STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045450	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Midtown Rehab & Nursing Center	5720 West Markham Street 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, it was determined that the facility failed to ensure a comfortable homelike environment for Rooms #430, #428, and #433 occupied by residents reviewed for a homelike environment. The findings include: During an observation on 08/25/2025 at 12:34 PM, the bathroom in room [ROOM NUMBER] was noted to have an unidentified brownish/black residue on the walls of the shower stall walls, floors, and shower curtain. This surveyor observed a basin with brownish/black residue noted sitting on the floor of the shower stall. The bathroom smelled of urine. A urinal was observed sitting on the nightstand with toothbrushes beside it. During an observation on 08/25/2025 at 12:46 PM, a shower chair in room [ROOM NUMBER] was noted to have a brownish residue on the bars of the shower chair and the mesh-like backing. This surveyor observed in the same bathroom missing and cracked tiles on the floor. The wall was noted to have scrape marks towards the bottom of the wall near the floor and there were basins noted under the sink, not bagged. During an observation on 08/25/2025 at 1:03 PM, a in room [ROOM NUMBER] was noted to have a fall mat on the floor beside the bed with spots of brownish/black unidentified substance. The pillow on the bed did not have a pillow case on it, the pillow case was noted to be flat and showed cracks in the plastic like material. On the wall behind the bed were noted large scrapes. This surveyor observed a chair sitting beside the bed, the seat was worn, and the material was peeling off. The flooring at the bottom of the wall was observed peeling off of the wall, with scrapes and brownish/black scuff marks. During a concurrent interview and observation on 08/28/2025 at 11:30 AM, the Housekeeping Supervisor indicated, We deep clean specific rooms daily. I have a list of rooms that I keep that are scheduled. When I do rounds, I look at all the curtains to see if any of them need to be cleaned. Resident #31's room gets cleaned daily and we use mold spray in the bathroom and scrub it. We used to only use the disinfectant, but the mold spray works better. I don't know how fast mold grows back. During a concurrent interview and observation in room [ROOM NUMBER] on 08/28/2025 at 11:50 AM, the Maintenance Director indicated, I have only been here a few weeks. The cleaning is maintained by housekeeping. I can get them whatever supplies they need to prevent this. This looks like mold. I don't think this is homelike. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 08/28/2025 at 12:35 PM, Resident #31 indicated I've been back at the facility going on two months, and my bathroom has been like this the whole time. The smell is awful. It's just nasty and I take showers in there. I have told them several times about the condition. Housekeeping goes in there, but it doesn't do any good. During a concurrent interview and observation on 08/28/2025 at 12:21 PM, the Assistant Director of Nursing (ADON) indicated, This bathroom is disgusting. That looks like mold. This could cause all kinds of infections, like respiratory or skin infections. This is not being cleaned daily. The residents are breathing this and walking on it. I'm going to go get housekeeping now, this is unacceptable. During an interview with the Administrator, on 08/28/2025 at 12:35 PM indicated, We are trying to work on updates for the facility. That looks like mold or rust. If the resident use that bathroom they could get sick. That is not sanitary. This is unacceptable and I will immediately get this corrected. Deep cleans are not being done appropriately. We do not have a housekeeping policy.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to accurately assess and complete the Minimum Data Set (MDS) for two (Resident #71 and Resident #48) of two residents reviewed. The findings include: Resident #71Review of an admission Record indicated Resident #71 was admitted to the facility on [DATE] with diagnoses which included acute and chronic respiratory failure, obstructive sleep apnea, and presence of a surgically created opening through the neck into the windpipe to allow air to fill the lungs. Review of Physician Orders for Resident #71 indicated to change tracheostomy collar and to perform tracheostomy care daily. The Physician Orders also included to check oxygen saturation daily and to give oxygen via trach cuff at 5 liters as needed. Review of the quarterly MDS with an Assessment Reference Date (ARD) of 08/05/2025 incorrectly indicated that Resident #71 did not require tracheostomy care, did not use oxygen and did not require suctioning, which are needed when a resident has a tracheostomy. On 08/27/2025 at 10:30 AM, the MDS Nurse stated she followed the RAI manual when completing the MDS. The MDS Nurse continued that it was important to accurately assess and correctly code the care required so residents receive the care they need. When questioned how the residents were assessed when the MDS was completed, she reported the nursing assessments in the electronic health records were reviewed and that a head-to-toe assessment was not completed by the coordinator when filling out the MDS. Resident #48 Review of a Medical Diagnosis report revealed Resident #48 had diagnoses which included schizophrenia, diabetes II, and hepatitis C. Review of the annual MDS with an ARD of 06/22/25, revealed a Brief Interview for Mental Status score of 12, which indicated Resident #48 had moderate cognitive impairment. The MDS also indicated that section A1500 showed 0, meaning no serious mental illness of intellectual disability, or PASRR II A review of a Care Plan dated 04/20/2024, revealed Resident #48 had a level II PASRR, and would follow the state PASRR program. On 08/28/2025 at 9:00 AM, the Administrator provided a letter from the State Designated Authority dated 06/12/2023, which indicated approval for 60 days of convalescent care, a letter dated 08/22/2023 which stated Resident #48 would need a level II PASRR screening, and an evaluation letter dated 08/29/2023 which indicated Resident #48 required specialized services at this time including pharmacological program, master treatment plan with periodic review and mental health evaluation. During an interview on 08/28/2025 at 9:22 AM, the MDS Nurse checked in electronic records and revealed Resident #48 did have a level II PASRR. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/28/2025 at 9:53 AM, the MDS Nurse stated Resident #48 had a PASRR II and section A1500 of the MDS should have reflected 1, which indicated Resident #48 had a mental disorder or intellectual disability to ensure proper assessments were completed and accurately reflected the resident's needs. The MDS Nurse revealed the Resident Assessment Instrument (RAI) manual was used as a guide for coding the MDS. This surveyor requested a copy from the RAI manual that addressed filling out section A1500. The MDS Nurse stated, There is not a MDS policy. On 08/28/2025 at 10:01 AM, the MDS nurse provided documentation from the RAI manual showing section A1500 should have been coded 1, to reflect a mental illness or intellectual disability. During an interview on 08/28/2025 at 4:04 PM, the Administrator was made aware of MDS concerns, and the Administrator stated that everything would be done to correct coding to accurately reflect the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews the facility failed to ensure chemicals were properly stored away from residents to prevent accidents and injuries. Specifically, the storage room door, directly across the hall from the elevator door on 300 hall was left unlocked and unsecured. The room had chemicals, biohazard waste, a housekeeper's cart, and equipment stored inside. The Administrator provided a list of 55 ambulatory residents who could have been potentially affected. The facility failed to ensure razors were properly stored to prevent accidents and injury for one (Resident #57) of one resident reviewed for accidents. The findings include: Facility On 08/26/2025 at 11:06 AM, this surveyor observed a set of keys hanging from the doorknob of the soiled room directly across the hall from the elevator on 300-Hall. This surveyor turned the key and the door opened. This surveyor observed an unlocked housekeeping cart with a mop and water in a bucket on the cart, sitting just inside the door; a toilet/hopper bowl with water standing inside, chemicals sitting on shelves and on the counter, a red biohazard can, a cardboard bio-hazard box sitting directly on the floor, and a floor buffing machine. This surveyor was alone in the room approximately 40 minutes before surveyor left room and walked to the nurse's station to give the keys to the Unit Manager/Assistant Director of Nursing/Registered Nurse. The following were observed by this surveyor during the 40 minutes alone in the soiled room: A 32-ounce bottle of thermoplastic spray buff sitting in the open shelf of the cabinet in the room. The bottle was approximately 3/4 full without the lid on the bottle, leaving the chemical easily accessible. The Caution on the label documented may cause eye irritation. Contains ethylene glycol. Avoid contact with eyes. Wash thoroughly after handling. Do not ingest. First Aid: If splashed in eyes, flush with large quantities of water. Call physician if irritation persists. If swallowed, do not induce vomiting. Rinse out mouth with water. Call a physician or doctor for treatment advice. If in eyes: Hold eye open and rinse slowly and gently with water for 15-20 minutes. A tub of bleach disposable wipes. The caution on the label documented Causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco, or using the toilet. First Aid: Call a poison control center or doctor for treatment advice. Physical or Chemical hazards: This product contains bleach. Do not use this product with other chemicals such as ammonia, toilet bowl cleaners, rust removers, or acid, as this releases hazardous gases. A gallon size container of Advanced Alcohol Gel Sanitizer, approximately half full was sitting on the counter. The label contained warnings for external use only, avoid contact with eyes. If contact occurs to rinse thoroughly with water. Flammable. This product contains ethyl alcohol. Keep away from sources of ignition. Discontinue use of redness develops. If irritation persists for more than 72 hours, consult a physician. Keep away from children. If swallowed, get medical help or contact a Poison Control Center right away. Active ingredient: Ethyl Alcohol 70%, purpose Antiseptic. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Two-gallon size containers of concentrated glass cleaner were sitting in an open wire rack hanging on the wall. The gallon containers were not sealed; they contained a tube running from inside the container to the rack. The containers were approximately 3/4 full. The fluid inside the container was a blue liquid. A caution on the label documented: Eye Irritant, avoid eye and skin contact. First Aid - Eyes: flush thoroughly with plenty of water for at least 15 minutes. If irritation persists, seek medical attention. Skin - Wash thoroughly with plenty of water for at least 15 minutes. If irritation persists, seek medical attention. Internal - Drink plenty of water. Contact local poison control center or physician immediately. Contains: Isopropyl Alcohol. A gallon size container labeled concentrated glass cleaner was sitting in the open wire rack hanging on the wall. The container was approximately 1/8 full. The liquid inside was a pale yellow. A caution on the label documented: Eye Irritant, avoid eye and skin contact. First Aid - Eyes: flush thoroughly with plenty of water for at least 15 minutes. If irritation persists, seek medical attention. Skin - Wash thoroughly with plenty of water for at least 15 minutes. If irritation persists, seek medical attention. Internal - Drink plenty of water. Contact local poison control center or physician immediately. Contains: Isopropyl Alcohol. A gallon size container, labeled Glass Cleaner was sitting on the wire shelf hanging on the wall. The liquid inside the container was yellow in color. The label caution: Avoid contact with eyes and prolonged contact with skin. Avoid breathing vapors or spray mist. Do Not swallow this product. First Aid: Eyes - Flush eyes with plenty of water for at least 15 minutes. Get medical attention immediately. Skin - Wash skin with plenty of water, get medical attention if irritation develops. Inhalation - get to fresh air. If irritation persist get medical attention. Ingestion: Get medical attention immediately. A gallon size container, labeled Glass Cleaner was sitting on the wire shelf, hanging on the wall. The liquid inside the container was pink in color. The label gave a caution for eye irritant. Avoid eye and skin contact. First Aid - eyes: Flush thoroughly with plenty of water for at least 15 minutes. If irritation persists, seek medical attention. Skin: Wash thoroughly with plenty of water for at least 15 minutes. If irritation persists, seek medical attention Internal: Drink plenty of water. Contact local poison control center or physician immediately. Contains: Isopropyl Alcohol. A gallon size container of 3 in 1 carpet cleaner was sitting on an open shelf of a cabinet. The container was approximately 1/2 full. The label documented Warning - this product may cause irritation of exposed areas. Spilled materials is slippery. Avoid contact with eyes and skin. Us with adequate ventilation. Wash thoroughly after handling. Do not move to unmarked containers product residue. Do not reuse. Do not mix with anything but water, Use only in well-ventilated area. A clear spray bottle of 73 Disinfecting Acid Bathroom Cleaner, with a small amount of pink liquid inside was sitting on the open shelf of the cabinet. The label had a precautionary statement: Hazard to humans and domestic animals. Causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco or using the toilet. First Aid: if in eyes hold eye open and rinse slowly and gently for 15 - 20 minutes. Call poison control or doctor for treatment advice. For emergency medical information, call toll-free [PHONE NUMBER]. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An aerosol can of 2 in 1 odor eliminator/air freshener was sitting on the open shelf of the cabinet. If in eyes flush with water for 15 minutes, if irritation persist contact a doctor. If on skin, rinse with soap and water, contact a doctor if irritation develops or persists. If swallowed, call poison control or doctor immediately. A 24-ounce clear spray bottle of multi-surface degreaser was sitting on the shelf of the cabinet. The bottle contained a light blue colored liquid. It was approximately 1/3 full. The label contained a warning to keep away from children. Causes eye irritation. If in eyes rinse eyes cautiously with water for several minutes. If eye irritation persist get medical attention. Industrial use only. A clear spray bottle of all-purpose cleaner with a green liquid inside was sitting on the shelf of the cabinet. The container contained a small amount of green liquid. The label contained a cautious statement to avoid eye contact. A first aid treatment: in case of eye contact, flush well with water, if swallowed drink a glass of water and contact a physician. A clear spray bottle of rapid multi surface disinfectant cleaner was in the unlocked housekeeping cart. The bottle contained a blue liquid. The bottle was 32 ounces and was approximately 3/4 full. The label contained a precautionary statement: harmful to humans and domestic animals. Avoid contact with eyes or clothing. remove and wash contaminated clothing. Wash thoroughly with soap and water before handling and before eating, drinking, chewing, gum, using tobacco or using the toilet. First aid: if in eyes, hold eye open and rinse slowly and gently with water for 15-20 minutes. Call poison control center or doctor for treatment advice. For emergency medical information call toll-free [PHONE NUMBER]. A clear bottle of Bio-enzymatic odor eliminator. The label contained two sets of instructions. It was not clear which set the user would follow. The bottle was sitting inside the unlocked housekeeping cart. A clear spray bottle with a purple liquid inside was in the unlocked housekeeping cart. The bottle did not have any identifying label to identify the product, the use, or it's warnings. A clear spray bottle of 73 Disinfecting Acid Bathroom Cleaner, the bottle was approximately 3/4 full of pink liquid inside was sitting inside the unlocked door of the housekeeping cart. The label had a precautionary statement: Hazard to humans and domestic animals. Causes moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco or using the toilet. First Aid: if in eyes hold eye open and rinse slowly and gently for 15 - 20 minutes. Call poison control or doctor for treatment advice. For emergency medical information, call toll-free [PHONE NUMBER]. A clear bottle of disinfectant cleaner was in the unlocked housekeeping cart. The bottle had a small amount of purple liquid inside. The front label said keep out of reach of children. The caution statement said see back panel. The back label was not on the bottle, thereby making it impossible for someone to know what precautions to follow for eyes, inhalation, swallowing, or skin contact. A cardboard biohazard box sitting directly on the floor contained a yellow biohazard bag with what appeared to be linens. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A red biohazard can was sitting in the room with a red biohazard bag of what appeared biohazard trash. A trash bag full of trash on the housekeeping cart with trash inside. During an interview on 08/26/2025 at 11:40 AM, the Unit Manager/Assistant Director of Nursing/Registered Nurse (UM/ADON/RN) stated they did not know who the keys belonged to. The UM/ADON/RN stated the door should never be left unlocked because there were chemicals that were poisonous and hazardous in the room, and a resident could get in the room and drink the chemicals. The UM/ADON/RN stated if a resident were not alert or oriented, they could get stuck in the room. The UM/ADON/RN stated the biohazard box contained a yellow bag, which indicated it was biohazard linens possibly contained body fluids, urine, feces, sputum or worse. The UM/ADON/RN stated the red biohazard bin contained a red biohazard bag that looked like biohazard trash from a resident's room in isolation. The UM/ADON/RN identified the chemicals in the room to be spray buff, alcohol gel sanitizer, glass cleaner, all-purpose cleaners, air freshener, bleach wipes, carpet cleaner, acid bathroom cleaner, degreaser, disinfectant cleaner, odor eliminator, a clear bottle with purple liquid. UM/ADON/RN read the warnings on the chemical spray buff to cause eye irritation if splashed in the eyes. The UM/ADON/RN stated this chemical did not have a cap on it and it was pretty full. The UM/ADON/RN stated if swallowed do not induce vomiting, rinse out mouth with water and call physician. The UM/ADON/RN stated the alcohol gel indicated to avoid contact with eyes and rinse thoroughly with water, keep out of reach of children, it contained ethyl alcohol and if swallowed get medical help or poison control right away. The UM/ADON/RN stated the all-purpose cleaner indicated to keep out of reach of children, avoid eye contact, flush well with water, if swallowed drink water and contact physician. The UM/ADON/RN revealed that their concern with the biohazard box and red container would be if a resident got into the bags they would be exposed to whatever was on the linens or trash. The UM/ADON/RN said their concern with the commode/hopper toilet would be that it is full of water and if a resident put their hands in the water, it is just not safe or clean. The UM/ADON/RN said the equipment is not supposed to be in the room and their concern would be if a resident got in the room and plugged the machine in and turn it on, they could hurt themselves because they may not be able to control the machine. The UM/ADON/RN opened the door of the housekeeping cart and stated there was still water in the mop bucket, the gloves have been opened and were just laying here, the cart was in the middle of the room, and it was not locked. The UM/ADON/RN stated the disinfectant cleaner did not even have the back label so I would not know how to meet the resident's needs. I would not know if I should induce vomiting or not, which is important because you could cause damage to them if you induce and you shouldn't have. The UM/ADON/RN stated the keypad had not been working for a while now and they all had keys to the doorknob. During an interview on 08/26/2025 at 11:51 AM, Housekeeper (HK) #1 said they had left the keys in the door by mistake. HK #1 said their concern with leaving the keys in the door was someone could get their chemicals and stuff. HK #1 said someone could get sick or die if they got the chemicals and drank them because they could think it was a fruit drink. HK #1 said it would not be good if a resident got in the biohazard box or trash because you can't touch that stuff, they would be in trouble, they would get sick. HK #1 said they left their cart unlocked and left their keys in the door. HK #1 said they have to use keys because the keypad doesn't work and hasn't for a while now. On 08/26/2025 at 12:08 PM, the surveyor observed the back of the keypad, inside the soiled room did not have a cover on it and there were no batteries in the unit. The soiled room was across the hall from the elevator all resident's use to and from 300-hallway to other floors in the facility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/2025 at 12:10 PM, the surveyor observed approximately 12 residents pass the door of the soiled room as they ambulated to and from the hallway and elevator. On 08/27/2025 at 2:46 PM, surveyor observed approximately 15 residents pass the door to the soiled room as they came off the elevator. There was a total of 50 ambulatory residents residing in the facility. On 08/27/2025 at 2:47 PM, during an interview Social Services Coordinator (SSC), stated the residents who reside on 300 and 400 halls go back and forth between halls to visit and go to the vending machine. On 08/27/2025 at 2:53 PM, during an interview LPN #2, stated the residents from 400 Hall came to 300 Hall for the vending machine, it was the only place in the building where a vending machine was located that the residents could access. On 08/27/2025 at 2:54 PM, this surveyor observed the vending machine was in the dining room of 300-Hall. On 08/28/2025 at 8:30 AM, the Administrator said they had concerns with the door to the soiled storage area being unlocked and unsecured because a resident could have gotten in the room and been hurt. A confused resident could have possibly gotten into the chemicals and been harmed. The door should be secured at all times, and everyone was responsible for ensuring the door was locked. The Administrator provided a list of 50 residents who were ambulatory and used the vending machine on the third floor where the unsecured soiled storage area was located. The list contained 50 names of residents residing in the facility. The Administrator stated the UM/ADON/RN, assigned to that hall monitored the doors to ensure they were locked. The Administrator stated the facility also had department managers who made rounds twice a day and monitor the doors. On 08/28/2025 at 8:45 AM, the Director of Nursing (DON) stated they had started an in-service on keeping the doors of storage and soiled rooms locked and secured at all times. The DON stated had a resident gotten in the room the resident could have been poisoned by the chemicals. The DON continued that it was important for them to know if a resident ever went in the room unattended so they could monitor the resident, notify the provider and start any treatment the doctor would want initiated. The DON stated the doors should be locked when not in use by an employee. The DON stated the staff that had gone into the room was responsible for ensuring the door was secured. The DON stated any resident roaming freely in their wheelchair or walking could have been harmed had they gone into the room. The DON stated they monitor the doors during walking rounds each day and made sure the doors are secured and locked. Resident #57 Review of Resident #57's Medical Diagnosis report revealed Resident #57 had diagnoses which included Schizophrenia, dementia and depression. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The significant change Minimum Data Set (MDS) with an Assessment Reference date of 05/14/2025 indicated Resident #57 had a Brief Interview for Mental Status score of 10, which indicated moderate cognitive impairment. The MDS indicated 1-3 days a month resident had physical symptoms such as hitting, pacing, and scratching. The MDS also indicated Resident #57 was independent on toileting, bathing, dressing and personal care. Review of a Care Plan, dated 04/30/2025, revealed Resident #57 had a self-care deficit and required assistance of staff. The Care Plan also indicated to encourage Resident #57's participation in care and monitor and report changes. On 08/25/2025 at 11:50 AM, and 1:30 PM, a black razor was observed resting on the bathroom sink of the open bathroom door in Resident #57's room. Resident #57 was not in the room. This surveyor observed residents in wheelchairs going down 300 hall to the dining area. On 08/26/2025 at 9:00 AM, Resident #57 was observed in their room with a small red skin sheer on the chin. The razor was not observed in the bathroom. Resident #57 asked this surveyor, Can I have some shaving cream? Resident #57 did not indicate how the resident's chin was cut. Resident #57 was observed approaching the nurses station asking RN #8 for shaving cream. RN #8 stated, I will have to get the Certified Nursing Assistant (CNA) to help you because last time you nicked your chin. During an interview on 08/26/2025 at 3:00 PM, RN #8 said, CNAs assist residents with shaving on shower days and as needed residents are not allowed to keep razors in their room because they could harm themselves, and we have residents that wander on [Resident #57's] hall. RN #8 stated Resident #57 had schizophrenia and if the resident had an episode [pronoun] could harm [pronoun]self. RN #8 revealed she thought a razor was left out in Resident #57's room by someone that takes the resident shopping weekly and could have purchased razors for Resident #57. On 08/28/2025 at 1:00 PM, the Administrator revealed there was not a shaving or razor policy and provided an in-service binder. The Administrator confirmed that residents were not to shave themselves, the CNAs and nursing assist residents with razors, and razors are not to be left in resident rooms. The facility policy titled Accidents and Hazards indicated that the facility strives to ensure the resident environment remains as free of accident hazards as possible, and each resident receives adequate supervision and assistive devices to prevent accidents.

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	045450	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Blossoms at Midtown Rehab & Nursing Center	5720 West Markham Street Little Rock, AR 72205

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and facility policy review, the facility failed to ensure that the ice scoop holder was maintained in a sanitary manner; food items stored in the refrigerator, freezer, and dry storage area were covered or sealed; expired food items were promptly discarded on or before the expiration or use by-date; that dietary staff washed their hands between handling dirty and clean equipment; and hot food items were maintained at required temperature for one of one meal observed. The findings include: During an observation and interview on 08/26/2025 at 12:41 PM, this surveyor observed the ice scoop holder, on the wall by the ice machine, had an accumulation of wet black residue at the bottom of it, and the ice scoop was resting on the residue. The Dietary Manager (DM) confirmed the scoop holder was dirty and had mold-like residue at the bottom of it and should be cleaned daily. During an observation and interview on 08/26/2025 at 12:46 PM, this surveyor observed a box of alfredo sauce on a shelf in the refrigerator, the manufacturer's instructions specified that it must be kept frozen. The DM stated that she did not know who removed it from the freezer and placed it in the refrigerator and she would discard the sauce. During an observation and interview on 08/26/2025 at 12:52 PM, the following food items were improperly stored in the freezer: -One box of pizza opened was on a shelf, exposing it to freezer burn. The DM stated the pizza appeared dry and that the inner bag holding the pizza was not sealed -An opened box of cobbler dough, an open box of yeast roll, and an opened box of cheese omelets. The boxes were not covered or sealed, exposing the contents to freezer burn. -A box of chocolate ice cream, the container of ice cream was soft to touch. DM stated that it looked like it had been thawed and had been placed back in the freezer to re-freeze. During an observation and interview on 08/26/2025 at 1:10 PM, this surveyor observed a bag of breadcrumbs on a shelf in the storage room. The bag was opened, exposing the breadcrumbs to air, moisture, heat and potential pests. The DM stated that bugs could get into the bag and that the food content could become stale. During an observation and interview on 08/26/2025 at 4:09 PM, the following observations were made on a shelf in the kitchenette refrigerator on the third floor: -Seven bags of turkey sandwiches on a shelf. The bags were open, exposing the contents to air and cross contamination. -Two dated bowls of unidentified soup. The DM stated she had no idea what they were. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Seven bowls on a tray in the refrigerator. All bowls contained slices of honey dew melon. The slices of honey dew melon in one bowl had a greater than nine-millimeter circle of grayish, green material on it, the slices of honey dew melons in the remaining six bowls had spots of the same substance on either side of the top of the honey dew melon. The DM stated the melon were moldy. -Five bags of ham and cheese sandwiches on a shelf that had no date to allow for first in first out storage rotation. -Two bowls of salad with boiled eggs. The boiled eggs on top of the salad were discolored and there was no storage date on the bowls, the DM stated the salad was old. -A bag of grapes. The grapes had brown spots. The DM stated that the grapes had brown spots and a bit of fuzz, and she would throw them away. -A box that contained an egg, cheese and ham sandwich had no storage date on it. -A container of sour cream had an expiration date of 08/11/2025. -A plate that contained spaghetti leftovers, cut green beans, greens and cheese had a foul odor permeating from it. The DM stated it was spoiled. During an observation on 08/26/2025 at 4:33 PM, this surveyor observed a box of steak enchilada inside the freezer and had expiration date of 05/06/2025. During an observation on 08/26/2025 at 4:38 PM, this surveyor observed an open bag of bread on a shelf in the refrigerator. The bag was not sealed, exposing it to cross contamination. The Dietary Manager confirmed the bread would easily contaminate. A container of sour cream on a shelf in the refrigerator had an expiration date of 07/28/2025. During an observation and interview on 08/26/2025 at 5:00 PM, this surveyor observed Dietary [NAME] (DC) #4 use a rag to wipe off spilled leftover food items from the counter. Without washing her hands, she picked up a clean blade and attached it to the base of the blender to be used in pureeing food items to be served to the residents for supper. DC #4 stated she should have washed her hands after handling dirty objects and before handling clean equipment. During an observation and interview on 08/26/2025 at 5:53 PM, the temperatures of food on the steam tables in the kitchenette on the third floor were checked and read by DC #4 with the following results: Ground meat -115 degrees Fahrenheit. Mashed potatoes -130 degrees Fahrenheit. Hamburger patties- 103 degrees Fahrenheit. DC #4 stated she should have reheated the food items that were not hot enough to be served to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 08/26/2025 at 6:00 PM, the temperatures of food on the steam tables in the kitchenette on the fourth floor were checked and read by the DM with the following results: Chicken noodle soup -130 degrees Fahrenheit. Mashed potatoes-120 degrees Fahrenheit. Hamburger patties -103 degrees Fahrenheit. Cut green beans - 120 degrees Fahrenheit. The DM stated she should have reheated the food items that were not hot enough to be served to the residents. During an interview on 08/27/25 at 4:10 PM, this surveyor asked Licensed Practical Nurse (LPN) #5 who was responsible for cleaning the refrigerators in the kitchen areas of each floor. LPN #5 responded that she thought dietary workers were responsible for cleaning the refrigerators in the kitchen areas of each floor, and moving forward from today it would be assigned to the nurses. During an interview on 08/27/2025 at 4:20 PM, ADON #6 stated the night shift nurses would be assigned to ensure the refrigerators on each floor are checked and cleaned nightly. A review of a facility policy titled, Food Safety: Ice indicated ice will not be handled with bare hands, but rather with a sanitized scoop and container for transport and distribution. A review of a facility policy titled, Hand Washing indicated hands should be washed when entering the kitchen at the start of the shift, as often as necessary during food preparation to remove soil or contamination and to prevent cross contamination when changing tasks, and after engaging in other activities that contaminate the hands. A review of a facility policy titled, Food temperatures indicated all hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees Fahrenheit. A review of a facility policy titled Food Storage indicated all stock must be rotated with each new order received. Rotating stock is essential to ensure the freshness and highest quality of all foods. All foods should be covered, labeled and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure isolation practices were being followed by housekeeping staff to prevent the possible spread of infectious disease on one (Fourth) floor of the nursing facility. The findings include: On 08/25/2025, a contact isolation sign was observed on the door of room [ROOM NUMBER]. On 08/26/2025 at 11:00 AM, Housekeeper (HSK) #9 was observed on west 400 hall pushing the housekeeping cart with gloved hands. HSK #9, without changing gloves or performing hand hygiene, nor donning an isolation gown, was observed going into room [ROOM NUMBER] with a broom and dustpan. HSK #9 came out of the room and placed a small bag of trash in the trash compartment of the housekeeping cart. HSK #9 was observed, through the open room door, to move dirty linen and a trash container from room [ROOM NUMBER]'s bathroom to the room,. HSK #9 then came out of room [ROOM NUMBER] and picked up a bottle of spray and a toilet brush and went back into room [ROOM NUMBER]. A minute later, he replaced those two items on the housekeeping cart, got the mop and went back to mop the bathroom of room [ROOM NUMBER]. After mopping, HSK #9 returned the mop to the housekeeping cart and proceeded to push the housekeeping cart down the hall. HSK #9 did not change gloves or perform hand hygiene at any time during the cleaning of room [ROOM NUMBER], nor as he went to push the housekeeping cart down the hall. On 08/26/2025 at 11:13 AM, HSK #9, who had worked at this facility three years, confirmed he had been trained on what to do when cleaning a room where the resident was on isolation. He confirmed he knew what the contact isolation sign on the door of room [ROOM NUMBER] indicated, but that he was just trying to get it done quickly. On 08/28/2025 at 10:25 AM, the Administrator confirmed she expected housekeeping personnel to follow the same protocol as the nursing staff concerning isolation and to follow good infection control practices. Review of training for HSK #9 indicated HSK #9 had been in-serviced on infection control on 06/05/2025, and in-serviced on hand hygiene and personal protective equipment on 08/20/2025. The facility's policy on Infection Control and Prevention indicated infection prevention involved all disciplines, and staff would be monitored to ensure compliance with techniques and procedures to prevent the spread of infection. Based on observation, interview and record review the facility failed to ensure isolation practices were being followed by housekeeping staff to prevent the possible spread of infectious disease. On 08/25/2025 a contact isolation sign was observed on the door of room [ROOM NUMBER]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/2025 at 11:00 AM housekeeper (HSK) #9 was observed on west 400 hall pushing the housekeeping cart with gloved hands. HSK #9, without changing gloves or performing hand hygiene nor donning an isolation gown, was observed going into room [ROOM NUMBER] with a broom and dustpan. HSK #9 came out of the room and placed a small trash bag of trash in the trash compartment of the housekeeping cart. HSK #9 was observed, through the open room door, to move a dirty linen and a trash container from room [ROOM NUMBER]'s bathroom to the room, at the resident's request. HSK #9 then came out of room [ROOM NUMBER] and picked up a bottle of spray and a toilet brush and went back into room [ROOM NUMBER]. A minute later he came back to the housekeeping cart and replaced those two items and got the mop and went back to mop the bathroom of room [ROOM NUMBER]. After mopping HSK #9 returned the mop to the housekeeping cart, he proceeded to push the housekeeping cart down the hall. HSK #9 did not change gloves or perform hand hygiene at any time during the cleaning of room [ROOM NUMBER] nor as he went to push is cart down the hall. On 08/26/2025 at 11:13 AM HSK #9, who had worked at this facility 3 years, confirmed he had been trained on what to do when cleaning a room where the resident is on isolation. He confirmed he knew what the contact isolation sign on the door of room [ROOM NUMBER] indicated, but that he was just trying to get it done quickly. On 08/28/2025 at 10:25 AM the Administrator confirmed she expected housekeeping personnel to follow the same protocol as the nursing staff concerning isolation and to follow good infection control practices. Review of a training indicated HSK #9 had been in-serviced on infection control on 06/05/2025 and in-serviced on hand hygiene and personal protective equipment on 08/20/2025. The facility's policy on Infection Control and Prevention indicated infection prevention involved all disciplines and staff would be monitored to ensure to ensure staff compliance with techniques and procedures to prevent the spread of infection.