STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366169	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blossom Nursing and Rehab Center	109 Blossom Lane Salem, OH 44460

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of the facility investigation, interview with staff and review of facility policy, the facility failed to ensure Resident #1 was free from significant medication errors. This affected one resident (Resident #1) of three residents reviewed for medication administration. The facility census was 86. Findings include:Review of the medical record revealed Resident #1 was admitted to the facility on [DATE]. Diagnoses included hydronephrosis, urinary tract infection, acute kidney disease, atrial fibrillation, congestive heart failure, acute metabolic acidosis, diabetes, cerebral ischemia, obstructive sleep apnea, anxiety disorder, and major depressive disorder. Resident #1 was discharged to the hospital on [DATE]. Review of the admission Minimum Data Set assessment dated [DATE] revealed Resident #1 had intact cognition. Review of the progress note dated 03/31/26 at 10:05 P.M. which was recorded as a Late Entry on 04/01/26 at 6:26 A.M., revealed Resident #1 was given medication that was meant for another resident. A call was placed immediately to the nurse practitioner (NP) and it was explained to the NP what medication was given to the resident. Vital signs were taken and were as followed, Blood pressure 119/70, pulse 72, respirations 18, oxygen level 96 percent, and temperature 97.3, pupils were equal and reactive with pupil size three millimeter bilaterally. The resident was alert and oriented and speech clear. NP was to call back. Review of the progress note dated 03/31/26 at 10:45 P.M. which was recorded as a Late Entry on 04/01/26 at 6:41 A.M., revealed the NP called back and order placed to send Resident #1 to the emergency department (ED) for observation in case of cardiac and blood pressure issues. A call was placed to emergency services, to the Director of Nursing and the ED for nurse-to-nurse report. Resident remained alert and oriented and denied any discomfort or distress.Review of the facility's investigation of a medication error dated 04/01/26 revealed on 03/31/26 Resident #1 was given another resident's medication on the evening of 03/31/26. He was sent to the ED for evaluation. Resident #1 was evaluated and monitored in the ED and found free from injury and was sent back to the facility. The resident's overall condition was being monitored. The resident's physician was at the facility on 04/01/26 and checked the resident and the resident was without injury or harm from the medication error. An in-service was completed with Registered Nurse #173 on 03/31/26. The resident would be monitored for any significant change, and it would be reported to the physician. The son was aware. Medication inadvertently administrated to Resident #1 were carbidopa-levodopa (anti-Parkinson's) 25/100 milligrams (mg), gabapentin 600 mg (analgesic), pravastatin 40 mg (cholesterol reducing), trihexyphenidyl (anti-Parkinson's)5.0 mg and ropinirole 0.5 mg (anti-Parkinson's). Review of the progress note dated 04/01/26 at 2:20 A.M. revealed Resident #1 returned to the facility via ambulance and was assisted back to bed. Resident #1 stated he felt fine. No adverse effects were found during observation. He was resting in bed with his call light within reach.Review of the progress note dated 04/01/26 at 1:47 P.M. revealed Resident #1 remained drowsy and did not arouse to name. His call light was within reach, Skin was warm and dry and his respirations were even and regular. Diet intake was poor due to drowsiness and he was incontinent. Review of the progress note at 04/01/26 at 3:48 P.M. revealed the physician was at the facility to visit Resident #1. New orders received. Review of the new physician's orders for Resident #1 dated 04/01/26 revealed vital signs were to be obtained (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every two hours for 24 hours the every six hours, check and record fluid intake every day for three days, weights every Monday, Wednesday and Friday and notify the physician of any gain or loss of three or more pounds, and continue to follow the previous laboratory orders for every Monday and Thursday. Notify the physician with any abnormal. On 05/08/26 at 12:50 P.M. an interview with Director of Nursing revealed the nurse had prepared Resident # 52's medications and placed them in the top drawer of the medication cart because she wanted to make sure she got her medication right on time. She stated the nurse was worried if she did not get her medication right on time she would have aggravated symptoms of her Parkinson's disease, so she got them ready ahead of time. However, as she was getting the medication ready for Resident #1 she got an admission and also placed Resident #1 medication in the top drawer of the medication cart to go admit the new resident and when she came back to administer the medication cart she grabbed the wrong medication out of the top drawer for Resident #1 and gave them to him. She indicated it was around 9:00 P.M. She stated the nurse retired after this incident. Review of the facility policy titled, Medication Administration Procedures, dated 04/20 revealed medications would not be pre-poured and to identify the resident before administering medications. This deficiency represents non-compliance investigated under Complaint Number 2984888.