

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER The Blossoms at Cumberland Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48390</p> <p>Based on record review and interview, the facility failed to ensure residents' decisions as to whether they desired to have, or did have, an advance directive, were documented in a prominent part of the clinical record, to ensure their wishes were known regarding acceptance or rejection of any life-sustaining treatments in the event of their incapacitation for 1 (Resident # 30) of 1 sampled resident whose clinical records were reviewed for advance directive information.</p> <p>The findings are:</p> <p>1. Resident #30 was admitted to the facility on [DATE] and had a diagnosis of respiratory failure with hypoxia, chronic respiratory failure with hypercapnia, cerebral palsy, anxiety disorder, and emphysema. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/05/2024 documented the resident scored 15 (13-15 indicates intact cognition) on the Brief Interview for Mental Status (BIMS).</p> <p>a. On 01/15/2025 at 9:45 AM, the Administrator (AD) provided a 2-page form for Resident #30, titled Physician Orders for Life-Sustaining Treatment (POLST), dated 11/29/2024, section D, was marked, Advance Directive dated (blank) available and reviewed.</p> <p>b. On 01/15/2025 at 9:45 AM, the AD provided a Resuscitation Designation Order dated 11/29/2024 for Resident #30. #2 was marked - I do have an Advance Directive, if yes, then select which of the following will be on file: Power of Attorney was selected.</p> <p>c. On 01/15/2025 at 9:45 AM, the AD provided a six-page document titled Iowa General Durable Power of Attorney, for Resident #30. The power of attorney was dated 08/24/2022. On the first page, second paragraph, it states, This power of attorney does not authorize the agent to make health-care decisions for you.</p> <p>d. On 01/16/2025 at 10:57 AM, this surveyor asked the AD to review Resident #30's durable power of attorney and see what the second paragraph said. The AD read the power of attorney ' s second paragraph out loud This power of attorney does not authorize the agent to make health-care decisions for you. This surveyor asked the AD if this durable power of attorney covered health care decisions. The AD indicated it did not. This surveyor asked the AD if Resident #30 would need an advance directive based on what she just read in the power of attorney. The AD indicated that Resident #30 would need an advance directive to indicate what the resident wanted or did not want.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. On 01/16/2025 at 12:19 PM, the Administrator provided a policy for advance directives titled Policies and Procedures Subject: Advance Directives, Revise date 11/01/2022. #1 on the first page states Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48390</p> <p>Based on observation, interview, and record review the facility failed to coordinate assessments with the PASARR (Preadmission Screening and Resident Review) program by obtaining a copy of the completed Level II PASARR, so any recommendations could be incorporated into the resident's assessment, care planning and transition of care for 1 (Resident #7) of 1 sample resident reviewed for PASARR.</p> <p>These are the findings:</p> <p>1. Resident #7 was admitted to the facility on [DATE] and had diagnoses of schizoaffective disorder, auditory hallucinations, delusional disorders, unspecified mood [affective] disorder and anxiety disorder. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 12/17/2024, documented that the resident scored 15 (13-15 indicating cognitively intact).</p> <p>a. Resident #7 ' s Care Plan with an initiated date of 9/19/2024, documented, Focus: Resident expresses maladaptive behavioral symptoms related to: A diagnosis of chronic mental illness (schizophrenia). The resident's problems/symptoms are manifested by hallucinations (auditory), the resident's problems/symptoms are manifested by delusions (irrational/bizarre thoughts).</p> <p>b. On 01/15/2025 at 9:45 AM, the Administrator (AD) provided a letter dated 08/28/2024, from the designated state agency, which indicated Resident has been approved for nursing home placement by OLTC (Office of Long-Term Care) and may enter nursing home of his/her choice, Attention Nursing Facilities: You Must contact [designated state agency] with the Client's admitted in order to receive your client's completed PASRR evaluation.</p> <p>c. On 01/16/25 at 11:23 AM, the AD indicated they could not locate a completed Level II PASRR evaluation for Resident #7.</p> <p>d. On 01/6/25 at 12:18 PM, the AD indicated they did not have a policy for PASRRs.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>51381</p> <p>Based on observations, interviews, record review, and facility document review, it was determined the facility failed to ensure the resident received a bath/shower per the schedule to promote good hygiene for 1 (Resident #44) of 18 sampled residents reviewed for assisting residents to perform activities of daily living (ADLs).</p> <p>Findings include:</p> <p>The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/06/2024, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Diagnoses on the MDS included diabetes (abnormal blood sugar), seizure disorder (neurological condition), obesity, and an ulcer on the lower extremity. The resident was observed, and records were reviewed, for ADLs being completed.</p> <p>1) On 01/14/2025 at 9:35 AM, Resident #44 stated that some residents were not getting showers frequently enough. Resident #44 stated residents needed a shower three times per week and it was only carried out once or twice per week. Resident #44 stated [pronoun] needed minimal assistance but still must have staff in attendance to go to the shower and complete the shower.</p> <p>2) On 01/16/2025 at 3:28 PM, Licensed Practical Nurse (LPN) #3 was interviewed regarding the process for residents to have a shower or bath. LPN #3 stated the process for the resident hall was even-numbered rooms get a bath/shower on Monday, Wednesday, and Friday. The odd-numbered rooms get a bath/shower on Tuesday, Thursday, and Saturday. A-beds are the responsibility of the aides on the 7A-3P shift. B-beds are the responsibility of the aides on the 3P-11P shift. When LPN #3 was asked how a nurse would know if a resident did not get a bath or shower, they stated they would notice the resident was in the same clothes. An alert resident would notify the nurse that they did not get bathed. Since the responsibility of a bath/shower was up to the aide, a nurse would follow up with the aide, if needed.</p> <p>3) On 01/16/2025 at 3:37 PM, ADL records were reviewed for Resident #44 from October 2024 to the present. According to the process mentioned by LPN#3, there were 43 opportunities for a bath/shower to be documented and a total of 9 areas blank, with no staff initials to indicate a bath/shower was completed. The dates with no staff initials were as follows:</p> <ul style="list-style-type: none"> a. 10/03/2024 - Thursday b. 10/05/2024 - Saturday c. 10/26/2024 - Saturday d. 11/02/2024 - Saturday e. 11/05/2024 - Tuesday f. 12/05/2024 - Thursday <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>g. 12/14/2024 - Saturday</p> <p>h. 01/04/2025 - Saturday</p> <p>i. 01/09/2024 - Thursday</p> <p>4) On 01/16/2025 at 9:00 AM, LPN #3 was interviewed regarding the documentation for bathing/showering/ADLs. LPN #3 responded that the nurses do not have access to the documentation, and they are not able to review it.</p> <p>5) On 01/16/2025 at 11:00 AM, the Director of Nursing (DON) was interviewed regarding the gaps in the documentation of the ADLs for the records from October 2024 to the present. The DON verified that a total of 9 days of documentation were missing over the review period, to indicate a bath/shower was completed. The DON stated it was important to see if a bath was done or not done. The DON also stated that it was important to see if there was an issue with giving a bath, or if there was something they needed to fix.</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>42965</p> <p>Based on record review, interview, and policy review the facility failed to ensure residents received wound care as per Physician's orders for 2 (Resident #2 and #48) of 2 sampled residents who were reviewed for pressure ulcer care.</p> <p>The findings include:</p> <p>1. Review of an annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/20/2024, indicated Resident #2 had diagnoses of cancer, anoxic brain injury, and pressure ulcer stage 3, scored 3 (indicating severe impairment) on the Staff Assessment for Mental Status (SAMS), and had one stage 3 pressure ulcer.</p> <p>a. Review of a Care Plan that was updated 09/16/2024, indicated Resident #2 had a stage 3 pressure ulcer to the right heel and the goal of care was the resident would develop clean and intact skin by the review date.</p> <p>b. Review of a form titled Order Recap Report, dated Jan. 15, 2025, indicated Resident #2 had an order with a start date of 09/11/2024, and an end date of 01/08/2025, to cleanse pressure ulcer to right heel with [Name brand antiseptic] solution (topical antiseptic), apply [Narcotic pain medication] moistened gauze, and wrap with [name brand] wrap daily.</p> <p>c. Review of a Physician's Order dated 1/9/2025, indicated, Cleanse pressure ulcer to right heel with wound cleanser, apply silver alginate to wound bed, cover with gauze and wrap with [name brand] wrap. Change every other day and as needed (PRN) one time a day every Monday, Wednesday, Friday for wound management and as needed for missing/soiled dressing</p> <p>d. Review of Resident #2's November 2024, December 2024, and January 2025 Treatment Administration Records (TARs) did not show staff initials to indicate wound care was done as ordered on 11/02/2024, 11/03/2024, 11/05/2024, 11/10/2024, 11/16/2024, 11/17/2024, 11/17/2024, 11/17/2024, 11/19/2024, 11/23/2024, 11/29/2024, 11/30/2024, 12/02/2024, 12/03/2024, 12/07/2024, 12/11/2024, and 01/13/2025.</p> <p>e. On 01/16/25 at 9:10AM, the Treatment Nurse reviewed Resident #2's November 2024, December 2024 and January 2024 TARs in the electronic record and confirmed that wound care as per physician orders was not initialed as being done on 11/02/2024, 11/03/2024, 11/05/2024, 11/10/2024, 11/16/2024, 11/17/2024, 11/19/2024, 11/23/2024, 11/29/2024, 11/30/2024, 12/02/2024, 12/03/2024, 12/07/2024, 12/11/2024, and 01/13/2025. The Treatment Nurse stated that some of those dates were on the weekend and the floor nurses who are responsible for doing wound care might have forgotten to document. The Treatment Nurse confirmed the treatment record should have been initialed to verify the treatment was done and wound care orders should be followed for proper healing and to prevent infection.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>f. On 01/16/25 at 9:20 AM, the Director of Nursing reviewed the electronic record of Resident #2's TARs for November 2024, December 2024, and January 2025, and verified that wound care was not initiated as done as ordered on 11/02/2024, 11/03/2024, 11/05/2024, 11/10/2024, 11/16/2024, 11/17/2024, 11/19/2024, 11/23/2024, 11/29/2024, 11/30/2024, 12/02/2024, 12/03/2024, 12/07/2024, 12/11/2024, and 1/13/2025. The Director of Nursing stated floor staff and agency staff sometimes are busy and forget to chart, but if it was not charted it was not done and it was important that wound care was done as ordered so wounds healed properly and timely.</p> <p>g. On 01/16/25 at 9:30 AM, the Administrator was asked for a policy on wound care.</p> <p>h. On 01/16/2025 at 9:40AM, the policy titled Wound and Pressure Ulcer Management Policy (revision date 11/01/2022), provided by the Administrator, indicated the organization is committed to providing a comprehensive wound management program and any resident with wounds receives treatment and services consistent with the resident's goals of treatment.</p> <p>2. Review of a significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/10/2024, indicated Resident #48 had diagnoses of non-Alzheimer's dementia, hemiplegia (not able to move one side of the body), gastrostomy (feeding tube going directly to the stomach or G-tube), and encephalopathy (change in how the brain functions).</p> <p>Review of the December 2024 Treatment Administration Record (TAR) report, updated 12/06/2024, indicated Resident #48 needed treatment for a stage 2 pressure ulcer to the left gluteal cleft (left buttock). The verbiage on the TAR was as follows: Cleanse pressure ulcer to gluteal cleft with wound cleanser, pat dry, apply calcium alginate to wound bed. Cover with foam dressing Mon, Wed, Fri one time a day every Mon, Wed, Fri. As indicated on the TAR, the order started 12/06/2024. The TAR also indicated Resident #48 needed a daily dressing change to the gastrostomy site (G-Tube). The verbiage on the TAR was as follows: Cleanse G-Tube site with wound cleanser, pat dry, and cover with dressing daily. One time a day for tar. As indicated on the TAR, the order started 12/06/2024.</p> <p>A review of Resident #48 ' s January 2025 TAR did not show staff initials indicating wound care was done for the pressure ulcer dressing changes for 01/13/2025. In addition, the TAR did not show staff initials indicating wound care was done for the G-Tube on 01/05/2025, 01/07/2025, 01/11/2025, and 01/13/2025.</p> <p>A review of Resident #48 ' s December 2024 TAR did not have staff initials to indicate wound care was done for the pressure ulcer for 12/07/2024 and 12/27/2024. In addition, a review of the TAR did not show staff initials to indicate wound care was done for the G-tube for 12/07/2024, 12/22/2024, and 12/27/2024.</p> <p>On 01/16/2025 at 11:00 AM, The DON was interviewed regarding the dressing changes and missing documentation. The DON verified there should be initials in the blanks of the dressing changes, to indicate it was done. For December 2024, it was verified by the DON there was missing documentation for the pressure ulcer on 12/07/2024 and 12/27/2024. For December 2024, it was verified by DON there was missing documentation for the G-tube 12/07/2025, 12/22/2024, and 12/27/2024. For January 2025, it was verified by the DON there was missing documentation for the pressure ulcer on 01/13/2025. For January 2025, it was verified by the DON that there was missing documentation for the G-tube 01/05/2025, 01/07/2025, 01/11/2025, and 01/13/2025.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>51381</p> <p>Based on observations, interviews, record review, and facility document review, it was determined the facility failed to provide safety during the process of medication administration for one (Resident #44) of 18 sampled residents reviewed for being free of Accident Hazards/Supervision/Devices.</p> <p>The findings include:</p> <p>Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/06/2024, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. Diagnoses on the MDS included diabetes (abnormal blood sugar), seizure disorder (neurological condition), obesity, and an ulcer on the lower extremity. The resident was observed, and their record reviewed, for safe medication practices.</p> <p>1) On 01/05/2025 at 7:50 AM the medication pass process was observed for Resident #44:</p> <p>a. Licensed Practical Nurse (LPN) #3 had a cup with two medications in the cup. LPN #3 stated the medicines were [name brand anticonvulsant and nerve pain treatment medication] 50 mg and [Name brand combination pain relief medication] 10/325 mg - which were both handled as a controlled substance at the facility. LPN #3 was observed walking into Resident #44's room, gave the cup of medicines to Resident #44, and left the room prior to the resident taking the medications orally.</p> <p>b. Medication Technician (MT) #4 was observed to place thirteen medications into a cup, walk into the room, give the cup of medications to Resident #44, and leave the room prior to the resident taking the medications orally.</p> <p>c. Upon interview of LPN #3 and MT #4 regarding the process of medication pass, they agreed that leaving the medications with the resident to take unsupervised could lead to them pocketing the medications and causing self-harm or unintentional harm.</p> <p>2) On 01/16/2025 at 10:15 AM, the Administrator provided a policy/procedure titled Checklist for completing proper steps in the administration of medications. One step in the body of the document stated, Observe the resident take the medication.</p> <p>3) On 01/16/2025 at 11:00 AM, the Director of Nursing (DON) was interviewed regarding the process of administering medications. The DON stated the step listed in the facility policy,</p> <p>observe the resident take the medications, was present to ensure a resident did not take pills out of their mouth.</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508</p> <p>Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 1 of 1 meal observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. The [DATE] lunch menu documented the residents who received pureed diets were to receive a #10 scoop (3 ounces) of oven herb roasted turkey, a #8 scoop (,d+[DATE] cup) of candied sweet potatoes, a #8 scoop (,d+[DATE] cup) of seasoned mixed vegetables and a #16 (,d+[DATE] cup) of pureed dinner roll and for the residents on mechanical soft diets were to receive one dinner roll, a #8 scoop (4 ounces) which ground turkey would be 3 ounces plus one ounce of gravy for total of 4 ounces, and the residents on regular diets were to receive one dinner roll each. 2. On [DATE] 12:30 PM, the following observations were made during the noon meal service. <ol style="list-style-type: none"> a. On [DATE] at 12:30 PM, dietary cook (DC) #1 served no dinner roll or bread to the residents who received regular diets with their lunch meal, instead of one dinner roll to each resident who received regular diets. b. On [DATE] at 12:33 PM, DC #1 used a 2-ounce spoon to serve a single portion of ground turkey to the residents who required mechanical soft diets, instead of 3 ounces. There was no dinner roll served to the residents on mechanical soft diets, instead of one dinner roll. c. On [DATE] at 12:44 PM, DC #1 used a 2-ounce spoon to serve a single serving of pureed mixed vegetable and pureed sweet potatoes each to the residents on pureed diets, instead of ,d+[DATE] cup of pureed sweet potatoes and ,d+[DATE] cup of pureed mixed vegetables. There was no pureed dinner roll served to the residents on pureed diets, instead of ,d+[DATE] cup of pureed dinner roll. There were substitutes in place of the pureed bread not given. d. On [DATE] at 12:50 PM, DC #1 was interviewed and was asked what spoon size she had used in serving pureed turkey meat and mechanical soft meat and how many servings she gave to each resident. She stated she used a 2-ounce spoon and gave a serving each. e. On [DATE] at 12:53 PM, DC #2 was interviewed and was asked the reason residents on regular diets, mechanical soft diets and pureed diet were not served dinner rolls and he stated there was no reason, he forgot. DC #2 was interviewed and asked if he reviewed the menu before deciding on how much meat and vegetables to serve to the residents on mechanically soft diets and residents on pureed diets. He confirmed he did not review the menu. 		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure dented cans were promptly removed from stock; leftover meat products were used in a manner to maintain food quality; surfaces were cleaned to provide a sanitary environment for food preparation, floors, dish washer and kitchen walls, door and frames were free of, debris, dirt, grease, rust, stains, wall tiles were replaced; food items stored in the freezer were covered or sealed properly; expired food items were promptly removed from stock; ice machine was maintained in clean and sanitary condition; and dietary staff washed their hands before handling clean equipment for 1 of 1 meal observed.</p> <p>The Findings are:</p> <ol style="list-style-type: none"> On [DATE] at 1:05 PM, this surveyor observed a shelf on the bottom next to the two-door freezer in the pantry. The shelf had a sign that indicated dented cans go on that shelf. Other food product cans were stored above on different shelves in the pantry. The Dietary Manager (DM) was interviewed and was asked what she does if she had a dented can of food, she indicated kitchen staff put it on the shelf in the pantry and showed the surveyor the shelf in the pantry on the bottom that contained 20 dented cans. The DM was interviewed and was asked what happens to the dented cans if the provider gives them credit, or if she throws them away. The DM stated she normally just lets them sit there, our supplier does not give us credit for them and will not take them back. The DM then indicated she was not going to lie, she normally just let them sit there, unless she was short on stock and needed something, then the kitchen staff will use one of the dented can goods. On ,d+[DATE].25 at 10:01 AM, there was a bag of leftover sausage on a shelf in the refrigerator. The DM was interviewed and was asked what the leftover meat items were for. She stated kitchen staff reheated them the next day and used them for mechanical soft diets. On [DATE] at 10:10 AM, the following observations were made in the storage room: <ol style="list-style-type: none"> An opened box of crusts was on a shelf in the freezer. The box was not covered or sealed. A bag of potato chips was on a shelf and had an expiration date of [DATE]. On [DATE] at 10:56 AM, the area in the ice machine panel where ice touches before dropping into the ice collector had wet pinkish, and black colors on it. The Dietary Manager was asked if she could wipe the area. The pinkish and black residue easily transferred to the tissue. She confirmed the ice machine panel had pinkish and black residue on it. The Dietary Manager was interviewed and was asked if she could describe what was observed and who used the ice from the ice machine and how often she cleaned it. The Dietary Manager stated kitchen staff used it to fill beverages served to the residents at mealtimes, and she cleaned it every month. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045359	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER The Blossoms at Cumberland Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5. On [DATE] at 11:04 AM, Dietary [NAME] (DC) #1 removed a gallon of milk from the refrigerator and placed it on the counter, contaminating her hands. She used her contaminated gloved hands to pick up glasses by their rims and poured milk and placed them on the trays to be served to the residents for lunch. DC #1 was interviewed and was asked what she should have done after touching dirty objects and before handling clean equipment. DC #1 stated she should have washed her hands.</p> <p>6. On [DATE] at 1:07 AM, Dietary [NAME] (DC) #2 used oven mitts to place a pan of oven roasted turkey in the oven. He then removed the mitts from his hands, and placed them below the counter, contaminating his hands. Without washing his hands, he 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. When DC #2 was about to place meat items into a blender, DC #2 was interviewed and was asked what he should have done after touching dirty objects and before handling clean equipment. DC #2 stated he should have washed his hands.</p> <p>7. On [DATE] at 11:36 AM, the following observations were made in the kitchen areas:</p> <p>a. The wall by the door in the dishwashing machine leading to the dining room was cracked, exposing the sheet rock.</p> <p>b. The wall below the dish washing machine had sage color.</p> <p>c. The door frame in the dishwashing machine leading to the dining leading to the dining room was broken off at the bottom of the door, exposing the concert.</p> <p>d. There was a crack in the wall by the door in the dishwashing machine leading to the dining room, exposing the steel.</p> <p>e. The tile over the wall was broken off the wall, exposing the board.</p> <p>f. The overhead metal above the emergency window in the dishwashing machine had rusty stains.</p> <p>g. The inside of the vent hood above the dishwashing machine had rust stains.</p> <p>h. The panels across the ceiling in the dishwashing machine room had rust stains on them, and wood stand where dirty racks were kept was crumbled and had discoloration of rust stains.</p> <p>i. The 4 metal legs of the wood stand had discoloration of black and grayish colors on them.</p> <p>j. The wall below the hand washing sink had yellow stains on it.</p> <p>k. The floor by the deep fryer had thick buildup of grease on it. There was lint hanging from the edges of the deep fryer.</p> <p>l. The floor between the deep fryer and the oven had a buildup of greasy dry food stains settled on them.</p> <p>m. The back of the oven had brown stains.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>n. The wall below the 3-compartment sink was peeling off exposing the cement.</p> <p>o. The floor between the deep fryer and oven had thick buildup of grease on it.</p> <p>8. On [DATE] at 12:06 PM, DC #1 opened the refrigerator door and removed a block of cheese slices and placed it on the counter, contaminating her hands. DC #1 untied the bread bag and placed it on the counter, which contaminated her hands. DC #1 removed slices of bread and placed them on plastic wrap laid on the counter. DC #1 removed a slice of cheese from a clear bag and when DC #1 was ready to place a slice of cheese on top of the bread to make a grill cheese sandwich to be served to the resident who asked for it, DC #1 was interviewed. DC #1 was asked what she should have done after touching dirty objects and before handling clean equipment. She stated she should have washed her hands.</p> <p>9. A review of the facility policy titled Hand washing, not dated and provided by Dietary Manager indicated hands should be washed when entering the kitchen at the start of a shift and after engaging in other activities contaminating the hands.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50580</p> <p>Based on observation, record review, interview, and facility policy review, it was determined the facility failed to ensure that staff performed hand hygiene when changing gloves when contaminated during indwelling urinary irrigation catheter care for 1 (Resident #36) of 1 sampled resident reviewed for catheter care and failed to ensure staff performed hand hygiene when changing gloves during wound care for 1 (Resident #48) of 2 sampled residents observed for wound care.</p> <p>1. Review of Resident # 36 ' s Order Summary revealed had diagnoses of coronary artery disease (CAD), neurogenic bladder, acute kidney failure. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/08/24, indicated that the resident scored 15 on the Brief Interview for Mental Status (BIMS) (13-15 indicates cognitively intact), and Resident #36 had a catheter (indwelling).</p> <p>a. On 01/15/2025 at 9:00 AM, this surveyor observed the Treatment Nurse irrigate indwelling urinary catheter with 60 cubic centimeters (cc) of normal saline. Gloves were changed correctly. Hand hygiene was not performed with glove changes.</p> <p>b. On 01/15/2025 at 9:15 AM, this surveyor interviewed the Treatment Nurse regarding what she should have done differently. The Treatment Nurse stated she should have performed hand hygiene. This surveyor asked what the reason for hand hygiene was. The Treatment Nurse stated the purpose was to prevent infection.</p> <p>c. On 01/15/2025 at 12:30 PM, this surveyor requested a hand hygiene/hand washing policy.</p> <p>d. On 01/15/2024 at 1:11PM, the Administrator stated they do not have a policy on hand hygiene/hand washing.</p> <p>Review of Resident #48 ' s significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/10/2024, indicated Resident #48 had diagnoses of non-Alzheimer's dementia, hemiplegia (not able to move one side of the body), gastrostomy (feeding tube going directly to the stomach or G-tube), and encephalopathy (change in how the brain functions).</p> <p>On 01/15/2025 at 9:00 AM, the Treatment Nurse was observed while changing the dressings for both the gastrostomy tube (G-tube) and the pressure ulcer to the left buttocks for Resident #48. Resident #48's room displayed Enhanced Barrier Precautions (EBP) signage. Steps in the process observed were as follows:</p> <ol style="list-style-type: none"> 1) The nurse performed hand hygiene, donned gown and gloves, and removed the old G-tube dressing. 2) The nurse applied wound cleanser with 4x4 gauze. 3) The nurse took off dirty gloves and donned clean gloves without performing hand hygiene. 4) The nurse placed the new 4x4 gauze dressing around the G-tube and secured with tape. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5) The nurse removed the old dressing from the left buttocks, cleansed the area with wound cleanser, patted the area dry, and removed gown/gloves.</p> <p>6) The nurse went into the corridor, performed hand hygiene, and donned new gloves and gown.</p> <p>7) The nurse applied the new dressing to the buttocks.</p> <p>8) The nurse changed gloves, without performing hand hygiene, and concluded Resident #48's care by repositioning the resident and restarting the tube feeding.</p> <p>On 01/16/2025 at 9:50 AM, the Administrator verified there was no hand hygiene policy.</p> <p>On 01/16/2025 at 11:55 AM, the Treatment Nurse was interviewed regarding hand hygiene for EBP, and the wound care performed on 01/15/2025 at 09:00 AM, for Resident #48. The Treatment Nurse stated the process should be to sanitize hands prior to donning a new pair of gloves, and that was not done consistently during the dressing change observations. The Treatment Nurse stated it was important to perform hand hygiene because it could help reduce the spread of infection.</p> <p>51381</p>