

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045385	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/24/2025
NAME OF PROVIDER OR SUPPLIER The Blossoms at North Little Rock Rehab & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 2501 John Ashley Drive North Little Rock, AR 72114	

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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and facility policy review, the facility failed to ensure dietary staff washed their hands and changed their gloves before handling food items and clean equipment; the ice machine was maintained in clean and sanitary conditions; walls were free of accumulations of dust to ensure meals were prepared in clean, sanitary conditions for two of two meals observed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. <ul style="list-style-type: none"> On 04/21/25 at 11:10 AM, during the initial kitchen tour with Dietary [NAME] (DC) #1, the ice machine, in a room on the hallway leading to the kitchen, had a pink discoloration/substance to the inside of the plastic panel dispenser. 2. <ul style="list-style-type: none"> On 04/22/25 at 02:57 PM, the following observations were made in the kitchen: <ol style="list-style-type: none"> a. <ul style="list-style-type: none"> There was a puddle of grayish water over the concrete. During an interview with the Dietary Manager (DM), she stated that the water may have been coming from the concrete and was gray in color. a. <ul style="list-style-type: none"> The wall behind the oven had an accumulation of dust on it, near food being prepared for the residents. b. <ul style="list-style-type: none"> The floor tile on the right side of the juice machine, in the food preparation room, was missing. The area where the tile was missing had puddles of discolored liquid settled on it. The DM stated the area needed to be fixed and cleaned. 3. <ul style="list-style-type: none"> (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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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/22/25 at 3:30 PM, the inside right corner of the ice machine, close to the area where ice forms before dropping down into the collector, had wet black residue on it. This surveyor asked the Dietary Manager to wipe the wet black residue. She did so, and the wet black residue easily transferred to the tissue. The DM was asked to describe what was observed around the right corner of the ice machine, how often they cleaned the ice machine, and who used the ice from the ice machine. The Dietary Manager stated it was black residue. The staff cleaned it once a week, and the Maintenance Supervisor cleaned the upper part where the ice forms. The Certified Nursing Assistants (CNAs) use it for the water pitchers in the residents' rooms, for beverages served to the residents, and the kitchen staff use it to fill beverages served to the residents at mealtimes. The DM was asked what the concerns about the ice machine not been cleaned were, and she stated cross contamination.</p> <p>4.</p> <p>On 4/22/25 at 3:39 PM, during an interview with the Maintenance Supervisor, he was asked how often he cleaned the area in the ice machine where ice formed. He stated he cleaned it once a month.</p> <p>5.</p> <p>On 04/22/25 at 3:53 PM, this surveyor observed Dietary [NAME] (DC) #1 push the blender motor towards the edge of the counter. Without washing his hands, he picked up a clean blade with his contaminated bare hand and attached it to the base of the blender to be used in pureeing foods to be served to the residents who required pureed diets. DC #1 was asked what he should have done after touching dirty objects and before handling clean equipment. He stated he should have washed his hands.</p> <p>6.</p> <p>On 04/22/25 at 4:25 PM, this surveyor observed Dietary Aide (DA) #2 wearing gloves on her hands, when she picked up a box of plastic food wrap from the counter and placed it in another location. Without changing gloves and washing her hands, she picked up cornbread with her contaminated gloved hand and placed the cornbread in an individual bag to be served to the residents for supper.</p> <p>7.</p> <p>On 04/22/25 at 5:18 PM, during an interview with DA #2, she was asked what she should have done after touching dirty objects and before handling clean equipment. She stated she should have removed her gloves, washed her hands, and then put new gloves on.</p> <p>8.</p> <p>On 04/22/25 at 4:32 PM, this surveyor observed DA #3 wearing gloves when he picked up a pan of cornbread located on top of the oven and sat it on the counter. He then picked up a box of plastic food wrap and placed it on the counter, contaminating his gloved hands. He then picked up cornbread with his contaminated gloved hands and placed it individually in a bag to be served to the residents for supper meal. DA #3 was asked what he should have done after touching dirty objects and before handling clean equipment. He stated he should have washed his hands and changed his gloves.</p> <p>9.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/23/25 at 10:40 AM, DC #4, removed cartons of whole milk and placed them on the counter. Without washing her hands, she picked up the blender blade and attached it to the base of the blender, to be used in pureeing food items to be served to the residents who received pureed diets for the lunch meal.</p> <p>10.</p> <p>On 04/23/25 at 11:05 AM, this surveyor observed DC #4 turn on the three (3)-compartment sink faucet with her bare hand as she obtained water in a pitcher. After obtaining water, she used her bare hand to turn off the faucet. Without washing her hands, she picked up the blender blade and attached it to the base of the blender to be used in grounding food items to be served to the residents who received mechanically soft diets for the lunch meal. DC #4 was asked what she should have done after touching dirty objects and before handling clean equipment. She stated she should have washed her hands.</p> <p>11.</p> <p>A review of a facility policy titled, Handwashing indicated hands should be washed before entering the kitchen at the start of a shift, during food preparation, as often as possible to prevent cross contamination when changing tasks, and after engaging in other activities that contaminate the hands.</p> <p>12.</p> <p>A review of a facility policy titled, Food Storage indicated food should be stored by methods prepared, to prevent contamination or cross contamination.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, facility document review, and policy review, the facility failed to ensure Enhanced Barrier Precautions (EBP) were utilized for two (Resident #1 and Resident #202) of two residents reviewed for Enhanced Barrier Precautions.</p> <p>The findings include:</p> <p>1. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/15/2025 indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS also indicated Resident #1 had diagnoses which included: spina bifida, quadriplegia, neurogenic bladder, and a colostomy.</p> <p>a. Provider notes, dated 04/21/2025, and the Weekly Wound Evaluation, dated 04/21/2025, indicated the resident had a stage 4 ulcer to the right buttock area.</p> <p>b. On 04/21/25 at 2:25 PM, the Treatment Nurse (TN) was observed performing a dressing change to the right buttock for Resident #1. EBP signage was on the door of Resident #1's room, indicating the need for staff to wear both a gown and gloves when care was provided for Resident #1. The TN performed hand hygiene, put on gloves but no gown, and positioned the resident. The TN took off the old dressing with visible drainage, cleaned the wound, and completed the dressing change. During the procedure, the TN's clothing touched the bed linens and mattress, while the TN's bare forearm propped Resident #1's right hip, making skin-on-skin contact with the resident, in close proximity of the wound.</p> <p>c. Resident #1's Care Plan, revised 04/21/2025, had EBP listed as an intervention with wounds, with an initiation date of 04/04/2024. The Care Plan stated, gloves and gown required prior to the high-contact care. High-contact care activities listed included, but not limited to, wound care: any skin opening requiring a dressing.</p> <p>d. During an interview with the TN on 04/24/25 at 10:43 AM, the TN indicated that a gown should have been put on for the dressing change to prevent cross-contamination.</p> <p>e. During an interview 04/24/25 at 12:25 PM, the Medical Director (MD) indicated wearing a gown would be appropriate during wound care.</p> <p>2. The MDS with an ARD of 04/11/2025 indicated Resident #202 had a BIMS score of 4 (which indicated the resident was severely cognitively impaired). The MDS also indicated Resident #202 had diagnoses, which included: a urinary tract infection (last 30 days), dementia, sepsis, and osteomyelitis of the vertebra, sacral and sacrococcygeal region.</p> <p>a. On 04/23/25 at 7:25 AM, Licensed Practical Nurse (LPN) #5 was observed administering an intravenous (IV) antibiotic medication, to Resident #202. EBP signage was on the door of Resident #202's room, which indicated the need for staff to wear both a gown and gloves when care was provided for the resident. The nurse donned gloves, dated and timed the IV tubing, primed the line, entered the room, and began to manipulate the resident's arm, gown, and Peripherally Inserted Central Catheter (PICC), without putting on a gown.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>b. On 04/23/2025, immediately following the antibiotic administration observation described above, LPN #5 was interviewed and indicated a gown should have been put on for the encounter. LPN #5 indicated EBP should be followed anytime staff does personal care for the resident, because a PICC line goes straight into the bloodstream and to the heart, and a gown would help protect the resident.</p> <p>c. Resident #202's Care Plan , revised on 04/16/2025, indicated that EBP was required for high-contact care. The list of high-contact care included: the use of a central line.</p> <p>3. During an interview with the Director of Nursing (DON) on 04/24/2025 at 10:30 AM, the DON indicated a gown should have been put on during the dressing change for Resident #1.</p> <p>4. During an interview with the Administrator on 04/25/2025 at 3:03 PM, the Administrator indicated a gown should have been worn during the dressing change for Resident #1.</p> <p>5. A review of the policy titled Medication Administration, revised 11/25/2022, stated Staff shall follow established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of the medications, as applicable.</p> <p>6. A review of the posted EBP signage on both the doors of Resident #1 and Resident #202 revealed that providers and staff must wear gloves and gown for central line and wound care dressings.</p>		