

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2025
NAME OF PROVIDER OR SUPPLIER The Blossoms at Breckenridge Rehab & Nursing Cente		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Brookside Drive 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 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on observations, interviews, record review, and facility document review, the facility failed to ensure a resident who was at risk for elopement was adequately supervised in order to prevent the resident eloping from the secure unit for one (Resident #2) of three residents reviewed for accidents and supervision. The failed practice resulted in past noncompliance at the level of harm, which had the likelihood of causing more than minimal harm to Resident #2, who resided on the secure unit. The Administrator was notified of the past harm situation on 09/12/2025 at 3:50 PM.</p> <p>The findings include:</p> <p>A review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 05/15/2025, revealed Resident #2 had a Brief Interview for Mental Status score of 11 which indicated the resident had moderate cognitive impairment. The MDS also indicated Resident #2 had active diagnoses which included non-Alzheimer's dementia, psychotic disorder, schizophrenia, and Parkinsonism.</p> <p>A review of Resident #2's Care Plan, with an initiation date of 02/12/2025, had interventions related to preventing elopement, which included having the resident on the secure neighborhood, with a goal of having no episodes of elopement.</p> <p>A form titled "NSG (Nursing)-Elopement Risk with Care Plan", dated 04/09/2025 at 2:24 PM, indicated the resident had a score of 13, which was "High Risk". The form indicated Resident #2 was ambulatory, had a history of wandering, and had medical diagnoses of dementia /cognitive impairment and a diagnosis impacting gait/mobility or strength. No care plan interventions were delineated on the Care Plan section of the form.</p> <p>A review of the form titled "OLTC (Office of Long-Term Care) Witness Statement Form" dated 05/18/2025 at 7:00 AM, with signature of Certified Nursing Assistant (CNA) #3, indicated on 05/17/2025 at approximately 11:30 AM, Resident #2 was wandering the halls, asking to leave, and wanted cigarettes.</p> <p>A review of the form titled "OLTC Witness Statement Form", dated 05/19/2025 at 11:04 AM, with signature of CNA # 2, indicated on 05/17/2025 she could not locate Resident #2 at 4:50 PM, and the resident was last seen during rounds on the unit at 4:00 PM.</p> <p>A review of the Excerpt of Disaster Plan - Elopement, indicated if the missing resident was not found following an expedient search to call 911, and coordinate with public safety agencies in searching for the missing resident.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Emergency Medical Services (EMS) run sheet report, dated 05/17/2025, indicated bystanders observed Resident #2 staggering and confused. Bystanders notified EMS at 4:44 PM. EMS was on the scene at 5:29 PM, near a business location approximately 0.7 miles from the facility, with Resident #2 lying in the grass, accompanied by local Police Department and Fire Department personnel. The EMS report also indicated Resident #2 stated to have escaped the facility because of being paranoid. Resident #2 was released after LPN (Licensed Practical Nurse) #1 signed a Refusal of Treatment at 5:50 PM.</p> <p>During an interview on 09/09/2025 at 10:47 AM, LPN #1 indicated when the resident was thought to be missing just before 5:00 PM on 05/17/2025, staff were instructed to search for the resident but were unable to locate Resident #2 in the secure unit, or anywhere in the facility or facility grounds. LPN #1 left the facility in her private vehicle to begin looking for Resident #2. LPN #1 indicated she was made aware of Resident #2's location because she received a phone call from a CNA that saw the resident with EMS. LPN #1 found Resident #2 in the care of EMS, signed the Refusal of Treatment and EMS assisted Resident #2 to the passenger side of LPN#1's personal vehicle. LPN #1 made the first attempt to contact the Director of Nursing (DON) when in route back to the facility. LPN #1 indicated Resident #2 did not have the capacity to enter a code into a keypad to exit the facility, and it was more likely that the resident exited through a facility door that did not close completely.</p> <p>During an additional interview on 09/12/2025 at 12:41 PM, LPN #1 indicated she made the decision to take the resident out of the care of EMS and did not attempt to contact the provider or Administrator at that time. LPN #1 indicated the only assessment concern for Resident #2 was the resident's temperature was up &quot;just a bit&quot; because it was hot that day, and she was trying to get Resident #2 back to the facility.</p> <p>A review of a website for local weather indicated the temperature on the afternoon of 05/17/2025 was 87 degrees Fahrenheit (F) at 4:53 PM, and 87 degrees F at 5:53 PM.</p> <p>A review of a Progress Note, effective date 05/18/2025 at 10:49 AM, indicated Resident #2's physician was notified of the elopement incident on 05/17/2025 at 6:00 PM.</p> <p>A review of the DMS (Division of Medical Services) form 762 indicated Resident #2 had skin tears to both hands noted upon return to the facility.</p> <p>A review of the Treatment Administration Record (TAR) for May 2025, indicated Resident #2 received treatment on 05/19/2025, for the skin tears to both hands, including cleansing, applying medicated gauze, and covering with a dry dressing three times a week, until healed.</p> <p>During an interview on 09/12/2025 at 1:20 PM, the DON indicated LPN #1 did attempt to contact her, but they did not communicate until Resident #2 and LPN #1 were back in the facility.</p> <p>CORRECTIVE ACTION:</p> <p>The facility provided the following evidence of corrective actions that were initiated after the 05/17/2025 incident, but prior to entrance of surveyors for the survey:</p> <p>During an interview with CNA #2 on 09/09/2025 at 4:44 PM, it was indicated the immediate action taken on 05/17/2025 at 4:50 PM was:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>1. The nurse was notified, doors were checked, and a unit and facility search began.</p> <p>During an interview on 09/09/2025 at 10:47 AM, LPN #1 indicated Resident #2 was put on one-to-one monitoring upon return to the facility.</p> <p>Other immediate actions by the nursing staff included:</p> <ol style="list-style-type: none"> 1. A body audit was completed on 05/17/2025 at 5:50 PM for Resident #2. 2. An Elopement Risk assessment with Care Plan was completed on 05/17/2025 at 10:12 PM, for Resident #2, as well as all other residents in the facility <p>During an interview at 09/09/2025 at 11:28 AM, the Maintenance Director indicated he came up the night of the incident and checked all doors, checked all alarms on the doors and changed all the codes for the doors. The Maintenance Director also indicated that since there was nothing wrong with the doors, Resident #2 must have followed another person out of the door.</p> <p>The facility provided timecard sheets to demonstrate the presence of the Maintenance Director at 8:00 PM on 05/17/2025 until 8:17 PM.</p> <p>During an interview on 09/09/2025 at 12:48 PM, the DON indicated the Root Cause Analysis (RCA) Elopement Protocol and Root Cause Analysis, done between 05/17/2025 and 05/19/2025, revealed the only feasible way Resident #2 could have gotten out was the resident knew the codes to the door(s). The interventions implemented were as follows:</p> <ol style="list-style-type: none"> 1. The process was changed immediately when taking Resident #2 out of the unit &ndash; the door was to be opened first, then Resident #2 would be taken through the door. This process change did not allow Resident #2 the opportunity to see the code being used. 2. Doors on the secure unit were monitored three times per week, for June 2025 and July 2025, then weekly, to ensure the doors were locked and the alarms were functioning correctly. 3. Keypad covers were installed on 05/19/2025 to decrease visibility of the code entry 4. In-services to all staff on elopement policy and procedure began 05/17/2025 with a completion date of 05/19/2025. Education included in the training was to ensure doors are secure, not to allow residents to view the keypads when codes were entered, not to use exit doors on the secure unit unless it was an emergency.: <p>Interviews with staff were conducted to verify they were in serviced on how to prevent elopement and the correct process if a resident eloped. Staff interviewed were as follows: LPN #1, CNA #2, CNA #3, RN #4, CNA #5, LPN #6, Med Tech #7, LPN #8, Housekeeping #9, LPN #10, and CNA #11. These interviews were conducted with staff that worked on all shifts.</p>		