

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 045189	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2020
NAME OF PROVIDER OF SUPPLIER SOMERSET SENIOR LIVING AT PINE HILLS		STREET ADDRESS, CITY, STATE, ZIP 900 MAGNOLIA RD CAMDEN, AR 71701	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
<p>F 0677</p> <p>Level of harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Complaint # (AR 238) was substantiated, all or in part, with the following findings: Based on record review and interviews, the facility failed to ensure baths/showers were given on a regular basis to promote cleanliness/body hygiene and self-esteem for 1 (Resident #1) of 3 (Resident #s 1, 2, and 3) sampled residents. This failed practice had the potential to affect 55 residents who resided in the facility based on the Census by room count provided by the Administrator on [DATE]. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. An admission Minimum Data Set with an Assessment Reference Date of 2/10/20 documented the resident scored 0 (0-7 indicates severely impaired) on a Brief Interview for Mental Status and required extensive assistance with toileting, personal hygiene, and bathing. a. The resident's Care plan revised on 9/30/19 documented, .Bathing/Showering: I am extensive to totally dependent on (1-2) staff to provide bathing as stated per schedule (on evenings). Daily bed bath as well. Provide peri (perineal) care after each inc. (incontinent) episode. Res (resident) will refuse bath/showers . Provide sponge bath when a full bath or shower cannot be tolerated . b. On [DATE] at 4:29 PM, reviewed the January-March 2020 Bathing documentation provided by the Administrator. In January it was documented the resident refused a bath on the 9th, there was no entry documented for 1/18/20 and the resident was out to the hospital from 1/28/20-2/3/20. The February 2020 bathing schedule bath documented, not applicable on 2/15/20; the resident 'refused' bath on 2/18/20 and [DATE] and there were no documented entries for 2/20/20 and 2/29/20. The March 2020 bathing schedule had no documented entries on 3/5/20, 3/28/20 and 3/31/20; the dates 3/7/20, 3/21/20, and 3/24/20 were marked not applicable. The resident had been in the hospital from [DATE] through 3/21/20. After readmission to the facility and a 14-day quarantine, the bathing schedule documented the resident had one bed bath on 3/26/20 and no other documented baths or showers. c. On [DATE] at 11:39 AM, an interview with a non-case mix resident was conducted. She was asked if she got routine baths, and she stated, No, maybe once a month. I think it should be at least once a week. d. On [DATE] at 11:59 AM, an interview was conducted with another non-case mix resident. She was asked about her bath schedule. She replied, I'm supposed to get a bath on Tuesdays, Thursdays, and Saturdays. It's Saturday where the problem is. Every Saturday I don't (get a bath). e. On 3/31/20 at 11:40 AM, an interview was conducted with the resident's daughter. She was asked if she knew what days the resident was scheduled to have a bath, and she stated, I don't think there was a bath schedule. I asked the aides and nurses and they said she had not (had a bath) and they didn't know why but they were going to get to it. f. On 4/8/20 at 11:21 AM, a policy on Activities of Daily Living (ADL) care was provided by the Administrator. It documented, .The facility strives to promote a healthy environment by meeting the personal care needs of the residents . Personal care and support include but is not limited to the following .Bath/shower .</p>		
<p>F 0755</p> <p>Level of harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on record reviews and interviews, the facility failed to ensure antibiotic cream and oral antibiotics were administered daily as order to promote the effectiveness of the medication/ healing for 1 (Resident #1) of 1 sampled resident who received a prescribed cream and antibiotic. This failed practice had the potential to affect 2 residents who received antibiotic therapy for skin infections per a list provided by the Administrator on 4/7/20 at 4:10 PM. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. An admission Minimum Data Set with an Assessment Reference Date of 2/10/20 documented the resident scored 0 (0-7 indicates severely impaired) on a Brief Interview for Mental Status and required extensive assistance with toileting, personal hygiene, and bathing. a. A physician's orders [REDACTED].[MEDICATION NAME] 2% (Mupirocin Calcium) apply to [DEVICE] site topically three times a day for infection to [DEVICE] site for 10 days start 2/26 . b. The February 2020 Treatment Administration Record (TAR) was reviewed and documented the [MEDICATION NAME] was administered at 9:00 a.m., 1:00 p.m., and 5:00 p.m., per nurses' initials. On [DATE], there were no nurses' initials at 1:00 p.m. On [DATE] there was no nurse's initials at 5:00 p.m. On 2/28/20 there was no nurse's initials at 5:00 p.m., and on 2/29/20 there were no nurse's initial for the 1:00 p.m. and the 5:00 p.m. dose. This was a total of 5 doses missed over a 4-day period. c. On the February 2020 Medication Administration Record (MAR) documented, [MEDICATION NAME] tablet 100 mg (milligrams) Give 1 tablet via [DEVICE] every 12 hours for infection to [DEVICE] site for 7 days until finished Start 2/25/20 1800 (6 PM). The medication was started on 2/25/20 at 6:00 PM per nurses' initials documented on the MAR. The MAR documented initials on [DATE] for the 6:00 am and the 6:00 pm doses. On [DATE], only the 6:00 am dose was initiated. On 2/28/20, both 6:00 am and 6:00 p.m., doses were initiated and on 2/29/20 only the 6:00 am dose was initiated. d. On 4/7/20 at 12:38 PM, an interview was conducted with the Director of Nursing. She was asked if there are skips on the MARs or TARs would you say that it was given or administered, and she replied, That's a difficult question. I don't assume something. She was then asked, Would you say if it was not charted it was not done? She replied, Yes, I would have to say that. e. On 4/8/20 at 11:21 AM, a document entitled, Clinical Management Policy Medication Administration provided by the Administrator documented, .16. Document the following as applicable . Administration of medication on MAR as soon as medications are given .</p>		
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.