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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045357	A. BUILDING ____ B. WING ____	08/10/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER - NORTH LITTLE ROCK	**3600 RICHARDS ROAD NO LITTLE ROCK, AR 72117**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312 SS=E	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure the perianal area was cleansed of feces during incontinent care for 2 (Residents #11 and #12) of 11 (Residents #1 through #4 and #6 through #12) case mix residents who required incontinent care. This failed practice had the potential to affect the 78 residents in the facility who required incontinent care, according to the Director of Nurses on 8/9/07 at 4:44 p.m. The findings are: 1. Resident #11 had diagnoses of Bilateral Hemiplegia, Infantile Cerebral Palsy and Cerebral Artery Occlusion. The Quarterly Minimum Data Set dated 7/5/07 documented the resident had modified independence in cognitive skills for daily decision-making, had total dependence on the physical assistance of one staff person for personal hygiene and was incontinent of bowel and bladder. On 8/6/07 at 2:12 p.m., incontinent care was provided for the resident by Certified Nursing Assistant (CNA) #1. The resident was turned to her side and the CNA wiped the anal area of feces three times. The last time the resident's anal area was wiped, there was still feces on the wash cloth. The resident's mons pubis was not cleansed.	F 312		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 312	Continued From page 1	F 312		

2. Resident #12 had diagnoses of Hypernatremia, Hypothyroidism and Psychotic Conditions. The Minimum Data Set dated 5/17/07 documented the resident had severely impaired cognitive skills for daily decision-making, required extensive physical assistance of one staff person for hygiene and was incontinent of bowel and bladder.

On 8/8/07 at 9:22 a.m., incontinent care was provided for the resident by Certified Nursing Assistant (CNA) #2. The resident was turned to the left side and the buttocks were washed. The CNA wiped the resident's rectal area with a washcloth and the cloth had feces on it; the CNA did not wipe the anal area again to ensure all feces was removed. A new brief was then applied for the resident.

F 332 SS=E — 483.25(m)(1) MEDICATION ERRORS — F 332

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on observation of the 9:00 a.m. medication pass on 8/9/07 and record review, the facility failed to follow Physician orders to ensure the medication error rate was less than 5 %. Physician orders were not followed for 4 (Residents #8, #23, #24 and #25) of 5 residents observed during the medication pass. Medication errors were made by 3 (Licensed Practical Nurses [LPN] #1, #2 and #3) of 4 nurses that administered medications. This failed practice had the potential to affect 89 residents who received medications from these nurses,

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F 332	Continued From page 2 according to the Director of Nursing (DON) on 8/9/07. The medication error rate was 10.53 %, based on administration of 55 medications plus 2 medications ordered but not administered and observation of a total of 6 errors. The findings are: 1. Resident #8 had a diagnoses of Osteoarthrosis and a Physician order dated 5/10/04 that documented, "Miacalcin ...one spray alternate nares daily." On 8/9/07 at 8:14 a.m., LPN #1 administered one spray of Miacalcin nasal spray in both of the resident's nares. 2. Resident #23 had a diagnosis of Chronic Sinusitis and Physician orders dated 10/4/06 that documented, "Afrin 0.05% Spr (Spray)... 2 sprays - each nostril... BID (twice a day)." and "Flonase 0.05 mg (milligram) /Actuation Spr... 2 sprays both nostrils...QD (everyday)." On 8/9/07 at 8:32 a.m., only one spray of each medication was administered in each nostril by LPN #1, resulting in 2 medication errors. 3. Resident #24 had a diagnosis of Chronic Bronchitis and Physician orders dated 5/29/07 that documented, Albuterol Sulfate 0.083 % sol (solution) 1 inhalation two times per day... and Spiriva 18 mcg (microgram) 1 puff inhalation daily. On 8/9/07 at 9:22 a.m., LPN #2 did not administer Albuterol Sulfate 0.083% or the Spiriva Inhaler to the resident. 4. Resident #25 had a Physician order dated	F 332		

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F 332	Continued From page 3 6/6/07 that documented, Aspirin 81 mg (milligram) ECT (enteric coated tablet) 1 tab oral daily for Heart Failure, Congestive Heart Failure. On 8/9/07 at 9:37 a.m., LPN # 3 administered chewable aspirin 81 mg, instead of enteric coated aspirin, to the resident.	F 332		
F 371 SS=E	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food stored in the refrigerator and storage areas was sealed/covered to prevent cross contamination, food was stored and disposed as per the manufacturer's instructions/label and employees washed their hands before handling food, clean dishes, utensils and properly sanitized tray covers to prevent cross contamination. This failed practice had the potential to affect 111 residents who received their meal trays from the kitchen, according to the Resident Census and Conditions of Residents form dated 8/6/07. The findings are: 1. On 8/8/07 at 1:00 p.m., the following observations were made: a. Cheese slices, on the shelf in the walk-in refrigerator, were in the original plastic wrapper and had been opened; the package had not sealed back up, leaving the contents exposed.	F 371		

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F 371	Continued From page 4 b. Two boxes of potato pearls, one on the utility cart and one on the storage room shelf, were in the original boxes and had been opened. The boxes had not been covered back up or sealed, leaving the contents exposed. 2. On 8/8/07 at 3:00 p.m., Dietary Employee #1 was separating tray cards. At 3:10 p.m., she went to the dish washing room and, without washing her hands, started picking up clean dishes; the dietary employee was placing her fingers inside the plates while stacking them. She pushed carts in the kitchen area that were brought in the dish washing room and sprayed down with water and without washing her hands, proceeded to pick up clean plates and rub her fingers inside the plates, before stacking them up. The plates that had food particles on them she put to the side. At 3:19 p.m., the dietary employee picked up a tray cover, went to the dirty dish area, picked up a hose and sprayed the tray cover and without re-washing it, stacked it up with the clean ones. Then, without washing her hands, started picking up clean plates, with her fingers inside the plates, while stacking them up. 3. On 8/8/07 at 3:40 p.m., Dietary Employee #2 picked up a pan and placed it on the counter. The dietary employee then opened cans of mushroom soup, poured the contents into the pan and placed it on the stove. She picked up a whisk to stir the soup. The	F 371		

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F 371	Continued From page 5 dietary employee then poured the mushroom soup over tuna and slices of mushroom in a pan. She then poured noodles in the pan, over the tuna, and used her bare hand to push the noodles into the pan. She picked up a spoon, and while mixing up tuna with the spoon, her fingers were touching the tuna/noodle mixture. 4. On 8/8/07 at 3:48 p.m., a bottle of lemon juice was on the utility cart in the kitchen. The manufacturer's best if used by date on the bottle documented 6/7/06. The date on the lid documented that the facility received the lemon juice 9/2/[06]. The manufacturer's instruction on the bottle label was to refrigerate after opening. Half of the juice had been used. There were 5 more bottles of the lemon juice on the shelf in the storage room that were also dated 6/7/06; the received date on each bottle was documented as 9/2/[06].	F 371		