STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045139	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOMERSET SENIOR LIVING AT MCGEHEE	700 MARK DRIVE MCGEHEE, AR 71654

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 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, record review, and interview, the facility failed to ensure residents who were on COVID-19 quarantine and residing on the Secured Unit were instructed to wear a face mask when they exited their room for 4 (Residents #1, #2, #3, and #4) of 5 (Residents #1, #2, #3, #4, and #5) case mix residents. This failed practice had the potential to affect 11 residents who resided on the West Hall, Secured Unit, and 14 residents who dined in the Main Dining Room during the evening meal on 7/28/2020, according to the lists provided by the Administrator on 7/30/2020. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/15/2020 documented the resident scored 11 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status (BIMS). a. The COVID-19 Care Plan with a revised date of 7/10/2020 and signed by Licensed Practical Nurse (LPN) #2 documented, 6/25/2020 .Returned from Psych (Psychiatric) facility. Quarantine (times) 14 days . Resolved 7/10/2020 . The Care Plan contained no further documentation which indicated the interventions / approaches or precautions that should be planned for quarantine of the resident. b. A Readmission Assessment form dated 7/15/2020 at 5:40 p.m. documented, .Admission Details . 1 aa. readmitted to Facility On . 07/15/2020 . 1. Re-Admit to . a. Long Term Care . 2. readmitted from . a. Hospital . 2. a. readmitted From . (Behavioral unit) . 2. Resident #3 had [DIAGNOSES REDACTED]. The Admission Minimum Data Set with an ARD of 4/23/2020 documented the resident scored 15 (13-15 indicates cognitively intact) on a Brief Interview for Mental Status. a. The COVID-19 Care Plan with a revised date of 6/12/2020 and signed by LPN #2 documented, .Date Initiated . 3/13/2020 (Resident #3) is at risk for exposure and contracting [MEDICAL CONDITION] . 6/12/2020 cont (continue) POC (Plan of Care) . 3. On 7/28/2020 at 3:57 p.m., Resident #1 was in a room with a sign posted on the door that stated, .Quarantine . At 3:59 p.m., Resident #3, who was in the next room called out the resident's name. Resident #1 ambulated out of the room without a face mask on, walked down the hallway, and entered Resident #3's room. Certified Nursing Assistant (CNA) #1 was standing in the hallway by the kiosk and looked in the direction of Resident #1 when the quarantine room was exited, and watched the resident enter another resident's room. Resident #3 was seated in a geri-chair that faced the doorway and Resident #1 walked over to the geri-chair. Resident #1 was instructed by Resident #3 to take the flyswatter and kill the fly. Resident #1 picked up the flyswatter, hit at a fly, laid the flyswatter down across Resident #3's lower legs, and exited the room at 4:00 p.m. The resident ambulated back in the hallway and into the quarantine room. CNA #1 remained at the wall kiosk, looked in the direction of the resident, and did not intervene or direct the resident to wear a face mask when out of the room, or to remain in the quarantine room. a. On 7/30/2020 at 11:34 a.m., Licensed Practical Nurse (LPN #2) was asked if she was responsible for the Care Plans regarding COVID-19. LPN #2 stated, Yes. LPN #2 was asked what were the precautions for residents who are quarantined. LPN #2 stated, That they stay in their room, and if they do not, they should wear a mask when they go out. LPN #2 was asked if the resident was on quarantine on 7/28/2020. LPN #2 stated, He had a readmission assessment on 7/15/2020. I put 6/25/20 and that's when he went out. It should have been when he returned. LPN #2 was asked if the resident's Care Plan should have precautions that included wearing a mask when out of the quarantine room. LPN #2 stated, Yes. 4. Resident #2 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an ARD of 7/19/2020 documented the resident scored 14 (13-15 indicates cognitively intact) on a BIMS and had no isolation or quarantine. a. The Care Plan dated 7/19/2020 and signed by LPN #2 documented, .Out to hospital ER (emergency room) . Quarantine for 14 days . The Care Plan contained no documentation that indicated what precautions the resident should have taken for quarantine, such as face mask to be worn. b. On 7/28/2020 at 3:55 p.m., a sign posted on the closed door of the resident's room documented, .Quarantine . 5. Resident #4 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an ARD of 6/12/2020 documented the resident scored 9 (8-12 indicates moderately impaired) on a Brief Interview for Mental Status. a. The COVID-19 Care Plan dated 3/13/2020 and signed by LPN #2 documented, . (Resident #4) is at risk for exposure and contracting [MEDICAL CONDITION] . b. On 7/28/2020 at 5:09 p.m., the resident was in a wheelchair at the soda / snack vending machines located in the Main Dining Room where residents were being served the evening meal. Resident #2 stood next to the resident with LPN #1 also standing next to the residents. Resident #2 was out of the quarantine room without a face mask on. The resident propelled the wheelchair down the hallway to the West Hall, Secured Unit, with Resident #2 walking right behind the resident's wheelchair, with a distance of approximately 1-foot between the residents. LPN #1 accompanied the residents back to the Secured Unit, unlocked the door keypad, and held the door while the resident ambulated back into the Secured Unit. The resident continued to propel the wheelchair with Resident #2 walking closely behind the wheelchair until Resident #2 entered the quarantine room. Resident #4 proceeded into his room. Resident #2 had not worn a face mask while in close contact with Resident #4. c. On 7/28/2020 at 5:25 p.m., LPN #1 was asked who the residents were in the Main Dining Room at the vending machines. LPN #1 stated, (Resident #2) and (Resident #4). LPN #1 was asked why the resident from quarantine (Resident #2) had not worn a face mask. LPN #1 stated, Yeah, he forgot his mask and I didn't think about it until we got halfway down there. LPN #1 was asked if (Resident #2) should have worn a face mask when out of the quarantine room. LPN #1 stated, Just when out of the room. LPN #1 was asked if she was supposed to remind, direct, or assist the resident with a face mask. LPN #1 stated, I just forgot. LPN #1 was asked what the precautions were for quarantined residents. LPN #1 stated, I know they are supposed to stay in their room and wear a mask if they come out. LPN #1 was asked if she should have reminded the resident to put a face mask on. LPN #1 stated, Yes. 6. On 7/28/20 at 6:22 p.m., Registered Nurse (RN) #1 was asked, What are the procedure for residents who are on quarantine for COVID-19? RN #1 stated, Stay in their room, wear a mask. RN #1 was asked, If the quarantined resident came out of the room, should a mask be worn? RN #1 stated, If they have to leave their room, they should have a mask on. RN #1 was asked if a quarantined resident would be allowed to come out of their room without a mask and go into the Main Dining Room where other residents are gathered. RN #1 stated, No. RN #1 was asked, When residents are in the Main Dining Room for meal service, should there be an un-masked quarantined resident present? RN #1 stated, No. RN #1 was asked if staff had been in-serviced on infection control procedures for quarantine. RN #1 stated, I did. RN #1 was asked, If a resident on quarantine comes out of the room without a mask, should staff remind, redirect, or assist the resident to put a mask on? RN #1 stated, Right.

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