STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045457	A. BUILDING _____ B. WING _____	C 08/27/2014

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(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 This copy of the 2567 supercedes any previous copy. Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. Complaint #19488 was substantiated, all or in part, with a deficiency cited at F323. Complaint #19509 was substantiated, all or in part, with a deficiency cited at F309 and F323. Complaint #19484 (00017390) was unsubstantiated.	F 000		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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

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This REQUIREMENT is not met as evidenced by:
Complaint #19509 was substantiated, all or in part, with these findings.

Based on record review and interview, the facility failed to ensure Resident #7 was provided the necessary care and services to attain her highest practicable physical well-being in accordance with the comprehensive assessment and plan of care. The facility failed to conduct an assessment to include vital signs, lung sounds and bowel sounds to identify if there was a need to notify the physician for further interventions during a change in condition that required treatment; failed to ensure that Cardiopulmonary Resuscitation (CPR) included usage of a back board to ensure effective chest compressions; failed to ensure licensed staff was knowledgeable in the operation of the suction machine to aide in clearing the airway if needed for 1 of 1 (Resident #7) case mix resident who complained of nausea and who later required cardiopulmonary resuscitation. The failed practice resulted in Immediate Jeopardy, which likely caused or could have caused serious harm, injury or death to Resident #7, who was found unresponsive and without a pulse 1 hour after being medicated with a suppository for nausea and was a full code, and had the potential to cause more than minimal harm for 19 residents who had a Full Code status as documented on a list provided by the Minimum Data Set Coordinator on 8/26/14 at 9:10 a.m. The facility was informed of the Immediate Jeopardy on 8/25/14 at 2:25 p.m.

The findings are:

1. Resident #7 had diagnoses of Diabetes I,

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Hypertension, Congestive Heart Failure and Paralytic Syndrome. The Minimum Data Set with an assessment reference date of 7/25/14 documented the resident scored 15 (13-15 indicates cognitively intact) on a brief interview for mental status, was totally dependent on two persons for transfer and toilet use, one person physical assist for locomotion, personal hygiene and bathing and was frequently incontinent of bowel and bladder.

a. An Advance Directive in the Event of Cardiopulmonary Resuscitation form dated 4/24/14 was documented and signed by (Resident #7) on 4/24/14.

b. A Physicians order for a Full Code and signed by the Primary Care Physician was dated 5/7/14.

c. A Nurse's Progress Note dated 8/4/14 at 5:25 a.m. and signed by Licensed Practical Nurse (LPN) #2 documented "CNA [Certified Nurse Assistant] came to this nurse stating that res [resident] is complaining of nausea. Went to res room to assess res, pale and complaining that she was nauseated. Gave Promethazine HCL [Hydrochloride] Suppository 25 mg [milligram] at approximately 5:35 a.m. with no difficulty." The Nurses ' Progress note did not document any vital signs or assessment of bowel sounds.

On 8/27/14 at 9:45 a.m., the Director of Nursing stated, "[Resident #7's] last vital signs were taken on 8/3/14 at 4:51 p.m. On 8/4/14 at 5:25 a.m. [LPN #1] administered Phenergan and at 5:31 a.m., checked her blood sugar which was 288. That is the only assessment that she did."

d. A Nurse's Progress Note dated 8/4/14 at 6:25

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a.m. and signed by LPN #2 documented, "Went into res room. Observed res laying in bed dusky and non-responsive, skin was cold and clammy to the touch, eyes open and fixed, no respirations, no pulse noted. This nurse began CPR [cardiopulmonary resuscitation] immediately and yelled for help. [LPN #3] came in with crash cart to assist with CPR. [CNA #9] called 911 at 6:32 a.m. CPR remained in progress without pulse or respirations. [Fire Department] arrived at 6:37 a.m. and took over CPR. [Local Hospital Emergency Physician #1] called code at 6:57 a.m. EMT's [Emergency Medical Technician's] stopped CPR. Coroner pronounced death at 7:18 a.m..."

e. On 8/24/14 at 11:35 p.m., LPN #2 stated, "About three weeks ago around 5:30 a.m., the resident called me to the room by telling [CNA #9] that she was nauseated. I went to the room, assessed her. She was pale and complained of nausea and asked for something for nausea. I gave her a Phenergan suppository. [CNA #9] checked on her frequently. About 6:30 a.m., I went to her room. She had no pulse and her pupils were fixed. I started CPR and yelled for help. [LPN #3] and [CNA #9] came to assist. [LPN #3] brought the crash cart with her. She used an ambu bag and then [Resident #7] started vomiting green emesis. We tried to use the suction machine but it was not working properly. We swept the mouth with a sheet. [CNA #9] called 911. We continued CPR until the Fire Department and ambulance arrived. The paramedic suctioned her. She expired at approximately 6:50 a.m. Me and [LPN #3] reported the failure of the suction machine. I have not personally checked the crash cart since that time. I do know that the Director of Nursing

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checked the suction." LPN #2 and surveyor went to the crash cart. LPN #2 plugged in the suction, applied a suction cath and the suction worked to a pressure of 25 mm Hg [millimeters of mercury].

f. On 8/25/14 at 12:20 p.m., LPN #3 stated via phone "I heard [LPN #1] yell. I went down to [Resident #7's] room. I ran back and got the crash cart. [LPN #1] was doing chest compressions. I got the ambu. [Resident #7] vomited and it was like a slow erupting volcano. I tried to get the suction to seal. It never would suction. [LPN #2] tried. We both tried. It was a small suction. It would not suction the vomit. We wiped her mouth to remove the vomitus. The Fire Department arrived. They continued CPR and took her to the floor. We did not use the backboard. It was on the cart. It didn't cross my mind to use the board. This was my second code. I told the DON [Director of Nursing] that I could not get the suction to work. I have not had an inservice relative to the suction machine. Also, the tubing and all components were in packets. The canister was put together. Within a couple of days, I was told the suction machine worked just fine and it was prepped and ready to go by the DON."

g. The Fire Department's narrative dated 8/4/14 at 6:33 a.m. documented, "Engine #1 was dispatched for a code blue at [Facility]. Engine 1 arrived to find staff nurses performing CPR on a female pt [patient] lying in her bed. Engine 1 crew placed the pt on a backboard and moved her to the floor to continue CPR. [Fireman #1] took over compressions and [Fireman #2] suctioned the pt using the manual suction device in order to ventilate the pt via bag valve mask until [Emergency Medical Services] arrived and then

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we used their electrical suction machine. AED [Automated External Defibrillator] analyzed the pt again and advised 'No Shock. Continue CPR.' [Fireman #3] took over BVM [bag valve mask]. [Emergency Medical Services] disconnected our pads and attached their monitor which advised asystole. We continued CPR while [Medic] intubated the pt. [Emergency Medical Services] then administered cardio drugs. After several additional rounds of CPR, [Emergency Medical Services] contacted [local hospital] and [Physician #1] advised stop CPR and all resuscitative efforts at 6:57 a.m. Engine 1 requested a PD [Police Department] officer on scene and Deputy Coroner was notified. PD and Coroner arrived and conducted their investigation. Coroner advised that we could place the pt back in the bed as the pt was being released to the funeral home. Engine 1 moved the pt back to the bed and removed our backboard. Engine 1 crew and [Emergency Medical Services] returned to service."

h. The Emergency Medical Services note her pulseless and apneic so they started chest compressions and called 911. FD [Fire Department] rescue reports that they placed pt onto LSB [long spine board] and moved her from the bed to the floor and continued CPR. During BVM ventilations pt began to vomit large amounts of emesis. FD [Fire Department] also reports that they placed their AED on pt and had 'no shock advised' throughout their efforts. [Emergency Medical Services] to find pt in floor on LSB with CPR being performed by FD rescue. Pt's airway was suctioned and then the pt was intubated and BVM ventilations continued. Strong resistance felt during ventilations but placement of ET [endotracheal (tube)] was confirmed throughout

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by EtCO2 [End-Tidal Carbon Dioxide] readings. IV [Intravenous] attempted but unsuccessful so 1 dose of epi [epinephrine] and 1 dose of atropine was introduced down ET tube. Pt's rhythm on monitor changed from asystole to PEA [pulseless electrical activity] with epi admin [administration] but no pulse was present. At this point CPR had been ongoing for 30 minutes, so physician consult with ER MD [Emergency Room Medical Doctor] for orders to cease CPR efforts or transport. CPR stopped at 6:57 a.m. per [Physician #1]."

i. On 8/25/14 at 12:15 p.m., the Director of Nursing was asked to tell the surveyors about the incidents occurring during (Resident #7's) code. The Director of Nursing stated, "I did not know about any incident. I knew there was a code. [LPN #2] asked me if I would look at the suction machine as it wasn't working well. I checked the suction and it was working. The only thing I could think of was that the canister lid may not have been snapped shut to give it suction. I have not given inservice regarding the suction equipment to the staff. I did not get back with [LPN #2]."

j. On 8/25/14 at 12:55 p.m., LPN #7 was asked to turn on the suction machine on the crash cart and to first tell the surveyor where the on/off switch was located. LPN #7 stated, "I do not know where the on/off switch is. I have not had an inservice."

k. On 8/25/14 at 1:00 p.m., LPN #4 was asked to turn on the suction machine on the crash cart. LPN #4 stated, "I have been here two weeks. No one has showed me the suction machine on the crash cart. I do not know where the on/off switch is. I do not know how to adjust the mm Hg

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pressure."

l. On 8/25/14 at 1:05 p.m., LPN #5 was asked to turn on the suction machine on the crash cart and to first tell the surveyor where the on/off switch was located. LPN #5 stated, "I have not been inserviced on the suction machine or the crash cart at this facility. I do not know without investigating where the on/off switch is located."

m. On 8/25/14 at 1:40 p.m., the Director of Nursing stated, "I was not aware that the two LPNs did not use a backboard. I was not aware that the Fire Department placed the resident on the floor for a solid surface. There is a board on the crash cart. I have not inserviced the staff on the use of the crash cart." The backboard and the suction machine were located on the crash cart.

2. On 8/25/14 at 4:25 p.m., the immediate jeopardy was removed and the scope and severity reduced to "G" after the facility began implementation of the following plan of removal :

a. There are 19 residents who had signed a request for a Full Code and had physician authorization for same at risk for same failed practice.

b. On 8/25/14 at 2:35 p.m., DON immediately began in-servicing all current licensed staff members on duty regarding company Policy and Procedure of CPR and use of equipment to include suction machine and backboard and what to do if equipment is not in working condition with return demonstration. All staff will be in-serviced prior to starting work. The in-service will be documented to include topics and signature of attendance. Newly hired licensed nurses will be

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F 309	Continued From page 8 trained on company policy and procedure of CPR and use of suction machine and backboard prior to working the floor. c. On 8/25/14 at 2:38 p.m., the Administrator called and ordered a back-up suction for crash cart from [Medical Supply Company]. If machine is a different model, licensed nurses will be in-serviced on proper operation of machine. d. On 8/25/14 at 3:22 p.m., a checklist for crash cart was completed and Director of Operation will in-service DON and Administrator immediately. Contents will be checked daily by the Director of Nursing/designee and turned in to the Administrator at the end of each week. Any negative findings will be corrected immediately. Equipment failure, the Maintenance Supervisor will be notified immediately and repairs made. Monitoring sheets will be reported to the Administrator. Any negative findings will be addressed immediately. All findings will be reported to the QA & A [Quality Assessment and Assurance] meeting monthly."	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

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Complaint #19488 and #19509 was substantiated, all or in part, with these findings:

Based on observation, record review and interview, the facility failed to ensure planned interventions to prevent elopement were consistently implemented, as evidenced by failure to ensure the resident was taken outside by staff daily and failure to ensure all staff were trained on the facility's elopement policy after a resident wandered outside the facility, to ensure the wandering behaviors were effectively addressed and prevent potential injury for 1 (Resident #3) of 2 (Residents #3 and #6) case mix residents who had a history of wandering. The facility also failed to ensure bed and chair alarms were functioning to alert staff of unassisted transfer attempts and minimize the potential for injury from falls for 1 (Resident #10) of 3 (Residents #3, #9 and #10) case mix residents who had bed and/or chair alarms in use. The failed practices had the potential to affect 4 residents with a history of wandering, according to a list provided by the Registered Nurse Minimum Data Set (MDS) Coordinator on 8/13/14 at 10:40 a.m.; and, 19 residents who had bed and/or chair alarms in use, according to a list provided by the Administrator on 8/26/14. The findings are:

Resident #3, had diagnoses of Alzheimer's Disease, Hypothyroidism, Depression, Hypertension, Pain, Osteoporosis, Muscle spasms and Disease of the Upper Respiratory Tract. The Minimum Data Set with an assessment reference date of 5/20/14 documented the resident had modified independence in cognitive skills for daily decision making per staff assessment, had no behavioral

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symptoms, exhibited no wandering behaviors, required limited assistance of one person for transfers, did not walk in room or corridor, required supervision and setup for locomotion on and off unit, had no impairment in functional limitation in range of motion and used a wheelchair for mobility.

a. A Nursing Note dated 8/6/14 at 2:31 p.m. and signed by Licensed Practical Nurse (LPN) #1 documented, "Resident was spotted outside by the ditch and rocks. According to [Certified Nursing Assistant (CNA) #1] was going outside to get another resident and the man [passer] was yelling "you sse this you see this there is a patient in the ditch." [CNA #1] stayed with the resident and sent someone to get {LPN #1] since then, [Resident #3] has been on a one to one observation by CNAs and staff. She has not used tried to escape from the building since. Will continue to monitor ..."

On 8/14/14 at 9:15 a.m., CNA #1 was asked about the incident with the resident on 8/6/14 and stated, "I worked 3:00 p.m. to 11:00 p.m. that day. I was walking out the front door to check for a visitor for another resident. An agency LPN was walking out at the same time. A man in a white Jeep pulled up in the entrance and he said, 'Do you see that?', and he then repeated himself. He was pointing straight toward the road. I looked and I saw [Resident #3] in her wheelchair with her feet in the rocks. She was still in her wheelchair. I don't know how long she had been there. By my phone it was 3:45 p.m. I told the LPN agency nurse to go back in and get help. Me and the man in the white jeep, a white man, pulled her from that location to the driveway. I rolled her from the driveway to the building. I reported to

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LPN #1 and they assessed her. They, the Director of Nursing and Social Worker called me the next day and took my statement over the phone ..." When asked if she had been inserviced on resident elopement, the CNA stated, "Since that time I have not had any inservice on elopement."

At 9:25 a.m., CNA #1 was asked to show the surveyor where Resident #3 was located on 8/6/14. The CNA went outside the building and stood in front of the building by the rocks. The Corporate Maintenance Supervisor and the facility Maintenance Coordinator measured the distance in a straight line from the facility front door to the rocks indicated by CNA #1. The distance measured was 90 feet.

b. The Arkansas Department of Health and Human Services Division of Medical Services Office of Long Term Care Incident and Accident Next Day Reporting Form DMS(Division of Medical Services)7734 dated 8/6/14 documented the date of the Incident and Accident (I&A) as 8/6/14 at 3:43 p.m. The Summary of the incident section documented, "Resident was spotted outside of facility and reported to staff. CNA brought resident back into the building by staff. The Charge Nurse was notified and resident was assessed with no change due to incident. Investigation started with ADM [Administrator], DON [Director of Nursing], family and physician notified."

c. The form titled Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property And Exploitation of Residents in Long-Term Care Facilities, DMS form 762 dated 8/06/14 documented, " ...Steps taken to prevent

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continued abuse or neglect during the investigation ... Investigation made with staff being in-serviced on elopement policy with resident put on 1 to 1 supervision from staff. Family was notified and ask to the facility to discuss plan of care for the resident. With family input following interventions put in place: Sign at all exit doors replaced with larger notification to alert visitors making sure of surroundings before leaving building to assist us in keeping our residents safe by not assisting anyone out of any exit door unless they are in their party. [Alarm Company] inspected door alarm system for proper operation. Adjustments were made to door closure. The alarm magnet was adjusted to lock quicker once contact is made. Contacted [Alarm Company] regarding Wanderguard system. Resident will be taken outside daily. Resident put on 1 on 1 until alarm company came out. Dr. [Doctor] notified with new orders received."

d. The Care Plan with a review date of 8/06/14documented, "The resident is an elopement risk/wanderer r/t [related to] history of attempts to leave facility unattended ...Interventions ...monitoring: lab as ordered. Geropsych [geriatric-psychiatric] consult. ...date initiated 8/8/14 ... Take the resident outside in the mornings weather permitting. Larger sign on front door to remind visitors not to let residents outside. Alarm company to inspect alarms on exit door to ensure proper working condition ..."

e. On 8/14/14 at 10:11 a.m., CNA #2 (the Lead CNA) was asked about taking the resident outside daily and stated, "I did not know we were to take her [Resident #3] outside every day."

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STAGECOACH NURSING AND REHABILITATION CENTER	6907 HIGHWAY 5 NORTH BRYANT, AR 72022

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f. On 8/14/14 at 10:15, the Director of Nursing was asked for documentation that the resident had been taken outside daily and of inservices provided to staff on the facility's elopement policy. The DON stated, "I do not have any documentation of [Resident #3] going outside every day. We have inserviced 29 employees out of 83 employees related to elopement [since 8/6/14] ... I did interview [CNA #1] on 8/7/14 via phone of the 8/6/14 incident. [Director of Nursing] presented document regarding the phone interview at this time.] We kept [Resident #3] on 1:1 from 4:00 p.m. on 8/6/14 through 8/8/14 at 5:00 p.m. when the front door was repaired. We do not know which door she went out. The problem with the front door was that it was not completely closing with the magnet. All doors were checked. There were no other identified problems. "

g. On 8/14/14 at 10:45 a.m., the Administrator was asked about the incident with the resident on 8/6/14 and stated the resident was seen exiting the front door on 8/6/14 when the Maintenance Corporate Supervisor and the facility's Maintenance Coordinator viewed the video surveillance footage. The Administrator stated, "I was in a meeting [on 8/6/14] when they came in and said that [Resident #3] went out the front door and they had brought her back in. At that time, I told the nurse to complete an I&A [Incident and Accident Report]. On 8/7/14, I did not know details. On 8/11/14, I knew more details. They are supposed to take her outside every day." The surveyor requested to review the video surveillance of the incident. The Administrator, Corporate Maintenance Supervisor and Surveyor went to the viewing area. The Corporate Maintenance Supervisor stated that the video

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surveillance footage was timed at 1 hour before the correct time. The Administrator stated that she had not previously reviewed the video footage. The Administrator stated, "By the film footage and times displayed, a visitor let her [Resident #3] out at 2:34 p.m. [3:34 p.m. if the camera was actually timed 1 hour before the actual time]. A man in a Jeep summoned [CNA #1] at 2:39 p.m. She [Resident #3] entered the building at 2:41 p.m. We have ordered a Wanderguard system. We enlarged the notice and placed the notice on brighter paper for visitors to not let residents out of the facility."

h. On 8/14/14 at 1:10 p.m., LPN #2 [Charge Nurse for Resident #3] was asked about the resident and stated, "[Resident #3] likes to roam. She will go either to the front door, kitchen door or 100 hall door and look outside. She will push on the door until it alarms. One of us will come and get her. If folks are coming in the door, you have to move her back, so she won't go out. I try to watch all residents and so does the staff. There is no ideal way to watch her. We don't have a Wanderguard system."

i. On 8/14/14 at 1:27 p.m., CNA #3 was asked about the resident and stated, "Normally she looks out the 100 hall door. I try to take her away from the door. "

j. On 8/14/14 at 1:35 p.m., CNA #4 was asked about the resident and stated, "Every once in a while, she [Resident #3] goes to any hall door and pushes on the bar. It alarms and we come get her".

k. On 8/15/14 at 8:50 a.m., CNA #2 [Lead CNA] was outside the facility with Resident #3. CNA #2

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stated, "I was not aware until yesterday that she was to go outside every day. [Director of Nursing] told me that me and either Restorative was to take her out every day."

I. On 8/15/14 at 10:30 a.m., the Director of Nursing presented the surveyor with 4 Witness Statement Forms which documented the following information:

1.) "I [CNA #2] took [Resident #3] for an outside activity on August 7th, August 8th and August 11th." The form was dated 8/14/14 at 4:45 p.m., via telephone interview, and was signed by the Director of Nursing.

2.) "I [CNA #5] took [Resident #3] for an outside activity on August 12th". The form was dated 8/14/14 at 4:45 p.m. and was signed by the Director of Nursing.

3.) "I [CNA #11]took [Resident #3] outside today." The form was dated 8/14/14 and signed by CNA #5 as a phone interview on 8/14/14 at 5:00 p.m. with CNA #11.

4.) "I [CNA #4] took [Resident #3] for an outside activity on August 13th". The form was dated 8/15/14 and signed by CNA #4.

No documentation was provided to indicate the resident was taken outside on 8/9/14 and 8/10/14 (Saturday and Sunday).

2. Resident #10 had diagnoses of Personal History of Fall, Chronic Pain, Hypertension and Diabetes Mellitus. The Admission MDS with an ARD of 8/4/14 documented the resident scored 9 (8-12 indicates moderately impaired) on a Brief

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Interview for Mental Status, required limited assistance with transfers and had a fall in the last month prior to admission.

a. A Fall Risk Assessment dated 7/29/14 documented, " ...Score: 12.0 Category: High..."

b. A Physician's Order dated 8/5/14 documented, "Bed alarm and chair alarm q [every] shift. Check to ensure placement and in working order."

c. The Care Plan dated 8/5/14 documented, "Focus - The resident is at risk for injury from falls r/t [related to] history of falls... Interventions... Bed alarm, Chair alarm..."

d. On 8/25/14 at 2:55 p.m., the resident was in bed. The alarm box on the bed was not blinking. Certified Nurse Assistants (CNAs) #8 and #9 were present. CNA #8 looked at the box and stated the "in use" indicator, " ...is not blinking." CNA #8 looked at the box again and stated that the switch was turned off. CNA #8 attempted to turn the switch to the "on" position. The CNAs repositioned the resident onto her left side, but the alarm did not sound.

At 3:00 p.m., CNA #9 was asked about the problems with the alarm box. The CNA stated, "The 'in use' light was not blinking, the switch was half on, not all the way over. I turned it all the way to 'on' and I unplugged and plugged it back in and it beeped. The beep indicates it was on. Also the 'in use' light started blinking."

e. On 8/26/14 at 8:43 a.m., the resident was in a wheelchair in her room. The clip for the personal safety alarm was not attached to the resident's clothing. There was a cord coming from the seat

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