

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045418	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER The Blossoms at Oakdale Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Cynthia Street Judsonia, AR 72081	

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 - Some</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** 49596</p> <p>Based on interview and record review the facility failed to ensure a resident's Advance Directive was signed by resident or resident's power of attorney regarding the resident's right to request, refuse, and/or discontinue treatment, and to formulate an advance directive for 1 (Resident #49) of 1 resident reviewed for advanced directives/</p> <p>The findings are:</p> <p>Resident #49 ' s Minimum Data Set with an Assessment Reference Date of [DATE], identified the resident as having a Brief Interview for Mental Status (BIMS) of 12 , a score of ,d+[DATE] indicating the resident has moderate cognitive impairment.</p> <p>Resident #49 ' s Care Plan identified the resident's Brief Interview for Mental Status (BIMS) score was 9 indicting moderate cognitive impairment on [DATE].</p> <p>Resident #49 medical diagnoses, as identified on the resident's Order Summary Report , included type 2 diabetes mellitus; hypertension; depression; chronic kidney disease; abdominal pain.</p> <p>On [DATE], at 02:16 PM, a review of Resident #49 ' s Physician Order dated [DATE] revealed an order of Do not resuscitate (DNR).</p> <p>On [DATE] at 02:23 PM, a review of Resident #49 ' s Care Plan reflected the resident ' s code status to be Do not resuscitate (DNR), with a date initiated [DATE], with an intervention for DNR status: Check the resident's/responsible party signature on consent form. Verify physician's orders. Check for DNR status indicated on the resident's profile/face sheet. Date Initiated: [DATE].</p> <p>On [DATE] at 2:00 PM a review of Resident #49 ' s DNR form signed and dated by a friend, indicating Resident #49 does not want Cardiopulmonary Resuscitation (CPR). This form is signed by Friend. Per the record review, this Friend does not have Power of Attorney (POA) for Resident #49.</p> <p>On [DATE] at 2:00 PM, the Administrator said the friend does not have POA for R 49 per record review and Administrator interview. The Physician signed the order on [DATE].</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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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On [DATE] at 2:00 PM, the record review of a document titled, Do Not Resuscitate/Cardiopulmonary Resuscitations DNR/CPR Instruction and Physician Order signed on [DATE] by the same friend, was marked I do not choose to formulate or issue any Advance Directives at this time.</p> <p>A review of the Admission Packet, dated [DATE], reflected the resident signed the forms pertaining to Resident #49 's influenza and pneumococcal vaccines, but he did not sign the DNR forms.</p> <p>On [DATE] at 2:57 PM, the Administrator reviewed the DNR for Resident #49 in the electronic record on his computer and said, I do not know if this document is legal or not.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916</p> <p>Based on record review and interview, the facility failed to ensure a resident's discharge/transfer information was sent in a timely manner to the Office of the Ombudsman, affecting 1 (Resident 28) of 1 resident sampled for transfers and discharge, and any resident discharged or transferred since the system change.</p> <p>Findings include:</p> <p>A review of the Medical Diagnosis portion of the electronic health record revealed Resident 28 had diagnoses of respiratory failure, heart attack, and chronic obstructive pulmonary disease.</p> <p>The quarterly Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 10/15/2024 suggested a Brief Interview for Mental Status (BIMS) score of 15 (13-15 indicates the resident was cognitively intact).</p> <p>On 01/16/2025 at 09:45 AM, the Administrator was asked for a list of discharge/transfers that were sent to the Ombudsman since October 2024 showing Resident 28's hospitalization on [DATE], and he stated that he will be honest it got behind, and [MDS] is doing them and had to catch them up.</p> <p>On 01/16/2025 at 10:35 AM, the Administrator confirmed he does not have a list of resident discharge/transfers for the last 4 months. Administrator provided a copy of the SNF/NF to Hospital Transfer Form, dated 10/06/2024, and stated this is all he can find from Resident 28 's hospitalization . When asked to confirm whether the required information was sent to the Ombudsman regarding Resident 28 ' s hospitalization , he said it got behind, then the MDS nurse said they just found out about it yesterday and was told to get it caught up and done.</p> <p>On 01/16/2025 at 10:42 AM, MDS 2 stated she had been in her role for several years, and that she has never faxed a discharge transfer list to the Ombudsman and does not have a policy or procedure, and stated, I just found out about this yesterday. MDS 2 confirmed she does not know why this information is tracked for the Ombudsman.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure a resident or their representative received a written notice of the bed hold policy in a language they can understand for 1 of 1 sampled (Resident 28) resident.</p> <p>Findings include:</p> <p>A review of Medical Diagnosis revealed Resident 28 had diagnoses of respiratory failure, heart attack, and chronic obstructive pulmonary disease.</p> <p>The quarterly Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 10/15/2024 revealed Resident 28 received a Brief Interview for Mental Status (BIMS) score of 15 (13-15 indicates cognitively intact).</p> <p>On 01/16/2025 08:33 AM, the Administrator was asked for bed holds for Resident 28 for April and October of 2024. The Administrator revealed that they did not have a business office manager during that time, and he would be reaching out to the person that was doing bed holds to see if Resident 28 had one.</p> <p>On 01/16/2025 at 09:00 AM, Resident 28 was asked if she received a bed hold policy, or something explaining how Resident 28 could reserve residents room while hospitalized on [DATE]. Resident 28 did not recall being provided a bed hold policy.</p> <p>On 01/16/2025 at 09:40 AM, the Business Office Manager (BOM) stated that she does not know who was doing bed holds last year prior to the system change, and Resident 28 does not have any bed holds for last year. When asked why it is important to give residents bed holds, the BOM stated it is important so that residents and families know their financial responsibility if they return to the facility, and we hold their bed. She confirmed that residents sent to the hospital should have a bed hold. The BOM was asked to provide a bed hold policy or procedure.</p> <p>On 01/16/2025 at 09:50 AM, the Administrator provided a policy titled Bed Holds and Returns, effective 05/2021, revealing prior to transfers or therapeutic leave, residents or their representative will be informed in writing of the facility bed hold policy.</p> <p>On 01/16/2025 at 10:34 AM, the Administrator provided a copy of the SNF/NF to Hospital Transfer Form, dated 10/06/2024, revealing Resident 28 was sent to the hospital. The Administrator stated that he knows this is not a bed hold but it is the only paperwork he can find showing Resident 28 was sent to the hospital.</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37634</p> <p>Based on interview and record review, the facility failed to ensure the state designated authority was informed when 1 (Resident #39) of 2 (Resident #39 and #41) sampled residents reviewed for Preadmission Screening and Resident Review (PASARR) received a new diagnosis that required evaluation.</p> <p>The findings included:</p> <p>A review of Resident #39's Medical Diagnoses indicated that Resident #39 was diagnosed with bipolar disorder, unspecified on 9/01/2023.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/2024, revealed Resident #39 had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact.</p> <p>On 1/16/2025 at 10:22 AM, the state designated authority indicated the last Level 1 application for PASARR for Resident #39 was on 12/20/2021. When contacted by phone, the state designated authority indicated that they were not informed that Resident #39 was a resident at this facility, and they were not aware of his bipolar diagnosis.</p> <p>On 1/16/2025 at 11:09 AM, the Director of Nursing (DON) indicated that the MDS staff are responsible for notifying the state designated authority if a resident had a new diagnosis that requires a PASARR.</p> <p>On 1/16/2025 at 11:18 AM, MDS #2 indicated that Resident #39 was admitted before she took over the position as MDS Coordinator. MDS #2 indicated that Resident #39 transferred from another facility, and he had a PASARR from the other facility. MDS #2 indicated that Resident #39 was admitted [DATE], and the state designated authority was notified. MDS #2 indicated that she is now responsible for contacting the state designated authority if a resident had a new diagnosis that required a PASARR screening. MDS #2 indicated that Resident #39 was admitted with a PASARR, and a new PASARR was not obtained.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>37634</p> <p>49689</p> <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents who required assistance with activities of daily living were regularly provided with the necessary assistance to maintain good hygiene and grooming, as evidenced by failure to ensure fingernails were kept clean and trimmed for one out of one resident (Resident #69) and ensuring residents face and nails were cleaned before or after meals for one out of one resident (Resident #76).</p> <p>The significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/22/2024, revealed Resident #69 had a Brief Interview for Mental Status score of 5, which indicated severe cognitive impairment.</p> <p>A review of Resident #69's Care Plan, revised on 11/12/2024, revealed the resident had an ADL self-care performance deficit related to hemiplegia left side, strokes, and contractures of his left hand. Intervention initiated 12/06/2023 included assistance by one staff member with personal hygiene.</p> <p>On 1/14/2025 at 1:12 PM, Resident #69's nails were long with a black substance underneath.</p> <p>On 1/14/2025 at 1:24 PM Certified Nurse Aide (CNA) 11 indicated that nail care is supposed to be completed every day.</p> <p>On 1/14/2025 at 1:27 PM CNA #11 observed Resident #69 nails and indicated they were long with black stuff underneath them.</p> <p>On 1/15/2025 at 1:47 PM Resident #69's nails remained long, with a black substance underneath.</p> <p>On 1/16/2025 at 11:13 AM the Director of Nurse (DON) indicated that nail care is completed on Sundays and is dependent on staffing. The DON indicated that there are no particular days for nail care. She indicated that nail care is completed on shower days also.</p> <p>2. A facility review of the Dignity Inservice with a date of 10/16/2024 indicates that staff were responsible for, Grooming residents as they wished to be groomed (e.g. hair combed and styled, beards shaved/trimmed, nails clean and clipped.)</p> <p>A review of the Order Summary indicated Resident #76 had diagnoses that included schizoaffective disorder, traumatic brain injury, bipolar II disorder, and unspecified intellectual disabilities.</p> <p>The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/12/2024 revealed Resident #76 had scored a 9 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS). Section GG is coded for a 04 on personal hygiene, which indicated resident is a supervision/touching assistance with tasks.</p> <p>Review of Resident #76's Care Plan initiated on 06/07/2024 indicates had an activity of daily living self-care performance deficit, interventions included personal hygiene supervision.</p> <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 - Some</p>	<p>On 01/13/2025 at 10:50 AM, Resident #76 was walking with walker, the surveyor observed that Resident #76's hair is greasy and uncombed, there is dry skin around their nose, brown matter sits in the corners of their mouth and lines the bottom of their lip, and there is matter observed around nail beds on hands.</p> <p>On 01/13/2025 at 11:50 AM, Surveyor observed that Resident #76 had white cream on upper lip, brown and yellow matter is observed in the corner of their mouth, brown matter is observed in a line down their chin, dry skin deposits are noted around Resident #76 's nose, matter is observed around nail beds and underneath nails. An unidentified Certified Nursing Assistant (CNA) is washing residents' hands with sanitary towels, handed one to Resident #76 who sat it down on the table. The CNA did not encourage or help the resident with washing hands or face.</p> <p>On 01/13/2025 at 12:00 PM Surveyor observed that Resident #76 is eating meal with unwashed hands and face. Resident #76 is eating cookies for dessert with unwashed fingers, the surveyor observed Resident #76 eat meal and walk away with unwashed hands and face.</p> <p>On 01/14/2025 at 08:30 AM, the surveyor observed Resident #76 finishing coffee from breakfast, brown matter sits in the corner of their lips, three brown lines run down Resident #76's chin, matter is observed around nail beds and underneath nails.</p> <p>On 01/14/2025 at 09:00 AM, the surveyor observed Resident #76 was offered a snack, the resident 's face and hands were still dirty from breakfast, no attempts made at assisting or encouraging the resident with washing their hands or face before serving.</p> <p>On 01/15/2025 at 08:30 AM, the surveyor observed Resident #76 walking down hallway with walker, brown matter in corners of mouth, a brown line is observed down their chin, matter is observed around nail beds and underneath nails.</p> <p>On 01/15/2025 at 10:09 AM, during an interview CNA #9 stated that when they catch the resident, they attempt to wash hands and face daily or more depending on Resident #76's mood. CNA #9 then stated that it is gross to leave a resident 's face and hands unwashed, and it could be seen as a dignity issue. CNA #9 stated that more of an effort could be made to clean Resident #76 before and after meals, or in between meals.</p> <p>On 01/15/2025 at 2:30 PM, during an interview the Assistant Director of Nursing (ADON) #5 stated washing hands and faces for the residents should be done in the morning, bedtime, and before and after meals. ADON #5 continued by stating that hands should be washed before and after the bathroom. ADON #5 stated washing hands and faces help reduce infections and bacteria. ADON #5 stated it could be seen as dignity issue for the resident, nobody wants their face or hands dirty.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47916</p> <p>49596</p> <p>Based on observation, record review, interview, and facility policy review, the facility failed to ensure 1 of 1 sampled (Resident 47) resident was transferred from the chair to bed appropriately with a lift belt to prevent injury. The facility failed to ensure 1 of 1 sampled (Resident 62) the resident' environment remains as free of accident hazards as is possible. The facility failed to ensure 1 of 1 sampled (Resident 2) received adequate supervision to prevent accidents.</p> <p>Findings include:</p> <p>1. Review of Resident 47's Care Plan revealed diagnoses of dementia, depressive disorders, and anxiety.</p> <p>The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/17/2024 and Staff Assessment for Mental Status (SAMS) suggest long and short-term memory problems. Section GG 0170 shows resident requires moderate assistance transferring from the chair/bed-to-chair.</p> <p>Review of Resident 47's Care Plan revealed Resident 47 has a self-care deficit related to dementia and requires 1 person assistance.</p> <p>On 01/14/2025 at 02:18 PM, the surveyor observed Certified Nursing Assistant (CNA) 3 tell the resident that she was going to lift him up and get him back in the bed. From the privacy curtain CNA 3 was observed picking Resident 47 up at the hips and placing him in the bed, then picking up his legs and lift them up in the bed. A transfer belt was not used. CNA 3 was asked the protocol for assisting residents from the chair to the bed and should a transfer belt be used to transfer a resident back into the bed from their wheelchair. CNA 3 said, No, well . I think so, but I am not sure. We use gait belts but if a resident does not balance well then it does not work well. It probably works better with a gait belt. CNA 4 walked in and CNA 3 asked her if she is supposed to use a gait belt when transferring Resident 47 and CNA 4 confirmed Resident 47 required a gait belt for transfers. CNA 4 revealed that any resident that is capable of standing and pivoting to the bed should be assisted with a gait belt.</p> <p>On 01/14/2025 at 04:29 PM, Administrator provided a blank competency titled Transfers: Bed to Chair and Chair to Bed Skills Competency revealing transfers from chair to bed: wheelchair should be placed against the bed, on the side they are transferring to and encourage resident hands on the arm of the wheelchair and slide the buttocks forward until knees are over the feet. Apply gait belt or transfer belt if being used and stand on the count of 3. Assist resident to pivot by gradually turning with back side to the bed. Have resident reach back to the mattress if they are able and gently assist the resident to sit on the bed and assist in swinging both legs onto the bed, then reposition for comfort and make sure call light is in reach.</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 - Some</p>	<p>On 01/15/25 at 09:40 AM, the Director of Nursing (DON) was asked when staff were expected to use a gait belt and revealed that staff are expected to use a gait belt anytime they assist in transferring any resident from the chair to the bed, or bed to chair. When asked if it is appropriate to pick a resident up and place them in bed, the DON stated, No, because someone could get hurt if they are not transferring the resident properly. The DON confirmed that all residents needing transfer assistance should be transferred using a gait belt.</p> <p>2. Resident #2 's Care Plan dated 2/19/2020, identified the resident as having impaired cognitive function related to depressive episodes, anxiety disorder, delusional disorder, hallucinations, psychosis, schizophrenia, bipolar disorder, and dementia, and instructs the staff to monitor/document/report PRN any changes in cognitive function - specifically noting changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status.</p> <p>Resident #2 's Minimum Data Set with an Assessment Reference Date of 11/26/24 revealed the resident to have a Brief Interview for Mental Status score of 4, indicating severe cognitive impairment.</p> <p>Resident #2 Physician Order, dated 1/15/25, revealed Resident #2 has diagnoses of other schizophrenia, cardiac arrhythmia, dementia.</p> <p>On 01/14/25 at 11:31 PM, Resident #2 is observed ambulating in her wheelchair to the beauty shop. The surveyor overheard the Beautician ask Resident #2 what she wanted done today. Resident #2 told the Beautician they wanted a perm and color. The beautician said, I will need to go see if you have money for a perm and color. The Beautician left beauty shop, leaving the resident in the chair in front of the counter with the shampoo bowl. CNA #10 went to beauty shop to ask Resident #2 if she could get her weight. CNA #10 took the resident to the scales to get her weight and then returned Resident #2 back to the beauty shop. CNA #10 then returned to her job duties, leaving Resident #2 unattended in the beauty shop. The storage closet in the beauty shop was left opened, which contained several bottles of shampoo and conditioner. On the beautician's countertop, directly in front of the chair where Resident #2 was sitting, was a pair of scissors, a hair/beard trimmer, three aerosol cans of hair spray, a box of hair color, soap, a jar of blue liquid with combs inside and the word [brand] disinfectant written on the outside of the jar. Hanging on the wall beside the counter was rack containing a curling iron that was in the on position and hot to the touch. In the unlocked cabinet door of the counter there were several color care products:</p> <p>Items in unsecured cabinet:</p> <p>a. Permanent Creme Color - with a caution of product contains ammonia, 1-naphthol, and ingredients of cetyl alcohol, steareth-21, propylene glycol, steric acid. The MSDS sheet says potential acute health effects - Irritating to eyes, mucosa and skin and may cause burns.</p> <p>b. Demi-permanent cream color - Product contains isopropyl alcohol.</p> <p>c. Pre-bonded permanent color - Note on front of box states may cause allergic reaction. Caution to wear gloves, avoid contact with eyes. This product is intended for professional use only.</p> <p>d. Alkaline Toner - can cause an allergic reaction; contains cetearyl alcohol.</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 - Some</p>	<p>e. Semi-Permanent color - lilac - caution may cause allergic reaction. Wear suitable disposable gloves. The Safety data Sheet states Hazards Identification - This product is classified as a hazardous substance . cause serious eye irritation causes mild skin irritation. Keep out of reach of children.</p> <p>f. Permanent color 10-1: Important notice: may cause allergic reaction. Hazards identification - product classified as a hazardous substance. Warning causes serious eye irritation.</p> <p>g. Men ' s Shampoo-n Color warning this product contain ingredients that may cause skin irritation. Avoid contact with eyes. Can cause allergic reaction.</p> <p>Items on countertop:</p> <p>h. Red Aerosol can of hair spray - flammable</p> <p>i. Pump Thermal Spray Curler - hazardous components potassium metabisulfite sodium metabisulfite, hazard information, warning contains chemicals that cause irritation to eyes and skin. May be harmful if swallowed.</p> <p>j. Yellow Aerosol can of hair lift - can states can may explode if heated,</p> <p>k. Black can of Dry wax spray - Flammable aerosol; if in eyes rinse cautiously with water for several minutes; if eye irritation persists, get medical advice/attention.</p> <p>On 1/14/25 at 11:44 AM, the Beautician said this is her first day here and she had not received any training on working with the residents. She said she knew she shouldn't have left the curling iron turned on, but she turned it on when she arrived to work and left it on. The Beautician said she was a contract worker and is not an employee of the nursing home. The beautician said she had worked with the elderly before at a nursing home in Texas as a dietician.</p> <p>On 1/14/25 at 1:00 AM the Administrator said he had not provided any training to the beautician before she began working with the residents. The administrator said the beautician was a contract person and not an employee of the facility.</p> <p>3. Resident #62 Care Plan identified the resident to be at moderate risk for falls related to cognitive issues, weakness, and balance deficits. He is moderately confused and has poor safety awareness which increases his risks for continued falls. An intervention to remove fall mat from bedside was on initiated 11/14/24.</p> <p>Resident #62 ' s Physician Orders revealed diagnoses of hypertensive, encephalopathy, abnormalities of gait and mobility, muscle weakness, muscle wasting and muscle atrophy, and cognitive communication deficit.</p> <p>Resident #62 ' s Fall Risk assessment dated [DATE] and 11/13/24 identified Resident #62 ' s ability to see in adequate light to be impaired.</p> <p>On 1/13/24 at 10:45 AM, a fall mat was observed at Resident #62's bedside.</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 - Some</p>	<p>On 01/14/25 at 9:00 AM, Resident #62 was observed resting in bed with a fall mat at bedside.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>37634</p> <p>Based on interview and record review, the facility failed to ensure a physician order was followed for a dose reduction for 1 (Resident #43) of 5 residents reviewed for unnecessary medications.</p> <p>The findings are:</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/25/2024, revealed Resident #43 had a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact.</p> <p>A review of Resident #43's Care Plan, initiated on 6/07/2024, indicated staff were to administer antidepressant medications as ordered by the physician.</p> <p>A review of an Order Summary Report, revealed Aripiprazole, a medication that is used for depression, was ordered on 4/29/2024 at a dose of 15 milligrams.</p> <p>A review of a form titled Pharmacy MRR (Medication Regimen Review), indicated that the pharmacist made a recommendation to reduce the resident 's dose of Aripiprazole to 10 milligrams daily on 9/03/2024. The physician agreed with the pharmacist's recommendation on 9/04/2024. The Director of Nursing (DON) or designated nurse did not reduce the Aripiprazole. The DON or designated nurse did not sign or date the form acknowledging the dose reduction.</p> <p>On 1/16/25 at 11:11 AM, the DON indicated that she doesn't know why the dose reduction for Resident #43's Aripiprazole wasn't completed in September of 2024.</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>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** 49689</p> <p>Based on observation, record review, and interview, the facility failed to ensure that food was dated properly, food was sealed properly, drip pans under the stove top were cleaned, and that cross contamination did not occur during 2 of 2 observations in the kitchen.</p> <p>The findings are:</p> <p>On [DATE] at 10:22 am, in the dry storage area a large, opened bag of elbow pasta was not sealed, Dietary Manager confirmed this finding and stated that it is approximately eight pounds of pasta.</p> <p>On [DATE] at 10:26 am, a fifteen-pound box of dinner rolls was not sealed, left opened in the walk-in freezer. The Dietary Manager confirmed the findings.</p> <p>On [DATE] at 10:30 am, a gallon pitcher of reconstituted milk was in the double door fridge with no date. The Dietary Manger verified it was not dated.</p> <p>On [DATE] at 10:32 am, in a two-door cooler, a five-pound bag of shredded mozzarella cheese was observed with no receive date or open date. The Dietary Manager confirmed that the dates are missing and roughly a pound left in the bag.</p> <p>On [DATE] at 10:36 am Dietary Manager pulled out drip pan covered in foil from under the stove, the surveyor observed large splotches of brown and black matter. Surveyor observed large chunks of food on the drip pan.</p> <p>On [DATE] at 11:50 AM, the Surveyor observed the dietary cook while getting temperatures on the steam line, the unsanitized body of the thermometer touched the mechanical-soft textured chicken and riblet.</p> <p>On [DATE] at 12:56 PM, the Surveyor observed the Dietary [NAME] had mashed potato on the fingernail of their ungloved right hand. The mashed potatoes fell into the regular mixed vegetables intended to be served to the residents at 1:00 PM.</p> <p>On [DATE] at 2:30 PM, the Dietary Manager stated that food needs to be sealed proper to keep bugs and contaminants out. They then stated that food should be labeled with receive and open dates, so the staff does not use expired food and that staff knows when it was opened. The Dietary Manager then stated that the drip pans under the stove top are to be cleaned nightly and on Monday it was covered in a lot of dried food matter. The Dietary Manager stated that food should not be touched by anything to prevent cross contamination to prevent people from getting sick.</p> <p>On [DATE] at 08:05 AM, the Dietary [NAME] stated that food should not be touched by hands or items to prevent cross contamination and that it ' s an infection control risk.</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>Review of a facility policy titled, Used By Guidelines dated on [DATE] indicates All opened containers of food in the dry storage area should be place in an enclosed container and labeled with content, date opened and use by date.</p> <p>Review of a facility document titled, LC Cleaning List with no date indicated, Clean stove top and drip pan/burners after every meal.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37634</p> <p>50923</p> <p>Based on observation, record review, interviews, and facility policy review, it was determined that the facility failed to ensure an effective infection control program was implemented to prevent the potential spread of Clostridium Difficile (C. diff). for 1 resident (Resident #66) of 1 resident reviewed for isolation precautions, and the facility failed to ensure a gown was worn for 1 (Resident #39) of 1 resident that was on Enhanced Barrier Precautions.</p> <p>The findings are:</p> <p>Upon review of the Admission Record, Resident #66 was initially admitted to the facility on [DATE], then readmitted on [DATE] with an admitting diagnosis of cellulitis of left lower limb.</p> <p>The quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 12/16/2024 revealed Resident #66 had a Brief Interview for Mental Status (BIMS) score of 15 (13-15 suggest cognitively intact).</p> <p>On 01/13/25 at 11:53 AM, the surveyor observed Resident #66 in bed with multiple wounds to their lower extremities.</p> <p>Per review of Resident #66 ' s physician order set, the resident had been taking multiple antibiotics for skin infections and skin grafts to bilateral lower extremities. On the physician ' s order set on 1/9/25, an order was created to place Resident #66 on contact precautions due to a positive stool culture for C. diff.</p> <p>On 1/14/25 at 11:15 AM, the surveyor observed CNA #12 apply personal protective equipment (PPE) to go into Resident #66's room to provide assistance of repositioning. When exiting, CNA #12 removed her PPE, but did not wash her hands with soap and water. When asked about it, she stated, There's not a bathroom I can use in this room so I'm going to this bathroom here to wash them. The survey observed the bathroom CNA #12 used was approximately 30 feet away from Resident #66 ' s room, and this appeared to be the closest bathroom available.</p> <p>On 1/14/25 at 12:20 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) #5 regarding Resident #66 and their isolation. He stated, I see where it isn't best practice to have someone with C. diff in a room without access to soap and water.</p> <p>On 1/14/25 at approximately 2:15 PM, Resident #66 was moved to a room with a bathroom and sink available.</p> <p>On 1/15/25 at 9:40 AM, the surveyor interviewed the Director of Nursing (DON) regarding Resident #66 and their isolation procedure for a resident on contact precaution for C. diff. She confirmed those offering care for a resident should wash their hands with soap and water prior to leaving the room since hand sanitizer is not effective in killing the spores of C. diff bacteria.</p> <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 - Some</p>	<p>Upon review of the facility's policy titled Isolation-Categories for Transmission Based Precautions, dated 04/2021, it is noted under Contact Precautions, section 4, subsection m: Remove gloves before leaving the room and perform hand hygiene.</p> <p>2. A review of Resident #39's Order Summary Report, indicated that Resident #39 had a diagnoses of encounter for attention to cystostomy and colostomy status.</p> <p>A review of Resident #39's Order Summary Report, ordered 8/17/2024 revealed Resident #39 was on Enhanced Barrier Precautions (EBP) related to having a suprapubic catheter, and a colostomy.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/2024, revealed Resident #39 had a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The MDS indicated that Resident #39 had an indwelling catheter, and an ostomy.</p> <p>Review of Resident #39's Care Plan, revised on 9/04/2024 revealed Resident #39 was on Enhanced Barrier Precautions related to having a colostomy.</p> <p>Review of a door sign on Resident #39's door indicated that he was on Enhanced Barrier Precautions. The sign indicated that staff must wear a gown for dressing, bathing, transferring, changing linen, providing hygiene, and wound care.</p> <p>On 1/15/25 at 9:30 AM, the CNA Supervisor and Certified Nurse Aide (CNA) 4 went in Resident #39's room. The CNA Supervisor held Resident #39 over to his right side while care was provided. The CNA supervisor and CNA #4 did not have on a gown.</p> <p>On 1/15/25 at 9:32 AM, the Treatment Nurse entered Resident #39's room. The treatment nurse leaned over Residents # 39 ' s bed to perform a skin assessment, and her shirt touched the bed linen.</p> <p>On 1/15/2025 at 9:40 AM, the Treatment Nurse indicated that she should have worn a gown when doing a skin assessment on Resident #39 because he was on Enhanced barrier precautions.</p> <p>On 1/15/2025 at 9:49 AM the CNA supervisor indicated that she should have worn a gown when holding Resident #39 over because he is on Enhanced Barrier Precautions.</p> <p>Review of a facility policy titled, Enhanced Barrier Precautions dated 09/21/2022, indicated, The Enhanced Barrier Precaution requires gowns and gloves during high-contact resident care activities that provide for transfer of MDRO's (Multidrug-resistant Organisms) to staff hands and clothing. Consider using Enhanced Barrier Precautions when caring for residents indwelling medical devices.</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>47916</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident had a functional call light, and that call light was kept in reach to prevent accidents and injuries for 1 (Resident 25) of 1 resident sampled for resident communication availability and functionality.</p> <p>A review of Medical Diagnosis revealed Resident 25 with a diagnoses of dementia, stroke, and heart failure. The Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/07/2024 suggest a Brief Interview for Mental Status (BIMS) score of 00 (00-7 indicates severe cognitive impairment). Section GG0120 reveals resident uses a walker, and section GG0170 indicates Resident 25 can walk 50 feet with supervision.</p> <p>Findings include:</p> <p>On 01/13/2025 at 11:21 AM, Resident 25 was observed resting in A bed without a call light in reach. There is only one call light, and it is on the unoccupied B bed. The surveyor pulled the bathroom emergency cord and the light did not come on above the outside door. Resident 25 asked what would you do if you needed to call for help, and Resident 25 responded, I do not know.</p> <p>On 01/13/2025 at 11:33 AM, Certified Nursing Assistant (CNA) 3 pressed the call light button on the unoccupied B bed and said it did not work. CNA 3 stated the resident could fall and get stuck and need us and not be able to call. CNA 3 tested the call lights and revealed the only working call light is the bathroom call light and explained that the light does not come on above the door. The call light on the unoccupied B bed was observed not to be attached to the wall.</p> <p>On 01/14/2025 at 08:45 AM, CNA 4 was observed in Resident 25's room and was asked if the call lights were working. CNA 4 pressed the call light button now resting on A bed and confirmed It is not lighting up on the wall and stated it does not work.</p> <p>On 01/15/2025 at 08:10 AM, Resident 25 was observed sitting on the toilet, and she stood up and is hanging on to the wall trying to get to the bed. Resident 25 appeared shaky and unsteady.</p> <p>On 01/15/2025 at 08:14 AM, Licensed Practical Nurse (LPN) 7 presented to Resident 25's room, and handed Resident 25 a rolling walker and Resident 25 rolled to the sink to wash her hands. LPN 7 was asked if the resident is capable of using her call light, and LPN 7 confirmed that she does know how to use the call light and should call for assistance. CNA 8 was asked if the call light had been fixed. Yes, I believe so. They said they did. The surveyor pressed the call light button, and it did not light up at the control on the wall by Resident 25 ' s bed.</p> <p>On 01/15/2025 at 09:02 AM, LPN 7 confirmed they have a 500-hall maintenance log (the unit on which Resident 25 resided), and did not find a report that Resident 25 did not have a call light in her room.</p> <p>On 01/15/2025 at 09:10 AM, the surveyor observed Resident 25 sitting up in a wheelchair watching TV, and the call light was out of reach wrapped around the rail of A bed and resting in the floor behind Resident 25's wheelchair.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/15/25 at 09:40 AM, the Administrator confirmed that all residents should have a working call light for safety reasons. He stated that the battery might be dead and need changed. Administrator revealed that he is aware they have some call light issues.</p> <p>During an interview on 01/15/25 at 01:00 PM, the Director of Nursing (DON) was asked for the process staff were expected to follow when leaving a resident room and ensuring they can call for assistance. The DON reported that the call light should be placed in residents reach. The DON stated that a resident not having a call light would not be appropriate, and residents would not be able to call staff if they had a concern, it is a safety issue.</p> <p>On 01/15/2025 at 01:17 PM, the DON provided documentation of an in-service titled November-CNA In-Service, dated 11/07/2024, revealing topic included rounds, falls, call-ins, documentation, meal service, showers, nails, and call lights/pagers. No other information applies to Resident 25 not having a call light.</p>		