STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045144	A. BUILDING _____ B. WING _____	01/27/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROWNPOINT HEALTH & REHAB CENTER	**1203 SOUTH BEND DRIVE HORSESHOE BEND, AR 72512**

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 935) was substantiated (all or in part) in these findings: Based on record review and interview, the facility failed to ensure the Physician was promptly consulted regarding a significant change in condition as evidenced by failure to consult with the physician upon attaining a pulse oximetry reading of 84% in order to provide the physician with necessary information to guide treatment for 1 (Resident #1) of 4 (Residents #1, #3, #4 and #5) case mix residents who had orders for pulse oximetry. The facility's failure to consult with the physician resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident #1 who after experiencing an upper respiratory infection had episodes of [MEDICAL CONDITION] and expired on [DATE], and had the potential to cause more than minimal harm for 34 residents who had orders for pulse oximetry, according to the room bed list provided by the Administrator at 1:56 p.m. on [DATE]. The Administrator was notified of the Immediate Jeopardy on [DATE] at 9:47 a.m. The findings are: 1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an assessment reference date of [DATE] documented the resident scored 15 (,[DATE] indicates cognitively intact) on the Brief Interview for Mental Status; required extensive physical assistance of two-plus people for bed mobility and toilet use; required extensive physical assistance of one person for personal hygiene; had limitation in range of motion of both lower extremities; had shortness of breath upon exertion and when lying flat; and required oxygen therapy. a. A Care Plan with a review date of [DATE] documented, Resident has potential for difficulty breathing related to chronic condition: [MEDICAL CONDITION] . Report changes in respiratory status to physician . Administer / monitor effectiveness of the following treatments: Oxygen 2 (liters per minute) per NC (nasal cannula) to maintain SPO2 greater than 90%. Check SPO2 every shift and prn . b. The [DATE] physician's orders [REDACTED]. Shortness of breath . [DATE] SPO2 (peripheral capillary oxygen saturation) every shift . [DATE] Oxygen . prn (as needed) O2 (oxygen) (at) ,[DATE] L (liter) per nasal cannula to maintain SPO2 greater than 90% . c. The Physician order [REDACTED]. Chest X-ray . [MEDICATION NAME] 500 mg (milligram) (times) 5 days . [MEDICATION NAME] . 400 mg Give 1.5 tabs (tablets) to (equal) 600 mg PO (by mouth) BID (twice daily) (times) 10 days r/t (related to) URI (upper respiratory infection) . The Radiology Report dated [DATE] documented, .Examination: Chest - 1 view (AP (anterior / posterior)) . There are mild left base opacities -- pneumonia . Conclusion: Left base pneumonia new since [DATE] . d. The Physician order [REDACTED]. e. The Physician order [REDACTED]. CBC (Complete Blood Count) (with) diff (differential) . CMP (Comprehensive Metabolic Panel) . The Radiology Report dated [DATE] documented, .Examination: Chest - 1 view (AP) . There are mild bibasilar opacities -- possible atelectasis . Conclusion: Mild bibasilar atelectasis new since [DATE] . The Physician order [REDACTED]. [MEDICATION NAME] dose pack . [MEDICATION NAME] (updraft) TID (three times a day) (times) 7 days . [MEDICATION NAME] 1 GM (gram) IM (intramuscular) (times) (one) dose . The laboratory report dated [DATE] documented, .Chloride 97 (low) (reference range ,[DATE]) . Carbon [MEDICATION NAME] 40 (high) (reference range ,[DATE]) . BUN (Blood Urea Nitrogen) . 26 (high) (reference range ,[DATE]) . BUN / Creatinine Ratio 29 (high) . (reference range ,[DATE]) . Hemoglobin (low) . 13.2 (low) (reference range 14XXX,[DATE].0) . The Physician order [REDACTED]. f. The Physician order [REDACTED]. BNP (B-type Natriuretic Peptide) . CMP in one week . chest x-ray . Schedule EKG (Electrocardiogram) and Echo (Echocardiogram) . The Radiology Report dated [DATE] documented, .Examination: Chest - 1 view (AP) . There are modest right lower lobe and modest left lower lobe infiltrates. There is venous congestion . Conclusion: Modest bilateral lower lobe patchy infiltrates. The findings are worse than [DATE] . The Physician order [REDACTED]. Start [MEDICATION NAME] 750 mg (one) PO daily (times) 5 days. [MEDICATION NAME] TID (times) 10 days. [MEDICATION NAME] 600 mg BID (times) 10 days (with) 8 (ounces) fluid (diagnosis) URI . The laboratory report dated [DATE] documented, B-Type Natriuretic Peptide (BNP) . 356.4 (high) . (reference range 0XXX,[DATE].0) . g. The [DATE] Treatment Record documented, [DATE]: SPO2 every shift DX . [MEDICAL CONDITION] . [DATE]: Oxygen . ,[DATE] (liters) per nasal cannula to maintain SPO2 greater than 90% . [MEDICAL CONDITION] . Pulse oximetry readings were recorded with spaces provided on the Treatment Record for each shift (10:00 p.m. to 6:00 a.m., 6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m.). On [DATE], in the space provided for the documentation of the 10:00 p.m. to 6:00 a.m. shift SPO2 reading, Registered Nurse (RN) #1 documented the resident had an SPO2 reading of 84%. As of [DATE] at 4:00 p.m., the Nurse's Notes contained no documentation, for the 10:00 p.m. to 6:00 a.m. shift on [DATE], of physician consultation regarding the resident's SPO2 reading. The first Nurse's Note entry for [DATE] was at 8:45 a.m. and documented, .cont (continue) [MEDICATION NAME] (related to) URI (with) (no) N.V.D (nausea, vomiting, diarrhea) SOB, rash. Resp (Respirations) even (and) non labored (with) crackles (and) wheezes noted, O2 (oxygen) at ,[DATE] LPM (liters per minute) (per nasal cannula) . The entry was signed by Licensed Practical Nurse (LPN) #1, the 6:00 a.m. to 2:00 p.m. shift nurse. h. The [DATE] Treatment Record documented, XXX[DATE]: SPO2 every shift DX . [MEDICAL CONDITION] . [DATE]: Oxygen . PRN O2 (at) ,[DATE] liters per nasal cannula to maintain SPO2 greater than 90% . [MEDICAL CONDITION] Spaces were provided on the Treatment Record for each shift to document pulse oximetry readings. 1) The Treatment Record documented the resident's SPO2 reading on [DATE] for the 6:00 a.m. to 2:00 p.m. shift on [DATE] was 88. The Nurse's Notes entry dated [DATE] at 9:00 a.m. documented, .cont [MEDICATION NAME] r/t URI (with) (no) N.V.D SOB., rash noted. Resp even (and) shallow, lung sounds diminished (with) crackles (and) wheezes noted . cont [MEDICATION NAME] (up) drafts . The entry was signed by LPN #1. As of [DATE] at 4:00 p.m., there was no documentation in the 6:00 a.m. to 2:00 p.m. shift Nurse's Notes that the physician had been consulted regarding the reading of 88. On [DATE] at 2:05 p.m., LPN #1 was asked, How would you monitor (Resident #1)'s SPO2 and changes in condition? LPN #1

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 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) stated, Check SPO2 at beginning of each shift and as needed throughout the day . anytime below 90, I notify MD, if it's like 88 or 89% . I would do an updraft treatment and recheck it . 2) The Treatment Record documented the resident's SPO2 reading on [DATE] for the 10:00 p.m. to 6:00 a.m. shift was 84. The Nurse's Notes entry dated [DATE] at 12:07 a.m. documented, .(Respirations) 20 even (and) un-labored. SPO2 84% on 3 (liters) O2 via NC (nasal cannula), continuous, continues [MEDICATION NAME] . non-productive (cough) present. Lung sounds auscultated (with) diminished bases bilaterally, crackles in upper lobes bilaterally, (resident) states, 'I wasn't like this till all these new meds (medications)', educated (resident) on the purpose of the [MEDICATION NAME] and updrafts . As of [DATE] at 4:00 p.m., there was no documentation in the Nurse's Note that the physician was consulted regarding the residents SPO2 reading of 84. i. The Nurse's Note entry dated [DATE] at 6:10 a.m. documented, (Resident) sitting straight up in bed (with) sputum coming out of mouth and gray colored (at) 0510 (5:10 a.m.). (Resident) appeared to be not breathing (with) what appeared to be rigor mortis, (Resident) was (awake alert and oriented) (times) 3 talking and joking (with) staff (at) 0010 (12:10 a.m.) . County Coroner notified at 0510, DNS (Director of Nursing Services) notified (at) 0512 (5:12 a.m.), (Family) notified (at) 0513 (5:13 a.m.) and asked that we notify . Funeral home . APRN Advanced Practice Registered Nurse) notified (at) 0514 (5:14 a.m.). (with) orders to wait on coroner and release body to funeral home of family's choice . Coroner . arrived (at) 0600 (6:00 a.m.) and pronounced body deceased . The entry was signed by RN #1. j. The untimed Nurse's Note entry dated [DATE] documented, L.E. (Late Entry) for [DATE] (at) 0514 (5:14 a.m.). Upon notification of resident expiring reviewed (resident) condition earlier in the evening (with) APRN . VS (vital signs) WNL (within normal limits) and stable, SPO2 84% on 3 (liters) O2 via NC, APRN stated '(decreased) SPO2 to be expected (with) [MEDICAL CONDITION] and pneumonia'. (Resident) (awake alert oriented) (times) 3, (no) s/s (signs / symptoms) of distress present, denied SOB or breathing difficulty . The entry was signed by RN #1. 1) On [DATE] at 9:15 a.m., RN #1 was asked via telephone, Did you provide care for (Resident #1)? She stated, Yes. She was asked, Did you work with the resident on [DATE]? The RN stated, Yes ma'am. The RN was asked to describe the events prior to the resident's expiration on [DATE]. She stated, I was in there about 20 after eleven (11:20 p.m.). I gave him his [MEDICATION NAME] was in there about 10 to 20 minutes; he was alert, oriented talking with no signs or symptoms of distress. Resident was educated on updraft treatments and to turn, cough, deep breathe (TCDB) and he said it hurt too bad to (TCDB) due to his hernia. Resident had been refusing updraft treatments, but stated he understood about updrafts . he has chronic [MEDICAL CONDITIONS] and was receiving treatments all through the month of December (2015) also for Pneumonia. I remember he was looking at his pics (pictures) of his grandkids on the night stand and he said he had to get better because he wanted to be able to see his grandchildren. Then at a quarter to 1 a.m. (12:45 a.m.) Certified Nursing Assistants (CNA) were in the room . I went to his room about 20 after 5:00 a.m. (5:20 a.m.) because he had another pain pill due at 6:00 a.m. and when I checked him he was cold to the touch, pulseless, no respirations, and rigor mortis had set in and he was mottled . The RN was asked, Did you notify the MD? She stated, Yes, after he passed away I did call the APRN. RN #1 was asked, At what point did you last see the resident, make a room check or CNAs check on (Resident #1) before he passed away? She stated, 12:30 a.m. or about a quarter to 1:00 a.m. (12:45 a.m.), around that time. She was asked, And he was not checked on again until 20 after 5 a.m. (5:20 a.m.)? RN #1 stated, Correct. She was asked, How often do you check on your residents? The RN stated, Usually every two hours. 2) On [DATE] at 11:13 a.m., CNA #1 was asked via telephone, Did you work with (Resident #1)? She stated, Yes, and had on several occasions. She was asked, Did you work with (Resident #1) on [DATE]? She stated, I did. The CNA was asked to describe the events prior to the resident's expiration on [DATE]. She stated, We would go into his room when he called or when we delivered briefs or he put his call light on. We (CNAs) were in the room around midnight talking about the New York Ball drop and did vitals. Resident was short of breath, but I think that may have been from talking. He told me he would see me in the morning . CNA #1 was asked, At what point did you last see the resident, make a room check? She stated, I saw him at midnight . then I went in with the nurse around 4:30 or 5:00 a.m. She was asked, Did you check on the resident between midnight and the time the visit was made with the nurse? She stated, No, I can't say I did. I do remember the nurse calling me in there, but the resident was already gone; he was not breathing . When asked, CNA #1 declined and would not describe the resident at the time she entered the room. She only said, Resident was not breathing. k. On [DATE] at 11:10 a.m., CNA #2 was asked via telephone if he provided care for the resident. He stated, Yes. The CNA was asked, Did you work with the resident on [DATE]? He stated, I wasn't on his hall, but I passed ice to him and briefs. CNA #2 was asked to describe the events prior to the resident's expiration on [DATE]. He stated, Yeah I seen him two times that night; last around midnight. I passed him briefs and at 11:00 p.m. ice. He talked to me and seemed fine both times. Those are the only two times I talked to him and I worked the other side . l. On [DATE] at 11:48 a.m. the APRN was asked, Are you familiar with (Resident #1)? She stated, Yes. She was asked, Did the staff at (nursing home) timely notify you with any changes in (Resident #1)'s condition? She stated, Well, I wouldn't have voluntarily told you this, but there was an incident that occurred the night he died and I have information that would prove this to be true. The APRN was asked, Can you tell me about the events that led up to the resident's death on [DATE]? She stated, Two days after his death. He desaturated to 84% and they forgot to call (physician) or myself . He had pneumonia. He was treated with Doxy ([MEDICATION NAME]). Did not want steroids or updrafts. On follow-up x-ray he was shown to have continued pneumonia and [MEDICATION NAME] started. He was resistant to go to the hospital. Inhalers are just not giving him what he needs. He did agree to do updrafts and the next call I got he was deceased . That was Saturday ([DATE]) at 5:00 a.m . The APRN was asked if she was notified of the resident's oxygen saturation of 84% on [DATE]. She stated, No, I was not aware of that on the 31st. She was asked, As a general rule, what saturation would you expect for the resident? She stated, Now, he is supposed to be in the 90% range. At 84% I would expect him to go to the hospital . She was asked, Were you or the physician notified of any changes in the resident's condition or oxygen saturation of 84% on [DATE]? She stated, No. The APRN was asked, Can you tell me about this Nurse's Note entry made on [DATE], as a late entry for [DATE]? She read the entry made by RN #1 and stated, Now that just makes me mad . I saved the text . She text me on the fourth ([DATE]) and I'm going to read it . January fourth 10:14 a.m. I was distraught regarding (Resident #1)'s death. I forgot to notify you of SPO2 84 . m. On [DATE] at 2:00 p.m., the Director of Nursing (DON) was asked, Did you identify any problems associated with the expiration of (Resident #1) on [DATE]? She stated, I noticed after speaking with (Assistant Director of Nursing (ADON) RN #1), I realized he had a low pulse oximetry and honestly it was late and he was fine so she said she checked on him . She didn't call the doctor or APRN, so I counseled her on the need to always call the doctor for an abnormal pulse oximetry of 84%, or less than 90% . RN #1 was temporarily the ADON . The DON was asked, How do you think (RN #1) should have handled the oxygen saturation of 84%? She stated, She should have gone back and rechecked his oxygen saturation, but she didn't . She was asked, How often should a resident be checked or rounds be made on residents? She stated, Every two hours, or at least peeked (in) on every two hours. I know, in this case, the nurse didn't, but think the CNAs did . The DON was asked, What is (Resident #1)'s SPO2 supposed to be? She stated, Greater or equal to 90%. She was asked, At what level should the MD be notified? The DON stated, Call MD if less than 90% and unable to get it back up. I would have resident TCDB, sit them up, updraft treatments and use any orders . The DON was asked, Did (RN #1) call the physician with the resident's pulse oximetry of 84%? She stated, No she did not. She called the APRN after resident had passed away. I thought she notified the nurse practitioner, but she told me it was after the resident passed away, that she was confused about when she actually called her, but then stated it was after. That's why she wrote this note late entry. She kept going back and forth on when she actually called. The DON was asked, Have you in-serviced your nursing staff since the incident with (Resident #1) occurred on [DATE]? She stated, The only person I in-serviced was the person at fault for the pulse oximetry because she did not monitor or notify anyone about the pulse oximetry. I didn't in-service any other staff; I did verbal consult, but I did not write it down on paper, but I did it as soon as I was aware that pulse oximetry was 84% and she didn't do anything. The DON was asked when RN #1's termination date was. She stated, [DATE], but HR (Human Resources) is unable to locate her termination form. But she was terminated because she was an RN, not (because of) what happened (with Resident #1).

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F 0157 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) 2. The Pulse Oximetry (Assessing Oxygen Saturation) policy and procedure received from the Administrator on [DATE] at 11:27 a.m. documented, .If SPO2 is less than 90 percent . re-evaluate readings . If (SPO2) is less than acceptable level for resident's condition, notify the physician . 3. The Change in A Resident's Condition or Status policy and procedure received from the Administrator on [DATE] at 11:27 a.m. documented, .Our facility shall promptly notify . Attending Physician . Charge Nurse will notify resident's Attending Physician or On-call Physician when there has been . Instructions to notify the physician of changes in the resident's condition . 4. The Immediate Jeopardy was removed and the scope and severity reduced to a H on [DATE] at 1:55 p.m. when the following plan of removal was implemented: a. DON to immediately In-service all nursing staff on policy to notify MD immediately of any change in condition. This is to include abnormal vital signs, abnormal pulse ox (oximetry), change in mental status, change in respiratory status, and/or accident or injury. The nurse on duty at the time of the change of condition will call the MD immediately after assessing the change of condition. After performing the ordered intervention, the nurse must then document a follow up assessment and continue monitoring. Oncoming nursing staff will continue to monitor and document monitoring at least every shift. All nursing staff to be in-serviced on policy at the beginning of each shift, beginning on [DATE] and will be ongoing to include new hires and staff returning from leave. Training will take place before staff work the floor. Training will be done by DON / Designee and in-service sign in sheets used. Training will include policy on the notification of MD of any resident change of condition. b. DON to immediately assess all current residents for any change of condition. MD to be notified of any negative findings. c. DON / Designee to assess / monitor residents with change of condition daily per shift to assure that MD was notified of any negative findings regarding change of condition and corrected. This will be implemented [DATE] and continue for 60 days or until compliance is achieved.

F 0309

Level of harm - Immediate jeopardy

Residents Affected - Some

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 935) was substantiated (all or in part) in these findings:
Based on record review and interview, the facility failed to ensure Resident #1 received the necessary care and services to attain or maintain the highest practicable physical well-being. The facility failed to ensure nursing staff promptly responded to episodes of [MEDICAL CONDITION] as evidenced by the failure to assess, monitor and identify a significant change in condition; failure to immediately consult the physician regarding low oxygen saturation readings in order to provide the physician with necessary information to guide treatment; failure to administer as needed updrafts as ordered by the physician; and failure to ensure pulse oximetry readings were consistently completed and documented for 1 (Resident #1) of 4 (Residents #1, #3, #4 and #5) case mix residents who had orders for pulse oximetry monitoring. This failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident #1 who after experiencing an upper respiratory infection had episodes of [MEDICAL CONDITION] and expired on [DATE]; and had the potential to cause more than minimal harm for 34 residents who had orders for pulse oximetry, according to the room bed list provided by the Administrator at 1:56 p.m. on [DATE]. The Administrator was notified of the Immediate Jeopardy on [DATE] at 9:47 a.m.
The findings are:
1. Resident #1 had [DIAGNOSES REDACTED]. The Quarterly Minimum Data Set with an assessment reference date of [DATE] documented the resident scored a 15 (,[DATE] indicates cognitively intact) on the Brief Interview for Mental Status, required extensive physical assistance of two-plus people for bed mobility and toilet use, required extensive physical assistance of one person for personal hygiene, had limitation in range of motion of both lower extremities, had shortness of breath upon exertion and when lying flat and required oxygen therapy.
a. A Care Plan with a review date of [DATE] documented, Resident has potential for difficulty breathing related to chronic condition: [MEDICAL CONDITION] . Report changes in respiratory status to physician . Administer / monitor effectiveness of the following treatments: Oxygen 2 (liters per minute) per NC (nasal cannula) to maintain SPO2 greater than 90%. Check SPO2 every shift and prn .
b. The [DATE] physician's orders [REDACTED]. Shortness of breath . [DATE] SPO2 (peripheral capillary oxygen saturation) every shift . [DATE] Oxygen . prn (as needed) O2 (oxygen) (at) ,[DATE] L (liter) per nasal cannula to maintain SPO2 greater than 90% .
c. The Physician order [REDACTED]. Chest X-ray . [MEDICATION NAME] 500 mg (milligram) (times) 5 days . [MEDICATION NAME] .
400 mg Give 1.5 tabs (tablets) to (equal) 600 mg PO (by mouth) BID (twice daily) (times) 10 days r/t (related to) URI (upper respiratory infection) .
The Radiology Report dated [DATE] documented, .Examination: Chest - 1 view (AP (anterior / posterior)) . There are mild left base opacities -- pneumonia . Conclusion: Left base pneumonia new since [DATE] .
d. The Physician order [REDACTED].
e. The Physician order [REDACTED]. CBC (Complete Blood Count) (with) diff (differential) . CMP (Comprehensive Metabolic Panel) .
The Radiology Report dated [DATE] documented, .Examination: Chest - 1 view (AP) . There are mild bibasilar opacities -- possible atelectasis . Conclusion: Mild bibasilar atelectasis new since [DATE] .
The Physician order [REDACTED]. [MEDICATION NAME] dose pack . [MEDICATION NAME] (updraft) TID (three times a day) (times) 7
days . [MEDICATION NAME] 1 GM (gram) IM (intramuscular) (times) (one) dose .
The laboratory report dated [DATE] documented, .Chloride 97 (low) (reference range ,[DATE]) . Carbon [MEDICATION NAME] 40 (high) (reference range ,[DATE]) . BUN (Blood Urea Nitrogen) . 26 (high) (reference range ,[DATE]) . BUN / Creatinine Ratio 29 (high) . (reference range ,[DATE]) . Hemoglobin (low) . 13.2 (low) (reference range 14XXX,[DATE].0) .
The Physician order [REDACTED].
f. The Physician order [REDACTED]. BNP (B-type Natriuretic Peptide) . CMP in one week . chest x-ray . Schedule EKG (Electrocardiogram) and Echo (Echocardiogram) .
The Radiology Report dated [DATE] documented, .Examination: Chest - 1 view (AP) . There are modest right lower lobe and modest left lower lobe infiltrates. There is venous congestion . Conclusion: Modest bilateral lower lobe patchy infiltrates. The findings are worse than [DATE] .
The Physician order [REDACTED]. Start [MEDICATION NAME] 750 mg (one) PO daily (times) 5 days. [MEDICATION NAME] TID (times)
10 days. [MEDICATION NAME] 600 mg BID (times) 10 days (with) 8 (ounces) fluid (diagnosis) URI .
The laboratory report dated [DATE] documented, B-Type Natriuretic Peptide (BNP) . 356.4 (high) . (reference range 0XXX,[DATE].0) .
g. The [DATE] Treatment Record documented, [DATE]: SPO2 every shift DX . [MEDICAL CONDITION] . [DATE]: Oxygen . ,[DATE]
(liters) per nasal cannula to maintain SPO2 greater than 90% . [MEDICAL CONDITION] .
Pulse oximetry readings were recorded with spaces provided on the Treatment Record for each shift (10:00 p.m. to 6:00 a.m., 6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m.). On [DATE], in the space provided for the documentation of the 10:00 p.m. to 6:00 a.m. shift SPO2 reading, Registered Nurse (RN) #1 documented the resident had an SPO2 reading of 84%.
1) The [DATE] Medication Record documented, [MEDICATION NAME] TID (times) 10 days [DATE] . The administration times were
documented as 8:00 a.m., 12:00 p.m. and 5:00 p.m. In the spaces provided to document administration of the scheduled [MEDICATION NAME], initials documented the medication was administered on all three shifts from 5:00 p.m. on [DATE] through 5:00 p.m. on [DATE].
The [DATE] Medication Record further documented, [DATE]: [MEDICATION NAME] inhalation solution 1 unit dose INH (inhalation)
prn Q 6 hours . DX . Shortness of Breath . [DATE] [MEDICATION NAME] 0.083% (one) Q 6 (hours) r/t SOB .
In the spaces provided to document administration of the [MEDICATION NAME] and [MEDICATION NAME], there were no initials for
the 10:00 p.m. to 6:00 a.m. shift to document either medication was administered on [DATE].
2) As of [DATE] at 4:00 p.m., the Nurse's Notes contained no documentation, for the 10:00 p.m. to 6:00 a.m. shift on [DATE], of an assessment of the resident, monitoring of the resident's condition, acknowledgement of a change in the resident's SPO2 reading or physician consultation regarding the resident's SPO2 reading.
The first Nurse's Note entry for [DATE] was at 8:45 a.m. and documented, .cont (continue) [MEDICATION NAME] (related to) URI

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F 0309 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) (with) (no) N.V.D (nausea, vomiting, diarrhea) SOB, rash. Resp (Respirations) even (and) non labored (with) crackles (and) wheezes noted, O2 (oxygen) at ,[DATE] LPM (liters per minute) (per nasal cannula) . The entry was signed by Licensed Practical Nurse (LPN) #1, the 6:00 a.m. to 2:00 p.m. shift nurse. h. The [DATE] Treatment Record documented, XXX[DATE]: SPO2 every shift DX . [MEDICAL CONDITION] . [DATE]: Oxygen . PRN O2 (at) ,[DATE] liters per nasal cannula to maintain SPO2 greater than 90% . [MEDICAL CONDITION] Spaces were provided on the Treatment Record for each shift to document pulse oximetry readings. 1) As of [DATE] at 4:00 p.m., the space provided for the documentation of the [DATE] SPO2 reading for the 10:00 p.m. to 6:00 a.m. shift was blank (no SPO2 reading was recorded). There was no documentation in the Nurse's Notes of an SPO2 reading for the 10:00 p.m. to 6:00 a.m. shift on [DATE]. 2) The Treatment Record documented the resident's SPO2 reading on [DATE] for the 6:00 a.m. to 2:00 p.m. shift on [DATE] was 88. The Nurse's Notes entry dated [DATE] at 9:00 a.m. documented, .cont [MEDICATION NAME] r/t URI (with) (no) N.V.D SOB., rash noted. Resp even (and) shallow, lung sounds diminished (with) crackles (and) wheezes noted . cont [MEDICATION NAME] (up) drafts . The entry was signed by LPN #1. As of [DATE] at 4:00 p.m., there was no documentation in the 6:00 a.m. to 2:00 p.m. shift Nurse's Notes that the physician had been consulted regarding the reading of 88. On [DATE] at 2:05 p.m., LPN #1 was asked, How would you monitor (Resident #1)'s SPO2 and changes in condition? LPN #1 stated, Check SPO2 at beginning of each shift and as needed throughout the day . anytime below 90, I notify MD if it's like 88 or 89% . I would do an updraft treatment and recheck it . 3) The Nurse's Note entry dated [DATE] at 6:20 p.m. documented, .Continues [MEDICATION NAME] for URI. Noted pt (patient) (with) now hoarse sounding speech. Pt reports 'Starting to cough'. Lung fields noted diminished bases. Noted scattered crackles (and) wheezing. Pt reports 'Feeling worse now than before I started taking all these meds'. Pt continues updrafts as ordered . The entry was signed by LPN #2, the 2:00 p.m. to 10:00 p.m. shift nurse. On [DATE] at 4:40 p.m., LPN #2 was asked, How would you monitor (Resident #1)'s SPO2 and changes in condition? The LPN stated, Deep breathe, oxygen on, updraft if ordered or call doctor and let them know what is going on with them. i. The Treatment Record documented the resident's SPO2 reading on [DATE] for the 10:00 p.m. to 6:00 a.m. shift was 84. 1) The Nurse's Notes entry dated [DATE] at 12:07 a.m. documented, .(Respirations) 20 even (and) un-labored. SPO2 84% on 3 (liters) O2 via NC (nasal cannula), continuous, continues [MEDICATION NAME] . non-productive (cough) present. Lung sounds auscultated (with) diminished bases bilaterally, crackles in upper lobes bilaterally, (resident) states, 'I wasn't like this till all these new meds (medications)', educated (resident) on the purpose of the [MEDICATION NAME] and updrafts . As of [DATE] at 4:00 p.m., there was no documentation in the Nurse's Note that the physician was consulted regarding the residents SPO2 reading of 84. 2) The [DATE] Medication Record documented, [DATE]: [MEDICATION NAME] inhalation solution 1 unit dose INH TID Dx . Unspecified bacterial pneumonia. The administration times were documented as 8:00 a.m., 12:00 p.m. and 5:00 p.m. In the spaces provided to document administration of the scheduled [MEDICATION NAME], initials documented the medication was administered on all three shifts from 8:00 a.m. on [DATE] through 5:00 p.m. on [DATE]. The [DATE] Medication Record further documented, [DATE]: [MEDICATION NAME] inhalation solution 1 unit dose INH prn Q 6 hours . DX . Shortness of Breath . [DATE]: [MEDICATION NAME] inhalation solution 1 unit dose INH prn Q 6 hours . [MEDICAL CONDITION]. In the spaces provided to document administration of the [MEDICATION NAME] and [MEDICATION NAME], there were no initials for the 10:00 p.m. to 6:00 a.m. shift to document either medication was administered on [DATE] or [DATE]. j. The Nurse's Note entry dated [DATE] at 6:10 a.m. documented, (Resident) sitting straight up in bed (with) sputum coming out of mouth and gray colored (at) 0510 (5:10 a.m.). (Resident) appeared to be not breathing (with) what appeared to be rigor mortis, (Resident) was (awake alert and oriented) (times) 3 talking and joking (with) staff (at) 0010 (12:10 a.m.) . County Coroner notified at 0510, DNS (Director of Nursing Services) notified (at) 0512 (5:12 a.m.), (Family) notified (at) 0513 (5:13 a.m.) and asked that we notify . Funeral home . APRN Advanced Practice Registered Nurse) notified (at) 0514 (5:14 a.m.). (with) orders to wait on coroner and release body to funeral home of family's choice . Coroner . arrived (at) 0600 (6:00 a.m.) and pronounced body deceased . The entry was signed by RN #1. k. The untimed Nurse's Note entry dated [DATE] documented, L.E. (Late Entry) for [DATE] (at) 0514 (5:14 a.m.). Upon notification of resident expiring reviewed (resident) condition earlier in the evening (with) APRN . VS (vital signs) WNL (within normal limits) and stable, SPO2 84% on 3 (liters) O2 via NC, APRN stated '(decreased) SPO2 to be expected (with) [MEDICAL CONDITION] and pneumonia'. (Resident) (awake alert oriented) (times) 3, (no) s/s (signs / symptoms) of distress present, denied SOB or breathing difficulty . The entry was signed by RN #1. 1) On [DATE] at 9:15 a.m., RN #1 was asked via telephone, Did you provide care for (Resident #1)? She stated, Yes. She was asked, Did you work with the resident on [DATE]? The RN stated, Yes ma'am. The RN was asked to describe the events prior to the resident's expiration on [DATE]. She stated, I was in there about 20 after eleven (11:20 p.m.). I gave him his [MEDICATION NAME] was in there about 10 to 20 minutes; he was alert, oriented talking with no signs or symptoms of distress. Resident was educated on updraft treatments and to turn, cough, deep breathe (TCDB) and he said it hurt too bad to (TCDB) due to his hernia. Resident had been refusing updraft treatments, but stated he understood about updrafts . he has chronic [MEDICAL CONDITIONS] and was receiving treatments all through the month of December (2015) also for Pneumonia. I remember he was looking at his pics (pictures) of his grandkids on the night stand and he said he had to get better because he wanted to be able to see his grandchildren. Then at a quarter to 1 a.m. (12:45 a.m.) Certified Nursing Assistants (CNA) were in the room . I went to his room about 20 after 5:00 a.m. (5:20 a.m.) because he had another pain pill due at 6:00 a.m. and when I checked him he was cold to the touch, pulseless, no respirations, and rigor mortis had set in and he was mottled . The RN was asked, Did you notify the MD? She stated, Yes, after he passed away I did call the APRN. RN #1 was asked, At what point did you last see the resident, make a room check or CNAs check on (Resident #1) before he passed away? She stated, 12:30 a.m. or about a quarter to 1:00 a.m. (12:45 a.m.), around that time. She was asked, And he was not checked on again until 20 after 5 a.m. (5:20 a.m.)? RN #1 stated, Correct. She was asked, How often do you check on your residents? The RN stated, Usually every two hours. 2) On [DATE] at 11:13 a.m., CNA #1 was asked via telephone, Did you work with (Resident #1)? She stated, Yes, and had on several occasions. She was asked, Did you work with (Resident #1) on [DATE]? She stated, I did. The CNA was asked to describe the events prior to the resident's expiration on [DATE]. She stated, We would go into his room when he called or when we delivered briefs or he put his call light on. We (CNAs) were in the room around midnight talking about the New York Ball drop and did vitals. Resident was short of breath, but I think that may have been from talking. He told me he would see me in the morning . CNA #1 was asked, At what point did you last see the resident, make a room check? She stated, I saw him at midnight . then I went in with the nurse around 4:30 or 5:00 a.m. She was asked, Did you check on the resident between midnight and the time the visit was made with the nurse? She stated, No, I can't say I did. I do remember the nurse calling me in there, but the resident was already gone; he was not breathing . When asked, CNA #1 declined and would not describe the resident at the time she entered the room. She only said, Resident was not breathing. l. On [DATE] at 11:10 a.m., CNA #2 was asked via telephone if he provided care for the resident. He stated, Yes. The CNA was asked, Did you work with the resident on [DATE]? He stated, I wasn't on his hall, but I passed ice to him and briefs. CNA #2 was asked to describe the events prior to the resident's expiration on [DATE]. He stated, Yeah I seen him two times that night; last around midnight. I passed him briefs and at 11:00 p.m. ice. He talked to me and seemed fine both times. Those are the only two times I talked to him and I worked the other side . m. On [DATE] at 11:48 a.m. the APRN was asked, Are you familiar with (Resident #1)? She stated, Yes. She was asked, Did the staff at (nursing home) timely notify you with any changes in (Resident #1)'s condition? She stated, Well, I wouldn't have voluntarily told you this, but there was an incident that occurred the night he died and I have information that would prove this to be true. The APRN was asked, Can you tell me about the events that led up to the resident's death on [DATE]? She stated, Two days after his death. He desaturated to 84% and they forgot to call (physician) or myself . He had pneumonia. He was treated with Doxy ([MEDICATION NAME]). Did not want steroids or updrafts. On follow-up x-ray he was shown to have continued

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045144	A. BUILDING _____ B. WING _____	01/27/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CROWNPOINT HEALTH & REHAB CENTER	1203 SOUTH BEND DRIVE HORSESHOE BEND, AR 72512

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F 0309 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 4) pneumonia and [MEDICATION NAME] started. He was resistant to go to the hospital. Inhalers are just not giving him what he needs. He did agree to do updrafts and the next call I got he was deceased . That was Saturday ([DATE]) at 5:00 a.m . The APRN was asked if she was notified of the resident's oxygen saturation of 84% on [DATE]. She stated, No, I was not aware of that on the 31st. She was asked, As a general rule, what saturation would you expect for the resident? She stated, Now, he is supposed to be in the 90% range. At 84% I would expect him to go to the hospital . She was asked, Were you or the physician notified of any changes in the resident's condition or oxygen saturation of 84% on [DATE]? She stated, No. The APRN was asked, Can you tell me about this Nurse's Note entry made on [DATE], as a late entry for [DATE]? She read the entry made by RN #1 and stated, Now that just makes me mad . She text me on the fourth ([DATE]) and I'm going to read it . January fourth 10:14 a.m. I was distraught regarding (Resident #1)'s death. I forgot to notify you of SPO2 84 . n. On [DATE] at 2:00 p.m., the Director of Nursing (DON) was asked, Did you identify any problems associated with the expiration of (Resident #1) on [DATE]? She stated, I noticed after speaking with (Assistant Director of Nursing (ADON) RN #1), I realized he had a low pulse oximetry and honestly it was late and he was fine so she said she checked on him . She didn't call the doctor or APRN, so I counseled her on the need to always call the doctor for an abnormal pulse oximetry of 84%, or less than 90% . RN #1 was temporarily the ADON . The DON was asked, Why is (RN #1) no longer working here? She stated, She educated herself out of a job. She was hired as an LPN, but graduated from RN school and we had to hire an LPN so we let her go. The DON was asked, How do you think (RN #1) should have handled the oxygen saturation of 84%? She stated, She should have gone back and rechecked his oxygen saturation, but she didn't . She was asked, How often should a resident be checked or rounds be made on residents? She stated, Every two hours, or at least peeked (in) on every two hours. I know, in this case, the nurse didn't, but think the CNAs did . The DON was asked, What is (Resident #1)'s SPO2 supposed to be? She stated, Greater or equal to 90%. She was asked, At what level should the MD be notified? The DON stated, Call MD if less than 90% and unable to get it back up. I would have resident TCDB, sit them up, updraft treatments and use any orders . The DON was asked, Did (RN #1) call the physician with the resident's pulse oximetry of 84%? She stated, No she did not. She called the APRN after resident had passed away. I thought she notified the nurse practitioner, but she told me it was after the resident passed away, that she was confused about when she actually called her, but then stated it was after. That's why she wrote this note late entry. She kept going back and forth on when she actually called. The DON was asked, Have you in-serviced your nursing staff since the incident with (Resident #1) occurred on [DATE]? She stated, The only person I in-serviced was the person at fault for the pulse oximetry because she did not monitor or notify anyone about the pulse oximetry. I didn't in-service any other staff; I did verbal consult, but I did not write it down on paper, but I did it as soon as I was aware that pulse oximetry was 84% and she didn't do anything. The DON was asked when RN #1's termination date was. She stated, [DATE], but HR (Human Resources) is unable to locate her termination form. But she was terminated because she was an RN, not (because of) what happened (with Resident #1). 2. The Pulse Oximetry (Assessing Oxygen Saturation) policy and procedure received from the Administrator on [DATE] at 11:27 a.m. documented, .Review the physician's orders [REDACTED]. Review the resident's care plan to assess for any special needs of the resident . Normally SPO2 is between 90 and 100 percent . Assess the resident . If SPO2 is less than 90 percent . re-evaluate readings . If (SPO2) is less than acceptable level for resident's condition, notify the physician . 3. The Change in A Resident's Condition or Status policy and procedure received from the Administrator on [DATE] at 11:27 a.m. documented, .Our facility shall promptly notify . Attending Physician . Charge Nurse will notify resident's Attending Physician or On-call Physician when there has been . Instructions to notify the physician of changes in the resident's condition . Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical / mental condition or status . 4. The immediate jeopardy was removed and the scope and severity reduced to a H on [DATE] at 1:55 p.m. when the following plan of removal was implemented: a. DON to immediately In-service all nursing staff on policy to notify MD immediately of any change in condition. This is to include abnormal vital signs, abnormal pulse ox (oximetry), change in mental status, change in respiratory status, and/or accident or injury. The nurse on duty at the time of the change of condition will call the MD immediately after assessing the change of condition. After performing the ordered intervention, the nurse must then document a follow up assessment and continue monitoring. Oncoming nursing staff will continue to monitor and document monitoring at least every shift. All nursing staff to be in-serviced on policy at the beginning of each shift, beginning on [DATE] and will be ongoing to include new hires and staff returning from leave. Training will take place before staff work the floor. Training will be done by DON / Designee and in-service sign in sheets used. Training will include policy on the notification of MD of any resident change of condition. b. DON to immediately assess all current residents for any change of condition. MD to be notified of any negative findings. c. DON / Designee to assess / monitor residents with change of condition daily per shift to assure that MD was notified of any negative findings regarding change of condition and corrected. This will be implemented [DATE] and continue for 60 days or until compliance is achieved.