

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  The Blossoms at West Dixon Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2821 W Dixon Rd Little Rock, AR 72206	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, interviews, and facility document review, the facility failed to ensure resident rights were protected for one (Resident #7) of three residents reviewed. Specifically, the facility failed to ensure the resident's right of dignity and quality of life was maintained regarding activities of daily living care resulting in psychosocial distress; and failed to ensure Resident #7 was free from reprisal after the resident made a grievance. The findings include:</p> <p>A review of Resident #7's admission Record revealed the facility admitted the resident on 09/27/2024, with diagnoses which included chronic kidney disease, type 2 diabetes, muscle weakness/paralysis of the left side, cognitive communication deficit, major depressive disorder, and history of homelessness.</p> <p>A review of Resident #7's quarterly Minimum Data Set, with an Assessment Reference Date of 01/01/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. The MDS also indicated that Resident #7 had no behaviors, had an indwelling catheter, and was frequently incontinent of bowel.</p> <p>A review of a Progress Note for Resident #7 dated 02/18/2025, for BIMS completed by the Social Worker revealed a BIMS of 15.</p> <p>A review of Resident #7's Care Plan Report, initiated 09/30/2024, revealed the resident had major depression with a goal to remain free from distress, anxiety, or sad mood. The Care Plan included interventions for medication and pharmacy review only.</p> <p>A review of a Grievance Form dated 02/18/2025, revealed it was assigned to the Registered Nurse (RN) Unit Manager to investigate. The resolved date of the grievance was 02/26/2025, with a summary statement of the resident's grievance; Resident #7 put their call light on and informed Certified Nursing Assistant (CNA) #1 they needed to be changed. CNA #1 did not change the resident when Resident #7 wanted. The RN Unit Manager spoke with Resident #7 and CNA #1. Summary of conclusion: CNA #1 was making rounds and did not change Resident #7 as quickly as the resident would have liked. Action taken: CNA #1 was removed from the hall. Date resolved: 02/26/2025.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  The Blossoms at West Dixon Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2821 W Dixon Rd Little Rock, AR 72206	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of an updated Care Plan for Resident #7 initiated on the date the grievance was received, 02/25/2025 revealed that the facility amended Resident #7's Care Plan to include, "expresses maladaptive behavioral symptoms related to calling, reporting false allegations to outside persons/entities stating [resident was] scared and fearful." The goal was for Resident #7 to demonstrate an improvement or reduction in distressing behavioral symptoms in responding to behavior interventions. The Care Plan also included interventions to explain the desired behavior to Resident #7, that the resident was expected to behave respectfully and with maturity, review rules and expectations to improve judgement and self-control, utilize psychiatric management to psycho-active medications, provide support, and enhance "structure", use behavior management techniques to promote and shape the desired behavior. Identify causal factors and work to reduce, minimize and/or treat the causal factors. Teach stress/anxiety, psychiatric symptom techniques to help resident cope with anger, poor ability to deal with frustration, impulsivity, hallucinations, and delusions.</p> <p>A review of Resident #7's Progress Notes indicated no behaviors documented from date of admission [DATE] to discharge date on 03/18/2025.</p> <p>During an interview on 07/16/2025 at 12:27 PM, the Social Worker stated, the process for a grievance/complaint was that it was written on the Grievance/Complaint form when a resident was not getting something done, their needs met, or Activities of Daily Living (ADL) not met. The Social Worker stated he gave the grievance from Resident #7 to the RN Unit Manager the same day Resident #7 made the complaint on 02/18/2025, and then mentioned it again during the 02/19/2025, morning meeting. When it was completed, it got returned to him and stored in his book. Typically, the Social Worker liked the grievances returned within 24 hours. All completed complaints were brought to the Social Worker and reportables went to the Administrator.</p> <p>During an interview on 07/14/2025 at 2:00 PM, Resident #7's Military Benefits Advanced Practice Nurse (MBAPN) stated, she came to visit the resident on 02/18/2025, and "found Resident #7 to be in dirty clothing, disheveled, and appearing to have lost weight." Resident #7 reportedly had been asking to go outside and was not taken. The next week, Resident #7 was put on weekly visits, remained in poor condition, and missed appointments. As stated by the MBAPN, Resident #7 reported being fearful of leaving the facility. The resident stated they were not allowed to get out of bed, stayed in feces for hours as a punishment, and it was CNA #1 who was assigned to Resident #7. The MBAPN stated Resident #7 was cognitively intact and the Ombudsman had also been contacted. The MBAPN stated that on 02/25/2025, the Business Office Manager (BOM) stopped the MBAPN and the Military Benefits Therapist (MBT) and stated they were soliciting the resident. The MBAPN reported the incident to the Director of Nursing (DON). The MBAPN did locate another facility for Resident #7 to transfer to per Resident #7's request and confirmed the request by the resident.</p> <p>During an interview on 07/14/2025 at 4:01 PM, the MBT stated both herself and the MBAPN visited the facility on 02/25/2025. She stated, Resident #7 looked much thinner since her last visit made on 02/18/2025. The MBT stated, Resident #7 acted nervous, watched the door, looked uneasy, and guarded. Resident #7 looked emaciated and wanted to go outside and stated, "The facility won't take me out; I just want some sunshine." The MBT stated Resident #7 revealed CNA #1 had been rough with them, and the resident would get scolded when they attempted to get up to the bathroom unassisted. The MBT stated Resident #7 told her, "I get in trouble when I try to get up," and that the resident was afraid of retaliation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  The Blossoms at West Dixon Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2821 W Dixon Rd Little Rock, AR 72206	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/15/2025 at 12:40 PM, Resident #7 stated, "The woman was very abusive and rude, her name was [CNA #1]. CNA #1 told the resident to wear a diaper and when CNA #1 provided perineal care, she was physically abusive. Resident #7 stated, "She [CNA #1] grabbed my sore hip and shook it. She let me know she was in charge, constantly yelling. Resident #7 continued, "I had to eat my meal with poop in my pants and wait all night to be changed." Resident #7 stated they had trouble eating, but the meals did not appeal to them, and [the facility] never offered me anything different to eat. The resident continued, "Occasionally I got a [meal replacement shake] maybe once a week. Sometimes I got snacks if I asked for them; cookies or something like that."</p> <p>During an interview on 07/16/2025 at 9:13 AM, the RN Unit Manager stated, "I believe it was a specific CNA who is not here anymore," the RN unit manager identified the CNA as CNA #1. The RN Unit Manager recounted that Resident #7 stated CNA #1 did not change them, so Resident #7 did not want CNA #1's care anymore. Resident #7 was assigned a different CNA from another hall.</p> <p>During a follow-up interview on 07/16/2025 at 10:57 AM, the RN Unit Manager stated Resident #7 did not get changed out of wet clothes in a timely manner. Resident #7 put their call light on, and CNA#1 told the resident they were going to have to wait. It was not as quick as Resident #7 wanted it to be or should have been, it was lunchtime. Resident #7 did not want the aide to care for them anymore. The RN Unit Manager stated, "We pulled another CNA from another hall to take care of Resident #7, I'm not sure if CNA #1 was suspended at that point." The RN Unit Manager stated, "well if there's meal trays out, that's an infection control issue, but we have one aide out on the floor to assist with resident's needs during meal pass. While a resident is eating, an aide cannot touch a meal tray and change a resident but the aide could have taken Resident #7 to the bathroom or shower room to change. The RN Unit Manager stated, "I wouldn't expect Resident #7 to sit in wet clothes, [the resident] should have been changed." The RN Unit Manager stated "If [the resident] told us they had to sit in soiled clothes during lunch, that's not acceptable. There are options to get residents changed." The RN Unit Manager then stated, CNA#1 was no longer employed at the facility.</p> <p>During an interview on 07/16/2025 at 11:15 AM, the DON revealed that the Lead CNA told her Resident #7 did not want CNA #1 to be assigned to them anymore but would not say why. The DON stated "Resident #7's original statement to me was they didn't want CNA #1 to come back into their room; [Resident #7] denied it when we went back to talk." The DON stated, "I wasn't aware of this grievance from 02/18/2025, about the wet clothes." Resident #7 did not like the way CNA #1 talked to them, and the Lead CNA was supposed to talk to CNA #1 about it. The DON stated Resident #7 made a lot of allegations, like even if something came up with door dash and due to Resident #7 changing their story when asked about the allegation of CNA#1 being verbally abusive and did not want her back in the room the resident's care plan was updated to reflect Resident #7 made false allegations.</p> <p>A Review of a Care plan report dated 09/30/2024 to 03/31/2025 indicated the resident exhibited maladaptive behavioral symptoms related to calling and reporting false allegations to outside agencies stating the resident was scared and fearful and denied allegations to facility staff. Date initiated: 02/25/2025, same date as complaint received from the MBAPN to the facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  The Blossoms at West Dixon Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2821 W Dixon Rd Little Rock, AR 72206	
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a second interview on 07/16/2025 at 12:02 PM, the DON stated, "Yes, I was the one that updated the Care Plan for Resident #7 on 02/25/2025." The update had nothing to do with the allegation; it was because of the back and forth with Resident #7 saying things. It was Resident #7's roommate that stated, "they just do not like each other," referring to Resident #7 and CNA #1. CNA #1 was moved off the hall.</p> <p>During an interview on 07/16/2025 at 1:20 PM, the Lead CNA stated all she could remember was the DON said CNA #1 had talked very rudely to Resident #7. The DON wanted the Lead CNA to send CNA #1 home, pending investigation. The Lead CNA did not recall any other complaints from Resident #7 and stated that Resident #7 was normally quiet.</p> <p>During an interview on 07/16/2025 at 2:11 PM, CNA #1 stated that the facility suspended them for nothing. CNA #1 said "One of the patients was afraid of me. I have never put my hands on a patient; I was dumbfounded." CNA #1 was passing trays when Resident #7 called for CNA #1 to change them during mealtime. CNA #1 stated the facility was short-staffed and she was the only one around. CNA #1 stated, "The DON told [Lead CNA] to move me to another hall."</p> <p>During an interview on 07/16/2025 at 2:36 PM, the Administrator stated that the Social Worker reported the next morning, in the morning meeting, any grievances from the day before. The grievance on 02/18/2025 regarding Resident #7 was that they had not been changed. The Administrator stated he was told Resident #7 had spilled something on his shirt, and that the resident told the lady passing out the trays [CNA #1]. The Administrator stated he did not recall if Resident #7 was changed at that time. He did not know if the resident had to eat while soiled and stated, "I can't speak to that." The Administrator confirmed Resident #7 no longer wanted CNA #1 to take care of them and was told it was a personality conflict. The facility started addressing it immediately. The Administrator stated, the resolution may be a few days down the road to make sure the solution worked. The Administrator stated the Military Benefit person called the facility and said Resident #7 was fearful and scared. An emotional assessment was performed for three days. The Administrator stated he was under the assumption another CNA was called to change [Resident #7] while CNA #1 continued to pass trays. The Administrator stated he did not know who put the revision into Resident #7's Care Plan or why, regarding the false allegations.</p> <p>A review of an undated facility document, "Resident Rights/Civil Rights, Ref: CMS.GOV," stated "You have the right to be treated with dignity and respect. You have the right to make a complaint to the staff of the SNF [Skilled Nursing Facility], or any other person, without fear of punishment. The SNF must resolve the dispute promptly By law, SNF's must develop a plan of care (care plan) for each resident. You have the right to take part in the process."</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  The Blossoms at West Dixon Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2821 W Dixon Rd Little Rock, AR 72206	
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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.</p> <p>Based on record review, interviews, and facility document review, it was determined that the facility failed to ensure unrestricted visitation for one (Resident #7) of three residents reviewed for visitation rights. Specifically, a health care liaison was interrupted by the Director of Nursing (DON) and not allowed to complete an assessment of Resident #7 following a received transfer referral to an outside facility. The findings include:</p> <p>A review of Resident #7's admission Record revealed the facility admitted the resident on 09/27/2024, with diagnoses which included chronic kidney disease, type 2 diabetes, muscle weakness/paralysis of the left side, cognitive communication deficit, major depressive disorder, and a history of homelessness.</p> <p>A review of Resident #7's quarterly Minimum Data Set, with an Assessment Reference Date of 01/01/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 08, which indicated the resident had moderate cognitive impairment.</p> <p>A review of a Progress Note, dated 02/18/2025, revealed Resident #7 had a BIMS of 15, completed by the Social Worker.</p> <p>A review of Resident #7's Care Plan Report, initiated on 09/30/2024, revealed the resident had major depression with a goal to remain free of distress, anxiety, or sad mood. The Care Plan also included interventions of medication and pharmacy review only.</p> <p>During an interview on 07/14/2025 at 2:59 PM, Resident #7's Military Benefits Advanced Practice Nurse case manager stated a health care liaison from another facility attempted to visit with the resident and complete a needed resident assessment after receiving a transfer referral but was kicked out by the facility.</p> <p>During an interview on 07/15/2025 at 1:28 PM, the Health Care Liaison for Resident #7 stated, "yes, I did visit with Resident #7 on February 20, 2025, I do not recall the time of day." The Health Care Liaison stated when she entered the facility, there was no sign-in sheet and no one at the door, so she went to the nurse's station and a nurse directed her to Resident #7's room. While in the room with Resident #7, a nurse came to get the Health Care Liaison out of the room and said the Administrator wanted to speak with her. The Health Care Liaison stated when she got to the front, a gentleman came out of the office and asked, "are you her?" He said, "you can't just come in here and talk to our residents, you need to call first." The Health Care Liaison stated she had called and spoken with the Business Office Manager (BOM) and told her a transfer referral for Resident #7 was received from the Social Worker. The Health Care Liaison stated the gentleman walked off and the BOM escorted her out.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  045446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/17/2025
NAME OF PROVIDER OR SUPPLIER  The Blossoms at West Dixon Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2821 W Dixon Rd Little Rock, AR 72206	
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 0563</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/17/2025 at 9:58 AM, the Director of Nursing (DON) stated an aide came to her and said there was a lady questioning Resident #7. The DON went and introduced herself asking, "Did you stop by and let the administration office know you were here?" The DON asked the Health Care Liaison, "Would you mind coming with me to the administration office." The DON stated "I stepped out of the office. I do remember him [the Administrator] saying, "Did you let someone know you were coming?" The Health Care Liaison said the BOM knew I was coming." The DON then stated, "I walked away and do not know if she left on her own or was asked to leave."</p> <p>During an interview on 07/16/2025 at 9:13 AM, the Registered Nurse (RN) Unit Manager stated, "I do not know who interrupted the visit, I want to say that it was the DON. We did have a change in DONs around that time," The circumstances as to why the visit was cut short were they did not introduce themselves, and it was like they were poaching. The RN Unit Manager stated residents were allowed visitors and denied visitors if there was a safety issue. There was no reason the Health Care Liaison would not have been allowed to visit Resident #7.</p> <p>During an interview on 07/16/2025 at 12:41 PM, the Social Worker stated under the Resident Rights-Visitation policy, residents were allowed visitors at any time and the facility had no set visiting hours. The only time a visitor would not be allowed was if the resident refused or did not want any visitors. This would then be documented in their medical record.</p> <p>During an interview on 07/16/2025 at 1:36 PM, the BOM stated Resident #7 told her about wanting to go to another facility. The BOM stated the Health Care Liaison called, and the BOM let the Health Care Liaison know Resident #7 had possibly changed their mind, and to wait on the Social Worker to call back. The BOM stated Resident #7 was back and forth about going or not going to another facility.</p> <p>During an interview on 07/16/2025 at 2:36 PM, the Administrator stated as far as visitation, the Health Care Liaison came in and was assisted by staff to Resident #7's room. The Administrator stated that residents were allowed to have visitors per their rights, unless of course there was an issue of safety to the resident. The Administrator did not recall the Health Care Liaison being told to leave.</p> <p>During an interview on 07/17/2025 at 8:45 AM, the Social Worker stated he had not withdrawn Resident #7's transfer referral and had not told the Health Care Liaison not to come visit the resident.</p> <p>A review of an undated document titled, "Resident Rights/Civil Rights, Ref: CMS.GOV," which is provided to the residents at admission indicated, as a resident of a skilled nursing facility (SNF), you have certain rights and protections under federal and state law. These laws help ensure you get the care and services you need. Visitors: You have the right to spend private time with visitors at any reasonable hour. Any person who gives you help with your health or legal services may see you at any reasonable time. This includes doctor, representative from the health department, and your Long-Term Care Ombudsman, among others.</p> <p>A review of the facility policy titled, "Resident Rights-Visitation" reviewed January 2024, indicated, the facility will provide immediate access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.</p>		