

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2025
NAME OF PROVIDER OR SUPPLIER The Blossoms at Van Buren Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916</p> <p>Based on record review, interview, and Resident Assessment Instrument (RAI) manual review, the facility failed to ensure a discharge was coded to the Minimum Data Set (MDS) in a timely manner for one (Resident #65) of one sampled resident reviewed for accuracy of assessments to accurately capture a residents health status at the time of discharge.</p> <p>The findings include:</p> <p>Review of Medical Diagnosis revealed Resident #65 had diagnoses that included vertebra and humerus fracture and malnutrition.</p> <p>Review of Progress Note dated 12/02/2024 at 3:10 PM, revealed Resident #65 was transported from the facility to [Local Hospital] via ambulance.</p> <p>Review of the Discharge MDS, with an Assessment Reference Date (ARD) of 12/02/2024, revealed a Staff Assessment for Mental Status (SAMS) of short-term memory problems, and moderate cognitive skills for daily living. Section A2000 indicated a discharge date of [DATE] to a short-term general hospital. Section Z revealed completion date: signed 04/30/2025 and RN Assessment Coordinator signed assessment as complete: 04/30/2025.</p> <p>During an interview on 04/30/2025 at 3:35 PM, the MDS Nurse indicated Resident #65's discharge had not been coded to the MDS, and after confirming with the Regional MDS consultant, it was revealed the facility had 14 days to report discharges on the MDS, and it should have been done after Resident #65 was discharged . The Regional MDS Consultant revealed they had no way to track and see that the discharge was not reported and confirmed the discharge assessment was not completed and submitted in the allowed 14 days.</p> <p>During an interview on 04/30/2025 at 3:41 PM, the MDS Trainer confirmed Resident #65's discharge was not reported within the allowed time. The MDS Trainer said, discharges are usually triggered in the MDS scheduled tab, and we discuss discharges during stand-up meetings held daily. The Regional MDS Consultant said, someone erased the tab. This surveyor asked for a copy of discharge instructions from the RAI manual.</p> <p>A review of the documents from the RAI (Omnibus Budget Reconciliation Act) OBRA, on 04/30/2025 at 4:46 PM, revealed discharge assessments were required within fourteen (14) days. Discharge under the RAI manual, refers to the date a resident was discharged .</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 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37634</p> <p>Based on interview and record review, the facility failed to ensure that the State Designated Agency was notified that one (Resident #6) of two residents, reviewed for Preadmission Screening and Resident Review (PASARR), had been admitted to the facility.</p> <p>The findings are:</p> <p>A review of Resident #6's Diagnosis Record revealed a diagnosis of schizoaffective disorder, bipolar type, with an onset date of 04/12/2025. There was no PASSAR noted in the electronic record.</p> <p>During a phone interview on 04/30/2025 at 9:59 AM, an employee at the State Designated Agency indicated Resident #6 had a level II PASARR in 2022. She indicated that Resident #6 had a review at a local facility in 09/2024. The State Designated Agency indicated the review was still open, because they had never been notified that Resident #6 had been admitted into any facility. The State Designated Agency indicated, Resident #6's new diagnosis of schizoaffective disorder, bipolar type that was diagnosed on [DATE], would not make the Preadmission Screening and Resident Review (PASARR) less or more since [pronoun] had already been diagnosed with bipolar, unless the resident had suicidal behavior.</p> <p>During an interview on 05/01/2025 at 11:00 AM, the Administrator indicated the State Designated Agency should have be notified when a resident entered the facility.</p> <p>During an interview on 05/01/2025 at 11:10 AM, the Director of Nursing (DON) indicated the MDS nurse was responsible for notifying the State Designated Agency when a resident had been admitted to the facility.</p> <p>During an interview on 05/01/2025 at 2:29 PM, the Marketing Director indicated she had been in her position for four months, and that she did not inform the State Designated Agency of Resident #6 ' s admission to the facility.</p> <p>During an interview on 05/01/2025 at 2:37 PM, the Marketing Director indicated she had just found out that she was responsible for contacting the State Designated Agency when a resident was admitted to the facility. She indicated, she was not aware that she was supposed to contact the State Designated Agency.</p> <p>During an interview on 05/01/2025 at 3:21 PM, the Administrator indicated the facility did not have a policy on PASARR's.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>47916</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure medications were not stored unlocked at the residents ' bedside, and failed to ensure medication treatment carts were locked to three (Resident #37, Resident #71, Resident #72) of 11 sampled residents, to prevent accidents and injuries.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A review of a policy titled Medication Administration, revised 11/25/2022, revealed the Director of Nursing (DON) directs and supervises staff that administer medications, and they were to be done in a safe, timely manner. Medication carts were to be closed and locked, when out of sight of the medication nurse. Topical medications were to be documented on the Treatment Administration Record (TAR), when used. Medications shall be administered in a safe and timely manner, and as prescribed. Item 1. Only persons licensed or permitted by this state to prepare, administrate and document the administration of medications may do so. Item 21. Topical medications used in treatments must be recorded on the resident's treatment record (TAR). Item 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. 2. A review of a policy titled Label/Store Drugs and Biologicals, revised 12/26/22, revealed nursing staff was responsible for making sure drugs were stored in a safe, and secure manner. Medication carts, used to transport medications, should be locked when not in use, and medications should not be stored in a resident ' s room, unless they were approved for self-administration. 3. A review of Medical Diagnoses revealed Resident #37 had diagnoses which included schizophrenia, stage III kidney disease, and osteomyelitis. <ol style="list-style-type: none"> a. A review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/17/2025 indicated Resident #37 had a Brief Interview for Mental Status (BIMs) of 15, which indicated no cognitive impairment. Section M0300, of the MDS, indicated Resident #37 had one unstageable pressure ulcer, due to moisture associated skin damage. Section M1200, of the MDS, suggested the resident required pressure reducing devices and had application of ointments/medications, other than to the feet. b. A review of Physicians Order, for Resident #37 dated 03/13/2025, revealed anti-fungal powder was to be used, twice a day, topically to affected areas. c. A review of Care Plan for Resident #37, dated 03/19/2025, revealed altered skin integrity including a stage three ulcer to the right second toe. Interventions included: provide medication as indicated, check skin daily basis, and report issues to the charge nurse and physician, as needed. d. On 04/28/2025 at 8:32 AM, this surveyor observed Resident #37 to have antifungal powder and hydrophilic wound dressing cream at the bedside. Resident #37 said it was the resident ' s medication <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>e. During a concurrent observation and interview on 04/28/2025 at 11:57 AM, the antifungal powder and hydrophilic wound dressing cream remained at Resident #37's bedside. Licensed Practical Nurse (LPN) #1 said that the medication should be left in the cart and offered to the resident, but not left in the room, because another resident could wander in and eat it or use it inappropriately.</p> <p>4. On 04/28/2025 at 8:11 AM, a medication treatment cart was observed unlocked sitting between the 200-300 hall, with residents observed ambulating and in wheelchairs going up and down the hallway. LPN #2 was asked who was responsible for the treatment cart. LPN #2 said weekend nursing, that used the cart, left the treatment cart unlocked. LPN #2 read off the following medications found in the unlocked treatment cart:</p> <ul style="list-style-type: none"> a. Silver Sulfadiazine cream b. Wound gel; x3 tubes c. Anti-microbial ointment; x2 tubes d. Collagenase ointment e. Butt paste d. Debriding paste; x2 tubes e. Hydrophilic Wound Dressing cream; x3 tubes f. Alcohol prep; 1 box g. A bottle of antibacterial/antimicrobial skin cleanser g. Peroxide 3% h. Sani-cloth i. Skin protectant j. Lanolin Moisture shield; x2 k. Anti-Fungal cream; 2% Miconazole Nitrate l. Honey with Anti-Bacterial properties; x3 tube m. Zinc Oxide ointment 20% n. Anti-Fungal spray 2% o. Open box with six (6) steel safety scalpels p. Arthritis gel; 10% Trolamine Salicylate <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>q. Tincture of Benzine</p> <p>a. During the observation mentioned above, LPN #2 revealed the facility process was to lock the medication carts when unattended and said residents should not have access to any of these medications, because residents could take and eat something they should not have.</p> <p>5. On 04/28/2025 9:08 AM, Resident #72 was observed sitting in a bedside chair reading and antifungal spray was observed resting on the over the bed table.</p> <p>a. During an interview on 04/28/2025 at 11:57 AM, LPN #1 was asked what the process was for keeping medications at the bedside. The question was not answered. This surveyor observed LPN #1 go to Resident #72's room and pick up the antifungal spray. Resident #72 told LPN #1 it was not theirs, and the resident did not know how the medication got in the resident ' s room. LPN #1 confirmed she did not know medication was at the bedside of Resident #37 or Resident #72. LPN #1 said someone with dementia or someone who wanders could eat it or misuse it.</p> <p>6. A review of the Physician's Order, dated 04/29/2025, for Resident #71 did not reveal an order for [Name Brand Wound/Burn Gel].</p> <p>a. A review of the resident's 5-Day MDS with an ARD of 04/04/2025, for Resident #71 identified in Section M item H: Applications of ointments/medications other than to feet was checked.</p> <p>b. A review of the resident's Care Plan identified Resident #71 to have little or no activity related to Physical Limitations; the resident has an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues related to gangrene left and right hand, left and right foot, stage 4 on coccyx, venous ulcer left and right lateral shin, and right ankle. With an intervention to administer wound care (treatments) per Medical Doctor orders.</p> <p>c. During an interview on 04/30/2025 at 8:25 AM, Resident #71 told this surveyor they were using a tube of ointment with [Name Brand Wound/Burn Gel], for itching.</p> <p>d. During an interview on 04/30/2025 at 8:50 AM, the Medical Director (MD) said a resident should not apply any type of medication to themselves, without a physician ' s order to do so, because the ointment could be harmful to the resident.</p> <p>e. During a concurrent interview on 05/01/2025 at 8:37 AM, the MD said he should have been aware of any medication left at the resident's bedside, and he must approve it, because they may take something that could harm them.</p> <p>7. During an interview on 05/01/2025 at 11:55 AM, the Administrator said medications could not be left at the bedside, because the resident had to be assessed for self-administration of medications and the medications should have been stored and locked in a secure area.</p> <p>8. During an interview on 04/30/2025 at 9:30 AM, the Director of Nursing (DON) was asked what the process was for medications being left at the bedside. The DON stated medications should not be left at the bedside, because another resident might come in and take the medication, which could cause harm to the resident. The DON stated they [the facility] did not have a self-administration policy, and no residents had been approved for self-administration rights.</p> <p>(continued on next page)</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>47916</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure hand hygiene was performed while assisting with wound care, to prevent the risk for infection for one (Resident #71) of three sampled residents observed for wound care. The facility also failed to ensure Enhanced Barrier Precautions (EBP) were followed during flushing of a feeding tube, for one of one observation for one (Resident #4) of one sampled resident observed for feeding tube care, to prevent infections and cross contamination.</p> <p>The findings include:</p> <p>1. A review of Diagnosis Report for Resident #71 revealed diagnoses which included frostbite with necrosis, gangrene, and vascular disease.</p> <p>a. A review of Resident #71 's Medicare-5 Day Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/04/2025, suggested a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Section M0300, of the MDS, revealed Resident #71 had four Stage IV pressure ulcers and had one Stage IV pressure ulcer on admission.</p> <p>b. During an observation on 04/29/2025 at 3:24 PM, Certified Nursing Assistant (CNA) #7 was observed handling trash, then without performing hand hygiene, donned gloves in the hallway and entering Resident #71's room to assist with wound care. CNA #7 put on a gown, then removed Resident #71's dirty gown, walked over to the right side of the bed and assisted Resident #71 in turning onto their right side, then pulled up the left buttocks to expose a large, open wound in the gluteal cleft to the nurse. CNA #7 removed their gloves and donned clean gloves after the dressing change, without using hand gel or hand washing. When asked, CNA #7 stated the process for assisting with wound care was to wash hands, puts on gloves and follow the direction of the nurse performing wound care. CNA #7 confirmed he did not perform hand hygiene before/or upon entering the room, after assisting with wound care, or use alcohol gel, when making a glove change because the alcohol gel pump on the wall was not working.</p> <p>c. During an interview on 04/30/2025 at 9:22 AM, the Director of Nursing (DON) stated staff should use hand gel or wash their hands before gloving up and change their gloves, as needed, and use hand gel in between glove changes, so that good infection control practices were maintained. The DON said she also expected staff to follow EBP during wound care.</p> <p>d. During an interview on 05/01/2025 at 1:02 PM, the Administrator said CNAs should perform hand hygiene before putting on gloves to assist with wound care, and when changing gloves, CNAs should perform hand hygiene by washing or using alcohol gel in between. Hand hygiene should also be performed after taking out trash, before gloving up to assist with wound care.</p> <p>2. A review of Medical Diagnoses revealed Resident #4 had diagnoses which included malnutrition, dysphagia (difficulty swallowing), and gastrostomy status (tube).</p> <p>(continued on next page)</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>a. A review of an MDS with an ARD of 02/04/2025 for Resident #4 revealed a Staff Assessment for Mental Status (SAMS) score of 3, which indicated severe cognitive impairment. Section V0200 Care Area #13 revealed the resident had a feeding tube.</p> <p>b. A review of Physician Orders 06/04/2024, revealed Resident #4 received a flush feeding with 35 cubic centimeters (cc) of water, before and after medication administration.</p> <p>c. A review of an In-service Education Report on EBP conducted on 08/20/2024, included a policy titled Enhanced Barrier Precautions, revised 03/21/2024, revealed identified residents on EBP will have appropriate signage, and required PPE Residents with indwelling medical devices such as feeding tubes require EBP.</p> <p>d. During an observation on 04/28/2025 at 9:21 AM, Licensed Practical Nurse (LPN) #1 was observed using a stethoscope to check Resident #4 for placement of a gastrostomy tube. LPN #1 flushed the tube with 35 (milliliters) mL of water. LPN #1 was not wearing a gown when the gastrostomy tube was flushed.</p> <p>e. During an interview on 04/28/2025 at 9:28 AM, LPN #1 said she was supposed to be wearing a gown when flushing Resident #4 ' s gastrostomy tube for EBP. This surveyor observed EBP signage on Resident #4 ' s outer door indicating staff were to wear gown and gloves during device care or use: feeding tubes.</p> <p>3. During an interview on 05/01/2025 at 11:55 AM, the Director of Nursing (DON) stated EBP should be used on a resident who had a gastrostomy tube, by donning a gown and gloves. PPE was located in the residents ' rooms. The DON stated if EBP was not used, it could cause the spread of germs.</p> <p>4. During an interview on 05/01/2025 at 12:47 PM, the Administrator said his expectations for staff regarding EBP was that staff would follow the policy.</p> <p>5. During an interview on 04/30/2025 at 12:52pm, LPN # 8 said EBP signage was outside the doors of residents with PEG tubes, IV ' s, and catheters. LPN #8 said PPE should be worn with any personal care, to prevent passing of germs.</p> <p>6. A review of an in-service titled, Infection Control, dated 10/29/2024, revealed topics covered included personal protective equipment (PPE) donning and removal, hand washing, hand cleanser, and hand hygiene. The in-service also revealed that EBP required gowns and gloves to be worn by staff during high-contact resident care activities.</p> <p>7. A review of a policy titled Wound and Pressure Ulcer Management Policy, revised 11/01/2022, did not address hand hygiene during wound care.</p> <p>8. A review of policy titled Infection Prevention and Control Programs, revised 11/02/2022, revealed the facility followed the guidance of the Center for Disease Control (CDC), implemented isolation precautions when appropriate, educating staff on proper procedures, and instituted measures to prevent infections.</p> <p>52432</p>		