STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045345	A. Building B. Wing	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Fort Smith Rehab & Nursing Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35684 Based on interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure staff reported allegations of verbal abuse to the Administrator within two hours of the allegation being made for 2 (Residents #2 and #3) of 3 sampled residents reviewed for abuse and/or neglect. The findings include: 1. A review of a facility policy titled, Abuse, Neglect, and exploitation revised on 12/2022 indicated, We are committed to the safety and well-being of all our residents. We believe that the resident has the right to be free from verbal abuse .The facility's goal is to prevent abuse through annual and ongoing in-service of staff . The facility has developed policies and procedures which provide essential components to an abuse prevention and intervention program. 1. Screening of potential hires .2. Training staff annually and on an ongoing basis in interventions, reporting detection, and prevention. 6. Protection for individuals from abuse during investigation of allegations. 7. Reporting/Response-assurance that incidents are reported, corrective actions are taken, and preventative measures are put into place .Reporting: All complaints, concerns or suspicions of abuse should be immediately reported to the Administrator .1. All personnel must immediately report suspected cases of abuse to the administrator. In the Administrators absence, suspected abuse should be reported to the Director of Nursing (DON) and immediate supervisor .2. Staff are trained upon hire during orientation . on the policy regarding reporting abuse, the types of abuse ., Types of Abuse: 1. Verbal abuse-Includes the use of oral, written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. 2. A review of the Admission Record indicated the facility admitted Resident #2 with diagnoses that included Alzheimer's disease, dementia, malignant neoplasm of brain, anxiety disorder, dysphagia, and cognitive communication deficit. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated the resident had severe cognitive impairment. Section GG was reviewed and indicated the resident required maximum to total assist with toileting and hygiene. (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #2's Care Plan Report with a revision date of 05/18/2023, revealed the resident's history indicated resident had experienced serious trauma in [Resident #2's] lifetime. Specifically, trauma related to abuse. Resident #2 had a self-care deficit and was a Hospice resident with a terminal diagnosis. Interventions included assistance from 1-2 staff for daily care, and using simple short instructions. A review of Order Summary Report, as of 03/14/2025 revealed Resident #2 resided on the Secure Unit and was monitored for pain and medication side effects. 3. A review of the Admission Record indicated the facility admitted Resident #3 with diagnoses that included dementia, cognitive communication deficit, lack of coordination, history of falls, muscle weakness, and abnormal gait and mobility. The quarterly MDS, with an ARD of 01/15/2025, revealed Resident #3 had a BIMS score of 8, which indicated the resident had moderate cognitive impairment. Section GG was reviewed and indicated resident #3 required oversight to moderate assistance from staff for daily care. A review of Resident #3's Care Plan Report with an initiated date of 10/07/2020, indicated the resident had a history of self-harmful behavior, had experienced trauma in [Resident #3's] lifetime, had an ADL [activities of daily living] self-care deficit, with assist of one for bathing, and is on the secure unit for safety. 4. During a phone interview on 03/17/2025 at 12:57 PM, CNA #3 was asked how long the CNA had been employed with the facility. CNA #3 responded approximately six or seven months. CNA #3 was asked to recount the incident that occurred on 01/29/2025 over to 01/30/2025 on the 11:00 PM-7:00 AM shift. CNA #3 stated, at around 12:00 AM, thinking a bug was seen on Resident #3's bed, Licensed Practical Nurse (LPN) #2 was notified. CNA #3 stated Resident #3 had to have a shower, but before Resident #3 could be given a shower, Resident #2 had to be taken to the toilet. Resident #3 was taken to the shower afterward. CNA #3 stated that Resident #3 was crying, because the resident had been gotten up in the middle of the night and was upset. CNA #3 stated Resident #3 was crying while in the shower. CNA #3 stated their [CNA's] voice was never raised to either one and they didn't jerk a wheelchair. CNA #3 denied any knowledge of why an allegation would have been made without cause. CNA #3 remarked that both CNA #3 and LPN #1 were arguing in front of resident #3. CNA #3 stated, That's when LPN #1 asked me if I needed to leave, and I said yes. CNA #3 denied using profanity in the presence of or to a resident. At no time during the shift did I raise my voice or curse at any of the residents. CNA #3 was asked if yelling at a resident was considered abuse. CNA #3 stating she didn't yell at anyone. CNA #3 was asked again if yelling or speaking loudly to a resident could be considered abuse? Again CNA #3 redirected and denied yelling or speaking loud to a resident. When asked if she had abuse training while in CNA classes, she stated yes, she did. CNA #3 denied having any type of abuse training, after being informed that the employee file had been reviewed and indicated the training for abuse had been documented to have occurred during orientation and again in November. CNA #3 began saying loudly Ok, yes, I had training! Just write it down, I had training alright! It doesn't matter anyway! They'll just say what they want! I ain't got time for this! CNA #3 hung up at that time. CNA #3's employee record was reviewed, and it revealed CNA #3 had abuse maltreatment training during orientation 07/2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility in-service trainings were reviewed and indicated CNA #3 had retraining on abuse and neglect on 11/01/2024, 11/15/2024 and 01/07/2025 with CNA #3's signature indicating understanding of training. During a phone interview on 03/17/2025 at 2:34 PM, LPN #1 was asked how long she had been employed by the facility? LPN #1 responded over [AGE] years and had a total of [AGE] years of experience as a nurse. LPN #1 was asked to recount the incident that occurred on the night of 01/29/2025 going into 01/30/2025 on the 11:00 PM-7:00 AM shift, with Resident #2 and Resident #3. LPN #1 stated, I was called by LPN #2 from my station to check on a concern on the Secure Unit. When I got to the women's Secure Unit, I was walking past the shower and could here CNA #3 yelling loudly from inside. CNA #3 was yelling loudly to whomever was in the shower. LPN #1 denied being able to recall what was said, or if it was understandable, just that it was loud enough to hear through the door. LPN #1 entered the shower and saw that it was Resident #3. LPN #1 was asked if she removed CNA #3 from the resident. I went in and told CNA #3 she needed to calm down. Then LPN #1 stated I asked if she needed to go home? CNA #3 responded, Yes I do., and left. LPN #1 was unsure of the time that CNA #3 left the premises. I went back to the hall to check on LPN #2. And that's when she told me about the incident between CNA #3 and Resident #2. LPN #1 was asked to clarify the statement. LPN #1 confirmed that prior to notifying the Assistant Director of Nursing (ADON) of the incident that occurred between CNA #3 and Resident #3, LPN #1 had been made aware of an incident between CNA #3 and Resident #2 by LPN #2. LPN #1 stated, Yes. LPN #1 was asked if the incident with Resident #2 had been reported to the Assistant Director of Nursing (ADON) when the incident with Resident #3 had been reported. LPN #1 stated, No, I forgot, that's on me, it's my bad. LPN #1 recalled talking with the ADON on the phone, and couldn't recall the conversation, but thought they also discussed the incident with CNA #3. LPN #1 reported that it was several hours later when the ADON was contacted. LPN #1 indicated I got sidetracked and forgot. She was out of the building, and I forgot. CNA #3 was out of the building, so I didn't worry about it. LPN #1 was asked when allegations of abuse should be reported. LPN #1 stated, Immediately, I did not report the allegation to the Administrator immediately. LPN #1 was asked if yelling at a resident would be considered abuse. LPN #1 stated, It wasn't nice, [CNA #3] shouldn't have done it. LPN #1 was asked if yelling at a resident would be considered verbal abuse. LPN #1 responded, I guess it would, yes. LPN #1 was asked when the last time she had abuse/neglect training was. LPN #1 stated, Prior to the incident abuse/neglect training, [AGE] years in long term care I've had lots of training. With my years of experience and training, I know I should have reported the incident immediately. LPN #1's abuse training was reviewed for the last 5 months; retraining was indicated for the following dates: 11/15/2024, 11/18/2024, 01/07/2025, 01/26/2025, 01/28/2025, 02/07/2025, 02/24/2025 and 02/28/2025. Employee Disciplinary Action reports dated 01/31/2025 and 03/04/2025 were reviewed and indicated that on 01/30/2025 and 02/28/2025, LPN #1 was disciplined for failure to report an allegation of abuse immediately. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/17/2025 at 3:23 PM, the ADON was asked to recount the incidents with Residents #2 and #3 that occurred on the night of 01/29/2025 going into 01/30/2025. The ADON recalled being contacted after midnight, maybe around 1:00 AM. LPN #1 informed the ADON that CNA #3 was raising her voice at Resident #3, and that LPN #1 stated she had already sent her packing. The next day the ADON realized there was more to the story. The ADON was asked when she became aware that there was another resident involved. The ADON stated, When I came in, LPN #2 had provided a witness statement to the DON. The ADON was asked if LPN #1 had a habit of not reporting incidents of abuse. The ADON stated, Not really, she calls us all the time. This was a failure to report. I recall that LPN #1 reported at the initial phone call, that CNA#3 was talking loudly. I found out about the incident with Resident #2 that next morning. The ADON was asked when allegations of abuse should be reported. The ADON stated, Immediately, usually to the Administrator, but [LPN #1] called me. I didn't call the Administrator at that time. The ADON was asked when staff were expected to report allegations of abuse. The ADON stated, Immediately, we're constantly in-servicing. During a phone interview on 03/18/2025 at 9:02 AM, LPN #2 was asked to recount the incidents that occurred on 01/29/2025 to 01/30/2025 at around midnight. LPN #2 stated she saw CNA #3 grab Resident #2's wheelchair and rammed it into the toilet area with Resident #2 in the wheelchair. LPN #2 was asked what type of reaction Resident #2 had to this action. LPN #2 stated, Resident #2 started crying. LPN #2 stated then CNA #3 was overheard talking loudly to Resident #2 saying, pull your own [expletive] pants down. When Resident #2 was finished in the restroom, CNA #3 brought Resident #2 out and sat the resident next to the nurse's station. CNA #3 then brought Resident #3 out to the shower. LPN #2 stated the conversation could be heard, and Resident #3 could be heard crying. LPN #2 indicated being able to hear CNA #3 yelling at Resident #3. LPN #2 called for LPN #1. LPN #1 confronted CNA #3 at that time. CNA #3 left the facility. LPN #2 was asked about her nursing experience. LPN #2 stated that she had 7 years of nursing experience. LPN #2 was asked when her last abuse training had been completed. LPN #2 was unsure of the date of the last abuse training. LPN #2 was asked if she knew how to identify suspected abuse. LPN #2 responded Yes. LPN #2 was asked if a staff member yelling at a resident was considered abuse. LPN #2 responded, Yes, in my opinion, verbal abuse. LPN #2 was asked if CNA #3 was separated from Resident #2 when LPN #2 witnessed the incident with Resident #2's wheelchair and CNA #3 yelling at Resident #2. LPN #2 stated No. LPN #2 was asked why she did not stop CNA #3 when she first heard her yelling at Resident #2. LPN #2 responded, It was the first time I dealt with anything like that, I was kind of in shock. LPN #2 was asked how long Resident #2 had been sitting at the nurse's station before CNA #3 brought Resident #3 to the shower. LPN #2 stated, It was only a couple of minutes. LPN #2 was asked if she notified the Administrator or her supervisor of the incident. LPN #2 stated I was instructed to write a statement by LPN #1, who stated she would call the ADON. LPN #2 was asked if an alleged perpetrator should be removed from the facility to protect the residents, according to the abuse training that was provided by the facility. LPN #2 responded Yes. LPN #2 was asked, if CNA #3 had of been stopped or removed after the incident with Resident #2, would the incident with Resident #3 have occurred. LPN #2 responded, Probably not, that's why I went and got help. LPN #2 was asked if Resident #3 protected by the facility. LPN #2 responded, No ma'am. LPN #2's employee records were reviewed and indicated LPN #2 received abuse/maltreatment training on 01/26/2025, 01/28/2025, 02/7/2025 and 02/28/2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/18/2025 at 10:37 AM, the Director of Nursing (DON) stated she had been with the facility for 3 weeks but had [AGE] years of other nursing experience. The DON was asked to name the types of about, as outlined in the facility policy. The DON stated, verbal, sexual, financial, and injury of unknown origin. The DON was asked when suspected abuse should be reported. She stated immediately, it should be reported it to the charge nurse, and up the chain of command. The DON was asked what the procedure was for when abuse is suspected. The DON's response was to keep the resident safe, separate the alleged perpetrator and the resident. The DON was asked if abuse was witnessed, and if the alleged perpetrator wasn't removed, if that would protect the resident. The DON responded, No. The DON was asked if employees were expected to follow the facility policy. She responded, I expect it. If staff witness abuse, the DON stated she would expect the nurse to protect the resident. The DON stated yelling at a resident was a form of abuse, and she would expect it to be reported immediately and remove the staff immediately. During an interview on 03/18/2025 at 11:03 AM, the Administrator was asked what was considered abuse. The Administrator responded, according to the facility policy abuse/neglect, anything done with willful intent against the resident, the willful intent of injury was considered abuse. The Administrator was asked when abuse should be reported. The Administrator stated that abuse should be reported immediately upon any allegation. The Administrator was asked if yelling at a resident would be considered abuse. The Administrator stated, yelling at a resident to me is abuse. The Administrator was asked if facility staff witnessed another staff member yelling or screaming at a resident and using profanities would be considered abuse. The Administrator stated, Yes, and they should report the incident. The Administrator was asked if a staff member witnessed abuse what would be the process for protecting the residents. The Administrator stated, To protect, then report, make sure the resident is safe, get the staff member away from the resident. The Administrator was asked if a staff member didn't remove the perpetrator when abuse was witnessed, was that behavior protecting the resident. He responded No.