STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045334	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Newport Rehab & Nursing Center	326 Lindley Lane 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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to protect one (Resident #85) of two residents from physical abuse during a resident-to-resident altercation that occurred between Resident #85 and Resident #86 after the secured unit was left unsupervised by LPN #2 and CNA #5, staff who were assigned to the secured unit. The findings include: Resident #85 Review of an admission Record revealed the facility admitted Resident #85 on 03/28/2025 with diagnoses that included dementia, falls, panic disorders, heart conditions, anxiety, a pacemaker, a defibrillator, muscle weakness, lack of coordination, unsteadiness on feet, mild cognitive impairment, and insomnia. Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/30/2025, revealed Resident #85 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS also revealed Resident #85 had delusions, used a wheelchair and a walker for ambulation, required partial assistance for sitting and standing, and was taking antipsychotic medications on a routine basis. Review of Resident #85's Care Plan initiated on 04/28/2025, revealed the resident had impaired cognitive function due to dementia, and that antipsychotic medications were used for behavior management. Interventions included administering medications, reducing distractions, and supervision as needed. Review of Clinical Physician Orders revealed Resident #85 resided on the secured unit as of 04/01/2025. Review of Progress Notes dated 06/20/2025 at 9:56 AM, revealed Resident #85 started displaying behaviors of restlessness, exit seeking, and wandering. -On 06/21/2026 at 12:57 AM, Resident #85's behaviors of restlessness, exit seeking and wandering continued and Licensed Practical Nurse (LPN) #2 assisted Resident #85 to bed. -On 06/22/2025 at 3:30 AM, Resident #85 was found in the day room with Resident #86, Resident #85 was on the floor with a laceration and discoloration noted to the left eye and skin tear to right ring (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	finger of Resident #85. -A marked-out section of notes on 06/21/2025 at 5:07 AM and 06/23/2025 at 8:51 AM indicated a detailed description of a resident entering the day room where a Certified Nursing Assistant (CNA) #5 and Resident #85 were. Resident #86 began hollering at Resident #85. CNA #5 attempted to redirect Resident #86 without success. Resident #86 then assaulted CNA #5 by hitting her and grabbing her hair, causing them to fall to the ground. LPN #2 arrived and helped CNA #5 get away from Resident #86 before both LPN #2 and CNA #5 left the secure unit. The aggressive resident, [Resident #86] then attacked Resident # 85, hitting Resident #85 in the face and causing Resident #85 to fall. Review of Resident #85's emergency room (ER) Report dated 06/21/2025 at 3:57 AM revealed Resident #85 was transported to the ER by Emergency Medical Services (EMS) for evaluation related to a physical assault by another resident. EMS reported, patient was pinned down by another resident and struck several times to the face and head. The ER report revealed, Per nursing home and EMS report the patient was the victim of an altercation where another resident was found beating up on [Resident #85]. Resident #85 reported being hit around the head and the neck area. The ER Report also revealed Resident #85 had a laceration to the left eyebrow measuring two millimeters. Resident #86 Review of an admission Record revealed the facility admitted Resident #86 on 01/02/2025 with diagnoses that included dementia, depression, mild cognitive impairment, delusional disorder, insomnia, history of falls, restlessness, and agitation. Review of a quarterly MDS with an ARD of 04/09/2025, revealed Resident #86 had a BIMS score of 10, which indicated moderate cognitive impairment. The MDS also revealed Resident #86 had no impairments to arms or legs and required supervision or touching assistance to independence for mobility. Review of Resident #86's Care Plan, initiated on 01/02/2025, revealed Resident #86 had aggressive behaviors towards staff, had a distorted sense of entitlement with explosive, impulsive behaviors, and could not be redirected at times. Resident #86's Care Plan also revealed a history of aggressive and inappropriate behaviors, conflicts/altercations with others and verbal or physical aggression. Interventions included using psychiatric management and using behavior techniques to promote and shape the desired behavior. Review of Resident #86's Clinical Physician Orders revealed Resident was admitted to the secured unit on 01/30/2025. Review of Resident #86's Progress Notes dated 06/09/2025 revealed aggressive and combative behaviors of Resident #86, which included yelling, cursing, and chasing/hitting multiple staff with fist and phone receiver after being unable to get the phone at the nurse's station to dial out. Staff were unable to redirect Resident #86. Resident #86 was sent out for psych evaluation and returned to the facility on [DATE]. - A marked-out section of notes dated 06/21/2025 at 3:47 AM and 06/23/2025 at 8:55 AM, revealed Resident #86 entered the day room of the secured unit where CNA #5 and Resident #85 were. CNA #5 reported Resident #86 began to holler at Resident #85. CNA #5 attempted to redirect Resident #86. Redirection was unsuccessful. Resident #86 cornered CNA #5, hit her, and grabbed her hair, causing (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	both Resident #86 and CNA #5 to fall. LPN #2 helped CNA #5 to get away from Resident #86. Both CNA #5 and LPN #2 left the secured unit. The Progress Note revealed Resident #86 then got up and began hitting Resident #85 in the face causing Resident #85 to fall. Review of a document titled Emergency Discharge Letter dated 06/21/2025 at 4:30 AM, revealed an emergency discharge from the facility due to physical violence. Review of a document titled Daily Census dated 06/20/2025, revealed a total of eight residents resided on the secured unit, including Resident #85 and Resident #86 who were involved in the incident on 06/21/2025. The daily census dated 06/21/2025 indicated Resident #86 no longer resided on the secured unit. Review of a document titled Incident Report and dated 06/21/2025 from the local police department revealed on 06/21/2025 at approximately 3:18 AM officers were dispatched to an incident at the facility. The report revealed that after CNA #5 got away from Resident #86, she (CNA #5) exited the area and left Resident #86 unattended. The report revealed that nursing staff reported being ordered to leave the area by the Director of Nursing (DON). The report revealed the officers asked staff if there were any other residents in danger, and the officers were informed there were no staff on the secured unit. The report revealed there was a fight on the ground. Both Resident #85 and Resident #86 were found lying on the ground on their right sides and Resident #86 had a hold of Resident #85's right arm. EMS arrived and assessed each resident. Resident #86 had a bump to the back of the head, numerous skin tears to both arms, bruising on the right knee, and a skin tear to the right cheek. Resident #85 had an opened wound to the face above the right eye and a skin tear to the top of the right hand. The report revealed the nurse stated she was not going back in there and the nurse was told (by the DON) not to let anyone else go back onto the secured unit. Review of a document titled Office of Long-Term Care (OLTC) Incident and Accident Report (I&A) dated 06/21/2025 revealed Resident #85 and Resident #86 were found on the floor in the day room by two CNAs. The report revealed staff statements were taken. Only one CNA statement was obtained and LPN #2's statement was obtained. LPN #2's statement indicated she did not see the altercation between Resident #85 and Resident #86. The CNA's statement indicated she was called to the locked down unit to assist with an altercation between two residents. Both residents were on the floor on their sides. One resident had ahold on the other. Both residents had blood on them. Review of a document titled Employee File for Registered Nurse (RN) #1 revealed RN #1 was the Director of Nursing (DON) at the time of the incident on 06/21/2025. RN #1 was terminated on 09/24/2025 due to job performance. The employee file contained a document titled Residents Rights/Civil Rights signed by RN #1 on 04/10/2025 that revealed a resident has the right to remain free from abuse and neglect even at the hand of another resident. On 04/10/2025, RN #1 signed a document titled Resident to resident altercations: the prevention of resident altercations revealed the goal was to keep the agitated resident safe and keep residents around the agitated resident safe. On 04/10/2025 the RN #1 signed a document titled abuse prevention program which revealed, it is the policy of this facility to prevent resident abuse. During an interview on 05/06/2026 at 5:08 PM, Licensed Practical Nurse (LPN) #2 indicated on 06/21/2025 around 3:00 AM, there was an altercation between Resident #85 and Resident #86. LPN #2 reported the aggressive resident [Resident #86] punched CNA #5 in the face and had CNA #5 on the floor. Resident #86's legs were wrapped around CNA #5 with her hair in the resident's hands. The nurse was able to free CNA #5 from Resident #86. LPN #2 reported both CNA #5 and herself exited the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	unit to call the DON. LPN #2 reported that the DON instructed her and the other staff to stay off of the secured unit. LPN # 2 reported once the police arrived, they (the police) entered the secure unit and found Resident #85 and Resident #86 lying on the floor in the day room During an interview on 05/06/2026 at 8:44 PM, CNA #3 indicated on 06/21/2025 LPN #2 came outside to the smoking area and stated the police were on the way and that she had left the unit. CNA #3 stated, What do you mean you left the unit? CNA #3 indicated, you were never to leave the secured unit uncovered. CNA #3 reported meeting the police at the door of the secure unit and entering with them. CNA #3 indicated there were no staff members standing near the secured unit door when she approached and there were no staff present on the secured unit. CNA #3 reported after entering the secured unit with the police. Resident #85 and Resident #86 were found on the floor in the day room. CNA #3 reported the female police officer grabbed Resident #86 off the top of Resident #85. CNA #3 reported there was blood everywhere. CNA #3 reported, LPN #2 refused to reenter the secured unit to assess the residents, even with the police, sheriffs, and fire department present. During an interview on 05/07/2026 at 10:07 AM, CNA #4 indicated she was outside on a smoke break when LPN #2 came outside and said she needed help on the secured unit. CNA #4 indicated there were no other staff on the secured unit at the time. CNA #4 reported Resident #85 and Resident #86 were found in the day room on the floor. CNA #4 reported Resident #85 and Resident #86, had a hold of each other. CNA #4 reported staff were never to leave the secured unit alone. During an interview on 05/07/2026 at 12:50 PM, the current DON indicated the secured unit floor was never to be left uncovered (unstaffed). The DON indicated if a secured unit was left uncovered after an aggressive resident attacked a staff member, the resident could then turn and hurt the other residents. During an interview on 05/07/2026 at 1:03 PM, the Administrator stated, We protect the person being assaulted and remove the aggressor. The Administrator indicated his expectations of staff would be to stop any resident-to-resident altercation and that ideally the secured unit is not to be left alone; someone is expected to be on that unit at all times. The Administrator indicated a resident could get hurt if the secured unit was left without direct care staff present. The Administrator indicated he was not the Administrator at the time of the incident on 06/21/2025. The Administrator was unable to provide contact information of the CNA listed in the OLTC incident report, or for CNA #5, who was assaulted on 06/21/2025. The Administrator stated that both CNAs were working out of an agency. The Administrator indicated the facility put a wearable alarm in place for the CNAs to alert for help when needed on the unit but that it was broken and now the staff have been instructed to utilize the call lights for help. The Administrator stated, I would hope [the staff] would get to safety or at least a place where they weren't being assaulted. Maybe step on the other side of the door. You can't protect six other people at one time so I think they should hit the alarm and not leave but I don't expect them to stay there and be beaten either. Review of a facility policy titled Abuse, Neglect, and Exploitation with a reviewed date of 01/2024 revealed, We believe that the resident has the right to be free from verbal, sexual, physical or mental and psychosocial abuse, neglect, misappropriation of property and involuntary seclusion. The policy also revealed, The facility has developed policies and procedures which provides essential components to an abuse prevention and intervention program: Training staff annually and on an on-going basis on interventions, reporting, detection and prevention. Review of a facility policy titled Resident Rights with a reviewed date of 01/2024, revealed Federal (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: be free from abuse, neglect, misappropriation of property and exploitation; a safe, clean homelike environment including but not limited to treatment and supports daily living safely. Review of a document titled OLTC I&A Report, dated 06/21/2025, indicated an in-service was completed on abuse; the DON, LPN #3, and CNA #5's signatures were included. An Emergency Discharge Letter indicated Resident #86 was discharged from the facility immediately following the incident with Resident #85. The facility had implemented call devices to allow staff to request assistance if needed (currently inactive, but an alternate was provided). These corrective actions had been implemented prior to the survey team entering the facility, resulting in this finding being cited at Past Non-Compliance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, record review and facility policy review, it was determined that the facility failed to ensure staff followed Enhanced Barrier Precautions (EBP) and wore appropriate Personal Protective Equipment (PPE) to prevent the potential for cross contamination when providing direct, high contact care to a resident that had a feeding tube for one (Resident #34) of one resident reviewed for infection control. The findings include: Review of an admission Record revealed the facility admitted Resident #34 on 06/24/2025, with diagnoses that included cerebral palsy (a group of conditions that affect movement, balance and posture); lennox-gastaut syndrome (severe form of seizures), and dysphagia (difficulty or discomfort when swallowing). Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 03/26/2026, revealed Resident #34 had a Brief Interview for Mental Status score of 0, which indicated the resident had severe cognitive impairment. The MDS also revealed Resident #34 had a feeding tube while a resident. Review of Resident #34's Care Plan initiated on 06/25/2025, revealed Resident #38 required EBP related to feeding tube. Interventions included gloves and gown were required prior to the high contact care such as dressing, bathing/shower, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use- central line, urinary catheter, feeding tube, tracheostomy/ventilator, or wound care. On 05/06/2026 at 1:16 PM, this surveyor observed PPE available in a clear bin in Resident #34's room by the door and EBP signage on the door. Certified Nursing Assistant (CNA) #6 transferred Resident #38 from wheelchair to bed without Personal Protective Equipment (PPE) such as a gown. During an interview on 05/06/2026 at 1:45 PM, CNA #7 reported that PPE was used when EBP signage was on the door and then you will put on a gown, gloves, mask, and shoe covers if you need to. CNA #7 reported that EBP was used when someone had an infection that can spread, open sores, a feeding tube, or a catheter. During an interview on 05/06/2026 at 2:10 PM, CNA #6 reported that EBP was used when there is a sign on the door that says EBP and when someone has open wounds, a catheter or something like that. CNA #6 also reported that you wear gloves, gowns and shoe covers when someone is on EBP. During an interview on 05/06/2026 at 5:30 PM, the Director of Nursing (DON) reported that she expected staff to wear proper PPE when required. The DON stated that PPE bins were in rooms, always stocked and signage was on the residents' doors to alert staff that PPE was required. The DON stated that the outcome of not wearing proper PPE could be increased numbers of infections in the facility. Review of a facility policy titled Enhanced Barrier Precautions (EBP) dated 09/21/2022, indicated, The EBP requires gowns and gloves during high-contact resident care activities that provide opportunities to transfer of MDROs to staff hands and clothing. All residents with any of the following: Indwelling medical devices (central line, urinary catheter, feeding tube, tracheostomy/ventilator) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regardless of MDRO colonization status. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities: dressing, bathing/shower, transferring, providing hygiene, changing briefs, or assisting with toileting, device care or use, wound care.