STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045359	A. Building B. Wing	03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Cumberland Rehab & Nursing Center	1516 Cumberland St Little Rock, AR 72202

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37634 Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to prevent resident abuse for 2 (Resident #1 and Resident #2) of 6 residents reviewed for abuse. The findings include: A review of a facility policy titled, Resident Rights, dated 04/2021, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: c. be free from abuse, neglect. g. exercise his or her rights as a citizen of the facility. h. be supported by the facility in exercising his or her rights; A review of a facility policy titled, Resident [NAME] of Rights for Nursing Home Residents, dated 07/12/1988, indicated, 2. The right to a safe and clean environment. 10. The right to be free from physical or mental abuse A review of the facility's undated policy titled Abuse Prevention Program, indicated It is the policy of this facility to prevent resident abuse .VI. Protection of Residents. Residents who allegedly mistreat another resident will be immediately removed from contact with that resident. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of the other residents and employees of the facility. VII. Prevention staff will identify residents with increased vulnerability .or who have needs ad behaviors that might lead to conflict. For the purposes of this policy. 1. Abuse: the willful infliction of injury resulting in physical harm, pain, mental anguish or deprivation by an individual. 4. Physical Abuse: Hitting, slapping, pinching, kicking, etc. 1. A review of the Admission Record, indicated the facility admitted Resident #1 on 07/20/2023, with diagnoses that included transient cerebral ischemic attack (brief stroke like attack requiring immediate medical attention), cerebral infarction (interrupted blood flow to the brain causing brain tissue death), and malignant neoplasm of the prostate. (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 0600 Level of Harm - Actual harm Residents Affected - Some	The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/23/2025, revealed Resident #1 had a Brief Interview for Menal Status (BIMS) score of 7, which indicated the resident had moderate cognitive impairment. Resident #1 was able to walk independently 150 feet and did not require the assistance of a wheelchair. Diagnoses included cancer and stroke. Resident #1 was 66 inches in height and weighed 117 pounds. Resident medications included an antidepressant and an antiplatelet (medication to prevent blood clotting). A review of Resident #1's Care Plan Report, revealed the resident was at risk for abnormal bleeding related to daily usage of antiplatelet and at increased risk for bruising and/or bleeding; was at increased risk for alteration in skin integrity related to cancer and antiplatelet medication; expressed maladaptive behavioral symptoms, related to blocked blood flow to the brain, that included inappropriate sexual behavior with female, urinating on the floor and spreading stool in bathroom. Interventions included monitor and report bleeding; protect skin from accidental injury, monitor skin daily for bruising or bleeding; admission to male secure unit, explain and remind resident of desired behaviors, psychiatric management. A review of Order Summary Report, revealed Resident #1 was admitted to the secured unit; was to be observed for signs and symptoms of bleeding/bruising every shift; and received an antiplatelet daily. A review of Resident Rights and Protection, dated 07/20/2023, indicated Resident #1 received resident rights and abuse protection information from the facility. A review of Consent for Admission to Special Care Unit, signed 10/27/2023, by Resident #1's representative, indicated the care unit provided a supportive, quieter living environment, structured to be a warm, nurturing environment to meet physical, mental, and psychosocial needs. Protection from external stressors and expectations promotes enhanced function and improved quality of life for the resident with dementia. There can also be some risks to residing on the Special Care Unit. Residents on the unit may have inappropriate verbal or physical behaviors, at times including incidents of resident-to-resident altercations. Residents may wander into the personal space of others. A review of eInteract Change in Condition Evaluation, dated 02/11/2025, revealed Resident #1 was sent to the hospital for injuries related to resident to resident. A review of Interact SNF (skilled nursing facility) to Hospital Transfer Form, dated 02/10/2025, indicated Resident #1 was sent to the emergency room at 11:59 PM, for an altercation with resident, was alert and disoriented, and had no skin/wound care. Resident #1's medical record from [Hospital Name] indicated: a. CT head without contrast Result Date:2/21/2025 Interval increased density of bilateral subdural hematomas. On the right measures 1.2 cm in maximum diameter with mildly increased mass effect on the frontal lobe and stable 3mm left midline shift. b. CT angiogram head and neck with 3D reconstruction (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Result Date:2/21/2025 Non-contrast CT head: Large right convexity subdural hemorrhage has mildly increased in size with interval dependent hyper-density within the collection suggestive of acute on chronic subdural hemorrhage. Moderate left convexity subdural hygroma has also increased in size. Mild 4 mm midline shift to the left without evidence of descending trans tentorial herniation. Left lens subluxation is again noted. c. X-Ray chest AP portable Result Date:2/21/2025 Diffuse emphysematous changes in both lungs. Interval new-ill-defined patchy airspace opacities are seen in the right lower lung, may represent developing pneumonia/aspiration. d. X-Ray foot right AP lateral and oblique Result Date: 2/11/2025 Findings and Impressions: Revisualization of distal fibular and tibial fractures are seen. e. X-Ray hand left AP and lateral portable Result Date: 2/11/2025 Findings and Impression: Diffuse soft tissue swelling is seen throughout the dorsum of the hand and wrist. f. CT head without contrast Result date: 2/11/2025 Stable acute on chronic subdural hemorrhage along the right cerebral convexity with 4mm leftward midline shift. Redemonstration of trace subarachnoid hemorrhage along the right temporal sulci. Left frontal, premaxillary and periorbital soft tissue contusions with traumatic lens subluxation. g. X-Ray hand left PA lateral and oblique Result Date:2/11/2025 Dorsal soft tissue swelling h. ED ultrasound ocular Result Date: 2/11/2025 Lens dislodged; Left lens dislocation; left vitreous hemorrhage (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	i. CT maxillofacial area with contrast Result Date:2/11/2025 Redemonstration of large soft tissue hematoma overlying the left orbit and extending to the frontal and pre maxillary regions. Mild stranding within the left intraconal and extraconal regio concerning for post-septal hemorrhage. Mild proptosis of the left orbit with partial dislocation of the lens. Subtle hyper-densities within left globe concerning for vitreous hemorrhage. Mild displaced left nasal bone fracture. Redemonstration of 1. 4 cm mixed density extra-axial fluid collection along the right cerebral convexity. j. CT head without contrast Result date 2/11/2025 Significant subcutaneous soft tissue contusions over the left frontal, orbital, and pre maxillary regions with associated post-septal hemorrhage. There is a partial dislocation of the left lens. Scalp soft tissue contusion over the left parietal convexity. Mixed density subdural hemorrhage. This measures approximately 1.4 cm in maximum dimension and exerts mass effect upon the right cerebral hemisphere. There is approximately 4 mm of leftward midline shift without evidence of herniation. The subarachnoid hemorrhage is also seen along right temporal sulci. 2. A review of the Admission Record, indicated the facility admitted Resident #2 with diagnoses that included Alzheimer's disease, adjustment disorder with disturbance of conduct, dementia with agitation, neurocognitive disorder due to known physiological condition with behavioral disturbance, hallucinations, and disorientation. The quarterly MDS, with an ARD of 01/08/2025, revealed Resident #2 had a BIMS score of 00, which indicated the resident had severe cognitive impairment. Resident #2 had physical and verbal behavior symptoms directed toward others, occurring 1 to 3 days, and other behavioral symptoms not directed toward others that occurred 1 to 3 days. Resident #2 was independent, walking 10 feet and required supervision or touch assistance to walk 150 feet. Active diagnoses included Alzheimer's disease, non-Alzheimer's dementia, adjustment disorder with disturbance of conduct, neurocognitive disorder due to known psychosocial condition with behavioral disturbance, hallucinations, and disorientation. Resident #2 had pain occasionally that rarely affected sleep or activities. Resident #2 was 67 inches in height and weighed 184 pounds. Resident #2 was taking an antipsychotic and antidepressant. A review of Care Plan Report, initiated 07/15/2024, revealed Resident #2 had maladaptive behavioral symptoms related to Alzheimer's dementia, neurocognitive disorder, and hallucinations, resident to resident altercation; used antipsychotic medications related to behavior management; used anti-anxiety medications. Interventions included: utilizing behavior management to promote and shape desired behavior, respectful conduct, no profanity or yelling, make effort to get along with peers; 02/11/2025 resident separated, and Resident # 1was sent via ambulance to the emergency room . A review of Order Summary Report, revealed Resident #2 was admitted to the secured unit on 12/03/2024; had [Brand Name extended-release medication used to treat dementia with agitation] had [Brand Name medication used to treat dementia with mild agitation]; and [Brand Name antidepressant] for neurocognitive disorder with behavioral disturbance and hallucinations. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	A review of Resident Rights and Protection, dated 07/02/2024, indicated Resident #2 received resident rights and abuse protection information from the facility. A review of Consent for Admission to Special Care Unit. Dated 07/02/2024, by Resident #2's power of attorney (POA)/guardian, indicated the care unit provided a supportive, quieter living environment, structured to be a warm, nurturing environment to meet physical, mental, and psychosocial needs. Protection from external stressors and expectations promotes enhanced function and improved quality of life for the resident with dementia. There can also be some risks to residing on the Special Care Unit. Residents on the unit may have inappropriate verbal or physical behaviors, at times including incidents of resident-to-resident altercations. Residents may wander into the personal space of others. A review of psychiatric Progress Note and Psychiatric Periodic Evaluation, revealed Resident #2 was seen via telemedicine and in person by Psychiatric Mental Health Nurse Practitioner (PMHNP) on 08/02/2024, 08/06/2024, 09/03/2024, 10/15/2024, 12/02/2024, and 12/17/2024. A review of Trauma Screening, dated 02/24/2024, indicated Resident #2 had no screening indicators. Questions 3, 5, 7, 8, and 9 were contradictory to resident diagnoses and documented behaviors. A review of Progress Notes, dated 02/10/2025 at 11:45 PM, indicated Resident #2 attacked another resident (identified as Resident #1), punched Resident #1 4 to 5 times after Resident #1 entered Resident #2's room. During a police interview, Resident #2 stated [pronoun] was in my room and my hand hurts. A review of Progress Notes, dated 02/11/2025 at 4:19 AM, indicated Resident #2 was transferred via EMS to Geri Psych at [Hospital Name]. A review of Progress Notes, dated 02/11/2025 at 2:40 AM, indicated Resident #2 had a change in condition nursing observation and evaluation described as This resident physically attacked another resident. This resident has no injuries. Intervention and recommendation indicated resident was transferred to Geri psych at [Hospital Name]. A review of Progress Notes, dated 02/11/2025 at 4:19 AM, indicated Resident #2 was transferred by ambulance to Geri psych [Hospital Name] per physician order. A review of Progress Notes, dated 02/16/2025 at 5:30 AM, indicated Resident #2 was one on one (constant supervised observation by staff member) and exhibited no behaviors. A review of [City Name] Police Department Incident Report, incident number 2025-017726 dated 02/10/2025 at 11:45 PM, indicated the offence was Battery 2nd degree; weapon force was blunt object; victim Resident #1 with possible internal injury; aggravated assault/homicide category was other circumstances. Suspect identified as Resident #2, mentally afflicted. Narrative stated upon law enforcement arrival, Resident #1 was observed on their knees bleeding from the head, left eye was swollen shut, had dark bruising, cuts and abrasions throughout head area. EMS called to transport to [Hospital Name] for treatment. Resident #2 identified themselves as a federal judge and US Marshall and was [AGE] years old. Neither party were in a clear mental state to answer questions. [Hospital Name] staff advised Resident #1 was stable with a brain bleed and detached eye lens. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	A review of Licensed Practical Nurse (LPN) # 2 witness statement indicated LPN #2 arrived after the incident occurred and observed Resident #1 laying on floor against Resident #2's bed, surrounded by blood on floor, eye was swollen, laceration to back of head, and blood dripping from nose. Wet floor sign was on the ground, bloody and broken. Resident #2 was agitated and escorted out of the room to the dayroom. LPN #2 returned to Resident #1 and called 911. A review of Resident #2's statement indicated Resident #1 entered Resident #2's room and jumped on Resident #2 four times before Resident #2 pushed Resident #1 out of room. Resident #1 bent Resident #2's finger back and they started fighting, [pronoun] is pretty strong, and I was still trying to get help. We were finally broken up. A review of OLTC Witness Statement indicated Certified Nursing Assistant (CNA) #1 was entering 700 Hall for shift, walked down the hall and went into Resident #2's room and saw Resident #2 hit Resident #1 with a wet floor sign, grabbed Resident #2 to move [pronoun] from room. Resident #2 broke away and swung and hit Resident #1 again. Calmed Resident #2 and went and got LPN #2 to come and check Resident #1. A review of a facility policy titled Abuse, Neglect, and Exploitation, indicated, We are committed to the safety and well-being of all residents. We believe that the resident has the right to be free from verbal, sexual, physical, or mental and psychosocial abuse, neglect, misappropriation of property, and involuntary seclusion. The facility's goal is to prevent abuse through annual and ongoing in-service of staff, maintaining confidentiality of information, informants, or concerns regarding interactions with the residents, proactively addressing situations which may lead to abuse, providing thorough staff screening, training, and sufficient staff to effectively care for and monitor residents. Resident #2 had diagnoses of Alzheimer's disease, adjustment disorder with disturbance of conduct, dementia with agitation, mild neurocognitive disorder with behavioral disturbance, and hallucinations. Resident #2 had a Brief Interview of Mental Status (BIMS) score of 00 (severely cognitively impaired) per quarterly Minimum Data Set (MDS). The MDS indicated that Resident #2 had physical behavioral symptoms directed towards others that occurred for 1 to 3 days. Resident #2 had a history of being in prison due to attacking someone with a baseball bat, and [pronoun] family does not have anything to do with [pronoun] as he is suspected of molesting [pronoun] granddaughter. [Pronoun] is hard of hearing, and in Adult Protective Services (APS) custody. Review of Resident #2's Care Plan, initiated 07/15/2024, revealed the resident used antipsychotic medications related to behavior management. Interventions included to monitor/record occurrence of target behavior symptoms such as pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others, and document per facility protocol. Monitor, document, and report as needed adverse reactions to anti-anxiety therapy. Unexpected side effects of anti-anxiety therapy: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. A review of Resident #2's Progress Note dated 2/11/2025 at 4:19 AM, indicated that Resident #2 had physically attacked another resident. Resident #2 was transferred to Geri-Psych at [Hospital Name] for evaluation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	A review of Resident #1's Medical Records from [Hospital Name] Medical Center dated 2/11/2025, indicated Resident #1 was assaulted at a nursing facility with a wet floor sign. A brain scan revealed bleeding on the brain, swelling around the eye, left nasal bone fracture, leg fractures, and eye dislocation. A review of Resident #1's Event Note dated 2/20/2025 at 11:41 PM, revealed Resident #2 was attacked by another resident. Resident #2 was punched 4-5 times and had a laceration across the back of [pronoun] head. [Pronoun] left eye was grossly swollen, nose was bloody, and left hand was badly bruised, with a cut on the top. Resident #1 was disoriented and weak, but conscious and able to respond to verbal prompting. Not oriented to time, place or location. Pain level was very high but not rated due to disorientation. Resident #1 was transported to [Hospital Name] around 40 minutes after the incident During an interview on 2/25/25 at 12:02 PM, Family member #4 indicated that Resident #1 had transferred to another facility because Resident #1 was afraid to come back to Facility #5 where the resident had been attacked. During a phone interview on 2/25/2025 at 11:45 AM Certified Nursing Assistant (CNA) #1 indicated that he was the only CNA working on the 700 Hall when Resident #2 attacked Resident #1. The 700 Hall was a locked unit at the back of the facility. CNA #1 indicated that he was in another room helping with the heater. CNA #1 indicated that he was making rounds and that's when he observed Resident #2 attacking Resident #1. He indicated that Resident #2 had a wet floor sign striking Resident #1 with it. CNA #1 indicated that Resident #2 had to have grabbed the wet floor sign from the hall, and the sign was not far from Resident #2 ' s room. CNA #1 indicated that the wet floor signs are usually hidden. CNA #1 indicated that Resident #2 had behaviors when the resident felt angry. CNA #1 indicated that he believed Resident #2 had a military background, and some days all the resident talked about was the military. CNA #1 indicated that Resident #1 had attacked another resident before, and it's on file. CNA #1 indicated that Resident #1 roamed into other resident's rooms, and if he takes Resident #1 to the resident ' s room, resident stays 2-3 minutes. I did a double that night and she [The Administrator] sent me home that night. CNA #1 indicated that he was sent home after the incident, and the Administrator informed him that she would give him some protocols to follow the next time he was assigned to the unit. During an interview on 2/25/2025 at 12:30 PM, with Resident #2 while the resident was on one-on-one observation, a staff member was observed sitting outside of Resident #2 ' s door. Resident #2 was deaf, and this surveyor wrote out questions on blank computer paper. Resident #2 was able to answer the questions. Resident #2 indicated that a person came in the resident ' s room around 4:00 in the morning and shut the door. Resident #2 indicated that the person was kicking and choking Resident #2. Resident #2 indicated that the person got meaner and meaner and Resident #2 had to defend theirself. Resident #2 indicated that the wet floor sign was right outside the door. Resident #2 picked up a sign and popped the person with it. Resident #2 indicated that the person was small, but Resident #1 was very strong. Resident #2 indicated that the person bent their hand all the way back, and the person was really trying to hurt Resident #2. Resident #2 indicated that they [EMS] came and picked the person up in a stretcher and took the person out of Resident #2 ' s room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	During an interview on 2/26/2025 at 2:32 PM, the Administrator indicated that on 2/10/2025, Resident #2 attacked Resident #1. The Administrator indicated that Resident #2 was placed on one-to-one observations to protect other residents. The Administrator indicated that Resident #2 would be one-to-one observation until the stop sign for Resident #2 ' s door comes, and the resident was evaluated by the provider. The Administrator indicated that she had reached out to the State Hospital for possible evaluation for Resident #2 During an interview on 2/26/2025 at 4:28 PM, LPN #2 indicated Resident #1 was kneeling by the bed on the night Resident #1 was attacked by Resident #2. LPN #2 indicated that Resident #2 was still in Resident 2 ' s room and CNA #1 was standing in front of Resident #2 keeping the resident from approaching Resident #1 again. LPN #2 indicated she told Resident #2 to get out of the room. LPN #2 and CNA #1 escorted Resident #2 to the common area where Resident #2 sat down in a chair. CNA #1 stayed with Resident #2, and LPN#2 stayed with Resident #1. LPN #2 indicated that she did not know if she saw the wet floor sign right away. She indicated that her attention was focused on Resident #1. LPN #2 indicated that Resident #2 had to have gone out of the room and grabbed the wet floor sign, and when she saw the sign, it was shattered and bloody. LPN #2 indicated Resident #1 was kneeling in a praying position beside Resident#2's bed and she ended up leaving Resident #1 there after she determined a level of consciousness and made sure Resident #1 could talk and was breathing. LPN #2 indicated that she did not really want to move Resident #1 because the resident was not in very good shape. LPN #2 indicated that she needed to go call the police, and after determining Resident #1 was okay for the moment right where the resident was CNA #1 stayed with Resident #2. LPN #2 indicated that she came out of the room and called 911 and got an ambulance. LPN #2 indicated that there's a reason Resident #2 was in the room by themself. LPN #2 indicated that Resident #2 had not had a roommate because of Resident #2 ' s behavior. LPN #2 indicated that she thought Resident # 1 and Resident #2 used to be roommates, but there was a lot of hostility. LPN #2 indicated that Resident #1 had dementia and was confused most of the time. LPN #2 indicated that Resident #1 and Resident #2 had never had any other interactions other than being roommates. LPN #2 indicated that Resident #1 and Resident #2 had to be separated when they were roommates, but she was not sure how long ago it was. LPN #2 indicated that Resident # 2 had been on one-to-one observations since the incident happened. LPN #2 indicated that she and CNA #1 were the only staff that witnessed the incident. During an interview on 3/04/2025 at 10:20 AM, CNA #1 indicated that he was responsible for 10-12 residents on average. CNA #1 indicated that when he first made it to the unit Resident #1 was standing by the door close to Resident #1's room. CNA #1 indicated that he was informed by the Administrator that he should have put Resident #1 in the resident ' s room when CNA #1saw Resident #1 wandering. CNA#1 indicated that he lets Resident #1 walk up and down the hall until the resident is tired. CNA #1 indicated that when he entered Resident #2's room that Resident #1 was swinging and hitting Resident #2 when he walked in, and Resident # 2 swung over him. CNA #1 indicated that Resident #2 hit Resident #1 with the wet floor sign while he was in the room. CNA #1 indicated that the wet floor sign broke into pieces, and he got the pieces and put them outside.