STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045098	A. BUILDING ____ B. WING ____	C 08/11/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY HEALTHCARE - GOLF LINKS	552 GOLF LINKS ROAD HOT SPRINGS, AR 71901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #11848 was unsubstantiated.	F 000		
F 226 SS=C	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure their policy for staff screening was followed for 5 of 5 personnel records reviewed. This failed practice had the potential to affect 80 residents, according to the entrance conference on 8/10/06 at 8:00 a.m. The findings are: 1. The facility's Reporting Alleged Violations policy documented the following under "staff screening": "All applicants for employment in the facility shall, at a minimum, have the following screening checks conducted: Reference checks with the current and/or past employer, appropriate licensing board or registry check, drug testing per facility policy, fingerprinting as required by state law and criminal background check pursuant to facility policy or state law. a. On 8/11/06 at 9:00 a.m., the following information was not included in the specified employee file. 1) Nurse Assistant (NA) #5 was hired 6/20/06; the NA's personnel file did not include reference	F 226		

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.

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F 226	Continued From page 1 check(s) or registry check. 2) NA #2 was hired 6/20/06; the NA's personnel file did not include reference check(s) or registry check. 3) NA #6 was hired 6/20/06; the NA's personnel file did not include a criminal record check, reference check(s) or registry check. 4) NA #4 was hired 6/22/06; the NA's personnel file did not include reference check(s) or registry check. 5) Certified Nurse Assistant (CNA) #7 was hired 6/28/06; the CNA's personnel file did not include reference check(s), registry check or validation of current certification. b. On 8/11/06 at 9:30 a.m., the Administrator stated that the "information is not available."	F 226		
F 324 SS=G	483.25(h)(2) ACCIDENTS The facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff had keys available to lock the shower room on the Alzheimer's Unit and that a cognitively impaired, wandering resident with an unsteady gait was monitored. This failed practice resulted in past noncompliance at harm level for Resident #5 who experienced an unwitnessed fall causing	F 324	Past noncompliance: no plan of correction required.	

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F 324	Continued From page 2	F 324		

fractures and a scalp laceration and had the potential to affect 28 residents residing in the Alzheimer's Unit, according to the facility's Nurse's Midnight Census Worksheet printed 8/10/06 at 8:11 a.m. The findings are:

1. Resident #5 had diagnoses of Alzheimer's Disease, Arrhythmias and Glaucoma. A Minimum Data Set dated 6/22/06 documented the resident was moderately impaired in cognitive skills for daily decision-making, had behavioral symptoms of wandering, required one person physical assist for transfer, was independent in mobility, was unsteady but able to rebalance self without physical support while standing and had no functional limitations in range of motion. The Plan of Care updated 3/6/06 documented, a problem of "risk for fall r/t (related to) unsteady gait" with interventions which included "monitor resident for increased unsteadiness during ambulation." The Plan of care also documented a problem of "risk of injury due to impaired visual functioning due to glaucoma" with interventions which included "staff to assure environment is free of wet spots and small items placed low on floor." There was no Plan of Care available for surveyor's review on 8/11/06 at 10:00 related to his assessed "wandering."

a. On 8/6/06 at 1:30 p.m., the Nurses's Notes documented "summoned to shower room per CNA (Certified Nurse Assistant) and observed resident on floor cursing and squirming and attempting to get up. Observed small area of blood on the floor and resident assessed to have one inch open area on back of head. No other complaints voiced or observed. RN (Registered Nurse) notified and stayed with resident while this nursed called [Name] APN (Advanced Practice

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F 324	Continued From page 3	F 324		

Nurse) and orders given to send to [Hospital] ER (Emergency Room) for eval (evaluation). 911 called and ambulance summoned. B/P (blood pressure) 72/27, P (pulse) 65. Resident continued to curse loudly. Ambulance here and transported resident per 2 attendants via stretcher at 1:50 p.m. [Name] POA (Power of Attorney) notified and ADON (Assistant Director of Nursing) here and aware."

b. On 8/6/06 at no time noted, CNA #1 documented "I was walking down the hall. I heard someone shout out, 'help'. I said who is that. I kept walking toward the shower room and notice [Resident #5] on the floor. His head was in between the shower chair. I ran and got the nurse. Vital signs was gotten."

c. On 8/10/06 at 11:30 a.m., (Nurse Assistant) NA #2 stated "I don't know how he got in the shower room. We were working on the Alzheimer's Unit with [CNA #1]. We shower all residents. They are never by themselves. The shower is kept locked. Each person, staff member, has a key to the shower. The unit is locked. The shower is locked. We keep track of him, he was [NA #4's] patient. [CNA #1] found the resident. [LPN #1] was on the unit and I ran and got her. The resident was in the shower room fully dressed, on his back. Blood was coming from the back of his head. Everything else was ok. With two CNA's support, he could stand. I did not unlock the room for him. At the time of the incident, we shared keys. I don't know how he got in there."

d. On 8/10/06 at 11:56 a.m., NA #4 stated "the resident was mine. It was during dinner time. I didn't have a key to the shower. He had finished eating and left the dining room. I was still feeding

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residents. I heard that he had fallen. The RN took care of him after that."

e. On 8/10/06 at 12:00 noon, CNA #1 stated "Me and [NA #2] were sharing the key to the shower. One of us had to leave it open. Yeah, I left it open that day. We both were guilty of leaving it open because we had just moved our patients to B and C (halls) and we didn't have keys and had to borrow from [CNA on another hall] who was working elsewhere.

f. On 8/10/06 at 2:20 p.m., LPN #1 stated "I was at the Nursing Station [on 8/6/06 at the time of the incident]. The CNA hollered. I went swiftly down the hall to the shower room. [Resident #5] was on the floor of the shower room. He has gotten very combative. He will hit you. There was a little spot of blood on the floor. He was kicking and yelling. Finally we got to look at the back of his head. I sent a CNA to get the RN to assess him further. I left when she arrived. I called the APN and got orders to send to the ER. He was fully dressed. I guess he walked in the shower room. The shower was supposed to be locked. I never asked the CNA's if the door was locked. I did not have a key to the shower room. There used to be one on the ring but it wasn't."

g. On 8/10/06 at 4:06 p.m., CNA #3 stated "We try to keep the shower locked."

h. The Advanced Practice Nurse's orders dated 8/6/06 documented, "Send to [Hospital] ER (Emergency Room) for eval (evaluation) head injury."

i. The Emergency Room Record, dated 8/6/06 at 3:47 p.m., documented the chief complaint as,

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F 324	Continued From page 5 "This is an 87-year-old male who presents from nursing home for fall with laceration to his scalp. The patient complains of some left lower abdominal discomfort and sometimes right lower quadrant discomfort. He does not speak completely clearly. It is difficult to get a review of systems." The impression was documented as "1. Left hip fracture, acetabular fracture. Possible surgical neck fracture. 2. Dementia 3. Left scalp laceration." j. The Radiology Report dated 8/6/06 documented, "An AP (anterior posterior) view of the pelvis with crosstable lateral views of the left hip were obtained demonstrating what appears to be an acetabular fracture of the pelvis. The fracture line appears to extend through the innominate bone to the ilium. Deformity of the pelvis is seen. I believe there is also fracture of the inferior pubic ramus. The superior pubic ramus is difficult to visualize. Considering the degree of fracture, I suspect that it is also fractured." The impression documented "fracture of the pelvis, acetabulum and pubic rami. The fracture line appears to extend into the left ilium." k. Twenty-seven (27) Nursing staff employees [including CNA #1, CNA #3, NA #2 and NA #4 who were present at the time of the 8/6/06 incident] were inserviced on 8/7/06 relative to the requirement for the shower doors throughout the facility to be maintained in a locked manner when not in use. l. On 8/10/06 at 11:48 a.m., the door to the shower room on the Alzheimer's Unit was observed to be locked. m. On 8/10/06 at 1:00 p.m., the Director of	F 324		

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F 324	Continued From page 6 Nursing provided documentation of random multiple time monitoring of the shower doors on all halls on 8/7/06, 8/8/06, 8/9/06 and 8/10/06. n. On 8/10/06 at 2:51 p.m., the door to the shower room on the Alzheimer's Unit was observed to be locked. o. On 8/11/06 at 8:00 a.m., the door to the shower room on the Alzheimer's Unit was observed to be locked. p. On 8/10/06 on initial rounds, at 9:52 a.m., 1:30 p.m. and 3:30 p.m. and on 8/11/06 at 6:45 a.m., 8:20 a.m. and 11:00 a.m., the staff in the Alzheimer's Unit were observed monitoring the residents.	F 324		