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	05/23/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42016 43262 Based on observation, record review, and interview it was determined the facility failed to ensure a Resident who was lying in bed wearing only a brief, and a Resident who was receiving a brief change with perineal care, were not visually exposed from the hall in order to maintain dignity and privacy for 2 (Resident #7 and Resident #88) of 2 sampled residents reviewed who required total assistance. The findings include: 1. Resident #7 had diagnoses (dx) of Cerebral Palsy, Calorie Malnutrition. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/10/2024 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS). On 05/20/24 12:03 PM during initial rounds, Resident #7 was observed lying in bed on back, fully uncovered with only a brief on. The Resident's door was open to the hallway and the privacy curtain was not pulled closed. On 05/20/24 3:55 PM, Resident #7 was observed lying in bed on back fully uncovered, wearing only a brief. Certified Nursing Assistant (CNA) #9 walked past the Resident's room, looked in and continued down the hallway. On 05/20/24 3:56 PM, the nurse consultant walked past Resident's room, briefly paused, and looked in the room. Resident #7 was uncovered, only wearing a brief. The nurse consultant continued down the hallway looking in each room. On 05/20/24 3:58 PM, Certified Nursing Assistant (CNA) #1 was observed standing in doorway of room [ROOM NUMBER], across the hall from Resident #7. CNA #1 looked in Resident # 7's room then turned around and went back into another room. On 05/20/24 3:59 PM, the Surveyor observed the nurse consultant walk back up the hallway, look in Resident #7's room again for a moment, then continue toward the end of the hallway and stopped at the nurses' station. A staff member left the nurses' station and walked to Resident #7's room, paused before entering, entered and immediately pulled the privacy curtain. (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: 045345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/24 4:01 PM, the surveyor entered the room and the Business Office Manager (BOM) identified herself. The BOM said I pulled the privacy curtain, (Resident's name) always kicks the covers off. I put the covers back on to promote the Resident's dignity. On 05/23/24 9:47 AM, Registered Nurse (RN) #18 was asked if you observed a Resident in bed wearing only a brief, what would you do? RN #18 said I would cover the Resident up, put on a gown or ask the aid to take care of the situation for privacy and dignity. On 05/23/24 10:30 AM, the Director of Nurses (DON) asked if you observed a Resident in bed wearing only a brief, what would you do? The DON said, if you are talking about (Resident's name), that Resident is care planned to not use covers and Resident is scared to have the curtain pulled. The Surveyor asks How do you know Resident is scared to have the curtain pulled when Resident is nonverbal? The DON said, the Resident starts screaming when the curtain is pulled. For other residents, unless its care is planned differently, I would cover the Resident up or pull the privacy curtain to promote dignity. Review of Resident #7's Plan of Care saved on 5/20/24 at 12:42 PM did not mention Resident #7 preference to be uncovered or have the privacy curtain pulled. 2. A review of the Admission Record, indicated the facility admitted Resident #88 with diagnoses that included Signs and symptoms involving cognitive functions and awareness, arthritis, osteoarthritis, weakness, lack of coordination unsteadiness on fee, reduced mobility problems related to life management difficulty. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2024, revealed Resident #88 had a Staff Assessment of Mental Status (SAMS) score of 3 which indicated the resident had severe cognitive impairment. Resident #88 was dependent on staff for all activities of daily living (ADL), including toileting transfer and hygiene. A review of Resident #88's Care Plan, revised, revealed the resident has an ADL self-performance deficit related to confusion and dementia. Resident #88 is incontinent of bladder and always incontinent of bowel and wears disposable briefs. Interventions included, requires extensive assistance of 1 staff to check for incontinence, change brief, and perform peri care assistance. During an observation on 05/21/2024 at 9:24 AM, Certified Nursing Assistant (CNA) #7 and CNA #8 had removed Resident #88's clothing and brief, performing peri care. CNA #10 knocked on door, opened without response stepped into room, immediately exited room, leaving the door open. CNA #8 stated CNA #10 just left the door so there is no privacy. CNA #7 replied, I know. CNA #8 closed the door. During an interview on 05/21/2024 at 9:33 AM, CNA #10 indicated the door was not pulled closed due to forgetfulness and should have closed the door to provide privacy. On 05/22/2024 at 12:41 PM, the DON provided a document stating, We do not have a policy on peri care. During an interview on 05/23/2024 at 2:19 PM, RN #12 stated staff should be providing privacy, closing shades, pulling curtains, and closing doors when providing care that exposes a resident.

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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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 42016 Based on interviews and record review, the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 (Resident #83) of 1 resident reviewed for abuse. Specifically, the facility failed to protect Resident #83 from a resident with known behaviors, Resident #19, which resulted in Resident #83 being hit by Resident #19 hard enough in the back of the head to move Resident #83 out of their wheelchair. Findings include: A review of the Admission Record indicated the facility admitted Resident #83 with diagnoses that included cerebral infarction, vascular dementia, other speech, and language deficits following other cerebrovascular disease, lack of coordination, cognitive communication deficit, and amnesia. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/01/2024 revealed Resident #83 had a Staff Assessment of Mental Status (SAMS) score of 2, which indicated the resident was moderately cognitively impaired for daily decision making. Resident #83 used a wheelchair for ambulation, required setup/cleanup assistance with eating and was dependent on staff for oral hygiene, toileting hygiene, bathing, dressing, and personal hygiene. A review of Resident #83's Care Plan, revised 05/19/2023, revealed the resident had a history of trauma that included trauma related to confusion and dementia. Interventions included staff providing trauma-informed care to eliminate or mitigate triggers that may cause re-traumatization. Resident #83 has impaired cognitive function or impaired though processes. Interventions indicate to cue, reorient, and supervise as needed. Resident #83 had the potential for communication problems. Interventions include anticipate and meet needs. Ensure/Provide a safe environment. Resident #83 used antianxiety medications related to anxiousness. Interventions included to monitor for safety. Review of a SBAR (Situation Background Appearance Review and Notify) Communication Form, dated 02/26/2024, revealed Resident #83 was observed and being evaluated for Other change in condition after another resident, Resident #19 slapped Resident #83 on the back of Resident #83's head. Review of a Progress Notes New, dated 02/26/2024 at 1:15 PM, revealed that [Resident #19] was walking through the dining room and slapped another resident [Resident #83] in the back of his/her head, hard enough that it made the resident [Resident #83] lift his bottom out of his wheelchair .staff intervened before anyone else got hit. The Resident that slapped the Resident in the back of his head was put on a one on one. Notified DON [Director of Nursing]. Review of a Privileged and Confidential document, dated 02/26/2024 at 1:06 PM, revealed Resident #83 was sitting in their wheelchair in the dining room when another resident slapped Resident #83 on the back of Resident #83's head, hard enough that Resident #83's bottom lifted out of the wheelchair. A review of eINTERACT Change in Condition Evaluation V5 dated 02/27/2024 at 10:23 AM revealed Resident #19 slapped Resident #83 on the back of Resident #83's head. Responses to evaluation status for skin and pain were answered as Not clinically applicable to the change in condition being reported. (continued on next page)

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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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the Admission Record, indicated the facility admitted Resident #19 with diagnoses that included cerebral infarction, vascular dementia with agitation, bipolar disorder, delirium, aphasia, restlessness, and agitation. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/27/2024 revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Section E, - Behavior revealed physical behavioral symptoms directed toward others such as hitting, kicking, and pushing occurred 1 to 3 days during the review period. Resident #19's behaviors put others at significant risk for physical injury and change in behavior such as behavior status worsened during the review period. A review of Resident #19's Care Plan, revised 07/26/2022, revealed the resident hads the potential for behavior problem related to hitting, kicking, and pushing others when upset. Interventions included to intervene as necessary to protect the rights and safety of others refer to psychiatry as needed: monitor/record occurrence of target behavior symptoms including violence/aggression towards others. A review of Progress Notes New, dated 02/26/2024 at 9:50 AM, for Resident #19, revealed a Late Entry Situation: The Change in Conditions .are/were: Behavioral symptoms A review of Progress Notes Type: eINTERACT SBAR Summary for Providers, with an effective date of 02/26/2024 at 9:50 AM, revealed Resident #19 had a change in condition identified as behavioral symptoms. A review of Progress Note New with an effective date 02/26/2024 at 1:03 PM, indicated Resident #19 was walking through the dining room and slapped Resident #83 in the back of Resident #83's head, hard enough that it made the resident lift their bottom out of their wheelchair. A review of Progress Note, dated 2/27/2024 at 1:01 PM, revealed Resident #19 status as one on one meaning one staff member was assigned to the resident for observation. A review of Progress Note dated 02/27/2024 at 1:55 PM, revealed Resident #19 required care for behaviors and aggression. Review of a Progress Note with effective date of 04/02/2024 indicated Resident #19 was readmitted from senior care with the same negative behaviors .trying to go into another resident room .does not respond to redirecting .becomes angry .threatens . A review of Privileged and Confidential, untitled document, dated 02/26/2024 at 12:49 PM, revealed Resident #19, was walking through the dining room and slapped another resident in the back of their head, hard enough that it made the resident lift their bottom out of their wheelchair. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/22/2024 at 3:32 PM, the Director of Nursing (DON) and Administrator were asked when the DON was notified of the resident-to-resident altercation involving Resident #19 and Resident #83. The DON responded, This was not abuse. Resident #19 has a BIMS of 3 and there was no injury so Resident #19 hadn't known what they were doing. The surveyor asked, There was contact between the residents, correct? The DON stated, If we thought this was abuse it would have been reported. The Administrator stated, We would do a reportable, that is obvious we do them, we gave you a stack. The DON stated that body audits were done, and the residents separated, If there is no red place, we do an I&A (incident and accident) and we don't do a reportable. The surveyor asked how notification is made regarding incidents involving residents. The DON stated staff notifies the DON when it happens and if there is no injury an I&A is done. The surveyor asked if one resident willfully striking another resident, could this be considered abuse. The DON stated, I feel this is not abuse. No one had any marks. If I thought this was abuse, I would have done a reportable. The DON was asked to clarify the statement that one resident willfully striking another is not abuse. The DON stated, They bump each other all day long. If I reported every bump into each other, I would be reporting 20 a day. The surveyor relayed that the documentation on the event indicated Resident #19 was walking through the dining room and slapped Resident #83 hard enough that the resident was lifted up in the wheelchair. The DON stated, That is exaggerated. If the resident was not seated all the way or leaning, could have been trying to stand up. So, you are saying that if I tap the Administrator like this, (the DON tapped the side of Administrator's head) that is abuse? There were no marks. Male residents walk by each other all the time and tap each other on the head. Is that abuse? The surveyor was unable to continue due to the interview taking on an adversarial tone.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42016 Based on observations, interviews, record review, and facility document review, it was determined the facility failed to ensure supervision of a cognitively impaired resident at risk for choking for 1 (Resident #91) of 2 residents observed during in room meal service. Findings include: A review of the Admission Record, indicated the facility admitted Resident #91 with diagnoses that included early onset Alzheimer's Disease, mild protein-calorie malnutrition, psychosis, dementia unspecified severity, depression, lack of coordination, cognitive communication deficit, need for assistance with personal care. The Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/15/2024, revealed Resident #91 had a Brief Interview for Mental Status (BIMS) score of 1 which indicated the Resident had severe cognitive impairment. Resident rarely had feelings of social isolation, did not refuse care, requires set up and clean up assistance with eating, oral hygiene, toileting, and bathing, and had no swallowing or nutritional deficits. A review of Resident #91's Care Plan, revised 03/30/2023, revealed Resident had a potential for nutritional problem. Interventions included general diet, pureed texture; monitor/document/report to MD (Medical Director) PRN (as needed) for s/sx (signs/symptoms) of dysphagia (difficulty swallowing): pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, appears concerned during meals; prefers food to be in bowls; need food and fluids offered. Revised 08/10/2023 revealed the resident had an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) dementia and requires set up and supervision with eating. A review of Order Summary Report, revealed Resident #91 had a dietary order for general diet, pureed texture, thin liquids consistency, small bowls for each meal; ST to treat . treatment to include dysphagia therapeutic exercises, therapeutic activities until 07/31/2024. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A review of the Speech Therapy SLP (Speech Language Pathologist) Evaluation and Plan of Treatment, dated 05/16/2024, indicated the SLP evaluated and began treatment for Resident #91, per a physician referral to assess/treat dysphagia and swallow function. The evaluation indicated diagnoses of Alzheimer's disease with early onset and dysphagia, pharyngeal phase. Prior level of functioning (PLOF) indicated Swallowing Abilities = Min/Close Supervision. Patient behaviors are documented as reduced recognition of routine/tasks. Strategies during oral intake included alteration of liquids/solids, alteration of tastes and temperatures, upright posture during meals and for greater than 30 minutes after meals. Treatment approaches of swallowing dysfunction and/or oral function for feeding, eval (evaluation) of oral and pharyngeal swallow function. Goals, with a target date of 05/30/2024, included, .increase ability to initiate . swallowing to within functional limits (WFL) to facilitate ability to consume intake with decreased supervision of caregivers; increase ability to safely swallow .demonstrate increased sensory responses .to enhance patient's ability to safely swallow without sighs/symptoms of dysphagia .and, improve functional swallowing abilities .from max (maximum) to min-mod (minimum-moderate) impairment level .target date 07/12/2024. Precautions/Contraindications are listed as confusion and swallow precautions in place on 05/15, 5/16, 5/20, and 05/21/2024. SLP evaluation on 5/22/2024 at 10:12 AM, documented changes of, Supervision for intake: Current Value changed from Close Sup to Occ Sup. During an observation on 05/20/2024 at 1:31 PM, Resident #91 served meal in room, food in bowls. Staff did not remain in the Resident's room. During an observation on 05/20/2024 at 1:58 PM, Resident #91 was alone in room, stood up from chair, picked up fork from a bowl and scraped the bottom of the bowl making a scratching sound, placed fork in mouth, then back into bowl, sat back down in chair. Resident # 91 repeated this action several times. Picked up tray card and placed it on top of dresser, walked to bed, and laid down. A review of Resident #91's tray card (paper on tray with meal), documented, . Adap.Equip (Adaptive Equipment): All food in Bowls . During an observation on 05/21/2024 at 08:29 AM, Certified Nursing Assistant (CNA) #7 placed food on Resident #91's overbed table and told Resident to get up to eat. CNA #7 left the room and continued passing trays. At 08:33 AM, Resident #91 stood up from bed and stood between brown chair and overbed table, picked up spoon and began to eat the meal. During an observation and interview on 05/21/2024 at 08:40 AM, CNA #8 was asked to enter Resident #91's room and identify what meal bowls contained. CNA #8 was familiar with the Resident and was not aware this Resident required monitoring or assistance. CNA was aware of the Resident standing using the fork and spoon to scrape bowls but did not know if that indicated a need for additional food. During an interview on 05/22/2024 at 9:16 AM, the Director of Nursing (DON) stated the resident should not be left in the room alone if they have dysphagia due to possible choking. During an interview on 05/22/2024 at 10:00 AM, SLP #20 indicated Resident #91 is receiving services at this time and will provide initial assessment and notes. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 05/22/2024 at 11:30 AM, SLP #20 stated Resident #91 was eating less and a CNA notified their nurse, who notified therapy. Evaluation and Plan of Care are Communicated from therapy, it goes to a nurse, and then to the CNAs. Clarification of assessment changes dated 05/22/2024 at 10:14 AM, Supervision for intake: Current Value changed from Close Sup to Occ Sup Resident #91 needed 1:1 supervision with meals and now needs occasional supervision. The Resident should be in the dining room for observation. The staff are not required to sit with the Resident for the entire meal but be able to look over to ensure there are no issues with intake, as Resident #91 has difficulty recognizing food on the plate. When food is in bowls Resident does much better at recognizing it as food to be eaten and ensuring there are no swallowing difficulties or choking. The resident should not be alone in their room.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48630 Based on observations, interviews, record review, facility document review, and facility policy review, it was determined that the facility failed to ensure prescribed medications remain with the nurse for a Resident who is not assessed to self-administer medications for 1 (Resident #31) of 1 Resident reviewed for medications left at the bedside. Findings include: A review of a facility policy titled, Label/Store Drugs and Biologicals, dated 12/26/2022, indicated, Medication will not be stored in a Resident room unless the Resident has been approved for self-administration of medication. If approved, the Resident will be provided with a lockbox to safely store medications. Residents will not order and store medications without the DON (Director of Nursing) approval. A review of the Order Summary Report, indicated the facility admitted Resident #31 with diagnosis that included Chronic Obstructive Pulmonary Disease. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/22/2024, revealed Resident #31 had a Brief Interview of Mental Status (BIMS) score of 12 which indicated the Resident was cognitively intact. A review of Resident #31's Care Plan, revised, revealed the Resident has asthma. Interventions included giving medications as ordered. Monitor/document side effects and effectiveness on 12/22/2023. A review of Order Summary Report, revealed Resident #31 had an order for (named) Inhalation Aerosol Powder Breath Activated (Albuterol Sulfate) 2 puff inhale orally every 6 hours as needed for wheezing/COPD (Chronic Obstructive Pulmonary Disease) .wait at least 1 min between puffs During an observation on 05/20/2024 at 1:51 PM, Surveyor observed an albuterol inhaler on the bedside table of Resident #31 with Resident #31's name on it. During an observation on 05/20/2024 at 4:32 PM, Surveyor observed a second time the same albuterol inhaler on the bedside table of Resident #31 with Resident #31's name on it. During a concurrent observation and interview on 05/20/2024 at 4:35 PM, Registered Nurse (RN) #19 confirmed there was an Albuterol Inhaler on Resident #31's bedside table and the name on it was Resident #31's. The Surveyor asked, What is your facilities policy on self-administration of medications? RN #19 stated, Some Residents are care planned to self-administer medications, I am unsure if Resident #31 is care planned to self-administer medications. RN #19 confirmed that it is important that they are assessed to self-administer, and care planned because they can take too much of the medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/23/2024 at 1:34 PM, the Director of Nursing (DON) confirmed there are no residents in the facility assessed to self-administer medications and specifically Resident #31 is not assessed to self-administer medications. The DON added that it is important for the medications to stay at the nurse's station with the nurses for the safety of the Residents.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 03508 Based on observation and interview, the facility failed to ensure that pureed food items were blended to a smooth, lump free consistency to minimize the risk of choking or other complications for those residents who required pureed diets for 2 of 2 meals observed. The failed practice had the potential to affect 6 residents who received pureed diets. The findings are: 1. On 05/22/24 at 11:22 AM, Dietary Cook #14 used 4-ounce spoon to place 5 servings of cut green beans into a blender, pureed, added 2 tablespoons of thickened, pureed, added 4 more tablespoons of thickened, and pureed. At 11:32 AM, Dietary Cook # 14 added a tablespoon of thickened on cut green beans and pureed it more. At 1:33 AM, she poured the pureed cut green beans in the same pan. She covered the pan with foil and placed it in the oven. The consistency of the pureed cut green beans was running and not formed. 2. On 05/22/24 at 11:52 AM, Dietary Cook #14 used a 6-ounce spoon to place 4 servings of chili into a blender, added a tablespoon of thickener, added beef broth, and pureed. At 11:57 AM, Dietary Cook # 14 poured the pureed chili into a pan. At 11:58 AM Dietary Cook # 14 used a 6-ounce spoon to place 3 servings of chili into a blender, added 2 tablespoons of thickener and pureed. At 12:02 PM, Dietary Cook #14 poured the pureed chili into a pan using a 6-ounce spoon to place 3 servings more of chili into a blender, added 2 tablespoons of thickener and pureed. On 05/22/24 at 12:06 PM, Dietary Cook #14 poured the pureed chili in the same pan. Covered the pan with foil and placed it in the oven. The consistency of the pureed chili was thin and not formed. 3. On 05/23/24 at 8:15 AM, during the breakfast meal observation the residents who required pureed diets were served the following food items. a. Pureed sausage was gritty and not smooth. b. Pureed oatmeal was thin and was not formed. 4. On 05/23/24 at 8:20 AM, the surveyor asked the Dietary Supervisor to describe the consistency of the pureed food items served to the residents on pureed diets at the lunch meal on 05/22/24 and breakfast meal on 05/23/24. She stated, For lunch yesterday. Pureed chili pureed cut green beans were thin. Pureed oatmeal was thin and pureed sausage was gritty. 5. On 05/23/24 at 8:25 AM, the surveyor asked Dietary Cook #16 to describe the consistency of the pureed sausage served to the residents on pureed diets. Dietary cook # 16 stated, It was gritty.

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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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation and interview, the facility failed to ensure food items stored in the freezer were covered or sealed to prevent potential freezer burn; expired food items were promptly removed/discarded by the expiration or use by dates; one of 2 ice scoops and 1 of 2 ice machines were maintained in clean and sanitary condition to prevent food and beverages contamination; staff washed hands prior to clean tasks and before handling clean equipment or food items to minimize the potential for contaminating food items; and cold food items were maintained at or low 41 degrees Fahrenheit while awaiting service to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. This failed practice had the potential to affect 104 residents who received meals from the kitchen. The findings are: 1. On [DATE] at 9:15 AM, the following observations were made on a shelf in the refrigerator. a. A gallon of 2 % milk with an expiration of [DATE]. b. Two of 2 gallons of 2 % milk in the milk crate had expiration date of [DATE]. 2. On [DATE] at 9:18 AM, an opened box of French toast was on a shelf in the walk-in freezer. The box was not covered, and the bag was not sealed. 3. On [DATE] at 9:27 AM, the ice scoop on the right side of the ice machine has brown/black corroded water standing in it. The ice scoop was touching the residue. The surveyor asked the Dietary Supervisor to describe what was found in the ice scoop holder. She stated, It was a brown standing water gunk goo. The surveyor asked the Dietary Supervisor how often the ice machine is cleaned and who uses the ice from the machine? She stated, We use it to fill the beverages served to the residents at mealtimes. We clean it daily. 4. On [DATE] at 9:55 AM, Dietary Cook #13 wore gloves on her hands, when she picked up a can of peach halves and placed it on the counter. Without washing her hands, she picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents on pureed diets. The surveyor asked Dietary Cook #13, what should you have done after dirty objects and before handling clean equipment? She stated, I should have washed my hands. 5. On [DATE] at 10:10 AM, Dietary Cook #14 lifted a metal rack meant for holding individual snack bags and set it on the counter between the and the steam table. Taking off the [NAME] papers covering the pans of cornbread, disposed of them in the trash, then grabbed gloves from the box, she donned them, contaminating them. Finally, she picked up the cornbread and packed them into separate bags. 6. On [DATE] at 10:44 AM, Dietary Aide #15 touched his beard cover and without washing his hands, he picked up a clean bade and attached it to the base of the blender to be used in pureeing food items to be served to the residents on pureed diets. (continued on next page)

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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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. On [DATE] at 11:12 AM, Dietary Aide #15 pushed a plate warmer towards the clean area of the dish washing machine, without washing her hands. He picked up plates and placed them on the plate warmer to be used in portioning lunch meal to be served to the residents. 8. On [DATE] at 12:31 PM, the temperatures of the food item when tested and read by the Dietary Cook #14 were pureed corn bread with milk 112 degrees The above food item was not reheated before being served to the residents on pureed diets. 9. On [DATE] at 1:36 PM, the temperatures of the cold food items were tested and read by the Dietary Supervisor as follows: a. Cottage cheese 50 degrees Fahrenheit. b. Turkey with cheese sandwiches 55 degrees Fahrenheit. c. Turkey salad with cheese 60 degrees Fahrenheit. The surveyor asked the Dietary Supervisor how you should serve the cold foods? She stated, Put them on ice or in the refrigerator before serving them. 10. On [DATE] at 3:33 PM, the inside top panel of the ice machine had wet black residue on it. The surveyor asked the Dietary District Manager to wipe the wet-colored substances found on the panel. He did with tissue paper. The wet black substances easily transferred on the tissue papers. The surveyor asked the Dietary Manager who uses ice from the ice machine and how often the ice machine has been cleaned. She stated, We clean it biweekly. We use it to fill beverages served to the resident at mealtimes. 11. A facility policy titled Hand washing under when to wash hands documented, When entering the kitchen at the start of a shift. Before donning disposable gloves for working with food and after gloves are removed and after engaging in other activities that contaminate the hands.

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide and implement an infection prevention and control program.

42016

49071

Based on observations, interviews, and record review, it was determined that the facility failed to ensure proper hand hygiene was performed during perineal care for 1 (Resident#88) of 1 Resident reviewed for perineal care; and to ensure proper hand hygiene was performed during medication pass, and meal and beverage service.

Findings include:

A review of a facility policy titled, Policies and Procedures, with a revised date 11/03/2022, indicated, . 7. Prevention of Infection a. Important facets of infection prevention: (3) educating staff and ensuring that they adhere to proper techniques and procedures . (7) following established general .guidelines such as those of the Centers for Disease Control (CDC) .

A review of the facility's document titled, Staff In-Service Sheet, dated 05/22/2024, indicated the information provided was when performing peri-care . you must put sanitizer in a med cup to use in between dirty glove change to clean gloves. The signatures included CNA #7 and CNA #8.

A review of the facility document titled, Handwashing, dated 10/31/2023, contained signatures for Certified Nursing Assistant (CAN) #7 and CNA #8.

A review of the facility document titled, Staff In-Service Sheet, dated 05/16/2024, indicated the information provided was Handwashing - going in and out of room use hand sanitizer. Use soap & water if hands are soiled ., that contained signatures of CNA #7 and CNA #8. This Inservice contained an attachment from the Center for Disease Control (CDC) titled, Handwashing in Communities: Clean Hands Save Lives. Page 4 of the attachment, Hand Hygiene and Healthcare Settings indicates, . Alcohol-based hand sanitizers effectively reduce the number of germs that may be on the hands of healthcare workers. Healthcare personnel often clean their hands more than 7 times an hour.

A review of the Admission Record, indicated the facility admitted Resident #88 with diagnoses that included signs and symptoms involving cognitive functions and awareness, arthritis, osteoarthritis, weakness, lack of coordination unsteadiness on fee, reduced mobility problems related to life management difficulty.

The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/26/2024, revealed Resident#88 had a Staff Assessment of Mental Status (SAMS) score of 3 which indicated the Resident had severe cognitive impairment. Resident #88 was dependent on staff for all activities of daily living (ADL), including toileting transfer and hygiene.

A review of Resident #88's Care Plan, revised, revealed the Resident has an Activities of Daily Living (ADL) self-performance deficit related to confusion and dementia. Resident #88 is incontinent of bladder and always incontinent of bowel and wears disposable briefs. Interventions included, requires extensive assistance of 1 staff to check for incontinence, change brief, and perform peri care assistance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 05/21/2024 at 9:24 AM, CNA #7 and CNA #8 entered Resident #88's room to perform a brief change and provide perineal care. Gloves were placed on by CNAs, without hand hygiene. CNAs removed Resident's soiled brief and clothing. CNAs changed gloves and did not perform hand hygiene. CNA #7 closed the Resident's room door and did not perform hand hygiene or change gloves after touching door. The CNAs did not perform hand hygiene or change gloves when moving from dirty to clean tasks. During an interview on 05/21/2024 at 9:38 AM, CNA #7 stated they should be sanitized before gloving and when changing gloves, but we do not have any sanitizer in the rooms and would have to leave the room and the Resident unattended. CNA #7 stated they were told by the facility; individual sanitizer could not be carried in their pockets. On 05/21/2024 at 9:40 AM, CNA #7 and CNA #8 asked Registered Nurse (RN) #12 how they were supposed to sanitize during care without sanitizer in the room. RN #12 responded, You use the ones in the hallway. CNAs pointed out that would require them to leave the Resident several times during care to exit the room. RN #12 indicated an answer would be obtained. During an interview on 05/22/2024 at 8:55 AM, the Director of Nursing (DON) and RN #12 were asked about staff performing hand hygiene during peri care. The DON stated sanitizers were not in the resident rooms because residents would drink them and corporate does not allow small bottles of sanitizer due to cross contamination. RN #12 stated in services were started on performing hand hygiene. The DON stated staff will be taking in a medication cup of hand sanitizer to use in the room and must wrap it in a glove to dispose of it, so residents do not have access to it. During an observation of meal and beverage service on 05/20/2024 at 1:12 PM, CNA #7, #8, and #9 were providing meals and beverages without hand hygiene or the use of gloves. CNA #7 spilled tea on the beverage cart, while pouring tea for a resident, placed 1 packet of powdered sweetener into the cup. A portion of sweetener missed the cup and was sprinkled onto the top of the cart, in the spilled tea. CNA used a white plastic spoon to stir sweetener and tea. CNA #7 then placed the spoon on top of the cart in the spilled fluid and powdered sweetener. At 1:13 PM, CNA #7 poured coffee into a cup and splashed onto the top of the beverage cart. CNA #7 added 1 packet of sugar granules to the cup. A portion of the sugar missed the cup and was sprinkled onto the top of the cart, in the spilled tea, coffee, and sweetener. CNA #7 picked up a second white plastic spoon and stirred the coffee, laid the spoon on top of the beverage cart in the spilled fluids. CNA #7 did not clean the top of the beverage cart during the beverage pass to residents on 100 hall. CNA #7 did not perform hand hygiene upon entry or exit of resident rooms during the beverage pass. During observation on 05/20/2024 at 1:14 PM, CNA #8 did not perform hand hygiene upon entry or exit of resident rooms, while providing meal trays on 100-hall. During observation on 05/20/2024 at 1:41 PM in the 100-hall dining room, CNA #7, #8, and CNA #9 opened resident milk cartons, with ungloved hands, touching the area where residents place their mouth to drink. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA #9 opened a carton of milk, using an ungloved hand, touching the area where resident places mouth to drink. CNA #9 put index finger of right hand inside carton to fully pull open, at top of carton indicated by OPEN and outlined arrow. Resident placed mouth directly on the carton, drank all the milk. No straw was provided or used. During an interview on 05/21/2024 at 2:56 PM, Surveyor asked CNA #8, if hands should be sanitized during meal service, when serving trays and beverages, to residents who choose to eat in their rooms and to residents served in the dining room. CNA #8 stated hands should be sanitized all the time when going in and out of rooms, and when serving in the dining room to prevent contamination. Surveyor asked CNA #8 if the beverage cart should be kept clean, spoons used to stir coffee and tea should be left on the top of the beverage cart, laying in spilled artificial sweetener, sugar, creamer, coffee, and tea, and then reused to serve beverages to other residents. CNA #8 stated it should be clean, and the utensils should be cleaned and put in a cup not laid on the cart to prevent cross contamination. Surveyor asked CNA #8 if the CNAs hands should be touching the opening of a milk carton or placing a finger in the carton to fully extend the opening, where a resident's mouth touches it, to drink the milk. CNA #8 stated if it is necessary to touch the area, gloves should be worn so there is no contamination of the milk. On 05/21/2024 at 2:43 PM, Surveyor asked CNA #7 if hands should be sanitized during meal service, when serving trays and beverages, to residents who choose to eat in their rooms and to residents served in the dining room. CNA stated, We were told every 3rd tray sanitize or wash. Surveyor asked CNA #8 if they performed hand sanitation during meal and beverage service. CNA #8 stated they did not, and it should be done, because you do not know if someone has something that we do not know about and spread it. Surveyor asked CNA #8 if the beverage cart should be kept clean, spoons used to stir coffee and tea should be left on the top of the beverage cart, laying in spilled artificial sweetener, sugar, creamer, coffee, and tea, and reused to serve beverages to residents. CNA #8 stated it should have been wiped and not left on the cart due to cross contamination. Surveyor asked CNA #8 if the CNAs hands should be touching the opening of a milk carton or placing a finger in the carton to fully extend the opening, where a resident's mouth touches it, to drink the milk. CNA #8 stated a fork should be used to open the carton and wearing gloves to touch the area. During an interview on 05/22/2024 at 9:34 AM, the DON stated to prevent infection, staff should be sanitizing hands before serving resident trays, immediately cleaning the top of the beverage cart if coffee, tea, or condiments are spilled, and opening milk cartons using a fork, not fingers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/20/24 at 1:05 PM Certified Nursing Assistants (CNA) #1, #2, #3, and #4 were observed removing a tray from the tray cart without sanitizing hands before pulling tray. CNA's #1, #2, #3, and #4 set up the tray and opened condiments, milk cartons, and returned to tray cart to obtain a tray for another resident. Surveyor observed CNA #1 and CNA #3 open milk cartons with their fingers touching the top of carton where a resident would drink from. Each CNA went down the hall with tray cart to pass trays to the residents who were in their rooms after serving in dining room. CAN #1, # 2, #3, and #4 removed a tray from the cart without sanitizing hands and took the tray into the Resident's room, set the tray up opened the Resident's condiments, and opened the milk carton with their hands, pulling it open touching the top where the Resident would drink from with their hands, then came out of Resident's room and obtained another tray without sanitizing hands. On 5/20/24 at 1:23 PM, Surveyor asked CNA #1, what could you have done differently before beginning to pass trays? CNA 1 replied, sanitize my hands. What could you have done differently in between passing trays to different residents? CNA# 1 replied, sanitize my hands. Can you explain the proper way to open a milk carton. CNA#1 replied, pull back with both hands and squeeze the outside of the top so it pulls away, and creates an opening for them to drink from. The Surveyor asked should someone's finger ever touch the inside of the carton where the resident drinks from? CNA#1 replied, no it shouldn't. Can you explain the importance of sanitizing your hands CNA #1 replied, to prevent spreading germs. On 5/20/24 at 1:25 PM, Surveyor asked CAN #2, what could you have done differently before beginning to pass trays and open condiments? CNA #2 replied, sanitize my hands. What could you have done differently between passing trays from one resident to another? CNA #2 replied, sanitize my hands.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation, record review, and interview the facility failed to ensure an effective pest control program was maintained to keep the facility free of pests. This failed practice had the potential to affect 110 residents. The findings are: 1. 05/22/24 at 9:13 AM, the following observations were made during noon meal preparation in the kitchen. a. There were 2 flies on a pole attached to the food preparation counter. b. One fly was at the back of a spoon hanging on the metal bar over the counter. The surveyor pointed it out to the Dietary Supervisor who then removed the spoon and took it to the dish washing machine to be washed. 2. On 05/22/24 at 9:32 AM, the following observations were made around the area where dessert for the noon meal were being prepared. a. A fly on top of the bread bag located on the counter. b. Two flies on the counter where bowls of plated dessert were kept. c. One fly was on a utility food cart where plated covered dessert bowls were stored. 3. On 05/22/24 at 9:57 AM, a fly was on top of the steam table bar. Another fly was at the edge of the wood facing above the steam table. 4. On 05/23/24 at 10:28 AM, the following uncovered serving spoons were hanging on a metal utensil hanging board. a. Eleven uncovered serving spoons. b. One spatula. c. Two sifter. d. Four whisks. e. One funnel. f. One perforated spatula and a tong. There was a fly at the back of a sauce and a fly on a ladle spoon. The surveyor asked the Dietary Supervisor how long has there been a problem with flies? She stated, It started with weather changing. I took some of the utensils down yesterday and washed them. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	5. Inspection report provided 03/15/2024 at 2:03 AM Comment: I inspected the interior and exterior of the building for rodent and pest activity. Cleaned and rebated rodent [NAME] stations (5). Treated cracks and crevices for occasional invaders. C/B for roaches in CAN closet. Flies were not reported. 6. Pest Elimination Service provided 04/04/24 at 2:28 PM documented, The monthly pest control service and inspection was performed today. All exterior bait stations were inspected, cleaned, dated, and bait was replaced where needed. Treated and replaced all glue boards in areas with roach findings. Target: Pest. Flies were not reported. 7. Pest Elimination Service Provided 05/17/24 at 9:41 AM documented, The monthly pest control service and inspection. Location- baseboards, breakrooms, common area, entry points, kitchen, lobby, offices, and restrooms. Target pests- ants, beetles, crickets, spiders, and wasps. Flies were not reported.