STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045357	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOMERSET SENIOR LIVING AT PREMIER	3600 RICHARDS ROAD NORTH LITTLE ROCK, AR 72117

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify the resident's representative or Power of Attorney (POA) in writing of the residents' transfer to the hospital and / or discharge for 4 (Residents #13, #85, #17, and #58) of 12 (Residents #70, #55, #100, #70, #13, #85, #64, #66, #1, #58, #17, and #82) sampled residents who were transferred and / or discharged from 3/1/2020 through 7/2/2020. This failed practice had the potential to affect 12 residents who were transferred or discharged from 3/1/2020 through 7/2/2020, according to a list provided by the Administrator on 7/2/2020. The findings are: 1. Resident #13 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); required extensive assistance with bed mobility; and was totally dependent with transfers, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing. a. A Discharge Return Anticipated MDS dated [DATE] documented the resident was discharged to the hospital. An Entry MDS dated [DATE] documented the resident was readmitted to the facility. b. A Nurses Note dated 5/8/2020 at 03:31 (3:31 p.m.) documented, .Elder remains NPO (Nothing by Mouth) due to him pulling out his PEG (Percutaneous Endoscopic Gastrostomy) tube . He has an order to send to ER (emergency room) in the AM (morning) to have it replaced at that time . He continues to have problems with behaviors throwing pillows off bed and the covers . c. A Social Services Note dated 5/8/ 0 at 08:31 (8:31 a.m.) documented, .Social Worker called (Name) Geripsych (Geriatric Psychiatric Facility) and advised of referral for resident. Social Worker was advised that resident would need to go to the ER (emergency room) for screening and they would see him there. Social Worker called ER and advised resident would need to be screened by Geripsych and that they had been contacted and were awaiting the call. Social worker advised the Charge Nurse named (Name) . d. As of 7/1/2020 at 2:50 p.m., the clinical record contained no documentation indicating a transfer notification was sent to the family / representative. e. On 7/1/2020 at 2:51 p.m., the Business Office Manager was asked, Should you send a Transfer Notice and Bed Hold Policy notice to the family when a resident is transferred to the emergency room or Geri psych? She stated, Yes, normally we do. The system will generate them, and all I have to do is complete them and mail them out. I'm not sure what happened? f. A facility policy titled Change in Condition Notification received from the Administrator on 7/2/2020 at 8:57 a.m., documented, .It is the policy of this facility to monitor residents for Change in their Condition, to respond appropriately to those changes, and to notify the physician and responsible party / family member of changes . Procedure . 3. The responsible party / family member will be notified of Changes in Condition unless directed otherwise in the resident's chart / IPOC (Individualized Plan of Care) . 2. Resident #85 had [DIAGNOSES REDACTED]. The Readmission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 5/31/2020 documented the resident scored 6 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS) and required oxygen. a. The Progress Note dated 5/23/2020 at 1935 (7:35 p.m.) documented, .Late Entry . Resident alert and oriented. Breathing 36 breaths a minute sating (oxygen saturation) at 78% . Put on 2 lpm (liters of oxygen per minute) . Resident raised to 85% at 3 lpm . Resident stayed steady at 85% . On call (Physician) notified with order to send to ER (emergency room) . At 1920 (7:20 p.m.) when MEMS (Metropolitan Emergency Medical Services) showed up . Resident saturation at 59% on 3 lpm (liters of oxygen per minute) . b. On 7/1/2020 at 3:05 p.m., the Director of Nursing (DON) was asked if Licensed Practical Nurse (LPN) #1) notified the resident's sister of his transfer to the hospital on [DATE] regarding an oxygen saturation of 59% on 3 L/M (liters per minute) oxygen? She stated, No, she said she didn't because he was his own Responsible Party. She was asked if the resident was capable of understanding the reason for his transfer with an oxygen saturation of 59% on 3 Liters of oxygen. She stated, No. She was informed that his sister was notified of a new medication order two days prior to his transfer to the facility and was asked, Since he was unable to understand the reason for his transfer due to his decreased oxygen level, should the nurse have notified his sister? She stated, Yes, absolutely. 3. Resident #17 had [DIAGNOSES REDACTED]. A Significant Change MDS with an ARD of 3/23/2020 documented the resident scored 9 (8-12 indicates moderate impairment on a Brief Interview for Mental Status; a. A Progress Note dated 2/20/2020 at 11:11 a.m. documented, . (Name) Center called and stated that Dr. (Doctor) had spoken with the daughter and it was decided that resident needs to go to Geriatric Psych. (Psychiatric Facility) due to decline with [MEDICAL CONDITION] with Behaviors . b. On 7/2/2020 at 8:20 a.m., the Business Office Manager was asked for a copy of the letter indicating the reason for transfer that was sent to the Responsible Party and Ombudsman. The Business Office Manager stated, The (facility computer system) was supposed to generate the report and didn't. 4. Resident #58 had [DIAGNOSES REDACTED]. A Quarterly MDS with an ARD of 5/6/2020 documented the resident scored 1 (0-7 indicates severe impairment) on a Brief Interview for Mental Status. a. The Situation Background Assessment (SBAR) dated 4/21/2020 at 15:27 (3:27 p.m.) documented, .Non-responsive to stimuli . Unarousable . Contacted (Advanced Practice Nurse) . Order to send to emergency room . MEMS (Metropolitan Emergency Medical Service) notified . Transferred to emergency room at hospital . b. On 7/2/2020 at 8:20 a.m., the Business Office Manager was asked for a copy of the letter which indicated the reason for the resident's transfer that was provided to the Responsible Party and Ombudsman. The Business Office Manager stated, The facility (Computer System) was supposed to generate the report and didn't.
F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to notify resident representatives and / or Power of Attorneys (POA) in writing of the facility Bed Hold Policy upon a residents' transfer to the hospital and / or discharge for 2 (Residents #13 and #85) of 12 (Residents #70, #55, #100, #70, #13, #85, #64, #66, #1, #58, #17, and #82) sampled residents who were transferred and / or discharged from 3/1/2020 through 7/2/2020. This failed practice had the potential to affect 12 residents who were transferred or discharged from 3/1/2020 through 7/2/2020, according to a list provided by the Administrator on 7/2/2020. The findings are: 1. Resident #13 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/20/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); required extensive assistance with bed mobility; and was totally dependent with transfers, locomotion on and off the unit, dressing, eating, toilet use, personal

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

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F 0625 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) hygiene, and bathing. a. A Discharge Return Anticipated MDS dated [DATE] documented the resident was discharged to the hospital. An Entry MDS dated [DATE] documented the resident was readmitted to the facility. b. A Nurses Note dated 5/8/2020 at 03:31 (3:31 p.m.) documented, .Elder remains NPO (Nothing by Mouth) due to him pulling out his PEG (Percutaneous Endoscopic Gastrostomy) tube . He has an order to send to ER (emergency room) in the AM (morning) to have it replaced at that time . He continues to have problems with behaviors throwing pillows off bed and the covers . c. A Social Services Note dated 5/8/ 0 at 08:31 (8:31 a.m.) documented, .Social Worker called (Name) Geripsych and advised of referral for resident. Social Worker was advised that resident would need to go to the ER (emergency room) for screening and they would see him there. Social worker called ER and advised resident would need to be screened by Geripsych and that they had been contacted and were awaiting the call. Social worker advised the Charge Nurse named (Name) . d. As of 7/1/2020 at 2:50 p.m., the clinical record contained no documentation indicating a Bed Hold Policy notification was sent to the family / representative. e. On 7/1/2020 at 2:51 p.m., the Business Office Manager was asked, Should you send a Transfer Notice and Bed Hold Policy notice to the family when a resident is transferred to the emergency room or Geri psych? She stated, Yes, normally we do. The system will generate them, and all I have to do is complete them and mail them out. I'm not sure what happened? f. The facility policy titled Bed Hold Prior to Transfer provided by the Administrator on 7/2/2020 at 8:38 a.m. documented, .Prior to transferring a resident to the hospital or the resident goes on therapeutic leave, the facility will provide written information to the resident and / or the resident representative regarding Bed Hold . Procedure / Protocol . Notice Before Transfer . 1. The following information will be given to the resident and / or resident representative . a. The duration of the State Bed Hold, if any, during which the resident is permitted to return and resume residence in the nursing facility . b. The reserve bed payment policy in the State plan, if any . c. The facility policy regarding Bed Hold periods to include permitting residents to return . 2. Resident #85 had [DIAGNOSES REDACTED]. The Readmission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 5/31/2020 documented the resident scored 6 (0-7 indicates severe impairment) on a Brief Interview of Mental Status (BIMS) and required oxygen. a. The Progress Note dated 5/23/2020 at 1935 (7:35 p.m.) documented, .Late Entry . Resident alert and oriented. Breathing 36 breaths a minute sating (oxygen saturation) at 78% . Put on 2 lpm (liters of oxygen per minute) . Resident raised to 85% at 3 lpm . Resident stayed steady at 85% . On call (Physician) notified with order to send to ER (emergency room) . At 1920 (7:20 p.m.) when MEMS (Metropolitan Emergency Medical Services) showed up . Resident saturation at 59% on 3 lpm (liters of oxygen per minute) . b. On 7/1/2020 at 3:05 p.m., the Director of Nursing (DON) was asked, Did (Licensed Practical Nurse (LPN) #1) notify the resident's sister of his transfer to the hospital on [DATE] regarding an oxygen saturation of 59% on 3 Liters of oxygen? She stated, No. She said she didn't because he was his own Responsible Party. She was asked if he was capable of understanding reason for his transfer with an oxygen saturation of 59% on 3 liters of oxygen. She stated, No. c. On 7/1/2020 at 3:11 p.m., the DON was asked if a facility Bed Hold policy notice was sent to him or his sister. She left the room to check, but came back in approximately 5 minutes and stated, No. A Bed Hold policy notice was not sent to him or his sister. She was asked if one should have been sent. She stated, Yes.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** Based on record review, the facility failed to ensure the Modified Minimum Data Set (MDS) assessments were transmitted within 14 days after completion for 2 (Residents #17 and 55) of 23 (Residents #70, #55, #100, #77, #85, #64, #66, #4, #63, #37, #1, #87, #13, #61, #39, #79, #68, #6, #80, #58, #73, #17 and #82) sampled residents whose assessments were reviewed, in order to provide accurate and up-to-date information for quality measures. This failed practice had the potential to affect 23 residents who had a Modification Assessment from 1/1/2020 through 3/31/2020, according to the list provided by the MDS Coordinator on 7/2/2020 at 9:26 a.m. The findings are: 1. Resident #17 had a Modification of a Significant Change of Status Minimum Data Set Assessment completed with an Assessment Reference Date (ARD) of 3/23/2020. As of 7/2/2020 at 9:15 a.m., the electronic system documented the status of the assessment was Export Ready which indicated the assessment had not been transmitted. 2. Resident #55 had a Modification of a Significant Change of Status Assessment completed with an ARD of 1/30/2020. As of 7/2/2020 at 9:20 a.m., the electronic system documented the status of the assessment was Export Ready which indicated the assessment had not been transmitted.
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 record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments accurately reflected the use of oxygen for 2 (Resident #39 and #80) of 28 (Residents #39, #80, #4, #6, #13, #17, #22, #24, #37, #44, #50, #52, #55, #58, #61, #63, #66, #68, #70, #75, #76, #77, #85, #87, #91, #94, #99 and #100) sampled residents who had physician's orders [REDACTED]. The findings are: 1. Resident #39 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/24/2020 documented the resident scored 12 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); required extensive assistance with bed mobility, transfer, locomotion on the unit, dressing, toilet use, and personal hygiene; was totally dependent for bathing; did not have shortness of breath; and did not require oxygen. a. A physician's orders [REDACTED].Oxygen 2 LPM (liters per minute) Via NC (nasal cannula) as needed for Shortness of Breath QD (every day) . b. The Care Plan with a revised date of 4/29/2020 documented, .The resident has altered cardiovascular status r/t (related to) arrhythmia . Oxygen Settings . O2 (oxygen) as ordered . c. On 7/2/2020 at 3:19 p.m., the Minimum Data Set (MDS) Coordinator was asked, If a resident receives oxygen, should Section O0100, Special Treatments, Procedures and Programs on the Minimum Data Set document oxygen use for the resident? He stated, Yes. 2. Resident #80 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 5/21/2020 documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene; did not have shortness of breath; and did not require oxygen. a. A physician's orders [REDACTED].Oxygen 2L (2 liters) via NC (nasal cannula) as needed for SOB (shortness of breath) . b. The Care Plan with a revised date of 2/24/2020 contained no documentation related to the resident's requirement for oxygen.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the Comprehensive Care Plans were individualized and addressed appropriate care and services for 1 (Resident #80) of 23 (Residents #70, #55, #100, #77, #85, #64, #66, #4, #63, #37, #1, #87, #13, #61, #39, #79, #68, #6, #80, #58, #73, #17, and #82) sampled residents who had physician's orders [REDACTED]. This failed practice had the potential to affect 23 residents, according to the list provided by the Administrator on 6/29/2020. The findings are: 1. Resident #80 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/21/2020 documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); required extensive assistance with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing; and did not require oxygen. a. A physician's orders [REDACTED].Oxygen 2 L (liters) via NC (nasal cannula) as needed for SOB (shortness of breath) . b. The Care Plan with a revised date of 2/24/2020 contained no documentation related to the administration of oxygen for the resident. c. On 6/29/2020, 6/30/2020, and 7/1/2020 the resident was receiving oxygen with a flow rate of 2 liters per minute via nasal cannula. d. On 7/2/2020 at 3:19 p.m., the Minimum Data Set (MDS) Coordinator was asked, If a resident receives oxygen, should it be on their Care Plan? He stated, Yes.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Based on observation, record review, and interview, the facility failed to ensure fingernails were trimmed and clean to promote good personal hygiene for 1 (Resident #13) of 23 (Resident #70, #55, #100, #77, #85, #64, #66, #4, 63, #37, #1, #87, #13, #61, #39, #79, #68, #6, #80, #58, #73, #17, and #82) sampled residents who were dependent for nail care, as documented on a list provided by the Administrator on 7/2/2020. The findings are: 1. Resident #13 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 3/20/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); required extensive assistance with bed mobility; and was totally dependent with transfers, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing. a. The Care Plan dated 9/11/2018 documented, .The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia, Limited Mobility . Nail Care . Check nail length and trim and clean as necessary . b. On 6/30/2020 at 1:54 p.m., the resident's fingernails were approximately 1/4 inch long and were dirty. (The Surveyor took a photograph of the resident's fingernails at this time.) c. On 7/2/2020 at 3:14 p.m., Licensed Practical Nurse (LPN) #4 was asked, Should residents' nails be clean and trimmed? She stated, Yes. d. A facility policy titled Personal Needs provided by the Administrator on 7/1/2020 at 8:46 a.m. documented, .The facility strives to promote a healthy environment by meeting the personal care needs of the resident, as indicated . The facility also provides the needed support when the resident performs their activities of daily living (ADLs) . Personal care and ADL support will be provided according to the residents Plan of Care . Personal care and support include but is not limited to the following . Nail care .
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on observation, record review, and interview, the facility failed to ensure hand rolls and splints were applied to prevent further decline in range of motion (ROM) for 3 (Residents #13, #61, and #68) of 15 (Residents #64, #58, #66, #7, #13, #61, #4, #79, #68, #82, #6, 100, #63, #77, and #85) sampled residents who had functional limitation in range of motion / contractures, as documented on the list provided by the Director of Nursing (DON) on 7/2/2020. 1. Resident #13 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 3/20/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); required extensive assistance with bed mobility; was totally dependent with transfer, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing; and had functional limitation in range of motion of the upper extremities on both sides. a. The Care Plan with a revised date of 9/27/19 documented, .The resident has limited physical mobility r/t (related to) [MEDICAL CONDITION] and Abnormal Involuntary Movement . Hand Rolls to both hands . b. On 6/30/2020 at 10:01 a.m., the resident's hands appeared contracted. There were no positioning devices in place. c. On 6/30/2020 at 1:55 p.m., the resident's hands appeared contracted. The resident was asked if he could open his left hand. His index finger of his left hand was contracted downward, and the resident was unable to open it. The resident's right hand was contracted, and the resident was unable to open it. There were no positioning devices present. (The Surveyor took a photograph of the resident's hands at this time.) d. On 7/2/2020 at 3:14 p.m., Licensed Practical Nurse (LPN) #4 was asked, Should residents with contractures have a device in place to prevent further contractures? She stated, Yes. e. A facility policy titled Range of Motion . Restorative Nursing provided by the Administrator on 7/1/2020 at 8:38 a.m. documented, .The facility promotes enabling residents to attain or maintain their highest functional level of physical, mental, and psychosocial functioning . Increased independence fosters self-esteem and promotes positive quality of life for residents . 1. Resident requiring . Contracture prevention and management (including passive range of motion (PROM), active range of motion (AROM), splint / brace assistance) . 3. Ensure Resident does not experience a decline in functional status . 2. Resident #61 had [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 5/13/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status (SAMS); was totally dependent with bed mobility, transfer, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene, and bathing; and had functional limitation in range of motion to the upper extremities on both sides. a. The Care Plan dated 5/27/2020 documented, .The resident has limited physical mobility r/t (related to) Alzheimer's, Contractures to hands . Clean hands and apply rolls in hands daily . b. On 6/30/2020 at 9:37 a.m., the resident was sitting up in geri chair. The resident had contractures to both hands. There were no positioning devices in place. (The Surveyor took a photograph of the resident's hands at this time. 3. Resident #68 had [DIAGNOSES REDACTED]. The Annual MDS with an ARD of 5/10/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a BIMS; required extensive assistance with bed mobility, locomotion on and off the unit, dressing, toilet use, and personal hygiene; was totally dependent with bathing and transfer; and had functional limitation in range of motion of the upper extremities on one side. a. The Care Plan with a revised date of 11/18/19 documented, .The resident has limited physical mobility r/t (related to) Left [MEDICAL CONDITION] . Contracture to Left hand . PT (Physical Therapy) / OT (Occupational Therapy) to eval (evaluate) for contracture management and mobility . ROM (range of motion) to upper left upper and lower extremities during care to prevent contractures . b. On 7/1/2020 at 9:28 a.m., the resident's left hand was contracted, and no positioning device was present. (The surveyor took a photograph of the resident's left hand at this time.)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 observation, record review, and interview, the facility failed to ensure mechanical lift transfers were performed according to the manufacturer's instructions to prevent potential injury for 1 (Resident #58) of 11 (Residents #58, #61, #13, #79, #39, #6, #73, #17, #82, 63 and #70) sampled residents who required a mechanical lift and two-person assistance with transfers. This failed practice had the potential to affect 15 residents who required a mechanical lift and two-person assistance for transfer and resided on the 300 Hall, according to a list provided by the Director of Nursing on 7/2/2020 at 10:18 a.m. The findings are: 1. Resident #58 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 5/6/2020 documented the resident scored 1 (0-7 indicates severe impairment) on a Brief Interview for Mental Status and was totally dependent with two-person assistance for transfers. a. The Care Plan with a revised date of 8/7/18 documented, .Transfer . Resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Activity Intolerance, Confusion, Dementia . The resident requires extensive assist (assistance) w (with) / Mechanical Lift with (2) staff for transfers . b. On 6/29/2020 at 10:20 a.m., Certified Nursing Assistants (CNAs) #1 and #2 were obtaining the resident's weight utilizing the mechanical lift. The mechanical lift legs were together and not separated while the lift was under the resident's bed during the transfer of the resident. c. On 7/2/2020 at 8:45 a.m., CNA #2 was asked, When was your last training on the mechanical lift? She stated, At a different facility. It's been rescheduled here due to COVID-19. She was asked, How were the legs positioned when you weighed (Resident #58)? She stated, They were closed. I realized my mistake when you all left. d. The manufacturer's instructions provided by the Administrator on 7/2/2020 at 8:05 a.m. documented, .With the legs of the base open and locked, use the steering handle to push the patient lift into position .
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure an enteral feeding formula container, a water container, and the tubing used to administer the formula / flush were properly labeled and dated when initiated to prevent complications of enteral feeding for 1 (Resident #63) of 5 (Residents #6, #13, #43, #63, and #99) sampled residents who had physician's orders [REDACTED]. This failed practice had the potential to affect 7 residents who had physician's orders [REDACTED]. The findings are: 1. Resident #63 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference date of 5/14/2020 documented the resident was severely impaired in cognitive skills for daily decision making per

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F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) a Staff Assessment for Mental Status, and received at least 51% nutrition via percutaneous endoscopic gastrostomy (PEG) tube. a. A physician's orders [REDACTED].NPO (nothing by mouth) related to Dysphagia, . Gastrostomy Status . A physician's orders [REDACTED].Enteral feeding order every shift . Glucerna 1.5 . at 45 ml/hr (milliliters per hour) . with water at 125 ml/hr . b. On 6/29/2020 at 10:42 a.m., the resident was lying in his bed with his eyes closed and was receiving an enteral feeding formula of Glucerna 1.5 at a rate of 45 milliliters (ml) per hour and a water flush at a rate of 125 ml every 4 hours. The containers of enteral feeding formula and water were not dated, and the tubing used to deliver the feeding and flushes were not dated. c. On 6/29/2020 at 10:45 a.m., Licensed Practical Nurse (LPN) #3 was asked when the formula and water were hung / initiated. She stated, Last night. The night nurses always hang them, but I guess they forgot (to date and time). d. On 7/2/2020 at 8:48 a.m., the Director of Nursing (DON) was asked about the labeling of tubing and containers used in enteral feeding. She stated, The tubing is to be changed and labeled with the date and time at the time it is hung (initiated).
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure oxygen tubing, storage bags, and nebulizer tubing were stored in a closed bag or container when not in use to prevent potential contamination for 3 (Residents #85, #80, and #63); oxygen / nebulizer tubing and storage bags were dated when initiated for 4 (Residents #63, #39, #77, and #80) of 28 (Residents #4, #6, #13, #17, #22, #24, #37, #39, #44, #50, #52, #55, #58, #61, #63, #66, #68, #70, #75, #76, #77, #80, #85, #87, #91, #94, #99 and #100) sampled residents who had physician's orders [REDACTED].#39 and #85) of 28 (Residents #4, #6, #13, #17, #22, #24, #37, #39, #44, #50, #52, #55, #58, #61, #63, #66, #68, #70, #75, #76, #77, #80, #85, #87, #91, #94, #99 and #100) sampled residents who had physician's orders [REDACTED]. The findings are: 1. Resident #39 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/24/2020 documented the resident scored 12 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); required extensive assistance with bed mobility, transfer, locomotion on the unit, dressing, toilet use, personal hygiene; had no shortness of breath; and did not require oxygen. a. A physician's orders [REDACTED].Oxygen 2 LPM (liters per minute) Via NC (nasal cannula) as needed for Shortness of Breath QD (every day) . b. The Care Plan with a revised date of 4/29/2020 documented, .The resident has altered cardiovascular status r/t (related to) arrhythmia . Oxygen settings . O2 (oxygen) as ordered . c. On 6/29/2020 at 3:22 p.m., the resident was in her room lying in her bed at a 45' angle watching television. The resident was receiving oxygen at a flow rate of approximately 2.5 liters per minute (LPM) via nasal cannula. The oxygen tubing was dated. The storage bag was not dated. The resident continued to receive oxygen each day of the survey. d. On 7/1/2020 at 4:05 p.m., the Director of Nursing (DON) was asked if (Resident #85) had been diagnosed with [REDACTED]. She stated, Yes, that's right. She was informed there had been three observations of the resident's oxygen nasal canula / tubing being on the floor, draped over the concentrator, and lying in the seat of his wheelchair and not in a storage bag or other container. She stated, That shouldn't happen. I'll start in-servicing my staff this afternoon about this. e. On 7/2/2020 at 9:41 a.m., the DON was asked when oxygen tubing was supposed to be changed. She stated, Every Sunday. She was asked if it should be dated. She stated, Yes. The DON was informed the resident's oxygen tubing was not dated, and the resident had told the Surveyor that she didn't know when the last time was that the oxygen tubing had been changed. She stated, I'll make sure all residents' oxygen tubing is dated this evening. 2. Resident #80 was admitted on [DATE] with [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference Date of 5/21/2020 documented the resident scored 8 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS); required extensive assistance with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing; had no shortness of breath; and did not require oxygen. a. A physician's orders [REDACTED].Oxygen 2L (2 liters) via NC (nasal cannula) as needed for SOB (shortness of breath) . b. On 6/29/2020 at 3:39 p.m., the resident was receiving oxygen with the flow rate set at 2 liters per minute via nasal cannula. The resident's oxygen tubing and storage bag were not dated, and the oxygen tubing was lying on the floor. (The Surveyor took a photograph of the oxygen tubing at this time.) The resident received oxygen each day of the survey. c. As of 7/1/2020 at 8:25 p.m., the resident's Care Plan contained no documentation related to oxygen. 3. Resident #63 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an Assessment Reference date of 5/14/2020 documented the resident was severely impaired in cognitive skills for daily decision making per a Staff Assessment for Mental Status; had decreased range of motion in all extremities; received at least 51% nutrition via a Percutaneous Endoscopic Gastrostomy tube; did not have shortness of breath; and did not require oxygen. a. The physician's orders [REDACTED].Oxygen therapy to be administered via nasal canula at 2 liters per minute . b. On 6/29/2020 at 10:42 a.m., the resident was lying in his bed nd was receiving oxygen with the oxygen flow rate on the oxygen concentrator set at 2 liters per minute via nasal cannula. The tubing attached to the oxygen concentrator extending to the resident's nares was not dated. The small-volume nebulizer was on the bedside table with tubing connected. Licensed Practical Nurse (LPN) #3 entered the room and began to auscultate the resident's breath sounds. She was asked, Where are the updraft supplies and mask stored when not in use? She stated, In the drawer of the bedside table. She opened the drawer of the bedside table and removed a bag with an updraft mask inside the bag. The bag and nebulizer supplies were not dated. She was asked, When were these supplies brought in the room? She stated, I just brought them in today because he has not been needing them, but now he does. I just forgot to date them. c. On 7/2/2020 at 8:48 a.m., the Director of Nursing (DON) was asked about the labeling of oxygen supplies and tubing. She stated, The tubing is to be changed and labeled with the date and time on Sundays and as needed. 4. Resident #77 had [DIAGNOSES REDACTED]. The Readmission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/2/2020 documented the resident scored 10 (8-12 indicated moderate impairment) on a Brief Interview of Mental Status. a. A physician's orders [REDACTED].Oxygen 2 L/M (liters per minute) per N/C (nasal cannula) as needed for shortness of breath every day . b. On 6/30/2020 at 10:50 a.m., Resident #77 had oxygen in use per N/C at a flow rate of 2 liters per minute. The oxygen tubing was not dated. c. On 7/1/2020 at 8:14 a.m., Resident #77 had oxygen in use per N/C at a flow rate of 2 liters per minute. The oxygen tubing was not dated. The resident was asked if she knew when the tubing had been changed. The resident stated she did not know when the oxygen tubing was changed. d. On 7/1/2020 at 9:41 a.m., the Director of Nursing (DON) was asked when oxygen tubing was supposed to be changed. She stated, Every Sunday. She was asked if the oxygen tubing should be dated. She stated, Yes. The DON was informed the resident's oxygen tubing was not dated and the resident had stated she did not know when the oxygen tubing had been changed. She stated, I'll make sure all residents' oxygen tubing is dated this evening. 5. Resident #85 had [DIAGNOSES REDACTED]. The Readmission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) 5/31/2020 documented the resident scored 6 (0-7 indicates severe impairment) on a Brief Interview for Mental Status (BIMS) and required oxygen. a. A physician's orders [REDACTED].Oxygen 3 liters per nasal canula every shift . b. A Nursing Progress Note dated 5/23/20 at 1935 (7:35 p.m.) documented, .Late Entry . Resident alert and oriented. Breathing 36 breaths a minute . Sating (oxygen saturation) at 78% . Put on 2 LPM (liters per minute) . Resident raised to 85% . At 3 LPM resident stayed steady at 85% . On call (physician) notified with order to send to ER. (emergency room) . At 1920 (7:20 p.m.) when MEMS (Metropolitan Emergency Medical Services) showed up . Resident saturation at 59% on 3 LPM . c. On 6/30/2020 at 9:30 a.m., the resident was not receiving oxygen, and the oxygen tubing and nasal cannula were lying in the seat of the resident's wheelchair which was next to the resident's bed. d. On 6/30/2020 at 2:22 p.m., the resident's oxygen tubing and nasal cannula were lying on the floor next to the head of the resident's bed. e. On 7/1/2020 at 8:22 a.m., the resident's oxygen tubing and nasal canula were draped over the oxygen concentrator tank and was not in a storage bag or container. f. On 7/1/2020 at 4:05 p.m., the Director of Nursing was asked if Resident #85 had been diagnosed with [REDACTED]. She stated, Yes, that's right. She was informed there had been three observations of his oxygen nasal canula / tubing being on the floor, draped over the oxygen concentrator, and lying in the seat of his wheelchair and not in a storage bag or other container. She stated, That shouldn't happen. I'll start this afternoon in-servicing my staff about this. 6. The facility policy titled Oxygen Management provided by the Administrator on 7/2/2020 at 8:38 a.m. documented, .It is the policy of this facility . Oxygen tubing must be kept off the floor . Humidifier (if applicable) and nasal cannula shall be changed every week and when needed . Procedure / Protocol . 6. Oxygen materials are to be changed weekly and PRN (as needed) .

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.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045357	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOMERSET SENIOR LIVING AT PREMIER	**3600 RICHARDS ROAD NORTH LITTLE ROCK, AR 72117**

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 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) Based on interview and observation, the facility failed to ensure the ice scoop containers were cleaned and sanitized and dishes and food preparation utensils were dried properly to prevent potential contamination. These failed practices had the potential to affect 103 residents (Total census:110) who resided in the facility, according to the Resident Census List provided by the Administrator on 6/29/2020. The findings are: 1. On 6/29/2020 at 10:34 a.m., wet serving pitchers were improperly stacked on a flat surface. Dietary Employee #1 was asked if they saw anything wrong with how the serving pitchers were stored. The Dietary Manager attempted to fix it. The Dietary Manager was informed the wet dishes were unable to properly air dry if they are placed on a flat surface. a. On 6/29/2020 at 10:42 a.m., the Dietary Manager stated the facility had 3 ice machines. The ice scoop compartment contained debris. The Dietary Manager was asked what the substance could be. The Dietary Manager stated, I'm not sure. b. On 6/29/2020 at 10:51 a.m., the freezer part of the refrigerator on the 200 Hall needed to be defrosted and cleaned and had a buildup of ice and a spilled substance. The ice scoop compartment on the 200 Hall contained a dark colored substance on the inside. The Dietary Manager and the Assistant Director of Nursing (ADON) were made aware of this. The microwave on the 200 Hall contained a splattered substance. The ADON was asked if the microwave was used for residents or staff. The ADON confirmed the microwave was used to reheat the meals for the residents. c. On 6/29/2020 at 10:53 a.m., a microwave was sitting directly on the floor on the 500 Hall. Employee #2 stated the microwave broke over the weekend. The paper towels at the sink were not placed in a dispenser. The ice scoop compartment on the 500 Hall contained a black substance. A dark colored substance was located at the bottom of the ice scoop compartment. The Dietary Manager was asked for a white napkin to wipe the substance in the ice scoop compartment. The surveyor wiped it and the black substance was on the white napkin when removed. The white napkin with the black substance was shown to Employee #2. d. On 6/29/2020 at 11:49 a.m., there were wet serving containers piled on top of each other on the shelf in the kitchen. Employee #1 was asked if that was the proper way to store the containers. Employee #1 stated, No. Employee #1 began to take the serving containers down. e. On 6/30/2020 at 10:20 a.m., wet cups were stacked on top of each other with a flat surfaced serving tray dividing every two columns. The surveyor reminded the Dietary staff of why this could be an issue and asked if they had a drying rack. Dietary Employee #2 stated, We do not have enough space to properly dry all the dishes.