STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045142	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOMERSET SENIOR LIVING AT CANYON SPRINGS	**1401 PARK AVENUE HOT SPRINGS, AR 71901**

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 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 327) was substantiated, all or in part, with these findings. Based on observation of the 8:00 a.m. medication pass on 8/4/20, record review and interview, the facility failed to ensure physician orders [REDACTED].#1 and 2) of 2 residents observed during the medication pass resulting in medication errors. Medication errors were made by 1 Registered Nurse (RN #1) of 1 RN observed administering medications. This failed practice had the potential to affect 24 residents who received medications from this nurse, as documented on a list provided by the Administrator on 8/5/20. The medication error rate was 24.0% based on observation of 23 medications administered, 2 medications ordered and not administered, for a total of 25 opportunities for a total of 6 medication errors detected. The findings are: 1. Resident #2 had [DIAGNOSES REDACTED]. A Physician order [REDACTED]. give 4 tablets to equal 4000 units. The August 2020 Medication Administration Record [REDACTED]. On 8/4/20 at 8:01 a.m., RN #1 prepared the resident's 8:00 am medications in a medication cup and added only one [MEDICATION NAME] Tablet 1000 unit instead of 4 to equal 4000 units. He entered the resident's room and administered the medications. When the RN returned to the medication cart, he was asked if all the scheduled medications had been given to the resident. He stated, Yes. 2. Resident (R) #1 had [DIAGNOSES REDACTED]. a. The August 2020 Physician order [REDACTED]. 1/3/20 [MEDICATION NAME] Handihaler Capsule ([MEDICATION NAME]) 18 MCG (microgram) 1 capsule inhale orally one time a day for SOB (shortness of breath) . 1/4/20 [MEDICATION NAME] Aerosol 80-4.5 ([MEDICATION NAME]-[MEDICATION NAME]) MCG/ACT (actuation) 2 puff inhale orally two times a day for SOB wait one minute between puffs, rinse mouth and spit after each use . 4/5/20 [MEDICATION NAME] Tablet 125mg give 1 tablet by mouth two times a day for abdominal gas . 6/9/20 [MEDICATION NAME] HCL ([MEDICATION NAME]) Tablet 5mg give 1 tablet by mouth three times a day for anxiety . b. On 8/4/20 at 8:30 a.m., RN#1 prepared the 8:00 am medications for R#1, putting oral medications in a clear medication cup. He did not include [MEDICATION NAME] 5 mg tablet and [MEDICATION NAME] 100mg tablet in the prepared medications for the resident. He administered [MEDICATION NAME] 80 MG tablet, not [MEDICATION NAME] 125 mg tablet as ordered. After preparing the medications, he entered the resident's room and set the medications in front of the resident. She picked up the [MEDICATION NAME]-[MEDICATION NAME] inhaler, shook the applicator and inhaled 2 puffs. RN #1 did not instruct the resident to wait between inhalations nor did he instruct her to rinse and spit after administration. The resident then picked up the [MEDICATION NAME] and inhaled the medication without waiting 1 minute between inhalations. She then took the remaining prepared medications. When the RN returned to the medication cart he was asked if all the medications ordered at this time had been administered. He stated, .Yes .three held waiting on the pharmacy to deliver . c. On 8/4/20 at 10:29 AM, RN#1 was asked to look at Resident #2 physician orders [REDACTED]. He stated, It says give 4 . He was asked did you give her 4. He stated, I gave her 1. He was then asked to look at and read the physician orders [REDACTED]. He was asked what dose he gave her. He stated, 80mg . He was asked if he popped the [MEDICATION NAME] 5mg tablet. He stated, I don't remember that. He looked at the medication card and stated, It's not popped . He was asked if the [MEDICATION NAME] 100mg tablet was included in the medication administered. He stated, I don't remember He was asked did the resident wait between puffs when taking the inhalers. He stated, She should have . d. On 8/4/20 at 11:15 AM, the Assistant Director of Nursing (ADON) was asked, Should medications be given as ordered? She stated, Yes. She was asked, Should you wait between puffs when administering inhalers? She stated, Yes. e. A facility policy on Medication Administration provided by the Administrator on 8/4/20 at 11:35 AM documented, .Medication as ordered . f. A facility policy on Medication Administration .oral and nasal inhalations administration procedures' provided by the Administrator on 8/4/20 at 12:03 PM documented, .if more than one inhalation is ordered, wait one minute .if more than one inhaled medication is ordered wait 5 minutes between the administration of each medication .

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

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.