STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045385	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at North Little Rock Rehab & Nursing	2501 John Ashley Drive North Little Rock, AR 72114

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were free from significant medication errors related to omitted antiseizure medication administration for one (Resident #2) of three residents reviewed for medication administration. The findings include: Review of Resident #2's admission Record revealed the facility admitted Resident #2 on 10/05/2025 with diagnoses that included epilepsy intractable with status epilepticus, acute respiratory failure with hypoxia, cognitive communication deficit, cerebral aneurysm, dementia, Alzheimer's disease, dysphagia, depression and anxiety. Review of an admission Minimum Data Set (MDS), with an Assessment Reference Date of 10/10/2025, revealed Resident #2 had a Brief Interview for Mental Status score of 7, which indicated the resident had severe cognitive impairment. The MDS also revealed the resident was being administered anti-seizure medications. Review of Resident #2's Care Plan, initiated on 10/08/2025, revealed the resident had a seizure disorder. Interventions included administering seizure medications as ordered by doctor. Review of an After Visit Summary revealed Resident #2 was to be discharged from the hospital to the facility on [DATE]. Resident #2's medication list in the After Visit Summary indicated the resident needed to take antiseizure medication, 25mg (milligrams), once daily for 180 days. Review of the Medical Director's History and Physical (H&P) visit note dated 10/08/2025, revealed Resident #2 had an active medical problem of status epilepticus. The assessment and plan of the H&P revealed Resident #2 would continue antiseizure medication for epilepsy. Review of Resident #2's Order Summary Report revealed an active order with a start date of 10/07/2025 for an antiseizure medication to be administered one tablet by mouth one time a day related to epilepsy, intractable with status epilepticus for 180 days. Review of Resident #2's Medication Administration Record (MAR) for October 2025 revealed the antiseizure medication was coded as the following per the chart codes list: -10/15/2025 coded 5 (Hold/See Nurse Notes) by Registered Nurse (RN) #6. -10/16/2025, 10/17/2025 and 10/18/2025 coded 9 (other/see nurse notes) by Licensed Practical Nurse (LPN) #3.-10/19/2025 coded 5 by the Assistant Director of Nursing (ADON). -10/20/205,10/21/2025, and 10/22/2025 coded 5 by RN #6. -10/23/2025 and 10/24/2025 coded 9 by LPN #3. -10/25/2025 coded as administered by (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #3. -10/26/2025 coded 9 by LPN #7.-10/27/2025 coded 5 by RN #6. -The resident was discharged from the facility on 10/27/2025. Review of Resident #2's Progress Notes revealed that on 10/15/2025 there was no note that indicated the antiseizure medication was on hold. On 10/16/2025, 10/17/2025, and 10/18/2025 LPN #3 noted the antiseizure medication order and included that the medication was on order. On 10/19/2025, 10/20/2025, 10/21/2025, and 10/22/2025 there were no notes regarding the antiseizure medication. On 10/23/2025 and 10/24/2025 LPN #3 noted the antiseizure medication order with no further details. On 10/26/2025 LPN #7 indicated medication not available regarding the antiseizure medication. On 10/27/2025, RN #6 noted the antiseizure medication order with no further details. During a telephone interview on 05/14/2026 at 9:40 AM, the Pharmacist indicated seven tablets of the antiseizure medication were sent to the facility on [DATE] for Resident #2 with permission from the Director of Nursing (DON) to bill the facility for the medication. On 10/13/2025 the Pharmacist reported the pharmacy had a memo from the DON not to bill the facility. The Pharmacist reported she did not have any more processing request for the antiseizure medication and no additional doses of Resident #2's antiseizure medication had been provided to the facility following the initial seven doses. She reported the prescription for the antiseizure medication was not exhausted, and additional doses were available for the facility to request. The Pharmacist indicated if a resident suddenly stopped taking antiseizure medication the resident would be at an increased risk of seizures. She explained that a resident may take more than one antiseizure medication as different medications work in different ways. She reported it was not unusual for a resident to be prescribed more than one antiseizure medication because the medication's mechanism of action was usually different. During an interview on 05/12/2026 at 2:04 PM, LPN #4 indicated if a medication was not available for administration to the resident, the nurse should inform the provider that the medication was not available and an order to hold the medication should be obtained. She reported that the nurse should contact the pharmacy to inquire of the reason the medication was not available in the facility. During an interview on 05/13/2026 at 1:40 PM, LPN #5 indicated if a medication was not available for administration to the resident, the nurse should inform the pharmacy, the provider and the resident's family that the medication was not available to be administered. She reported that once a medication was ordered from the pharmacy, the pharmacy would have the medication delivered to the facility within two hours if it was ordered stat. She reported it was important for a resident to receive their medication because it was ordered for a reason, they need their medication and it could have a bad effect on the resident if medications were missed. During an interview on 05/13/2026 at 2:17 PM, the ADON indicated if a 5 or a 9 was in the date box of the MAR, a progress note should be present to explain the reason the medication was not administered. He reported that if a medication was not available for a resident, the nurse should call the pharmacy and inquire about the missing medication and make sure the medication had been ordered and that the pharmacy did have the order. He indicated that it was important that a resident received their prescribed medications because they have been diagnosed by a provider, so they need to take the medications. During an interview on 05/13/2026 at 3:02 PM, LPN #4 indicated if a medication was not available to administer to the resident, the nurse should call the provider to hold the medication, notify the pharmacy so we can get the medication and notify the family of the resident. She stated, we must have an order to hold the medication. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/13/2026 at 3:59 PM, the Director of Nursing (DON) reported the floor nurses were responsible for administering medications. She reported a provider order was required for a medication to be held. She indicated if a medication was not available for administration the doctor should be notified and the pharmacy needed to be contacted. She stated, the floor nurse that cannot find the medication, should be trying to find out where it [the medication] is. She indicated it was important for a resident to receive their prescribed medication because that was the plan of care the provider made for them. During an interview on 05/13/2026 at 5:12 PM, LPN #3 indicated if a medication was not available for administration, she will usually find out if the pharmacy had received the order. She reported that when a medication was not available, the nurse should contact the provider and the family. She indicated she did not recall if she notified the provider or family. She reported that she went to the DON about the medication not being available. She verified in a Progress Note dated 10/16/2025 she indicated the medication was on order. She indicated it was important for a resident to receive prescribed medication to keep the resident from having problems that the medication was treating. When asked about the 10/25/2025 entry in Resident #2's MAR, LPN #3 stated the medication was not available on that date, but verified she had indicated the medication was administered. During an interview on 05/14/2026 at 9:00 AM, Medication Assistant Certified (MAC) #2 reported if a medication was not available for administration, she would tell the charge nurse and place a stat order on the pharmacy website. She indicated that if she noticed a medication was not being administered to a resident, she would notify the charge nurse. During an interview on 05/14/2026 at 9:10 AM, LPN #1 reported if a medication was not available for administration, she would contact the pharmacy to ensure the medication had been ordered. She indicated she would also notify the resident or the resident's representative and let the provider know about it. During a telephone interview on 05/14/2026 at 10:09 AM, Advanced Practice Registered Nurse (APRN) reported she expected if a medication was not available the nurse would let her know and the nurse would reach out to the pharmacy. She reported it was important that a resident's prescribed medication was administered as ordered because they needed the medication. She indicated she could not recall being notified of Resident #2 not receiving the antiseizure medication. During a telephone interview on 05/14/2026 at 10:24 AM, Medical Director reported that if medication was not available, he would expect the nurse to contact him and the pharmacy. He reported he could not recall if he was notified of Resident #2 not receiving medication. During an interview on 05/14/2026 at 11:45 AM, Administrator reported she was told by the DON on 10/28/2025 that the family had made an allegation of the resident not receiving one dose of seizure medication. She reported that the pharmacy had not notified the facility that they had not sent the medication yet. She indicated cost was not an issue with the medication being filled, not on the facility side. She reported it was important that a resident received prescribed medication as ordered for their health and safety.