STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045470	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Prescott Rehab & Nursing Center	700 Manor Rd Prescott, AR 71857

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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility document review, the facility failed to ensure one (Resident #1) of four residents reviewed for quality of care, received prescribed medications. The findings include: A review of Resident #1's admission Record revealed the facility admitted the resident on 01/29/2026, with a primary diagnosis of schizophrenia. A review of Resident #1's Progress Notes revealed Resident #1 arrived at the facility via the facility transportation van at 6:34 PM on 01/29/2026. A review of Resident #1's Hospital Records revealed that upon discharge from the hospital, the medication list that was current on 01/29/2026 at 11:41 AM, included a generic medication for extrapyramidal and movement disorder, a generic mood stabilizer medication, a generic anti-psychotic medication, a generic thyroid medication, a generic medication for hypertension (high blood pressure), a generic medication for hyponatremia (low sodium in the body), a generic medication for sleep, and a vitamin. A review of Resident #1's admission Minimum Data Set (MDS) with an assessment reference date of 02/04/2026, revealed a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact. Resident #1's MDS also revealed the resident's active diagnoses, which included schizophrenia, anxiety disorder, moderate intellectual disabilities, thyroid disorder, and hyponatremia. A review of Resident #1's Care Plan, with an initiation date of 01/30/2026, revealed interventions related to anxiety medications and schizophrenia medications, which included to administer the respective medications, educate the resident about toxic symptoms, and observe for reactions and side effects to the medications. In addition, the resident's Care Plan included interventions related to Resident #1's risk for elopement and being placed on the secured unit. A review of Resident #1's Progress Notes dated 01/31/2026 at 3:30 AM, revealed Resident #1's behaviors included asking to leave by ambulance to go to another facility in a neighboring town, no complaints of pain, pacing back and forth, and that the resident's medications had arrived from the pharmacy. In addition, the Progress Notes revealed Resident #1 was noted to have eloped the facility on 01/31/2026, sometime after last being seen at 3:00 AM – 3:15 AM. A review of the Elopement Risk Evaluation, completed on 01/31/2026 at 3:32 PM, completed by the (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 - Few	Director of Nursing (DON), described Resident #1's cognitive processes as impulsive behavior. A review of Resident #1's January 2026 Medication Administration Record (MAR) – Treatment Administration Record revealed 15 doses of medications that were not administered on 01/30/2026, with the respective rationales listed in Resident #1's Progress Notes: - On 01/30/2026 at 8:00 AM, a generic mood stabilizer once a day, was documented as drug refused. - On 01/30/2026 at 8:00 PM, a generic mood stabilizer at bedtime, was documented as meds unavailable. - On 01/30/2026 at 8:00 AM, a generic Non-Steroidal Anti-Inflammatory Drug (NSAID), was documented as drug refused. - On 01/30/2026 at 6:00 AM, a generic thyroid medication in the morning, related to hypothyroidism, was documented as drug not available. - On 01/30/2026 at 8:00 PM, a generic medication for schizophrenia at bedtime, was documented as drug not available. - On 01/30/2026 at 8:00 AM, a vitamin once a day for B12 deficiency, was documented as drug refused. - On 01/30/2026 at 8:00 AM and at 8:00 PM, a generic medication for extrapyramidal and movement disorder, the 8:00 AM dose was documented as drug refused, and the 8:00 PM dose was documented as meds unavailable. - On 01/30/2026 at 8:00 AM and at 4:00 PM, a generic medication for hyponatremia. The 8:00 AM dose was documented as drug refused - On 01/30/2026 at 8:00 PM, a generic anti-psychotic medication, related to schizophrenia, was documented as med unavailable. - On 01/30/2026 at 8:00 AM, at 12:00 PM, and at 8:00 PM, a generic anti-anxiety medication, related to anxiety disorder. The 8:00 AM dose was documented as drug refused. The 12:00 PM and 8:00 PM doses were documented as med unavailable. - On 01/30/2026 at 8:00 AM and at 8:00 PM, a generic medication for hypertension. The 8:00 AM dose was documented as drug refused, and the 8:00 PM dose was documented as med unavailable. During an interview on 02/04/2026 at 11:31 AM, Licensed Practical Nurse (LPN) #2 indicated the process for a new resident to receive their medications once admitted would be for the nurse to first see what was available in the Pyxis, fax to the pharmacy, then wait for the pharmacy to deliver, generally at 9:00 PM. LPN #2 also indicated the reason Resident #1 did not get any medications on her shift was because they [the medications] had not been delivered. LPN #2 also indicated Resident #1 did have some behaviors on the day shift of 01/30/2026, including being upset about money, not having as much coffee as wanted, and not having chewing tobacco. A review of the Drug Manifest Log indicated the following medications for Resident #1 were signed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as received from the medication delivery service on 01/30/2026 at 8:40 PM, by Licensed Practical Nurse (LPN) #1: - A generic medication for hypertension - A generic medication for schizophrenia - A generic medication for the treatment of extrapyramidal and movement disorders - A generic mood stabilizer medication - A generic anti-psychotic medication - A generic thyroid medication - A generic NSAID During an interview on 02/05/2026 at 8:37 AM, LPN #1 indicated she was the nurse responsible for Resident #1 on 01/30/2026 and stated, Resident #1's medications were delivered after the nighttime medication pass, and that was why no medications were given to Resident #1 on the evening shift of 01/30/2026. LPN #1 also indicated she was unsure if any of Resident #1's medications could have been obtained from the Pyxis. During an interview on 02/05/2026 at 11:00 AM, the DON indicated that the omitted medication doses for Resident #1 and rationales listed above were correct. The DON also indicated that for a medication to be considered on time, it was to be administered one hour before, or one hour after the scheduled time on the MAR. It was also confirmed with the DON that the only dose of any medication administered to Resident #1 from admission on [DATE], until Resident #1 eloped on 01/31/2026, was a dose of a generic medication for hyponatremia at 4:00 PM on 01/30/2026. During an interview on 02/05/2026 at 3:55 PM, the Administrator indicated that a generic anti-psychotic medication, a generic medication for schizophrenia, and a generic medication for anxiety were available in the Pyxis and she could not determine why LPN #1 did not access the Pyxis for administration of those three medications. In addition, the Administrator stated she was unable to determine why the medications were not administered to Resident #1, after the delivery from the pharmacy. The Administrator indicated that the medications were received from the pharmacy on 01/30/2026 at 8:40 PM, as indicated on the pharmacy manifest log. It was also confirmed with the Administrator that the only dose of any prescribed medications administered to Resident #1 from admission on [DATE], until Resident #1 eloped on 01/31/2026, was a dose of a generic medication for hyponatremia at 4:00 PM on 01/30/2026. A review of a policy titled Medication Administration and General Guidelines, indicated that medications were to be administered within one hour of the scheduled time.