

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045323	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER The Blossoms at White River Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 North Pecan St Newport, AR 72112	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, and interview, the facility failed to monitor and supervise a severely cognitively impaired resident to prevent elopement, and failed to ensure staff responded promptly to an exit door alarm and thoroughly check the area outside the building after a door alarm sounded for 1 (Resident #1) of 3 sampled residents (Residents #1, #4, and #5) who were at risk for elopement. Consequently, Resident #1 eloped from the facility without staff knowledge, traveled across rough ground, and was found by law enforcement in a dehydrated state. It was determined the facility's past 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 the State Operations Manual, Appendix PP, S483.25 (Quality of Care) at a scope and severity of J. The IJ began on 06/15/2025 at approximately 4:15 PM. The facility did not have camera surveillance, but staff suspect Resident #1 who resided on the secured 300 Hall followed a visitor to the secured 400 Hall, before exiting the facility via the North exit door. Resident #1 held down the door handle until it opened and went outside to a fenced-in area and removed two wood pickets from a fence. Resident #1 walked approximately 30 yards behind the facility to a tree line, then down approximately 100 yards of plowed field, then approximately 30 yards of waist high grass to a cemetery, which was where Resident #1 was found at 8:00 PM by an officer from the local police department. The resident had exited the facility without staff knowledge. The Administrator and the Registered Nurse Consultant (RNC) were notified of the Past Non-Compliance (PNC) IJ on 06/25/2025 at 11:24 AM. The facility was found to have returned to compliance on 06/16/2025 when the facility's corrective actions were completed. The findings include: A review of the admission Record indicated the facility admitted Resident #1 on 04/07/2025 with diagnoses which included intracranial injury, dementia, and type 2 diabetes. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/21/2025, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 04 which indicated the resident had severe cognitive impairment. Resident #1 was independent with sitting, standing, walking, transfers, and repositioning in bed, and was receiving antipsychotic, antianxiety, antidepressant, hypnotic, antiplatelet and hypoglycemic medications. A review of Admission/readmission Nursing Evaluation dated 04/07/2025 in Section III: Elopement Risk Evaluation revealed a score of 10 indicating Resident #1 was high risk for elopement although there was no documented history of elopement episodes for the past three months before admission to the facility. A review of Resident #1's Care Plan initiated 04/07/2025 revealed the resident required placement on a secured unit related to behaviors affecting self or others and risk for elopement. Interventions included: assist the resident to develop methods of coping and interacting, and distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television or books. 06/16/2025 holidays could be possible trigger for elopement attempts, 06/16/2025 Resident #1 was placed on one to one. A review of a late entry Behavior Note written 04/13/2025 at 5:57 AM revealed at approximately 6:40 PM one of the Certified Nursing Assistants (CNA) was getting ready to take the smoking residents out when Resident #1 pressed down the handle of the door until it opened and then ran out and proceeded to try and climb a fence. Resident #1 was redirected and taken back in the building. A review of an Incident Report from the local police department revealed a narrative provided by a law enforcement officer (LEO), dated 06/16/25 at 12:16 AM. The narrative revealed that on Sunday, June 15, 2025, at approximately 5:55 PM, the LEO reported for start of his shift. Dispatch advised that there was a resident who walked out of [facility was named]. Multiple agencies such as the local fire department, state police, the sheriff department, a neighboring city 's police department, and the state department of corrections began assisting in the search for the resident. The resident was located in a cemetery located approximately 1,500 feet from the facility at 8:02 PM. Resident #1 was returned to the facility, treated by Emergency Medical Services (EMS) and later transported to a local hospital for further treatment. The LEO and a detective walked to the rear of the facility where staff believed the resident walked out of. Once opening the door leading outside, an audible alarm sounded off, notifying that the door had been opened. He observed two pieces of the wooded fence to be higher than the rest of the fence, it was advised that the employees believed the resident had removed those two pieces of the fence to leave the area and walk off the property. When the detective attempted to secure the door leading outside, the door had trouble latching and locking therefore making it easy to open. It was also advised that earlier in the day the alarm from the door sounded and that an employee walked outside but did not further inspect the reason for the alarm</p>		