STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045142	A. BUILDING _____ B. WING _____	08/07/2014

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANYON SPRINGS HEALTH AND REHABILITATION, LLC	1401 PARK AVENUE HOT SPRINGS, AR 71901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 381) was substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to ensure staff immediately reported a suspicion / allegation of neglect to Administrator / Designee to ensure prompt investigation and to ensure residents were protected from the potential of further neglect as evidenced by staff failure to immediately report to the Administrator / Designee when Registered Nurse (RN) #1 refused to stay and assist with Cardiopulmonary Resuscitation (CPR) and Licensed Practical Nurse (LPN) #1 failed to immediately start CPR on a resident found without vital signs ([DATE]) for 1 (Resident #1) of 3 (Residents #1 through #3) case mix residents who had documentation of full code status within their resident clinical records. This failed practice resulted in a past Immediate Jeopardy which caused or could have caused death to Resident #1 who did not have cardiopulmonary resuscitation initiated when the resident's condition declined. This failed practice had the potential to cause more than minimal harm for 49 residents, who had documented full code status within their clinical records, according to a list provided by the Director of Nursing (DON) on [DATE]. On [DATE] at 11:39 a.m., the facility was informed of the past Immediate Jeopardy. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set with an Assessment Reference Date of [DATE] documented the resident was totally dependent for all Activities of Daily Living. a. The Care Plan dated [DATE] documented, I have requested that CPR measures ARE to be performed (Full code status). Staff will respect my wishes and rights in regards to my decision to have CPR performed. Communicate my choice to all appropriate staff members. Please continue to administer any ordered medications and treatments as per my physician's orders [REDACTED]. I need you to initiate CPR if you find me pulseless or breathless and continue CPR until Paramedics arrive to take over. Physicians' Orders dated [DATE] documented, Full Code b. Nurses' Notes dated [DATE] at 12:25 a.m. and signed by RN #1 documented, At approx. (approximately) 11 p.m., CNA (Certified Nursing Assistant) called this nurse (RN #1) into room because resident needs to be suctioned. Breathing was labored. Suctioned thick mucus white / yellow approx 30 cc (cubic centimeters). B/P (blood pressure) ,[DATE], P. (pulse) 78, R. (respirations) 24, O 2 sat (oxygen saturation) ,[DATE]. Doctor notified. ,[DATE] (11:00 p.m. to 7:00 a.m. shift) nurse here. 1) On [DATE] at 12:45 p.m., RN #1 stated she was working the A hall ([DATE]) and the resident needed to be suctioned. She stated it was not uncommon for the resident to be suctioned. She stated the resident's oxygen saturation was 80% and she suctioned him. She stated she then called the doctor at approximately 11:15 p.m. (11:,[DATE]:30 p.m.) and that she had not had a return call. RN #1 was asked if she had checked the resident and she replied that she did not. She stated she made only one call to the doctor. 2) On [DATE] at 12:45 p.m., CNA #2 stated she worked the 3:00 p.m. to 11:00 p.m. shift ([DATE]). She was asked if she remembered the resident having something coming out of his mouth and she replied he had yellow sputum coming out of his mouth. She stated she changed the resident with another CNA. She stated she called the nurse (RN #1) to come check him. She stated RN #1 came in while the resident was being changed. She stated she remembered the nurse clearing his mouth, but did not remember if she suctioned the resident. CNA #2 was asked if RN #1 delayed coming when she called her and she replied, No ma'am. When I called, she came. c. Nurses' Notes dated [DATE] at 1:28 a.m. and signed by LPN #1 documented, After receiving report, delegated CNA (CNA#1) to check resident vital signs. Aide signaled this nurse (LPN #1) to resident's room. Assessed resident. No pulse found. Performed CPR with other nurse (LPN #2) while other nurse call ambulance. 1) On [DATE] at 4:30 p.m., CNA #1 stated she was running behind schedule the evening of the incident ([DATE]) and at approximately 12:00 a.m. or 12:30 a.m. she started doing vital signs .She stated she went to the resident's room and tried to get vital signs on him. She stated she was not getting anything; no pulse. She stated she hollered for LPN #1 and she said to hold on and continued to talk to RN #1. She stated she went back in a few minutes to the nurses' station and said to LPN #1, Look. I'm not getting nothing! No respirations, no pulse, nothing! CNA #1 stated, (LPN #1 and RN #1) were still talking. (LPN #1) came in the resident's room, looked at the resident and said, 'He's died '. CNA #1 stated LPN #1 touched the resident and checked for a pulse. She stated she could not remember if LPN #1 did vital signs or not, as that part was a little hazy. CNA #1 was asked if she was certain she had made it clear to LPN #1 there were no vital signs and she stated, I actually told her, I'm not getting nothing. She stated LPN #1 stepped out of the room and called for LPN #2. CNA #1 was asked if she knew what role RN #1 played in the incident and she replied she knew she did come into the resident's room at some point, but she didn't remember when. She stated LPN #1 and RN #1 did not know what to do. 2) On [DATE] at 12:45 p.m., LPN #1 stated she arrived at the nursing home at 11:49 p.m. She stated she went to count out on the other hall and then went over to the A hall to count with RN #1. She stated that the narcotics were counted and then RN #1 gave the report. She stated RN #1 reported the resident was having respiratory distress earlier (in the shift) and that he required suctioning. She stated RN #1 said she had called the doctor, who had not returned the call at that time. She stated, I asked (CNA #1) to go get vital signs on the resident. She stated it was not very long, a minute or two, and the CNA stuck her head out the door and told her (LPN #1) to come to the room. She stated when she arrived in the room, the resident's eyes were wide open, with no movement or reaction, no apical pulse, no rise and fall of the chest. She stated she said to CNA #1, I think he deceased , and asked the CNA to get RN #1, while she (LPN #1) finished assessing the resident. She stated the resident was so cool, he was cold. LPN #1 stated, (RN #1) said she was going home and I asked her to stay to help her. She stated the CNA was not there and she went back to RN #1 to ask her to stay. The RN had left the facility. LPN #1 stated she saw LPN #2 and told him the resident did not have a pulse or respirations. She stated he initiated CPR and she went to call 911 and to get the crash cart. She stated she went to the resident's room and assisted with CPR. She stated they continued CPR for 8 to 10 minutes, before the paramedics arrived and called the resident's death. LPN #1 was asked what dependent lividity was. She replied, That's not stiffness? She was asked if she knew to check for dependent lividity and she said, No. After it was explained to her that dependent lividity was pooling of blood. she stated she did not notice it if he had it. LPN #1 was questioned about the CNA's allegation that she had to tell her (LPN #1) more than once that the resident did not have vital signs before she (LPN #1) went to the room. LPN #1 denied the CNA told her more than once before she went into the room to check the resident. LPN #1 was asked what RN #1 said or did when she went to the resident's door and she replied that RN #1 said she was going home and that she did not want to get in involved in the situation. She stated RN #1 then turned around and went home. She stated, I made it clear to her (RN #1) that I needed her to help me do CPR and she still turned around and went home. She stated RN #1 stayed outside the door, did not go into the room and did not assess the resident. LPN #1 was asked how much time had passed since the CNA had reported the resident had no vital signs and CPR was initiated and she replied, 3 to 5 minutes. It happened so fast. It didn't take too much time to assess him. She was asked how nurses identify

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 0225 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) code status prior to the incident. She stated, Prior to the incident, I was not aware of what the dots meant. I knew they had the cards posted on the doors, but I didn't know what the dots meant. I do now. 3) On [DATE] at 12:45 p.m., RN #1 stated she and LPN #1 were counting narcotics when LPN #1 asked CNA #1 to get vital signs for the resident. She stated the CNA came out to LPN #1 and asked her to come to the resident's room. She stated LPN #1 called her to the room and said the resident's dead. She stated LPN #1 used either the word stiff or hard. She stated LPN #1 wanted to do CPR and RN #1 stated, I didn't see the need to do it. The man's already gone. He's passed. She stated she walked back to nurses' station to finish what she was doing. RN #1 stated she saw LPN #2 coming down the hall. She stated she believed LPN #1 knew the resident was dead and passed. She stated the signs were there that he did not need it (CPR). RN #1 was asked what were the signs that indicated there was no need to initiate CPR and she replied, No respirations, no pulse. She (LPN #1) said he was cool. She used the word stiff or hard. RN #1 was asked if she assessed or touched the resident and she replied that she did not go over and look at him. She was asked when she would do CPR and she replied that if the signs were there, she would do it immediately. She stated, He just had a list of signs. I read somewhere not to do CPR. RN #1 stated that LPN #1 had been in the room for a while with the resident and she was there when the CNA #1 called her into the (resident's) room. She stated it was 5 to 10 minutes she knew she was in the room with the resident. RN #1 was asked what dependent lividity was and she replied that she did not know. She stated she told LPN #1 at the resident's door that she was not going to do CPR. RN #1 stated she could not tell how long the resident had no vital signs or whether the resident had dependent lividly. She stated she did not go into the room to assess the resident to find out. RN #1 stated, I know now I should have started CPR. She was asked when would CPR be done and she replied that if the resident was a full code, without pulse or respirations. RN #1 was reminded that the resident was a full code. She stated, Yes, I know, but based on what the nurse (LPN #1) said, I did not. 4) On [DATE] at 1:20 p.m., LPN #2 stated LPN #1 had called and said she would be late. He stated she arrived at the nursing home at 11:45 p.m. He stated, She asked me to come over to her hall, she said the resident didn't have a pulse. He stated he told her the resident is a full code and they needed to do CPR. He stated he started compressions (CPR). He stated there was no rigidity and he was able to move the resident's extremities easily. He stated the paramedics stopped the resuscitation, due to the rigidity of the resident's body and absent vital signs. LPN #2 was asked if he would have clocked out and left the facility and he replied, I would've stuck around, just to see if they needed my help. d. On [DATE] at 10:00 a.m., the Assistant Director of Nursing stated LPN #1 had left a message that there had been a death. She stated, The morning after we reviewed the nurses' notes and everything in general. She was asked if she knew there was a problem and she stated she did not even know that RN #1 was involved in it and did not remember her being in the facility. She stated LPN #1's message was very vague. On [DATE] at 9:56 a.m., LPN #1 was interviewed again. She was asked if she reported to the Director of Nursing that she felt that it was neglect on RN #1's part when she decided not to do CPR for the resident, who was a full code. She replied she reported it to the Assistant Director of Nursing when she called. She was asked if she reported it as neglect and she replied that she reported that RN #1 had refused to do CPR. e. The Facility Investigation Report DMS-762 documented date and time reported as [DATE] at 11:00 a.m. and date and time of discovery as [DATE] at 9:30 a.m. and designated the type of incident as Neglect. The Section II-Complete Description of Incident documented, Arkansas State Board of Nursing received an anonymous complaint that the nurse did not follow CPR procedure correctly. The Section III-Findings and Actions Taken documented, .(RN #1's) statements and the nurses notes show that she had been with the resident at 11:00 p.m. and suctioned him, then showed vital signs were better. (RN #1) gave report to the oncoming nurse (LPN #1) at approximately 12:11 a.m. and during the report she told the oncoming nurse that this resident had to be suctioned at 11:00 p.m., so to please watch him closely to make sure he doesn't have any other change of condition. She told her that she had called the doctor, but no return call at that time. (LPN #1) oncoming nurse took the report close to end of (the) report she asked her CNA (CNA #1) to get this resident's vital signs. When (LPN #1) got close to the resident's room, the CNA told her she could not get any vital signs and thought the resident was dead. (LPN #1) assessed the resident and immediately and told (CNA #1) to have (RN #1) to come and help her. This is when (LPN #1) told (RN #1), 'he does not have a pulse and was expired.' This is when (RN #1) thought she was not needed anymore and went home. (RN #1) passed (LPN #2) in the hall on her way to clock out and this is when she heard (LPN #1) call for (LPN #2) for help. (LPN #2) responded immediately and he knew he (the resident) was a full code, because he had a conversation with (RN #1) earlier in the shift. 1) The Witness Statement dated [DATE] and signed by LPN #1 documented, .During report (RN #1) stated that the resident was in respiratory distress and she had suctioned resident and notified M.D. (medical doctor) because she wanted to get permission to get resident sent out, but M.D. had not responded. I asked (CNA #1) to get resident vital signs. At approx. 12:30 a.m. (CNA #1) stood at resident doorway and asked I (LPN#1) to come to pt (patient) room. I immediately went to pt bedside and (CNA # 1) stated she couldn't get vital signs. LPN #1 documented asking CNA #1 at approx. 12:32 a.m. and 12:35 a.m. to get RN #1. LPN #1 stated RN #1 came to the resident's door and was told that the resident had no pulse, no respirations and was cool to touch. LPN #1 stated RN #1 stated she was going home. LPN #1 stated she asked RN #1 to stay and assist and RN #1 refused and left the facility. 2) The Witness Statement dated [DATE] and signed by RN #1 documented she was called to the resident's room. She stated the resident's breathing was labored, with an oxygen saturation of 88%. She stated the resident needed to be suctioned. She stated that after suctioning, the resident's oxygen saturation was 90% and his respirations were even and unlabored. She stated she called the doctor, but had not received a return call. RN #1 stated that at approx. She stated that at 11:49 p.m., the ,[DATE] nurse arrived. The oncoming nurse (LPN #1) asked CNA #1 to get the resident's vital signs. The statement documented, At approx. 12:30 a.m., ,[DATE] nurse (LPN #1) called this nurse to the resident's room stating the resident had no pulse or respirations, was cool to touch and 'hard'. This nurse did not do CPR because the resident had passed. 3) The Witness Statement (no date) and signed by LPN #2 documented, Approximately 11:15 p.m., (RN #1) came over to C hall where I was and asked 'What do I do when a resident is in respiratory distress. I told her to give them oxygen and if that doesn't help .to get them sent out to the hospital. In his statement he noted that at approx. 12:15 a.m., he went to make copies and was called over by LPN #1. He stated LPN #1 said the resident had no pulse and that he has died . He stated that he asked if the resident was a full code and she replied that he was. He stated he told LPN #1 that CPR needed to be started and to have 911 called. He stated they performed CPR immediately and the resident's body was cold, but the extremities were easily moved and positioned to do CPR. He stated CPR continued until the paramedics arrived at approx. 12:50 a.m. 2. On [DATE] at 4:25 p.m., the Administrator was asked what the facility had done to prevent recurrence. She stated the facility was not informed there was an issue with the resident's death until [DATE] by the Arkansas State Board of Nursing. She stated: a. RN #1 and LPN #1 were suspended. b. LPN #1 had returned to work; however, she had to have Red Cross CPR training and provide a return demonstration. c. LPN #1 was given a written reprimand. d. Staff in-services regarding code status were completed, to include LPN #1 and RN #1. e. The concern was presented to the Quality Assessment and Assurance committee and an action plan was developed and implemented. f. RN #1 had not returned to work. Decision made to not allow RN #1 to return to work. 3. The Administrator was asked how the facility was monitoring to ensure this incident was not repeated. She stated the Director of Nursing checks all deaths to ensure everything was right at the time. Arrangements have been made with the ambulance service to notify the Administrator if there is an issue when they are called to the facility. The Director of Nursing has developed a plan to have the staff contact her or Assistant Director of Nursing in the event of a death. She or her assistant will go to the facility. All parties involved will write a statement regarding the occurrence. There has been no similar occurrences since the facility was informed. Two staff in-services on [DATE] and [DATE] were completed regarding the actions to be taken in the event of a death and the residents' code status. Staff was also in-serviced regarding the Unwitnessed Death law. There had been three previous in-services concerning the law on [DATE], [DATE] and [DATE].
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 381) was substantiated (all or in part) in these findings. Based on record review and interview, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being for Resident #1, in accordance with documented full code status within the resident's comprehensive assessment and physician plan of care. The facility failed to ensure nurses (Licensed Practical Nurse #1 and Registered Nurse #1) immediately provided cardio-pulmonary resuscitation (CPR) when a resident was found without vital signs for 1 (Resident #1) of 3 (Residents #1 through #3) case mix residents who had documentation of full code status within their clinical records.

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) This failed practice resulted in a past Immediate Jeopardy which caused or could have caused death to Resident #1 who did not have cardiopulmonary resuscitation initiated when the resident's condition declined. This failed practice had the potential to cause more than minimal harm for 49 residents who had documented full code status within their clinical record, according to a list provided by the Director of Nursing (DON) on [DATE]. On [DATE] at 11:39 a.m., the facility was informed of the past Immediate Jeopardy. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set with an Assessment Reference Date of [DATE] documented the resident was totally dependent for all Activities of Daily Living. a. The Care Plan dated [DATE] documented, I have requested that CPR measures ARE to be performed (Full code status). Staff will respect my wishes and rights in regards to my decision to have CPR performed. Communicate my choice to all appropriate staff members. Please continue to administer any ordered medications and treatments as per my physician's orders [REDACTED]. I need you to initiate CPR if you find me pulseless or breathless and continue CPR until Paramedics arrive to take over. Physicians' Orders dated [DATE] documented, Full Code b. Nurses' Notes dated [DATE] at 12:25 a.m. and signed by RN #1 documented, At approx. (approximately) 11 p.m., CNA (Certified Nursing Assistant) called this nurse (RN #1) into room because resident needs to be suctioned. Breathing was labored. Suctioned thick mucus white / yellow approx 30 cc (cubic centimeters). B/P (blood pressure) ,[DATE], P. (pulse) 78, R. (respirations) 24, O 2 sat (oxygen saturation) ,[DATE]. Doctor notified. ,[DATE] (11:00 p.m. to 7:00 a.m. shift) nurse here. 1) On [DATE] at 12:45 p.m., RN #1 stated she was working the A hall ([DATE]) and the resident needed to be suctioned. She stated it was not uncommon for the resident to be suctioned. She stated the resident's oxygen saturation was 80% and she suctioned him. She stated she then called the doctor at approximately 11:15 p.m. (11:,[DATE]:30 p.m.) and that she had not had a return call. RN #1 was asked if she had checked the resident and she replied that she did not. She stated she made only one call to the doctor. 2) On [DATE] at 12:45 p.m., CNA #2 stated she worked the 3:00 p.m. to 11:00 p.m. shift ([DATE]). She was asked if she remembered the resident having something coming out of his mouth and she replied he had yellow sputum coming out of his mouth. She stated she changed the resident with another CNA. She stated she called the nurse (RN #1) to come check him. She stated RN #1 came in while the resident was being changed. She stated she remembered the nurse clearing his mouth, but did not remember if she suctioned the resident. CNA #2 was asked if RN #1 delayed coming when she called her and she replied, No ma'am. When I called, she came. c. Nurses' Notes dated [DATE] at 1:28 a.m. and signed by Licensed Practical Nurse (LPN) #1 documented, After receiving report, delegated CNA (CNA#1) to check resident vital signs. Aide signaled this nurse (LPN #1) to resident's room. Assessed resident. No pulse found. Performed CPR with other nurse (LPN #2) while other nurse call ambulance. 1) On [DATE] at 4:30 p.m., CNA #1 stated she was running behind schedule the evening of the incident ([DATE]) and at approximately 12:00 a.m. or 12:30 a.m. she started doing vital signs .She stated she went to the resident's room and tried to get vital signs on him. She stated she was not getting anything; no pulse. She stated she hollered for LPN #1 and she said to hold on and continued to talk to RN #1. She stated she went back in a few minutes to the nurses' station and said to LPN #1, Look. I'm not getting nothing! No respirations, no pulse, nothing! CNA #1 stated, (LPN #1 and RN #1) were still talking. (LPN #1) came in the resident's room, looked at the resident and said, 'He's died '. CNA #1 stated LPN #1 touched the resident and checked for a pulse. She stated she could not remember if LPN #1 did vital signs or not, as that part was a little hazy. CNA #1 was asked if she was certain she had made it clear to LPN #1 there were no vital signs and she stated, I actually told her, I'm not getting nothing. She stated LPN #1 stepped out of the room and called for LPN #2. CNA #1 was asked if she knew what role RN #1 played in the incident and she replied she knew she did come into the resident's room at some point, but she didn't remember when. She stated LPN #1 and RN #1 did not know what to do. 2) On [DATE] at 12:45 p.m., LPN #1 stated she arrived at the nursing home at 11:49 p.m. She stated she went to count out on the other hall and then went over to the A hall to count with RN #1. She stated that the narcotics were counted and then RN #1 gave the report. She stated RN #1 reported the resident was having respiratory distress earlier (in the shift) and that he required suctioning. She stated RN #1 said she had called the doctor, who had not returned the call at that time. She stated, I asked (CNA #1) to go get vital signs on the resident. She stated it was not very long, a minute or two, and the CNA stuck her head out the door and told her (LPN #1) to come to the room. She stated when she arrived in the room, the resident's eyes were wide open, with no movement or reaction, no apical pulse, no rise and fall of the chest. She stated she said to CNA #1, I think he deceased , and asked the CNA to get RN #1, while she (LPN #1) finished assessing the resident. She stated the resident was so cool, he was cold. LPN #1 stated, (RN #1) said she was going home and I asked her to stay to help her. She stated the CNA was not there and she went back to RN #1 to ask her to stay. The RN had left the facility. LPN #1 stated she saw LPN #2 and told him the resident did not have a pulse or respirations. She stated he initiated CPR and she went to call 911 and to get the crash cart. She stated she went to the resident's room and assisted with CPR. She stated they continued CPR for 8 to 10 minutes, before the paramedics arrived and called the resident's death. LPN #1 was asked what dependent lividity was. She replied, That's not stiffness? She was asked if she knew to check for dependent lividity and she said, No. After it was explained to her that dependent lividity was pooling of blood. she stated she did not notice it if he had it. LPN #1 was questioned about the CNA's allegation that she had to tell her (LPN #1) more than once that the resident did not have vital signs before she (LPN #1) went to the room. LPN #1 denied the CNA told her more than once before she went into the room to check the resident. LPN #1 was asked what RN #1 said or did when she went to the resident's door and she replied that RN #1 said she was going home and that she did not want to get in involved in the situation. She stated RN #1 then turned around and went home. She stated, I made it clear to her (RN #1) that I needed her to help me do CPR and she still turned around and went home. She stated RN #1 stayed outside the door, did not go into the room and did not assess the resident. LPN #1 was asked how much time had passed since the CNA had reported the resident had no vital signs and CPR was initiated and she replied, 3 to 5 minutes. It happened so fast. It didn't take too much time to assess him. She was asked how nurses identify code status prior to the incident. She stated, Prior to the incident, I was not aware of what the dots meant. I knew they had the cards posted on the doors, but I didn't know what the dots meant. I do now. 3) On [DATE] at 12:45 p.m., RN #1 stated she and LPN #1 were counting narcotics when LPN #1 asked CNA #1 to get vital signs for the resident. She stated the CNA came out to LPN #1 and asked her to come to the resident's room. She stated LPN #1 called her to the room and said the resident's dead. She stated LPN #1 used either the word stiff or hard. She stated LPN #1 wanted to do CPR and RN #1 stated, I didn't see the need to do it. The man's already gone. He's passed. She stated she walked back to nurses' station to finish what she was doing. RN #1 stated she saw LPN #2 coming down the hall. She stated she believed LPN #1 knew the resident was dead and passed. She stated the signs were there that he did not need it (CPR). RN #1 was asked what were the signs that indicated there was no need to initiate CPR and she replied, No respirations, no pulse. She (LPN #1) said he was cool. She used the word stiff or hard. RN #1 was asked if she assessed or touched the resident and she replied that she did not go over and look at him. She was asked when she would do CPR and she replied that if the signs were there, she would do it immediately. She stated, He just had a list of signs. I read somewhere not to do CPR. RN #1 stated that LPN #1 had been in the room for a while with the resident and she was there when the CNA #1 called her into the (resident's) room. She stated it was 5 to 10 minutes she knew she was in the room with the resident. RN #1 was asked what dependent lividity was and she replied that she did not know. She stated she told LPN #1 at the resident's door that she was not going to do CPR. RN #1 stated she could not tell how long the resident had no vital signs or whether the resident had dependent lividly. She stated she did not go into the room to assess the resident to find out. RN #1 stated, I know now I should have started CPR. She was asked when would CPR be done and she replied that if the resident was a full code, without pulse or respirations. RN #1 was reminded that the resident was a full code. She stated, Yes, I know, but based on what the nurse (LPN #1) said, I did not. 4) On [DATE] at 1:20 p.m., LPN #2 stated LPN #1 had called and said she would be late. He stated she arrived at the nursing home at 11:45 p.m. He stated, She asked me to come over to her hall, she said the resident didn't have a pulse. He stated he told her the resident is a full code and they needed to do CPR. He stated he started compressions (CPR). He stated there was no rigidity and he was able to move the resident's extremities easily. He stated the paramedics stopped the resuscitation, due to the rigidity of the resident's body and absent vital signs. LPN #2 was asked if he would have clocked out and left the facility and he replied, I would've stuck around, just to see if they needed my help. d. On [DATE] at 10:00 a.m., the Assistant Director of Nursing stated LPN #1 had left a message that there had been a death. She stated, The morning after we reviewed the nurses' notes and everything in general. She was asked if she knew there was a problem and she stated she did not even know that RN #1 was involved in it and did not remember her being in the facility. She stated LPN #1's message was very vague. On [DATE] at 9:56 a.m., LPN #1 was interviewed again. She was asked if she reported to the Director of Nursing that she felt that it was neglect on RN #1's part when she decided not to do CPR for the resident, who was a full code. She replied she reported it to the Assistant Director of Nursing when she called. She was asked if she reported it as neglect and she replied that she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045142	A. BUILDING _____ B. WING _____	**08/07/2014**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANYON SPRINGS HEALTH AND REHABILITATION, LLC	**1401 PARK AVENUE HOT SPRINGS, AR 71901**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) reported that RN #1 had refused to do CPR. e. The Facility Investigation Report DMS-762 documented date and time of The Facility Investigation Report DMS-762 documented date and time reported as [DATE] at 11:00 a.m. and date and time of discovery as [DATE] at 9:30 a.m. and designated the type of incident as Neglect. The Section II-Complete Description of Incident documented, Arkansas State Board of Nursing received an anonymous complaint that the nurse did not follow CPR procedure correctly. The Section III-Findings and Actions Taken documented, .(RN #1's) statements and the nurses notes show that she had been with the resident at 11:00 p.m. and suctioned him, then showed vital signs were better. (RN #1) gave report to the oncoming nurse (LPN #1) at approximately 12:11 a.m. and during the report she told the oncoming nurse that this resident had to be suctioned at 11:00 p.m., so to please watch him closely to make sure he doesn't have any other change of condition. She told her that she had called the doctor, but no return call at that time. (LPN #1) oncoming nurse took the report close to end of (the) report she asked her CNA (CNA #1) to get this resident's vital signs. When (LPN #1) got close to the resident's room, the CNA told her she could not get any vital signs and thought the resident was dead. (LPN #1) assessed the resident and immediately and told (CNA #1) to have (RN #1) to come and help her. This is when (LPN #1) told (RN #1), 'he does not have a pulse and was expired.' This is when (RN #1) thought she was not needed anymore and went home. (RN #1) passed (LPN #2) in the hall on her way to clock out and this is when she heard (LPN #1) call for (LPN #2) for help. (LPN #2) responded immediately and he knew he (the resident) was a full code, because he had a conversation with (RN #1) earlier in the shift. 2. On [DATE] at 4:25 p.m., the Administrator was asked what the facility had done to prevent recurrence. She stated the facility was not informed there was an issue with the resident's death until [DATE] by the Arkansas State Board of Nursing. She stated: a. RN #1 and LPN #1 were suspended. b. LPN #1 had returned to work; however, she had to have Red Cross CPR training and provide a return demonstration. c. LPN #1 was given a written reprimand. d. Staff in-services regarding code status were completed, to include LPN #1 and RN #1. e. The concern was presented to the Quality Assessment and Assurance committee and an action plan was developed and implemented. f. RN #1 had not returned to work. Decision made to not allow RN #1 to return to work. 3. The Administrator was asked how the facility was monitoring to ensure this incident was not repeated. She stated the Director of Nursing checks all deaths to ensure everything was right at the time. Arrangements have been made with the ambulance service to notify the Administrator if there is an issue when they are called to the facility. The Director of Nursing has developed a plan to have the staff contact her or Assistant Director of Nursing in the event of a death. She or her assistant will go to the facility. All parties involved will write a statement regarding the occurrence. There has been no similar occurrences since the facility was informed. Two staff in-services on [DATE] and [DATE] were completed regarding the actions to be taken in the event of a death and the residents' code status. Staff was also in-serviced regarding the Unwitnessed Death law. There had been three previous in-services concerning the law on [DATE], [DATE] and [DATE].