

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>045142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>08/21/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>SOMERSET SENIOR LIVING AT CANYON SPRINGS</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1401 PARK AVENUE HOT SPRINGS, AR 71901</b>	
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 0558  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Reasonably accommodate the needs and preferences of each resident.</b>  <b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b>  Based on observation, record review and interview the facility failed to ensure call lights were in reach for 2 (Residents #3 and #1) sampled residents who were dependent on staff for Activities of Daily Living (ADLs). This failed practice had the potential to affect 45 residents who were dependent on staff for ADLs as documented on a list provided by the Administrator on 8/21/2020 at 12:49 p.m. The findings are: 1. Resident (R) #3 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/2/2020 documented the resident scored 3 (0-7 indicates severe impairment) on a Brief Interview for Mental Status, required extensive assistance of two, for bed mobility and transfers and had limited range of motion impairment on both sides of the lower extremities, with no documented falls. a. The care plan dated 8/15/2020 documented, I am at risk for falls. Encourage me to use call light or ask for assistance as needed. b. On 8/19/2020 at 1:11 PM, R #3 was lying in bed with eyes closed with the call light on the recliner, approximately 2.5 feet out of reach of the resident. (Photo was taken). c. On 8/20/2020 at 9:23 AM, R #3 was in a low bed with a fall mat on one side. The call light was on the floor, approximately 2 feet out of reach of the resident. (Photo was taken) d. On 8/20/2020 at 3:08 PM, the Administrator was asked if call lights should be within reach in case the residents needed something? She stated, Yes.</p> <p>2. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly MDS with an ARD of 5/17/2020 documented the resident scored 1 (0-7 indicates severe impairment) on the Brief Interview for Mental Status (BIMS). The resident was a one-person physical assist with bed mobility, transfers, dressing, eating and toilet use. a. On 8/20/2020 at 9:42 AM, R #1 was lying in bed with eyes closed and call light draped over a mini refrigerator, approximately 3 feet out of reach of the resident. Photo taken. b. On 8/20/2020 at 10:00 AM, record review of the Care Plan with an initiated date of 4/4/18 documented, I am at risk for falls r/t (related to) impaired mobility and poor safety awareness. Encourage the resident to use call light or ask for assistance as needed. c. On 8/20/2020 at 9:45 AM, Certified Nursing Assistant (CNA) # 3 was asked, Can R #1 use her call light? She stated, She can. 3. On 8/21/2020 at 11:12 AM, the Administrator provided the policy and procedure for call lights which documented, The purpose of the policy is to assure the facility is adequately equipped with a call light at each residents bedside, toilet and bathing to allow residents to call for assistance.</p>		
F 0880  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Some	<p><b>Provide and implement an infection prevention and control program.</b>  Based on observation, and record review, the facility failed to ensure face masks were worn to cover the mouth and nose to prevent potential transmission of COVID-19 and other communicable disease in 1 of 1 facility. This failed practice had the potential to affect 53 residents who resided in the facility according to the Midnight Census Report provided by the Administrator on 8/19/20 at 12:59 p.m. The findings are: 1. On 8/19/20 at 2:21 p.m., on the C Hall, by room C 8, Certified Nursing Assistant (CNA) #1 had a face mask on that only covered her mouth. 2. On 8/19/2020 at 2:34 p.m., at the A hall Nurses Station, CNA #2 was sitting in a chair at the nurses' station with a face mask that covered her mouth only. 3. On 8/21/20 at 9:27 a.m., record review of the titled, Mask-Surgical, Cloth, N 95 documented, The facility will strive to ensure PPE, (personal protective equipment) mask is worn appropriately. 3. HCP (health care personnel) should wear masks to the extent possible while in the facility. Anytime social distancing cannot be practiced a mask should be worn.</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.