STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045342	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Nashville Rehab and Nursing Center	810 North 8th St Nashville, AR 71852

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Number of residents sampled: Number of residents cited: Based on observations, record review, interview and facility policy review, 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 administrating medications through a feeding tube for one (Resident #5) of three residents observed for medication administration. The findings include: Review of Resident #5's quarterly Minimum Data Set with an Assessment Reference Date of 01/25/2026 revealed Resident #5 had diagnoses which included stroke, dysphagia (difficulty swallowing), critical illness myopathy. The MDS revealed Resident #5 had a Brief Interview for Mental Status score of 8, which indicated Resident #5 had moderate cognitive impairment. The MDS also revealed Resident #5 had a Percutaneous Endoscopic Gastrostomy (PEG)–feeding tube). Review of Resident #5's Order Summary Report dated 04/29/2026, revealed the resident had an order with a start date of 03/18/2026 for EBP related to the PEG feeding tube. Review of Resident #5's Care Plan initiated on 04/27/2026 revealed Resident #5 required EBP related to a feeding tube with a goal that the resident would not transmit or receive any Multi-Drug Resistant Organisms (MDRO) related to high-risk comorbidities. Interventions included that gloves and gown were required prior to providing high-contact care to devices such as feeding tubes. During an observation on 04/29/2026 at 9:20 AM, Licensed Practical Nurse (LPN) #1 prepared Resident #5's medications to administer through the resident's feeding tube. The surveyor noted a sign at the entrance to Resident #5's room that stated, See the nurse before entering the room. LPN #1 washed her hands and put on gloves. LPN #1 did not put on a gown. This surveyor noted a cart at the entrance to Resident #5's room that contained PPE including gowns. LPN #1 entered Resident #5's room and explained to the resident what she was about to do. LPN #1 took off the cap to the resident's feeding tube and checked for patency and residual. LPN #1 flushed the feeding tube with 60 ml (milliliters) of water and administered the residents' medications per gravity. After administering the medication, LPN #1 flushed the gastrostomy tube with 60 ml of water. After completing the procedure LPN #1 removed her gloves and washed her hands. LPN #1 exited the resident's room once she ensured the resident was comfortable and had no requests. During an interview on 04/29/2026 at 9:30 AM, LPN #1 confirmed that Resident #5 was on EBP and (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045342	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had not put on a gown when administering medications through Resident #5's feeding tube. LPN #1 stated she should have worn a gown so that nothing got on her clothing and so that she did not carry anything to any of the other residents. During an interview on 04/29/2026 at 9:38 AM, LPN #2 stated that when administering medications through a feeding tube EBP should be followed which included wearing gloves and a gown to prevent the spread of infections. During an interview on 04/29/2026 at 9:57 AM, the Infection Preventionist (IP) stated that staff should follow EBP when administering medications through a feeding tube. The IP stated gloves and a gown should be worn to protect the residents from any infection and so as not to introduce any new bacteria into the residents feeding tube. The IP was asked if the facility had a policy on EBP. The Infection Preventionist stated she would look and get back with the surveyor. During an interview on 04/29/2026 at 12:23 PM, the Director of Nursing (DON) stated that when staff were administering medications through a feeding tube, EBP should be followed and staff should wear a gown and gloves. The DON stated EBP should be followed because a feeding tube goes through an artificial opening in the resident's body and wearing the gown and gloves protects the resident from any risk of infection staff might bring to them. During an interview on 04/29/2026 at 12:30 PM, the Administrator stated staff should wear a gown and gloves when administering medications through a feeding tube because fluids from the feeding tube could get on the staff member providing care to the resident and that staff member could take whatever was in the fluid to another resident they were providing care to. Review of a facility policy titled Enhanced Barrier Precautions, revised 03/21/2024, revealed the facility will follow the Centers for Disease Control and Prevention (CDC) guidance for EBP. The EBP requires gowns and gloves are worn during high-contact resident care activities that provide opportunities for transfer of MDRO's to staff hands and clothing. EBP are required during device care or use which includes care to a feeding tube. MDRO transmission is common in nursing facilities contributing to significant morbidity for residents and increased costs for health care systems.