

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>	
(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 272 SS=K	<p>Complaint #12590 was substantiated (all or in part) with deficiencies cited at F272 F324, F490, F498 and F520.</p> <p>483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following:                      Identification and demographic information;                      Customary routine;                      Cognitive patterns;                      Communication;                      Vision;                      Mood and behavior patterns;                      Psychosocial well-being;                      Physical functioning and structural problems;                      Continence;                      Disease diagnosis and health conditions;                      Dental and nutritional status;                      Skin conditions;                      Activity pursuit;                      Medications;                      Special treatments and procedures;                      Discharge potential;                      Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and                      Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 272		

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: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	Continued From page 1 by: Complaint #12590 was substantiated (all or in part) with these findings.  Based on observation, record review and interview, the facility failed to ensure assessments were accurate in order to ensure interventions regarding safe transfers were developed and implemented for 3(Residents #3, #5, and #7) of 7 (Residents #1 through #7) case mix residents assessed for the use of a mechanical lift. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Residents #3, #5 and #7. This failed practice had the potential to affect 27 residents who required the use of the Marisa Lift, 16 residents who required the use of the Sara Lift, and 27 residents who were non-weight bearing, according to the Nurse Consultant on 6/8/07 at 3:00 p.m. The facility was notified of the Immediate Jeopardy on 6/7/07 at 4:18 p.m. The findings are:  1. The facility Policy and Procedure titled Transfer Activities, received from the Administrator on 6/8/07 at 2:55 p.m., documented: "Procedure 655, Basic Responsibility: Licensed Nurse and Nursing Assistant, Restorative Nursing Assistant. Purpose: To transfer the resident from bed to chair, toilet or tub safely. ASSESSMENT GUIDELINES: May include, but not limited to: Loss of range of motion, Location and amount of pain or discomfort., Ability to perform ADL's, Contractures, Deformity, Ability to stand and bear weight, Loss of Balance, Loss of voluntary control of extremities, Paresis or paralysis, Amputation, Fracture. PROCEDURE: Transfer from bed to wheelchair: 1. Obtain assistance of another individual if necessary for safe transfer.	F 272			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	<p>Continued From page 2</p> <p>Care Plan Documentation Guidelines: Problem: Identify the appropriate problem under which to list transfer activity as an approach... Consider listing possible risks and complications... Approaches: List Instructions unique to this resident, List necessary monitoring and observation of the resident's ability to participate in care... List Monitoring for proper body alignment.</p> <p>2. A document titled Lift/Movement Assessment was received from the administrator on 6/8/07 at 2:55 p.m., which was used by the facility to assess the most appropriate mechanical lift for transfer for each individual resident documented the following:</p> <p>a. "Lift required (circle after completing questions below): SARA Maxi - Lift. Marisa Lift ...No lift needed'</p> <p>b. "If patient can stand, pivot and walk with no physical assistance from staff with no risk of falling - No Lift Needed. Otherwise please continue.</p> <p>c. Patient can bear weight on at least one leg? Patient is able to follow simple instructions? Patient is able to grip with at least one hand or a 2nd staff member is available to assist with the transfer? patient is able to undergo moderate pressure to the mid to lower back? If the four questions are answered YES, then the patient is a candidate for the Sara Lift. If any of the questions were NO, then proceed to the next questions.</p> <p>d. Patient can undergo a semi - reclined position as shown in the picture to the right? Patient weighs less that 350 pounds? Maxi -Lift. Patient</p>	F 272			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	Continued From page 3 weighs less than 420 pounds? - Marisa Lift. If the first two [questions] were answered Yes, then the patient is a candidate for the MAXI Lift. If more than 350 pounds or lift from the floor is needed - MARISA lift.  3. Resident #3 had diagnoses of Alzheimer's Disease, Abnormal Gait with Symptoms of the Nervous and Musculoskeletal System.  a. The most recent "Lift/Mobility Assessment..." completed for this resident was dated 11/16/06. It documented "Resident can bear weight on at least one leg" the response "both" and "yes" were circled. "Resident is able to follow simple instructions? yes" is circled. "Resident is able to grip with at least one hand or a 2nd staff member is available to assist with the transfer? yes" is circled. "Resident is able to undergo moderate pressure to the mid to lower back? "Yes". Resident weighs less than 350 pounds? "Yes" the diagram of the Sara lift on the form was circled. The section titled " #of staff" was blank.  b. A Quarterly Minimum Data Set, (MDS) dated 4/23/07 documented the resident was severely impaired in cognitive skills for daily decision making, had short and long term memory problems, required extensive assistance for transfer with assistance of 1 staff member, was non-ambulatory, and unable to attempt standing or sitting tests for balance without physical help.  c. On 6/4/07 at 2:16 p.m. Licensed Practical Nurse (LPN) # 1 stated the Resident was lifted with a lift and one assistant.  d. On 6/5/07 at 4:20 p.m. Certified Nurse Aide	F 272			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	<p>Continued From page 4</p> <p>(CNA) # 1 and CNA # 2 were observed transferring the resident from the bed to chair. CNA # 2 pulled Resident to edge of bed by bending down and asking the Resident to put arms around the CNA's neck. The Resident was not able to follow instructions. The CNA then put the Resident's arm around her neck and pulled the Resident to the edge of the bed. No gait belt was used. The CNA placed the Sara lift in front of the resident and placed the belt around the Resident's back at the level of the axilla. CNA # 1 raised the Resident with the Sara lift which was pulling the Resident up by the arms. CNA # 2 attempted to get the Resident to hold onto the hand grips but the Resident did not follow the instructions. The Resident's feet were both bent to the left side of the foot plate and there was no attempt by the CNA's to place the Resident's legs in the correct position. The CNA's were asked if the Resident could bear weight and they both responded "No". CNA # 1 stated "Not at all".</p> <p>4. Resident #7 had diagnoses of Cerebral Vascular Accident with Hemiplegia of the Right side and Blindness.</p> <p>a. The most recent "Lift/Mobility Assessment" dated 11/16/06 documented the resident could bear weight on at least one leg, resident was able to follow simple instructions, resident was able to grip with at least one hand or a 2nd staff member was available to assist with the transfer. The Sara Lift diagram was circled. The section requiring 3 of staff was blank.</p> <p>b. An Annual Minimum Data Set, (MDS) dated 5/14/07 documented the resident was severely impaired in cognitive skills for daily decision making, had long and short term memory</p>	F 272			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	<p>Continued From page 5</p> <p>problems, required extensive assistance of 2 staff members for transfers, was non - ambulatory, was not able to attempt balance while standing test without physical help and had no limitation of range of motion or loss of voluntary movement to hand arm leg or foot.</p> <p>c. On 6/4/07 at 2:16 p.m. Licensed Practical Nurse (LPN) # 1 stated the Resident was lifted with a lift and one assistant.</p> <p>d. On 6/5/07 at 10:45 a.m. the resident was sitting on the side of the bed. CNA # 1 placed the Sara lift belt around the resident's back at the level of the axilla. CNA # 1 then raised the resident using the Sara lift, pulling the resident up by the arms. CNA # 1 attempted to get the Resident to hold onto the hand grips. The resident had contractures of both hands and had the left hand on top of the bar trying to hold on, and with the right hand could only get one finger over the grip bar. The resident's feet were not positioned for the knees to bend into the knee plate and the resident's buttocks were bent out placing her weight was under axilla area. There was no attempt by the CNA's to get the Resident's legs in the correct position or get the Sara belt down around the resident's waist. the CNA was asked if the resident could bear weight and she responded "No". The CNA was asked if she usually transferred the resident alone and she stated yes.</p> <p>e. Plan of Care dated 5/14/07 documented: Problems/Strengths: Needs to be lifted mechanically due to Dx. of CVA. At risk for fall. Interventions: Encourage out of bed daily, Use: two staff to assist getting out of bed. Problem: ADL- at risk for decline in ADL function due to</p>	F 272			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	Continued From page 6 CVA with right side Hemiplegia. Interventions: .... Lift Transfers with Assist x 2  5. Resident #5 had diagnoses of Acute Cerebrovascular Disease, Hypertensive Heart Disease, Chronic Anemia, Diabetes Mellitus, Chronic Renal Insufficiency, Cerebrovascular Accident, Peripheral Edema, B12 Deficiency, Alzheimer's Disease, Dementia with Behavioral Disturbance and History of Multiple Falls.  a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented, "Resident would benefit from SARA Lift but cognitively & behavior wise resident will not comply therefore for safety resident needs MARISA lift." As of 6/6/07, there was no reassessment of the resident's requirement for that specific type of lift.  b. The MDS Quarterly Review and 5-Day Medicare Assessment dated 5/10/07 documented the resident had severely impaired cognitive skills for daily decision-making and short/long-term memory problems; required extensive assistance of two persons for transfers; was rarely/never understood and sometimes understood others; was unable to attempt a test for balance while standing without physical assistance; and had behavioral symptoms, that were not easily altered, of verbal abusiveness, physical abusiveness and resistance to care.  c. The 14-Day Medicare MDS dated 5/11/07 documented the resident required extensive assistance of one person for transfers and was unable to attempt tests for balance while standing and sitting without physical assistance.  d. The resident's Plan of Care dated 8/18/07 and	F 272			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	<p>Continued From page 7</p> <p>last reviewed/updated 5/11/07 documented "ADL - [Resident #5] remains at risk for decline in ADL function due to cognitive deficits. She has STM (short term memory) and LTM (long term memory) loss, impaired decision making ability, and poor safety awareness. Interventions were "Transfers with limited to extensive assistance x 1 person". 5/10/07 "CPOC (continue plan of care)."</p> <p>e. A plan of care dated 12/4/06 documented "Actual Fall". Interventions dated 12/4/06 were "Inserviced &amp; instructed staff about leaving resident alone sitting on side of bed; Marisa lift to be used x 2; and SL (Sara Lift) x 2 when getting resident OOB (out of bed)." A line was drawn through "Marisa lift to be used x 2" and "SL x 2 when getting resident OOB" with D/C (discontinue) written to the right side of the two interventions. There was no date to indicate when the interventions were discontinued.</p> <p>f. The Nursing Assistant Assignments sheet documented that Resident #5 required the Marisa Lift for the shower and the Sara Lift to transfer out of bed.</p> <p>g. On 6/6/07 at 9:24 a.m., 11:10 a.m. and 2:10 p.m., the resident was observed in a wheel chair. There was no lift sling underneath the resident.</p> <p>h. On 6/6/07 at 2:10 p.m., the resident's daughter was asked if she had been in the room when the staff transferred her mother. She stated yes, she had several times. When asked how the staff transferred her mother she stated that one CNA would get on one side and another CNA would get on the other side. The CNAs would place their arm under her mothers arm and lift her to the bed or chair. When asked if she had seen</p>	F 272			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	<p>Continued From page 8</p> <p>the staff use a mechanical lift on her mother, she stated no she hadn't. The daughter was then asked if her mother was able to bear weight. She stated " No, the CNAs lift her."</p> <p>i. On 6/8/07 at 10:53 a.m., CNA #5 was asked how she knew what residents needed a mechanical lift for transfers. She stated there would be a sign on the door. She also stated that if they have a lift sling underneath them in the wheel chair they would need the Marisa lift. The CNA pointed to a resident nearby that was in a wheel chair and a lift sling was visible around the back of the resident and on each side along side the arms of the wheel chair.</p> <p>6. The Immediate Jeopardy was removed and the scope and severity lowered to an "E" when the facility implemented the following plan of removal on 6/8/07.</p> <p>PLAN OF REMOVAL:</p> <p>"Please accept this as our Immediate Plan of Removal for Assessments, Supervision to prevent Accidents and C.N.A. [Certified Nurse Assistant] Proficiency effective 6-7-07 at 7:15 pm</p> <p>1. Identification of residents who use a lift and what kind is currently being used.</p> <p>a. MDS [Minimum Data Set] Coordinator will pull MDS Query to identify residents who require a lift for transferring from bed to chair on 6-7-07.</p> <p>b. Staffing Coordinator will identify the type lift each resident is currently being transferred with on 6-7-07.</p>	F 272			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	Continued From page 9 c. MDS Coordinator will pull MDS Query to identify residents who are at a high risk for falls.  2. Assessment of resident to determine if lift is required and type lift needed.  a. Registered Nurses on 06-07-2007 will visually assess all residents residing in the facility to include but not limited to those who have been identified by the MDS as requiring a mechanical lift for transfer from the bed to the chair and/or vice versa using the Lift/Movement Assessment and visual observation.  b. The assessment findings will be documented on the Lift/Movement Assessment to include the number of staff required for the transfer and placed in the resident's medical record.  c. The Physical Therapist and the Physician Assistant will assist in determining if the assessment for each resident has resulted in the correct method of transfer of the resident from bed to chair. 6-8-07.  d. The Care Plan and the C.N.A. Assignment sheet will be updated by the MDS Coordinator and the RN Nurse Consultant on 6-7-07 and be completed by 6-8-07 end of day.  e. The Registered Nurse will assess resident who may be in the hospital or on leave upon return to the facit using the Lift/Movement Assessment and visual observation.  f. The Care Plan and the C.N.A. Assignment Sheets, and ML,SL stickers on name plates will be updated daily by the RN with changes in assessment/type lift required.	F 272			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	Continued From page 10  3. Training of staff to assure safety for residents requiring a lift for transfer.  a. The R.N. Clinical Nurse Consultant trained the Registered Nurses in the facility to perform a transfer assessment on a resident requiring assistance with transfers from bed to chair on 6-07-07  b. The Registered Nurse Director of Clinical Education will retrain all Certified Nursing Assistants beginning on 6-7-07 and completing on 6-8-07 for those on the schedule.  c. C.N.A's on sick leave, vacation, etc who are not on the schedule for 6-7-07 thru 6-8-07 will be retrained on the next scheduled work day prior to providing care to a resident by the Registered Nurse.  d. Training will be documented on the In-Service Record and maintained in the RN DCE's [Director of Clinical Education] office.  e. New employees hired by the facility will be trained on use of the lift by the DCE or DNS prior to giving care to a resident. Training record will be placed in the new employee file in the business office.  f. The Operating Instructions Manual for the Marisa Lift and the Sara Lift will be placed in a binder at each nurses station as a reference for direct care givers to use as a reference.  4. Monitoring to assure effectiveness of the system:	F 272			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 272	Continued From page 11 a. The DNS/Designee [Director of Nursing Services] will visually observe 5 C.N.A.'s transfer 5 residents from bed to chair and/or chair to bed 7 days a week, alternating shifts to assure safe transfers are being performed with the designated lift for residents.  b. The DNS/Designee will document the visual observation with return demonstration on the Transfer of Resident from Bed to Chair Care Audit. The audits will be completed on alternating shifts to assure all C.N.A.'s are visually monitored and have a clear understanding of the training/system."	F 272			
F 324 SS=K	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: Complaint #12590 was substantiated (all or in part) with these findings.  Based on observation, record review, and interview, the facility failed to ensure the most appropriate mechanical lift was in use, staff were competent in using specific types of mechanical lifts, and that staff were transferring residents according to assessed/care planned needs in order to safely conduct transfers for 5 (Residents #1, #3, #5, #6, and #7) of 7 (Residents #1 thru #7) case-mix residents assessed for the use of a mechanical lift. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Residents #1, #3, #5, #6 and #7 and resulted in	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	Continued From page 12 actual harm for Resident #6 who sustained a fracture during a transfer. This failed practice had the potential to affect 27 residents who required the use of the Marisa Lift, 16 residents who required the use of the Sara Lift and 27 residents who were non-weight bearing, according to the Nurse Consultant on 6/8/07 at 3:00 p.m. The facility was notified of the Immediate Jeopardy on 6/7/07 at 4:18 p.m. The findings are:  1. The facility Policy and Procedure titled Transfer Activities, received from the Administrator on 6/8/07 at 2:55 p.m., documented: " Procedure 655, Basic Responsibility: Licensed Nurse and Nursing Assistant, Restorative Nursing Assistant. Purpose: To transfer the resident from bed to chair, toilet or tub safely. ASSESSMENT GUIDELINES: May include , but not limited to: Loss of range of motion, Location and amount of pain or discomfort., Ability to perform ADL's, Contractures, Deformity, Ability to stand and bear weight, Loss of Balance, Loss of voluntary control of extremities, Paresis or paralysis, Amputation, Fracture. PROCEDURE: Transfer from bed to wheelchair: 1. Obtain assistance of another individual if necessary for safe transfer. Care Plan Documentation Guidelines: Problem: Identify the appropriate problem under which to list transfer activity as an approach... Consider listing possible risks and complications... Approaches: List Instructions unique to this resident, List necessary monitoring and observation of the resident's ability to participate in care... List Monitoring for proper body alignment.  2. A document, received from the Nurse Consultant 6/7/07, titled Beverly Lift Program Mechanical Skills Check-Off documented: "SARA	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	Continued From page 13 2000 [Bullet # 1]: Extensive assist, partial weight-bearing (at least one leg) individual... SAFETY QUESTIONS for SARA 2000, [Bullet #1]: Can Resident bear weight on one leg? [Bullet # 2]: Does Resident have some upper body strength and trunk stability? [Bullet #3]: Does Resident understand verbal instructions? ...Back of page: SARA 2000 # 2 : Explain lift procedure to Resident. #3: Position SARA sling around the resident's back at waist... #5 Fasten safety belt around resident's waist... #7: Cue resident to place feet onto the platform of the lift... # 14: Cue resident to remove feet from footplate and move lift away from the resident.  3. Resident #6 had diagnoses of Osteoporosis, Osteoarthritis, Dysphagia, Chronic Airway Obstruction, Peripheral Vascular Disease, Decubitus Ulcer and Hypertension.  a. The Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident required a Marisa mechanical lift with 1-2 for the number of staff needed.  b. The Minimum Data Set (MDS) Annual full assessment, dated 1/12/07, documented the resident required extensive assistance of two person for transfers and required a mechanical lift.  c. The Minimum Data Set (MDS) Quarterly Review assessment, dated 4/6/07, documented the resident had moderately impaired cognitive skills for daily decision-making with short and long term memory problems and required extensive assistance of one person for transfers. The MDS documented the following in regards to balance and range of motion:	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>	
(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 324	Continued From page 14  Test For Balance: The resident was not able to attempt Test for Balance without physical help while standing and while sitting - trunk control.  Functional Limitation in Range of Motion (Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury): The resident had limitation in range of motion on both sides with full loss of voluntary movement of legs - including hip or knee, and both feet - including ankle or toes. The arm - including shoulder or elbow, and the hand - including wrist or fingers, had limitation of range of motion on one side with full loss of voluntary movement.  d. The Plan of Care documented the following:  (1) Problem, identified on 1/12/07 and last reviewed on 4/7/07: "ADL - Resident at risk for decline in ADL (activities of daily living) R/T (related to) needs assistance with bed mobility; had limited ROM (range of motion) to bil. (bilateral) lower extremities." Interventions were assist times 2 staff for transfers into wheel chair; mechanical lift as needed.  (2) Problem, identified on 1/12/07 and last reviewed on 4/7/07: "Risk for fractures R/T (related to) Osteoporosis." Interventions were "Movements should be slow with no sudden jerking or dropping of limbs. Discourage flexion exercises and sudden bending or jarring."  (3) Problem, identified on 3/21/07 and last reviewed on 4/7/07: "Fall risk - [Resident #6] is at risk for falls d/t (due to) has impaired cognition with memory loss, impaired decision making	F 324		

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	Continued From page 15 ability, poor safety awareness, limited physical mobility, and receives medications that may increase the risk of falls." Interventions were "assist R (resident) with transfers as needed x 1-2 staff mechanical lift."  (4) Problem, identified on 5/18/07: "Resident @ risk for injury 2nd to (secondary to) foot drop. Actual injury during transfer." Interventions were X-ray, Marisa lift only, and Retrain staff.  e. The Nurse's Notes, dated 5/18/07 at 2:21 p.m., documented "Resident is assisted up to wheel chair for lunch. During meal Resident C/O (complained of) right knee hurting. LPN (Licensed Practical Nurse) checked knee noted it to be swollen discolored, warm to touch. Resident denies knee being bumped. Triage for [Physician #1] made aware new order for stat right knee x-ray, Lortab 5/500 1 po (by mouth) q (every) 6 prn (as needed) pain. Lortab given at 1305 (1:05 p.m.). Little relief at 1410 (2:10 p.m.). [Daughter] made aware of condition and of new orders. 1320 (1:20 p.m.) mobile x here to do x-ray awaiting results. 1430 (2:30 p.m.) Results are called as Acute impacted proximal tibial shaft fracture. [Physician Assistant] made aware new order to send res. (resident) to ER (emergency room)."  1) An X-ray Report for the right knee, dated 5/18/07, documented "There is a fracture involving right proximal tibial shaft with impaction. The joint shows no dislocation. There is associated joint effusion. Osteoporosis is present." Impression: "Acute impacted proximal tibial shaft fracture."  2) A handwritten OLTC (Office of Long Term	F 324			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	<p>Continued From page 16</p> <p>Care) Witness Statement Form, dated 5/18/07 and signed by LPN #2, documented "I asked [CNA #3] (Certified Nurse Assistant) to get resident up for lunch. As the CNA came to day area with [Resident #6] the CNA stated You know you were wrong for that, she slid all over everywhere. While [Resident #6] was at the table I was covering Res's legs &amp; feet with a sheet. I bumped the pillow that was between Res legs. At that time [Resident #6] yelled 'Oh my leg.' I looked at her leg noted a swollen area, warm to touch &amp; red. I called Triage to get a order for stat x-ray &amp; pain medication."</p> <p>3) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by RN #1, documented "@ 1300 (1:00 p.m.) LPN reported to me that [Resident #6] c/o (complained of) severe pain to her (R) leg. When she moved pillow when resident up @ lunch time. Residents leg is swollen @ and below the (R) knee. Bruising noted - worm to touch. Portable X-ray had already been ordered by LPN. Resident denies having been dropped or fallen. Reports that she doesn't remember anyone bumping her leg on anything. X-ray report shows fracture to the (R) leg. Sent to [Hospital #1] ER per M.D. order."</p> <p>f. The CNAs involved in the incident did not use a mechanical lift as resident was assessed and care planned to need:</p> <p>1) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by CNA #3, documented: "While transferring resident to w/c (wheel chair) for lunch me &amp; another care specilities [sic] sat resident up on side of bed. Her feet have a foot drop so we body lift resident to w/c. I did not look down at her feet when</p>	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	<p>Continued From page 17</p> <p>transferring. Resident did not yell or scream out during transfer. Pushed resident at into dining room c (with) no c/o pain."</p> <p>2) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by CNA #4, documented "I was helping [CNA #3] put [Resident #6] in her chair for lunch. We got her up and set her on the side of the bed to put a gown on her. We bodied lifted her to put her in the chair. Her feet did not touch the floor and she didn't complain of pain when we got her up."</p> <p>g. The Verification of Investigation report documented:</p> <p>1) Causal/contributing Factors and Observations was "While transferring resident CNAs sat her on the side of the bed and transferred."</p> <p>2) Summary and Outcome of investigative findings was "No abuse or neglect suspected. During a transfer resident's foot was hit on bedrail. Staff was retrained on proper transfers and proper use of lift."</p> <p>h. An inservice Summary Report of Meeting, dated 5/21/07 at 10:00 a.m., documented training on transfers by the DCE (Director of Clinical Education) via demonstration, lecture, and handouts with return demonstrations on lifts. CNA #3 and CNA #4 were the only two staff that signed as attending the inservice.</p> <p>i. Review of the inservice Summary Report of Meeting forms and return demonstration forms, provided by the Administrator on 6/6/07 at 5:50 p.m., revealed that no other staff were inserviced/trained on transfers and the use of a</p>	F 324			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	Continued From page 18 lift until 6/4/07.  j. Nurses Notes dated 5/21/07 documented the resident was admitted to the hospital at 1:30 p.m. for Chronic Obstructive Pulmonary Disease. The resident was not present during the survey.  4. Resident #1 had diagnoses of Muscle Weakness, Spasm of Muscles, Occlusion of Cerebral Arteries, Cerebral Vascular Accident (CVA), Hypertension, Thyrotoxicosis with or without Goiter and Diabetes Mellitus.  a. The Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident required a Marisa mechanical lift with 1-2 for the number of staff needed. As of 6/6/07, there was no reassessment of the resident's requirement for that specific type of lift.  b. The MDS Annual full assessment, dated 9/5/06, documented the resident was totally dependent on two plus persons for transfers and mode of transfer and required a mechanical lift.  c. The MDS Quarterly Review assessment, dated 3/6/07, documented the resident had severely impaired cognitive skills for daily decision-making with short and long term memory problems and required extensive assistance of two plus persons for transfers. The MDS documented the following in regards to balance and range of motion:  Test For Balance: The resident was not able to attempt Test for Balance without physical help while standing and while sitting - trunk control.  Functional Limitation in Range of Motion (Code	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	<p>Continued From page 19</p> <p>for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury): The resident had limitation in range of motion on one side with full loss of voluntary movement of the arm, hand, leg, and foot.</p> <p>d. The Plan of Care documented the following:</p> <p>1) Problem, original date 12/5/06 and reviewed 6/4/07: "Risk for falls/total dependence from staff needed for locomotion on unit due to: CVA." Interventions were "Have assistance when transferring resident."</p> <p>2) Problem, original date 12/5/06 and reviewed 6/4/07: "Risk for falls due to impaired physical mobility cognitive deficits. 4/19/07 Actual fall - Lowered to the floor without injury." Interventions were 4/19/07 Mechanical lift for all transfers."</p> <p>e. The resident was assessed to need a mechanical lift and extensive assistance of 2 or more staff. On 4/19/07 1 CNA attempted transfer, the resident had to be lowered to floor:</p> <p>The Change in Condition Report - Post Fall/Trauma form documented "On 4/19/07 at 2:30 p.m., the following occurred: Falls: Lowered to the floor by staff in resident's room. (During transfer from wheel chair to bed resident became tense, CNA was unable to complete transfer, lowered resident to floor.)" The Report documented ITD (Interdisciplinary Team) recommendations that staff would use the lift at all times with the resident and staff would be inserviced on use of lifts only.</p> <p>5. Resident #5 had diagnoses of Acute Cerebrovascular Disease, Hypertensive Heart</p>	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	<p>Continued From page 20</p> <p>Disease, Chronic Anemia, Diabetes Mellitus, Chronic Renal Insufficiency, Cerebrovascular Accident, Peripheral Edema, B12 Deficiency, Alzheimer's Disease, Dementia with Behavioral Disturbance and History of Multiple Falls.</p> <p>a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented, "Resident would benefit from SARA Lift but cognitively &amp; behavior wise resident will not comply therefore for safety resident needs MARISA lift." As of 6/6/07, there was no reassessment of the resident's requirement for that specific type of lift.</p> <p>b. The MDS Quarterly Review and 5-Day Medicare Assessment dated 5/10/07 documented the resident had severely impaired cognitive skills for daily decision-making and short/long-term memory problems; required extensive assistance of two persons for transfers; was rarely/never understood and sometimes understood others; was unable to attempt a test for balance while standing without physical assistance; and had behavioral symptoms, that were not easily altered, of verbal abusiveness, physical abusiveness and resistance to care.</p> <p>c. The 14-Day Medicare MDS dated 5/11/07 documented the resident required extensive assistance of one person for transfers and was unable to attempt tests for balance while standing and sitting without physical assistance.</p> <p>d. The resident's Plan of Care documented the following:</p> <p>1) Problems/Strengths, original date 8/18/06: "ADL - [Resident #5] remains at risk for decline in ADL function due to cognitive deficits. She has</p>	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	<p>Continued From page 21</p> <p>STM (short term memory) and LTM (long term memory) loss, impaired decision making ability, and poor safety awareness. Interventions were "Transfers with limited to extensive assistance x 1 person." 5/10/07 "CPOC (continue plan of care)."</p> <p>2) Problems/Strengths, original date 8/18/06: "Fall risk - [Resident #5] remains at risk for falls due to cognitive deficits. She has cognitive deficits with STM, LTM loss, impaired decision making ability and poor safety awareness. On daily psychotropic medication." Interventions were "Orient R (Resident) to surroundings; Call light in reach and answer promptly; Keep bed in lowest position; Assist R with transfers as needed x 1-2 staff; Assure non-skid footwear is worn when OOB (out of bed), ambulating, or transferring; Mattress alarm; Chair alarm; Refer to PT/OT; Observe frequently d/t (due to) hx (history) of falls - encourage/assist R to sit/stay in highly visible area; Night light on after dusk." Last reviewed/updated 5/11/07.</p> <p>3) Problems/Strengths, original date 8/18/06: "General IPN (Interdisciplinary Progress Note) Note: Acute illnesses and summaries. 12/4/06 Actual Fall." Interventions dated 12/4/06 were "Inserviced &amp; instructed staff about leaving resident alone sitting on side of bed; Marisa lift to be used x 2; and SL (Sara Lift) x 2 when getting resident OOB (out of bed)."</p> <p>A line was drawn through "Marisa lift to be used x 2" and "SL x2 when getting resident OOB" with D/C (discontinue) written to the right side of the two interventions. There was no date to indicate when the interventions were discontinued.</p> <p>e. The Nursing Assistant Assignments sheet</p>	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	Continued From page 22 documented that Resident #5 required the Marisa Lift for the shower and the Sara Lift to transfer out of bed.  1) On 6/6/07 at 9:24 a.m., 11:10 a.m. and 2:10 p.m., the resident was observed in a wheel chair. There was no lift sling underneath the resident.  2) On 6/6/07 at 2:10 p.m., the resident's daughter was asked if she had been in the room when the staff transferred her mother. She stated yes, she had several times. When asked how the staff transferred her mother she stated that one CNA would get on one side and another CNA would get on the other side. The CNAs would place their arm under her mothers arm and lift her to the bed or chair. When asked if she had seen the staff use a mechanical lift on her mother, she stated no she hadn't. The daughter was then asked if her mother was able to bear weight. She stated " No, the CNAs lift her."  3) On 6/8/07 at 10:53 a.m., CNA #5 was asked how she knew what residents needed a mechanical lift for transfers. She stated there would be a sign on the door. She also stated that if they have a lift sling underneath them in the wheel chair they would need the Marisa lift. The CNA pointed to a resident nearby that was in a wheel chair and a lift sling was visible around the back of the resident and on each side along side the arms of the wheel chair.  6. Resident #3 had diagnoses of Alzheimer's Disease and Abnormal Gait with Symptoms of the Nervous and Musculoskeletal System.  a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident was a	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	<p>Continued From page 23</p> <p>candidate for the Sara Lift, the illustration of a Sara Lift was circled and the illustrations of the Marisa Lift and the MaxiSide were marked with X's. The assessment failed to document the number of staff needed to assist with transfer per mechanical lift. As of 6/6/07, there was no reassessment of the resident's requirement for that specific type of lift.</p> <p>b. The Quarterly MDS dated 4/23/07 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive to total assistance with activities of daily living with the assistance of one staff, was unable to attempt the tests for balance while standing or sitting-position-or trunk control.</p> <p>c. The Resident's Plan of Care dated 7/24/06 and updated 4/23/07 documented: Problems/Strengths: "Fall risk -[Resident #3] is at risk for falls r/t history of falls, dependence for transfers and cognitive status..... Interventions: orient to surroundings as needed, call light in reach and answer promptly check frequently. Resident may not use call light due to cognitive status. keep bed in lowest position, assist resident with transfers as needed, assure non-skid footwear is worn when out of bed, ambulating or transferring, side rails up x 2 when in bed, night light after dusk. 12/3/06 Found in floor on rounds at bedside, to hospital for Pelvic x-ray Interventions: Bed/Chair alarm, ...siderails to be placed back on bed. 2/1/07 Problem: Actual Fall, no goal, Intervention: Physical Therapy to Evaluate... " The Plan of Care failed to include the need for the Sara Lift and the amount of assistance required for transfers.</p> <p>d. On 6/4/07 at 2:16 p.m., LPN #1 stated the</p>	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	<p>Continued From page 24</p> <p>resident was lifted with a lift and one assistant, had no falls and had 1 skin tear in the past few months.</p> <p>e. On 6/5/07 at 4:20 p.m., the resident was transferred from the bed to a chair by CNA #1 and CNA #2. CNA #2 pulled the resident to the edge of the bed by bending down and asking the resident to put their arms around the CNA's neck. When the resident did not follow the CNA 's instructions, the CNA put the resident's arm around her neck and pulled the resident to the edge of the bed. No gait belt was used. The CNA placed the Sara lift belt under the resident's axilla and around the resident's back, at the level of the axilla.</p> <p>CNA #1 then attempted to raise the resident using the Sara lift, however the lift pulled the resident up by the arms. CNA #2 attempted to get the resident to hold onto the hand grips, but the resident did not follow instructions. CNA #2 continued to cue the resident to hold the hand grips, but there was no attempt by the resident to do so. The resident's feet were bent to the left side of the foot hold and there was no attempt by the CNAs to get the resident's legs in the correct position. When the CNAs were asked if the resident could bear weight, they both responded "No." CNA # 1 stated, "Not at all."</p> <p>7. Resident #7 had a diagnosis of Cerebrovascular Accident with Hemiplegia of the Right Side.</p> <p>a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident was a candidate for the Sara Lift, the illustration of a Sara Lift was circled and the illustrations of the</p>	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>	
(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 324	<p>Continued From page 25</p> <p>Marisa Lift and the MaxiSide were marked with X's. The assessment failed to document the number of staff needed to assist with transfer per mechanical lift. As of 6/7/07, there was no reassessment of the resident's requirement for that specific type of lift.</p> <p>b. The Annual MDS dated 5/14/07 documented the resident was severely impaired in cognitive skills for daily decision making, had short/long-term memory loss, required extensive to total assistance of one staff with activities of daily living, was sometimes understood and sometimes could understand, was unable to attempt a test for balance while standing, and had no limitation in range of motion or voluntary movement.</p> <p>c. The Plan of Care dated 5/14/07 documented: "Problems/Strengths: Needs to be lifted mechanically due to Dx. (diagnosis) of CVA (Cerebrovascular accident). At risk for fall. Goals: Will move in bed as desired and no falls x 90 days. Interventions: Encourage out of bed daily, Use: two staff to assist getting out of bed. Problem: ADL- at risk for decline in ADL function due to CVA with right side Hemiplegia. Interventions: ...8th intervention: Lift Transfers with Assist x 2"</p> <p>d. The Nursing Assignment sheet documented the resident was to be transferred with a Sara Lift with the assistance of 1 to 2 staff.</p> <p>On 6/4/07 at 2:16 p.m., LPN #1 stated the resident was lifted with a lift and one assistant and had no falls.</p> <p>e. An in-service on Transfers and Lifts dated</p>	F 324		

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	<p>Continued From page 26</p> <p>6/5/07 at 10:30 a.m., received from the Director of Nursing on 6/6/07 at 5:50 p.m., documented that CNA #1 had signed the in-service training sheet.</p> <p>f. On 6/5/07 at 10:45 a.m., CNA #1 transferred the resident from the bed to a chair. With the resident sitting on the side of the bed, CNA #1 placed the Sara lift belt under the resident's axilla area and around the resident's back at the level of the axilla. The CNA then attempted to raise the resident. As the Sara lift was pulling the resident up by the arms, CNA #1 attempted to get the resident to hold onto the hand grips. The resident had contractures of both hands and had the left hand on top of the bar trying to hold on and could only get one finger of the right hand over the grip bar.</p> <p>The resident's feet were not positioned for the knees to bend into the knee plate. The resident's buttocks were bent out and the resident's weight was on the axilla area. There was no attempt by the CNA to get the resident's legs in the correct position or get the Sara belt down around the resident's waist. When asked if the resident could bear weight, the CNA responded "No." When asked if she transferred the resident by herself all the time, the CNA stated " Yes."</p> <p>8. The Immediate Jeopardy was removed and the scope and severity lowered to an "G" when the facility implemented the following plan of removal on 6/8/07.</p> <p>PLAN OF REMOVAL:</p> <p>"Please accept this as our Immediate Plan of Removal for Assessments, Supervision to prevent Accidents and C.N.A. [Certified Nurse</p>	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	Continued From page 27 Assistant] Proficiency effective 6-7-07 at 7:15 pm  1. Identification of residents who use a lift and what kind is currently being used.  a. MDS [Minimum Data Set] Coordinator will pull MDS Query to identify residents who require a lift for transferring from bed to chair on 6-7-07.  b. Staffing Coordinator will identify the type lift each resident is currently being transferred with on 6-7-07.  c. MDS Coordinator will pull MDS Query to identify residents who are at a high risk for falls.  2. Assessment of resident to determine if lift is required and type lift needed.  a. Registered Nurses on 06-07-2007 will visually assess all residents residing in the facility to include but not limited to those who have been identified by the MDS as requiring a mechanical lift for transfer from the bed to the chair and/or vice versa using the Lift/Movement Assessment and visual observation.  b. The assessment findings will be documented on the Lift/Movement Assessment to include the number of staff required for the transfer and placed in the resident's medical record.  c. The Physical Therapist and the Physician Assistant will assist in determining if the assessment for each resident has resulted in the correct method of transfer of the resident from bed to chair. 6-8-07.  d. The Care Plan and the C.N.A. Assignment	F 324			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 324	Continued From page 28 sheet will be updated by the MDS Coordinator and the RN Nurse Consultant on 6-7-07 and be completed by 6-8-07 end of day.  e. The Registered Nurse will assess resident who may be in the hospital or on leave upon return to the facit using the Lift/Movement Assessment and visual observation.  f. The Care Plan and the C.N.A. Assignment Sheets, and ML,SL stickers on name plates will be updated daily by the RN with changes in assessment/type lift required.  3. Training of staff to assure safety for residents requiring a lift for transfer.  a. The R.N. Clinical Nurse Consultant trained the Registered Nurses in the facility to perform a transfer assessment on a resident requiring assistance with transfers from bed to chair on 6-07-07  b. The Registered Nurse Director of Clinical Education will retrain all Certified Nursing Assistants beginning on 6-7-07 and completing on 6-8-07 for those on the schedule.  c. C.N.A's on sick leave, vacation, etc who are not on the schedule for 6-7-07 thru 6-8-07 will be retrained on the next scheduled work day prior to providing care to a resident by the Registered Nurse.  d. Training will be documented on the In-Service Record and maintained in the RN DCE's [Director of Clinical Education] office.  e. New employees hired by the facility will be	F 324			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>	
(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 324	Continued From page 29 trained on use of the lift by the DCE or DNS prior to giving care to a resident. Training record will be placed in the new employee file in the business office.  f. The Operating Instructions Manual for the Marisa Lift and the Sara Lift will be placed in a binder at each nurses station as a reference for direct care givers to use as a reference.  4. Monitoring to assure effectiveness of the system:  a. The DNS/Designee [Director of Nursing Services] will visually observe 5 C.N.A.'s transfer 5 residents from bed to chair and/or chair to bed 7 days a week, alternating shifts to assure safe transfers are being performed with the designated lift for residents.  b. The DNS/Designee will document the visual observation with return demonstration on the Transfer of Resident from Bed to Chair Care Audit. The audits will be completed on alternating shifts to assure all C.N.A's are visually monitored and have a clear understanding of the training/system."	F 324		
F 490 SS=K	483.75 ADMINISTRATION  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Complaint #12590 was substantiated (all or in	F 490		

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	Continued From page 30 part) with these findings.  Based on observation, record review, and interview, Nursing Administration failed to ensure the most appropriate mechanical lift was in use, staff were competent in using specific types of mechanical lifts, and that staff were transferring residents according to assessed/care planned needs in order to safely conduct transfers for 5 (Residents #1, #3, #5, #6, and #7) of 7 (Residents #1 thru #7) case-mix residents assessed for the use of a mechanical lift. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Residents #1, #3, #5, #6 and #7 and resulted in actual harm for Resident #6 who sustained a fracture during a transfer. This failed practice had the potential to affect 27 residents who required the use of the Marisa Lift, 16 residents who required the use of the Sara Lift and 27 residents who were non-weight bearing, according to the Nurse Consultant on 6/8/07 at 3:00 p.m. The facility was notified of the Immediate Jeopardy on 6/7/07 at 4:18 p.m. The findings are:  1. The facility Policy and Procedure titled Transfer Activities, received from the Administrator on 6/8/07 at 2:55 p.m., documented: " Procedure 655, Basic Responsibility: Licensed Nurse and Nursing Assistant, Restorative Nursing Assistant. Purpose: To transfer the resident from bed to chair, toilet or tub safely. ASSESSMENT GUIDELINES: May include , but not limited to: Loss of range of motion, Location and amount of pain or discomfort., Ability to perform ADL's, Contractures, Deformity, Ability to stand and bear weight, Loss of Balance, Loss of voluntary control of extremities, Paresis or paralysis, Amputation, Fracture. PROCEDURE: Transfer	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	Continued From page 31 from bed to wheelchair: 1. Obtain assistance of another individual if necessary for safe transfer. Care Plan Documentation Guidelines: Problem: Identify the appropriate problem under which to list transfer activity as an approach... Consider listing possible risks and complications... Approaches: List Instructions unique to this resident, List necessary monitoring and observation of the resident's ability to participate in care... List Monitoring for proper body alignment.  2. A document, received from the Nurse Consultant 06/07/07, titled Beverly Lift Program Mechanical Skills Check-Off documented: "SARA 2000 [Bullet # 1]: Extensive assist, partial weight-bearing (at least one leg) individual... SAFETY QUESTIONS for SARA 2000, [Bullet #1]: Can Resident bear weight on one leg? [Bullet # 2]: Does Resident have some upper body strength and trunk stability? [Bullet #3]: Does Resident understand verbal instructions? ...Back of page: SARA 2000 # 2 : Explain lift procedure to Resident. #3: Position SARA sling around the resident's back at waist... #5 Fasten safety belt around resident's waist... #7: Cue resident to place feet onto the platform of the lift... # 14: Cue resident to remove feet from footplate and move lift away from the resident.  3. Resident #6 had diagnoses of Osteoporosis, Osteoarthritis, Dysphagia, Chronic Airway Obstruction, Peripheral Vascular Disease, Decubitus Ulcer, and Hypertension.  a. The Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident required a Marisa mechanical lift with 1-2 for the number of staff needed.	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	<p>Continued From page 32</p> <p>b. The Minimum Data Set (MDS) Annual full assessment, dated 1/12/07, documented the resident required extensive assistance of two person for transfers and required a mechanical lift.</p> <p>c. The Minimum Data Set (MDS) Quarterly Review assessment, dated 4/6/07, documented the resident had moderately impaired cognitive skills for daily decision-making with short and long term memory problems and required extensive assistance of one person for transfers. The MDS documented the following in regards to balance and range of motion:</p> <p>Test For Balance: The resident was not able to attempt Test for Balance without physical help while standing and while sitting - trunk control.</p> <p>Functional Limitation in Range of Motion (Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury): The resident had limitation in range of motion on both sides with full loss of voluntary movement of legs - including hip or knee, and both feet - including ankle or toes. The arm - including shoulder or elbow, and the hand - including wrist or fingers, had limitation of range of motion on one side with full loss of voluntary movement.</p> <p>d. The Plan of Care documented the following:</p> <p>(1) Problem, identified on 1/12/07 and last reviewed on 4/7/07: "ADL - Resident at risk for decline in ADL (activities of daily living) R/T (related to) needs assistance with bed mobility; had limited ROM (range of motion) to bil.</p>	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	<p>Continued From page 33</p> <p>(bilateral) lower extremities." Interventions were assist times 2 staff for transfers into wheel chair; mechanical lift as needed.</p> <p>(2) Problem, identified on 1/12/07 and last reviewed on 4/7/07: "Risk for fractures R/T (related to) Osteoporosis." Interventions were "Movements should be slow with no sudden jerking or dropping of limbs. Discourage flexion exercises and sudden bending or jarring."</p> <p>(3) Problem, identified on 3/21/07 and last reviewed on 4/7/07: "Fall risk - [Resident #6] is at risk for falls d/t (due to) has impaired cognition with memory loss, impaired decision making ability, poor safety awareness, limited physical mobility, and receives medications that may increase the risk of falls." Interventions were "assist R (resident) with transfers as needed x 1-2 staff mechanical lift."</p> <p>(4) Problem, identified on 5/18/07: "Resident @ risk for injury 2nd to (secondary to) foot drop. Actual injury during transfer". Interventions were X-ray, Marisa lift only, and Retrain staff.</p> <p>e. The Nurse's Notes, dated 5/18/07 at 2:21 p.m., documented "Resident is assisted up to wheel chair for lunch. During meal Resident C/O (complained of) right knee hurting. LPN (Licensed Practical Nurse) checked knee noted it to be swollen discolored, warm to touch. Resident denies knee being bumped. Triage for [Physician #1] made aware new order for stat right knee x-ray, Lortab 5/500 1 po (by mouth) q (every) 6 prn (as needed) pain. Lortab given at 1305 (1:05 p.m.). Little relief at 1410 (2:10 p.m.). [Daughter] made aware of condition and of new orders. 1320 (1:20 p.m.) mobile x here to do</p>	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	<p>Continued From page 34</p> <p>x-ray awaiting results. 1430 (2:30 p.m.) Results are called as Acute impacted proximal tibial shaft fracture. [Physician Assistant] made aware new order to send res. (resident) to ER (emergency room)."</p> <p>1) An X-ray Report for the right knee, dated 5/18/07, documented "There is a fracture involving right proximal tibial shaft with impaction. The joint shows no dislocation. There is associated joint effusion. Osteoporosis is present." Impression: "Acute impacted proximal tibial shaft fracture."</p> <p>2) A handwritten OLTC (Office of Long Term Care) Witness Statement Form, dated 5/18/07 and signed by LPN #2, documented "I asked [CNA #3] (Certified Nurse Assistant) to get resident up for lunch. As the CNA came to day area with [Resident #6] the CNA stated You know you were wrong for that, she slid all over everywhere. While [Resident #6] was at the table I was covering Res's legs &amp; feet with a sheet. I bumped the pillow that was between Res legs. At that time [Resident #6] yelled 'Oh my leg.' I looked at her leg noted a swollen area, warm to touch &amp; red. I called Triage to get a order for stat x-ray &amp; pain medication."</p> <p>3) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by RN #1, documented "@ 1300 (1:00 p.m.) LPN reported to me that [Resident #6] c/o (complained of) severe pain to her (R) leg. When she moved pillow when resident up @ lunch time. Residents leg is swollen @ and below the (R) knee. Bruising noted - worm to touch. Portable X-ray had already been ordered by LPN. Resident denies having been dropped or fallen. Reports that she</p>	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	<p>Continued From page 35</p> <p>doesn't remember anyone bumping her leg on anything. X-ray report shows fracture to the (R) leg. Sent to [Hospital #1] ER per M.D. order."</p> <p>f. The CNAs involved in the incident did not use a mechanical lift as resident was assessed and care planned to need:</p> <p>1) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by CNA #3, documented: "While transferring resident to w/c (wheel chair) for lunch me &amp; another care specilities [sic] sat resident up on side of bed. Her feet have a foot drop so we body lift resident to w/c. I did not look down at her feet when transferring. Resident did not yell or scream out during transfer. Pushed resident at into dining room c (with) no c/o pain."</p> <p>2) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by CNA #4, documented "I was helping [CNA #3] put [Resident #6] in her chair for lunch. We got her up and set her on the side of the bed to put a gown on her. We bodied lifted her to put her in the chair. Her feet did not touch the floor and she didn't complain of pain when we got her up."</p> <p>g. The Verification of Investigation report documented:</p> <p>1) Causal/contributing Factors and Observations was "While transferring resident CNAs sat her on the side of the bed and transferred."</p> <p>2) Summary and Outcome of investigative findings was "No abuse or neglect suspected. During a transfer resident's foot was hit on bedrail. Staff was retrained on proper transfers</p>	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	Continued From page 36 and proper use of lift."  h. An inservice Summary Report of Meeting, dated 5/21/07 at 10:00 a.m., documented training on transfers by the DCE (Director of Clinical Education) via demonstration, lecture, and handouts with return demonstrations on lifts. CNA #3 and CNA #4 were the only two staff that signed as attending the inservice.  i. Review of the inservice Summary Report of Meeting forms and return demonstration forms, provided by the Administrator on 6/6/07 at 5:50 p.m., revealed that no other staff were inserviced/trained on transfers and the use of a lift until 6/4/07.  j. Nurses Notes dated 5/21/07 documented the resident was admitted to the hospital at 1:30 p.m. for Chronic Obstructive Pulmonary Disease. The resident was not present during the survey.  4. Resident #1 had diagnoses of Muscle Weakness, Spasm of Muscles, Occlusion of Cerebral Arteries, Cerebral Vascular Accident (CVA), Hypertension, Thyrotoxicosis with or without Goiter, and Diabetes Mellitus.  a. The Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident required a Marisa mechanical lift with 1-2 for the number of staff needed. As of 6/6/07, there was no reassessment of the resident's requirement for that specific type of lift.  b. The MDS Annual full assessment, dated 9/5/06, documented the resident was totally dependent on two plus persons for transfers and mode of transfer and required a mechanical lift.	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	Continued From page 37  c. The MDS Quarterly Review assessment, dated 3/6/07, documented the resident had severely impaired cognitive skills for daily decision-making with short and long term memory problems and required extensive assistance of two plus persons for transfers. The MDS documented the following in regards to balance and range of motion:  Test For Balance: The resident was not able to attempt Test for Balance without physical help while standing and while sitting - trunk control.  Functional Limitation in Range of Motion (Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury): The resident had limitation in range of motion on one side with full loss of voluntary movement of the arm, hand, leg, and foot.  d. The Plan of Care documented the following:  1) Problem, original date 12/5/06 and reviewed 6/4/07: "Risk for falls/total dependence from staff needed for locomotion on unit due to: CVA." Interventions were "Have assistance when transferring resident."  2) Problem, original date 12/5/06 and reviewed 6/4/07: "Risk for falls due to impaired physical mobility cognitive deficits. 4/19/07 Actual fall - Lowered to the floor without injury." Interventions were 4/19/07 Mechanical lift for all transfers."  e. The resident was assessed to need mechanical lift and extensive assistance of 2 or more staff. On 4/19/07 1 CNA attempted transfer, the resident had to be lowered to floor:	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	Continued From page 38  The Change in Condition Report - Post Fall/Trauma form documented "On 4/19/07 at 2:30 p.m., the following occurred: Falls: Lowered to the floor by staff in resident's room. (During transfer from wheel chair to bed resident became tense, CNA was unable to complete transfer, lowered resident to floor.)" The Report documented ITD (Interdisciplinary Team) recommendations that staff would use the lift at all times with the resident and staff would be inserviced on use of lifts only.  5. Resident #5 had diagnoses of Acute Cerebrovascular Disease, Hypertensive Heart Disease, Chronic Anemia, Diabetes Mellitus, Chronic Renal Insufficiency, Cerebrovascular Accident, Peripheral Edema, B12 Deficiency, Alzheimer's Disease, Dementia with Behavioral Disturbance and History of Multiple Falls.  a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented, "Resident would benefit from SARA Lift but cognitively & behavior wise resident will not comply therefore for safety resident needs MARISA lift." As of 6/6/07, there was no reassessment of the resident's requirement for that specific type of lift.  b. The MDS Quarterly Review and 5-Day Medicare Assessment dated 5/10/07 documented the resident had severely impaired cognitive skills for daily decision-making and short/long-term memory problems; required extensive assistance of two persons for transfers; was rarely/never understood and sometimes understood others; was unable to attempt a test for balance while standing without physical assistance; and had behavioral symptoms, that were not easily	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	Continued From page 39 altered, of verbal abusiveness, physical abusiveness and resistance to care.  c. The 14-Day Medicare MDS dated 5/11/07 documented the resident required extensive assistance of one person for transfers and was unable to attempt tests for balance while standing and sitting without physical assistance.  d. The resident's Plan of Care documented the following:  1) Problems/Strengths, original date 8/18/06: "ADL - [Resident #5] remains at risk for decline in ADL function due to cognitive deficits. She has STM (short term memory) and LTM (long term memory) loss, impaired decision making ability, and poor safety awareness. Interventions were "Transfers with limited to extensive assistance x 1 person." 5/10/07 "CPOC (continue plan of care)."  2) Problems/Strengths, original date 8/18/06: "Fall risk - [Resident #5] remains at risk for falls due to cognitive deficits. She has cognitive deficits with STM, LTM loss, impaired decision making ability and poor safety awareness. On daily psychotropic medication." Interventions were "Orient R (Resident) to surroundings; Call light in reach and answer promptly; Keep bed in lowest position; Assist R with transfers as needed x 1-2 staff; Assure non-skid footwear is worn when OOB (out of bed), ambulating, or transferring; Mattress alarm; Chair alarm; Refer to PT/OT; Observe frequently d/t (due to) hx (history) of falls - encourage/assist R to sit/stay in highly visible area; Night light on after dusk." Last reviewed/updated 5/11/07.  3) Problems/Strengths, original date 8/18/06:	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	<p>Continued From page 40</p> <p>"General IPN (Interdisciplinary Progress Note) Note: Acute illnesses and summaries. 12/4/06 Actual Fall". Interventions dated 12/4/06 were "Inserviced &amp; instructed staff about leaving resident alone sitting on side of bed; Marisa lift to be used x 2; and SL (Sara Lift) x 2 when getting resident OOB (out of bed)."</p> <p>A line was drawn through "Marisa lift to be used x 2" and "SL x2 when getting resident OOB" with D/C (discontinue) written to the right side of the two interventions. There was no date to indicate when the interventions were discontinued.</p> <p>e. The Nursing Assistant Assignments sheet documented that Resident #5 required the Marisa Lift for the shower and the Sara Lift to transfer out of bed.</p> <p>1) On 6/6/07 at 9:24 a.m., 11:10 a.m. and 2:10 p.m., the resident was observed in a wheel chair. There was no lift sling underneath the resident.</p> <p>2) On 6/6/07 at 2:10 p.m., the resident's daughter was asked if she had been in the room when the staff transferred her mother. She stated yes, she had several times. When asked how the staff transferred her mother she stated that one CNA would get on one side and another CNA would get on the other side. The CNAs would place their arm under her mothers arm and lift her to the bed or chair. When asked if she had seen the staff use a mechanical lift on her mother, she stated no she hadn't. The daughter was then asked if her mother was able to bear weight. She stated " No, the CNAs lift her."</p> <p>3) On 6/8/07 at 10:53 a.m., CNA #5 was asked how she knew what residents needed a</p>	F 490			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	<p>Continued From page 41</p> <p>mechanical lift for transfers. She stated there would be a sign on the door. She also stated that if they have a lift sling underneath them in the wheel chair they would need the Marisa lift. The CNA pointed to a resident nearby that was in a wheel chair and a lift sling was visible around the back of the resident and on each side along side the arms of the wheel chair.</p> <p>6. Resident #3 had diagnoses of Alzheimer's Disease and Abnormal Gait with Symptoms of the Nervous and Musculoskeletal System.</p> <p>a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident was a candidate for the Sara Lift, the illustration of a Sara Lift was circled and the illustrations of the Marisa Lift and the MaxiSide were marked with X's. The assessment failed to document the number of staff needed to assist with transfer per mechanical lift. As of 6/6/07, there was no reassessment of the resident's requirement for that specific type of lift.</p> <p>b. The Quarterly MDS dated 4/23/07 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive to total assistance with activities of daily living with the assistance of one staff, was unable to attempt the tests for balance while standing or sitting-position-or trunk control.</p> <p>c. The Resident's Plan of Care dated 7/24/06 and updated 4/23/07 documented: Problems/Strengths: "Fall risk -[Resident #3] is at risk for falls r/t history of falls, dependence for transfers and cognitive status..... Interventions: orient to surroundings as needed, call light in reach and answer promptly check frequently.</p>	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	<p>Continued From page 42</p> <p>Resident may not use call light due to cognitive status. keep bed in lowest position, assist resident with transfers as needed, assure non-skid footwear is worn when out of bed, ambulating or transferring, side rails up x 2 when in bed, night light after dusk. 12/3/06 Found in floor on rounds at bedside, to hospital for Pelvic x-ray Interventions: Bed/Chair alarm, ...siderails to be placed back on bed. 2/1/07 Problem: Actual Fall, no goal, Intervention: Physical Therapy to Evaluate..." The Plan of Care failed to include the need for the Sara Lift and the amount of assistance required for transfers.</p> <p>d. On 6/4/07 at 2:16 p.m., LPN #1 stated the resident was lifted with a lift and one assistant, had no falls and had 1 skin tear in the past few months.</p> <p>e. On 6/5/07 at 4:20 p.m., the resident was transferred from the bed to a chair by CNA #1 and CNA #2. CNA #2 pulled the resident to the edge of the bed by bending down and asking the resident to put their arms around the CNA's neck. When the resident did not follow the CNA 's instructions, the CNA put the resident's arm around her neck and pulled the resident to the edge of the bed. No gait belt was used. The CNA placed the Sara lift belt under the resident's axilla and around the resident's back, at the level of the axilla.</p> <p>CNA #1 then attempted to raise the resident using the Sara lift, however the lift pulled the resident up by the arms. CNA #2 attempted to get the resident to hold onto the hand grips, but the resident did not follow instructions. CNA #2 continued to cue the resident to hold the hand grips, but there was no attempt by the resident to</p>	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	<p>Continued From page 43</p> <p>do so. The resident's feet were bent to the left side of the foot hold and there was no attempt by the CNAs to get the resident's legs in the correct position. When the CNAs were asked if the resident could bear weight, they both responded "No." CNA # 1 stated, "Not at all."</p> <p>7. Resident #7 had a diagnosis of Cerebrovascular Accident with Hemiplegia of the Right Side.</p> <p>a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident was a candidate for the Sara Lift, the illustration of a Sara Lift was circled and the illustrations of the Marisa Lift and the MaxiSide were marked with X's. The assessment failed to document the number of staff needed to assist with transfer per mechanical lift. As of 6/7/07, there was no reassessment of the resident's requirement for that specific type of lift.</p> <p>b. The Annual MDS dated 5/14/07 documented the resident was severely impaired in cognitive skills for daily decision making, had short/long-term memory loss, required extensive to total assistance of one staff with activities of daily living, was sometimes understood and sometimes could understand, was unable to attempt a test for balance while standing, and had no limitation in range of motion or voluntary movement.</p> <p>c. The Plan of Care dated 5/14/07 documented: "Problems/Strengths: Needs to be lifted mechanically due to Dx. (diagnosis) of CVA (Cerebrovascular accident). At risk for fall. Goals: Will move in bed as desired and no falls x 90 days. Interventions: Encourage out of bed daily,</p>	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	<p>Continued From page 44</p> <p>Use: two staff to assist getting out of bed. Problem: ADL- at risk for decline in ADL function due to CVA with right side Hemiplegia. Interventions: ...8th intervention: Lift Transfers with Assist x 2"</p> <p>d. The Nursing Assignment sheet documented the resident was to be transferred with a Sara Lift with the assistance of 1 to 2 staff.</p> <p>On 6/4/07 at 2:16 p.m., LPN #1 stated the resident was lifted with a lift and one assistant and had no falls.</p> <p>e. An in-service on Transfers and Lifts dated 6/5/07 at 10:30 a.m., received from the Director of Nursing on 6/6/07 at 5:50 p.m., documented that CNA #1 had signed the in-service training sheet.</p> <p>f. On 6/5/07 at 10:45 a.m., CNA #1 transferred the resident from the bed to a chair. With the resident sitting on the side of the bed, CNA #1 placed the Sara lift belt under the resident's axilla area and around the resident's back at the level of the axilla. The CNA then attempted to raise the resident. As the Sara lift was pulling the resident up by the arms, CNA #1 attempted to get the resident to hold onto the hand grips. The resident had contractures of both hands and had the left hand on top of the bar trying to hold on and could only get one finger of the right hand over the grip bar.</p> <p>The resident's feet were not positioned for the knees to bend into the knee plate. The resident's buttocks were bent out and the resident's weight was on the axilla area. There was no attempt by the CNA to get the resident's legs in the correct position or get the Sara belt down around the</p>	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	Continued From page 45 resident's waist. When asked if the resident could bear weight, the CNA responded "No." When asked if she transferred the resident by herself all the time, the CNA stated " Yes."  8. The Immediate Jeopardy was removed and the scope and severity lowered to an "G" when the facility implemented the following plan of removal on 6/8/07.  PLAN OF REMOVAL:  "Please accept this as our Immediate Plan of Removal for Assessments, Supervision to prevent Accidents and C.N.A. [Certified Nurse Assistant] Proficiency effective 6-7-07 at 7:15 pm  1. Identification of residents who use a lift and what kind is currently being used.  a. MDS [Minimum Data Set] Coordinator will pull MDS Query to identify residents who require a lift for transferring from bed to chair on 6-7-07.  b. Staffing Coordinator will identify the type lift each resident is currently being transferred with on 6-7-07.  c. MDS Coordinator will pull MDS Query to identify residents who are at a high risk for falls.  2. Assessment of resident to determine if lift is required and type lift needed.  a. Registered Nurses on 06-07-2007 will visually assess all residents residing in the facility to include but not limited to those who have been identified by the MDS as requiring a mechanical lift for transfer from the bed to the chair and/or	F 490			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	Continued From page 46 vice versa using the Lift/Movement Assessment and visual observation.  b. The assessment findings will be documented on the Lift/Movement Assessment to include the number of staff required for the transfer and placed in the resident's medical record.  c. The Physical Therapist and the Physician Assistant will assist in determining if the assessment for each resident has resulted in the correct method of transfer of the resident from bed to chair. 6-8-07.  d. The Care Plan and the C.N.A. Assignment sheet will be updated by the MDS Coordinator and the RN Nurse Consultant on 6-7-07 and be completed by 6-8-07 end of day.  e. The Registered Nurse will assess resident who may be in the hospital or on leave upon return to the facit using the Lift/Movement Assessment and visual observation.  f. The Care Plan and the C.N.A. Assignment Sheets, and ML,SL stickers on name plates will be updated daily by the RN with changes in assessment/type lift required.  3. Training of staff to assure safety for residents requiring a lift for transfer.  a. The R.N. Clinical Nurse Consultant trained the Registered Nurses in the facility to perform a transfer assessment on a resident requiring assistance with transfers from bed to chair on 6-07-07  b. The Registered Nurse Director of Clinical	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	Continued From page 47 Education will retrain all Certified Nursing Assistants beginning on 6-7-07 and completing on 6-8-07 for those on the schedule.  c. C.N.A's on sick leave, vacation, etc who are not on the schedule for 6-7-07 thru 6-8-07 will be retrained on the next scheduled work day prior to providing care to a resident by the Registered Nurse.  d. Training will be documented on the In-Service Record and maintained in the RN DCE's [Director of Clinical Education] office.  e. New employees hired by the facility will be trained on use of the lift by the DCE or DNS prior to giving care to a resident. Training record will be placed in the new employee file in the business office.  f. The Operating Instructions Manual for the Marisa Lift and the Sara Lift will be placed in a binder at each nurses station as a reference for direct care givers to use as a reference.  4. Monitoring to assure effectiveness of the system:  a. The DNS/Designee [Director of Nursing Services] will visually observe 5 C.N.A.'s transfer 5 residents from bed to chair and/or chair to bed 7 days a week, alternating shifts to assure safe transfers are being performed with the designated lift for residents.  b. The DNS/Designee will document the visual observation with return demonstration on the Transfer of Resident from Bed to Chair Care Audit. The audits will be completed on alternating	F 490			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 490	Continued From page 48 shifts to assure all C.N.A's are visually monitored and have a clear understanding of the training/system."	F 490			
F 498 SS=K	483.75(f) PROFICIENCY OF NURSE AIDES  The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.  This REQUIREMENT is not met as evidenced by: Complaint #12590 was substantiated (all or in part) with these findings.  Based on observation, record review and interview, the facility failed to ensure Certified Nursing Assistants (CNA) were competent in providing assistance with transfers for 4 (Residents #1, #3, #5, #6 and #7) of 7 (Residents #1 thru #7) case mix residents who required assistance with transfers. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Residents #1, #3, #5, #6 and #7 and resulted in actual harm for Resident #6 who sustained a fracture during a transfer. This failed practice had the potential to affect 27 residents who required the use of the Marisa Lift, 16 residents who required the use of the Sara Lift and 27 residents who were non-weight bearing, according to the Nurse Consultant on 6/8/07 at 3:00 p.m. The facility was notified of the Immediate Jeopardy on 6/7/07 at 4:18 p.m. The findings are:  1. The facility Policy and Procedure titled Transfer Activities, received from the Administrator on	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	Continued From page 49 6/8/07 at 2:55 p.m., documented: " Procedure 655, Basic Responsibility: Licensed Nurse and Nursing Assistant, Restorative Nursing Assistant. Purpose: To transfer the resident from bed to chair, toilet or tub safely. ASSESSMENT GUIDELINES: May include , but not limited to: Loss of range of motion, Location and amount of pain or discomfort., Ability to perform ADL's, Contractures, Deformity, Ability to stand and bear weight, Loss of Balance, Loss of voluntary control of extremities, Paresis or paralysis, Amputation, Fracture. PROCEDURE: Transfer from bed to wheelchair: 1. Obtain assistance of another individual if necessary for safe transfer. Care Plan Documentation Guidelines: Problem: Identify the appropriate problem under which to list transfer activity as an approach... Consider listing possible risks and complications... Approaches: List Instructions unique to this resident, List necessary monitoring and observation of the resident's ability to participate in care... List Monitoring for proper body alignment.  2. A document, received from the Nurse Consultant 06/07/07, titled Beverly Lift Program Mechanical Skills Check-Off documented: "SARA 2000 [Bullet # 1]: Extensive assist, partial weight-bearing (at least one leg) individual... SAFETY QUESTIONS for SARA 2000, [Bullet #1]: Can Resident bear weight on one leg? [Bullet # 2]: Does Resident have some upper body strength and trunk stability? [Bullet #3]: Does Resident understand verbal instructions? ...Back of page: SARA 2000 # 2 : Explain lift procedure to Resident. #3: Position SARA sling around the resident's back at waist... #5 Fasten safety belt around resident's waist... #7: Cue resident to place feet onto the platform of the lift... # 14: Cue	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	Continued From page 50 resident to remove feet from footplate and move lift away from the resident.  3. Resident #3 had diagnoses of Alzheimer's Disease and Abnormal Gait with Symptoms of the Nervous and Musculoskeletal System.  a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident was a candidate for the Sara Lift, the illustration of a Sara Lift was circled and the illustrations of the Marisa Lift and the MaxiSide were marked with X's.  b. The Quarterly MDS dated 4/23/07 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive to total assistance with activities of daily living with the assistance of one staff, was unable to attempt the tests for balance while standing or sitting-position-or trunk control.  c. The Resident's Plan of Care dated 7/24/06 and updated 4/23/07 documented: Problems/Strengths: "Fall risk -[Resident #3] is at risk for falls r/t history of falls, dependence for transfers and cognitive status..... Interventions: orient to surroundings as needed, call light in reach and answer promptly check frequently. Resident may not use call light due to cognitive status. keep bed in lowest position, assist resident with transfers as needed, assure non-skid footwear is worn when out of bed, ambulating or transferring, side rails up x 2 when in bed, night light after dusk. 12/3/06 Found in floor on rounds at bedside, to hospital for Pelvic x-ray Interventions: Bed/Chair alarm, ...siderails to be placed back on bed. 2/1/07 Problem: Actual Fall, no goal, Intervention: Physical Therapy to	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	Continued From page 51 Evaluate... "  d. On 6/5/07 at 4:20 p.m., the resident was transferred from the bed to a chair by CNA #1 and CNA #2. CNA #2 pulled the resident to the edge of the bed by bending down and asking the resident to put their arms around the CNA's neck. When the resident did not follow the CNA's instructions, the CNA put the resident's arm around her neck and pulled the resident to the edge of the bed. No gait belt was used. The CNA placed the Sara lift belt under the resident's axilla and around the resident's back, at the level of the axilla.  CNA #1 then attempted to raise the resident using the Sara lift, however the lift pulled the resident up by the arms. CNA #2 attempted to get the resident to hold onto the hand grips, but the resident did not follow instructions. CNA #2 continued to cue the resident to hold the hand grips, but there was no attempt by the resident to do so. The resident's feet were bent to the left side of the foot hold and there was no attempt by the CNAs to get the resident's legs in the correct position. When the CNAs were asked if the resident could bear weight, they both responded "No." CNA #1 stated, "Not at all."  4. Resident #7 had a diagnosis of Cerebrovascular Accident with Hemiplegia of the Right Side.  a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident was a candidate for the Sara Lift, the illustration of a Sara Lift was circled and the illustrations of the Marisa Lift and the MaxiSide were marked with X's.	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	Continued From page 52  b. The Annual MDS dated 5/14/07 documented the resident was severely impaired in cognitive skills for daily decision making, had short/long-term memory loss, required extensive to total assistance of one staff with activities of daily living, was sometimes understood and sometimes could understand, was unable to attempt a test for balance while standing, and had no limitation in range of motion or voluntary movement.  c. The Plan of Care dated 5/14/07 documented: "Problems/Strengths: Needs to be lifted mechanically due to Dx. (diagnosis) of CVA (Cerebrovascular Accident). At risk for fall. Goals: Will move in bed as desired and no falls x 90 days. Interventions: Encourage out of bed daily, Use: two staff to assist getting out of bed. Problem: ADL- at risk for decline in ADL function due to CVA with right side Hemiplegia. Interventions: ...8th intervention: Lift Transfers with Assist x 2"  d. The Nursing Assignment sheet documented the resident was to be transferred with a Sara Lift with the assistance of 1 to 2 staff.  e. An in-service on Transfers and Lifts dated 6/5/07 at 10:30 a.m., received from the Director of Nursing on 6/6/07 at 5:50 p.m., documented that CNA #1 had signed the in-service training sheet.  f. On 6/5/07 at 10:45 a.m., CNA #1 transferred the resident from the bed to a chair. With the resident sitting on the side of the bed, CNA #1 placed the Sara lift belt under the resident's axilla area and around the resident's back at the level of the axilla. The CNA then attempted to raise	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	<p>Continued From page 53</p> <p>the resident. As the Sara lift was pulling the resident up by the arms, CNA #1 attempted to get the resident to hold onto the hand grips. The resident had contractures of both hands and had the left hand on top of the bar trying to hold on and could only get one finger of the right hand over the grip bar.</p> <p>The resident's feet were not positioned for the knees to bend into the knee plate. The resident's buttocks were bent out and the resident's weight was on the axilla area. There was no attempt by the CNA to get the resident's legs in the correct position or get the Sara belt down around the resident's waist. When asked if the resident could bear weight, the CNA responded "No." When asked if she transferred the resident by herself all the time, the CNA stated " Yes."</p> <p>5. Resident #6 had diagnoses of Osteoporosis, Osteoarthritis, Dysphagia, Chronic Airway Obstruction, Peripheral Vascular Disease, Decubitus Ulcer, and Hypertension.</p> <p>a. The Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident required a Marisa mechanical lift with 1 - 2 for the number of staff needed.</p> <p>b. The Minimum Data Set (MDS) Annual full assessment, dated 1/12/07, documented the resident required extensive assistance of two person for transfers and required a mechanical lift.</p> <p>c. The Minimum Data Set (MDS) Quarterly Review assessment, dated 4/6/07, documented the resident had moderately impaired cognitive</p>	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	<p>Continued From page 54</p> <p>skills for daily decision-making with short and long term memory problems and required extensive assistance of one person for transfers. The MDS documented the following in regards to balance and range of motion:</p> <p>Test For Balance: The resident was not able to attempt Test for Balance without physical help while standing and while sitting - trunk control.</p> <p>Functional Limitation in Range of Motion (Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury): The resident had limitation in range of motion on both sides with full loss of voluntary movement of legs - including hip or knee, and both feet - including ankle or toes. The arm - including shoulder or elbow, and the hand - including wrist or fingers, had limitation of range of motion on one side with full loss of voluntary movement.</p> <p>d. The Plan of Care documented the following:</p> <p>(1) Problem, identified on 1/12/07 and last reviewed on 4/7/07: "ADL - Resident at risk for decline in ADL (activities of daily living) R/T (related to) needs assistance with bed mobility; had limited ROM (range of motion) to bil. (bilateral) lower extremities." Interventions were assist times 2 staff for transfers into wheel chair; mechanical lift as needed.</p> <p>(2) Problem, identified on 1/12/07 and last reviewed on 4/7/07: "Risk for fractures R/T (related to) Osteoporosis." Interventions were "Movements should be slow with no sudden jerking or dropping of limbs. Discourage flexion exercises and sudden bending or jarring."</p>	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	Continued From page 55  (3) Problem, identified on 3/21/07 and last reviewed on 4/7/07: "Fall risk - [Resident #6] is at risk for falls d/t (due to) has impaired cognition with memory loss, impaired decision making ability, poor safety awareness, limited physical mobility, and receives medications that may increase the risk of falls." Interventions were "assist R (resident) with transfers as needed x 1-2 staff mechanical lift."  (4) Problem, identified on 5/18/07: "Resident @ risk for injury 2nd to (secondary to) foot drop. Actual injury during transfer". Interventions were X-ray, Marisa lift only, and Retrain staff.  e. The Nurse's Notes, dated 5/18/07 at 2:21 p.m., documented "Resident is assisted up to wheel chair for lunch. During meal Resident C/O (complained of) right knee hurting. LPN (Licensed Practical Nurse) checked knee noted it to be swollen discolored, warm to touch. Resident denies knee being bumped. Triage for [Physician #1] made aware new order for stat right knee x-ray, Lortab 5/500 1 po (by mouth) q (every) 6 prn (as needed) pain. Lortab given at 1305 (1:05 p.m.). Little relief at 1410 (2:10 p.m.). [Daughter] made aware of condition and of new orders. 1320 (1:20 p.m.) mobile x here to do x-ray awaiting results. 1430 (2:30 p.m.) Results are called as Acute impacted proximal tibial shaft fracture. [Physician Assistant] made aware new order to send res. (resident) to ER (emergency room)."  1) An X-ray Report for the right knee, dated 5/18/07, documented "There is a fracture involving right proximal tibial shaft with impaction. The joint shows no dislocation. There is	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	<p>Continued From page 56</p> <p>associated joint effusion. Osteoporosis is present." Impression: "Acute impacted proximal tibial shaft fracture."</p> <p>2) A handwritten OLTC (Office of Long Term Care) Witness Statement Form, dated 5/18/07 and signed by LPN #2, documented "I asked [CNA #3] (Certified Nurse Assistant) to get resident up for lunch. As the CNA came to day area with [Resident #6] the CNA stated You know you were wrong for that, she slid all over everywhere. While [Resident #6] ws at the table I was covering Res's legs &amp; feet with a sheet. I bumped the pillow that was between Res legs. At that time [Resident #6] yelled 'Oh my leg.' I looked at her leg noted a swollen area, warm to touch &amp; red. I called Triage to get a order for stat x-ray &amp; pain medication."</p> <p>3) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by RN #1, documented "@ 1300 (1:00 p.m.) LPN reported to me that [Resident #6] c/o (complained of) severe pain to her (R) leg. When she moved pillow when resident up @ lunch time. Residents leg is swollen @ and below the (R) knee. Bruising noted - worm to touch. Portable X-ray had already been ordered by LPN. Resident denies having been dropped or fallen. Reports that she doesn't remember anyone bumping her leg on anything. X-ray report shows fracture to the (R) leg. Sent to [Hospital #1] ER per M.D. order."</p> <p>f. The CNAs involved in the incident did not use a mechanical lift as resident was assessed and care planned to need:</p> <p>1) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by CNA #3,</p>	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	<p>Continued From page 57</p> <p>documented: "While transferring resident to w/c (wheel chair) for lunch me &amp; another care specilities [sic] sat resident up on side of bed. Her feet have a foot drop so we body lift resident to w/c. I did not look down at her feet when transferring. Resident did not yell or scream out during transfer. Pushed resident at into dining room c (with) no c/o pain."</p> <p>2) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by CNA #4, documented "I was helping [CNA #3] put [Resident #6] in her chair for lunch. We got her up and set her on the side of the bed to put a gown on her. We bodied lifted her to put her in the chair. Her feet did not touch the floor and she didn't complain of pain when we got her up."</p> <p>g. The Verification of Investigation report documented:</p> <p>1) Causal/contributing Factors and Observations was "While transferring resident CNAs sat her on the side of the bed and transferred."</p> <p>2) Summary and Outcome of investigative findings was "No abuse or neglect suspected. During a transfer resident's foot was hit on bedrail. Staff was retrained on proper transfers and proper use of lift."</p> <p>h. An inservice Summary Report of Meeting, dated 5/21/07 at 10:00 a.m., documented training on transfers by the DCE (Director of Clinical Education) via demonstration, lecture, and handouts with return demonstrations on lifts. CNA #3 and CNA #4 were the only two staff that signed as attending the inservice.</p>	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	<p>Continued From page 58</p> <p>i. Review of the inservice Summary Report of Meeting forms and return demonstration forms, provided by the Administrator on 6/6/07 at 5:50 p.m., revealed that no other staff were inserviced/trained on transfers and the use of a lift until 6/4/07.</p> <p>j. Nurses Notes dated 5/21/07 documented the resident was admitted to the hospital at 1:30 p.m. for Chronic Obstructive Pulmonary Disease. The resident was not present during the survey.</p> <p>6. Resident #1 had diagnoses of Muscle Weakness, Spasm of Muscles, Occlusion of Cerebral Arteries, Cerebral Vascular Accident (CVA), Hypertension, Thyrotoxicosis with or without Goiter, and Diabetes Mellitus.</p> <p>a. The Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident required a Marisa mechanical lift with 1-2 for the number of staff needed.</p> <p>b. The MDS Annual full assessment, dated 9/5/06, documented the resident was totally dependent on two plus persons for transfers and mode of transfer and required a mechanical lift.</p> <p>c. The MDS Quarterly Review assessment, dated 3/6/07, documented the resident had severely impaired cognitive skills for daily decision-making with short and long term memory problems and required extensive assistance of two plus persons for transfers. The MDS documented the following in regards to balance and range of motion:</p> <p>Test For Balance: The resident was not able to attempt Test for Balance without physical help</p>	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	<p>Continued From page 59</p> <p>while standing and while sitting - trunk control.</p> <p>Functional Limitation in Range of Motion (Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury): The resident had limitation in range of motion on one side with full loss of voluntary movement of the arm, hand, leg, and foot.</p> <p>d. The Plan of Care documented the following:</p> <p>1) Problem, original date 12/5/06 and reviewed 6/4/07: "Risk for falls/total dependence from staff needed for locomotion on unit due to: CVA." Interventions were "Have assistance when transferring resident."</p> <p>2) Problem, original date 12/5/06 and reviewed 6/4/07: "Risk for falls due to impaired physical mobility cognitive deficits. 4/19/07 Actual fall - Lowered to the floor without injury." Interventions were 4/19/07 Mechanical lift for all transfers."</p> <p>e. The resident was assessed to need mechanical lift and extensive assistance of 2 or more staff. On 4/19/07 1 CNA attempted transfer, resident had to be lowered to floor:</p> <p>The Change in Condition Report - Post Fall/Trauma form documented "On 4/19/07 at 2:30 p.m., the following occurred: Falls: Lowered to the floor by staff in resident's room. (During transfer from wheel chair to bed resident became tense, CNA was unable to complete transfer, lowered resident to floor.)" The Report documented ITD (Interdisciplinary Team) recommendations that staff would use the lift at all times with the resident and staff would be inserviced on use of lifts only.</p>	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	Continued From page 60  7. Resident #5 had diagnoses of Acute Cerebrovascular Disease, Hypertensive Heart Disease, Chronic Anemia, Diabetes Mellitus, Chronic Renal Insufficiency, Cerebrovascular Accident, Peripheral Edema, B12 Deficiency, Alzheimer's Disease, Dementia with Behavioral Disturbance and History of Multiple Falls.  a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented, "Resident would benefit from SARA Lift but cognitively & behavior wise resident will not comply therefore for safety resident needs MARISA lift."  b. The MDS Quarterly Review and 5-Day Medicare Assessment dated 5/10/07 documented the resident had severely impaired cognitive skills for daily decision-making and short/long-term memory problems; required extensive assistance of two persons for transfers; was rarely/never understood and sometimes understood others; was unable to attempt a test for balance while standing without physical assistance; and had behavioral symptoms, that were not easily altered, of verbal abusiveness, physical abusiveness and resistance to care.  c. The 14-Day Medicare MDS dated 5/11/07 documented the resident required extensive assistance of one person for transfers and was unable to attempt tests for balance while standing and sitting without physical assistance.  d. The resident's Plan of Care documented the following:  1) Problems/Strengths, original date 8/18/06: "ADL - [Resident #5] remains at risk for decline in	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	<p>Continued From page 61</p> <p>ADL function due to cognitive deficits. She has STM (short term memory) and LTM (long term memory) loss, impaired decision making ability, and poor safety awareness. Interventions were "Transfers with limited to extensive assistance x 1 person". 5/10/07 "CPOC (continue plan of care)."</p> <p>2) Problems/Strengths, original date 8/18/06: "Fall risk - [Resident #5] remains at risk for falls due to cognitive deficits. She has cognitive deficits with STM, LTM loss, impaired decision making ability and poor safety awareness. On daily psychotropic medication." Interventions were "Orient R (Resident) to surroundings; Call light in reach and answer promptly; Keep bed in lowest position; Assist R with transfers as needed x 1-2 staff; Assure non-skid footwear is worn when OOB (out of bed), ambulating, or transferring; Mattress alarm; Chair alarm; Refer to PT/OT; Observe frequently d/t (due to) hx (history) of falls - encourage/assist R to sit/stay in highly visible area; Night light on after dusk." Last reviewed/updated 5/11/07.</p> <p>3) Problems/Strengths, original date 8/18/06: "General IPN (Interdisciplinary Progress Note) Note: Acute illnesses and summaries. 12/4/06 Actual Fall". Interventions dated 12/4/06 were "Inserviced &amp; instructed staff about leaving resident alone sitting on side of bed; Marisa lift to be used x 2; and SL (Sara Lift) x 2 when getting resident OOB (out of bed)."</p> <p>A line was drawn through "Marisa lift to be used x 2" and "SL x2 when getting resident OOB" with D/C (discontinue) written to the right side of the two interventions. There was no date to indicate when the interventions were discontinued.</p>	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	<p>Continued From page 62</p> <p>e. The Nursing Assistant Assignments sheet documented that Resident #5 required the Marisa Lift for the shower and the Sara Lift to transfer out of bed.</p> <p>1) On 6/6/07 at 9:24 a.m., 11:10 a.m. and 2:10 p.m., the resident was observed in a wheel chair. There was no lift sling underneath the resident.</p> <p>2) On 6/6/07 at 2:10 p.m., the resident's daughter was asked if she had been in the room when the staff transferred her mother. She stated yes, she had several times. When asked how the staff transferred her mother she stated that one CNA would get on one side and another CNA would get on the other side. The CNAs would place their arm under her mothers arm and lift her to the bed or chair. When asked if she had seen the staff use a mechanical lift on her mother, she stated no she hadn't. The daughter was then asked if her mother was able to bear weight. She stated " No, the CNAs lift her."</p> <p>3) On 6/8/07 at 10:53 a.m., CNA #5 was asked how she knew what residents needed a mechanical lift for transfers. She stated there would be a sign on the door. She also stated that if they have a lift sling underneath them in the wheel chair they would need the Marisa lift. The CNA pointed to a resident nearby that was in a wheel chair and a lift sling was visible around the back of the resident and on each side along side the arms of the wheel chair.</p> <p>8. Review of facility Inservice Training revealed the CNAs were inserviced as follows:</p> <p>a. 11/13/06: Retraining on Lifts "Mechanical". All CNAs &amp; Nurses will retrain on the Marisa &amp; Sarita</p>	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	Continued From page 63 (Sara) Lifts. All CNAs & Nurses will transfer residents per protocol. All safety measures will be used while using any mechanical lifts or transferring a patient.  b. 11/28/06: Mechanical lift transfers. Have an extra person to assist you when using mechanical lifts. Do not use the lift if you are not 100% sure how to use it.  c. 12/23/06: Sara lift demonstration & return demonstration.  d. 2/17/07: Inservice with demonstration and return demonstration. We are a no lift facility. Make sure you utilize another CNA while using the lifts.  e. 4/1/07: When transferring a resident wait for assistance if you are unable to transfer resident safely. Utilize lifts on all residents that are to be transferred with lift only.  f. 4/3/07: This is a "No lift facility". Please use mechanical lifts when indicated.  g. 5/21/07: Transferring from bed to chair. Return demonstration used on all transfer types. Maris lift, Sara lift, and bed to chair transfer. Participants watched film on 'Give yourself a lift'.  h. 6/5/07 at 10:30 a.m.(during survey): Transfers/Lifts. It is imperative that you use the transfer/lift method listed on the assignment sheets. Failure to do can result in injury and may lead to disciplinary action. If you feel the method listed for a resident is incorrect/inappropriate, please inform your unit manager or nurse. We will reassess the resident to ensure the safest	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	Continued From page 64 method of transfer.  9. The Immediate Jeopardy was removed and the scope and severity lowered to an "G" when the facility implemented the following plan of removal on 6/8/07.  PLAN OF REMOVAL:  "Please accept this as our Immediate Plan of Removal for Assessments, Supervision to prevent Accidents and C.N.A. [Certified Nurse Assistant] Proficiency effective 6-7-07 at 7:15 pm  1. Identification of residents who use a lift and what kind is currently being used.  a. MDS [Minimum Data Set] Coordinator will pull MDS Query to identify residents who require a lift for transferring from bed to chair on 6-7-07.  b. Staffing Coordinator will identify the type lift each resident is currently being transferred with on 6-7-07.  c. MDS Coordinator will pull MDS Query to identify residents who are at a high risk for falls.  2. Assessment of resident to determine if lift is required and type lift needed.  a. Registered Nurses on 06-07-2007 will visually assess all residents residing in the facility to include but not limited to those who have been identified by the MDS as requiring a mechanical lift for transfer from the bed to the chair and/or vice versa using the Lift/Movement Assessment and visual observation.	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	Continued From page 65 b. The assessment findings will be documented on the Lift/Movement Assessment to include the number of staff required for the transfer and placed in the resident's medical record. c. The Physical Therapist and the Physician Assistant will assist in determining if the assessment for each resident has resulted in the correct method of transfer of the resident from bed to chair. 6-8-07. d. The Care Plan and the C.N.A. Assignment sheet will be updated by the MDS Coordinator and the RN Nurse Consultant on 6-7-07 and be completed by 6-8-07 end of day. e. The Registered Nurse will assess resident who may be in the hospital or on leave upon return to the facit using the Lift/Movement Assessment and visual observation. f. The Care Plan and the C.N.A. Assignment Sheets, and ML,SL stickers on name plates will be updated daily by the RN with changes in assessment/type lift required. 3. Training of staff to assure safety for residents requiring a lift for transfer. a. The R.N. Clinical Nurse Consultant trained the Registered Nurses in the facility to perform a transfer assessment on a resident requiring assistance with transfers from bed to chair on 6-07-07 b. The Registered Nurse Director of Clinical Education will retrain all Certified Nursing Assistants beginning on 6-7-07 and completing on 6-8-07 for those on the schedule.	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 498	Continued From page 66  c. C.N.A's on sick leave, vacation, etc who are not on the schedule for 6-7-07 thru 6-8-07 will be retrained on the next scheduled work day prior to providing care to a resident by the Registered Nurse.  d. Training will be documented on the In-Service Record and maintained in the RN DCE's [Director of Clinical Education] office.  e. New employees hired by the facility will be trained on use of the lift by the DCE or DNS prior to giving care to a resident. Training record will be placed in the new employee file in the business office.  f. The Operating Instructions Manual for the Marisa Lift and the Sara Lift will be placed in a binder at each nurses station as a reference for direct care givers to use as a reference.  4. Monitoring to assure effectiveness of the system:  a. The DNS/Designee [Director of Nursing Services] will visually observe 5 C.N.A.'s transfer 5 residents from bed to chair and/or chair to bed 7 days a week, alternating shifts to assure safe transfers are being performed with the designated lift for residents.  b. The DNS/Designee will document the visual observation with return demonstration on the Transfer of Resident from Bed to Chair Care Audit. The audits will be completed on alternating shifts to assure all C.N.A's are visually monitored and have a clear understanding of the training/system."	F 498			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>	
(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 520 SS=K	<p><b>483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE</b></p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #12590 was substantiated (all or in part) with these findings.</p> <p>Based on observation, record review, and interview, the facility Quality Assessment and Assurance (QA&amp;A) Committee failed to ensure issues were identified and corrective actions were implemented to ensure that 5 (Resident #1, #3, #5, #6, and #7) of 7 (Residents #1 thru #7) case mix residents assessed for the use of a</p>	F 520		

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 68</p> <p>mechanical lift were transferred in a safe manner, assessments were accurate, and Nurse Assistants were proficient with transfers. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death for Residents #1, #3, #5, #6 and #7 and resulted in actual harm for Resident #6 who sustained a fracture during a transfer. This failed practice had the potential to affect 27 residents who required the use of the Marisa Lift, 16 residents who required the use of the Sara Lift and 27 residents who were non-weight bearing, according to the Nurse Consultant on 6/8/07 at 3:00 p.m. The facility was notified of the Immediate Jeopardy on 6/7/07 at 4:18 p.m. The findings are:</p> <p>1. On 6/8/07 staff members were interviewed and asked about the facility's QA&amp;A Committee.</p> <p>(1) At 1:07 p.m. CNA #7 stated no, they didn't have a QA.</p> <p>(2) At 1:15 p.m. Housekeeper #1 stated that she had never heard of QA.</p> <p>(3) At 1:45 p.m. CNA #6 stated that they had one but she didn't know what it did.</p> <p>(4) At 1:55 p.m. LPN #3 stated that she could not attest to one. They used to have one but doesn't think they have one now.</p> <p>2. The facility Policy and Procedure titled Transfer Activities, received from the Administrator on 6/8/07 at 2:55 p.m., documented: " Procedure 655, Basic Responsibility: Licensed Nurse and Nursing Assistant, Restorative Nursing Assistant.</p>	F 520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 69</p> <p>Purpose: To transfer the resident from bed to chair, toilet or tub safely. ASSESSMENT GUIDELINES: May include , but not limited to: Loss of range of motion, Location and amount of pain or discomfort., Ability to perform ADL's, Contractures, Deformity, Ability to stand and bear weight, Loss of Balance, Loss of voluntary control of extremities, Paresis or paralysis, Amputation, Fracture. PROCEDURE: Transfer from bed to wheelchair: 1. Obtain assistance of another individual if necessary for safe transfer. Care Plan Documentation Guidelines: Problem: Identify the appropriate problem under which to list transfer activity as an approach... Consider listing possible risks and complications... Approaches: List Instructions unique to this resident, List necessary monitoring and observation of the resident's ability to participate in care... List Monitoring for proper body alignment.</p> <p>3. A document, received from the Nurse Consultant 06/07/07, titled Beverly Lift Program Mechanical Skills Check-Off documented: "SARA 2000 [Bullet # 1]: Extensive assist, partial weight-bearing (at least one leg) individual... SAFETY QUESTIONS for SARA 2000, [Bullet #1]: Can Resident bear weight on one leg? [Bullet # 2]: Does Resident have some upper body strength and trunk stability? [Bullet #3]: Does Resident understand verbal instructions? ...Back of page: SARA 2000 # 2 : Explain lift procedure to Resident. #3: Position SARA sling around the resident's back at waist... #5 Fasten safety belt around resident's waist... #7: Cue resident to place feet onto the platform of the lift... # 14: Cue resident to remove feet from footplate and move lift away from the resident.</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 70</p> <p>4. Resident #6 had diagnoses of Osteoporosis, Osteoarthritis, Dysphagia, Chronic Airway Obstruction, Peripheral Vascular Disease, Decubitus Ulcer, and Hypertension.</p> <p>a. The Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident required a Marisa mechanical lift with 1-2 for the number of staff needed.</p> <p>b. The Minimum Data Set (MDS) Annual full assessment, dated 1/12/07, documented the resident required extensive assistance of two person for transfers and required a mechanical lift.</p> <p>c. The Minimum Data Set (MDS) Quarterly Review assessment, dated 4/6/07, documented the resident had moderately impaired cognitive skills for daily decision-making with short and long term memory problems and required extensive assistance of one person for transfers. The MDS documented the following in regards to balance and range of motion:</p> <p>Test For Balance: The resident was not able to attempt Test for Balance without physical help while standing and while sitting - trunk control.</p> <p>Functional Limitation in Range of Motion (Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury): The resident had limitation in range of motion on both sides with full loss of voluntary movement of legs - including hip or knee, and both feet - including ankle or toes. The arm - including shoulder or elbow, and the hand - including wrist or fingers, had limitation of range of motion on one side with full loss of voluntary</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	Continued From page 71 movement.  d. The Plan of Care documented the following:  (1) Problem, identified on 1/12/07 and last reviewed on 4/7/07: "ADL - Resident at risk for decline in ADL (activities of daily living) R/T (related to) needs assistance with bed mobility; had limited ROM (range of motion) to bil. (bilateral) lower extremities." Interventions were assist times 2 staff for transfers into wheel chair; mechanical lift as needed.  (2) Problem, identified on 1/12/07 and last reviewed on 4/7/07: "Risk for fractures R/T (related to) Osteoporosis." Interventions were "Movements should be slow with no sudden jerking or dropping of limbs. Discourage flexion exercises and sudden bending or jarring."  (3) Problem, identified on 3/21/07 and last reviewed on 4/7/07: "Fall risk - [Resident #6] is at risk for falls d/t (due to) has impaired cognition with memory loss, impaired decision making ability, poor safety awareness, limited physical mobility, and receives medications that may increase the risk of falls." Interventions were "assist R (resident) with transfers as needed x 1-2 staff mechanical lift."  (4) Problem, identified on 5/18/07: "Resident @ risk for injury 2nd to (secondary to) foot drop. Actual injury during transfer". Interventions were X-ray, Marisa lift only, and Retrain staff.  e. The Nurse's Notes, dated 5/18/07 at 2:21 p.m., documented "Resident is assisted up to wheel chair for lunch. During meal Resident C/O (complained of) right knee hurting. LPN	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 72</p> <p>(Licensed Practical Nurse) checked knee noted it to be swollen discolored, warm to touch. Resident denies knee being bumped. Triage for [Physician #1] made aware new order for stat right knee x-ray, Lortab 5/500 1 po (by mouth) q (every) 6 prn (as needed) pain. Lortab given at 1305 (1:05 p.m.). Little relief at 1410 (2:10 p.m.). [Daughter] made aware of condition and of new orders. 1320 (1:20 p.m.) mobile x here to do x-ray awaiting results. 1430 (2:30 p.m.) Results are called as Acute impacted proximal tibial shaft fracture. [Physician Assistant] made aware new order to send res. (resident) to ER (emergency room)."</p> <p>1) An X-ray Report for the right knee, dated 5/18/07, documented "There is a fracture involving right proximal tibial shaft with impaction. The joint shows no dislocation. There is associated joint effusion. Osteoporosis is present." Impression: "Acute impacted proximal tibial shaft fracture."</p> <p>2) A handwritten OLTC (Office of Long Term Care) Witness Statement Form, dated 5/18/07 and signed by LPN #2, documented "I asked [CNA #3] (Certified Nurse Assistant) to get resident up for lunch. As the CNA came to day area with [Resident #6] the CNA stated You know you were wrong for that, she slid all over everywhere. While [Resident #6] ws at the table I was covering Res's legs &amp; feet with a sheet. I bumped the pillow that was between Res legs. At that time [Resident #6] yelled 'Oh my leg.' I looked at her leg noted a swollen area, warm to touch &amp; red. I called Triage to get a order for stat x-ray &amp; pain medication."</p> <p>3) A handwritten OLTC Witness Statement</p>	F 520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 73</p> <p>Form, dated 5/18/07 and signed by RN #1, documented "@ 1300 (1:00 p.m.) LPN reported to me that [Resident #6] c/o (complained of) severe pain to her (R) leg. When she moved pillow when resident up @ lunch time. Residents leg is swollen @ and below the (R) knee. Bruising noted - worm to touch. Portable X-ray had already been ordered by LPN. Resident denies having been dropped or fallen. Reports that she doesn't remember anyone bumping her leg on anything. X-ray report shows fracture to the (R) leg. Sent to [Hospital #1] ER per M.D. order."</p> <p>f. The CNAs involved in the incident did not use a mechanical lift as resident was assessed and care planned to need:</p> <p>1) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by CNA #3, documented: "While transferring resident to w/c (wheel chair) for lunch me &amp; another care specilities [sic] sat resident up on side of bed. Her feet have a foot drop so we body lift resident to w/c. I did not look down at her feet when transferring. Resident did not yell or scream out during transfer. Pushed resident at into dining room c (with) no c/o pain."</p> <p>2) A handwritten OLTC Witness Statement Form, dated 5/18/07 and signed by CNA #4, documented "I was helping [CNA #3] put [Resident #6] in her chair for lunch. We got her up and set her on the side of the bed to put a gown on her. We bodied lifted her to put her in the chair. Her feet did not touch the floor and she didn't complain of pain when we got her up."</p> <p>g. The Verification of Investigation report documented:</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	Continued From page 74  1) Causal/contributing Factors and Observations was "While transferring resident CNAs sat her on the side of the bed and transferred."  2) Summary and Outcome of investigative findings was "No abuse or neglect suspected. During a transfer resident's foot was hit on bedrail. Staff was retrained on proper transfers and proper use of lift."  h. An inservice Summary Report of Meeting, dated 5/21/07 at 10:00 a.m., documented training on transfers by the DCE (Director of Clinical Education) via demonstration, lecture, and handouts with return demonstrations on lifts. CNA #3 and CNA #4 were the only two staff that signed as attending the inservice.  i. Review of the inservice Summary Report of Meeting forms and return demonstration forms, provided by the Administrator on 6/6/07 at 5:50 p.m., revealed that no other staff were inserviced/trained on transfers and the use of a lift until 6/4/07.  j. Nurses Notes dated 5/21/07 documented the resident was admitted to the hospital at 1:30 p.m. for Chronic Obstructive Pulmonary Disease. The resident was not present during the survey.  5. Resident #1 had diagnoses of Muscle Weakness, Spasm of Muscles, Occlusion of Cerebral Arteries, Cerebral Vascular Accident (CVA), Hypertension, Thyrotoxicosis with or without Goiter, and Diabetes Mellitus.  a. The Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 75</p> <p>required a Marisa mechanical lift with 1-2 for the number of staff needed. As of 6/6/07, there was no reassessment of the resident's requirement for that specific type of lift.</p> <p>b. The MDS Annual full assessment, dated 9/5/06, documented the resident was totally dependent on two plus persons for transfers and mode of transfer and required a mechanical lift.</p> <p>c. The MDS Quarterly Review assessment, dated 3/6/07, documented the resident had severely impaired cognitive skills for daily decision-making with short and long term memory problems and required extensive assistance of two plus persons for transfers. The MDS documented the following in regards to balance and range of motion:</p> <p>Test For Balance: The resident was not able to attempt Test for Balance without physical help while standing and while sitting - trunk control.</p> <p>Functional Limitation in Range of Motion (Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury): The resident had limitation in range of motion on one side with full loss of voluntary movement of the arm, hand, leg, and foot.</p> <p>d. The Plan of Care documented the following:</p> <p>1) Problem, original date 12/5/06 and reviewed 6/4/07: "Risk for falls/total dependence from staff needed for locomotion on unit due to: CVA." Interventions were "Have assistance when transferring resident."</p> <p>2) Problem, original date 12/5/06 and reviewed</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 76</p> <p>6/4/07: "Risk for falls due to impaired physical mobility cognitive deficits. 4/19/07 Actual fall - Lowered to the floor without injury." Interventions were 4/19/07 Mechanical lift for all transfers."</p> <p>e. The resident was assessed to need mechanical lift and extensive assistance of 2 or more staff. On 4/19/07 1 CNA attempted transfer, resident had to be lowered to floor:</p> <p>The Change in Condition Report - Post Fall/Trauma form documented "On 4/19/07 at 2:30 p.m., the following occurred: Falls: Lowered to the floor by staff in resident's room. (During transfer from wheel chair to bed resident became tense, CNA was unable to complete transfer, lowered resident to floor.)" The Report documented ITD (Interdisciplinary Team) recommendations that staff would use the lift at all times with the resident and staff would be inserviced on use of lifts only.</p> <p>6. Resident #5 had diagnoses of Acute Cerebrovascular Disease, Hypertensive Heart Disease, Chronic Anemia, Diabetes Mellitus, Chronic Renal Insufficiency, Cerebrovascular Accident, Peripheral Edema, B12 Deficiency, Alzheimer's Disease, Dementia with Behavioral Disturbance and History of Multiple Falls.</p> <p>a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented, "Resident would benefit from SARA Lift but cognitively &amp; behavior wise resident will not comply therefore for safety resident needs MARISA lift." As of 6/6/07, there was no reassessment of the resident's requirement for that specific type of lift.</p> <p>b. The MDS Quarterly Review and 5-Day</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 77</p> <p>Medicare Assessment dated 5/10/07 documented the resident had severely impaired cognitive skills for daily decision-making and short/long-term memory problems; required extensive assistance of two persons for transfers; was rarely/never understood and sometimes understood others; was unable to attempt a test for balance while standing without physical assistance; and had behavioral symptoms, that were not easily altered, of verbal abusiveness, physical abusiveness and resistance to care.</p> <p>c. The 14-Day Medicare MDS dated 5/11/07 documented the resident required extensive assistance of one person for transfers and was unable to attempt tests for balance while standing and sitting without physical assistance.</p> <p>d. The resident's Plan of Care documented the following:</p> <p>1) Problems/Strengths, original date 8/18/06: "ADL - [Resident #5] remains at risk for decline in ADL function due to cognitive deficits. She has STM (short term memory) and LTM (long term memory) loss, impaired decision making ability, and poor safety awareness. Interventions were "Transfers with limited to extensive assistance x 1 person". 5/10/07 "CPOC (continue plan of care)."</p> <p>2) Problems/Strengths, original date 8/18/06: "Fall risk - [Resident #5] remains at risk for falls due to cognitive deficits. She has cognitive deficits with STM, LTM loss, impaired decision making ability and poor safety awareness. On daily psychotropic medication." Interventions were "Orient R (Resident) to surroundings; Call light in reach and answer promptly; Keep bed in lowest position; Assist R with transfers as needed</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 78</p> <p>x 1-2 staff; Assure non-skid footwear is worn when OOB (out of bed), ambulating, or transferring; Mattress alarm; Chair alarm; Refer to PT/OT; Observe frequently d/t (due to) hx (history) of falls - encourage/assist R to sit/stay in highly visible area; Night light on after dusk." Last reviewed/updated 5/11/07.</p> <p>3) Problems/Strengths, original date 8/18/06: "General IPN (Interdisciplinary Progress Note) Note: Acute illnesses and summaries. 12/4/06 Actual Fall". Interventions dated 12/4/06 were "Inserviced &amp; instructed staff about leaving resident alone sitting on side of bed; Marisa lift to be used x 2; and SL (Sara Lift) x 2 when getting resident OOB (out of bed)."</p> <p>A line was drawn through "Marisa lift to be used x 2" and "SL x2 when getting resident OOB" with D/C (discontinue) written to the right side of the two interventions. There was no date to indicate when the interventions were discontinued.</p> <p>e. The Nursing Assistant Assignments sheet documented that Resident #5 required the Marisa Lift for the shower and the Sara Lift to transfer out of bed.</p> <p>1) On 6/6/07 at 9:24 a.m., 11:10 a.m. and 2:10 p.m., the resident was observed in a wheel chair. There was no lift sling underneath the resident.</p> <p>2) On 6/6/07 at 2:10 p.m., the resident's daughter was asked if she had been in the room when the staff transferred her mother. She stated yes, she had several times. When asked how the staff transferred her mother she stated that one CNA would get on one side and another CNA would get on the other side. The CNAs would place</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 79</p> <p>their arm under her mothers arm and lift her to the bed or chair. When asked if she had seen the staff use a mechanical lift on her mother, she stated no she hadn't. The daughter was then asked if her mother was able to bear weight. She stated " No, the CNAs lift her."</p> <p>3) On 6/8/07 at 10:53 a.m., CNA #5 was asked how she knew what residents needed a mechanical lift for transfers. She stated there would be a sign on the door. She also stated that if they have a lift sling underneath them in the wheel chair they would need the Marisa lift. The CNA pointed to a resident nearby that was in a wheel chair and a lift sling was visible around the back of the resident and on each side along side the arms of the wheel chair.</p> <p>7. Resident #3 had diagnoses of Alzheimer's Disease and Abnormal Gait with Symptoms of the Nervous and Musculoskeletal System.</p> <p>a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident was a candidate for the Sara Lift, the illustration of a Sara Lift was circled and the illustrations of the Marisa Lift and the MaxiSide were marked with X's. The assessment failed to document the number of staff needed to assist with transfer per mechanical lift. As of 6/6/07, there was no reassessment of the resident's requirement for that specific type of lift.</p> <p>b. The Quarterly MDS dated 4/23/07 documented the resident was severely impaired in cognitive skills for daily decision making, required extensive to total assistance with activities of daily living with the assistance of one staff, was unable to attempt the tests for balance</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 80</p> <p>while standing or sitting-position-or trunk control.</p> <p>c. The Resident's Plan of Care dated 7/24/06 and updated 4/23/07 documented: Problems/Strengths: "Fall risk -[Resident #3] is at risk for falls r/t history of falls, dependence for transfers and cognitive status..... Interventions: orient to surroundings as needed, call light in reach and answer promptly check frequently. Resident may not use call light due to cognitive status. keep bed in lowest position, assist resident with transfers as needed, assure non-skid footwear is worn when out of bed, ambulating or transferring, side rails up x 2 when in bed, night light after dusk. 12/3/06 Found in floor on rounds at bedside, to hospital for Pelvic x-ray Interventions: Bed/Chair alarm, ...siderails to be placed back on bed. 2/1/07 Problem: Actual Fall, no goal, Intervention: Physical Therapy to Evaluate..." The Plan of Care failed to include the need for the Sara Lift and the amount of assistance required for transfers.</p> <p>d. On 6/4/07 at 2:16 p.m., LPN #1 stated the resident was lifted with a lift and one assistant, had no falls and had 1 skin tear in the past few months.</p> <p>e. On 6/5/07 at 4:20 p.m., the resident was transferred from the bed to a chair by CNA #1 and CNA #2. CNA #2 pulled the resident to the edge of the bed by bending down and asking the resident to put their arms around the CNA's neck. When the resident did not follow the CNA ' s instructions, the CNA put the resident's arm around her neck and pulled the resident to the edge of the bed. No gait belt was used. The CNA placed the Sara lift belt under the resident's axilla and around the resident's back, at the level</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 81 of the axilla.</p> <p>CNA #1 then attempted to raise the resident using the Sara lift, however the lift pulled the resident up by the arms. CNA #2 attempted to get the resident to hold onto the hand grips, but the resident did not follow instructions. CNA #2 continued to cue the resident to hold the hand grips, but there was no attempt by the resident to do so. The resident's feet were bent to the left side of the foot hold and there was no attempt by the CNAs to get the resident's legs in the correct position. When the CNAs were asked if the resident could bear weight, they both responded "No." CNA # 1 stated, "Not at all."</p> <p>8. Resident #7 had a diagnosis of Cerebrovascular Accident with Hemiplegia of the Right Side.</p> <p>a. A Lift/Mobility Assessment for Residents, dated 11/16/06, documented the resident was a candidate for the Sara Lift, the illustration of a Sara Lift was circled and the illustrations of the Marisa Lift and the MaxiSide were marked with X's. The assessment failed to document the number of staff needed to assist with transfer per mechanical lift. As of 6/7/07, there was no reassessment of the resident's requirement for that specific type of lift.</p> <p>b. The Annual MDS dated 5/14/07 documented the resident was severely impaired in cognitive skills for daily decision making, had short/long-term memory loss, required extensive to total assistance of one staff with activities of daily living, was sometimes understood and sometimes could understand, was unable to attempt a test for balance while standing, and had</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 82</p> <p>no limitation in range of motion or voluntary movement.</p> <p>c. The Plan of Care dated 5/14/07 documented: "Problems/Strengths: Needs to be lifted mechanically due to Dx. (diagnosis) of CVA (Cerebrovascular accident). At risk for fall. Goals: Will move in bed as desired and no falls x 90 days. Interventions: Encourage out of bed daily, Use: two staff to assist getting out of bed. Problem: ADL- at risk for decline in ADL function due to CVA with right side Hemiplegia. Interventions: ...8th intervention: Lift Transfers with Assist x 2"</p> <p>d. The Nursing Assignment sheet documented the resident was to be transferred with a Sara Lift with the assistance of 1 to 2 staff.</p> <p>On 6/4/07 at 2:16 p.m., LPN #1 stated the resident was lifted with a lift and one assistant and had no falls.</p> <p>e. An in-service on Transfers and Lifts dated 6/5/07 at 10:30 a.m., received from the Director of Nursing on 6/6/07 at 5:50 p.m., documented that CNA #1 had signed the in-service training sheet.</p> <p>f. On 6/5/07 at 10:45 a.m., CNA #1 transferred the resident from the bed to a chair. With the resident sitting on the side of the bed, CNA #1 placed the Sara lift belt under the resident's axilla area and around the resident's back at the level of the axilla. The CNA then attempted to raise the resident. As the Sara lift was pulling the resident up by the arms, CNA #1 attempted to get the resident to hold onto the hand grips. The resident had contractures of both hands and had the left hand on top of the bar trying to hold on</p>	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	<p>Continued From page 83 and could only get one finger of the right hand over the grip bar.</p> <p>The resident's feet were not positioned for the knees to bend into the knee plate. The resident's buttocks were bent out and the resident's weight was on the axilla area. There was no attempt by the CNA to get the resident's legs in the correct position or get the Sara belt down around the resident's waist. When asked if the resident could bear weight, the CNA responded "No." When asked if she transferred the resident by herself all the time, the CNA stated " Yes."</p> <p>9. The Immediate Jeopardy was removed and the scope and severity lowered to an "G" when the facility implemented the following plan of removal on 6/8/07.</p> <p>PLAN OF REMOVAL:</p> <p>"Please accept this as our Immediate Plan of Removal for Assessments, Supervision to prevent Accidents and C.N.A. [Certified Nurse Assistant] Proficiency effective 6-7-07 at 7:15 pm</p> <p>1. Identification of residents who use a lift and what kind is currently being used.</p> <p>a. MDS [Minimum Data Set] Coordinator will pull MDS Query to identify residents who require a lift for transferring from bed to chair on 6-7-07.</p> <p>b. Staffing Coordinator will identify the type lift each resident is currently being transferred with on 6-7-07.</p> <p>c. MDS Coordinator will pull MDS Query to identify residents who are at a high risk for falls.</p>	F 520			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	Continued From page 84  2. Assessment of resident to determine if lift is required and type lift needed.  a. Registered Nurses on 06-07-2007 will visually assess all residents residing in the facility to include but not limited to those who have been identified by the MDS as requiring a mechanical lift for transfer from the bed to the chair and/or vice versa using the Lift/Movement Assessment and visual observation.  b. The assessment findings will be documented on the Lift/Movement Assessment to include the number of staff required for the transfer and placed in the resident's medical record.  c. The Physical Therapist and the Physician Assistant will assist in determining if the assessment for each resident has resulted in the correct method of transfer of the resident from bed to chair. 6-8-07.  d. The Care Plan and the C.N.A. Assignment sheet will be updated by the MDS Coordinator and the RN Nurse Consultant on 6-7-07 and be completed by 6-8-07 end of day.  e. The Registered Nurse will assess resident who may be in the hospital or on leave upon return to the facit using the Lift/Movement Assessment and visual observation.  f. The Care Plan and the C.N.A. Assignment Sheets, and ML,SL stickers on name plates will be updated daily by the RN with changes in assessment/type lift required.  3. Training of staff to assure safety for residents	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	Continued From page 85 requiring a lift for transfer.  a. The R.N. Clinical Nurse Consultant trained the Registered Nurses in the facility to perform a transfer assessment on a resident requiring assistance with transfers from bed to chair on 6-07-07  b. The Registered Nurse Director of Clinical Education will retrain all Certified Nursing Assistants beginning on 6-7-07 and completing on 6-8-07 for those on the schedule.  c. C.N.A's on sick leave, vacation, etc who are not on the schedule for 6-7-07 thru 6-8-07 will be retrained on the next scheduled work day prior to providing care to a resident by the Registered Nurse.  d. Training will be documented on the In-Service Record and maintained in the RN DCE's [Director of Clinical Education] office.  e. New employees hired by the facility will be trained on use of the lift by the DCE or DNS prior to giving care to a resident. Training record will be placed in the new employee file in the business office.  f. The Operating Instructions Manual for the Marisa Lift and the Sara Lift will be placed in a binder at each nurses station as a reference for direct care givers to use as a reference.  4. Monitoring to assure effectiveness of the system:  a. The DNS/Designee [Director of Nursing Services] will visually observe 5 C.N.A.'s transfer	F 520			

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

PRINTED: 06/22/2007  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>045357</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/08/2007</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVING CENTER - NORTH LITTLE ROCK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3600 RICHARDS ROAD</b> <b>NO LITTLE ROCK, AR 72117</b>		
(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 520	Continued From page 86 5 residents from bed to chair and/or chair to bed 7 days a week, alternating shifts to assure safe transfers are being performed with the designated lift for residents.  b. The DNS/Designee will document the visual observation with return demonstration on the Transfer of Resident from Bed to Chair Care Audit. The audits will be completed on alternating shifts to assure all C.N.A's are visually monitored and have a clear understanding of the training/system."	F 520			