STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045450	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Midtown Rehab & Nursing Center	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50505 Based on interviews, record review, and facility policy review, it was determined the facility failed to ensure medications were administered as ordered by the physician for 2 (Residents #2 and #4) of 3 residents reviewed for correct medication administration as ordered by the physician. The findings include: A review of a facility policy titled, Policies and Procedures: Subject: Medication Administration, revised on 11/25/2022, indicated that medications were to be administered as ordered, including the required time frame. 1. A review of the Admission Record, indicated the facility admitted Resident #2 with diagnoses that included schizophrenia, bipolar disorder, major depressive disorder, and generalized anxiety disorder. The quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/10/2025, revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Resident #2 was marked as taking antipsychotic and antianxiety medications. A review of Resident #2's Care Plan, initiated on 07/12/2023, revealed the resident was at risk for behavior problems related to schizophrenia and bipolar disorder. Interventions included: administer medications as ordered, monitor and document for side effects and effectiveness and reward the resident for appropriate behavior. A review of the Order Summary Report, revealed Resident #2 had an order for [second generation atypical antipsychotic medication name] 100 milligrams (mg), give 1.5 tablets by mouth two times a day. According to December 2024 Medication Administration Record (MAR), Resident #2 had an order for [second generation atypical antipsychotic medication name] 100 mg give 2 tablets by mouth at bedtime from 12/01/2024 until 12/16/2024. A new order was written for [second generation atypical antipsychotic medication name] 100 mg give 3 tablets by mouth at bedtime to start 12/17/2024. [Antimanic agent medication name] 300 mg, give 2 tablets to equal 600 mg by mouth at bedtime. (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of December 2024, Medication Administration Record, revealed Resident #2 had not received [second generation atypical antipsychotic medication name] 100 mg, 2 tablets at bedtime for the dates of 12/08/2024, 12/09/2024, and 12/10/2024, and was marked hold/see nurses notes, 12/11/2024, 12/12/2024, 12/13/2024, 12/15/2024, and 12/16/2024 were marked other/see nurses notes. On 12/17/2024, Resident #2 refused the medication and on 12/18/2024 the resident was hospitalized . Resident #2 had not received [anti-manic agent medication name] 300 mg (2 tablets to equal 600 mg) on 12/07/2024 and was marked other/see nurses notes and 12/08/2024 was marked hold/see nurses notes. Resident #2 refused [antimanic agent medication name] on 12/17/2024 and was marked hospitalized for [DATE]. A review of Progress Notes, revealed Resident #2 had the following notes written: 12/07/2024: [antimanic medication name] 300 mg Give 2 tablets by mouth at bedtime . Out of medication at this time. This nurse will fax a refill form to the pharmacy. 12/08/2024: Clozapine 100 mg, Give 2 tablets by mouth at bedtime, pharmacy. 12/09/2024: Complete Blood Count (CBC) ordered per medical doctor this am to check levels before pharmacy can deliver meds. 12/09/2024: [second generation atypical antipsychotic medication name]100 mg, Give 2 tablets by mouth at bedtime, waiting on lab results. 12/10/2024: [second generation atypical antipsychotic medication name]100 mg, Give 2 tablets by mouth at bedtime, pharmacy. 12/11/2024: [second generation atypical antipsychotic medication name]100 mg, Give 2 tablets by mouth at bedtime, pharmacy. 12/12/2024: [second generation atypical antipsychotic medication name]100 mg, Give 2 tablets by mouth at bedtime, waiting on pharmacy. 12/13/2024: [second generation atypical antipsychotic medication name]100 mg, Give 2 tablets by mouth at bedtime, waiting on pharmacy. 12/15/2024: [second generation atypical antipsychotic medication name] 100 mg. Give 2 tablets by mouth at bedtime, pharmacy. 12/16/2024: [second generation atypical antipsychotic medication name] 100 mg, Give 2 tablets by mouth at bedtime, pharmacy. 12/17/2024: Pharmacy called for resident's [second generation atypical antipsychotic medication name] refill. Most recent CBC faxed to pharmacy. Awaiting call back. 12/17/2024: received resident's [second generation atypical antipsychotic medication name] from pharmacy. 12/17/2024: resident does not respond to verbal stimuli but has verbal response to physical stimuli. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/17/2024: refused all meds and nourishment. 12/18/2024: resident was very confused and started yelling for help last evening, became combative, so disoriented, order to transfer. A review of the pharmacy manifest revealed Resident #2's [second generation atypical antipsychotic medication name] had been ordered from the facility on 12/10/2024 and was filled on 12/17/2024. A review of the Lab Results Report, revealed that Resident #2 had a CBC collected on 12/13/2024 at 7:30 AM and was reported on 12/14/2024 at 3:04 AM. A review of the hospital records, revealed that Resident #2 was admitted to the hospital on 12/18/2024 and the reason for admission stated, after speaking with a nurse at the [Facility Name] and indicated that Resident #2 had not received [second generation atypical antipsychotic medication name] for several days as their pharmacy would not release it due to the resident not having a current absolute neutrophil count and that Resident #2 had been stable for a long period of time on the combination of [second generation atypical antipsychotic medication name] and [antimanic medication name], but that since Resident #2 had not received the [second generation atypical antipsychotic medication name] in the last week, the resident had grown increasingly psychotic and disorganized. During an observation on 02/10/2025 at 11:38 AM, Resident #2 was lying in bed with the head of bed slightly elevated talking and laughing with the nursing staff. Resident #2 was singing a different version of Happy Birthday. 2. A review of the Admission Record, indicated the facility admitted Resident #4 with diagnoses that included discitis, cervical region, lumbago with sciatica, cord compression, acute respiratory failure and surgical aftercare following surgery on the nervous system. The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/06/2025, revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. Resident #4 was marked as taking an antibiotic medication. A review of Resident #4's care plan, initiated on 01/14/2025 revealed the resident was on antibiotic therapy via peripherally inserted central catheter (PICC) to right upper extremity. Intervention included: administer antibiotic medications as ordered by physician and monitor/document side effects and effectiveness. A review of the Order Summary Report, revealed Resident #4 had an order for [glycopeptide antibiotic medication name] intravenous solution 1000 mg/200 milliliter (ml) intravenously twice a day. A review of Medication Administration Record, for February 2025 revealed Resident #4 had not received [glycopeptide antibiotic medication name] on 02/04/2025, 02/05/2025, 02/06/2025 and 02/10/2025. A review of Progress Notes, revealed Resident #4 had the following notes written: 02/04/2025 [glycopeptide antibiotic medication name] intravenous solution 1750 mg/350 ml, unavailable. Called pharmacy to stat over. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/04/2025 resident did not receive afternoon antibiotic (ABT) due to being unavailable. Pharmacy notified and asked to stat over, pharmacy spoke with physician assistant and orders are to be sent over to lower the dose of antibiotic. 02/04/2025 waiting on delivery from pharmacy 02/05/2025 [glycopeptide antibiotic medication name] Intravenous Solution 1000mg/200ml no note written. 02/06/2025 [glycopeptide antibiotic medication name] Intravenous Solution 1000mg/200ml, has to have a new PICC line tomorrow. 02/10/2025 [glycopeptide antibiotic medication name] Intravenous Solution 1000mg/200ml, drug not available. During an interview on 02/10/2025 at 11:58 AM, Resident #4 stated, I was supposed to get my antibiotic at eight (8) this morning and I still haven't had it. Resident #4 confirmed that no one had spoken to him about why the medication had not been given. During an interview on 02/11/2025 at 11:50 AM, Licensed Practical Nurse (LPN) #1 confirmed that no intravenous (IV) antibiotic had been administered on 02/10/2025 due to not being able to locate the antibiotic and that the medication was searched for by LPN #1 and another LPN. During an interview on 02/11/2025 at 11:55 AM, LPN #2 confirmed that the medication had been searched for with LPN #1 and the antibiotic was unable to be located. During an interview on 02/11/2025 at 12:00 PM, the Administrator asked this surveyor to speak with the Regional Nurse Consultant, who was asked to review the documentation and confirmed per the MAR documentation and the progress notes that Resident #2 had not received [second generation atypical antipsychotic medication name] on 12/08/2024, 12/09/2024, 12/10/2024, 12/11/2024, 12/12/2024, 12/13/2024, 12/15/2024 and 12/16/2024 due to the medication not being available. The Regional Nurse Consultant agreed that [second generation atypical antipsychotic medication name] had been ordered on 12/10/2024 but was not delivered to the facility until 12/17/2024. During an interview on 02/11/2025 at 12:10 PM, the Regional Nurse Consultant explained that the antibiotic was not given to Resident #4 on 02/04/2025 due to the medication had been reduced and the facility was waiting for the medication to be delivered and on 02/05/2025 and 02/06/2025, Resident #4's PICC had malfunctioned, and a third-party vendor had to come in and re-insert a new PICC. He confirmed per the progress note and the MAR for 02/10/2025 that the antibiotic had not been administered due to the medication was unavailable. When asked what the importance of medications being administered as ordered, he stated, not getting their medications can lead to exacerbation of chronic medical conditions and we will have some things to look at concerning these issues.