

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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	F 000		
F 164 SS=E	<p>Complaint #13921 was unsubstantiated.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure privacy was provided during incontinent care for 3 (Resident #1, #2,</p>	F 164		
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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 164	<p>Continued From page 1</p> <p>and #5) and during a treatment for 1 (Resident#2) of 20 (Resident #1 through #20) case mix residents who were dependent on staff for incontinent care and treatments. This failed practice had the potential to affect all 98 residents. The findings are:</p> <p>1. Resident #5 had diagnoses of Osteoporosis and Hypertension. The Quarterly Minimum Data Set (MDS) dated 7/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with ADL's (activities of daily living), was frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>On 9/23/08 at 5:05 p.m., Certified Nursing Assistant (CNA) #4 entered the resident's room, applied gloves, pulled the resident's pants down past the knees and removed the soiled incontinent brief. She then removed her gloves and left the room. The privacy curtain was not pulled and the resident's peri area was exposed when the CNA opened the door, left the room then returned to finish incontinent care.</p> <p>2. Resident #4 had diagnoses of Paraplegia, Traumatic Head Injury and Pressure Ulcers. The Significant Change MDS dated 7/25/08 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on the staff for all ADL's.</p> <p>On 9/22/08 at 3:20 p.m., this surveyor knocked on the door, announced surveyor and opened the door. CNA #7 and Registered Nurse (RN) #2 were doing a treatment. The privacy curtain was not pulled and the resident's back and buttocks</p>	F 164		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 164	<p>Continued From page 2</p> <p>were exposed when the door was opened. The resident's roommate was in his bed and the privacy curtain between the residents was not closed.</p> <p>3. Resident #1 had diagnoses of Alzheimer's, Cerebral Vascular Accident and Left Hip Fracture. The MDS dated 9/24/08 documented the resident was severely impaired in cognitive skills for daily decision making, dependent on staff for toileting and personal hygiene and incontinent of bowel and bladder.</p> <p>On 9/22/08 at 5:15 p.m., CNA #4 was dressing the resident for the evening meal and changing the incontinent brief. The privacy curtain was not closed. Licensed Practical Nurse #3 opened the door, the resident was exposed from the waist to the knees.</p> <p>4. Resident #2 had diagnoses of Joint Contractures, Muscle Spasms and Chronic Ulcers of the Lower Extremities. The MDS dated 7/2/08 documented the resident was independent in cognitive skills for daily decision making, required extensive assistance with ADL's and was incontinent of bowels.</p> <p>On 9/24/08 at 10:05 a.m., CNA #8 and CNA #9 performed incontinent care on the resident. The privacy curtain was not pulled and the resident was visible from the doorway. The Director of Nurses opened the door, the resident's entire body was exposed, then LPN #1 opened the door and entered the room, the resident's entire nude body was exposed, CNA #8 left the room with the resident's body exposed. The LPN then closed the privacy curtain prior to doing treatments.</p>	F 164			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 241 SS=E	<p>483.15(a) DIGNITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure clothing was worn as designed to cover the abdomen and buttocks area for 1 (Resident #16) and covering was provided during incontinent care for 2 (Resident #1 and #5) of 19 (Resident #1 through 18 and 20) case mix residents who required assistance with dressing and incontinent care. These failed practices had the potential to affect 90 residents who required assistance with dressing and personal hygiene as documented by the Resident Census and Conditions of Residents form dated 9/22/08. The findings are:</p> <p>1. Resident #16 had diagnoses of Dementia with Psychosis and Alzheimers Disease. The Quarterly Minimum Set (MDS) dated 7/15/08 documented the resident was severely impaired in cognitive skills for daily decision-making, and required extensive assistance of two persons for dressing.</p> <p>a. The Plan of Care dated 2/5/08 documented, "Problem; Activities of Daily Living (ADL) Resident is totally dependent for ADLs. Intervention; Dress resident in appropriate clothing. Preserve dignity as much as possible while assisting with ADLs."</p> <p>b. On 9/24/08 at 12:50 p.m., the resident was in</p>	F 241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 241	<p>Continued From page 4</p> <p>the dining room at the dinner table. The resident was sitting in a geri-chair asleep waiting for lunch. The resident had on a rust-colored sweat shirt which was mid way up his stomach exposing his abdomen. The resident had on grey sweat pants which were down around his buttocks. Approximately 1/3 of the resident's incontinent brief was exposed.</p> <p>c. On 9/24/08 at 4:40 p.m., the resident was in the dining room waiting for dinner. The resident was in a geri chair. The resident's rust-colored sweat shirt was mid way up the abdomen exposing the resident's abdomen. The resident's gray sweat pants were down to the groin area.</p> <p>2. Resident #1 had diagnoses of Alzheimer's, Cerebral Vascular Accident and Left Hip Fracture. The MDS dated 9/24/08 documented the resident was severely impaired in cognitive skills for daily decision making, dependent on staff for toileting and personal hygiene and incontinent of bowel and bladder.</p> <p>On 9/22/08 at 5:15 p.m., CNA (Certified Nursing Assistant) #4 left the resident lying in the bed with her pants pulled up to the knees, with no covering over the resident. The CNA left the room and returned with a clean incontinent brief to place on the resident.</p> <p>3. Resident #5 had diagnoses of Osteoporosis and Hypertension. The Quarterly MDS dated 7/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with ADL's, was frequently incontinent of bladder and occasionally incontinent of bowel.</p>	F 241			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 241	Continued From page 5 On 9/23/08 at 5:05 p.m., CNA #4 entered the resident's room, applied gloves, pulled the resident's pants down past the knees and removed the soiled incontinent brief. The CNA then removed her gloves and left the room. The resident was left with her pants down and not covered when the CNA left the room. The CNA returned in a few seconds and completed incontinent care.	F 241			
F 282 SS=E	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility to ensure thickened liquids were served for 2 (Resident #1 and #4) of 4 case mix residents (Resident #1, 4, 17, and 18) who received thickened liquids. The facility failed to ensure a treatment order was followed for 1 (Resident 4) of 4 (Resident #2, #4, #5 and #8) case mix residents who had received treatment for wounds. These failed practices had the potential to affect 13 residents who received thickened liquids as documented on a list provided by the Administrator on 9/24/08 and 10 residents who had pressure ulcers according to the Resident Census and Conditions of Residents form dated 9/22/08. The findings are: 1. Resident #1 had diagnoses of Alzheimer's Disease, Symbolic Dysfunction and Dementia with Lewy Bodies. The Significant Change	F 282			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 282	<p>Continued From page 6</p> <p>Minimum Data Set (MDS) dated 9/22/08 documented the resident was severely impaired in cognitive skills for daily decision making, required one person assist for eating, and had swallowing and chewing problems.</p> <p>a. A physician order dated 9/5/08 documented puree diet and nectar thickened liquids every shift.</p> <p>b. The Nursing/Dietary Communication Form dated 9/5/08 documented under Special Comments: "Feeder/Aspiration Precautions."</p> <p>c. On 9/22/08 at 5:45 p.m., the resident was served a bowl of thickened tomato soup, pureed chef salad, ensure pudding and a carton of sherbet. The resident should not have received sherbet.</p> <p>d. On 9/23/08 at 12:08 p.m., the resident was served mashed potatoes, a roll, 8 oz glass of thickened cranberry juice, 8 oz glass of thickened water and 4 oz carton of sherbet. The resident should not have received sherbet.</p> <p>2. Resident #4 had diagnoses of Esophageal Reflux and Hypertension. The Significant Change MDS dated 6/24/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required one person assist for eating, had swallowing problem and a history of weight loss.</p> <p>a. A physician order dated 7/9/08 documented regular puree diet. Another physician order dated 7/24/08 documented Nectar Thickened Liquids per speech Therapy every shift.</p>	F 282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 282	<p>Continued From page 7</p> <p>b. On 9/23/08 at 12:50 p.m., the resident was served pureed meat, mashed potatoes, pureed broccoli and a carton of sherbet. The resident should not have received sherbet.</p> <p>c. On 9/23/08 at 5:45 p.m., the resident was served an 8 oz glass of regular tea and a carton of ice cream. The resident should have received thickened tea and no ice cream.</p> <p>3. Resident #4 had diagnoses of Paraplegia, Traumatic Head Injury and Pressure Ulcers. The Significant Change MDS dated 7/25/08 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on the staff for all ADL's (activities of daily living).</p> <p>a. A physician order dated 9/16/08 documented, "Dakins Solution 0.025% Solution. Cleanse with Normal Saline, apply Dakins wet to dry to Left (L) great trochanter and cover with dry dressing."</p> <p>b. On 9/22/08 at 3:20 p.m., Registered Nurse (RN) #2 was doing the treatment to the trochanter. She applied a green ointment to the outer edges of the wound and placed Dakins Solution wet to dry dressing over the wound and covered with a mepore tape. RN #2 was asked what the green ointment was that she had applied on the resident. She stated that it was Panafil.</p> <p>c. The Treatment Administration Record (TAR) dated 9/16/08 to 9/30/08 documented asterisks in all the dates across the form for the Panafil.</p> <p>d. On 9/25/08 at 9:25 a.m., Licensed Practical Nurse (LPN) #1 was asked what the asterisks meant and she stated that it meant the treatment</p>	F 282			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 282	Continued From page 8 was discontinued.	F 282			
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure hair care was provided for 1 (Resident #19) of 20 (Resident #1 through #20) who were dependent on staff for personal hygiene. The facility failed to ensure staff completely cleaned all areas during incontinent care for 1 (Resident #12) and that incontinent care was provided for 1 (Resident #15) of 7 (Resident #1, #5, #6, #8, #9, #10 and #15) case mix residents who were dependent on staff for incontinent care. These failed practices had the potential to affect 78 residents who were incontinent according to the list provided by the Administrator on 9/24/08 and 60 residents who required assistance with grooming according to the Administrator on 9/25/08. The findings are: 1. Resident #19 had diagnoses of Organic Psychotic Condition, Dementia & Alzheimer's Disease. The Medicare 14 day MDS dated 9/5/08 documented the resident required supervision for bathing. a. The Care Plan updated on 9/5/08 documented, "...Resident needs assistance with ADL's (Activity of Daily Living)... Assist with hygiene as needed... needs extensive assist with bathing..."	F 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 312	Continued From page 9 b. On 9/23/08 at 12:10 p.m., 9/24/08 at 1:30 p.m. and at 9/25/08 at 8:43 a.m., the resident's hair was not combed. c. On 9/25/08 at 9:40 a.m., this surveyor went with the DON (Director of Nurses) to look at the resident's hair. The surveyor asked why the resident's hair was unkept she stated that the resident sometimes argues with the girls and doesn't want her hair washed. The DON then asked the resident if "the girls" could wash her hair. At first the resident refused. The DON then spoke with the resident for a few more minutes and the resident agreed to have her hair washed. d. On 9/25/08 at 10:05 a.m., the DON told the surveyor the resident was allowing the girls to wash her hair. She stated she asked the aides why they had not washed the resident's hair. She stated the CNA's told her the resident sometimes refuses baths and showers. She stated she asked the CNA's had they told the nurse the resident was refusing bathing, etc. She stated the CNA's stated they had not told the nurse. When the DON looked at the resident's hair and was asked by this surveyor if the resident's hair was unkept and needed attention she stated, "Yes, her hair needs to be trimmed." e. The facility Policy & Procedure provided by the Administrator on 9/25/08 at 12:40 p.m. documented, "...Basic Responsibility of the Licensed Nurse and Nursing Assistant... Purpose: To clean the hair and scalp. To provide comfort and increase circulation. To provide the resident with an attractive appearance and improve morale... Procedure:... Resident's hair is to be combed during morning and evening care; more	F 312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 312	Continued From page 10 often if necessary... If hair is tangled, apply a small amount of hair conditioner, if available..." 2. A Policy and Procedure on Incontinence Care received from Administration 9/24/08 at 4 p.m. documented, "Purpose; To keep skin clean, dry, free of irritation and odor. To identify skin problems as soon as possible so treatment can be started. To prevent skin breakdown. To prevent infection. Assessment guidelines; Color, consistency and amount of urine and feces. Pain or discomfort. Dehydration and fluid balance. Condition of skin and perineum... Procedure;... 2. Drape resident for privacy. 3. Place protective covering on bed. 4. Put on gloves. 5. wash all soiled skin areas, washing from front to back, rinse and dry very well, especially between skin folds. 6. Apply protective skin lubricant and rub well into skin. 7. Change linen as necessary..." 3. Resident #12 had diagnoses of Cerebral Palsy, Mental Retardation, Symptoms involving Urinary System Continuous Leakage, Chronic Urinary Tract Infections (UTI), Suprapubic Foley Catheter and Pressure Ulcers. The Admission MDS dated 7/27/08 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for toilet use, and had an indwelling catheter. a. The Plan of Care dated 6/27/08 documented, Problem; Activities of Daily Living (ADL) At risk for alterations in ADL's due to needing total assist. Interventions; Total care for supra pubic tube. Prompt Incontinent care." b. On 9/22/08 at 6:30 p.m. Licensed Practical Nurse (LPN) #5 entered the resident's room. She lifted the covers and the resident had had a large	F 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 312	<p>Continued From page 11</p> <p>liquid stool and it was between her legs and down below the pad and on her gown. Part of the stool had started to dry along her thighs approximately 3 inches in length by 1/4 inch. The LPN put the covers back over the resident and went to get help.</p> <p>At 6:35 p.m. LPN#5 returned with CNA#2 to do incontinent care. The resident was repositioned on her back. CNA #2 sprayed the peri wash on the perineal area. LPN #2 wiped down the front of the perineal area one time. The thighs were then sprayed and wiped and then the resident was turned to the left side again. The sheet and mattress had stool on them. The mattress was wiped and the sheet was changed. The buttocks and right side was sprayed and then wiped, changing a different area of towel past each wipe. The resident was positioned onto her back and a new gown was placed on her. The surveyor then asked if they were through with incontinent care. They both stated, "Yes". The LPN and CNA were asked to perform the incontinent care again on the groin area and inner and outer labia showing the surveyor the towel past each wipe. The left groin was sprayed and wiped and the towel had a medium amount of brown stool on it as did the right groin and whole peri area past each wipe.</p> <p>4. Resident #15 had diagnoses of Cerebrovascular Disease and Dementia with Lewy Bodies. The Quarterly MDS dated 6/24/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with toileting and was incontinent of bowel and bladder.</p>	F 312			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 312	Continued From page 12 a. The Care Plan dated 6/24/08 documented, "Problem: Risk for skin issues, UTI (urinary tract infection) due to (d/t) needing extensive assist with bed mobility, is incontinent of bowel and bladder. Goal: No pressure ulcer formation/skin issues/ UTI's. Interventions:... Check on rounds/as needed (PRN) and give incontinent care as needed. Wash with soap and water and dry. Apply skin barrier after each incontinent episode." b. On 9/22/08 at 4:45 p.m., CNA #3 began incontinent care. CNA #3 removed the soiled incontinent brief, placed a new incontinent brief underneath the resident and fastened it. She then pulled the resident's pants up. No soap and water was used.	F 312			
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure turning and repositioning was completed at least every two hours for 1 (Resident #12) of 6 (Resident #1, #2, #4, #5, #8, and #12) case mix residents who were at risk and/or had pressure ulcers. This failed practice had the potential to affect 45 residents	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 314	<p>Continued From page 13</p> <p>who were dependent for positioning as documented by a listing provided by the Administrator on 9/24/08 at 4:00 p.m. The findings are:</p> <p>Resident #12 had diagnoses of Cerebral Palsy, Mental Retardation, Symptoms involving Urinary System Continuous Leakage, and Chronic Urinary Tract Infections (UTI). The Admission Minimum Data Set dated 7/27/08 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent for toilet use, and had indwelling catheter, and two Stage 2 pressure ulcers.</p> <p>a. The resident was admitted on 5/22/08 and the Admission Assessment (not dated) documented, "Two Stage II on the buttocks area."</p> <p>b. The Plan of Care dated 6/27/08 documented, "Problem; ...Risk for skin breakdown due to mental retardation and being incontinent of bowel. She needs total assist with bed mobility. She was admitted with two stage II wounds to both buttocks. Now resolved. Interventions; Give prompt incontinent care. Apply skin barrier after each incontinent episode."</p> <p>c. On 9/22/08 at 3:10 p.m., 5:00 p.m. and 5:45 p.m., the resident was in bed laying on her left side. The head of the bed was elevated 40 degrees.</p> <p>d. On 9/22/08 at 6:25 p.m., Certified Nursing Assistant (CNA) #2 was asked about positioning and incontinent care. The CNA was asked "Are you the CNA for this hall?" She stated, "Yes". The CNA was asked "How often do you do incontinent care and reposition the residents?"</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 314	Continued From page 14 She stated, "Every two hours. The CNA was asked "When did you reposition this resident?" She stated, "At 4 p.m." The surveyor stated that the resident was on her left side at 3 p.m. and was still on her left side. The CNA was asked "So did you reposition her?" CNA#2 just looked at the surveyor and did not answer. e. On 9/22/08 at 6:30 p.m., Licensed Practical Nurse (LPN) #5 entered the resident's room and was asked if she noticed anything different about the resident. (LPN#5 had hung a new bag and tubing earlier at 4 p.m. for the tube feeding.) She stated, "She is still in the same position, I will reposition her myself."	F 314		
F 315 SS=E	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the labia was separated and cleaned for 1 (Resident #8) and incontinent care was completed for 1 (Resident #1) of 7 (Resident #1, 5, 6, 8, 9, 10 and 15) case mix residents who were dependent on staff for incontinent care. The facility failed to ensure there was a physician order for a suprapubic catheter	F 315		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 315	<p>Continued From page 15</p> <p>and staff completely cleaned the groin and outer labia area during incontinent care to prevent the potential for developing urinary tract infections for 1 (Resident #12) of 4 case mix residents (Resident #2, 4, 11 and 12) who had an indwelling catheter. These failed practices had the potential to affect 78 residents who were incontinent according to the list provided by the Administrator on 9/24/08 and 10 residents who had an indwelling catheter according to the Resident Census and Conditions of Residents form dated 9/22/08. The findings are:</p> <p>1. Resident #8 has a diagnosis of Incontinence. The Medicare 60 day MDS dated 9/2/08 documented the resident was severely impaired in cognitive skills for daily decision making, incontinent of bladder and bowels, required extensive assistance for personal hygiene and was totally dependent on staff for bathing.</p> <p>a. The Plan of Care updated on 8/29/08 documented, "...Incontinent of bowel and bladder... Provide pericare after each incontinent episode... History of urinary tract infections... Clean Peri area well after a BM (Bowel Movement) in order to help prevent reintroduction of bacteria into urinary tract..."</p> <p>b. On 9/23/08 at 9:15 a.m., the resident had a large incontinent bowel movement and CNA #1 provided incontinent care to the resident's peri and rectal area with no rinse peri-wash and a face cloth. After CNA #1 finished the incontinent care and was about to put an incontinent brief on the resident this surveyor asked CNA #1 to again wash the resident's peri area especially the labia. When CNA #1 cleansed the peri area, separating the labia it was noted there was feces on the face</p>	F 315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 315	<p>Continued From page 16</p> <p>cloth after the labia was separated and cleansed.</p> <p>2. Resident #1 had diagnoses of Alzheimer's, Cerebral Vascular Accident and Left Hip Fracture. The Minimum Data Set (MDS) dated 9/24/08 documented the resident was severely impaired in cognitive skills for daily decision making, dependent on staff for toileting and personal hygiene, and incontinent of bowel and bladder.</p> <p>On 9/22/08 at 5:15 p.m., Certified Nursing Assistant (CNA) #4 removed the resident's incontinent brief. The incontinent brief had liquid feces in it. The CNA placed a clean incontinent brief on the resident. The CNA stated, "Its just water." The CNA did not cleanse any of the resident's perineum or buttocks.</p> <p>3. Resident #12 had diagnoses of Cerebral Palsy, Mental Retardation, Symptoms involving Urinary System Continuous Leakage, Chronic Urinary Tract Infections (UTI), Suprapubic Foley Catheter and Pressure Ulcers. The Admission MDS dated 7/27/08 documented the resident was severely impaired in cognitive skills for daily decision-making, totally dependent on staff for toilet use, and had an indwelling catheter.</p> <p>a. The Plan of Care dated 6/27/08 documented, Problem; Activities of Daily Living (ADL) At risk for alterations in ADL's due to needing total assist. Interventions; Total care for supra pubic tube. Prompt Incontinent care."</p> <p>b. 9/22/08 at 11:17 a.m., during initial rounds, the DON stated the resident had a supra-pubic catheter. As of 9/23/08, there was no documentation in the clinical record of a physician order for a supra pubic catheter or how to care for</p>	F 315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 315	Continued From page 17 the catheter. c. On 9/22/08 at 6:30 p.m. Licensed Practical Nurse (LPN) #5 entered the resident's room. She lifted the covers and the resident had had a large liquid stool and it was between her legs and down below the pad and on her gown. Part of the stool had started to dry along her thighs approximately 3 inches in length by 1/4 inch. The resident had a suprapubic catheter which was secured with a leg band and had stool on it. The LPN put the covers back over the resident and went to get help. At 6:35 p.m. LPN#5 returned with CNA#2 to do incontinent care. The resident was repositioned on her back. CNA #2 sprayed the peri wash on the perineal area. LPN #2 wiped down the front of the perineal area one time. The sheet and mattress had stool on them. The mattress was wiped and the sheet was changed. The resident was positioned onto her back and a new gown was placed on her. The surveyor then asked if they were through with incontinent care. They both stated, "Yes". The LPN and CNA were asked to perform the incontinent care again on the groin area and inner and outer labia showing the surveyor the towel past each wipe. The left groin was sprayed and wiped and the towel had a medium amount of brown stool on it as did the right groin and whole peri area past each wipe.	F 315			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS	F 332			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 332	<p>Continued From page 18</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation of the 12:00 p.m. and the 4:00 p.m. medication pass on 9/22/08 the facility failed to follow physician's orders to ensure that the medication error rate was less than 5 %.</p> <p>Physicians orders were not followed on 4 (Resident #5, #11, #13 and #14) of 13 residents observed during the medication passes.</p> <p>Medication errors were made by LPN (Licensed Practical Nurse) #1, #2, #3 and #4 of 6 nurses who administered medication according to RN (Registered Nurse) #1. The medication error rate was 13.33 % based on administration of 43 medications plus 2 medications ordered but not administered and observation of a total of 6 errors. This failed practice had the potential to affect 78 residents who received medications from these nurses according to RN #1 on 9/22/08. The findings are:</p> <p>1. Resident #13 had a physician order dated 7/16/08 for Artifical Tears to administer 2 drops in each eye for times a day.</p> <p>On 9/22/08 at 12:44 p.m., LPN #1 did not administer the Artifical Tears.</p> <p>2. Resident #5 had a physician order dated 9/12/08 for Prednisolone 1% ophthalmic solution to use one drop in the left eye every 2 hours while awake.</p> <p>a. On 9/22/08 at 1:38 p.m., LPN #2 did not</p>	F 332			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 332	<p>Continued From page 19</p> <p>administer the Prednisolone 1% ophthalmic solution.</p> <p>b. The September 2008 Medication Administration Record documented the drops were to be administered "7-3 (7:00 a.m. - 3:00 p.m. shift)." There was no documentation of nursing initials that the eye drops were administered more than one time and only on the 7-3 shift.</p> <p>3. Resident #14 had a physician order dated 8/13/08 for Coreg 25 mg (milligrams) to be administered two times a day (must be given with food).</p> <p>On 9/22/08 at 3:35 p.m., LPN #3 did not administer the Coreg 25 mg with food.</p> <p>4. Resident #14 had a physician order dated 8/23/08 for Glucophage 1000 mg to be administered two times a day (must be given with food).</p> <p>On 9/22/08 at 3:35 p.m., LPN #3 did not administer the Glucophage 1000 mg with food.</p> <p>5. Resident #11 had a physician ordered dated 8/16/08 to flush the G-tube (gastrostomy tube) with 30 ml (milliliters) of water before and after medication administration.</p> <p>On 9/22/08 at 4:15 p.m., LPN #4 did not flush with water before administering the medications.</p> <p>6. Resident #11 had a physician order dated 3/27/08 for Artificial Tears to be administered one drop in both eyes two times a day.</p>	F 332		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 332	Continued From page 20	F 332		
F 333 SS=E	<p>On 9/22/08 at 4:15 p.m., LPN #4 did not administer the Artificial Tears to the right eye.</p> <p>483.25(m)(2) MEDICATION ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on the observation and record review, the facility failed to ensure medications were administered as ordered for 1 (Resident #5) of 20 case mix residents (Resident #1 - 20) who received medications. This failed practice had the potential to affect all 98 residents. The findings are:</p> <p>Resident #5 had diagnoses of tear film insufficiency. The Minimum Data Set (MDS) dated 6/25/08 documented the resident was moderately impaired in cognitive skills for daily decision making.</p> <p>a. A physician order dated 9/12/08 documented Prednisolone 1% ophthalmic solution to administer one drop in the left eye every 2 hours while awake.</p> <p>1) On 9/22/08 at 1:38 p.m., LPN #2 did not administer the Prednisolone.</p> <p>2) The September 2008 Medication Administration Record (MAR) documented Prednisolone 1% was to be administered on the 7:00 a.m. - 3:00 p.m. shift, 3:00 p.m. to 11:00 p.m. shift and 11:00 p.m. - 7:00 a.m. shift. The September 2008 MAR documented through nurses initials that the medication was</p>	F 333		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 333	Continued From page 21 administered once a day on the 7:00 a.m. - 3:00 p.m., 7 times on the 3:00 p.m. to 11:00 p.m. shift and 9 times on the 11:00 p.m. - 7:00 a.m. shift from 9/12/08 through 9/22/08 instead of every 2 hours. 3) On 9/22/08 at 2:15 p.m., LPN #2 stated that she had only administered the eye drops one time since starting her shift at 7:00 a.m. on 9/22/08. 4) This was a significant medication error due to the resident's condition and frequency of the error.	F 333		
F 363 SS=E	483.35(c) MENUS AND NUTRITIONAL ADEQUACY Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the planned written menu was followed for (Resident #1, 4 and 8) of 4 case mix residents (Resident #1 4, 8 and 18) who received a pureed diet and 1 (Resident #5) of 5 case mix residents (Resident #5, 6, 7, 8, and 10) who received a mechanical soft diet. These failed practices had the potential to affect 11 residents who received a pureed diet and 29 residents who received a mechanically soft diet as identified on the diet list dated 9/22/08. The findings are:	F 363		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 363	<p>Continued From page 22</p> <p>1. On 9/22/08, the menu for supper meal documented 1/2 cup of Emerald pears and on 9/23/08 the menu for lunch documented chocolate pudding for all diets.</p> <p>2. Resident #1 had diagnoses of Alzheimer's Disease, Symbolic Dysfunction and Dementia with Lewy Bodies. The Significant Minimum Data Set (MDS) dated 9/22/08 documented the resident was severely impaired in cognitive skills for daily decision making, required one person assist for eating, had swallowing and chewing problems and experienced weight loss of 5.83 % in month according to the weight record.</p> <p>a. The weight record documented the resident's weight went from 120 pounds in August to 113 pounds in September which was a significant weight loss of 5.83 % in month.</p> <p>b. A physician order dated 9/5/08 documented pureed diet.</p> <p>c. On 9/22/08 at 5:45 p.m., the resident was served a bowl of tomato soup, pureed chef salad, ensure pudding, a carton of sherbet. There was no emerald pears served to the resident as per the menu.</p> <p>d. On 9/23/08 at 12:08 p.m., the resident was served mashed potatoes, roll, 8 oz (ounce) glass of thickened cranberry juice, 8 oz glass of thickened water. There was no chocolate pudding served to the resident with her meal as per the menu.</p> <p>3. Resident #4 had diagnoses of Esophageal Reflux and Hypertension. The Significant Change MDS dated 6/24/08 documented the</p>	F 363			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 363	<p>Continued From page 23</p> <p>resident was moderately impaired in cognitive skills for daily decision making, required one person assist for eating, had a swallowing problem and history of weight loss.</p> <p>a. A physician order dated 7/9/08 documented regular pureed diet.</p> <p>b. On 9/22/08 at 5:43 p.m., the resident was served a pureed chef salad, tomato soup, ensure pudding and a carton of sherbet. There was no pureed emerald pears served to the resident as per the menu.</p> <p>4. Resident #5 had diagnoses of Esophageal Reflux and Hypertension. The Quarterly MDS dated 7/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, had a history of weight loss and required set up help for eating.</p> <p>a. A physician order dated 9/12/08 documented mechanical soft diet.</p> <p>b. On 9/22/08 at 5:30 p.m., the resident was served a bowl of tomato soup, chef salad, and bread stick. There were no emerald pears served to the resident.</p> <p>5. Resident #8 had diagnoses of Organic Psychotic Conditions, Essential Hypertension, Presenile Organic Psychotic and Alzheimer Disease. The Significant Change MDS dated 8/12/08 documented the resident was severely impaired in cognitive skills for daily decision making, required one person assist for eating, had a chewing problem and history of weight loss.</p> <p>a. A physician order dated 7/29/08 documented</p>	F 363			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 363	Continued From page 24 regular pureed diet.	F 363			
F 365 SS=E	<p>b. On 9/22/08 at 5:39 p.m., the resident was served a chef salad, tomato soup, bread stick, 8 oz glass of milk, 8 oz glass of water and 8 oz glass of tea. There was no dessert served to the resident.</p> <p>6. On 9/24/08 the menu for the lunch meal for mechanical soft diet documented 1/2 cup of chicken tender which equaled 2 pieces of chicken tender each as specified on the menu for the regular diets. At 11:37 a.m., Dietary Employee #1 placed 22 pieces of chicken tenders in the mixer and ground them up for the residents on a mechanical soft diet, instead of 58 pieces of chicken tender as per the menu.</p> <p>483.35(d)(3) FOOD</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure thickened liquids were served in the correct consistency for 3 (Resident #1, 17 and #10) of 4 case mix residents who received thickened liquids. This failed practice had the potential to affect 13 residents who received thickened liquids according to the form provided by the Administrator on 9/24/08. The findings are:</p> <p>1. Resident #1 had diagnoses of Alzheimer's Disease, Symbolic Dysfunction and Dementia with Lewy Bodies. The Significant Minimum Data</p>	F 365			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 365	<p>Continued From page 25</p> <p>Set (MDS) dated 9/22/08 documented the resident was severely impaired in cognitive skills for daily decision making, required one person assist for eating, and had swallowing and chewing problems.</p> <p>a. A physician order dated 9/5/08 documented pureed diet and nectar thickened liquids.</p> <p>b. The Nursing /Dietary Communication Form dated 9/5/08 documented under Special Comments: "Feeder/Aspiration Precautions."</p> <p>c. On 9/22/08 at 5:45 p.m., the resident was served a bowl of thickened tomato soup, pureed chef salad, ensure pudding, a carton of sherbet, instead of no sherbet as per order.</p> <p>d. On 9/23/08 at 12:08 p.m., the resident was served mashed potatoes, a roll, 8 oz (ounce) glass of thickened cranberry juice, 8 oz glass of thickened water and 4 oz carton of sherbet, instead of no sherbet.</p> <p>e. On 9/24/08 at 8:15 a.m., the resident was served fortified oatmeal, 4 oz nectar apple juice, pureed eggs, honey thickened water and the milk was pudding consistency.</p> <p>f. On 9/24/08 at 12:42 p.m., the resident was served 8 oz honey consistency milk and 8 oz honey consistency of water, instead of nectar thickened liquids.</p> <p>2. Resident #17 had diagnoses of Congestive Heart Failure, Hypertension, Diabetes Mellitus and Abdominal Pain. The Quarterly Assessment dated 6/23/08 documented the resident was severely impaired in cognitive skills for daily</p>	F 365			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 365	<p>Continued From page 26</p> <p>decision making, required one person assist for eating, and had swallowing and chewing problems.</p> <p>a. A physician order dated 12/10/07 documented mechanical soft diet. Another physician order dated 10/1/04 documented Nectar Thickened Liquids every shift.</p> <p>b. On 9/24/08 at 8:18 a.m., the resident was served super cereal, 4 oz nectar apple juice, 8 oz glass of honey thickened milk and 8 oz glass of honey thickened water, instead of nectar thicken liquids as per order.</p> <p>c. On 9/24/08 at 12:40 p.m., the resident was served a carton of sherbet, 8 oz glass of honey thickened milk and 8 oz glass of honey thickened water. The Nursing Assistant #6 feeding the resident stated, "This is a thick nectar."</p> <p>3. Resident #18 had diagnoses of Alzheimer's Disease and Hypothyroidism. The Quarterly Assessment dated 7/22/08 documented the resident was severely impaired in cognitive skills for daily decision making, required one assist for eating and had swallowing and chewing problems.</p> <p>a. The Dysphagia Medical Work Up Form dated 3/24/08 documented the resident had a history of Aspiration problems, definite risk for aspiration, aspiration pneumonia, choking, evidence of delayed or slow swallow reflux, frequent coughing during swallow, wet or gurgle vocal quality after swallowing liquids and leakage of food or liquids placed in mouth.</p> <p>b. A physician order dated 9/12/08 documented</p>	F 365			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 365	Continued From page 27 regular pureed diet with nectar thickened liquids every shift. c. On 9/24/08 at 8:23 a.m., the resident was served an 8 oz glass of honey thickened milk, a bowl of watery grits and 8 oz glass of honey thickened water, instead of nectar thickened liquids. d. On 9/24/08 at 12:36 p.m., the resident was served pureed chicken tenders, pureed cut green beans, pureed cream corn, 8 oz glass of honey thickened milk and 8 oz glass of honey thickened water, instead of nectar thickened liquids.	F 365			
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was thawed properly to prevent spoilage, employees handled food items in a sanitary manner to prevent the potential for cross contamination, and employees changed gloves and washed hands between handling food, dirty dishes and clean dishes. These failed practices had the potential to affect 95 residents who received their meal trays from the kitchen according to the Resident Census and Conditions	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 371	<p>Continued From page 28 of Residents form dated 9/22/08. The findings are:</p> <p>1. On 9/23/08 at 2:30 p.m., the following observations were made:</p> <p>a. A zip lock bag that contained tea bags located in a rubber container under the counter was not sealed closed.</p> <p>b. Dietary Employee #3 had gloves on both hands and picked up a dirty pot holder, pan, touched the oven door, oven knobs and used a strainer to get Tatar tots out of the pan of oil on the stove. Without washing her hands she started picking up buns and fish to be served to the residents at the supper meal.</p> <p>c. Dietary Employee #2, while pouring tea into individual drinking glasses, scratched his face. Without washing his hand he started picking up drinking glasses at the tip that goes into the mouth as he poured the tea into the glasses to be served to the residents at the supper meal.</p> <p>2. On 9/24/08 at 8:55 a.m., there were two 10 pound rolls of ground sausage sitting in a pan of cold water in the food preparation sink thawing. At 9:06 a.m., Dietary Employee #3 started running cold water over the pan of meat. At 9:12 a.m., Dietary Employee #4 turned off the water from the meat. At 9:44 a.m., Dietary Employee #1 took the ground sausage and put it in the refrigerator. At 4:09 p.m., Dietary Employee #1 stated, "We are going to use the meat at breakfast tomorrow." One of the packages had a small hole on it where the meat was sticking out.</p> <p>3. On 9/24/08 at 10:00 a.m., Dietary Employee</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 371	Continued From page 29 #4 was in the dish room washing dishes left in the dirty area. Without washing his hands he walked to the clean area and started drying cooking pans with a towel before stacking them up. He then placed the towel on his shoulder. 4. On 9/24/08 at 10:45 p.m., Dietary Employee #4 had a wet dirty towel tucked in front of his apron. He used the same towel to wipe his hands as he stacked up the dishes that came out of the machine in the plate warmer. He pushed the plate warmer into the dining room. He used the towel to wipe off the metal counter where clean dishes were kept, then laid the towel on the metal rack where dish racks were kept. He picked up the same towel and dried the inside of clean pans before stacking them.	F 371			
F 444 SS=E	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure Certified Nursing Assistants (CNA) washed their hands after providing incontinent care and before conducting other tasks for 3 (Resident #4, 5, and 15) of 8 (Resident #2, #4, #5, #6, #8, #9, #10, and #15) case mix residents who required assistance with incontinent care. This failed practice had the potential to affect 78 residents who were incontinent as identified by the Resident Census and Conditions of Residents form dated 9/22/08.	F 444			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 444	<p>Continued From page 30</p> <p>The findings are:</p> <ol style="list-style-type: none"> Resident #15 had diagnoses of Cerebrovascular Disease and Dementia with Lewy Bodies. The Quarterly MDS (Minimum Data Set) dated 6/24/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with toileting and was incontinent of bowel and bladder. <p>On 9/22/08 at 4:45 p.m., CNA (Certified Nursing Assistant) #3 completed incontinent care. Without changing her gloves, the CNA went to the resident's closet and sorted through his clothes to obtain a shirt, then proceeded to put the shirt on the resident. CNA #3 then removed her gloves and took the trash and soiled linen to the barrels in the hall. CNA #3 never washed her hands.</p> <ol style="list-style-type: none"> Resident #4 had diagnoses of Paraplegia, Traumatic Head Injury and Pressure Ulcers. The Significant Change MDS dated 7/25/08 documented the resident was moderately impaired in cognitive skills for daily decision making and totally dependent on the staff for all ADL's (activities of daily living). <p>On 9/22/08 at 5:00 p.m., after completing incontinent care on the resident's roommate, CNA #3 left the room placed the soiled items in the dirty laundry barrel, got the lift sling, returned to the room and placed the sling under the resident. CNA #3 applied a glove to her right hand and assisted CNA #5 in getting the resident up. CNA #3 did not wash her hands before leaving the room or before caring for this resident.</p> <ol style="list-style-type: none"> Resident #5 had diagnoses of Osteoporosis 	F 444			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/08/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045098	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/25/2008
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GOLF LINKS			STREET ADDRESS, CITY, STATE, ZIP CODE 552 GOLF LINKS ROAD HOT SPRINGS, AR 71901		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 444	Continued From page 31 and Hypertension. The Quarterly MDS dated 7/27/08 documented the resident was moderately impaired in cognitive skills for daily decision making, required extensive assistance with ADL's, frequently incontinent of bladder and occasionally incontinent of bowel. On 9/23/08 at 5:05 p.m., CNA #4 completed incontinent care, then transferred the resident to the wheelchair using the lift. CNA #4 did not wash her hands after the incontinent care or before she left the room to assist the resident to the dining room.	F 444			