

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2024
NAME OF PROVIDER OR SUPPLIER The Blossoms at Midtown Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5720 West Markham Street Little Rock, AR 72205	
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>43409</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure residents were free from misappropriation of property for 4 (Resident #3, #4, #5, #7) of 15 residents reviewed for misappropriation of property.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Abuse, Neglect, and Exploitation revised on 01/01/2024, indicated, Policy Statement: We are committed to the safety and well-being of all our residents. We believe that the resident has the right to be free from .misappropriation of property .The facility considers all the above to be abuse and uses the general term abuse to specify all .Investigation: 3. In the event of misappropriation, a thorough search of the building is conducted to determine possible misallocation of missing items. A Missing Item Form is completed, and missing items are analyzed for patterns, location and care givers .</p> <p>A review of a facility policy titled, Controlled Substances, revised on 01/31/2023, indicated, .Schedule II, III, IV, and V medications remaining in the facility after the resident has been discharged or the order discontinued, the charge nurse should surrender the narcotics to the DON/ADON [Director of Nursing/Assistant Director of Nursing]. Both the charge nurse and the DON/ADON should sign in the appropriate location in the narcotic book. The medications should be logged on the Arkansas Department of Health Report of Drugs Surrendered from and signed by both nurses. When possible, narcotic surrender should be completed when the pharmacy consultant is present to double check the medications. When narcotics are surrendered to the DON/ADON, they should be taken to or mailed to the ADH Pharmacy Services division immediately. These logs should be stored in a binder and reconciled when the completed form is returned from pharmacy services.</p> <p>A review of the Arkansas Department of Health Report of Loss of Controlled Substances form, indicated the facility, identified on 9/24/24 discontinued narcotics were not surrendered to Pharmacy Services and are unaccounted for .List of controlled substance lost. See attached . This form was signed by the Chief Nursing Officer [CNO] on 9/26/24.</p> <p>A review of the Arkansas Department of Health Report of Loss of Controlled Substances form identified 15 residents affected and 693 drugs that were discontinued and unaccounted for. Further review revealed the faxed form failed to be transmitted to the Pharmacy Division of ADH.</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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/21/2024 at 11:45 a.m , the CNO confirmed 693 drugs had been discontinued and had not been surrendered to the state. CNO confirmed the 693 missing narcotics had been reported to the Pharmacy Division of the Arkansas Department of Health [ADH] on 9/26/24. Upon review of listed missing narcotics, it was determined the fax failed to send to the Pharmacy Division of ADH. CNO verbalized the list would be faxed again today to ADH.</p> <p>The CNO provided successful fax confirmation on 10/21/24 at 1:32 p.m</p> <p>A review of the Admission Record indicated the facility admitted Resident #3 with diagnoses that included Huntington's disease, protein calorie malnutrition, and adult failure to thrive.</p> <p>The significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/16/2024, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 99, which indicated the resident was unable to finish the assessment.</p> <p>A review of Resident #3's Care Plan initiated on 04/23/2024, revealed the resident was at risk for pain and has PRN [as needed] order for opioids. Interventions included give medications as ordered, observe and documented the frequency and intensity of the pain symptoms, and observed/documentated for side effects of pain medication.</p> <p>A review of physician orders revealed Resident #3 had morphine sulfate oral solution 20 mg/5 ml [20 milligrams/5 milliliters] give 0.5 ml via G-tube [gastrostomy tube-flexible plastic tube used for delivering nutrition and medication into the stomach from outside the abdominal wall] every 4 hours as needed for pain.</p> <p>A review of record of loss of controlled substances revealed Resident #3 had oxycodone 5 mg [milligram] quantity 26 missing.</p> <p>A review of the Admission Record indicated the facility admitted Resident #5 with diagnoses that included type II diabetes mellitus with diabetic peripheral angiopathy [narrowing of the arteries restricting blood flow] with gangrene, bilateral above the knee amputation, and essential (primary) hypertension [high blood pressure]</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/30/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident cognitively intact.</p> <p>A review of Resident #5's Care Plan, initiated on 11/30/2020, revealed the resident has chronic pain due to osteoarthritis and has and order for opioids for pain. Interventions included give medications as ordered, observed and document the frequency and intensity of the pain symptoms, and observe/ document the effectiveness or ineffectiveness of medications.</p> <p>A review of physician orders and medication administration record [MAR] revealed Resident #5 had Norco oral tablet 5-325 mg (hydrocodone-acetaminophen) 1 tablet by mouth every 6 hours as needed for pain.</p> <p>A review of Arkansas Department of Health Report of Loss of Controlled Substances form revealed Resident #5 had Hcd/APAP [hydrocodone/acetaminophen] 5/325 mg quantity 1 missing.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the narcotic book page 19 indicated Resident #5 had 32 tablets remaining of hydrocodone/acetaminophen 5/325 mg. The medication balance was transferred to page 29 of the narcotic book with a starting balance of 31 tablets indicating one tablet was unaccounted for.</p> <p>During an interview on 10/21/2024 at 1:20 p.m., Resident #5 confirmed taking opioid pain medication and denied any issues or concerns receiving the medication.</p> <p>A review of the admission record indicated the facility admitted Resident #4 with diagnoses that included acute and chronic respiratory failure, chronic lymphocytic leukemia of B-cell type not having achieved remission, chronic obstructive pulmonary disease with (acute) exacerbation, and osteoarthritis of hip and knee.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident was cognitively intact.</p> <p>A review of Resident #4's Care Plan initiated on 02/22/2023, revealed the resident was at risk for pain and had an order for opioids for pain. Interventions included give medications as ordered, observe/document for side effects, and monitor for effectiveness and adverse reactions.</p> <p>A review of physician orders and MAR revealed Resident #4 had Norco oral tablet 5-325 mg give 1 tablet by mouth every 4 hours as needed for pain/wound care starting on 9/3/24.</p> <p>A review of the record of loss of controlled substance revealed Resident #4 had Hcd/APAP [hydrocodone/acetaminophen] 5/325 mg quantity 42 missing.</p> <p>During an interview on 10/21/2024 at 1:02 p.m , Resident #4 confirmed taking opioid pain medication and denied any issues or concerns receiving the medication.</p> <p>A review of the admission record indicated the facility admitted Resident #7 with diagnoses that included acute and chronic respiratory failure, end stage renal disease, tracheostomy status [an opening in neck used for breathing], and dementia in other diseases.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/26/2024, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment.</p> <p>A review of Resident #7's Care Plan initiated on 01/04/2024, revealed the resident had anti-anxiety medications, at risk for a mood problem related to anxiety and risk for pain related to diagnosis. Interventions included administering medications as ordered, observe and documented the intensity and frequency of symptoms and monitor for safety.</p> <p>A review of physician orders revealed Resident #7 had clonazepam oral tablet 1 mg give 1 tablet by mouth one time a day for anxiety and tramadol oral tablet 50 mg give 1 tablet by mouth every 6 hours as needed for pain moderate 4-6.</p> <p>A review of the record of loss of controlled substance revealed Resident #7 had clonazepam 1 mg quantity 14 missing and tramadol 50 mg quantity 4 missing.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the narcotic book page 37 indicated Resident #7 had 14 tablets remaining of clonazepam 1 mg. Page 37 indicated the medication had been discontinued and had been surrendered with a count of 14 tablets.</p> <p>A review of narcotic book page 46 indicated Resident #7 had 4 tablets remaining of tramadol 50 mg.</p> <p>During an interview on 10/21/2024 at 1:15 p.m., Resident #4 confirmed taking pain medication and denied any issues or concerns receiving the medication.</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>43409</p> <p>Based on observations, interviews, record review, facility document review, and facility policy review, it was determined the facility failed to ensure allegations of misappropriation of property were reported to the State Agency for 15 Resident, with 3 residents remaining on medications, (Resident #4, Resident #5, Resident #7) of 15 residents reviewed for abuse. Specifically, the facility failed to ensure alleged misappropriations of Resident #4, #5, #7 medications were reported.</p> <p>Findings include:</p> <p>A review of a facility policy titled, Abuse, Neglect, and Exploitation revised on 01/01/2024, indicated, Policy Statement: We are committed to the safety and well-being of all our residents. We believe that the resident has the right to be free from .misappropriation of property .The facility considers all the above to be abuse and uses the general term abuse to specify all .Reporting .3. The facility will report all alleged violations involving mistreatment, neglect, or abuse to the Office of Long-Term Care, Family, Police, and MD [medical doctor]. Suspicion or allegation of abuse shall be reported immediately, not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury .</p> <p>A review of a facility policy titled, Controlled Substances, revised on 01/31/2023, indicated, .Schedule II, III, IV, and V medications remaining in the facility after the resident has been discharged or the order discontinued, the charge nurse should surrender the narcotics to the DON/ADON [Director of Nursing/Assistant Director of Nursing]. Both the charge nurse and the DON/ADON should sign in the appropriate location in the narcotic book. The medications should be logged on the Arkansas Department of Health Report of Drugs Surrendered from and signed by both nurses. When possible, narcotic surrender should be completed when the pharmacy consultant is present to double check the medications. When narcotics are surrendered to DON/ADON, they should be taken to or mailed to the ADH Pharmacy Services division immediately. These logs should be stored in a binder and reconciled when the completed form is returned from pharmacy services.</p> <p>A review of the Arkansas Department of Health Report of Loss of Controlled Substances form indicated the facility, identified on 9/24/24 discontinued narcotics were not surrendered to Pharmacy Services and are unaccounted for .List of controlled substance lost. See attached . This form was signed by the Chief Nursing Officer [CNO] on 9/26/24.</p> <p>A review of the document attached to the Arkansas Department of Health Report of Loss of Controlled Substances form identified 15 residents affected and 693 drugs that were discontinued and unaccounted for. Further review revealed the faxed form failed to be transmitted to the Pharmacy Division of ADH.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/21/2024 at 11:4 a.m., the CNO confirmed that 693 drugs had been discontinued and had not been surrendered to the state. CNO confirmed the 693 missing narcotics had been reported to the Pharmacy Division of the Arkansas Department of Health [ADH] on 9/26/24. Upon review of listed missing narcotics, it was determined the fax failed to send to the Pharmacy Division of ADH. CNO verbalized the list would be faxed again today to ADH.</p> <p>The CNO provided successful fax confirmation on 10/21/24 at 1:32 p.m.</p> <p>During an interview with the CNO on 10/22/24 at 2:58 p.m., the CNO verbalized not reporting to the office of long-term care due to the medications had been discontinued and there were no negative outcomes for the residents.</p> <p>A review of the loss of controlled substance record submitted to ADH indicated Resident #4, R#5, R#7 still had current orders for the missing medications.</p> <p>A review of the admission record indicated the facility admitted Resident #4 with diagnoses that included acute and chronic respiratory failure, chronic lymphocytic leukemia of B-cell type not having achieved remission, chronic obstructive pulmonary disease with (acute) exacerbation, and osteoarthritis of hip and knee.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/30/2024, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 12 which indicated the resident was cognitively intact.</p> <p>A review of Resident #4's Care Plan initiated on 02/22/2023, revealed the resident was at risk for pain and had an order for opioids for pain. Interventions included give medications as ordered, observe/document for side effects, and monitor for effectiveness and adverse reactions.</p> <p>A review of physician orders and MAR revealed Resident #4 had Norco oral tablet 5-325 mg [milligram]give 1 tablet by mouth every 4 hours as needed for pain/wound care starting on 9/3/24.</p> <p>A review of the record of loss of controlled substance revealed Resident #4 had HCD/APAP [hydrocodone/acetaminophen] 5/325 mg quantity 42 missing.</p> <p>During an interview on 10/21/2024 at 1:02 p.m., Resident #4 confirmed taking opioid pain medication and denied any issues or concerns receiving the medication.</p> <p>A review of the Admission Record indicated the facility admitted Resident #5 with diagnoses that included type II diabetes mellitus with diabetic peripheral angiopathy with gangrene, bilateral above the knee amputation, and essential (primary) hypertension.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/30/2024, revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident #5's Care Plan initiated on 11/30/2020, revealed the resident has chronic pain due to osteoarthritis and has an order for opioids for pain. Interventions included give medications as ordered, observed and document the frequency and intensity of the pain symptoms, and observe/document the effectiveness or ineffectiveness of medications.</p> <p>A review of physician orders and medication administration record [MAR] revealed Resident #5 had Norco oral tablet 5-325 mg (hydrocodone-acetaminophen) 1 tablet by mouth every 6 hours as needed for pain.</p> <p>A review of the record of loss of controlled substance revealed Resident #5 had HCD/APAP [hydrocodone/acetaminophen] 5/235 mg quantity 1 missing.</p> <p>A review of the narcotic book page 19 indicated Resident #5 had 32 tablets remaining of hydrocodone/acetaminophen 5/325 mg. The medication balance was transferred to page 29 of the narcotic book with a starting balance of 31 tablets indicating one tablet was unaccounted for.</p> <p>During an interview on 10/21/2024 at 1:20 p.m., Resident #5 confirmed taking opioid pain medication and denied any issues or concerns receiving the medication.</p> <p>A review of the admission record indicated the facility admitted Resident #7 with diagnoses that included acute and chronic respiratory failure, end stage renal disease, tracheostomy status [an opening in neck used for breathing], and dementia in other diseases.</p> <p>The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/26/2024, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment.</p> <p>A review of Resident #7's care plan initiated on 01/04/2024, revealed the resident had anti-anxiety medications, at risk for a mood problem related to anxiety and risk for pain related to diagnosis. Interventions included administering medications as ordered, observe and documented the intensity and frequency of symptoms and monitor for safety.</p>		