STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045372	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at White Hall Rehab & Nursing Center	9209 Dollarway Road White Hall, AR 71602

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46724 Based on observation, interview, and record review, the facility failed to ensure a call light was kept in reach to ensure a resident had a means to call for assistance for 1 (Resident #296) of 1 resident sampled for accommodation of needs. The findings are: Review of the Medical Diagnosis Screen indicated Resident #296 had diagnoses which included anxiety disorder, schizophrenia, muscle weakness wasting and atrophy, and abnormality of gait. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/01/2024, indicated Resident #296's vision was highly impaired. The MDS indicated a Brief Interview of Mental Status (BIMS) of 12, which indicated moderate cognitive impairment. The MDS also indicated Resident #296 rejected care daily, was independent with toileting, was continent of bladder and bowel, and ambulated short distances without assistance. Review of Resident #296's Care Plan with an initiated date of 10/17/2023, indicated the resident was blind, and that staff were to ensure the call light was within reach and to respond to needs promptly. On 04/14/25 at 9:12 AM, Resident #296 was observed in their room sitting in a recliner. Resident #296's call light was lying on the floor in front of the recliner. When asked if the resident could reach the call light, Resident #296 stated No, where is it? Resident #296 confirmed experiencing blindness and was unable to locate call light. The call light was observed again on the floor at 11:48 AM, and again when checked at 3:24 PM. On 04/15/25 at 8:25 AM, Resident #296 was observed sitting in the recliner in their room with the call light lying on the floor in front of the recliner, out of reach of the resident. During an interview, on 04/15/2025 at 8:30 AM, Licensed Practical Nurse (LPN) #15 confirmed Resident #296 had impaired vision and that the call light should be placed in reach of the resident so that the resident could use it to call for assistance when needed.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51814 Based on observation, record review, and interview, the facility failed to ensure incontinent care was provided in a timely fashion and in accordance with the resident ' s needs for one (Resident #247) of one sampled resident dependent on facility staff for incontinent care. The findings are: Review of a Medical Diagnosis report revealed Resident #247 was admitted to the facility with diagnoses that included a fracture in the lower part of the upper left arm bone, a fracture in the upper part of the upper left arm bone, and obesity class 3, with body mass index 45.0 - 49.9, adult. Review of a Baseline Care Plan for admitted d 04/10/2025, indicated the resident could easily communicate with staff, was cognitively intact and required maximal assistance for toileting hygiene. The health conditions section indicated that the resident was always incontinent of bowel and bladder. The functional abilities section for mobility indicated the resident was dependent to roll left and right in bed. Review of a Care Plan assessment dated [DATE], indicated the resident required staff assistance times two for incontinent/perineal care. On 04/14/25 at 10:36 AM, a review of Resident #247 ' s Wound Evaluation, dated 04/10/2025, indicated the resident had a pre-admission stage 2 pressure injury at the sacrum. On 04/14/25 at 9:04 AM, Resident #247 was interviewed and reported incontinence of bowel and bladder. Resident #247 stated a request to receive incontinent care was made to two different staff members within the last twenty minutes. On 04/14/25 at 9:37 AM, Resident #247 verified staff had not provided incontinent care. The room had a foul odor. On 04/14/25 at 10:48 AM, Resident #247 verified staff had not provided incontinent care. The room had a foul odor. On 04/14/2025 from 9:04 AM until 11:22 AM, this surveyor remained in the hallway within view of Resident #247's room and no staff were observed entering the room during that time to assist the resident. On 04/14/25 at 11:22 AM, Certified Nursing Assistant (CNA) #1 and CNA #2 knocked on the resident's door, announced themselves, and entered Resident #247's room. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/14/2025 at 11:26 AM, this surveyor knocked on Resident #247's door, announced self, and with Resident #247 ' s permission, entered the room. Resident #247 was observed lying in bed in a hospital gown. The resident's left arm was in a full plastic arm brace, and a purple bruise about the size of a sheet of copy paper was on the resident's left flank/shoulder areas. The resident's brief was down, exposing the brief was over half full of loose stool. CNA #1 had on gloves, no gown, and was standing on the left side of the resident handing CNA #2 cleaning wipes. She used the cleaning wipes several times each and tucked the used wipes into the soiled brief between the resident's legs. CNA #1 was observed multiple times to reach into her jacket pockets for gloves. She was observed touching both curtains in the room, dispensing cleaning wipes and providing perineal care with dirty gloves on her hands. She was not observed using hand sanitizer at any time in the room or during perineal care. During perineal care CNA #1 removed her gloves and went outside of the room. CNA #1 came back into the resident's room, reached into her jacket pocket again for gloves to wear. CNA #2 had gloves on, no gown and was standing on the right side of the resident. She used the cleaning wipes several times each and tucked the used wipes into the soiled brief between the resident's legs. She changed gloves multiple times. She was not observed performing hand hygiene at any time in the room during perineal care. On 04/14/2025 at 11:42 AM, CNA #1 and CNA #2 were placing a clean brief on Resident #247. Before the brief was fastened, this surveyor asked CNA #2 and CNA #1 if the resident's perineal care was completed, and each CNA indicated the perineal care was complete. This surveyor requested one of the CNAs to please take a cleaning wipe and wipe down one side of the resident's groin. The Director of Nursing (DON) peered over the resident and asked, did we not get it all? CNA #1 obtained a cleaning wipe and wiped down the side of the resident's groin with a large amount of fecal material being present on the wipe. The DON left the resident's room. Within 5 minutes the Restorative CNA knocked on the door, announced self and entered the room. The Restorative CNA had on a gown, used hand sanitizer located by the door and put on gloves. She then assisted with perineal care. CNA #1, CNA #2 and Restorative CNA continued cleaning the resident's groin area utilizing over a half bag of wipes to finish cleaning the resident after CNA #1 and CNA #2 stated they were finished providing perineal care. On 04/14/2025 at 12:00 PM, upon the completion of incontinent care, CNA #1 and CNA #2 verified the only hand sanitizer in the room was next to the door on the opposite side of the room. CNA #1 and CNA #2 confirmed they did not utilize any hand sanitizer during the incontinent care. On 04/14/25 at 12:12 PM, the Restorative CNA was interviewed and indicated it was important for the resident to receive proper incontinence care to avoid cross contamination and prevent urinary tract infections. The Restorative CNA reported gloves should be changed and hands sanitized between each clean and dirty task. On 04/14/25 at 12:16 PM, CNA #1 was interviewed and indicated it was important for a resident to receive proper incontinent care to keep the resident from getting a bacterial infection or having skin problems. She reported the process for incontinent care included gathering supplies, knocking on the door, greeting the resident, explaining the care, and providing proper incontinent care. CNA #1 stated during incontinent care, hand sanitizing should take place when changing gloves and every time the gloves are dirty. She indicated she did not wash her hands, nor sanitize her hands at any time during incontinent care provided to Resident #247 today. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/14/25 at 12:17 PM, CNA #2 was interviewed and indicated it was important for a resident to receive proper incontinent care to prevent infection and prevent skin breakdown. She indicated each cleaning wipe should be used for one wipe and then disposed. She stated proper incontinent care would provide the resident with thoroughly cleansed skin. CNA #2 indicated hand sanitizer should be used every time gloves were removed, and verified she did not use hand sanitizer while providing incontinent care for Resident #247 today. On 04/14/25 at 3:38 PM, the DON was interviewed and indicated it was important to promptly and thoroughly clean the perineal area during incontinent care to prevent infection and to protect the skin. The DON reported the incontinent care provided by CNA #1 and CNA #2 to Resident #247 did not meet her expectation of incontinent care. She verified she was in the room during incontinent care and observed that CNA #1 and CNA #2 did not change gloves when indicated, did not sanitize hands and did not provide proper incontinent care. On 04/17/25 at 2:59 PM, the Administrator verbally verified the facility did not have a policy for incontinent care. On 04/14/2025 at 2:59 PM, the Administrator was asked to provide documentation of a facility hand washing policy. No hand washing policy was provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37925 Based on record review and interview, the facility failed to ensure a resident was re-assessed for safe smoking behaviors before being allowed to smoke after the admission smoking evaluation indicated the resident did not smoke for 1 (Resident #91) of 1 sampled resident reviewed for smoking. The findings are: On 04/14/2025, the Administrator provided a list of residents who use tobacco products and Resident #91's name was listed on the document. Review of an admission Minimum Data Set with an Assessment Reference Date of 03/04/2025, revealed the resident had a brief interview for mental status score of 07, which indicated Resident #91 had moderate cognitive impairment and did not use tobacco products. Review of an Admission/Readmission Nursing Evaluations Packet with an effective date of 02/27/2025, revealed Resident #91 did not use smoking/tobacco/nicotine products and the smoking evaluation was stopped. Review of the Progress Notes revealed the following: -A Nursing Note dated 02/27/2025 at 4:41 PM, which indicated Resident #91 was admitted to the facility by way of an emergency medical service. -A Medication Administration Note, dated 02/28/2025 at 7:46 AM, which indicated a nicotine patch 24 hour 14 milligrams per 24 hours (14GM/24HR), apply 1 patch on the skin (transdermally) one time a day for nicotine, remove per schedule and the note indicated the medication was not available. - A Medication Administration Note dated 03/01/2025 at 5:19 AM, Nicotine Patch 24-hour 14 MG/24HR. The resident refused the medication. - A Progress Note/ H and P (History and Physical) by the APRN (Advance Practice Registered Nurse), dated 03/23/2025 at 11:00 PM, revealed a date of service of 03/24/2025, and indicated Resident #91 was in the dayroom at the time of the visit. The note indicated Resident #91 wanted to smoke a cigarette. The note indicated the APRN checked on the resident later and the resident was sitting in front of a door to go out to smoke at 11:30 AM. - A Progress Note/ H and P by the APRN, dated 03/24/2025 at 11:00 PM, revealed a date of service of 03/25/2025, and indicated Resident #91 was sitting up in a wheelchair in the resident's room getting ready to go outside and smoke. - A Weight Note dated 04/04/2025 at 1:56 PM, revealed the nicotine patch had been discontinued because the resident was smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the April 2025 Electronic Medication Administration Record (eMAR) revealed the nicotine patch 24-hour 14 MG/24HR apply 1 patch transdermally [on the skin] one time a day for Nicotine and remove per schedule with a start date 02/28/2025 at 6:00 AM, had a discontinued date of 04/04/2025. Review of an Admission/Readmission Nursing Evaluation packet 02/27/2025, revealed Resident #91 did not use smoking/tobacco/nicotine products. Review of the Care Plan Report dated 3/25/2025, revealed Resident #91 had a behavior problem related to at times Resident #91refused to wear a smoking apron when smoking initiated on 04/15/2025. Review of a Smoking/Nicotine Devices form, dated 4/15/25, indicated Resident #91 had a score of 6, which a score of 10 or greater should be considered at risk and needs supervision when smoking. The form indicated the resident smoked cigarettes, morning, afternoon and evening and required supervision, including retrieval. On 04/17/25 at 9:02 AM, Resident #91 was seen walking in the hall by the dining room with a walker waiting to go outside to smoke. At 9:06 AM, an unidentified female staff member went out the door on hall 600 with this resident and two other residents. She handed Resident #91 a cigarette and lit the cigarette. Resident #91 was observed with a lit cigarette to the resident's mouth and white smoke coming from the resident's mouth. On 04/17/2025 at 4:02 PM, during an interview with the Director of Nursing (DON) and the Administrator, the DON stated the nurse completed the smoking assessment for residents on admit, quarterly, and as needed. The Administrator stated she would need to check if a resident was allowed to smoke before being assessed for smoking behaviors. On 04/17/2025 at 5:41 PM, the Administrator and DON were asked if residents were assessed before being given smoking privileges. The Administrator stated residents had the right to smoke. The Administrator stated residents were assessed on admission, quarterly, and as needed. Review of a Smoking Policy, not dated, and located in the admission packet provided by the administrator on 04/14/2025, indicated the purpose was to determine if a resident was an independent smoker or an at-risk smoker before the resident exercised the privilege to smoke while residing in the facility and to establish guidelines for all residents that desired to smoke at the facility. The policy also indicated residents will be assessed for safe smoking behavior prior to smoking at the facility. On 04/17/2025 the Administrator provided a Smoking Policy, not dated and stated the smoking policy was revised Friday, 04/11/2025. The smoking policy was reviewed and indicated the resident would be evaluated on admission to determine if the resident was a smoker or non-smoker. The policy indicated that staff would consult with the attending physician and DON to determine if safety restrictions needed to be placed on a resident's smoking privileges based on the smoking assessment and the resident's ability to smoke would be re-evaluated as determined by staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51814 Based on observation, record review, and interview, it was determined the facility failed to ensure staff changed gloves and performed proper hand hygiene during incontinent care for 1 (Resident #247) of 1 sampled resident reviewed for incontinent care. The findings are: Review of a Medical Diagnosis report indicated Resident #247 was admitted with diagnoses that included a fracture in the lower part of the upper left arm bone, and a fracture in the upper part of the upper left arm bone, and obesity class 3, with body mass index of 45.0 - 49.9, adult. Review of a Baseline Care Plan for admitted d 04/10/2025, indicated Resident #247 could easily communicate with staff, was cognitively intact and required maximal assistance for toileting hygiene. The health conditions section indicated Resident #247 was always incontinent of bowel and bladder. The functional abilities for mobility section indicated Resident #247 was dependent to roll left and right in bed. Review of a Care Plan assessment dated [DATE], indicated Resident #247 required staff assistance times two for incontinent/perineal care. On 04/14/25 at 10:36 AM, review of Resident #247 ' s Wound Evaluation report dated 04/10/2025, indicated the resident had a pre-admission, stage 2 pressure injury at the sacrum. On 04/14/2025 at 10:36 AM, review of Resident #247 ' s Order Summary dated 04/11/2025, indicated to follow Enhanced Barrier Precautions (EBP). On 04/14/25 at 9:04 AM, Resident #247 was interviewed and reported incontinence of bowel and bladder and stated a request to receive incontinent care was made to 2 different staff members within the last 20 minutes. A sign on the resident's door indicated Enhanced Barrier Precautions (EBP). On 04/14/25 at 11:22 AM, Certified Nursing Assistant (CNA) #1 and CNA #2 knocked on Resident #247's door, announced themselves and entered the resident ' s room without Personal Protective Equipment (PPE). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/14/2025 at 11:26 AM, this surveyor knocked on Resident #247's door, announced self, and with Resident #247s permission, entered the room. Resident #247 was observed lying in bed in a hospital gown. The resident's left arm was in a full plastic arm brace, and a purple bruise about the size of a sheet of copy paper was on the resident's left flank/shoulder areas. The resident's brief was down, exposing the brief over half full of loose bowel. CNA #1 had on gloves, no gown, and was standing on the left side of the resident handing CNA #2 cleaning wipes. She used the cleaning wipes several times each and tucked the used wipes into the soiled brief between the resident's legs. CNA #1 was observed multiple times to reach into her jacket pockets for gloves. She was observed touching both curtains in the room, dispensing cleaning wipes and providing perineal care with dirty gloves on her hands. She was not observed using hand sanitizer at any time in the room during perineal care. During perineal care, CNA #1 removed her gloves and went outside of the room. CNA #1 came back into Resident #247's room, reached into her jacket pocket again for gloves to wear. CNA #2 had gloves on, no gown and was standing on the right side of the resident. She used the cleaning wipes several times each and tucked the used wipes into the soiled brief between the resident's legs. She changed gloves a few times. She was not observed to sanitize hands at any time in the room during perineal care. The Director of Nurses (DON) knocked on the door, announced self, entered the room and indicated to the CNAs they should have gowns on while providing care, stating the resident had a wound. CNA #1 and CNA #2 went to resident's door with the DON and discussed what PPE should be utilized for a resident on EBP. CNA #1, CNA #2 and the DON donned gowns and then continued with perineal care. The DON went into the resident's bathroom to wash her hands, donned gloves, and began to assist with resident care. The DON was observed to tuck the soiled brief under the resident. Using the same gloves the DON was observed holding the resident's left arm brace to offer support during repositioning. On 04/14/2025 at 12:00 PM, upon the completion of incontinent care, CNA #1 and CNA #2 verified the only hand sanitizer in the room was next to the door on the opposite side of the room. CNA #1 and CNA #2 confirmed they did not utilize any hand sanitizer during the incontinent care. On 04/14/25 at 12:12 PM, the Restorative CNA was interviewed and reported gloves should be changed and hands sanitized between each clean and dirty task. On 04/14/25 at 12:16 PM, CNA #1 was interviewed and stated during incontinent care, hand sanitizing should take place when changing gloves and every time the gloves are dirty. She indicated she did not wash her hands, nor sanitize her hands at any time during incontinence care provided to Resident #247 today. On 04/14/25 at 12:17 PM, CNA #2 was interviewed and indicated each cleaning wipe should be used for one wipe and then disposed of. CNA #2 indicated hand sanitizer should be used every time gloves are removed. She verified she did not use hand sanitizer while providing incontinent care for Resident #247 today. On 04/14/25 at 3:38 PM, the DON was interviewed and verified she was in the room during incontinent care and observed CNA #1 and CNA #2 did not change gloves when indicated, did not sanitize hands, and did not provide proper incontinent care. The DON indicated the CNAs and nurses had been in-serviced for EBP including which PPE is required. She confirmed that staff with gloves on who have touched a dirty brief should not touch a resident's arm brace with the same dirty gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/17/25 at 2:59 PM, the Administrator provided handwritten documentation that the facility did not have a policy for enhanced barrier precautions (EBP) and verbally verified the facility did not have a policy for incontinent care. On 04/14/2025 at 2:59 PM, the Administrator was asked to provide documentation of a facility hand washing policy. No hand washing policy was provided.