STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045326	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Van Buren Rehab and Nursing Center	2010 Main Street Van Buren, AR 72956

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42016 Based on observations, interviews, and record review, the facility failed to ensure medications were not left in resident rooms unattended for 2 (Resident #3 and Resident #6) of 2 residents and failed to ensure medication was not left on the floor of a resident's room for 1 (Resident #2) of 1 resident family interviewed for unattended medications. Findings include: 1. A review of the Admission Record, indicated the facility admitted Resident #3 with diagnoses that included malignant neoplasm of the tongue, bipolar disorder, and schizophrenia. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/27/2024 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 9 which indicated the resident required moderate cognitive impairment. Resident #3 required supervision to moderate assistance with activities of daily living. A review of Resident #3's Care Plan, initiated on 10/13/2023, revealed the resident had a history of malignant neoplasm of the tongue, was dependent on staff for activities related to cognition deficit, had short- and long-term memory deficits with impaired decision-making skills, was at risk for further cognitive decline, had poor safety awareness, and pain related to neoplasm of the tongue. Interventions included: to administer medications as ordered, activities compatible with mental capabilities, and maintaining physical environment to help ensure safety. A review of the Order Summary, revealed Resident #3 had a physician's order for a medicated mouth rinse 5 milliliters (ml) by mouth for mouth pain with instructions to swish, gargle and spit, 2 times daily as needed. A review of the Medication Administration Record for June 2024, revealed Resident #3 had medicated mouth rinse administered on 06/29/2024 at 10:40 AM. A review of the July 2024 Medication Administration Record revealed Resident #3 had not received the medicated mouth rinse. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the Standard Assessments revealed Resident #3 did not have an assessment for self-administration of medication. During an observation on 07/01/2024 at 12:00 PM, a 30 milliliter (ml) medication cup with graduated markings was located on the bedside table. The cup contained an opaque pink liquid filled to the top graduated mark, indicating 30 ml of fluid, 6 times the dose ordered. During a concurrent observation and interview on 07/01/2024 at 3:07 PM, a 30 ml medication cup with graduated markings, containing an opaque pink liquid, filled to the top graduated mark, was located on the bedside table. Resident #3 stated the medication was for mouth cancer and was provided by a nurse to use when it was needed. During an observation on 07/02/2024 at 8:10 AM, a 30 ml medication cup was located on the bedside table. The medication cup contained 20 ml of an opaque pink liquid. During a concurrent observation and interview on 07/02/2024 at 10:34 AM, Resident #3 placed the opaque pink liquid, from the medication cup, into the resident's mouth and spit the liquid back into the medication cup. Resident #3 stated the nurse leaves the medication in the room so it can be used when needed. Resident #3 indicated the resident just puts some of the fluid in their mouth and swishes it around and puts it back in the cup. Resident #3 could not recall when the medication was placed in the room. During a concurrent observation and interview on 07/02/2024 at 10:36 AM, Certified Nursing Assistant (CNA) #2 stated they did not know what the medication cup contained. During an interview on 07/02/2024 at 10:41 AM, Licensed Practical Nurse (LPN) #1 stated the fluid in the medication cup was Resident #3's swish and spit medication for mouth cancer, and it should be given by a nurse and not left in resident's room. Resident #3 does not have an order to self-administer medication. If a resident can self-administer medication they would have a physician's order, only if their BIMS score was competent, and if they were able to take the medication. A review of Staffing Sheets revealed LPN #3 was working Saturday 06/29/2024 day shift and was assigned to Resident #2's hall. On 07/02/2024 at 2:27 PM, LPN #3 was interviewed by telephone. LPN #3 stated she was familiar with Resident #3 and on 06/29/2024 did administer medications to Resident #3 twice during the shift. LPN #3 stated the swish and spit was administered to the resident after other medications, due to Resident #3 should not drink after administration. The medication was not left at the bedside and should not be left at the bedside because Resident #3 did not have an order to self-administer medications and LPN #3 was not aware of an assessment for self-administration being done. 2. A review of the Admission Record, indicated the facility admitted Resident #6 with diagnoses that included metabolic encephalopathy, transient ischemic attack (TIA), and dementia. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/28/2024 revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Resident #6 required a wheelchair for mobility and was dependent upon staff for activities of daily living. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #6's Care Plan initiated on 02/01/2024 revealed the resident had a history of TIA and was at risk for complications, short- and long-term memory deficits with impaired decision making with diagnosis of dementia. Interventions included administering medications as ordered. A review of the Order Summary, revealed Resident #6 did not have an order to self-administer mediations, did not have an order for triple antibiotic ointment and did not have an order for a medicated gel shampoo. A review of the June 2024 Medication Administration Record, revealed Resident #6 did not have orders to receive triple antibiotic ointment or medicated gel shampoo. A review of the June 2024 Treatment Administration Record, revealed Resident #6 did not have orders for triple antibiotic ointment or medicated gel shampoo. A review of the July 2024 Medication Administration Record, revealed Resident #6 did not have orders for triple antibiotic ointment or medicated gel shampoo. A review of the July 2024 Treatment Administration Record, revealed Resident #6 did not have orders for triple antibiotic ointment or medicated gel shampoo. A review of the Standard Assessments revealed Resident #3 did not have an assessment for self-administration of medication. During an observation on 07/01/2024 at 1:20 PM, a tube of triple antibiotic ointment and a bottle of medicated gel shampoo, was in a gray bath basin, located on the bedside table in reach of Resident #6. During an observation on 07/01/2024 at 3:20 PM, a tube of triple antibiotic ointment and a bottle of medicated gel shampoo was located on the bedside table in reach of Resident #6. During an observation on 07/02/2024 at 8:17 AM, a tube of triple antibiotic ointment and a bottle of medicated gel shampoo was located on the bedside table in reach of Resident #6. During a concurrent observation and interview on 07/02/2024 at 10:48 AM, Licensed Practical Nurse (LPN) #1 identified the shampoo as a medicated gel shampoo containing coal tar, and the tube as triple antibiotic ointment. LPN #1 stated there was no order for this resident to receive the shampoo or triple antibiotic ointment. LPN #1 stated only nurses should have access to the shampoo and triple antibiotic ointment and should not be left in a resident's room because anyone would have access to it and cause injury. The label instructed to ask a doctor before use, use as directed by a doctor, and warnings instructed the product was for external use only. During a concurrent observation and interview on 07/02/2024 at 10:58 AM, medicated gel shampoo was located on a shelf in the supply room. Medical Records stated they did the order of supplies and did order the shampoo. Medical Records stated supplies are kept locked in the supply room to keep residents out of the supply room, so they do not access and get sick or injured, to keep them safe. 3. A review of the Admission Record, indicated the facility admitted Resident #2 with diagnoses that included Cerebral Infarction and Convulsions. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/29/2024 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 6 which indicated the resident had severe cognitive impairment. Care Area Assessment indicated cognitive loss. A review of Resident #2's Care Plan, initiated on 05/06/2024, revealed the resident had short- and long-term memory deficits with impaired decision making and was at risk for further cognitive declines and impaired decision making and memory loss. Interventions included administering medication as ordered. During an interview on 07/01/2024 at 12:57 PM, Resident #2's responsible party stated a cup of pills was left on the bedside table within reach of Resident #2. It had another resident's name on it. Resident #2 did not have a roommate at that time, was not aware of a resident with that name and the nurse said there was no one on the hall with that name. The nurse removed the cup of pills from the room. Resident representative stated on Saturday morning there was a pill laying on the floor, under the overbed table, next to the bed. The nurse was notified and came in and removed the medication. Resident representative stated they were unsure whose medication it was. Review of staffing sheets revealed Licensed Practical Nurse (LPN) #3 was working Saturday 06/29/2024, day shift, and was assigned to Resident #2's hall. During an interview on 07/02/2024 at 12:11 PM, the Director of Nursing (DON) stated medications should not be left at the bedside to be self-administered. Medications and supplies are locked so residents cannot access for safety and if left at bedside anyone could access. The resident with dementia could consume the medication and it could cause harm. On 07/02/2024 at 2:27 PM, LPN #3 was interviewed by telephone. LPN #3 stated she was familiar with Resident #2 and their representative, and on 06/29/2024, Resident #2's representative called LPN #3 to Resident #2's room regarding a pill that was found on the floor. LPN #3 stated the pill looked like it had been in someone's mouth, and she had taken the pill and disposed of it. LPN #3 stated they had not passed medication at that time, so she was not able to determine what it was or whose medication it was. LPN #3 was not aware of any cup of pills. A review of a facility policy titled, Medication Administration, with an effected date 04/2021, and a revised date of 11/25/2022, indicated, .1. Only persons licensed or permitted by this state . administer . medication may do so . 3. Medications must be administered in accordance with orders . 24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely . A review of a facility policy titled, Label/Store Drugs & Biologicals, with an effective date of 04/2021, and a reviewed date of 12/26/2022, indicated, The nursing staff shall be responsible for maintaining medication storage AND preparation . Compartments (including, but not limited to, drawers, cabinets, rooms .) containing drugs . shall be locked when not in use . items shall not be left unattended if open or otherwise potentially available to others . Medication will not be stored in a resident room unless the resident has been approved for self-administration of medication .