing a desire to fight staff. Review of Resident #4's Care Pan, initiated on 8/19/2024, revealed Resident #4's care plan did address the resident's behaviors. Review of a 1:1 Behavior Monitoring Visual Check Sheet revealed Resident #4 was monitored one-on-one starting 8/20/2024 at 2:30 AM, through discharge on 8/21/2024 at 12:00 PM. Review of a facility In-Service Education Report dated 8/22/2024 noted if a resident exhibits a behavior, follow the resident's care plan. If necessary, follow up with the physician. Document the behavior and the notification to the physician if he was notified. During a telephone interview with Licensed Practical Nurse (LPN) #3 on 8/20/2024 at 4:19 PM, LPN #3 revealed Resident #4 was impulsive. During a telephone interview with Certified Nurse's Aide (CNA) #5 on 8/20/2024 at 6:37 PM, CNA #5 revealed Resident #4 swung a full blown punch at him and that Resident #4 could be aggressive. During an interview with LPN #7 on 8/20/2024 at 7:24 PM, the LPN revealed Resident #4 was very aggressive toward staff, that on 8/19/2024 Resident #4 threw a glass of water in the LPN's face and then threw a chair at the LPN during medication administration. LPN #7 revealed the DON was trying to talk to the resident, but Resident #4 kept balling up their fists. LPN #7 then revealed CNA #8 assisted her with trying to get the resident to take their medication, but Resident #4 went straight to fighting. During an interview with CNA #8 on 8/20/2024 at 7:39 PM, CNA #8 revealed Resident #4 was very aggressive and wanders. During an interview with CNA #9 on 8/20/2024 at 7:51 PM, CNA #9 revealed Resident #4 was aggressive, anxious, confused, always asking for a beer, and very argumentative. CNA #9 revealed he was the CNA involved on 8/20/2024 when the residents barricaded themselves in their room using their body up against the door. CNA #9 indicated he went to the resident's room and tried to get the resident to come to the dining room for dinner and Resident #4 kept refusing, slammed the door shut. CNA indicated he tried to open the door but could tell the resident was holding it so for resident safety he backed away and notified the DON who was present in the facility. Resident #4 eventually came to dining room but refused to eat and sit down. During an interview with CNA #10 on 8/20/2024 at 8:00 PM, CNA #10 revealed Resident #4 was terrible, liked to argue, and could not be redirected at all on 8/19/2024. During an interview with CNA #11 on 8/20/2024 at 8:13 PM, CNA #11 revealed Resident #4 hits, curses, slaps, and throws chairs. CNA #11 revealed the resident barricaded the door to Resident #4's room and wouldn't let CNA #9 in. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the DON on 8/21/2024 at 9:18 AM, the DON said she was familiar with Resident #4, and that the resident calls staff names in Spanish, was combative at times with staff, and could be difficult to redirect. She said that on Monday (8/19/2024) before she left at 7:00 PM, CNA staff came to her because the resident was standing in a corner down on the hallway and not allowing redirection. She said the nurse on duty was down on the hall and Resident #4 was talking about fighting and pumping their fists. To decrease agitation the nurse said she had it and the DON left. The DON said shortly afterward she received a call describing how the resident had thrown water in the LPN's face and thrown a chair at her. She said Resident #4 was really agitated. Once informed the resident had barricaded themselves in their room, she instructed staff to leave the resident alone, and the resident then went to the dining room. During an interview with the Administrator on 8/21/2024 at 9:45 AM, the Administrator said she was familiar with Resident #4. She said on Monday the resident became increasingly agitated and had some behaviors that night. She also said she heard about the Resident #4 not allowing staff in their room and that the resident was agitated. During an interview with the DON on 8/21/2024 at 3:51 PM, the DON confirmed Resident #4 was not care planned for behaviors. During an interview with the Minimum Data Set (MDS) Coordinator on 8/21/2024 at 3:55 PM, the MDS Coordinator confirmed Resident #4 was not care planned for behaviors.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38200 Based on observations, interviews, and record review, the facility failed to ensure adequate and/or increased supervision was provided by staff during periods of increased exit-seeking and aggressive behaviors for 1 (Resident #4) of 3 sampled residents reviewed for elopement. The lack of effective supervision resulted in Resident #4 eloping from the facility and facility staff being unaware of the resident's whereabouts for approximately one hour before the resident walked back into the facility. At the time of the survey, there were nine residents residing in the facility who were identified as at risk for elopement. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.25 (Quality of Care) at a scope and severity of J. The IJ began on 08/19/2024 at 6:24 PM, when Resident #4 began to have aggressive behaviors, which included blocking the resident's bedroom door so staff could not enter, throwing furniture and water at staff, refusing medication and dinner, and the resident stated they wanted to fight staff. Resident #4 was last seen at 8:30 PM, and by 9:00 PM, the facility was unable to locate the resident, who had dismantled an exterior window, and eloped from the facility for approximately one hour. The resident ambulated back into the facility at approximately 10:00 PM. The resident had exited the facility without staff knowledge. The Administrator and Director of Nursing were notified of the IJ on 08/21/2024 at 3:31 PM. A Removal Plan was requested. The Removal Plan was accepted by the State Survey Agency on 08/22/2024 at 12:11 PM. The IJ was removed on 08/22/2024 at 6:35 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance for F689 remained at the lower scope and severity of no actual harm with an isolated potential for more than minimal harm that was not immediate jeopardy. The findings are: A review of an Admission Record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of alcohol abuse, altered mental status, encephalopathy, and cognitive communication deficit. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/5/2024 revealed Resident #4 scored a 02 (indicates cognitively moderately impaired for daily decision making) on a Staff Assessment for Mental Status (SAMS) and was substantial/maximal assistance with mobility and used a wheelchair. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Order Summary Report initiated on 8/2/2024 revealed a physician's order for chlordiazepoxide HCL (a sedative and hypnotic medication) 25 milligrams (mg), to be given every 6 hours as needed for alcohol withdrawal related to alcohol abuse. Another physician's order, with a start date of 08/02/2024, indicated staff should monitor for behaviors including scratching, biting, sexual inappropriate behavior, hitting, attention seeking behaviors, hand wrenching, cussing, elopement attempts, refusal of care, hallucinations, anxiety, depression, change in mood, self-isolation, false accusations, and to include a nurses note for any behavior with added documentation for non-pharmacological interventions. Review of Resident #4's plan of care, initiated on 8/19/2024, revealed the resident was an elopement risk/ wanderer related to disorientation of place, history of attempts to leave facility unattended, and impaired safety awareness. Interventions included to check placement of the electronic wander management device to the left wrist every shift, distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, or a book. Staff were to identify patterns of wandering and intervene as appropriate. The plan of care did address the residents' preferences. On 8/20/2024 the plan of care noted Resident #4 required one-on-one care. A review of Progress Notes dated 8/17/2024 at 5:18 PM, revealed Resident #4 was in a wheelchair in the common area under staff supervision due to attempting to enter other resident's rooms. Resident #4 had multiple family members visiting throughout the day. A review of Progress Notes dated 8/18/2024 at 2:05 AM, revealed Resident #4 required frequent redirection, would become angry, would strike out, was an elopement risk and fall risk, and required frequent observation for safety. A review of Progress Notes, dated 8/18/2024 at 6:01 PM, revealed Resident #4 was in the common area watching television. Resident #4 showed signs and symptoms of increased anxiety, which were treated with chlordiazepoxide 25 mg with mild effect. Resident #4 was impulsive, with poor safety awareness, and difficult to redirect at times. Resident #4 wandered and entered other resident rooms, and staff were to keep Resident #4 within sight when not in bed. A review of Medication Administration Record for August 2024 indicated Resident #4 had a physician's order for staff to check placement of the electronic wander management device on the resident's left wrist every shift, with a start date of 08/19/2024 at 3:00 PM. A review of Progress Notes, dated 8/19/2024 at 6:42 PM, revealed Resident #4 began to verbally abuse staff when asked to go to the dining room. Resident #4 closed their bedroom door, blocking the door so staff could not enter and refused all medication and dinner. The Director of Nursing (DON) was present for all events. A review of Progress Notes, dated 8/19/2024 at 7:30 PM, revealed a nurse attempted to give Resident #4 their medication and the resident took the cup of water and threw it in the nurse's face, then proceeded to pick up a chair and tried to hit the nurse with it. Staff attempted to redirect the resident but were unsuccessful. The resident would ball up their fist and state they wanted to fight. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of a facility incident and accident report, dated 8/19/2024 at 9:00 PM and titled Elopement, revealed at 9:00 PM the staff went to check on Resident #4 and Resident #4 was not in their room. A bedroom window was discovered dismantled with the window removed from the frame. A search was initiated inside and outside of the facility. Family, police, DON, and Administrator were notified of the resident's absence. The resident's mental status was confused and/or disoriented. A review of Progress Notes, dated 08/17/2024 at 5:18 PM through 8/20/2024 at 2:58 AM, did not document facility nursing staff notifying the physician or Advance Practice Nurse (APN) of Resident #4's behaviors, wandering, and exit seeking. A review of Arkansas Incident Report, dated 8/19/2024, indicated the incident was received at 9:24 PM, The report noted the response was in reference to a missing person. Prior to the officer's arrival they were advised Resident #4 had left the facility through a window and was last seen by staff around 7:30 PM. Once the officer arrived, they were directed to the window Resident #4 eloped from. The window screen was sitting against the side of the building and the glass pane of the window was sitting inside the vacant room. It was noted what appeared to be a footprint in the mud just outside of the window. The officer proceeded inside the facility to speak with Licensed Practical Nurse (LPN) #7. LPN #7 advised the officer that around 7:30 or 8:00 staff had noticed Resident #4 was missing. LPN #7 provided medical diagnoses, a description of what the resident was last seen wearing, and a photo of Resident #4. LPN #7 advised the officer that Resident #4 had left the faciity on ce before on 8/17/2024, but the officer was unable to locate a call for that incident. Officer was advised prior to completing the Missing Person Questionnaire with LPN #7 that Resident #4 was located on the property walking back up to the front door. A review of the facility's OLTC Incident and Accident Report, dated 8/19/2024 at 11:56 PM, revealed Resident #4 was found to be missing after staff went to check on the resident and found a window had been dismantled. Previously in the shift, Resident #4 had barricaded the bedroom door to prevent staff from entering. Resident #4 later let staff in the room. Resident #4 was last seen at 8:30 PM by staff. Police, the Administrator, the Director of Nursing (DON), and family were notified at 9:00 PM of Resident #4's absence. At 10:00 PM, Resident #4 walked back to the facility stating the resident had been to Texas. Resident #4 was assessed by ambulance service and sent to the hospital as a precaution. A review of an Elopement Drill Code Silver In-Service with forty-seven out of sixty-eight staff signatures on it dated 8/19/2024 revealed a facility policy titled, Elopements with a reviewed date of 1/2024 that revealed, staff shall investigate and report all cases of missing residents and promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse of Director of Nursing. When the resident returns to the facility the DON or Charge nurse was to examine the resident for injuries, notify the attending physician, notify the resident's legal representative, complete and file Report of Incident/ Accident, and document the event in the resident's medical record. If an employee discovers that a resident is missing from the facility, they should initiate a Code Silver and search the building and premises. When the resident returns to the facility, the DON or charge nurse shall notify all parties involved and document relevant information in the resident's medical record. There was no information regarding how staff should handle a resident with behaviors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #4's hospital visit on 08/19/20245 at 10:38 PM revealed the facility staff last saw Resident #4 at 8:00 PM, the resident was oriented to self only, a records from recent admission indicated the resident likely had dementia and chronic alcohol related encephalopathy A review of Progress Notes, dated 8/20/2024 at 2:58 AM, revealed Resident #4 returned to the facility at 2:30 AM with no new orders. Review of 1:1 Behavior Monitoring Visual Check Sheet revealed Resident #4 was monitored one-on-one starting 8/20/2024 at 2:30 AM through discharge on 8/21/2024 at 12:00 PM. On 8/20/2024 at 9:29 AM, the Surveyor attempted to interview Resident #4 about the elopement on the night of 8/19/2024, but the resident had garbled speech and was unable to be interviewed. During a telephone interview with Certified Nurse Aide (CNA) #1 on 8/20/2024 at 2:15 PM, the CNA stated Resident #4 was exit seeking and wandered and that staff kept the resident in the day area on the weekends so staff could monitor Resident #4. During a telephone interview with LPN #2 on 8/20/2024 at 3:06 PM, the LPN revealed Resident #4 wandered the halls and talked about wanting alcohol and drugs. LPN #2 also indicated the resident wandered into other rooms. LPN #2 stated she redirected Resident #4 when they tried entering other resident rooms. During a telephone interview with LPN #3 on 8/20/2024 at 4:19 PM, the LPN revealed Resident #4 was impulsive, unsteady on their feet when walking around and the facility tried to get the resident to use a wheelchair due to being a fall risk. LPN #3 indicated the resident wandered quite a bit and staff had to keep the resident up at the nurse ' s station because the resident wandered, and the resident was confused. LPN #3 revealed family visited on weekends. During a telephone interview with CNA #4 on 8/20/2024 at 6:01 PM, the CNA revealed Resident #4 liked to roam and would go into wrong rooms and facility staff redirected Resident #4 by keeping the resident by the nurse's station in the day room because the resident wandered. During a telephone interview with CNA #5 on 8/20/2024 at 6:37 PM, the CNA revealed Resident #4 swung a full blown punch at him and that Resident #4 could be aggressive. CNA #5 indicated they redirected the resident by talking with Resident #4 and would give Resident #4 something to do, a snack, or having the resident watch television. During an interview with LPN #6 on 8/20/2024 at 7:19 PM, the LPN revealed Resident #4 wandered and that when she came on shift on 8/19/2024 she was notified Resident #4 had a electronic wander management device in place and that staff were to listen for alarms due to Resident #4's exit seeking behaviors. LPN #6 revealed Resident #4 went into an empty resident room, shut the door, and climbed out the window by taking the window off and climbing out of it. LPN #4 indicated the resident's nurse notified the police, the Administrator, and the DON, who came to the facility. Resident #4 was assessed by paramedics for injuries and upon the resident's return to the facility from the emergency room was placed one-on-one with staff. LPN #6 reported the facility did an in-service on elopement but not on behaviors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with LPN #7 on 8/20/2024 at 7:24 PM, the LPN revealed Resident #4 was very aggressive toward staff, that on 8/19/2024 Resident #4 threw a glass of water in the LPN's face and then threw a chair at the LPN during medication administration. LPN #7 revealed the DON was trying to talk to the resident, but Resident #4 kept balling up their fists. LPN #7 then revealed CNA #8 assisted her with trying to get the resident to take their medication, but Resident #4 went straight to fighting. LPN #7 indicated that staff kept resident doors closed because Resident #4 kept wandering into other resident rooms. LPN #7 revealed she continued medication pass and when she got to the end of Resident #4's hallway at approximately 8:10 PM, she opened the resident's room door, and the resident was not there. LPN #7 asked staff if anyone had seen Resident #4 and no one had so staff started searching rooms, and closets and then they noticed room [ROOM NUMBER] had the whole window out. LPN #7 indicated Resident #4 lifted the window up and went out. LPN #7 stated Resident #4 came back to the facility and walked up and told the police officer they had to go check on business. Resident #4 was transported to the emergency room and returned at 2:30 AM, was assessed, and a CNA was placed one-on-one with Resident #4. LPN #7 reported she signed an elopement in-service this week, but not one on behaviors. During an interview with CNA #8 on 8/20/2024 at 7:39 PM, the CNA revealed Resident #4 as very aggressive and wandered. CNA #8 revealed that when they do their rounds, the resident would get up out of the wheelchair and wander around and try to get in other rooms. CNA #8 revealed that Resident #4 was redirected by staff telling the resident they can't be in other rooms, and staff take Resident #4 to the resident's room or to the sitting area. CNA #8 revealed she was doing rounds on 08/19/2024 and went down the hallway looking for Resident #4 and could not find the resident in their room. CNA #8 then said she got another CNA to help her look for Resident #4, they let the nurse know and a search was started inside and outside the building. CNA #8 revealed they opened the door to an empty room, room [ROOM NUMBER], and the window was out. CNA #8 took the surveyor to room [ROOM NUMBER] to observe the window which was currently back in place. CNA #8 indicated that one side of the windowpane had been removed and the screen was gone. She revealed that she and another staff member also searched by vehicle and that the resident returned as staff were conducting their last rounds. CNA #8 stated the facility had staff sign an in-service after the resident left for elopement but not behaviors. During an interview with CNA #9 on 8/20/2024 at 7:51 PM, the CNA revealed Resident #4 was aggressive, anxious, confused, always asking for a beer, and very argumentative. CNA #9 indicated the resident wandered and had gone into other rooms like empty ones. CNA #9 indicated he redirected the resident. CNA #9 revealed he was the CNA involved on 8/19/2024 when Resident #4 barricaded themselves in their room using their body up against the door. CNA #9 indicated he went to the resident ' s room and tried to get the resident to come to the dining room for dinner and Resident #4 kept refusing and slammed the door shut. CNA #9 indicated he tried to open the door but could tell the resident was holding it so for resident safety he backed away and notified the DON who was present in the facility. Resident #4 eventually came to the dining room but refused to eat or sit down. CNA #9 said when he came back from his break around 8:20 PM he was alerted by another CNA while outside in his vehicle that Resident #4 eloped. CNA #9 drove around in his vehicle for 30-45 minutes looking for the resident until the police arrived. CNA #9 stated he was told Resident #4 got out through a window. CNA #9 stated he signed the elopement in-service when he came to work. There was not an in-service for behaviors. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with CNA #10 on 8/20/2024 at 8:00 PM, the CNA revealed Resident #4 was terrible, liked to argue, and could not be redirected at all on 8/19/2024. CNA #10 indicated the resident wandered in other rooms. Staff tried redirecting the resident with television, going to the resident ' s room, or just something else away from other resident's rooms. CNA #10 indicated that she and CNA #11, were on the resident ' s hallway on 08/19/2024, going toward the therapy room and that CNA #11 tried to redirect the resident up to the front of the building. CNA #11 finally managed to get Resident #4 to the day room. CNA #10 said the CNAs needed to start their rounds and were on their fifth resident and walked into Resident #4's room and couldn't find the resident. CNA #10 indicated they searched every room, closet and bathroom, looking in the dining room and went back to the resident ' s hallway and saw part of the window sitting on the floor and the screen outside. She stated two CNAs drove around looking, two CNAs were looking around outside of the building, and the nurses looked inside and made telephone calls. CNA #10 said Resident #4 was now one-on-one observation. CNA #10 stated, I think I might need to sign the elopement in-service they have one out for us to sign. During an interview with CNA #11 on 8/20/2024 at 8:13 PM, the CNA stated Resident #4 hit, cussed, slapped, and threw chairs. CNA #11 stated the resident wandered and was usually able to be redirected but not the night of 08/19/2024. CNA #11 sated Resident #4 barricaded the door to their room and would not let CNA #9 in. CNA #11 stated staff kept checking on the resident and that she last saw Resident #4 around the day room at 8:30 PM. She stated the resident took part of the window off in room [ROOM NUMBER] and went out and the resident was now one-on-one with a electronic wander management device. CNA #11 reported having signed an in-service for elopements but nothing for behaviors. During an interview with the DON on 8/21/24 at 9:18 AM, the DON stated she was familiar with Resident #4, and that the resident called staff names in Spanish, was combative at times with staff, and could be difficult to redirect. She stated that on Monday, 8/19/2024, before she left at 7:00 PM, CNA staff came to her because the resident was standing in a corner down on the hallway and was unable to be redirected. She stated the nurse on duty was down on the hall and Resident #4 was talking about fighting and pumping their fists at staff. To decrease agitation, the nurse said she was able to handle the situation and the DON left the facility. The DON said shortly after leaving the facility, she received a call that the resident had thrown water in the LPN's face and thrown a chair at her. The DON stated Resident #4 was really agitated. The DON stated Resident #4 had been roaming around and not exiting seeking until Monday. Once informed the resident had barricaded themselves in their room, the DON instructed staff to leave the resident alone, and the resident then went to the dining room. The DON stated she received a call on Monday night at 9:00 PM that staff could not find the resident after checking all the rooms and walking the perimeter of the facility. The DON said she notified the Administrator and then called the nurse back and told the nurse to call 911 and to conduct a head count of all other residents. The DON indicated when she arrived, emergency medical personnel were already assessing the resident and that she saw the window off the track. The resident went to the hospital to be checked out, the window was replaced, and the resident was one-on-one observation with a electronic wander management device. The DON indicated that Resident #4 was not exiting seeking until 8/19/2024, so the facility placed a electronic wander management device on the resident. The DON stated residents who have been newly admitted to the facility, the resident may be confused, and staff pay more attention to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Conway Rehab & Nursing Center	3501 College Avenue Conway, AR 72034

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Administrator on 8/21/2024 at 9:45 AM, the Administrator stated she was familiar with Resident #4 and that when the resident first came to the facility the resident required extensive assistance and then became more alert and wandering all over the building. The Administrator stated on Monday, 08/19/2024, the resident became increasingly agitated and had some behaviors that night and then eloped. The Administrator stated the resident was redirected by staff, reminding the resident where their room was, and directing the resident to the sit-in area. She also stated she heard about the resident not allowing staff in their room and that the resident was agitated. The Administrator stated she was notified by staff they could not locate Resident #4; the building had been searched, and police and family were notified. She revealed she received a call before she got to the facility that the resident was seen walking back toward the building. The Administrator stated Resident #4 went to the emergency room and when they returned, were provided with one-on-one observation with staff and Resident #4 had a electronic wander management device, and all windows are secured. The Administrator indicated that if a resident was exit-seeking they would put a electronic wander management device on the resident with staff doing frequent checks. During an interview with the Maintenance Director on 8/21/2024 at 2:34 PM, the Maintenance Director stated he came to the facility on Monday night, 08/19/2024, and the window was sitting on the floor. He stated he put the top part of the window in the track and was able to push it back over the bottom rail. There was a screw in it so it would move about six inches, but the window was picked up not slid over. On 8/21/2024 at 3:01 PM, with guidance from the State Agency, the facility was provided the IJ Template. At 3:31 PM the IJ Template was signed by the Administrator and Director of Nursing. During an interview with the DON on 8/21/2024 at 3:51 PM, the DON revealed she placed an order for Resident #4 to have a electronic wander management device around 3:00 PM on Monday, 8/19/2024 and that she took a picture of the back of the electronic wander management device, then she placed the device on Resident #4 and took the picture to the Minimum Data Set (MDS) Coordinator to enter in the computer. She said the order was obtained because Resident #4 was going around to the doors holding the handle and trying to get out. During an interview with the MDS Coordinator on 08/21/2024 at 3:55 PM, the MDS Coordinator revealed the resident was exhibiting behaviors and wandering around. A review of a letter from Resident #4's physician, dated 08/22/2024, revealed the physician was not notified of Resident #4's behaviors until 08/19/2024 at 7:20 PM, indicating the physician's order for the electronic wander management device was place prior to the physician being notified. The physician indicated the resident had an as-needed order for a sedative and hypnotic medication and the resident required no further interventions. Removal Plan: 1. On 8/19/24, Resident #4 was placed 1-on-1 immediately upon his return to the facility from the emergency room . Resident #4 remained 1-on-1 until he was transferred to a facility with a secure unit on 8/21/24 at approximately 12:00pm. On 8/19/24 all windows were checked by the Maintenance Director to ensure they were secure with any negative findings corrected. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045313	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. On 8/20/24 Elopement assessments were completed on all residents. The care plan for each resident identified at high risk of elopement was reviewed and updated as necessary. On 8/19/24 during the 11pm - 7am shift, all residents identified with a history of behaviors were assessed for behaviors on their Medication Administration Record, including Resident #4. The care plan for each resident identified at risk of behaviors was reviewed and updated as necessary. 3. On 8/19/24 the administrator/designee initiated an in-service for staff on elopement and/or wandering. All staff have/will be in-serviced prior to working their next shift. The in-service will be completed on 8/22/24. On 8/22/24, the administrator/designee initiated a behavior in-service with staff. All staff have/will be in-serviced prior to working their next shift. The in-service will be completed on 8/22/24. 4. Using a monitoring tool, elopement drills will be conducted 1x weekly on each shift x 8 weeks or until compliance is achieved. Negative findings will be reported to t the administrator immediately. 5. An Ad Hoc QAPI meeting was completed on 8/20/24. All corrections were completed on 8/22/24. Onsite Verification: The IJ was removed on 8/22/2024 at 6:35 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began on 8/22/2024 at 8:23 AM. Resident #4 was placed 1 on 1 monitoring with staff upon return to the facility from the emergency room and remained 1 on 1 until the resident was transferred to a facility with a secure unit, all windows were checked by the Maintenance Director to ensure they were secure, elopement assessments were completed on all residents, care plans for reach resident identified at high risk for elopement were reviewed and updated, all residents with a history of behaviors were assessed for behaviors on their Medication Administration Record including Resident #4, care plan for each resident identified at risk for behaviors was reviewed and updated, in-service on elopement and/ or wandering initiated 8/19/2024 to be completed by the end of the day on 8/22/2024, on 8/22/2024 Administrator/ designee initiated a behavior in-service with staff with in-service to be completed at the end of the day on 8/22/2024, the facility used a 1 on 1 monitoring tool, and conducted an elopement drill. A total of [16] staff interviews were conducted with staff from all shifts to verify training had been completed. The staff interviewed included Certified Nursing Assistants, Licensed Practical Nurses, Treatment Nurse, Activity Director, Housekeeping, Dietary staff, Social Director, Business Office Manager, and the Maintenance Director. The staff interviewed verified they had been trained on resident elopement and behaviors. A review of in-service sheets provided indicated [47] of [68] had been provided training. Those staff who were not physically present to receive the in-services were messaged via telephone, with the in-service information provided and the employee acknowledging receipt and voicing understanding.