STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045259	A. Building B. Wing	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Woodland Hills Rehab & Nursing Cen	8701 Riley 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. 37925 Based on observation, interview, and record review, the facility failed to ensure call lights were answered in a timely manner to ensure residents requests for assistance were addressed promptly for 2 (Residents #24 and 41) of 2 sampled residents whose call lights were activated. The findings are: 1. Resident #41 had diagnoses of Type 2 diabetes mellitus without complications and Hypertension. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/17/23 documented Resident #41 had a Brief Interview for Mental Status (BIMS) score of 13 (13-15 indicates cognitively intact) and did not receive oxygen (O2) while being a resident. a. A Care Plan with a completion date of 12/15/23 documented, .I have a dx [diagnosis] of Hypertension . monitor/document/report to MD [Medical Doctor] PRN [as needed] any s/sx [signs / symptoms] .difficulty breathing (Dyspnea) . b. A Progress Note dated 2/12/24 at 16:58 (4:58 PM) documented, .New order received for PRN oxygen at 2 liters via [by way of] nc [nasal cannula] . c. On 02/12/24 at 11:24 AM, the Surveyor was speaking with Resident #41 when the nasal cannula came out of Resident #41's nose and the Surveyor activated the call light for assistance. The Surveyor stepped outside of the resident's room and waited to see what time someone would come to assist the resident. The light on the wall in the room had a yellow hue. The light outside of the resident's room had a white hue. The Surveyor did not hear a sound coming from the call light on the wall at this time. At 11:28 AM, a staff member was in the hallway and entered another resident's room that did not have a call light on. At 11:28 AM, the Surveyor observed a staff member at the nurse's station. At 11:35 AM, the Surveyor was standing in the hallway and Resident #41's light remained activated. At 11:36 AM, Licensed Practical Nurse (LPN) #2 entered Resident #41's room and stated, I'm gonna have to go get you a concentrator. The light was activated for 12 minutes before a staff member went into the resident's room to address the resident's need. 2. Resident #24 had diagnoses of Partial traumatic amputation at elbow level, right arm and Acquired absence of left upper limb below elbow. A Modified Quarterly MDS with an ARD of 1/17/24 documented the resident had a BIMS score of 15 (13-15 indicates cognitively intact). a. A Care Plan with a completion date of 1/29/24 documented, .I am total dependent on x [times] 1 staff for personal hygiene, bathing, eating and locomotion. I require 2 person mechanical lift for transfers . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. On 02/14/24, at 5:47 AM, this Surveyor approached the nursing station for Halls E, F, G, and H, and there were two call lights activated at the nursing station, E12 was solid and H5 was flashing and there was an intermittent buzz coming from the nurse's station. This Surveyor walked down the E Hall towards the light, and it was E12. The Resident's door was open, and this Surveyor knocked and entered. The Resident was greeted and then asked how long had [Resident #24] light been on, and the resident stated, It's only been on about five minutes. He'll be down here in a little bit to take care of me. This Surveyor exited the resident's room and approached the nursing station and observed another person with navy blue pants on and a gray sweater with the hood on sitting opposite the nursing station looking down at a cellphone and the buzzing sound could be heard coming from the nursing station. This Surveyor entered the nursing station and two lights, E12 (solid) and H5 (flashing) were on. The staff member, who identified themselves as [Certified Nursing Assistant (CNA) #3] and said that they were assigned to H hall, then got up and walked away from the area. At 5:51 AM, CNA #3 entered room H5 and the light then went off outside that room. At 6:04 AM, CNA #5 entered Room E12 and stated, I'm making my way down to you [Resident #24]. The light outside the door went off and CNA #5 exited the room. (E12 call light had been on for 17 minutes while the Surveyor was in observance). At 6:38 AM, E12 call light came on again outside the door. At 6:46 AM, E12 call light went off and at 6:48 AM, CNA #5 was observed in the room looking through the resident's closet. (Call light was on 8 minutes). c. On 2/14/24 at 6:41 AM, CNA #3 was asked, Who is responsible for answering the call lights? CNA #3 stated, All CNAs. CNA #3 was asked, How do you know when the call lights are on? CNA #3 stated, You hear like a humming sound and there's a light at the top of the beginning of the halls and the rooms. CNA #3 was asked, How long should it take for a call light to be answered? CNA #3 stated, Depending on if you are already dealing with a resident, one to five minutes. If you're not doing anything, ASAP [as soon as possible]. CNA #3 was asked, If you are working with another resident and step out to get something and see another call light on and you go answer it, how long should it be before you go back to that resident to take care of the issue? CNA #3 stated, I wouldn't go in unless I'm going to answer it and take care of what they needed. CNA #3 was asked, If you leave a room and see a call light on, go to that room and let the resident know that you will be back shortly when you are done taking care of another resident and when you are done with resident care, should you go to the room that had the call light on or to another resident's room that does not have a call light on? CNA #3 stated, Go to the room that had the call light on. d. On 02/15/24 at 9:54 AM, LPN #4 was asked, How do you all know when a resident's call light is on? LPN #4 stated, Right above their room, it will be yellow. LPN #4 was asked, What is that faint buzzing sound I'm hearing here at the nursing station? LPN #4 stated, To be exact, I don't know but it sounds like the call light. LPN #4 was asked, What is that light at the top of the H hall? LPN #4 stated, That indicates that is a call light. e. On 02/16/24 at 12:14 PM, the Director of Nursing (DON) was asked, Who is responsible for answering call lights? The DON stated, Everyone. The DON was asked, When should they be answered? The DON stated, Within five to seven minutes but ASAP (as soon as possible). The DON was asked, When should a resident whose call light was answered concern / issue be taken care of? The DON stated, Immediately. The DON was asked, If a staff member is not busy and a call light is on, should they try to see if he/she can provide assistance to the resident? The DON stated, Yes. f. On 2/16/24 at 2:16 PM, the Administrator confirmed the facility did not have a policy on call lights.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37925 Based on record review and interview, the facility failed to ensure a Quarterly Minimum Data Set (MDS) was transmitted in a timely manner to promote individualized care for 1 (Resident #33) of 66 (All Residents, Census: 66) residents. The findings are: 1. Resident #33 was admitted to the facility on [DATE]. a. A Quarterly MDS with an Assessment Reference Date (ARD) date of 12/15/23 had a Registered Nurse (RN) completion date of 12/29/23 in section Z0500, but a signature for Z0400, which is the signature of persons completing the assessment or entry / death reporting, was not added until 2/12/24. This MDS was accepted by CMS (Centers for Medicare and Medicaid Services) on 2/12/24. b. On 2/15/24 at 3:40 PM, the MDS Coordinator was asked to look at Resident #33's Quarterly MDS with an ARD of 12/15/23 and identify the date section Z0400 was signed. The MDS Coordinator confirmed it was 2/12/24, and that section Z0500 completion date was signed 12/29/23. The MDS Coordinator was asked, How many days is it [MDS] supposed to be submitted after the completion date? and stated, I think it's 7 days. The MDS Coordinator added, I can't do that part because I'm an LPN [Licensed Practical Nurse] so we can't submit. The MDS Coordinator was asked, Who submits them? and stated, [Name], the MDS Consultant or [Name], who is the Regional MDS Consultant. The MDS Coordinator was asked, How do they know when you've completed it? and stated, When I make sure it's all done and all green, it's a verify button that I click and that alerts them that it's complete and they double check it and complete it.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 37925 Based on interview and record review, the facility failed to ensure care plans were reviewed and revised at least quarterly and/or when residents' care needs changed, as evidenced by failure to revise the plan of care to address the use of insulin, a high-risk medication, to ensure staff were aware of the necessary care, assessments and services required for 1 (Resident #24) of 1 sampled resident who had orders for insulin. The findings are: 1. Resident #24 had diagnoses of Long term (current) use of insulin and Type 1 diabetes mellitus with ketoacidosis without coma. a. A Quarterly Minimum Data Set (MDS) with as Assessment Reference Date (ARD) of 1/17/24 documented Resident #24 received insulin, a high-risk drug, injections 7 out of 7 days. b. The February 2024 Order Summary documented, . Insulin- Insulin Glargine Subcutaneous Solution 100 UNIT/ML (Insulin Glargine) . stat date 02/14/20; Inject 12 unit subcutaneously in the morning . Insulin Glargine . Inject 12 unit subcutaneously at bedtime . start date 02/08/20 . Insulin Lispro . Inject 11 units . before meals . start date 12/18/20 . c. A Care Plan with a completion date of 1/29/24 documented, .I have Diabetes Mellitus . Monitor/document/report PRN [as needed] any s/sx [signs/symptoms] of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue . It did not address insulin or the side effects and/or adverse reactions to monitor Resident #24 for. d. On 2/16/24 at 12:14 PM, the Director of Nursing (DON) was asked, Who is responsible for revising a care plan? The DON stated, Any of us nursing can, but we try to let MDS do that part. If something comes up that I'm aware of, I'll add to it. The DON was asked, When should it be done? The DON stated, I know they do them quarterly and annually, or when there is a significant change in condition or if something is going on with the resident. The DON was asked, Should a high-risk medication such as Insulin be added to a care plan? The DON stated, Yes, I guess. If they have Diabetes Mellitus it should be one of the interventions. The DON was asked, What information regarding this medication should be added to the care plan? The DON stated, Side effects of what it can do. The DON was asked, How does the staff know what side effects / adverse reactions to monitor the resident for? The DON stated, The Care Plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 37925 Based on observation, interview, and record review, the facility failed to ensure nail care was consistently provided to promote good grooming and personal hygiene for 1 (Resident #17) of 1 sampled resident who required staff assistance with nail care. The findings are: 1. Resident #17 had diagnoses of Age-related physical disability and Unspecified lack of coordination. An Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/14/24 documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 (13-15 indicates cognitively intact) and required partial/moderate assistance with shower/bathe self. a. A Care Plan with a completion date of 1/29/24 documented, I require moderate assist x 1 staff with bed mobility, transfer, dressing, toileting, bathing, and locomotion . Observe for my hygiene needs and render as needed each shift and prn [as needed] . b. A Documentation Survey Report for February 2024 documented Resident #17 had a shower / bathe self on 2/3/24, 2/6/24, 2/8/24, 2/10/24, 2/13/24 and 2/15/24. c. On 02/12/24 at 11:03 AM, Resident #17 was resting quietly in bed awake. The fingernails on both hands were greater than one quarter (1/4) inch in length. The toenails on both feet were greater than 1/4 inch in length and brittle. d. On 02/13/24 at 3:39 PM, Resident #17 was resting quietly in bed awake and the fingernails on both hands were greater than 1/4 inch in length. There were non-skid socks on both feet. e. On 02/15/24 at 7:43 AM, Resident #17 was resting quietly in bed and the toes on the left foot had jagged edges and the left great toenail was greater than 1/4 inch in length. f. On 02/15/24 at 7:52 AM, Certified Nursing Assistant (CNA) #2 was asked, Look at the resident's toenails and describe them for me? CNA #2 stated, They need to be clipped and they look like they may be diabetic, but I don't know if [Resident #17] is diabetic or not. CNA #2 was asked, Do you see any sharp edges? CNA #2 stated, Yes at the tips. CNA #2 was asked, Who is responsible for providing nail care to the residents? CNA #2 stated, The CNAs are, but if they are diabetic, the nurses do it. CNA #2 was asked, When is nail care done? CNA #2 stated, Majority of the time on bath days, but anytime we see them looking dirty or anything, we clean them. CNA #2 was asked, When are [Resident #17's] bath days? CNA #2 stated, Tuesdays, Thursdays and Saturdays. g. On 2/16/24 at 12:14 PM, the Director of Nursing (DON) was asked, Why should nail care be provided to the residents? The DON stated, We don't want them to scratch themselves or someone else or get food or dirt isn't under them. The DON was asked, When should this be done? The DON stated, As needed. The DON was asked, Who provides care to residents fingers or toenails? The DON stated, Nurses, CNAs and Podiatrist. The DON was asked, Who does the Podiatrist see? The DON stated, He sees everyone, even if they are part A and they need him, we will have him see them as well.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46868 Based on observation, interview, and record review, the facility failed to ensure services were provided to minimize the potential for further decline in range of motion (ROM) for 1 (Resident #5) of 1 sampled resident who had limited range of motion. The findings are: 1. Resident #5 had diagnoses of Cerebral infarction unspecified, and Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side 2. On 02/12/24 at 2:46 PM, Resident #5's left hand was in a fist like position and bent at the wrist. A hand splint was not in place. 3. On 02/13/24 at 09:17 AM, Resident #5 was in bed with no hand splint in place. 4. On 02/13/24 at 01:01PM, Resident #5 was in bed with hands in a fist like position. No splint present on left hand. 5. A Physician Order with order date 11/29/2023 documented, .left hand [NAME] grip splint to be worn at all times except during Adl's (activities of daily living) every shift . 6. A Care Plan initiated 02/12/2024 documented, Resident requires splint due to presence of contracture. left hand [NAME] grip splint to be worn at all times except during Adl's .Resident will maintain strength and joint integrity and to facilitate correct performance of passive and active movements to enhance flexibility of the joints. 7. On 2/14/24 at 08:31AM, LPN #2 was asked where Resident #5's splint was. LPN #2 stated, [Resident #5] don't want to wear it. Says it hurts her hand. LPN #2 was asked if it had been reported to anyone. LPN #2 stated, No. LPN #2 was asked to explain the need for a splint. LPN#2 stated, To prevent contractures. 8. 02/16/24 at 09:15 AM, the Director of Nurses (DON) was asked if Physicians orders were expected to be followed concerning splints or devices. The DON stated, Yes. The DON was asked if they were aware that Resident #5 wasn't wearing a splint. The DON stated, [Resident #5] refuses a lot. The DON was asked to explain the purpose of the splint and the outcome of it not being provided. The DON stated, It is for contractures; without it they will worsen. 9. On 2/15/24 at 12:52 PM, the Administrator reported that there was not a policy for handrolls/splints/devices.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37925 Based on observation, interview, and record review, the facility failed to ensure the smoking area outside of the dayroom for Halls E through H was safe to utilize for smoking for 1 (Resident #24) of 7 (Residents #4, #7, #18, #24, #30, #38 and #43) sampled residents who utilized the smoking area outside of the dayroom for Halls E through H; the facility failed to ensure that nail trimmers were not stored in residents room or within easy reach of the resident or other residents to prevent possible harm. This failed practice affected 1 (Resident #4) of 14 (Residents #18, #38, #43, #12, #47, #46, #30, #14, #44, #33, #31, #7, #63) sampled residents who ambulate or self-propel in the facility. The findings are: 1. Resident #24 had diagnoses of Nicotine dependence, cigarettes, Partial traumatic amputation at elbow level, right arm, and Acquired absence of left upper limb below elbow. A Modified Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/17/24 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status (BIMS). a. A Care Plan with a completion date of 1/29/24 documented, .I choose to smoke; potential for injury . Close monitoring while smoking in the smoking area . b. On 02/12/24 at 1:33 PM, Resident #24 was waiting in the dayroom to go out to smoke. After all the other residents had their smoking aprons on and a Certified Nursing Assistant (CNA) (name not identified at this time) had issued each resident a cigarette, the CNA placed a smoking apron on Resident #24 and propelled the resident out to the smoking area, where a cigarette was placed in Resident #24's mouth, lit the cigarette, and held it so Resident #24 could smoke it. c. On 02/14/24 at 9:53 AM, Resident #24 was observed outside the dayroom in the smoking area for Halls E through H while a staff member was holding a lit cigarette to the resident's mouth to smoke. There was a smoking container that was full, and another resident was observed putting tissue paper in it. d. On 02/15/24 at 9:55 AM, Resident #24 was observed in the smoking area outside the dayroom for Halls E through H. There was a smoking container that had white tissue paper in it that was being used by residents to put used cigarette butts in after smoking. e. On 02/15/24 at 10:06 AM, Certified Nursing Assistant (CNA) #4 was asked, Tell me what could happen if a resident puts tissue paper in a container with used cigarette butts that smoke is coming from? and stated, I don't know, but if someone catches on fire, we do have a fire bag out here and you just have to pull it down. e. On 02/15/24 at 10:15 AM, Housekeeper (HK) #1 was asked, Are the receptacles that the cigarette butts are placed in ever emptied? and stated, Yes. HK #1 was asked, When is it done? and stated, Maybe between when their smoke breaks are over with. HK #1 was asked, Tell me what could happen if a resident puts tissue paper in a container with used cigarette butts that smoke is coming from? and stated, It could catch fire. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. A Smoking Policy provided by the Administrator on 2/12/24 documented, .Purpose: To provide a healthy and safe smoke environment as possible for all residents, staff, and visitors . PROCEDRE: .The resident will be educated as to safe smoking practices . 2. Resident #4 had a diagnosis of Chronic atrial fibrillation. A Quarterly MDS with an ARD of 12/18/2023 documented the resident was taking an anticoagulant. A care plan with date initiated of 10/11/2023 stated, .Check nail length and clean and/or trim on bath day as necessary. Report any changes to the nurse . On 02/12/2024 at 12:14 PM, 2 sets of nail trimmers were in Resident #4's room within easy reach of resident. On 02/13/2024 at 11:30 AM, 1 set of nail trimmers were in Resident #4's room in front of the TV on the dresser. On 02/14/2024 at 10:19 AM, 1 set of nail trimmers were on the dresser in front of the TV, at which time the Surveyor asked Resident #4, Do you clip your own fingernails? Resident #4 stated, Yes I do. On 02/14/2024 at 01:57 PM, CNA #5 was asked, Are you familiar with the care of Resident #4? CNA #5 Replied, Yes. The Surveyor then asked, Is [Resident #4] assessed to trim their own fingernails? CNA #5 replied, I don't know. CNA #5 was then asked, Are residents able to keep nail trimmers in their room? CNA #5 replied, No. The Surveyor asked, What is the reason for not having nail trimmers in the room? CNA #5 replied, For safety, they could be diabetic or pinch the skin and cause a skin break that could cause an infection, or another resident could get them cause harm to themselves unintentionally. On 02/14/2024 at 02:01 PM, Licensed Practical Nurse (LPN) #5 was asked, Are you familiar with the care of Resident #4? LPN #5 Replied, Yes The Surveyor then asked, Is [Resident #4] assessed to trim their own fingernails? LPN #5 replied, No. The LPN was then asked, Are residents able to keep nail trimmers in their room? LPN #5 replied, No, we don't give trimmers to them. The Surveyor asked LPN #5, What medication is [Resident #4] on that would be a reason not to have the trimmers in the room? LPN #5 stated, Eliquis and 81 mg Aspirin. The surveyor asked, What is the reason for not having nail trimmers in the room? LPN #5 replied, The resident could bleed. On 02/14/2024 at 02:09 PM, the Director of Nursing (DON) was asked, Are you familiar with the care of Resident #4? The DON Replied, Yes The Surveyor asked, Is Resident #4 assessed to trim their own fingernails? The DON replied, We don't perform a formal assessment, but she can trim her nails. The DON was then asked, Are residents able to keep nail trimmers in their room? The DON replied, We prefer them not to keep nail trimmers in their room. The Surveyor asked the DON, What medication is she on that would be a reason not to have the trimmers in the room? The DON stated, Blood Thinners. The Surveyor asked, What is the reason for not having nail trimmers in the room? The DON replied, The resident could bleed if they cut themselves. On 02/15/2024 at 12:15 PM, the administrator provided a policy titled Accidents and Hazards Policy that documented, .The facility strives to ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48630

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 37925 Based on observation, record review and interview, the facility failed to ensure oxygen was administered only under the direction of a Physician's order for 1 (Resident #41); proper signage was posted outside the room pertaining to the use of oxygen for 2 (Residents #41 and #46); and the oxygen concentrator was free of debris for 1 (Resident #46) of 2 sampled residents who were receiving oxygen. The findings are: 1. Resident #41 had diagnoses of Type 2 Diabetes Mellitus Without Complications and Hypertension. A Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/17/23 documented Resident #41 did not receive oxygen while a resident. a. A Care Plan with a completion date of 12/15/23 documented, .I have a dx [diagnosis] of Hypertension . monitor/document/report to MD [Medical Doctor] PRN [as needed] any s/sx [signs/symptoms] .difficulty breathing (Dyspnea) . b. A Progress Note dated 2/12/24 at 16:58 (4:58 PM) documented, .New order received for PRN oxygen at 2 liters via [by way of] nc [nasal cannula] . c. The February 2024 Order Summary did not contain a Physician's Order for O2 administration. d. On 2/16/24 at 2:16 PM, the February 2024 electronic Medication Administration Record (eMAR) did not contain documentation of oxygen administration. e. On 02/12/24 at 11:17 AM, Resident #41's door did not have an Oxygen in Use sign posted outside the door. Resident #41 was in the bathroom sitting in a wheelchair and a green portable oxygen tank was inside the room to the left of the door with a nasal cannula attached and it was draped over the tank. Certified Nursing Assistant (CNA) #2 propelled Resident #41 from the bathroom and placed the nasal cannula in the resident's nose. The oxygen tank was set at 3 liters per minute and the tubing was not dated. At 11:24 AM, the Surveyor was speaking with the resident and the nasal cannula came out of Resident #41's nose and the Surveyor activated the call light for assistance. At 11:36 AM, Licensed Practical Nurse (LPN) #2 entered the resident's room and stated, I'm gonna have to go get you a concentrator. She stated, They did your chest x-ray and I'm just waiting on your results. f. On 02/13/24 at 11:31 AM, Resident #41 was not in the room and the O2 concentrator was on and set at 2 liters per minute. g. On 2/13/24 at 3:34 PM, Resident #41's door was closed and there was no O2 signage posted outside the door. The concentrator was set at 2 liters per minute, and it was on. Resident #41 was not in the room at this time. h. On 02/14/24 at 9:48 AM, Resident #41 was not in the room. There was an O2 concentrator in the room and there was no signage posted outside the door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045259	A. Building B. Wing	02/16/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	i. On 2/16/24 at 12:14 PM, the Director of Nursing (DON) was asked, Do you have standing orders for oxygen administration to residents? The DON stated, Not standing orders. Some of them do that have COPD [Chronic Obstructive Pulmonary Disease] or Asthma. The DON was asked, Why should the tubing/humidifier bottle be dated? The DON stated, To make sure that it hasn't been sitting too long. The DON was asked, What is the time frame for them to be changed? The DON stated, On Sundays, but sometimes the bottles are changed more often. The DON was asked, Why should oxygen be administered at the physician ordered flow rate? The DON stated, For safety. j. On 2/16/24 at 2:16 PM, the Administrator provided a list of all residents with Physician's orders for Oxygen and Resident #41 was not listed. 2. Resident #46 had a diagnosis of Acute Respiratory Failure with Hypoxia. A Quarterly MDS with an ARD of 11/15/2023 documented Resident #46 was receiving oxygen therapy while a resident and on admission. a. A Physicians order dated 09/07/2023 noted Resident #46 had an order for oxygen at 2 liters per minute via nasal cannula as needed for SOB (Shortness of Breath). b. On 02/12/2024 at 12:12 PM, an oxygen concentrator was in Resident #46's room. No oxygen signage was on the door. c. On 02/13/2024 at 08:54 AM, Resident #46 was on portable oxygen in the resident's room. No oxygen signage was on the door. d. On 02/14/2024 at 10:39 AM, the oxygen concentrator had a noticeable thick brown dried substance on the top right side. No oxygen signage was on the door. e. On 02/15/2024 at 02:55 PM, no oxygen signage was on Resident #46's door. The oxygen concentrator had a thick brown dried substance on top right side. f. On 02/15/2024 at 02:56 PM, the Surveyor asked LPN #4, What is in the room beside the [Resident #46's] bed? LPN #4 stated, An oxygen concentrator. The Surveyor asked, Can you describe the appearance of the concentrator? LPN #4 stated, It is dirty, unclean, not clean at all, and looks rigged up. The Surveyor asked, Should anything be placed outside the room? LPN #4 stated, There should be an Oxygen in Use sign on the door to show that oxygen is in use for safety and to prevent possible fire. g. On 02/15/2024 at 03:04 PM, the Surveyor asked the DON, What is in the room beside the residents bed? The DON stated, An oxygen concentrator. The Surveyor asked, Can you describe the appearance of the concentrator? The DON stated, There is something on it. They should be cleaning the oxygen concentrator on Sundays and when there is something visible on it. The Surveyor asked, Should anything be placed outside the room? The DON stated, There should be an Oxygen in Use sign on the door for safety. The staff is supposed to be checking that on rounds. h. On 02/15/2024 at 04:40 PM, the Administrator provided a policy titled, Oxygen Administration-Resident which stated, .Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . b. When oxygen is in a room, there must be signing on the door to indicate Oxygen In Use . (continued on next page)

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	045259	A. Building B. Wing	02/16/2024

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48630

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	045259	A. Building B. Wing	02/16/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37925 Based on observation, record review and interview, the facility failed to ensure the refrigerated narcotic medications in the medication storage room across from the nursing station for Halls A, B, C and D were stored in a permanently affixed compartment for 1 of 1 medication storage room to prevent the potential of misappropriation of resident property, and failed to ensure no medication was remaining in the chamber of a nebulizer to decrease the potential for health complications 1 (Resident #226) of 1 sampled resident who had physician orders for an updraft treatment. The findings are: 1. On 02/15/24 at 2:18 PM, Licensed Practical Nurse (LPN) #2 and the Surveyor were in the medication storage room located across from the nursing station for Halls A, B, C and D. LPN #2 was asked what this room contained and after listing the items, LPN #2 stated, There's a narc [narcotic] box in the refrigerator. LPN #2 was asked, What's in the narc box? LPN #2 stated, Liquid narcs. LPN #2 asked if the Surveyor wanted to see it, and the Surveyor stated, Yes. LPN #2 unlocked the refrigerator lock, opened the door, picked up a metal box and sat it on top of the refrigerator. LPN #2 unlocked the metal box, and the following medications were inside: a. Resident #26 - Two Morphine Sulfate 100 mg [milligrams]/5 ml [milliliter] (20 mg/ml) 30 ml suspension bottles. b. Resident #26 - One, Lorazepam 2 mg/ml (30 ml bottle that was opened with a dropper in the top). c. Resident #26 - One, Lorazepam 2 mg/ml (30 ml bottle unopened). d. (Non-sampled Resident) - Two, Ativan 2mg/ml vials (blue caps in place). e. Stock Ativan - Two, 2 mg/ml vials (blue caps in place). 2. On 2/15/24 at 2:18 PM, LPN #2 was asked, Do you have any residents taking these meds [medications]? LPN #2 stated, No ma'am. LPN #2 was asked, Who does these meds go to after the resident is no longer taking them? LPN #2 stated, The DON [Director of Nursing]. LPN #2 was asked, When? LPN #2 stated, As soon as we can. LPN #2 was asked, Has the narc box ever been attached to anything in the refrigerator? LPN #2 stated, I've been here over a year, and I don't think so. 3. On 2/16/24 at 12:14 PM, the DON was asked, Should the black box in the medication refrigerator located on the A, B, C, D halls be permanently affixed to the inside? The DON stated, Yes. The DON was asked, Tell me why? The DON stated, At the risk of someone taking it. I was told to do that, but I've been trying to find the right kind of lock. 4. Resident #226 had a diagnosis of Atelectasis (a partial collapse of the lung causing shortness of breath) A Physicians Order dated 02/09/2024 documented, (continued on next page)

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	045259	A. Building B. Wing	02/16/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Budesonide Inhalation Suspension 0.5 MG/2ML (Budesonide (Inhalation)) 2 ml inhale orally two times a day for shortness of breath . A Care Plan dated 2/13/24 documented, [Resident #226] has altered respiratory status requiring respiratory inhalers . Administer medication/puffers as ordered . On 02/12/24 at 3:54 PM, Resident #226 was lying in bed. A nebulizer chamber was at the bedside with liquid in it. On 02/13/24 at 8:51 AM, Resident #226 was lying in bed. A nebulizer chamber with a light discolored liquid in it was at the bedside. On 02/13/24 at 1:51 PM, Resident #226 was lying in bed. A nebulizer chamber was at the bedside. There was a light discolored liquid with a faint odor in the nebulizer chamber. On 02/14/24 at 12:02 PM, LPN #1 was asked to accompany the Surveyor to Resident #226 ' s room to observe the nebulizer. LPN #1 was asked to check the chamber. LPN#1 stated, That's some of the med [medication] in there. LPN #1 was asked to remove the liquid with a syringe. 0.4 milliliter was removed from the chamber. LPN #1 stated, That must be from last night because I sit with her when I give her updraft. LPN #1 was asked, why is it important for all meds to be completely taken. LPN #1 stated, One. It could contaminate the next dose. Two. The resident can be overdosed, and Three. The resident doesn't get the full dose ordered. LPN #1 was asked if this was acceptable practice. LPN #1 stated, No. On 2/15/24 at 9:10 AM, the Director of Nursing (DON) was asked if she expected the nurses to completely administer medications. The DON stated, Yes, then clean it out. The DON was asked the importance of physician ordered medications to be completely given. The DON stated, If they need a med then it needs to be given completely to get the full effect of it. The DON was asked if leaving a partial dose not given, was ok. The DON stated, No. 46868

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	045259	A. Building B. Wing	02/16/2024

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03508 Based on observation, record review, and interview, the facility failed to ensure meals were prepared and served according to the planned written menu to meet the nutritional needs of the residents for 2 of 2 meals observed. This failed practice had the potential to affect 1 resident who received pureed diets from 1 of 1 kitchen. The findings are: 1. On 02/12/24, the menu for lunch documented the residents who received pureed diets were to receive a 4 ounce of pureed herbed breaded pork chop with gravy, 4 ounces scalloped potatoes, 2 ounces brown homestyle gravy, 4 ounces pureed carrots, 4 ounces vanilla pudding with topping, an 8 ounce glass of tea and an 8 ounce glass of coffee. a. On 02/12/24 at 01:08 PM, the resident on the pureed diet was served pureed breaded fried pork chops with gravy, fortified mashed potatoes, vanilla pudding, and tea. b. There was no pureed carrots served to the resident. The menu specified 4 ounces of pureed carrots. 2. On 02/13/24, the menu for the lunch meal documented the residents who received pureed diets were to receive pureed chicken tenders with puree sauce, 1 ounce barbeque sauce, 4 ounces homestyle pureed macaroni salad, 4 ounces pureed coleslaw, 1 2x2 pureed orange gelatin cake with topping, an 8 ounce glass of tea, and an 8 ounce glass of coffee. a. On 02/13/24 at 01:10 PM, the resident on the pureed diet was served double pureed fried chicken tender with sauce, fortified potatoes, pureed orange gelatin cake with topping, a 4 ounce carton of yogurt, and an 8 ounce glass of punch. There was no pureed macaroni salad and pureed coleslaw served to the resident on pureed diet. b. On 02/13/24 at 01:13 PM, the surveyor asked Dietary Employee (DE) #2 the reason the resident on a puree diet was not served any pureed vegetable at the lunch meal on 02/12/24 and if there was a reason the resident was not served pureed macaroni salad and pureed coleslaw. DE #2 stated, I was in a hurry, and I forgot.

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	045259	A. Building B. Wing	02/16/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 03508 Based on observation, record review and interview, the facility failed to ensure meals were served at temperatures that were acceptable to the residents to improve palatability and encourage good nutritional intake during 2 of 2 meals observed. The failed practice had the potential to affect 31 residents who received meal trays in their rooms on the A, B, and C, Hall, 18 residents who received their meal trays in the room on the D, E and F Hall (Back) Hall, as documented on a list provided by the Regional Dietary Manager. The findings are: 1. On 02/12/24 at 11:45 AM, the Surveyor asked Resident #44 how the food was, and was the hot food hot when it arrived to the room on a tray cart? Resident #44 stated, The food is ice cold. 2. On 02/13/24 at 08:15 AM, when the Surveyor entered Hall A the breakfast cart was on the hall. At 08:21 AM, Resident #56 received his tray. He had 3 pieces of bacon, pancake, and eggs (large portions). Certified Nursing Assistant (CNA) #1 sat the tray in front of him and left. CNA #1 did not take off the lid or open any condiments. At 08:35 AM, CNA #1 went in to assist the resident. Resident #56 stated that his food was cold. The Dietary Supervisor was asked to check the temperature of the food items on the tray. She did so, and the scrambled egg was 80 degrees Fahrenheit, and the pancake was 61 degrees Fahrenheit. 3. On 02/12/24 at 01:14 PM, an unheated food cart that contained 10 trays for the lunch meal for A- Hall was delivered to the nurses' station for A, B and C Halls by Dietary Employee (DE) #2. At 01:39 PM, immediately after the last resident received their tray in their room on C Hall, the temperatures of food items on a test tray from the food cart were checked and read by the Dietary Supervisor with the following, results: a. Ground breaded fried pork chops - 109 Degrees Fahrenheit. b. Scalloped potatoes - 113 Degrees Fahrenheit. c. Mixed vegetables - 99.8 Degrees Fahrenheit. 4. On 02/13/24 at 07:45 AM, an unheated food cart that contained 10 trays for the breakfast meal was delivered to the A hall by DE #4. At 08:20 AM, immediately after the last resident received their tray in their room on the A hall, the temperatures of food items on a test tray from the food cart were checked and read by the Dietary Supervisor with the following results: a. Scrambled eggs - 100 degrees Fahrenheit. b. Pancake - 70 degrees Fahrenheit. c. Sausage links - 80 degrees Fahrenheit. The Dietary Supervisor asked for new food trays from the kitchen. (continued on next page)

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	045259	A. Building B. Wing	02/16/2024

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 02/13/24 at 07:55 AM, an unheated food cart that contained 20 trays for the breakfast meal were delivered to the B, C, and D Halls by DE #4. At 08:31 AM, immediately after the last resident received their tray in their room on the A hall, the temperatures of food items on a test tray from the food cart were checked and read by the Dietary Supervisor with the following results: a. Milk - 50 degrees Fahrenheit. b. Pancake - 88 degrees Fahrenheit. c. Scrambled eggs - 101 degrees Fahrenheit. d. Sausage links - 80 degrees Fahrenheit. e. Oatmeal - 100 degrees Fahrenheit. f. Ground sausage with gravy - 100 degrees Fahrenheit.

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	045259	A. Building B. Wing	02/16/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 03508 Based on observation and interview, the facility failed to ensure food items stored in the refrigerator and storage area were covered or sealed to maintain freshness and prevent potential cross contamination of food and beverages; expired food items were promptly removed/discarded by the expiration or use by dates; kitchen vents were cleaned to provide a sanitary environment for food preparation; floors, kitchen walls, door frames and baseboards were free of rotten wood, chipped floor tiles, debris, rust, and dirt; 2 of 2 ice scoop holders, and 1 of 2 ice machines were maintained in clean and sanitary condition to prevent food and beverages contamination; and hot food items were maintained at or above 135 degrees Fahrenheit while awaiting service to prevent potential food borne illness for residents who received meals from 1 of 1 kitchen. The failed practices had the potential to affect 62 residents who received food from the kitchen (total census 66), as documented on a list provided by the Dietary Supervisor. The findings are. 1. On [DATE] at11:02 AM, during the initial tour of the kitchen with the Dietary Supervisor, the following observations were made in the dry storage room: a. An opened package of 5 pound, 10 ounce box of corn meal mix was on a shelf. The package was not sealed. 2. On [DATE] at11:06 AM, the Walk in Refrigerator temperature was 40 degrees Fahrenheit and a piece of jewelry, a ring, was noted in the onion box. 3. On [DATE] at11:09 AM, the following observations were made in the freezer: a. An opened box of frozen dinner roll dough balls dated [DATE] was on a shelf. The box was not covered, and the bag was not tied. b. An opened box of southern style biscuit dough was on a shelf. The box was not covered or sealed. 4. On [DATE] at 11:15 AM, an opened resealable plastic bag that contained an unsealed bag of brown gravy mix was on the counter, exposing it to air. 5. On [DATE] at 11:33 PM, an opened box of sausage was on a shelf in the refrigerator. The box was not covered or sealed. On [DATE] at 11:35 AM, the following observations were made in the walk-in freezer: a. An opened box of fish was on a shelf in the freezer. The box was not covered or sealed. b. An opened box of chocolate chip cookies was on a shelf in the freezer. The box was not covered or sealed. c. An opened box of polish sausage was on a shelf in the walk-in freezer. The box was not covered or sealed. (continued on next page)

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	045259	A. Building B. Wing	02/16/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. On [DATE] at 11:39 AM, the ice scoop holder by the ice machine in the kitchen had a wet black residue on it. The ice scoop was resting directly in contact with the black residue. The Surveyor asked the Dietary Supervisor to describe what was observed in the scoop holder. The Dietary Supervisor stated, That it is black in color. The Dietary Supervisor was asked who uses the ice from the ice machine and how often do you clean it? She stated, We use it to fill beverages served to the residents at mealtimes. They clean it after every meal. They probably didn't get to it. 7. On [DATE] 11:48 AM, the following observations were made in the kitchen: a. The ceiling air vent by the 2-compartment sink had rust on it. The area around the air vent was chipped and peeled off, exposing the sheet rock. There were dust particles in the air vent and ceiling tile. b. The floor tiles leading to the Janitor's closet were missing, exposing the cement. c. The door frames leading to the dish washing machine room and the door frame leading to the A, B, and C Halls from the kitchen were rotten. d. The wall facing leading to the storage room was chipped, exposing the metal. 8. On [DATE] at 12:00 PM, the following observations were made in the storage room: a. Three of 3 boxes that contained 48, 4 ounce unopened honey thickened orange juice with an expiration date of [DATE]. b. Two of 2 unopened boxes that contained 48, 4 ounce honey thickened orange juice with an expiration date of [DATE]. c. An unopened box of apple juice with expiration date of [DATE]. 9. On [DATE] at 12:05 PM, the following observations were made in the kitchen: a. The ceiling air vent by the door leading to the storage room was chipped, exposing the sheet rock. b. The floor leading to the storage had smeared black matter on it. c. The metal wall between the walk-in freezer and the walk-in refrigerator has a drain attached to it. Water dripped from the faucet onto the metal wall before dripping in the drainage below the wall. The area of the metal wall where water touches, had 60 inches of wet rust on it that could be rubbed off with a finger. The baseboard on the wall leading to the freezer was loose and had brown stains on it. d. The baseboard on the wall leading to the walk-in refrigerator was loose. There was a sage color on the baseboard. 10. On [DATE] at 12:30 PM, the temperatures of the food items checked and read on the steam table by Dietary Employee (DE) #1 were as follows: (continued on next page)

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	045259	A. Building B. Wing	02/16/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Chicken nuggets - 103 degrees Fahrenheit. b. Mashed potatoes - 130 degrees Fahrenheit. c. Gravy - 125 degrees Fahrenheit. The above food items were not reheated before being served to the residents. 11. On [DATE] at 01:45 PM, the left inside corner of the ice machine opposite the nurses' station for the D, E, and F halls had a wet black residue on it. The Surveyor asked the Dietary Supervisor to wipe the area where the black residue was observed. She used a tissue to wipe the area inside of the ice machine which had a wet black residue on it that was easily transferred from the ice machine onto the tissue. The Surveyor asked the Dietary Supervisor to describe the residue observed inside the ice machine that showed on the tissue. The Dietary Supervisor stated, It is dirty and black in color. The Surveyor asked who uses the ice from the machine and how often do you clean it? She stated, I think the Maintenance Man cleans it. 12. On [DATE] at 01:47 PM, the ice scoop holder on the wall by the ice machine by the corner facing the nurse's station had a wet black residue on it. The ice scoop was resting directly in contact with the black residue. The Surveyor asked the Dietary Supervisor to describe what was observed in the scoop holder. The Dietary Supervisor stated, That is black in color. The Dietary Supervisor was asked who uses the ice from the ice machine and how often do you clean it? The Dietary Supervisor stated, That's the ice the CNAs [Certified Nursing Assistants] use to fill the water pitchers in the resident's rooms. 13. On [DATE] at 08:39 AM, the Surveyor asked the Maintenance Man how often do you clean the ice machine and the scoop holder? The Maintenance Man stated, I clean the ice machine quarterly. The nurses clean the scoop holder.

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The Blossoms at Woodland Hills Rehab & Nursing Cen	8701 Riley 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 37925 Based on observation, record review and interview, the facility failed to ensure the grounds of the smoking area outside of the dayroom for halls E through H was cleared of smoking remnants and the receptacles used to collect the smoking remnants were emptied after use to promote a clean and healthy environment for 1 (Resident #24) of 7 sampled residents who utilized the area outside of the dayroom to smoke as documented on a list provided by the Administrator; and failed to ensure a resident's environment was functional and sanitary for 1 (Resident #7) of 1 sampled resident who had a sheet with unknown substances wrapped around the plumbing under the sink. The findings are: 1. Resident #24 had diagnoses of Nicotine Dependence, Cigarettes, Partial Traumatic Amputation at Elbow Level, Right Arm and Acquired Absence of Left Upper Limb Below Elbow. A Modified Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/17/24 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status. a. A Care Plan with a completion date of 1/29/24 documented, .I choose to smoke; potential for injury . Close monitoring while smoking in the smoking area . b. On 02/12/24 at 1:33 PM, Resident #24 was waiting in the dayroom to go out to smoke. After all the other residents had their smoking aprons on and a Certified Nursing Assistant (CNA) had issued each resident a cigarette. The CNA placed a smoking apron on Resident #24 and propelled the resident out to the smoking area, where a cigarette was placed in Resident #24's mouth and the CNA held a lighter to the cigarette and lit it and held it so Resident #24 could smoke it. There were used cigarette butts in the smoking area on the concrete seating area and on the grounds. c. On 02/14/24 at 9:53 AM, Resident #24 was outside the dayroom for halls E through H and a staff member was holding a cigarette to Resident #24's mouth to allow the resident to smoke. There was a smoking container that was full, and another resident was observed putting tissue paper in it. There were cigarette butts on the ground around the bottom of the containers. There were several cigarette butts on the concrete area where the residents were sitting, and they were too numerous to count. d. On 02/15/24 at 9:40 AM, 13 residents were assisted to the smoking area outside the dayroom for halls E through H. The area had multiple (too many to count) cigarette butts on the ground, and a cigarette container had white paper inside it. e. On 02/15/24 at 10:06 AM, CNA #4 was asked, Who is responsible for cleaning the smoking area outside the dayroom between G and H halls? CNA #4 stated, I don't know. I've been here a month and I've never seen anyone come out here. CNA #4 looked to the right and stated, Maybe we are supposed to be cleaning it up because there's a broom over there, but I don't know. The Surveyor asked, Why should cigarette butts be picked up off the ground? CNA #4 stated, So nobody will pick it up and smoke it. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. On 02/15/24 at 10:15 AM, Housekeeper #1 was asked, Who is responsible for cleaning the smoking area outside the dayroom between G and H halls? Housekeeper #1 stated, Housekeeping. The Surveyor asked, Are the receptacles that the cigarette butts are placed in ever emptied? Housekeeper #1 stated, Yes. The Surveyor asked, When is it done? Housekeeper #1 stated, Maybe between when their smoke breaks are over with. The Surveyor asked, Tell me why cigarette butts should be picked up off the ground? Housekeeper #1 stated, Because to make it look presentable. It makes it look like don't nobody care. The Surveyor asked, What could happen if a resident picks up a cigarette butt? Housekeeper #1 stated, They can catch a disease, or they could smoke it. g. On 02/15/24 at 10:25 AM, the Housekeeping Supervisor was asked, Are the housekeepers responsible for cleaning the smoking areas? The Housekeeping Supervisor stated, They are responsible for cleaning the inside of the smoking area. The Surveyor asked, Please explain? The Housekeeping Supervisor stated, The dining area, the inside dayroom area is what we are responsible for cleaning. The outside cleaning is assigned to maintenance, which comes under ground keeping. Sometimes we go outside and help them clean. h. On 02/15/24 at 10:32 AM, Maintenance was asked, Is maintenance responsible for cleaning the smoking area? Maintenance stated, No. The Administrator stated she wanted nursing to clean the area because they are the ones who go out with the smokers. i. On 02/16/24 at 1:19 PM, the Administrator was asked, Who is responsible for cleaning the smoking area? The Administrator stated, On paper, maintenance is responsible for the smoking area. We have established it to be cleaned once a day in the morning by the Lead CNA and housekeeping. j. A Smoking Policy provided by the Administrator on 2/12/24 documented, .To provide a healthy and safe smoke environment as possible for all residents, staff, and visitors . PROCEDURE: .4. All smoking remnants will be discarded into an appropriate / approved receptacle by staff or under staff supervision . 2. The following observations were made in Resident #7's room: a. On 02/12/2024 at 12:04 PM, a sheet was wrapped around the plumbing under the sink, there was a brown and back dried substance on the fabric. b. On 02/14/2024 at 10:30 AM, a sheet remained around the plumbing below the sink with bath blankets on the floor. The sink faucet handles were rotated, and no water was produced. c. On 02/15/2024 at 02:40 PM, a sheet remained around the plumbing below the sink with bath blankets on the floor. The sink faucet handles were rotated, and no water was produced. d. On 02/15/2024 at 02:47 PM, Certified Nursing Assistant (CNA) #6 was asked, How is [Resident #7] able to wash their hands? CNA #6 stated, [Resident #7] would have to go to another room since [Resident #7's] sink is not working. The Surveyor asked, How long has the sink not worked? CNA #6 stated, For sure a couple days. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. On 02/15/2024 at 02:50 PM, Licensed Practical Nurse (LPN) #4 was asked, How is [Resident #7] supposed to wash their hands or brush their teeth? LPN #4 stated, Their sink is not working they will not be able to. The Surveyor asked, What is under the sink? LPN #4 stated, It appears to be some type of sheet and wrapped for leaking purposes. The Surveyor asked LPN #4 to describe the appearance. LPN #4 stated, Its dirty and nobody wants to look at that. I have not reported it to maintenance. f. On 02/15/2024 at 03:08 PM, the Surveyor asked the Maintenance Director, Can you turn on the residents sink? The Maintenance Director stated, The sink won't turn on. The Surveyor asked, Can you describe the appearance? The Maintenance Director stated, It appears to be wrapped in a sheet and the water is shut off. This is a mess. The Surveyor stated, Why is it important to fix the sink? The Maintenance Director stated, This is their home and it's not comfortable to them. g. On 02/15/2024 at 03:09 PM, the Surveyor asked the Director of Nursing (DON), Can you describe what you see under the sink? The DON stated, It is not providing a homelike environment. h. On 02/15/2024 at 4:40 PM, the Administrator stated there was no policy regarding the resident's environment. 48630

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46868 Based on observation and interview, the facility failed to ensure handrails were in proper working order to prevent possible injuries to residents, staff, and visitors. The findings are: On 02/13/24 at 11:50 PM, on hall B, on the ends of the handrails by room [ROOM NUMBER], 10, 11, and 12 were off and the metal was showing 1/2 inch out past the end. The top of the handrails between rooms [ROOM NUMBERS], was pulled apart from the metal rail exposing the metal. The door in room [ROOM NUMBER] had a 5inch by 3 inch area splintered on the entrance side of the door. On 2/13/24 at 12:10 PM, Maintenance was asked to round down Hall B to assess the handrails and asked to explain what was seen. Maintenance stated, I see the ends off of the handrails in several areas and the top part of the handrails are separated exposing the metal. Maintenance was asked to explain what could happen if the handrails remained broken. Maintenance stated, Someone could get cut and if they are on a blood thinner that would not be good, or they might get an infection from a cut. On 2/15/24 at 12:38 PM, the Administrator was asked what the purpose of siderails was. The Administrator stated, They are for people to secure mobility. The Administrator was asked to explain the purpose of properly fixed and unbroken side rails. The Administrator stated, Someone could be injured. On 2/15/24 at 12:52 PM, the Administrator stated, We have no policy on handrails.