STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045446	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at West Dixon Rehab & Nursing Center	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)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview, it was determined that the facility failed to ensure pharmacist recommendations were addressed for two (Resident #4 and Resident #19) of five residents reviewed for unnecessary medications. Specifically, Resident #4 had pharmacist recommendations to decrease an antidepressant and change an insulin order that were not followed. Resident #19 had a pharmacist recommendation to have a laboratory blood draw for an anti-seizure medication that was not completed. The findings include: Resident #4 A review of the Resident #4's admission Record indicated the facility admitted the resident with diagnoses which included type two diabetes mellitus, major depressive disorder, and a long-term use of insulin. A review of Resident #4's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/23/2025, revealed a Brief Interview for Mental Status (BIMS) score of 09, which indicated the resident had moderate cognitive impairment. A review of Resident #4's Care Plan Report, initiated on 04/07/2025, revealed the resident had diabetes with insulin therapy and was at risk for low and high blood sugars. Interventions included referring to the medication administration record in the electronic health record for insulin therapy and to have a fasting serum blood sugar, as ordered by the doctor. Resident #4's Care Plan also indicated the resident used antidepressant medication. A review of Resident #4's Order Summary Report revealed the resident had an order for a 30 milligram (mg) antidepressant, and to give two capsules to equal 60 mg daily. A review of a Pharmacy Review, with an effective date of 09/23/2025, revealed the pharmacist recommended to complete a gradual dose reduction of Resident #4's antidepressant from 60 mg to 30 mg daily. The physician reviewed the recommendation and indicated to decrease the medication to 30 mg, once the current supply was completed. A review of Resident #4's Order Summary Report, from 05/01/2025 through 01/31/2026, indicated there was no decrease to Resident #4's antidepressant. Resident #4's Order Summary Report also revealed an order for a short-acting insulin and to inject 11 units before meals and at bedtime. A review of a Pharmacy Review, with an effective date of 11/28/2025, revealed the pharmacist (continued on next page)

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommended to discontinue Resident #4's bedtime short-acting insulin and initiate five units of a long-acting insulin, due to the residents elevated blood sugar levels. The physician reviewed the recommendation and agreed with the pharmacist's recommendations. A review of Resident #4's Order Summary Report, from 05/01/2025 through 01/31/2026, indicated there was not an order to discontinue Resident #4's short-acting insulin and initiate five units of a long-acting insulin. A review of a Pharmacy Review from 07/2025 to 01/2026, indicated the pharmacist did not acknowledge that Resident #4 did not have a laboratory order for an A1C (a laboratory test to show an average blood sugar over the past two to three months). A review of a Diabetes Care article titled, Management of Diabetes in Long-Term Care and Skilled Nursing Facilities: A Position Statement of the American Diabetes Association, indicated, At the time of admission to a facility, transitional care documentation should include laboratory tests (including A1C, lipids, and renal function) . During an interview on 01/15/2026 at 10:45 AM, the Director of Nursing (DON) stated the process for a Pharmacy Review, included the pharmacist completing their review monthly. Once the pharmacist had completed their review, the pharmacist notified the unit manager, who then notified the resident's provider. If there were any new orders, the physician notified the unit manager, who in turn carried out any recommendations the physician may have had. The DON stated if a resident was taking insulin and there was not a physician's order for an A1C, staff were to contact the physician to get an order. The DON stated that Resident #4 did not have a physician's order for an A1C and after reviewing Resident #4's medical record, she indicated there was no order to discontinue the bedtime short-acting insulin or for the addition of five units of a long-acting insulin. Resident #19 A review of the Resident #19's admission Record, indicated the facility admitted the resident with diagnoses that included schizophrenia, epilepsy, major depressive disorder, mild intellectual disabilities, convulsions, and dissociative and conversion disorder. A review of Resident #19's quarterly MDS, with an ARD of 11/10/2025, revealed a BIMS score of 05, which indicated the resident had severe cognitive impairment. A review of Resident #19's Care Plan Report, initiated on 05/24/2024, revealed the resident had potential for complications associated with seizure disorder. One intervention included to obtain and monitor lab work as ordered and to report results to the physician and follow up as indicated. A review of Resident #19's Order Summary Report was completed from 05/01/2025 though -01/31/2026, which revealed Resident #19 had an order for 1500mg of anti-seizure medication to be administered two times a day. Further review indicated Resident #19 had a laboratory test for an anti-seizure medication on 05/29/2025, and on 07/31/2025. There were no other lab orders for the anti-seizure medication within the review period. A review of Resident #19's Lab Results Report indicated on 08/06/2025, Resident #19 had an anti-seizure lab result of 68.2 ug/mL (normal range was from 5.0 – 45.0 ug/mL). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #19's Progress Notes indicated on 08/07/2025, Advanced Practice Registered Nurse #3 reviewed Resident #19's labs and indicated there were new orders to repeat the anti-seizure lab in one month. A review of Resident #19's Hospital Records indicated on 08/12/2025, Resident #19 was admitted to the emergency room due to possible seizures. Resident #19's Hospital Records also revealed that on 08/13/2025, the resident had an anti-seizure lab result of 166 ug/mL (normal range was from 10.0 – 40.0 ug/mL). A review of a Pharmacy Review, with an effective date of 08/29/2025, revealed the pharmacist indicated Resident #19 was taking 1500 mg of an anti-seizure medication and on 08/06/2025, the resident's level was high and consider follow-up levels, as levels were used more for toxicity than indicators of seizure control. There was no physician review completed, however the Assistant Director of Nursing indicated there were no changes made. During an interview on 01/15/2026 at 10:45 AM, the Director of Nursing (DON) reviewed Resident #19's electronic health record and acknowledged that on 08/29/2025, the pharmacist recommended the resident's seizure medication lab levels were to be checked in one month. The DON stated that the lab was not done and by not following the request to have a lab redrawn, the result could have led to seizures. The DON also stated that the physician did not review the pharmacist recommendations, and that the DON herself, along with the unit managers, were responsible for ensuring the pharmacist recommendations were being reviewed by the physician.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the water temperature in a resident's room was maintained in a comfortable temperature for use for one (Resident #78) of two resident's rooms located on the secured unit and failed to ensure three (100-Hall, 300-Hall, and 600-Hall, across the hall from room [ROOM NUMBER]) of six hall showers were maintained in a clean and sanitary condition. The findings include: Resident #78 During an observation on 01/12/2026 at 10:37 AM, this surveyor entered the bathroom in room [ROOM NUMBER] and turned on the hot water at the faucet and allowed the water to run. At 10:41 AM, this surveyor placed fingers from the right hand under the running water from the hot faucet and the water was cold to touch. At 10:43 AM, this surveyor again placed the fingers from the right hand under the water from the hot faucet and the water was still cold to touch. During an observation on 01/12/2026 at 3:39 PM, Resident #78 was sitting up in their chair, with their eyes closed. The hot water in the bathroom sink was tested using this surveyor's thermometer. The temperature on the thermal thermometer displayed 70.2 degrees Fahrenheit (F). During an observation on 01/14/2026 at 2:57 PM, Resident #78 was not in their room at this time. The hot water in the bathroom sink was tested using this surveyor's thermometer. After running the hot water for three minutes, the temperature on the thermal thermometer displayed 72.7 degrees F. During an observation on 01/14/2025 at 3:30 PM, this surveyor and the Maintenance Director entered Resident #78's bathroom. The Maintenance Director turned on the hot water at the sink in Resident #78's bathroom, and stated the water was cold and it may take a few minutes to warm up. At 3:35 PM, the water was still cold to touch, and the Maintenance Director stated he was leaving the room to turn on the hot water in another room on the odd side of the hall. He turned on the hot water in room [ROOM NUMBER]. At 3:37 PM, the hot water from the bathroom sink was still cold, and the Maintenance Director left the room again and turned on the hot water in a third room to see if that would help the water get warm in Resident #78's bathroom sink, because he stated the hot water in Resident #78's bathroom was only 60 degrees at that time. At 3:41 PM, after running for 11 minutes, the hot water from Resident #78's bathroom sink's temperature displayed 65.8 degrees F on the Maintenance Director's thermometer. A review of Resident #78's admission Record revealed the facility admitted the resident on 11/07/2025, with diagnoses which included Alzheimer's disease late onset, dementia, and full incontinence of feces. A review of Resident #78's admission Minimum Data Set (MDS) with an Assessment Reference Date of 11/09/2025, revealed a Brief Interview for Mental Status score of 00, which indicated the resident had severe cognitive impairment. Resident #78's MDS also indicated the resident did not use any mobility devices, required partial/moderate assistance with shower/bathing self, and was independent with transfers to the toilet and walking up to 150 feet. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #78's Care Plan, dated 12/22/2025, revealed the resident required extensive assist of one staff with toileting, personal hygiene, and bathing. A review of the December 2025 Grievance Log revealed a grievance for Resident #78 on December 08, 2025, which indicated no working water. The grievance log indicated the department head responsible was Social/Maintenance. During a telephone interview on 01/12/2026 at 1:42 PM, Resident #78's family member stated there was no hot water in Resident #78's bathroom. The family member stated they allowed the hot water to run for five minutes one day, and the water never got hot. Resident #78's family member stated during some visits, the resident needed to be cleaned and the FM would clean Resident #78 up, if needed, using a towel and water [from the bathroom faucet]. The family member then stated they did inform the Director of Nurses (DON) of their concern about no hot water in Resident #78's room, after the resident returned from a recent hospital stay, but FM could not remember the exact date of this discussion. The family member stated they were told the facility was aware of the matter and was working on getting it fixed. During an interview on 01/14/2026 at 3:38 PM, the Maintenance Director stated the hot water temperature range for resident rooms should be 90-100 degrees Fahrenheit. He stated he did not know if 80 degrees [F] was a sufficient temperature for the hot water in the resident rooms because he didn't know what 80 degrees [F] would feel like. He then stated, 65.8 [F] was not a sufficient temperature for the hot water in a resident's room because it was too cool. The Maintenance Director indicated the holding tank should be set at 120 degrees [F], but he was not sure if the holding tank was where the water came from to the resident's rooms. He stated he had been at the facility over a year and was learning things. On 01/15/2026 as of 8:15 AM, the Nurse Consultant indicated the facility did not have a policy or guidance on water temperatures in resident room. During an observation on 01/12/2026 at 2:29 PM, this surveyor observed the 300-Hall shower and the grout on the floor. The walls and corners of the shower were black in color. During an observation on 01/13/2026 at 3:27 PM, this surveyor observed the 300-Hall shower and the grout on the floor. The walls and corners of the shower were black in color. During an observation on 01/15/2026 at 3:54 PM, this surveyor observed the 100-Hall shower and the grout on the floor. The walls and corners of the shower were black in color. During an observation on 01/15/2026 at 3:59 PM, this surveyor observed the 600-Hall shower, located across the hall from room [ROOM NUMBER]. The grout on the floor and the lower part of the wall of the shower was black in color. A review of a '73 Disinfecting Acid Bathroom Cleaner' sell sheet revealed this product was effective against soap scum and hard water build-up on hard, non-porous surfaces. The information sheet indicated this product could be used in bathrooms and showers. The dilution rate to disinfect was 8 ounces (oz) per gallon, with a dwell time of five minutes. A review of a 'Rapid Multi-Surface Disinfectant Cleaner' sell sheet revealed this product could be used in the following ways: for hospital disinfection, on different viruses, to sanitize non-food contact (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	areas, for soft surface sanitization and soft surface disinfection. The information sheet revealed this product could be used areas such as public spaces and bathrooms. During an interview on 01/15/2026 at 3:30 PM, Certified Nursing Assistant (CNA) #1 stated housekeeping was responsible for cleaning the showers. CNA #1 went with this surveyor to the 300-Hall shower room and stated the grout in the shower appeared blackish in color and the discoloration had been there for a while, but she did not elaborate as to a definitive length of time. During an interview on 01/15/2026 at 4:06 PM, the Housekeeping Supervisor (HSK SPVR) stated housekeeping disinfected all showers (six total in the building), once in the morning and once before they left for the day, daily. She stated housekeeping used a disinfectant and an acid cleaner through [company name]. She stated the contact time for the acid cleaner was 15 seconds and then the acid cleaner was removed by pressure washing the area and wiping the area down. The HSK SPVR was asked to look at the grout in the 300-Hall shower, and she stated the grout needed to be regrouted. She described the color of the grout in the 300-Hall shower as dark gray and black looking. She stated all the showers needed to be regrouted. The HSK SPVR stated she was responsible for overseeing that the showers did not have any discoloration and were clean. As of 01/15/2026 at 5:03 PM, the Administrator did not provide a policy or guidance on Environmental Services. The Administrator and other facility staff stated they did not have any further documentation to provide to the survey team regarding the concern of water temperatures in the resident rooms or the hall showers in the facility.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, the facility failed to ensure the physician was promptly notified of a significant change in a resident's condition, for one (Resident #4) out of five residents reviewed for unnecessary medications. Specifically, Resident #4 was receiving insulin with physician orders for blood glucose monitoring, the facility failed to obtain physician orders identifying parameters for blood glucose values requiring notification. As a result, when the resident's blood glucose level exceeded 500 mg/dL, staff failed to notify the physician of this significant change in condition, placing the resident at risk for adverse outcomes related to uncontrolled hyperglycemia. The findings include: A review of Resident #4's admission Record indicated the facility admitted the resident with diagnoses that included type two diabetes mellitus, major depressive disorder, and a long-term use of insulin. A review of Resident #4's quarterly Minimum Data Set with an Assessment Reference Date of 10/23/2025, revealed a Brief Interview for Mental Status score of 09, which indicated the resident had moderate cognitive impairment. Further review indicated the resident was on insulin therapy and antidepressant therapy. A review of Resident #4's Care Plan Report initiated on 04/07/2025, revealed the resident had diabetes with insulin therapy and was at risk for low and high blood sugars. Interventions included referring to the medication administration record in the electronic health record for insulin therapy and to have fasting serum blood sugar as ordered by the doctor. Further review indicated the resident used antidepressant medication. A review of Resident #4's Order Summary Report, from 05/01/2025-01/31/2026, revealed Resident #4 had an order for 11 units of insulin to be given subcutaneously before meals and at bedtime. There were no parameters indicated when to notify the physician and no A1C labs ordered. A review of Resident #4's Medication Administration Record for January 2026 indicated Resident #4's blood sugar on 01/05/2026 at 4:00 PM, was 444 mg/dL and on 01/06/2026 at 4:00 PM, it was 400 mg/dL. A review of Resident #4 Medication Administration Record for December 2026, indicated the following elevated blood sugars for Resident #4: 12/16/2025 at 4:00 PM: 479 mg/dL 12/16/2025 at 9:00 PM: 479 mg/dL 12/18/2025 at 9:00 PM: 400 mg/dL 12/19/2025 at 4:00 PM: 427 mg/dL 12/22/2025 at 4:00 PM: 432 mg/dL (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/24/2025 at 4:00 PM: 400 mg/dL 12/25/2025 at 9:00 PM: 415 mg/dL 12/29/2025 at 4:00 PM: 557 mg/dL 12/31/2025 at 11:00 AM: 400 mg/dL A review of Pharmacy Review, with an effective date of 11/28/2025, revealed the pharmacist recommended to discontinue the bedtime administration of 11 units of insulin and initiate 5 units, due to the resident's blood sugars being elevated. There was no indication for notification of physician or recommendation for an A1C order. During an interview on 01/15/2026 at 9:38 AM, Licensed Practical Nurse (LPN) #4, who had documented on Resident #4's December MAR a blood sugar at and/or over 400, stated parameters were different for every resident and if there were not any parameters, and she would make a note in the resident's medical record and notify the physician. Regarding Resident #4, LPN #4 stated she should have notified the physician of the resident's blood sugar and lack of parameters. During an interview on 01/15/2026 at 9:54 AM, LPN #5, who had documented on Resident #4's December MAR a blood sugar at and/or over 400, stated parameters should be listed on the residents MAR but if the resident did not have any, the physician should be notified. LPN #5 stated the facility never told her about parameters or when to notify the physician, since she was contracted staff. During an interview on 01/15/2026 at 10:45 AM, the Director of Nursing (DON) stated that an A1C was drawn whenever the physician ordered one for that particular resident, and if the resident was taking insulin and there was no A1C order, then the nurse needed to notify the physician to see how often an A1C should be ordered. The DON stated the parameters for blood sugars may be different for each resident but typically, if they were below 60 or above 400, the nurse should notify the physician and if there were no parameters listed for that resident, the nurse needed to notify the physician to have an order for parameters. The DON stated for Resident #4, the nurse should have called the physician and received an order for parameters. On 01/15/2026 at 12:29 PM, Resident #4's physician was called and a voicemail was left with a callback number, however, the physician did not return the surveyors call during the survey.