

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

PRINTED: 09/29/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045357	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/15/2006
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER - NORTH LITTLE ROCK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS	F 000			
F 176 SS=D	<p>Complaint # 11965, unsubstantiated.....</p> <p>483.10(n) SELF ADMINISTRATION OF DRUGS</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review & interview the facility failed to ensure that before residents were allowed to self-administer medications the Interdisciplinary team determined this practice would be safe for 1 [Resident # 6] of 6 case-mix residents [Residents # 1 thru # 6] for self-administration of oral medication . This failed practice has the potential to effect 114 residents in the facility that take oral medications according to the Roster/Sample Matrix provided by the facility on 9/14/06. The findings are:</p> <p>1. Resident # 6 had diagnoses of Cerebral Vascular Accident, Aphasia with Swallowing Problems and Depression and has a Quarterly Minimum Data Set dated 7/28/06 documented the resident had short and long term memory problems, had moderately impaired cognitive skills for daily decision making and had swallowing problems.</p> <p>2. The resident's Care Plan updated on 7/28/06 documented, "...Cognitive loss/dementia as evidenced by self report of short term memory loss and poor decision making ability...She has</p>	F 176			

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 176	<p>Continued From page 1</p> <p>cognitive deficits with poor safety awareness..."</p> <p>3. On 9/14/06 at 11:40 a.m. when this surveyor and D.O.N. [Director of Nurses] entered the resident's room the resident was sitting in a wheel chair at the bedside. There were 3 pills on a napkin that was laying on the over bed table that was positioned in front of her. The resident put one of the pills in her mouth and attempted to swallow the pill with water. She began to cough and choke before she swallowed the pill. The resident then picked up one of two or the remaining two pills that was lying on the napkin on the overbed table as one of them fell on the floor. The resident was not aware the pill had fallen on the floor. The D.O.N. was asked what were the names of the pills the resident had, she stated, "Calcium and Aggrnox, I can't identify the other medication." The D.O.N. also stated that the resident did not have a physician's order to self administer medication. The D.O.N. asked the Licensed Practical Nurse [LPN] #1, when she entered the room, why the medication had been left with the resident. The LPN stated, " I was called out of the room due to a big spill, I left 2 aides with the resident. I guess I should have sent them [the aides] to take care of the spill and stayed in the room with the resident." The D.O.D. informed the LPN # 1 that the resident had dropped the calcium on the floor.</p> <p>4. On 9/14/06 at 4:50 p.m. after completing record review of the clinical record, no documentation was found that the resident had been assessed by an Interdisciplinary Team to assess if it was safe to self administration medications. There was no doctor's order for the self administration of medications and there was nothing in the care plan about the self</p>	F 176			

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F 176	Continued From page 2 administration of medications. 6. The facility Policy and Procedure documented, " Each patient who desires to self-administer medication is permitted to do so if the facility's interdisciplinary team had determined that the practice would be safe for the patient, other patients of the facility and the physician provides an order to do so...All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside..."	F 176			