

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/08/2025
NAME OF PROVIDER OR SUPPLIER  The Blossoms at Fort Smith Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5301 Wheeler Avenue Fort Smith, AR 72901	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>50924</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to maintain dignity by supplying toilet paper and paper towels for 1 (Resident #10) of 1 resident reviewed for resident rights with the potential to affect all 24 residents residing on the women's secured unit.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Resident Rights, dated 11/01/2022, indicated residents had a right to a dignified existence and be treated with respect, kindness, and dignity.</p> <p>During an observation on 01/06/2025 at 4:30 PM, neither of two stalled bathrooms on the locked women's unit had toilet paper or paper towels available. Both bathrooms had signs on the paper towel dispenser which stated, NO PAPER TOWELS.</p> <p>A review of Resident #10's Admission Record, indicated the facility admitted Resident #10 with diagnoses that included intellectual disabilities, mental disorder due to know physiological condition, psychosis, schizophrenia, and anxiety.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/02/2025, revealed Resident #10 had a Staff Assessment of Mental Status (SAMS) score of 3 which indicated the resident was had severe cognitive impairment. Assessment of Resident #10's toileting hygiene shows the resident required partial to moderate assistance.</p> <p>A review of Resident #10's Care Plan with revisions up to 01/06/2025, revealed the resident a history of trauma related to childhood abuse/mistreatment/abusive foster care/involuntary seclusion, homelessness living without food/medicine/shelter, living through depravation and now needing to be under Adult Protective Services (APS). Interventions included providing culturally competent, sensitive trauma-informed care in accordance with personal standards accounting for Resident #10's experiences and preferences to eliminate or mitigate triggers which may cause re-traumatization. Resident #10 had an Activities of Daily Living (ADL) self-care deficit interventions included extensive assistance of one staff member with toileting to check for incontinence, change brief, and perform peri care assistance every two hours and as needed.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 01/06/2025 at 4:50 PM, Resident #10 walked into the bathroom while Certified Nursing Assistant #3 retrieved a new white brief from the nurses' station. CNA #3 entered a stall in the bathroom after Resident #10 only carrying a brief. A few minutes later Resident #10 left the stall and the bathroom followed by CNA #3 who was carrying a clear plastic bag with a small white article inside. No water was run in the bathroom and no toilet was flushed. CNA #3 went to a small hallway across from the women's unit shower room and came back without the clear plastic bag. CNA #3 stated due to residents using too much toilet paper and paper towels the toilets got clogged, so paper products were not available in either women's bathroom for their use. CNA #3 stated perineal care should be performed when changing residents brief to ensure residents don't get infections and their skin is clean. CNA #3 stated she forgot and that was my bad.</p> <p>During an observation on 01/06/2025 at 4:52 PM, on the women's secure unit an unidentified female resident who was ambulatory was seen using the bathroom. CNA #3 and another staff member were outside the bathroom, no offer of toilet paper or paper towels were made.</p> <p>During an observation on 01/07/2025 at 8:45 AM, an unidentified female resident of the women's secure unit was seen in a wheelchair taking herself to the bathroom. No toilet paper or paper towels were provided or accessible to the resident for hygiene use.</p> <p>A review of the facility's Certified Nursing Assistant Competency Skills Check-off for CNA #3 revealed, an orientation period from 10/06/2024-10/09/2024 signed off by both CNA#3 and her preceptor for demonstrating knowledge related to: hand washing policy and procedures, performs nursing care based on resident's needs, verbalized the importance of acting as a resident advocate, was competent in resident rights, personal centered care, and cultural competency. The competency skills check off packet was signed off by CNA #3's Unit Manager as completed on 10/09/2024.</p> <p>During an interview on 01/08/2025 at 1:48 PM, the Director of Nursing (DON) stated she had no idea who made the decision not to have paper products available to residents in the women's lock unit bathroom and was unaware it was happening. The DON stated the facility has angel rounds and each supervisor has a different area they round on, so a member of management would have been rounding through the women's unit routinely. The DON stated the residents on the locked units were there because they lack the ability to make good rational decisions. The DON stated the facility had immediately addressed the issue and she was mortified when she found out.</p> <p>A review of an in-service provided to staff on 01/07/2025 stated, Residents should have toilet paper and paper towels available to them at all times! and was signed by 40 staff members on 01/08/2025.</p> <p>During an interview on 01/08/2025 at 2:41 PM, the Administrator stated he was unaware the women's secure unit bathrooms were not providing toilet paper and paper towels to the residents. The Administrator stated the pipes were no excuse. The Administrator stated, few things make me mad, but I was mad. He stated he contacted the facility's former DON and when informed she was aware, the Administrator asked her, Why would you do that? The Administrator acknowledged it was the same plumbing throughout the facility and no other unit had quit supplying toilet paper.</p>		

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<p>F 0567</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to manage his or her financial affairs.</p> <p>50924</p> <p>Based on interviews, record review, facility document review, facility policy review, it was determined that the facility failed to obtain written authorization to manage personal funds, ensure a resident was aware of process to access personal funds, and had knowledge of facility charges for 1 (Resident #8) of 5 residents reviewed for personal funds.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Resident Rights, dated 11/01/2022, indicated residents had a right to manage their own funds or choose to have the facility manager funds.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #8 on 08/26/2024 with diagnoses that included injury at C7 level of the cervical spine, functional quadriplegia, depression, and panic disorder. Resident #8 was their own Power of Attorney (POA) and made their own decisions.</p> <p>The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/05/2024, revealed Resident #3 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact.</p> <p>During an interview on 01/06/2025 at 2:30 PM, Resident #8 stated they were unaware if the facility was managing money for them or not. No one had talked to the resident about it, Resident #8 did not know how to access their funds, or if there was a balance. Resident #8 stated they had received two haircuts since being in the facility but did not know the cost or who paid for it. The resident stated they thought they were to get \$40 a month to spend but had never seen any money or any account information.</p> <p>During an interview on 01/08/2025 at 11:11 AM, the Business Office Manager (BOM) was unable to find an authorization to manage personal funds for Resident #8. The BOM stated she had spoken to the resident's brother at one time, but agreed Resident #8 was their own Power of Attorney and made their own decisions.</p> <p>During a concurrent observation and interview on 01/08/2025 at 1:20 PM, the BOM stated herself and the Social Services Director went to Resident #8's room and obtained an authorization to manager funds, explained how the resident could access their personal funds, and a current balance was provided.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50924</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure safe wheelchair transport techniques were used for 1 resident (Resident #6) and cigarettes were stored out of residents access for 1 resident (Resident #11) of 11 residents reviewed; the facility failed to ensure the women's secure unit shower was clean, sanitary, and decluttered; failed to repair broken tile in the doorway of room [ROOM NUMBER]; and the facility failed to ensure an employee's cigarettes were not securely stored away from residents of the 200 Hall and 300 Hall for 4 halls reviewed; and failed to provide adequate number of fitted sheets for resident beds in the men's secured unit when reviewed for a safe, clean, comfortable, homelike environment.</p> <p>Findings include:</p> <p>1. A review of a facility policy titled, Resident Rights, dated 11/01/2022, indicated residents had a right to a safe, clean, homelike environment including but not limited to treatment and supports for daily living safely.</p> <p>On 01/07/2025 the Director of Nursing (DON) stated the facility had no policy or procedure for wheelchair transportation.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #6 on 08/01/2024 with diagnoses that included Parkinson's disease with dyskinesia (uncontrolled, involuntary muscle movements), dementia, anxiety, depression, schizophrenia, post-traumatic stress disorder (PTSD), muscle weakness, abnormal gait and mobility, lack of coordination, and cognitive communication deficit.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/05/2024, revealed Resident #6 had a Staff Assessment of Mental Status (SAMS) score of 2 which indicated the resident was had moderate cognitive impairment. Resident #6 is non ambulatory and requires a wheelchair for mobility assistance.</p> <p>During an observation on 01/06/2024 at 3:28 PM, Certified Nursing Assistant (CNA) #4 was pushing Resident #6 in a wheelchair out of the resident's room towards the TV common area. CNA #4 had a clear bag with a white article inside, as CNA #4 approached the dirty laundry and trash receptacles he gave Resident #6's wheelchair a push forward then let go of the wheelchair handles. CNA #4 then lifted the lid off the receptacles and placed the plastic bag inside. CNA #4 then caught and turned the wheelchair handles towards the left just before Resident #6's right foot hit a door frame. Resident #6 was then taken to the common area to watch TV.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #6's Care Plan with revision up to 01/06/2025, revealed the resident had experienced trauma in their life, specifically related to diagnosis of serious illness leading to the inability to care for themselves independently. Interventions included provide a culturally competent, sensitive trauma-informed care in accordance with professional standards accounting for the person's experience and preferences to eliminate or mitigate triggers which may cause re-traumatization of the resident. Resident #6 used an anti-anxiety medication related to diagnoses of anxiety, schizophrenia, PTSD, and dementia. Interventions included monitoring the resident for safety. Due to the anti-anxiety medications Resident #6 was at increased risk of confusion, loss of balance, falls such as broken hips and legs. Resident #6 is at risk for falls related to confusion, Parkinson's, schizophrenia, dementia, balance/gait problems, weakness, PTSD, lack of coordination, psychoactive drug use, and being unaware of safety needs. Interventions included anticipating resident's needs, and staff assistance with transfers. Resident #6 was at risk for mood and behavioral problems related to confusion, Parkinson's, schizophrenia, dementia, and anxiety. Interventions included caregivers should provide opportunities for positive interaction and attention.</p> <p>During an interview on 01/07/2025 at 3:18 PM, CNA #4 stated he remembered getting Resident #6 cleaned up and taking them to watch TV, but did not remember letting go of the wheelchair. CNA #4 stated he was in a rush due to other resident needing assistance. CNA #4 stated he was a bigger guy therefore he got pulled to other area to help. CNA #4 stated he was preoccupied at the time but apologized stating he usually comes to a complete stop.</p> <p>A review of the Certified Nursing Assistant Competency Skills Check-Off signed by CNA #4 on 10/24/2024 revealed CNA #4 met expectation for care areas: Performs nursing care consistent with resident's needs, resident's rights and the facility's responsibilities, person centered care, wheelchair locomotion, fall prevention, and specific knowledge of Parkinson's disease. The checkoff was not signed by a preceptor or unit manager, but the DON was named as the department head/supervisor.</p> <p>During an interview on 01/08/2025 at 1:48 PM, the DON stated safety precautions during wheelchair transport would be to assure the resident's feet are up and their extremities are inside the wheelchair and no clothing or other articles could get caught. The DON responded no; the CNA transporting should not let go of the wheelchair their hands should remain on it. The DON stated the CNA could run into a wall and cause an injury or hit another resident bystander.</p> <p>During an interview on 01/08/2025 at 2:41 PM, the Administrator stated during wheelchair transport of a resident he would not want to see a resident being pulled backwards. The Administrator responded yes; I would expect the CNA to always have control of the wheelchair. In response to CNA #4 response of helping in other area the Administrator stated, we are short nurse on the floor and use agency to cover, but we are never short CNA's.</p> <p>2. A review of a policy titled, Resident Smoking, revised on 06/03/2023, indicated Smoking was not permitted inside the facility, and all smoking materials were to be kept by the facility in a secure location. Smoking for residents, staff, and visitors was only allowed outside 15 feet away from doorways, windows, or a vent system. Residents will have no smoking materials in their possession, Resident smoking materials will be labeled to keep an accurate inventory of each resident's supplies. All smoking materials will be kept in the facility's smoking cart/receptacle and secured. All residents will be under supervision while smoking. Residents must remain within eyesight of the smoking monitor, no more than 8-10 feet away.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and observation on 01/07/2025 at 8:38 AM, Resident #11 was coming out of their room located on the men's secure unit in a wheelchair with a cigarette in their mouth. Licensed Practical Nurse (LPN) #5 was standing by the medication cart and also observed Resident #11 with the cigarettes. LPN #5 stated she was unaware of how the resident was getting the cigarettes, but it has been occurring lately. LPN #5 stated Resident #11 denies having a lighter, but I didn't do a body search.</p> <p>A review of the Admission Record, indicated the facility admitted Resident #11 on 11/01/2024 with diagnoses that included dementia, depression, muscle spasms, and neuropathy (weakness, numbness, and pain from nerve damage usually of the hands and feet).</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/08/2024, revealed Resident #11 had a Brief Interview of Mental Status (BIMS) score of 9 which indicated the resident was had moderate cognitive impairment. Resident #11 was identified as not a current tobacco user.</p> <p>A review of Resident #11's smoking assessment dated [DATE] at 1:56 AM indicated, Resident does not use smoking/tobacco/nicotine products.</p> <p>A review of Resident #11's care plan does not identify smoking, or any safety precautions related to smoking.</p> <p>During an interview on 01/07/2025 at 9:01 AM, Resident #11 stated the cigarette was left over from last night's smoke break. Resident #11 stated the CNA was not watching so they brought it in with them. Resident #11 denied having a lighter and stated they would never smoke it inside.</p> <p>During an interview on 01/08/2025 at 1:48 PM, the DON stated she was made aware of the cigarette Resident #11 had and the staff was unaware how the resident was getting the cigarettes, but thought family might be bringing them in. The DON stated staff had looked in Resident #11's room but could not find any cigarettes. The DON stated residents are not supposed to have access to cigarettes because it could be a safety and hazard issue. She denied knowing the procedure or location of where cigarettes are kept between smoke breaks because she was new to the facility. The DON 's start date was 07/07/2024 as the MDS nurse and 08/17/2024 in her current position.</p> <p>During an interview on 01/08/2024 at 2:41 PM, the Administrator stated the facility had 4 or 5 smoke breaks a day and the facility oversaw storing all cigarettes at the nurses' station. The Administrator stated the family will bring in cigarettes to residents and they must remind them the facility must keep them.</p> <p>3. During a concurrent observation and interview on 01/06/2025 at 4:58 PM, CNA #3 opened the women's secured unit shower room door. Two plastic tubs sitting on the back left floor had standing water in them, a black substance just above the bottom tile trim covered four tiles wide and up to the second cinder block high, a non-rolling shower chair had a stack on clean linens in it. The larger rolling shower chair had rust at the bottom, two bedside commodes were against the right wall, and one had personal hygiene products on the lid as well as a wet used towels, a luffa was on the floor in the corner under it. The other bedside commode which was rusted was sitting next to the rolling shower chair. A linen basket was in the front right corner with wet dirty linens falling out. The floor had dark colored scum covering it. When asked about the black substance on the wall, CNA #3 stated, I would call it mold.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 01/07/2025 at 8:43 AM, Housekeeping Assistant Supervisor (Housekeeping AS) stated a housekeeper was assigned to the women's secure unit every day from 8am-4pm. Their duties included cleaning, sweeping, mopping, and dusting in the two dining rooms, and down the hall including all resident rooms, both bathrooms, and the shower room. The housekeeper will also address anything which might come up during the day. Housekeeping cleans the shower with the mop and wipes down all surfaces. The blue cleaner is for the floor and the pink is for all surfaces including the tiled walls. Showers are cleaned once a day and all problems are reported to the Housekeeping &amp; Laundry Supervisor (H&amp;L Supervisor) who answers to the Administrator. The housekeeper fills out a paper at the end of their shift and identifies any issues. The Housekeeping AS reported no issues with the shower lately, but stated he had looked in there this morning and it needed to be swept.</p> <p>During a follow-up interview and observation on 01/07/2025 at 8:53 AM with the Housekeeping AS the 01/06/2025 check sheet was provided. No notes or issues identified on the sheet pertaining to the shower room which was turned in at the end of the housekeepers 01/06/2025 shift at 4:00 PM. The Housekeeping AS and the surveyor entered the women's secure unit shower room, the black substance on the wall was less than the previous day but still present. The wet used towels were still on the bedside commode lid and a used dirty glove was in the floor. The floor was still grimy with a dark colored substance and two bedside commodes were still present. The Housekeeping AS stated the substance on the wall was definitely black and looked like mold to him. Housekeeping AS stated he would not personally take a shower in there.</p> <p>During an interview on 01/08/2025 at 1:08 PM, the H&amp;L Supervisor stated he had been to inspect the women's secure unit shower room. He was then shown the pictures from the 01/06/2025 4:58 PM observation and stated, the black area on the wall was not as bad today as in the picture. He observed missing tiles on the wall and the discoloration behind it, the shower chair had orange rings on it, and the wet towels were still present. The H&amp;L Supervisor stated he would not take a shower in there and it was not a fair condition for the residents to live in. He stated they planned to take the shower chair apart tomorrow and clean it.</p> <p>A review of a job description for Director of Housekeeping signed on 11/21/2024 by the H&amp;L Supervisor indicated, his responsibilities are for daily operation of the housekeeping department including staffing, supply ordering, and supervision, and the delegation of responsibilities and assigned duties in accordance with current state and federal regulation to maintain residents' rooms in a safe, comfortable, and maintained in an attractive manner. Supervises housekeeping personnel and schedules adequate coverage and assist with all aspects of cleaning and maintaining the facility's interior and grounds.</p> <p>During an interview on 01/08/2025 at 1:48 PM, the Director of Nursing (DON) stated the facility had angel rounds and each supervisor had a different area they round on, so a member of management would have been rounding through the women's unit routinely.</p> <p>During an interview on 01/08/2025 at 2:41 PM, the Administrator was shown pictures from the 01/06/2025 at 4:58 PM observation of women's secure unit shower room and stated the black area back wall looks like mold. The Administrator stated, No, I would not take a shower in there.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent observation and interview on 01/07/2025 at 8:59 AM, review of the 01/06/2025 housekeeping check sheet revealed room [ROOM NUMBER] was deep cleaned, but the comments stated the floor tiles were still broken. Housekeeping AS stated he was familiar with the room because it was his grandmother's room. He stated the floor tiles in the doorway had been broken and the facility process was to go tell the maintenance director or text him which had been done. Observations revealed all but one partial tile stretching the width of the doorway were broken down to the sub floor. Housekeeping AS stated he had personally told the Maintenance Director about the tile, but they could only work on it at night because the residents would walk on it.</p> <p>During an interview on 01/08/2025 at 1:08 PM, the H&amp;L Supervisor stated any issues are placed into a logbook, maintenance has one at every nurse's station. We are supposed to log it in there and maintenance will check it then a paper report will come back to the person reporting it. He believed the process was being utilized, but right now the maintenance department is overloaded. The H&amp;L Supervisor was surprised to hear he was the only one to acknowledge a maintenance logbook but admitted he had not received one back since he started in December.</p> <p>During an interview on 01/06/2025 at 5:18 PM, the Maintenance Director stated we learned of issue either through in person communication, a text message, or in a communication application utilized by the department heads. The Maintenance Director stated if you use paper, it gets put back and not always on the top of the pile, so he doesn't use a paper system, and it works good for the facility. The Maintenance Director stated some updating projects have been put on hold because of budget issues. He denied any current work orders in the women's unit.</p> <p>A review of a job description titles Maintenance Director, and signed by the Maintenance Director on 10/24/2024 indicated, responsibilities for planning, organizing, developing, and directing the overall operation of the maintenance department in accordance with current local, state, and federal regulations and to ensure the facility is well-maintained in a safe and comfortable manner. Completes carpentry and other building repairs within the scope of expertise, makes electrical and plumbing repairs within the scope of expertise, coordinates maintenance services and activities with other related departments, and reviews and develops a plan of correction for maintenance deficiencies noted during survey inspections.</p> <p>During an interview on 01/08/2025 at 1:48 PM, DON stated she report any maintenance issues to the Administrator or Maintenance Director. She stated, I know he is supposed to have a program, but I do not know the official process.</p> <p>During an interview on 01/08/2025 at 2:41 PM, the Administrator stated he was unaware the Maintenance Director did not use a paper tracking system and stated we need to tighten things up for closed communication.</p> <p>4. During an observation on 01/07/2025 at 3:14 PM, a green pack of cigarettes was seen while walking past Resident #4's door. Resident #4 is a dependent, nonverbal resident and a nonsmoker. The pack of cigarettes was visible and accessible to resident ambulation in the hallway. Surveyor waited in doorway until staff was present to alert them hazard.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and observation on 01/07/2025 at 3:18 PM, CNA #4 stated Resident #4 was bed bound and not a smoker. He retrieved the pack of cigarettes and stated it was a big no-no. CNA #4 suggested the pack could have fallen out of a first shift employee's pocket. CNA #4 left with the pack of cigarettes and stated he would turn them in.</p> <p>During an interview on 01/08/2025 at 1:48 PM, the DON stated yes, they did find out the pack of cigarettes in Resident #4's room belonged to a CNA and had fallen out of their pocket. The DON stated residents should not have access to cigarettes as it could be an accident or hazard.</p> <p>During an interview on 01/08/2025 at 2:41 PM, the Administrator stated he was made aware of the pack of cigarettes in Resident #4's room and belonged to an employee who lost them out of their pocket. The Administrator stated residents should not have access to them.</p> <p>5. During an observation on 01/06/2025 at 2:21 PM, Resident #6 had no fitted sheet on the bed, a folded flat sheet and blanket were on the mattress.</p> <p>During a concurrent interview and observation on 01/06/2025 at 2:30 PM, Resident #8 had no fitted sheet on the bed, a folded flat sheet and a blanket were on the mattress. Resident #8 stated they didn't believe the facility had fitted sheets and they put the blanket down to catch the water. Resident #8 explained they received a shower this morning and got dried off with only one little towel.</p> <p>During an interview on 01/08/2025 at 12:31 PM, H&amp;L Supervisor stated a new facility wide linen count was completed in the middle of December which resulted in him placing two orders for towels, washcloths, fitted sheets, and bariatric sheets. Another order for towels, washcloths, and sheets was placed today (01/08/2025).</p> <p>During an interview on 01/08/2025 at 1:48 PM, when asked about CNAs on the men's unit yesterday unable to make beds due to lack of linens, the DON stated, Yes, that is an occurrence that has happened before. The DON stated it was about a month ago and they ordered new linens then too.</p> <p>During an interview on 01/08/2025 at 2:30 PM, CNA #6 stated earlier today the facility ran out of fitted sheets and she had to use flat sheets to make one or two beds.</p>		

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NAME OF PROVIDER OR SUPPLIER  The Blossoms at Fort Smith Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5301 Wheeler Avenue Fort Smith, AR 72901	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>50924</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to provide perineal care during a soiled brief change for 1 (Resident #10), and failed to ensure physician orders were followed for medication administration, specifically not crushing and administering iron tablets labeled DO NOT CRUSH for 1 (Resident #7) of 11 residents reviewed for Quality of Care.</p> <p>Findings include:</p> <p>1. A review of a facility policy titled, Resident Rights, dated 11/01/2022, indicated residents have a right to a dignified existence and be treated with respect, kindness, and dignity.</p> <p>A review of Resident #10's Admission Record, indicated the facility admitted Resident #10 with diagnoses that included intellectual disabilities, mental disorder due to know physiological condition, psychosis, schizophrenia, anxiety, and lack of coordination.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/02/2025, revealed Resident #10 had a Staff Assessment of Mental Status (SAMS) score of 3 which indicated the resident had severe cognitive impairment. Assessment of Resident #10's toileting hygiene shows the resident required partial to moderate assistance.</p> <p>A review of Resident #10's Care Plan with revisions up to 01/06/2025, revealed the resident a history of trauma related to childhood abuse/mistreatment/abusive foster care/involuntary seclusion, homelessness living without food/medicine/shelter, living through depravation and now needing to be under Adult Protective Services (APS). Interventions included providing culturally competent, sensitive trauma-informed care in accordance with personal standards accounting for Resident #10's experiences and preferences to eliminate or mitigate triggers which may cause re-traumatization. Resident #10 had an Activities of Daily Living (ADL) self-care deficit interventions included extensive assistance of one staff member with toileting to check for incontinence, change brief, and perform peri care assistance every two hours and as needed.</p> <p>During an observation on 01/06/2025 at 4:30 PM, neither two stalled bathrooms on locked women's unit had toilet paper or paper towels. Both bathrooms had signs on the paper towel dispenser which stated, NO PAPER TOWELS.</p> <p>During a concurrent observation and interview on 01/06/2025 at 4:50 PM, Resident #10 walked into the bathroom while Certified Nursing Assistant #3 retrieved a new white brief from the nurses' station. CNA #3 entered a stall in the bathroom after Resident #10 only carrying a brief. A few minutes later Resident #10 left the stall and the bathroom followed by CNA #3 who was carrying a clear plastic bag with a small white article inside. No water was run in the bathroom and no toilet was flushed. CNA #3 went to a small hallway across from the women's unit shower room and came back without the clear plastic bag. CNA #3 stated due to residents using too much toilet paper and paper towels the toilets got clogged, so paper products were not available in either women's bathroom for their use. CNA #3 stated peri care should be performed when changing residents brief to ensure residents don't get infections and their skin is clean. CNA #3 stated she forgot and that was my bad.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  The Blossoms at Fort Smith Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5301 Wheeler Avenue Fort Smith, AR 72901	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's Certified Nursing Assistant Competency Skills Check-off for CNA #3 revealed, an orientation period from 10/06/2024-10/09/2024 signed off by both CNA#3 and her preceptor for demonstrating knowledge related to: hand washing policy and procedures, knowledge of infection control system, performs nursing care based on resident's needs, verbalized the importance of acting as a resident advocate, was competent in resident rights, personal centered care, cultural competency, and basic nurse aide skills of toileting assistance and perineal care/incontinence care. The competency skills check off packet was signed off by CNA #3's Unit Manager as completed on 10/09/2024.</p> <p>During an interview on 01/08/2025 at 1:48 PM, the Director of Nursing (DON) stated she had no idea who made the decision not to have paper products available to residents in the women's lock unit bathroom and was unaware it was happening. DON stated the facility has angel rounds and each supervisor has a different area they round on, so a member of management would have been rounding through the women's unit routinely. DON stated perineal care should be performed when a resident is changed from a soiled brief to a clean one for infection control management and hand hygiene should also be performed. The DON stated the residents on the locked units were there because they lack the ability to make good rational decisions. The DON wanted to know if the CNA went back to perform proper perineal care after they were questioned by the surveyor and the DON was informed no.</p> <p>2. A review of facility policy titled Medication Administration with revision date of 11/25/2022 revealed the following: Medications must be administered in accordance with the orders.</p> <p>A review of the Resident #7 ' s Admission Record indicated the facility initially admitted Resident #7 on 05-28-2015 with current diagnosis of Metachromatic Leukodystrophy, gastrostomy status and dysphagia.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/2024, revealed Resident #7 had a Staff Assessment of Mental Status (SAMS) score of 1 which indicated the resident was severely cognitively impaired. Resident #9 required a feeding tube for nutrition, medications, and fluids.</p> <p>A review of Resident #7 ' s care plan with initiated date of 1-6-17 revealed the resident has need for feeding tube for nutrition and hydration. Resident #7 is at risk for malnutrition, dehydration and complications. Interventions included to check residual per physician orders and notify physician of any problems and to check placement prior to medication administration and flushes by auscultation and aspiration.</p> <p>A review of Resident #7 ' s physician orders with active date of 12/24/24 revealed that Resident #7 was to receive Iron Oral Tablet 325 (65 Fe) MG (Ferrous Sulfate) Give 1 tablet via PEG-Tube one time a day for iron supplement Do not crush. (Percutaneous endoscopic gastrostomy is a surgery to place a feeding tube (PEG tube). PEG tubes allow you to get nutrition through your stomach.)</p> <p>A review of Resident #7 ' s January 2025 medication administration record (MAR), revealed Resident #7 was to</p> <p>receive Iron Oral 325 (65 Fe) MG (Ferrous Sulfate) Give 1 tablet via PEG-Tube one time a day for iron supplement Do not crush.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  The Blossoms at Fort Smith Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  5301 Wheeler Avenue Fort Smith, AR 72901	

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of December 2024/January 2025 Medication Administration Record (MAR) revealed Iron tab had been administered at total of 22 doses.</p> <p>During an interview on 01/07/2025 at 1:54 pm, Licensed Practical Nurse #1 reported that he used liquid Iron previously for Resident 7 but has run out. He reported he held the Iron that morning because Iron is not crushable. Reported that there was not a physician order for liquid Iron but substituted it and gave 7.5ml he thought to equal the dose ordered.</p> <p>During an interview on 01/07/2025 at 3:13 pm, Director of Nursing (DON) revealed that there is no liquid iron in the building. She reported the nurses had to have been crushing the Iron and giving it to Resident 7. She revealed that Iron should not be crushed because it is enteric coated. Revealed that if you crush an enteric coated medication, it could be all released at one time. Also, Iron should not be crushed because it could cause a Gastrointestinal bleed.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</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>50924</p> <p>Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure staff used safe laundry transport techniques to prevent accidents for 1 (Resident #1) of 11 residents reviewed for accidents and hazards.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Resident Rights, dated 11/01/2022, indicated residents have a right to a safe environment.</p> <p>A review of Resident #1's Admission Record, indicated the facility admitted Resident #1 with diagnoses which included generalized anxiety disorder, psychosis, schizophrenia, abnormal gait and mobility, abnormal auditory perception, lack of coordination, cognitive communication, and a history of falls.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/02/2024, revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 9 which indicated the resident was had moderate cognitive impairment.</p> <p>A review of Resident # 1's Care Plan, revisions as of 01/06/2025, revealed the resident was at risk for falls. Interventions included anticipating the resident's needs. Resident #1 was at risk for abnormal bleeding related to antiplatelet therapy. Interventions included protecting Resident #1's skin from accidental injuries.</p> <p>A progress note dated 10/23/2024 at 1:44 PM, revealed Resident #1 was walking to the bathroom with their head down while laundry staff was coming through the laundry entrance with a laundry cart. The resident ran into the cart and fell backwards onto the floor. Resident #1 complained of pain in the head and assessment revealed blood to the back of the resident's head. The provider was notified, and the resident was sent to the emergency room .</p> <p>A review of Resident #1 ' s Incident and Accident (I&amp;A) Report dated 10/23/2024 indicated Resident #1 was ambulating to the bathroom when laundry person with a laundry cart was moving from the laundry to the nurses' station and the resident ran into the laundry cart. Resident #1 fell back striking her head on the ground. Resident #1 was sent to the emergency room for evaluation and treatment. It was found Resident #1sustained a hematoma. Immediate action taken by the facility was, instructed staff to be aware of residents at all times and make path to bathrooms free of carts and persons.</p> <p>During an interview on 01/07/2025 at 4:07 PM, the Laundry Tech #2 stated she was entering the women's locked unit from the laundry area and pushing the cart from behind. The Laundry Tech #2 stated she believed Resident #1 was walking towards the bathrooms and they collided. Laundry Tech #2 stated the cart was very tall and hard to see around, so she should have been on the side where she could have seen any residents in the path.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/08/2025 at 1:08 PM, the Housekeeping &amp; Laundry Supervisor (H&amp;L Supervisor) stated during transportation to prevent hitting the residents with the cart laundry techs should stand in front of the carts so any residents in the path can be seen.</p> <p>During an interview on 01/08/2025 at 2:41 PM, the Administrator stated to prevent accidents during transport of laundry carts the techs should stand in front of the cart to see everything in their path like residents. The Administrator stated yes, they are preventable accidents with education and training.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>49866</p> <p>Based on observations, interviews, record reviews, and review of facility policy, the facility failed to provide appropriate treatment and services to prevent complications from enteral feedings for 2 of 3 residents (Resident #7 and Resident #9) reviewed for tube feeding. Specifically, the facility failed to appropriately check tube placement prior to administering flushes and/or medications for Resident #7 and Resident #9.</p> <p>The findings include:</p> <p>A review of facility policy titled Enteral Feeding with revision date of 11/25/2022 revealed the following, Check enteral tube placement prior to each feeding and administration of medication and if resident is not alert and able to voice symptoms of bloating, nausea or abdominal pain then nurse is to monitor gastric residual volume prior to administration of feeding or medication.</p> <p>A review of the Resident #7's Admission Record indicated the facility initially admitted Resident #7 on 05-28-2015 with current diagnosis of metachromatic leukodystrophy, gastrostomy status, and dysphagia.</p> <p>A review of Resident's #9's Admission Record indicated the facility initially admitted Resident #9 on 11-04-2014 with a diagnoses of Huntington Disease, gastronomy status, and dysphagia.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/2024, revealed Resident #7 had a Staff Assessment of Mental Status (SAMS) score of 1 which indicated the resident had memory problem and severely cognitively impaired. Resident #7 required a feeding tube for nutrition and fluids.</p> <p>The quarterly MDS with ARD date of 10-16-2024 revealed that Resident #9 is in a vegetative state/no discernible consciousness and requires all nutrition and fluids through a feeding tube.</p> <p>A review of Resident #7's care plan with initiated date of 1-6-17 revealed the resident has need for feeding tube for nutrition and hydration. Resident #7 is at risk for malnutrition, dehydration and complications. Interventions included to check residual per physician orders and notify physician of any problems and to check placement prior to medication administration and flushes by auscultation and aspiration.</p> <p>A review of Resident #9's care plan with initiated date of 11-07-2014 revealed that Resident #9 has need for PEG tube placement and requires staff assist with feedings/flushes per orders. Interventions included that PEG tube feedings/flushes are per physician orders.</p> <p>A review of Resident #7's physician orders with active date of 12/24/24. Revealed that GT/PEG tube placement to be checked every shift.</p> <p>A review of Resident #7's January 2025 medication administration record (MAR), revealed Resident #7 was to have Gastronomy Tube (GT)/PEG tube placement checked every shift.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #9's January 2025 MAR revealed that staff is to check PEG tube place every shift.</p> <p>During an observation on 01/07/2025 at 9:54 am, a surveyor observed Licensed Practical Nurse (LPN) #1 administering Resident #9 water through PEG tube without checking placement prior. After flushing LPN #1 realized he had not checked placement of PEG tube and then checked placement after flushing of water was completed. LPN #1 dropped stethoscope on floor and then hung back up on PEG tube pole without cleaning.</p> <p>During an observation on 01/07/2025 at 10:09 am, a surveyor observed LPN #1 used the same stethoscope that had not been cleaned, to check for air movement in the stomach of Resident #9 but did not aspirate gastric residual for placement check. PEG tube was clogged and instead of using tube clamp was bending tube together to stop flow of liquids. PEG tube plunged numerous times but due to being clogged had to milk tube to try and get it unclogged in order to administer medication/fluid through the PEG tube. After medications were administered LPN #1 then aspirated residual of PEG tube.</p> <p>During an interview on 01/07/2025 at 1:35 pm with Registered Nurse (RN) #2 revealed that PEG tubes should be checked for placement every shift and prior to medication administration through the PEG tube. She revealed it should be done several times a day.</p> <p>During an interview on 01/07/2025 at 1:54 pm, Licensed Practical Nurse (LPN) #1 revealed that the facility's policy is to check placement prior to medications through a PEG tube and prior to PEG tube feedings. He also revealed that the methods of verifying PEG tube placement is by auscultation and aspiration. He revealed that he did not verify placement by aspiration on Resident #7 and Resident #9 on 01/07/2025 while giving medicine via PEG tube.</p> <p>During an interview on 01/07/2025 at 3:13 pm, the Director of Nursing (DON) revealed that it is important to check placement of a PEG to prior to medication administration or PEG tube feedings because you want to make sure it is in the stomach and not going into other organs.</p>