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	06/04/2026

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 - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Number of residents sampled: Number of residents cited: Based on observations, interviews, record review, and facility policy review, it was determined that the facility failed to prevent staff to resident abuse for one (Resident #76) of four residents reviewed for abuse. The findings include: Review of an admission Record indicated the facility admitted Resident #76 with diagnoses that included adjustment disorder with mixed disturbances of emotions and conduct, mood affective disorder, bipolar disorder, nicotine dependence, problem related to social environment, intellectual disabilities, symptoms and signs involving appearance and behavior and traumatic brain injury. Review of the quarterly Minimum Data Set with an Assessment Reference Date of 04/02/2026, revealed Resident #76 had a Brief Interview of Mental Status score of 14, which indicated the resident was cognitively intact. Resident #76's Resident Mood Interview was scored 0 for any negative symptoms. The assessment identified no behavioral symptoms towards others or rejection of care. Review of Resident #76's Care Plan Report, initiated on 07/04/2024, revealed the resident chose to smoke and required supervision to do so. Resident #76 expressed maladaptive behavior symptoms related to chronic mental illness and adjustment disorder with mixed disturbance of emotions and conduct interventions included separate and redirect, explain the desired behavior to the resident, remind the resident they were expected to behave respectfully and maturely, and utilize behavior management techniques to promote and shape the desired behaviors. Techniques such as controlling the environment noise level, over-stimulation, commotion, and close contact were indicated. The Care Plan also indicated to direct the resident to stay away from people who increase their agitation and provide opportunities to have space and fresh air. Review of an Office of Long-Term Care (OLTC) Incident & Accidents (I&A) Report dated 04/16/2026 summarized the incident as, resident put employee in headlock. While employee was trying to release the resident's grip from neck the resident alleged that they were hit with a cup. Certified Nursing Assistant (CNA) #1 reported that Resident #76 had her in a headlock, and they both hit the wall which caused the injury to the resident. CNA #2 reported CNA #1 hit Resident #76 in the head with a cup attempting to release herself from the headlock. CNA #2 separated both parties and reported the altercation to the charge nurse. The facility found CNA #1 did abuse Resident #78 during their investigation and she did not return to the facility following her suspension. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #76's Witness Statement Form dated 04/17/2026, revealed CNA #1 was standing in the television room doorway being a [explicate] to the resident and called Resident #76 a [racial slur]. Resident #76 then called CNA #1 a [racial slur]. CNA #1 then grabbed at Resident #76 who grabbed back at CNA #1. Resident #76 then placed CNA #1 in a headlock. CNA #1 then hit Resident #76 in the head with her cup eight times. Resident #76 stated they started gushing blood and were taken to the bathroom by CNA #2 and cleaned up. Review of CNA #1's Witness Statement Form dated 04/21/2026, revealed 30 minutes after the start of the shift on 04/16/2026 Resident #76 began calling CNA #1 a racial slur and using profane language towards her. CNA #1 stated she followed protocol and reported it to the Social Director (Social) but was directed to inform someone else. CNA #1 stated she reported it to the Licensed Practical Nurse (LPN) #3 when she arrived. LPN #3 went and spoke with Resident #76 which temporarily de-escalated the situation for about one hour. Resident #76 resumed aggressive behaviors towards CNA #1. CNA #1 notified CNA #2, and when no other help arrived, CNA #1 and CNA #2 entered Resident #76 room in an attempt to verbally de-escalate the resident. The CNAs asked Resident #76 what was wrong and encouraged the resident to calm down. Resident #76 then became physically aggressive and attacked CNA #1. CNA #1 stated she followed protocol by reporting the escalating behavior early and sought assistance multiple times prior to the incident. Review of CNA #2's Witness Statement Form dated 04/17/2026, revealed when she arrived on the unit Resident #76 was yelling slurs at CNA #1. Resident #76 stated they did not like CNA #1 because she was always messing with the resident. CNA #1 walked into Resident #76's room asking the resident what she was doing to the resident [to clarify why the resident did not like CNA #1]. Resident #76 got up out of bed and stepped in CNA #1's face screaming and telling her, to do something. CNA #1 was face to face with the resident yelling back. Resident #76 swung at CNA #1, who swung back. They began fighting. CNA #2 attempted to separate them and was struck in the mouth. CNA #2 stepped back and attempted to call for help. CNA #2 observed Resident #76 bleeding and asked the resident to let go of CNA #1. Resident #76 let go and the two were separated. CNA #2 reported once CNA #1 left the resident's room she left the unit to get LPN #3. LPN #3 entered the unit and instructed CNA #2 to clean up the resident. Resident #76 was repeatedly asking to smoke, so CNA #2 was directed to take the resident on a smoke break as the Assistant Director of Nursing (ADON) arrived. Review of LPN #3's Witness Statement Form dated 04/16/2026 revealed, LPN #3 was notified by CNA #2 that Resident #76 jumped on CNA #1 and there was blood. When LPN #3 arrived on the unit CNA #1 was sent out to ensure separation of the two parties. Resident #76 was bleeding but would not allow LPN #3 to assess [the resident] until after the resident was allowed to smoke. CNA #2 took resident to smoke. The ADON entered the room and notified the Administrator. LPN #3 was later called to the Administrator's office and suspended for three days due to violation of Resident #76's right to a smoke break. Review of Resident #76's emergency room Records dated 04/16/2026 at 3:47 PM, revealed chief complaint of agitation. Resident #76 reported being struck in the head by a CNA at the nursing home facility. Emergency Medical Services (EMS) reported the resident was told no to a cigarette and placed a CNA in a headlock. Resident presented with a head laceration and reported the incident happened at 11:00 AM and had experienced a headache ever since. Head Computed Tomography (CT) Report revealed, no acute processes, symmetric volume loss of the cerebral hemispheres [diffuse reduction in brain tissue] greater than expected for age, and periventricular microangiopathy [chronic, progressive condition affecting the tiny blood vessels in the brain] greater than expected (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	for age. The head laceration was cleaned, and six staples were placed without complications. The facility was contacted and stated they were comfortable taking the resident back. Review of a Police Report filed on 04/16/2026 revealed, the Administrator stated Resident #76 had been displaying aggressive behavior throughout the day and began using racial slurs. Resident #76 then jumped on CNA #1 and attempted to place her in a headlock, at which point both parties fell into a wall. Staff members intervened before the altercation escalated further. The Administrator stated she only needed a report for documentation purposes. On 04/17/2026 the officers responded to the emergency room and spoke with Resident #76 who revealed they did call CNA #1 a racial slur and told the CNA to do something about it. Resident #76 reported CNA #1 struck her in the head with a water mug causing the laceration. Officers reported observing a deep, dried scar on Resident #76's head. Nursing staff at the emergency room advised the officer the injury appeared to have been left untreated for an extended period. Review of a facility in-service titled Abuse In Long Term Care-Types and Reporting dated 04/16/2026, revealed the facility in-serviced 70 staff members on types of abuse, when to report, and the facility's Abuse, Neglect, and Exploitation policy. During an interview on 06/01/2026 at 3:09 PM, Resident #76's family member stated that the resident had memory and mental issues, but they could trust what the resident told them. Resident #76 reported being agitated about a smoke break and both the resident and the staff were calling each other names and racial slurs. Resident #76 would get aggressive over smoking. Both parties reported the other initiated physical contact, but the resident reported being struck in the head with a metal cup and received 7 staples to the head. The family member reported the resident had a history of a traumatic brain injury and they were told by a medical professional that the resident functioned around a sixth-grade level mentally. The resident had been homeless previously and would wander around and ask people for money. My main concern is [the resident] has been like this for years and they are a trained facility. I understand they have to defend themselves, but I feel like it was excessive. [The resident] was bludgeoned in the head multiple times and received staples. During an interview on 06/03/2026 at 10:44 AM, CNA #2 stated Resident #76 had been agitated all day, and an attempt was made to get assistance from Social, but she could not deal with it at the time. CNA #2 stated that the nurse was late passing out medications, that could have been a part of it. CNA #1 stopped in front of Resident #76's doorway to ask why the resident did not like her and kept saying stuff to her. I do not know if Resident #76 felt attacked, but the resident got in CNA #1's face. CNA #1 said to the resident swing on me, swing on me. CNA #2 told CNA #1 to get out of the resident's room, but Resident #76 swung at CNA #1. CNA #2 tried to separate them and was struck in the mouth. CNA #1 hit Resident #76 with a cup on the side of the head. When they got calmer and separated CNA #2 finally left the room, I left and got LPN #3. Attempts to clean up the resident was made but Resident #76 wanted to smoke. CNA #2 took Resident #76 out to smoke. I feel like [CNA#1] could have handled the situation different. I think if she would not have gone in the resident's room it would not have happened. During an interview on 06/03/2026 at 11:00 AM, CNA #1 stated about 30 minutes after the shift started Resident #76 started cursing and became aggressive towards her and other staff. CNA #1 notified Social and was redirected to someone else. CNA #1 stated the nurse was late that day too. Resident #76 was upset with staff regarding a smoke break. CNA #1 reported the resident was denied a smoke break due to their behavior and acting out and a housekeeper was getting the resident worked up about it. Resident #76 started with aggressive behaviors again and I told the nurse again; I (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	need to get off the unit. When CNA #2 came on the unit we entered Resident #76 room and began to try and de-escalate the situation. CNA #1 stated, Resident #76 came at me and put me in a headlock, and the resident struck the wall. Resident #76 and I had been good before; I don't know if it was the smoke break. I feel like I was attacked because [the resident] was not allowed a cigarette. CNA #1 stated, The Administrator told me Resident #76 was a racist and didn't like women. If they knew that then why didn't they come help when I asked for it. During an interview on 06/03/2026 at 11:56 AM, the Ombudsman stated, They never have two staff on the unit and there were not two that day. They had to call for help. During an interview on 06/03/2026 at 2:30 PM, Social stated she received a call from CNA #1 regarding Resident #76 behaviors but was in court with another resident and directed CNA #1 to call LPN #3. LPN #3 did not respond to messages regarding an interview related to the incident. During an interview on 06/04/2026 at 10:08 AM, the ADON stated that during an investigation of the incident she suspended LPN #3 because she did not allow Resident #76 to smoke when the resident refused a shower. CNA #1 and CNA #2 stated the resident was upset because the resident needed a cigarette. When the ADON made rounds the morning of 04/16/2026, she heard Resident #76 saying they needed their smoke break. I did not know they were saying no shower, no smoke break. The ADON stated that staff cannot deny them a smoke break and that was why the ADON suspended LPN #3. Staff should report concerns immediately before they get out of hand. During an interview on 06/04/2026 at 11:07 AM, the Director of Nursing (DON) stated she was not employed in the facility during the 04/16/2026 altercation but the facility had made changes since then. The number of staff had been increased on the secured unit and staff had also been provided with an alert bell they wear on a lanyard. If the button was pushed it rings out to the nurses so people could respond and help. The DON stated the expectation of staff dealing with resident verbal aggression was to calmly walk away and not interact right then. If it gets physical, staff should push their button so others can respond. During an interview on 06/04/2026 at 11:55 AM, the Administrator stated after being contacted she had come to the building to investigate. She learned there had been an altercation between CNA #1 and Resident #76. The Administrator stated, It began as verbal name calling and escalated to a physical altercation. Resident #76 grabbed CNA #1 and put her in a headlock. The Administrator believed it started in the hallway and ended up in the resident's room. The determination was the allegation of abuse from CNA #1 to Resident #76 was substantiated. The Administrator stated suspicion of abuse should be reported immediately to their charge nurse, if staff did not believe anything was being done about it they could report it to the Administrator, DON, ADON, or Social to get it taken care of. Review of a facility policy titled, Abuse, Neglect, and Exploitation, revised in 12/2022 revealed, 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 residents, proactively addressing situations which may lead to abuse, providing thorough staff screening, training, and sufficient staff to effectively care for and monitor residents. Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or anguish or the willful deprivation of necessary goods or services to maintain (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	physical or mental health, or any sexual act, harassment or placing one in reasonable fear of serious bodily harm. Mental abuse was defined as the use of verbal or nonverbal conduct which caused or had the potential to cause the resident to experience humiliation or intimidation. The prevention and intervention program included ongoing monitoring of staff interactions with residents and identifying events that may constitute or contribute to abuse. The facility re-educated all staff following the incident on 04/16/2026, on types of abuse, when to report, and the facility's Abuse, Neglect, and Exploitation policy. In addition, CNA #1 was terminated after the incident involving Resident #76. These actions were performed before the survey team entered the facility, verified by document review and staff interview resulting in this finding being cited at past non-compliance.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to provide written bed hold notification to a resident or the resident's representative upon transfer to the hospital for two (Resident #3 and Resident #71) of two residents who were reviewed for transfers. The findings include: Resident #3 Review of an admission Record indicated the facility admitted Resident #3 with diagnoses that included vascular dementia, schizoaffective disorder bipolar type, and anxiety disorder. Review of an admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/23/2026, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Review of Resident #3's Order Summary Report revealed an order dated 02/13/2026 to transfer to the emergency room (ER) for further evaluation and treatment. Review of the MDS tab in Resident #3's electronic health record revealed a Discharge, Return anticipated MDS was coded on 02/13/2026, with an Entry MDS coded on 03/17/2026. Review of Resident #3's Progress Notes revealed the resident was discharged to the hospital on [DATE] and returned to the facility on [DATE]. Review of a readmission – Bed Hold Policy included in the facility admission Packet was signed by Resident #3's Power of Attorney ([NAME]) on 06/20/2025. A written bed hold notice for the discharge of resident dated 02/13/2026 was not found in Resident #3's electronic medical records. During an interview on 06/02/2026 at 2:30 PM the Nurse Consultant (NC) stated there was not a bed hold completed on 02/13/2026 for Resident #3. Resident #71 Review of an admission Record indicated the facility admitted Resident #71 with diagnoses of adjustment disorder, multiple sclerosis, type II diabetes, and schizoaffective disorder. Review of a quarterly MDS with an ARD of 04/02/2026, revealed Resident #71 had a BIMS score of 15, which indicated the resident was cognitively intact. Review of Resident #71's Change of Condition included in the Progress Notes dated 05/06/2026, revealed Resident #71 complained of chest pains, with physician recommendation to send to the ER for evaluation. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #71's Behavior Note included in the Progress Notes dated 04/18/2026 revealed recommendations from the physician to send to the ER for evaluation. During an interview on 06/02/26 at 2:30 PM, the Nurse Consultant (NC) stated there was not a bed hold completed on 04/18/2026 or 05/06/2026 for Resident #71. The NC stated, We have already started a Performance Improvement Plan (PIP) with the Social Director who is the one that is supposed to be doing those. During an interview on 06/04/2026 at 8:30 AM, the Social Director stated that she had been in the social position for three or four years. She stated that she was the one responsible for sending written bed holds to the residents or their representative. She reviewed Resident #3 and Resident #71's electronic records and stated that there were no bed holds for either resident. She stated that the purpose of the bed hold was when residents go out to hospital we put them on bed hold. It assures residents that they can come back and have a place to live. She stated that she was counseled one on one and a PIP was started the day before. She stated she did not think that failing to send a bed hold would affect the actual care of the resident, but she guessed it could affect the psychosocial care of a resident especially since we have several mental health residents. Review of a facility policy titled Bed Holds and Returns dated 04/24/2025, revealed Prior to a transfer, written information will be given to the residents and the resident representatives that explains in detail: the rights and limitations of the resident regarding bed holds.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Number of residents sampled: Number of residents cited: Based on record review, interviews and facility policy review, it was determined that the facility inappropriately discharged one Resident (Resident #76) of three residents reviewed. The findings include: Review of an admission Record indicated the facility admitted Resident #76 with diagnoses that included adjustment disorder with mixed disturbances of emotions and conduct, mood affective disorder, bipolar disorder, nicotine dependence, problem related to social environment, intellectual disabilities, symptoms and signs involving appearance and behavior and traumatic brain injury. Review of the quarterly Minimum Data Set with an Assessment Reference Date of 04/02/2026, revealed Resident #76 had a Brief Interview of Mental Status score of 14, which indicated the resident was cognitively intact. Resident #76's Resident Mood Interview score was 0 for any negative symptoms. The assessment identified no behavioral symptoms towards others or rejection of care. Review of Resident #76's Care Plan Report initiated on 07/04/2024, revealed the resident chose to smoke and required supervision to do so. Resident #76 had no plans to discharge; the facility was their home. Interventions included knocking before entering resident's room, show respect and involve the resident in the plan of care to allow for decision making as able. Resident #76 expressed maladaptive behavior symptoms related to chronic mental illness and adjustment disorder with mixed disturbance of emotions and conduct. Interventions included separate and redirect, explain the desired behavior to the resident, remind the resident they were expected to behave respectfully and maturely, and utilize behavior management techniques to promote and shape the desired behaviors. Techniques such as controlling the environment noise level, over-stimulation, commotion, and close contact were indicated. Direct resident to stay away from people who increase their agitation. Provide opportunities to have space and fresh air. Review of Resident #76's Order Summary Report dated 06/02/2026, revealed Resident #76 had no discharge order given by a provider. Review of a Notice of Immediate Discharge for Resident letter dated 04/24/2026 and signed by the Administrator, revealed the decision has been made to immediately discharge you from the [Facility] due to inability of the facility to meet your safety needs and putting the safety of individuals in the facility in danger. The facility will assist you and your family in securing a safe place to discharge. Review of an Office of Long-Term Care (OLTC) Incident and Accident Report dated 04/16/2026, described an altercation between Resident #76 and Certified Nursing Assistant (CNA) #1 resulting in the suspension of CNA #1 and Resident #76 seeking treatment at the hospital. Review of Resident #76's Hospital Records dated 04/16/2026, revealed the hospital staff contacted the facility who stated they were comfortable taking the resident back. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #76's Progress Notes from 04/16/2026 to 04/24/2026 revealed no documentation of aggressive behaviors by the resident towards other resident or staff. Review of the Grievance Log from 04/16/2026 to 04/24/2026, revealed no resident had filed a grievance regarding Resident #76. Review of a Progress Note dated 04/17/2026 at 12:02 PM, revealed Resident #76 stated they were in a good mood and loved living in the facility. Review of a Progress Note dated 04/18/2026 at 6:27 AM, revealed Resident #76 had no behaviors during the shift, had a pleasant attitude, and was compliant with medications. Review of a Progress Note dated 04/18/2026 at 12:15 PM, revealed Resident #76 stated they were in a good mood and loved living in the facility. Review of a Progress Note written by the Administrator dated 04/19/2026, revealed Resident #76 was in a good mood, no emotional upset voiced or noted. Resident was participating in activities, especially smoke breaks, and was observed talking pleasantly to the Social Director (Social). Review of a Progress Note dated 04/20/2026 2:10 PM, revealed Social and the Administrator spoke with Resident #76 after a phone call with the resident's family and they wanted to transfer the resident closer to them. Resident #76 agreed. Review of a Progress Note written on 04/20/2026 at 2:18 PM by Registered Nurse #6 the Director of Nursing (DON) at the time, revealed, Resident #76 was alert at baseline mental status. Staff reports reviewed and no further incidents had been noted since the resident had returned from the hospital. Interventions were in place, including staff awareness of the residents' triggers. No other progress notes were found regarding Resident #76 behaviors or discharge process. During an interview on 06/01/2026 at 3:09 PM, Resident #76's family member stated they discussed a transfer to a closer facility with Social the week after the incident and Resident #76 was agreeable to the transfer. Then the family received a call from the behavioral health hospital questioning placement. The behavioral health hospital stated the facility had discharged Resident #76 to the hospital. The family was unaware she had been moved and stated the resident was upset because they thought they were transferred closer to the family as discussed. During an interview on 06/03/2026 at 11:56 AM, the Ombudsman stated she was contacted by the Administrator after the incident between Resident #76 and CNA #1 but was misled regarding the timeline. I was told it just happened and it was eight days later. The Administrator took the resident back then denied it later. The Ombudsman reported she came to the facility and followed up with the Administrator regarding the falsification of the altercation. The Ombudsman stated the facility never had two staff members on the secured unit and there were not two staff members on the secured unit the day of the incident, the staff member had to call for help. During an interview on 06/04/2026 at 2:30 PM, Social stated, Resident #76 loved living here and did not want to move until the family wanted the transfer. Referrals were started, then prior to discharging to the behavioral health hospital a 30-day discharge notice was given. It was 04/24/2026, eight days after the incident. Social stated she was not aware of any aggression in those eight days (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	towards other residents or staff. During an interview on 06/04/226 at 11:55 AM, the Administrator stated on 04/16/2026 Resident #76 and CNA #1 had an exchange of name calling which escalated to a physical altercation. Resident #76 was sent to the hospital for treatment and returned the same day. The Administrator stated, Resident #76 was heard boasting about the incident and if the resident was capable of the physical altercation that occurred with CNA #1 they did not need to be in their facility. The Administrator stated Resident #76 was not physically aggressive but would call staff names. Resident #76 family wanted the resident transferred closer to them. The transfer process was started on 04/20/2026 with referrals. The day after Resident #76 was transferred to the behavioral health hospital the resident's family was notified. The behavioral health hospital called to send the resident back and were told the facility was seeking placement closer to family. Review of a facility policy titled Discharge Planning Process dated 05/17/2022, revealed each resident will have a discharge plan that focuses on the residents' discharge goals, the preparation to be active partners. The planning process will include the caregiver, the resident, and the interdisciplinary team.

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	06/04/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Number of residents sampled: Number of residents cited: Based on interviews, record review, and facility policy review, it was determined that the facility failed to perform blood sugar testing as ordered by a Physician for one (Resident #74) of one resident reviewed. The findings include: Review of an admission Record revealed the facility admitted Resident #74 on 04/21/2025 with diagnoses that included type 2 diabetes (the body cannot use insulin correctly and sugar builds up in the blood.) and hypoglycemia (level of sugar in the blood drops below what is healthy for the person) with an onset date of 06/06/2025. Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/25/2025, revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated the resident had severe cognitive impairment. Review of an Order Summary revealed Resident #74 had an order dated 06/08/2025 to check blood glucose every morning. If greater than 250 notify Medical Doctor (MD). Review of a June 2025 Medical Administration Record (MAR) revealed Resident #74 order to check blood glucose every AM, if greater than 250 notify MD was not on the June MAR. During an interview on 06/04/2026 at 10:29 AM, Licensed Practical Nurse (LPN) #7 stated that once she received an order from the Physician, she repeated the order to make sure the order was correct. She would then enter the order into the electronic record and notify the oncoming nurse about the new order. LPN #7 stated, the order automatically gets put on the MAR once the order was entered into the system and she did not go and check to make sure the order goes to the MAR. During an interview on 06/04/2026 at 11:41 AM, the Director of Nursing (DON) stated that when an order was received from the Physician the order was put into the electronic record and then the order flowed over to the MAR and then the order was carried through. The DON was asked to review Resident #74's Order Summary and June 2025 MAR. The DON reported that the order to check blood glucose every AM, if greater than 250 notify MD was in the Order Summary but was not on the June 2025 MAR. The DON stated that she expected the staff to put in orders correctly and to make sure that orders were carried out and done. The DON stated there were no in services completed with staff for following physician orders or entering physician orders. On 06/04/2026 at 10:32 AM, the Nurse Consultant stated the facility did not have a policy for Physician Orders, Blood Glucose testing, or Quality of Care. Review of an article dated December 8, 2025, and obtained from a database maintained by the American Diabetes Association of Professional Practice Committee for Diabetes, indicated people with diabetes residing in long-term care settings need careful assessment to establish individualized glycemic goals.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Number of residents sampled: Number of residents cited: Based on observations, interviews, record review and facility policy review, it was determined that the facility failed to provide a comfortable, homelike environment for one (Resident #38) of three residents reviewed. The findings include: Review of an admission Record revealed the facility admitted Resident #38 with diagnoses that included chronic obstructive pulmonary disease (COPD), major depressive disorder, atrial fibrillation, pulmonary embolism (blood clot in the lung), allergic rhinitis (allergies) and housing instability (homeless in the last 12 months). Review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/26/2026, revealed Resident #38 had a Brief Interview for Mental Status score of 15 which indicated the resident was cognitively intact. The MDS also revealed Resident #38 identified as sometimes feeling lonely or isolated from those around, the resident required a walker for mobility, and experienced shortness of breath or trouble breathing with exertion, when lying flat, and was on oxygen therapy. Review of Resident #38's Care Plan Report initiated 08/26/2024, revealed the resident had no plans to discharge and the facility was their home. Resident #38 had impaired gas exchange related to COPD. Interventions included Bilevel Positive Airway Pressure (Bi pap), administer oxygen as ordered, monitor and report signs/symptoms of respiratory distress unrelieved with treatment, monitor resident for shortness of breath. The Care Plan also indicated to implement interventions as ordered, monitor and offer support if needed to prevent or decrease anxiety if increased shortness of breath occurs. The Care Plan did not mention the effects cleaning products had on the resident's breathing status or resulting anxiety. Review of an Order Summary Report revealed Resident #38 had an order dated 09/10//2024 for Bi pap at bedtime, to be removed in the morning, to provide positive airway pressure 10-12 breathes per minute at 100% oxygen related to COPD. The Order Summary also included an order dated 05/07/2026 for oxygen to be delivered through a nasal cannula (NC) at 2 Liters (L) per minute as needed. Review of the Medication Administration Record (MAR) dated 06/2026, revealed Resident #38 received inhalers twice a day and had a rescue inhaler available for emergencies. During a concurrent observation and interview on 06/01/2026 at 11:29 AM, Resident #38 was observed in their room wearing 2 L of oxygen per NC, a towel was seen on the floor inside the door. Resident #38 stated that the cleaning spray housekeeping used outside the door was exacerbating their COPD, and that the towel had been placed under the door in an attempt to block the fumes. During a concurrent observation at interview on 06/03/2026 at 6:57 AM, Housekeeper (HSKPER) #4 stated, there were three types of cleaners used in the facility; a bathroom cleaner, a chemical spray, (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and [Brand Name Glass Cleaner], the housekeeper showed a spray bottle of blue liquid and stated it was odor eliminating and used to keep down fragrance for allergies and things like that. The pink spray she used on a towel and wiped down the handrails in the hallways. HSKPER #4 stated no one had ever complained of the chemical spray, I keep an eye on them. I know there is a lot of asthma. During an observation of the facility on 06/03/2026 at 7:04 AM, this surveyor noted a heavy chemical smell in the hallway outside of Resident #38's room. During an interview on 06/03/2026 at 4:51 PM, the Housekeeping/Laundry Supervisor (HSKP Supervisor) stated the staff would get an empty bottle to fill and that the products were already diluted, just fill it up and you are ready to go. The pink cleaner was for bathrooms; the green cleaner was biohazard enzymes and was a deodorizer; and the blue cleaner was a multi surface cleaner. The HSKP Supervisor stated the blue cleaner should be used for the hallways, as it kills a lot of things in just a few seconds. The pink one was stronger as far as odor wise, we do not use it in resident rooms, only bathrooms, and try to catch the residents out at therapy or lunch before using it. The HSKP Supervisor stated he was aware of Resident #38's breathing issues and stated, they waited to clean Resident #38's room when the resident was out and sprayed it lightly because the pink cleaner does have more of an odor. Review of a Safety Data Sheet for the multi surface disinfectant cleaner (blue cleaner) issued 08/18/2022, revealed no inhalation health injuries were known or expected under normal use. Review of a Product Specification Document for the disinfecting acid bathroom cleaner (pink cleaner) dated 08/11/2021, revealed if the cleaner was inhaled remove the person to fresh air and treat symptomatically, get medical attention if symptoms occur. During an interview on 06/03/2026 at 5:15 PM, the Administrator and Nurse Consultant were made aware of the concern for an incorrect cleaning product being used outside of Resident #38's room. The Nurse Consultant instructed the HSKP Supervisor to start an in-service with HSKPER #4 and all other housekeepers the next morning regarding correct cleaning products. Review of a facility policy titled Resident Rights revised on 11/01/2022, revealed Federal and state laws guarantee certain basic rights to all residents of the facility These rights include the residents' rights to a safe, clean, homelike environment including but not limited to treatment and supports for daily living safely.