STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045417	A. BUILDING _____ B. WING _____	C 02/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE VETERANS HOME	1125 NORTH COLLEGE FAYETTEVILLE, AR 72703

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F 000	INITIAL COMMENTS 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 # 18093 was substantiated (all or in part) with deficiencies cited at F225, F226, F309, and F490	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		

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

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F 225	Continued From page 1 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint # 18093 was substantiated (all or in part) in these findings. Based on record review, and interview, the facility failed to ensure an allegation of neglect against 1 staff member (LPN#1) was thoroughly investigated, residents were protected during the investigation, and the allegation was reported to the Office of Long Term Care by 11:00 a.m. the next business day in accordance with state law for 1 of 1 (Residents # 5) case mix residents who was the subject of an allegation of neglect. This failed practice had the potential to affect 50 residents in the facility who had a change of condition since 1/1/13 according to the listing received from the Administrator on 2/8/13.	F 225		

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The findings are:

Resident # 5 was admitted to the facility on 12/28/12 with diagnoses of Dementia, Atrial Fibrillation, and Congestive Heart Failure. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/4/13 documented the resident scored 9 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status and required supervision with ambulation and locomotion.

a. A facility form titled "Concern" documented, "Date of Concern: 1/15/13. Name of Person Voicing Concerns: [OT (Occupational Therapist) # 1]. Title: OT. Nature of Concern [Be Specific]: OT entered room at [approximately] 11:30 a.m. [Patient] was only able to respond to verbal stimuli by opening eyes. No verbal response or other movement. It was noted that [patient] had severe rattling [with] breathing. OT went straight to Nurse [LPN (Licensed Practical Nurse) # 1] [and] asked how [patient] was doing this a.m. She stated that he was doing OK [and] had been up for breakfast earlier. I [OT] explained to her that [Resident # 5] was not responding to me like he normally does, that he sounds very congested [and] something is wrong. Nurse did not go check on [Resident # 5] at this time. I then found a CNA [Certified Nursing Assistant] and requested that she check his vitals. She did so right away. CNA stated, 'They are really low' upon leaving [patient] room. I asked what it was, she stated 84/47, as she proceeded to nurse office to tell nurse. There was still no response from nurse so I asked CNA to check [oxygen] level, which she did right away. As she came out of room she stated 'It's 90'. I then went back into room at [approximately] 11:45

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a.m. to check on [patient]. I immediately noticed very shallow breathing [with] [patient] and congested sounds. I attempted to wake [patient] by shaking him on [right] shoulder [without] any response ... It appeared that [patient] was in trouble, so I ran to hallway. [LPN # 1] was at the nurses station [and] I stated, '[LPN # 1], he is in big trouble, you need to come now'. She did follow me this time into [patient] room. I then attempted to arouse [patient] by saying '[name, name, name]' and shaking his [right] shoulder. I noted 1 breath taken by [patient] [and] then [no] chest movement as [patient] stopped breathing. [LPN # 1] was also saying '[name, name]'. I then asked [LPN # 1] what I could do to help. She said [I] need [RN (Registered Nurse) Supervisor # 1]. I immediately left room and found [RN Supervisor # 1] on opposite hall [and] told him that [LPN # 1] needed his help. He went straight to [Resident # 5's] room. As he entered room and saw [Resident # 5] he stated '[It] appears that [Resident # 5] is gone'. I then left room and went to 5th floor to begin writing statement of events that had happened. [OT Supervisor # 1] happened to walk by so I asked her to sit down [and] explained to her what happened. We then decided at that time to meet [with] Administrator to explain what had happened. Administrator did meet [with] [OT Supervisor # 1] [and] I, [and] I was able to explain exactly what had happened."

b. The Nurse's Notes dated 1/15/13 at 11:50 a.m., signed by Registered Nurse (RN) Supervisor # 1, documented, "[Resident] event [respiratory/cardiac arrest] pupils fixed, [non responsive], [no] [breath sounds], [no] pulse ... [resident] [expired] at 11:50 a.m."

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On 2/11/13 at 2:40 p.m., RN Supervisor # 1 was asked if he remembered [Resident # 5]. RN Supervisor # 1 stated "Yes." RN Supervisor # 1 was asked, "Can you tell me how you got involved with him on the day he died?" RN Supervisor # 1 stated, "[LPN # 1] came and got me when I was in the hallway on the 6th floor. She said she felt like the resident's vital signs were low and level of consciousness was decreased. She said [OT # 1] had come and reported a condition change and I needed to check him. As I walked in [Resident # 5] stopped breathing."

c. The OLTC [Office of Long Term Care] Incident and Accident Report (I & A) form DMS 7734 dated 2/5/13 documented, "Date and Time Submitted [if known] 2/5/13 11:00 a.m. Date [and] Time of Discovery: 1/15/13 12:00 [p.m.] ... Staff Reporting I [and] A: [Director of Nursing (DON)]. title: DON ... Date of I & A: 1/15/13 Time: 11:30 a.m. ... Name of Resident: [Resident # 5] ... Status of Alleged Perpetrator: Facility Employee ... Type of Incident: Neglect ... Notifications: Family, Doctor ... Administrator ... Summary of Incident: On 1/15/13 at [approximately] 11:30 a.m. Occupational Therapist [OT] entered the residents room for treatment, resident was lying in bed with eyes closed. Responded to verbal stimuli by opening eyes only, no verbal response. OT went to charge nurse who was in [the] nurse office eating lunch and asked how the resident was doing. Charge nurse stated that he was doing OK, he had been up for breakfast and a shower. OT conveyed to the charge nurse that the resident was not [responding] as he normally did, and that he sounded congested. Charge nurse ... did no go to check on the resident. OT

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then approached a CNA [Certified Nurses Assistant] and asked her to get vital signs on the resident. Vital signs were obtained and reported to the OT and charge nurse. Charge nurse still did not respond so OT then asked the CNA to get a pulse ox [oximetry], OT then reentered the resident's room at [approximately] 11:45 a.m. and noticed shallow breathing from the resident, the OT then approached the charge nurse again and stated 'you need to come now' charge nurse entered the room and asked the OT to get the RN [Registered Nurse] supervisor. As they were trying to get a response from the resident he took one deep breath and then there were no more breaths or chest movements. RN supervisor assess resident and notified the Medical Director of the absence of vital signs. Resident was a DNR [Do Not Resuscitate] so no CPR [Cardiopulmonary Resuscitation] was performed. Steps Taken to Prevent Continued Abuse or Neglect During the Investigation: Investigation was began due to concern from therapist that charge nurse did not appear concerned when he voiced a change of condition to her. Witness statements were obtained, interviews conducted. Investigation will continue. RN supervisor will monitor charge nurse performance." The fax report documented that this fax was sent on to OLTC on 2/6/13 at 10:08 a.m., not 2/5/13.

d. On 2/8/13 at 8:16 a.m., OT # 1 was asked, "What happened on 1/15/13 with [Resident # 5]?" OT # 1 stated, "I went into see [Resident # 5], tried to around him by calling his name and he didn't respond. He usually woke right up, so I left the room and went to the office on the 6th floor by the nursing station. I told [LPN # 1], she was just outside the office. I asked her how [Resident # 5]

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was doing and she said he was fine he'd been to breakfast and I said OK and told her he didn't look right and was not responding and his breathing was not right. She didn't do anything. I grabbed a CNA and asked them to do vital signs." OT # 1 was asked "Do you recall who the CNA was?" OT # 1 stated, "No. The CNA got stuff and went to [Resident # 5's] room and got vital signs. I sat down at the nursing station with another resident as the CNA went into the room. She came back out and said they were really low and I said what were they. She told me and they are in my written statement. She took the vital signs to [LPN # 1] in the office by the nursing station. The CNA came out and [LPN # 1] was still sitting there and I asked her [CNA] to check O2 [oxygen] level and she did. She said they were 90. At that point I stood up and went into [Resident # 5's] room. [LPN # 1] was still in the office eating lunch. I went back to [Resident # 5's] room and he was breathing really shallow and there was no response and he was in trouble. I went back to [LPN # 1] who was at a med cart and told her she had to get in there because he was in trouble. We went in and [Resident # 5] was gasping and she sent me for [RN Supervisor # 1] the RN and [RN Supervisor # 1] came right away and the resident had passed. I was really upset with this. I went down to 5th floor and grabbed a sheet of paper and started writing. My boss came by and I told her what happened and she said lets talk with [Administrator]. We went down and talked with [Administrator] within 15 minutes of this." OT # 1 was asked, "What happened after that?" OT # 1 stated, "Two or three days later [Administrator] asked me for a written statement and I put it on her form and gave it to [Administrator]."

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e. A sheet of paper dated 1/18/13, signed by CNA # 1, documented, "On January 15, 2013, I was asked get [Resident # 5's] vitals by the therapist. I got them and his blood pressure was very low so I told the nurse, [LPN # 1]. She was in the nurses office eating. She said his vitals were low that morning during breakfast about 2 hours before [Resident # 5's] passing. She also told me not [to] worry about doing the vitals and that she would do then as well. This was before breakfast."

On 2/11/13 at 2:30 p.m., CNA # 1 was asked, "What happened on the day [Resident # 5] died?" CNA # 1 stated, "[LPN # 1] told me she was going to get vital signs that day and not to worry about it. I walked the resident from the dining room to his room and he had to stop and sit down. He said he felt weak. He sat down for a little then I walked him on to bed. After that PT [Physical Therapy] or OT came to me and asked me to get [Resident # 5's] vital signs. I did and they were really low." CNA # 1 was asked, "Did you also get a pulse and respiration?" CNA # 1 stated, "Yes and they were low too." CNA # 1 was asked, "How was the resident breathing when you did the vital signs?" CNA # 1 stated, "Heavy, like he was short of breath and he wouldn't wake up like he normally did." CNA # 1 was asked, "After you took the vital signs, did you tell [LPN # 1] and tell her what the resident was like?" CNA # 1 stated, "Yes, she said his blood pressure was low. I told her he wasn't breathing right or acting right." CNA # 1 was asked, "What did she say when you told her about the resident not breathing right or acting right?" CNA #1 stated, "She said, 'OK,' that his vital signs were low that a.m. She wasn't concerned. She didn't come check him like I thought she should have." CNA #1 was asked,

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"Did you tell anyone else about the resident's problems?" CNA #1 stated, "I didn't see anyone else to tell." CNA #1 was asked, "With [LPN #1], had you ever had this concern before with her not responding to you concerns about the residents?" CNA #1 stated, "Yes, she usually say 'Whenever I get a second I'll come.' She was never very attentive." CNA #1 was asked, "Did you tell anyone about your concerns with [LPN # 1]? CNA #1 stated, "Not [RN Supervisor # 1] or [Director of Nursing (DON)] but I did talk with the other aides." CNA # 1 was asked, "Did you tell any of the other LPNs about your concerns with [LPN # 1]?" CNA #1 stated, "No." CNA #1 was asked, "What does the '4' mean on the schedule by your name for today?" CNA # 1 stated, "That's section 4, rooms [number] to [number]. I'm working that section today and that is where I always work." CNA #1 was asked, "Did anyone talk with you before today about letting someone else know when a nurse does not respond to you about a resident's condition change?" CNA # 1 stated, "No."

f. A lined sheet of paper dated 1/17/13, signed by LPN # 1, documented, "I had personally taken [Resident # 5's] [blood pressure] after counting narcotics with the 11:00 p.m. to 7:00 a.m. shift at 7:00 a.m. He was alert and getting ready to go to the dining room for breakfast. I administered his 8:00 a.m. medication in the dining room [and] he denied pain/discomfort. He was taken back to his room [at] approximately 8:30 a.m. Some time after the OT stated [Resident # 5] did not seem as alert, no urgency in his speech. I had a CNA check his [blood pressure] [and] SpO2 [pulse oximetry] - which were within normal limits for him. He was in bed [and] appeared to be sleeping

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when I entered the room to give his room a 10:00 a.m. medication. I had asked the RN Supervisor to examine him and he replied he would after accessing [assessing] the new admission. Around 10:45 a.m. the OT call out from [Resident # 5's] room [and] I entered to find him expired."

On 2/11/13 at 2:40 p.m., RN Supervisor #1 was asked, "Are you sure it was [LPN # 1] who came to get you and not OT?" RN Supervisor #1 stated, "No, It was [LPN # 1], I never saw that [OT #1] guy." RN Supervisor #1 was asked, "Had any of the staff reported concerns with [LPN #1] not responding to their concerns about residents?" RN Supervisor # 1 stated, "Seems to me a CNA did come to talk with me about a resident's dressing being off after his shower and that it had been some time since the shower and it still wasn't on. When I went to check the dressing, it was on and the aide didn't know [LPN #1] been in. I had one LPN tell me that [LPN # 1] was slow to respond." RN Supervisor #1 was asked, "Who was the nurse?" RN Supervisor # 1 stated, "[LPN # 2.]. RN Supervisor #1 was asked, "What did you do?" RN Supervisor #1 stated, "I talked with [LPN # 1] and she said she was busy with meds." RN Supervisor #1 was asked, "Did you tell [DON] or [Administrator] about the concerns regarding [LPN #1]?" RN Supervisor #1 stated, "No, once I had words with [LPN # 1] I thought that would be the end of it. I never heard anything else so I thought it was fixed." RN Supervisor #1 was asked, "Were you asked to monitor [LPN # 1's] residents for unnoticed/unreported condition changes after 1/15/13?" RN Supervisor # 1 stated, "No, I'd check residents when she asked me to."

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g. There were no documented statements from other staff regarding LPN # 1's response to reported resident condition changes provided by the Administrator with the DMS 7734 on 2/8/13. There was no assessment of other residents on 1/15/13 for possible unreported/unrecognized condition changes provided by the Administrator with the DMS 7734 on 2/8/13. There were no documented interviews with residents regarding response to condition changes provided by the Administrator with the DMS 7734 on 2/8/13.

h. On 2/8/13 at 9:00 a.m., LPN # 2 stated she had worked on the 6th floor for 1 1/2 years with last year being on the 7:00 a.m. to 3:00 p.m. shift. LPN # 2 was asked, "Do you work with [LPN # 1] much?" LPN # 2 stated, "Two of the four days I work every week, I worked with her. She relieved for me and the other LPN." LPN # 2 was asked, "Any concerns with [LPN # 1] not responding to resident condition changes?" LPN # 2 stated, "No. I did have CNAs come to me with concerns that she did not respond to them. I passed those on to [RN Supervisor # 1]. What I saw was a communication barrier. A CNA would tell her something and she'd say OK, then would go take care of it but never got back to the CNA who had the concern to let them know and she didn't go right away."

i. On 2/8/13 at 9:18 a.m., CNA #2 was asked, "Ever work with [LPN # 1]?" CNA # 2 stated, "Yes." CNA #2 was asked, "Did you ever tell [LPN # 1] that a resident had a condition change and have concerns that she didn't do anything?" CNA #2 stated, "Yes, about one month ago ... I told her and I didn't think she listened to me. I told [RN Supervisor # 1] about my concerns."

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j. On 2/8/13 at 10:05 a.m., the DON was asked, "Has any staff member reported a concern with a resident's condition change not being responded to?" The DON stated, "Yes, a therapist." The DON was asked, "When was this?" The DON stated, "1/15/13." The DON was asked, "Who was the resident?" The DON stated, "{Resident # 5]." The DON was asked, "What was the therapist concern?." The DON stated, "The concern went from the OT to the Administrator, who told me of the OT's concern." The DON was asked, "What was the concern?" The DON stated, "That he'd gone into [Resident # 5's] room for therapy and the resident did not arouse and he went to the charge nurse who was in the nursing office eating lunch and she did not get up to assess [Resident # 5]. Then he saw a CNA and asked the CNA to get vital signs on [Resident # 5]. The CNA got the blood pressure and told OT what it was. The OT asked the CNA to let the nurse know and then he asked if she had gotten a pulse ox and she said no. So he asked her to go back and get a pulse ox." The DON was asked, "Who was the CNA?" The DON stated, "[CNA # 1]. She got a pulse ox and was 90%. She told him and she told the nurse. His concern was the nurse still did not respond to [Resident 3 5's] needs. He was there so he went back to the room and now [Resident # 5] had labored breathing and that point [LPN # 1] was in the hall and he told [LPN # 1] 'You need to come now' and then [LPN # 1] went into the room. [OT # 1] asked 'What can I do to help' and she said 'Go get [RN Supervisor # 1]. When [RN Supervisor # 1] got there, the resident had expired." The DON was asked, "This was the story/allegation as you knew it on 1/15/13?" The DON stated, "Yes." The

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DON was asked, "What did you think the therapist was alleging?" The DON stated, "That [LPN # 1] was not responding to his concern, after we did our investigation then we identified the possibility of neglect." The DON was asked, "When did you come to this conclusion?" The DON stated, "That afternoon [1/15/13], when [name], Administrator got with me. We went over all of this. [Administrator] and I talked with the CNA and got a statement from the CNA and then we asked [OT # 1] to write out a statement. I reviewed the chart. We didn't get the statements that day. We got a statement from [OT # 1], [LPN # 1] and [CNA # 1]. I'd have to look at the statements to see when they were turned into us. We interviewed [LPN # 1] and [CNA # 1]. [CNA # 1] stated [Resident # 5] had gotten up and walked to breakfast and back and he got a shower. After the shower he ambulated back to the room for a nap. Then after that the OT asked her for vital signs and all of that. In reviewing his chart his blood pressures tended to run low and they had been running low." The DON was asked, "What next?" he DON stated, "We did interviews with [LPN # 1] and [CNA # 1]. When we talked with [CNA # 1] she said it was [OT # 1], the OT who asked for vital signs. When we interviewed [LPN # 1] she said she had asked for the CNA to get vital signs. [LPN # 1] stated she was in the hall the second time the OT came to her. She also wrote in her statement that between those times she'd asked [RN Supervisor # 1] to do an assessment on [Resident # 5]. So we had conflicting stories between OT and [LPN # 1]. So we talked with [CNA # 1] again about where [LPN # 1] was and who asked for vital signs and she stated [LPN # 1] in the the nursing office eating lunch." The DON was asked, "This was back

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around 1/15/13?" The DON stated, "After we got their statements. Then we went back and started investigating. [LPN # 1] stated [OT # 1's] voice was not urgent. To her [OT # 1] did not convey urgency and that's why she didn't go check the resident. In the mean time we batted this back and forth and talked with the Little Rock Arkansas Department of Veteran's Affairs on doing disciplinary counseling with [LPN # 1]. So we proceeded on with disciplinary action pending investigation from the Office of Long Term Care [OLTC] and because that had been her third disciplinary action it resulted in termination of the 4th or 5th of February." The DON was asked, "Did you identify then that the OT was alleging neglect?" The DON stated, "No, I felt he was saying [LPN # 1] didn't respond timely enough." The DON was asked, "If someone doesn't respond timely to a resident's condition change what happens?" The DON stated, "They can continue to decline." The DON was asked, "Is failure to respond timely the same as neglect?" The DON stated, "Yes." The DON was asked, "Why not report this to OLTC sooner?" The DON stated, "We were getting their stories we had conflicting stories." The DON was asked, "What did you do with [LPN # 1] on 1/15/13?" The DON stated, "We got her side of the story and let her work." The DON was asked, "How were you monitoring [LPN # 1]?" The DON stated, "The RN Supervisor was doing rounds and watching. [RN Supervisor # 1] and myself were doing that?" The DON was asked, "How often, any set times?" The DON stated, "No, I try to go out every 2 hours and [RN Supervisor # 1] is on 5 and 6 all the time, back and forth." The DON was asked, "Besides being on 6th and watching, did you do anything else?" The DON stated, "Not specifically, no."

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The DON was asked, "Did you go in and assess [LPN # 1's] assigned residents?" The DON stated, "No, I did not." The DON was asked, "How would you know that [LPN # 1] wasn't responding to a resident's condition change if you didn't go in and check the residents of hers?" The DON stated, "We wouldn't. I check the 24 hours report when I come in and when I go home. ..." The DON was asked, "Who does reportable to OLTC, you or [Administrator]?" The DON stated, "Both of us, it just depends. I did this one. We waited on reporting to the staff's stories." The DON was asked, "Any reports prior to this from staff that [LPN # 1] was not responding to their reports of resident condition changes?" The DON stated, "None brought to my attention." The DON was asked, "Did [RN Supervisor #1] ever share concerns that staff was telling him that [LPN # 1] was not responding to staff concerns?" The DON stated, "No, I never heard any complaints on that about [LPN # 1]." The DON was asked, "Is this investigation complete now?" The DON stated, "We are pretty well done and there was the possibility of neglect pending the investigation from OLTC." The DON was asked, "Was [LPN # 1] terminated due to the outcome of the investigation?" The DON stated, "No, it was her 3rd disciplinary action. It's an automatic termination no matter the outcome." The DON was asked, "What was it [disciplinary action] for?" The DON stated, "She didn't document on the resident."

k. On 2/8/13 at 10:55 a.m., the Administrator was asked, "When did [OT # 1] report his concerns to you regarding [Resident # 5]?" The Administrator stated, "Initially on 1/15/13." The Administrator was asked, "What did you think his concern

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was?" The Administrator stated, "A lack of response on the part of the LPN." The Administrator was asked, "What is the lack of response in this case?" The Administrator stated, "It could be neglect." The Administrator was asked, "Did you go assess or have others assess [LPN # 1's] other residents on 1/15/13?" The Administrator stated, "No." The Administrator was asked, "Did you get any staff statements from the other staff regarding concerns with reported condition changes not being responded to?" The Administrator stated, "No." The Administrator was asked, "Did you question residents if they had concerns with condition changes not being identified or treated?" The Administrator stated, "No." The Administrator was asked, "Any in-services with staff on reporting condition changes since 1/15/13?" The Administrator stated, "No." The Administrator was asked, "What has happened with [LPN # 1]?" The Administrator stated, "She worked until 2/6/13. She was terminated." The Administrator was asked, "Any reason this wasn't reported to OLTC sooner?" The Administrator stated, "We were investigating and waiting on an investigation by OLTC before we took action."

1) The Weekly Time Sheets from January 15 through February 4, 2013 receved from the Director of Nursing on 2/11/13 at 4:06 p.m. documented LPN # 1 worked from 6:30 a.m. until 3:30 p.m. on 1/15/13, 1/16/13, 1/17/13, 1/22/13, 1/23/13, 1/26/13, 1/27/13, 1/28/13, 1/29/13, 2/1/13, 2/2/13, 2/3/13, and 2/4/13.

2) The letter from the State of Arkansas Department of Veterans Affairs to [LPN # 1] dated 2/5/13 documented, "... Subject: Disciplinary

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F 225	Continued From page 16 Action, Administrative Leave Without Pay. You are being place on Administrative Leave Without Pay, effective immediately, pending the results of an investigation of the Office of Long Term Care (OLTC) regarding possible resident abuse or neglect on January 15, 2013. Regardless of the outcome of the investigation, your performance in the subject incident was substandard, and because you have been the subject of progressive disciplinary actions, will lead to your termination. ..." I. On 2/8/13 at 6:30 p.m., the Quality Assurance Nurse, the DON, and the Administrator were asked, "Any in-services with staff regarding reporting change of condition since 1/15/13?" The Quality Assurance Nurse, the DON, and the Administrator all stated, "No." The Quality Assurance Nurse, the DON, and the Administrator were asked, "Did you talk with [LPN # 1] about reporting/responding to reports of a residents change of condition?" The DON stated, "No, only about not documenting."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Complaint # 18093 was substantiated (all or in part) in these findings.	F 226		

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Based on record review, and interview the facility failed to ensure the policies and procedures implemented as evidenced by the facility's failures to ensure an allegation of neglect against 1 staff member (LPN#1) was thoroughly investigated, residents were protected during the investigation, and the allegation was reported to the Office of Long Term Care by 11:00 a.m. the next business day in accordance with state law for 1 of 1 (Residents # 5) case mix residents who was the subject of an allegation of neglect. This failed practice had the potential to affect 50 residents in the facility who had a change of condition since 1/1/13 according to the listing received from the Administrator on 2/8/13.

The findings are:

1. The facility's policy titled "Abuse, Neglect, and Mistreatment, Injuries of Unknown Origin and Misappropriation of Resident Property Policy and Procedure" documented "... Procedure: 1. Any allegation of mistreatment of resident or property will be reported as required by regulations and law. ... 4. Preventions, Identification and protection: The Administrators/Director of Nursing/RN [Registered Nurse] on duty must identify, intervene and correct situations in which abuse, neglect or misappropriation of resident property may occur. ... If an employee is suspected of abuse, neglect or misappropriation of resident property, the Administrator/Director of Nursing/RN on duty shall place the employee on immediate investigative suspension while completing an investigation. ... 5. Reporting: Any employee who suspects an alleged violation must immediately notify the Administrators/Director of Nursing/RN on duty. The supervisor on duty

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must notify the state agency and the local law enforcement agency as required by stated law. The Administrator of designee will complete form 7734 and fax to [fax number] or [fax number] by 11:00 a.m. the next business day ... 6. Investigation: The Administrators/Director of Nursing /designee will conduct all investigations and record the interviews and results of the investigation. The investigation includes interviews and results of the investigations. The investigation includes interviews of the alleged perpetrator, other employees or visitors or any resident who might have knowledge of the alleged incident. ... 7. Corrective Actions: Appropriate steps must be determined and taken to prevent recurrence of the incident. ...".

2. Resident # 5 was admitted to the facility on 12/28/12 with diagnoses of Dementia, Atrial Fibrillation, and Congestive Heart Failure. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/4/13 documented the resident scored 9 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status and required supervision with ambulation and locomotion.

a. A facility form titled "Concern" documented, "Date of Concern: 1/15/13. Name of Person Voicing Concerns: [OT (Occupational Therapist) # 1]. Title: OT. Nature of Concern [Be Specific]: OT entered room at [approximately] 11:30 a.m. [Patient] was only able to respond to verbal stimuli by opening eyes. No verbal response or other movement. It was noted that [patient] had severe rattling [with] breathing. OT went straight to Nurse [LPN (Licensed Practical Nurse) # 1] [and] asked how [patient] was doing this a.m. She

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stated that he was doing OK [and] had been up for breakfast earlier. I [OT] explained to her that [Resident # 5] was not responding to me like he normally does, that he sounds very congested [and] something is wrong. Nurse did not go check on [Resident # 5] at this time. I then found a CNA [Certified Nursing Assistant] and requested that she check his vitals. She did so right away. CNA stated, 'They are really low' upon leaving [patient] room. I asked what it was, she stated 84/47, as she proceeded to nurse office to tell nurse. There was still no response from nurse so I asked CNA to check [oxygen] level, which she did right away. As she came out of room she stated 'It's 90'. I then went back into room at [approximately] 11:45 a.m. to check on [patient]. I immediately noticed very shallow breathing [with] [patient] and congested sounds. I attempted to wake [patient] by shaking him on [right] shoulder [without] any response ... It appeared that [patient] was in trouble, so I ran to hallway. [LPN # 1] was at the nurses station [and] I stated, '[LPN # 1], he is in big trouble, you need to come now'. She did follow me this time into [patient] room. I then attempted to arouse [patient] by saying '[name, name, name]' and shaking his [right] shoulder. I noted 1 breath taken by [patient] [and] then [no] chest movement as [patient] stopped breathing. [LPN # 1] was also saying '[name, name]'. I then asked [LPN # 1] what I could do to help. She said [I] need [RN (Registered Nurse) Supervisor # 1]. I immediately left room and found [RN Supervisor # 1] on opposite hall [and] told him that [LPN # 1] needed his help. He went straight to [Resident # 5's] room. As he entered room and saw [Resident # 5] he stated '[It] appears that [Resident # 5] is gone'. I then left room and went to 5th floor to begin writing statement of events that had

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happened. [OT Supervisor # 1] happened to walk by so I asked her to sit down [and] explained to her what happened. We then decided at that time to meet [with] Administrator to explain what had happened. Administrator did meet [with] [OT Supervisor # 1] [and] I, [and] I was able to explain exactly what had happened."

b. The Nurse's Notes dated 1/15/13 at 11:50 a.m., signed by Registered Nurse (RN) Supervisor # 1, documented, "[Resident] event [respiratory/cardiac arrest] pupils fixed, [non responsive], [no] [breath sounds], [no] pulse ... [resident] [expired] at 11:50 a.m."

On 2/11/13 at 2:40 p.m., RN Supervisor # 1 was asked if he remembered [Resident # 5]. RN Supervisor # 1 stated "Yes." RN Supervisor # 1 was asked, "Can you tell me how you got involved with him on the day he died?" RN Supervisor # 1 stated, "[LPN # 1] came and got me when I was in the hallway on the 6th floor. She said she felt like the resident's vital signs were low and level of consciousness was decreased. She said [OT # 1] had come and reported a condition change and I needed to check him. As I walked in [Resident # 5] stopped breathing."

c. The OLTC [Office of Long Term Care] Incident and Accident Report (I & A) form DMS 7734 dated 2/5/13 documented, "Date and Time Submitted [if known] 2/5/13 11:00 a.m. Date [and] Time of Discovery: 1/15/13 12:00 [p.m.] ... Staff Reporting I [and] A: [Director of Nursing (DON)]. title: DON ... Date of I & A: 1/15/13 Time: 11:30 a.m. ... Name of Resident: [Resident # 5] ... Status of Alleged Perpetrator: Facility Employee

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F 226	Continued From page 21 ... Type of Incident: Neglect ... Notifications: Family, Doctor ... Administrator ... Summary of Incident: On 1/15/13 at [approximately] 11:30 a.m. Occupational Therapist [OT] entered the residents room for treatment, resident was lying in bed with eyes closed. Responded to verbal stimuli by opening eyes only, no verbal response. OT went to charge nurse who was in [the] nurse office eating lunch and asked how the resident was doing. Charge nurse stated that he was doing OK, he had been up for breakfast and a shower. OT conveyed to the charge nurse that the resident was not [responding] as he normally did, and that he sounded congested. Charge nurse ... did no go to check on the resident. OT then approached a CNA [Certified Nurses Assistant] and asked her to get vital signs on the resident. Vital signs were obtained and reported to the OT and charge nurse. Charge nurse still did not respond so OT then asked the CNA to get a pulse ox [oximetry], OT then reentered the resident's room at [approximately] 11:45 a.m. and noticed shallow breathing from the resident, the OT then approached the charge nurse again and stated 'you need to come now' charge nurse entered the room and asked the OT to get the RN [Registered Nurse] supervisor. As they were trying to get a response from the resident he took one deep breath and then there were no more breaths or chest movements. RN supervisor assess resident and notified the Medical Director of the absence of vital signs. Resident was a DNR [Do Not Resuscitate] so no CPR [Cardiopulmonary Resuscitation] was performed. Steps Taken to Prevent Continued Abuse or Neglect During the Investigation: Investigation was began due to concern from therapist that charge nurse did not appear concerned when he	F 226		

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voiced a change of condition to her. Witness statements were obtained, interviews conducted. Investigation will continue. RN supervisor will monitor charge nurse performance." The fax report documented that this fax was sent on to OLTC on 2/6/13 at 10:08 a.m., not 2/5/13.

d. On 2/8/13 at 8:16 a.m., OT # 1 was asked, "What happened on 1/15/13 with [Resident # 5]?" OT # 1 stated, "I went into see [Resident # 5], tried to around him by calling his name and he didn't respond. He usually woke right up, so I left the room and went to the office on the 6th floor by the nursing station. I told [LPN # 1], she was just outside the office. I asked her how [Resident # 5] was doing and she said he was fine he'd been to breakfast and I said OK and told her he didn't look right and was not responding and his breathing was not right. She didn't do anything. I grabbed a CNA and asked them to do vital signs." OT # 1 was asked "Do you recall who the CNA was?" OT # 1 stated, "No. The CNA got stuff and went to [Resident # 5's] room and got vital signs. I sat down at the nursing station with another resident as the CNA went into the room. She came back out and said they were really low and I said what were they. She told me and they are in my written statement. She took the vital signs to [LPN # 1] in the office by the nursing station. The CNA came out and [LPN # 1] was still sitting there and I asked her [CNA] to check O2 [oxygen] level and she did. She said they were 90. At that point I stood up and went into [Resident # 5's] room. [LPN # 1] was still in the office eating lunch. I went back to [Resident # 5's] room and he was breathing really shallow and there was no response and he was in trouble. I went back to [LPN # 1] who was at a med cart and told her she

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had to get in there because he was in trouble. We went in and [Resident # 5] was gasping and she sent me for [RN Supervisor # 1] the RN and [RN Supervisor # 1] came right away and the resident had passed. I was really upset with this. I went down to 5th floor and grabbed a sheet of paper and started writing. My boss came by and I told her what happened and she said lets talk with [Administrator]. We went down and talked with [Administrator] within 15 minutes of this." OT # 1 was asked, "What happened after that?" OT # 1 stated, "Two or three days later [Administrator] asked me for a written statement and I put it on her form and gave it to [Administrator]."

e. A sheet of paper dated 1/18/13, signed by CNA # 1, documented, "On January 15, 2013, I was asked get [Resident # 5's] vitals by the therapist. I got them and his blood pressure was very low so I told the nurse, [LPN # 1]. She was in the nurses office eating. She said his vitals were low that morning during breakfast about 2 hours before [Resident # 5's] passing. She also told me not [to] worry about doing the vitals and that she would do then as well. This was before breakfast."

On 2/11/13 at 2:30 p.m., CNA # 1 was asked, "What happened on the day [Resident # 5] died?" CNA # 1 stated, "[LPN # 1] told me she was going to get vital signs that day and not to worry about it. I walked the resident from the dining room to his room and he had to stop and sit down. He said he felt weak. He sat down for a little then I walked him on to bed. After that PT [Physical Therapy] or OT came to me and asked me to get [Resident # 5's] vital signs. I did and they were really low." CNA # 1 was asked, "Did you also get a pulse and respiration?" CNA # 1 stated, "Yes

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and they were low too." CNA # 1 was asked, "How was the resident breathing when you did the vital signs?" CNA # 1 stated, "Heavy, like he was short of breath and he wouldn't wake up like he normally did." CNA # 1 was asked, "After you took the vital signs, did you tell [LPN # 1] and tell her what the resident was like?" CNA # 1 stated, "Yes, she said his blood pressure was low. I told her he wasn't breathing right or acting right." CNA # 1 was asked, "What did she say when you told her about the resident not breathing right or acting right?" CNA #1 stated, "She said, 'OK," that his vital signs were low that a.m. She wasn't concerned. She didn't come check him like I thought she should have." CNA #1 was asked, "Did you tell anyone else about the resident's problems?" CNA #1 stated, "I didn't see anyone else to tell." CNA #1 was asked, "With [LPN #1], had you ever had this concern before with her not responding to you concerns about the residents?" CNA #1 stated, "Yes, she usually say 'Whenever I get a second I'll come.' She was never very attentive." CNA #1 was asked, "Did you tell anyone about your concerns with [LPN # 1]? CNA #1 stated, "Not [RN Supervisor # 1] or [Director of Nursing (DON)] but I did talk with the other aides." CNA # 1 was asked, "Did you tell any of the other LPNs about your concerns with [LPN # 1]?" CNA #1 stated, "No." CNA #1 was asked, "What does the '4' mean on the schedule by your name for today?" CNA # 1 stated, "That's section 4, rooms [number] to [number]. I'm working that section today and that is where I always work." CNA #1 was asked, "Did anyone talk with you before today about letting someone else know when a nurse does not respond to you about a resident's condition change?" CNA # 1 stated, "No."

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f. A lined sheet of paper dated 1/17/13, signed by LPN # 1, documented, "I had personally taken [Resident # 5's] [blood pressure] after counting narcotics with the 11:00 p.m. to 7:00 a.m. shift at 7:00 a.m. He was alert and getting ready to go to the dining room for breakfast. I administered his 8:00 a.m. medication in the dining room [and] he denied pain/discomfort. He was taken back to his room [at] approximately 8:30 a.m. Some time after the OT stated [Resident # 5] did not seem as alert, no urgency in his speech. I had a CNA check his [blood pressure] [and] SpO2 [pulse oximetry] - which were within normal limits for him. He was in bed [and] appeared to be sleeping when I entered the room to give his room a 10:00 a.m. medication. I had asked the RN Supervisor to examine him and he replied he would after accessing [assessing] the new admission. Around 10:45 a.m. the OT call out from [Resident # 5's] room [and] I entered to find him expired."

On 2/11/13 at 2:40 p.m., RN Supervisor #1 was asked, "Are you sure it was [LPN # 1] who came to get you and not OT?" RN Supervisor #1 stated, "No, It was [LPN # 1], I never saw that [OT #1] guy." RN Supervisor #1 was asked, "Had any of the staff reported concerns with [LPN #1] not responding to their concerns about residents?" RN Supervisor # 1 stated, "Seems to me a CNA did come to talk with me about a resident's dressing being off after his shower and that it had been some time since the shower and it still wasn't on. When I went to check the dressing, it was on and the aide didn't know [LPN #1] been in. I had one LPN tell me that [LPN # 1] was slow to respond." RN Supervisor #1 was asked, "Who was the nurse?" RN Supervisor # 1 stated, "[LPN

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2.]. RN Supervisor #1 was asked, "What did you do?" RN Supervisor #1 stated, "I talked with [LPN # 1] and she said she was busy with meds." RN Supervisor #1 was asked, "Did you tell [DON] or [Administrator] about the concerns regarding [LPN #1]?" RN Supervisor #1 stated, "No, once I had words with [LPN # 1] I thought that would be the end of it. I never heard anything else so I thought it was fixed." RN Supervisor #1 was asked, "Were you asked to monitor [LPN # 1's] residents for unnoticed/unreported condition changes after 1/15/13?" RN Supervisor # 1 stated, "No, I'd check residents when she asked me to."

g. There were no documented statements from other staff regarding LPN # 1's response to reported resident condition changes provided by the Administrator with the DMS 7734 on 2/8/13. There was no assessment of other residents on 1/15/13 for possible unreported/unrecognized condition changes provided by the Administrator with the DMS 7734 on 2/8/13. There were no documented interviews with residents regarding response to condition changes provided by the Administrator with the DMS 7734 on 2/8/13.

h. On 2/8/13 at 9:00 a.m., LPN # 2 stated she had worked on the 6th floor for 1 1/2 years with last year being on the 7:00 a.m. to 3:00 p.m. shift. LPN # 2 was asked, "Do you work with [LPN # 1] much?" LPN # 2 stated, "Two of the four days I work every week, I worked with her. She relieved for me and the other LPN." LPN # 2 was asked, "Any concerns with [LPN # 1] not responding to resident condition changes?" LPN # 2 stated, "No. I did have CNAs come to me with concerns that she did not respond to them. I passed those

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on to [RN Supervisor # 1]. What I saw was a communication barrier. A CNA would tell her something and she'd say OK, then would go take care of it but never got back to the CNA who had the concern to let them know and she didn't go right away."

i. On 2/8/13 at 9:18 a.m., CNA #2 was asked, "Ever work with [LPN # 1]?" CNA # 2 stated, "Yes." CNA #2 was asked, "Did you ever tell [LPN # 1] that a resident had a condition change and have concerns that she didn't do anything?" CNA #2 stated, "Yes, about one month ago ... I told her and I didn't think she listened to me. I told [RN Supervisor # 1] about my concerns."

j. On 2/8/13 at 10:05 a.m., the DON was asked, "Has any staff member reported a concern with a resident's condition change not being responded to?" The DON stated, "Yes, a therapist." The DON was asked, "When was this?" The DON stated, "1/15/13." The DON was asked, "Who was the resident?" The DON stated, "{Resident # 5]." The DON was asked, "What was the therapist concern?." The DON stated, "The concern went from the OT to the Administrator, who told me of the OT's concern." The DON was asked, "What was the concern?" The DON stated, "That he'd gone into [Resident # 5's] room for therapy and the resident did not arouse and he went to the charge nurse who was in the nursing office eating lunch and she did not get up to assess [Resident # 5]. Then he saw a CNA and asked the CNA to get vital signs on [Resident # 5]. The CNA got the blood pressure and told OT what it was. The OT asked the CNA to let the nurse know and then he asked if she had gotten a pulse ox and she said no. So he asked her to

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go back and get a pulse ox." The DON was asked, "Who was the CNA?" The DON stated, "[CNA # 1]. She got a pulse ox and was 90%. She told him and she told the nurse. His concern was the nurse still did not respond to [Resident 3 5's] needs. He was there so he went back to the room and now [Resident # 5] had labored breathing and that point [LPN # 1] was in the hall and he told [LPN # 1] 'You need to come now' and then [LPN # 1] went into the room. [OT # 1] asked 'What can I do to help' and she said 'Go get [RN Supervisor # 1]. When [RN Supervisor # 1] got there, the resident had expired." The DON was asked, "This was the story/allegation as you knew it on 1/15/13?" The DON stated, "Yes." The DON was asked, "What did you think the therapist was alleging?" The DON stated, "That [LPN # 1] was not responding to his concern, after we did our investigation then we identified the possibility of neglect." The DON was asked, "When did you come to this conclusion?" The DON stated, "That afternoon [1/15/13], when [name], Administrator got with me. We went over all of this. [Administrator] and I talked with the CNA and got a statement from the CNA and then we asked [OT # 1] to write out a statement. I reviewed the chart. We didn't get the statements that day. We got a statement from [OT # 1], [LPN # 1] and [CNA # 1]. I'd have to look at the statements to see when they were turned into us. We interviewed [LPN # 1] and [CNA # 1]. [CNA # 1] stated [Resident # 5] had gotten up and walked to breakfast and back and he got a shower. After the shower he ambulated back to the room for a nap. Then after that the OT asked her for vital signs and all of that. In reviewing his chart his blood pressures tended to run low and they had been running low." The DON was asked, "What

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next?" he DON stated, "We did interviews with [LPN # 1] and [CNA # 1]. When we talked with [CNA # 1] she said it was [OT # 1], the OT who asked for vital signs. When we interviewed [LPN # 1] she said she had asked for the CNA to get vital signs. [LPN # 1] stated she was in the hall the second time the OT came to her. She also wrote in her statement that between those times she'd asked [RN Supervisor # 1] to do an assessment on [Resident # 5]. So we had conflicting stories between OT and [LPN # 1]. So we talked with [CNA # 1] again about where [LPN # 1] was and who asked for vital signs and she stated [LPN # 1] in the the nursing office eating lunch." The DON was asked, "This was back around 1/15/13?" The DON stated, "After we got their statements. Then we went back and started investigating. [LPN # 1] stated [OT # 1's] voice was not urgent. To her [OT # 1] did not convey urgency and that's why she didn't go check the resident. In the mean time we batted this back and forth and talked with the Little Rock Arkansas Department of Veteran's Affairs on doing disciplinary counseling with [LPN # 1]. So we proceeded on with disciplinary action pending investigation from the Office of Long Term Care [OLTC] and because that had been her third disciplinary action it resulted in termination of the 4th or 5th of February." The DON was asked, "Did you identify then that the OT was alleging neglect?" The DON stated, "No, I felt he was saying [LPN # 1] didn't respond timely enough." The DON was asked, "If someone doesn't respond timely to a resident's condition change what happens?" The DON stated, "They can continue to decline." The DON was asked, "Is failure to respond timely the same as neglect?" The DON stated, "Yes." The DON was asked,

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"Why not report this to OLTC sooner?" The DON stated, "We were getting their stories we had conflicting stories." The DON was asked, "What did you do with [LPN # 1] on 1/15/13?" The DON stated, "We got her side of the story and let her work." The DON was asked, "How were you monitoring [LPN # 1]?" The DON stated, "The RN Supervisor was doing rounds and watching. [RN Supervisor # 1] and myself were doing that?" The DON was asked, "How often, any set times?" The DON stated, "No, I try to go out every 2 hours and [RN Supervisor # 1] is on 5 and 6 all the time, back and forth." The DON was asked, "Besides being on 6th and watching, did you do anything else?" The DON stated, "Not specifically, no." The DON was asked, "Did you go in and assess [LPN # 1's] assigned residents?" The DON stated, "No, I did not." The DON was asked, "How would you know that [LPN # 1] wasn't responding to a resident's condition change if you didn't go in and check the residents of hers?" The DON stated, "We wouldn't. I check the 24 hours report when I come in and when I go home. ..." The DON was asked, "Who does reportable to OLTC, you or [Administrator]?" The DON stated, "Both of us, it just depends. I did this one. We waited on reporting to the staff's stories." The DON was asked, "Any reports prior to this from staff that [LPN # 1] was not responding to their reports of resident condition changes?" The DON stated, "None brought to my attention." The DON was asked, "Did [RN Supervisor #1] ever share concerns that staff was telling him that [LPN # 1] was not responding to staff concerns?" The DON stated, "No, I never heard any complaints on that about [LPN # 1]." The DON was asked, "Is this investigation complete now?" The DON stated, "We are pretty well done and there was the

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possibility of neglect pending the investigation from OLTC." The DON was asked, "Was [LPN # 1] terminated due to the outcome of the investigation?" The DON stated, "No, it was her 3rd disciplinary action. It's an automatic termination no matter the outcome." The DON was asked, "What was it [disciplinary action] for?" The DON stated, "She didn't document on the resident."

k. On 2/8/13 at 10:55 a.m., the Administrator was asked, "When did [OT # 1] report his concerns to you regarding [Resident # 5]?" The Administrator stated, "Initially on 1/15/13." The Administrator was asked, "What did you think his concern was?" The Administrator stated, "A lack of response on the part of the LPN." The Administrator was asked, "What is the lack of response in this case?" The Administrator stated, "It could be neglect." The Administrator was asked, "Did you go assess or have others assess [LPN # 1's] other residents on 1/15/13?" The Administrator stated, "No." The Administrator was asked, "Did you get any staff statements from the other staff regarding concerns with reported condition changes not being responded to?" The Administrator stated, "No." The Administrator was asked, "Did you question residents if they had concerns with condition changes not being identified or treated?" The Administrator stated, "No." The Administrator was asked, "Any in-services with staff on reporting condition changes since 1/15/13?" The Administrator stated, "No." The Administrator was asked, "What has happened with [LPN # 1]?" The Administrator stated, "She worked until 2/6/13. She was terminated." The Administrator was asked, "Any reason this wasn't reported to OLTC sooner?"

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The Administrator stated, "We were investigating and waiting on an investigation by OLTC before we took action."

1) The Weekly Time Sheets from January 15 through February 4, 2013 receved from the Director of Nursing on 2/11/13 at 4:06 p.m. documented LPN # 1 worked from 6:30 a.m. until 3:30 p.m. on 1/15/13, 1/16/13, 1/17/13, 1/22/13, 1/23/13, 1/26/13, 1/27/13, 1/28/13, 1/29/13, 2/1/13, 2/2/13, 2/3/13, and 2/4/13.

2) The letter from the State of Arkansas Department of Veterans Affairs to [LPN # 1] dated 2/5/13 documented, "... Subject: Disciplinary Action, Administrative Leave Without Pay. You are being place on Administrative Leave Without Pay, effective immediately, pending the results of an investigation of the Office of Long Term Care (OLTC) regarding possible resident abuse or neglect on January 15, 2013. Regardless of the outcome of the investigation, your performance in the subject incident was substandard, and because you have been the subject of progressive disciplinary actions, will lead to your termination. ..."

I. On 2/8/13 at 6:30 p.m., the Quality Assurance Nurse, the DON, and the Administrator were asked, "Any in-services with staff regarding reporting change of condition since 1/15/13?" The Quality Assurance Nurse, the DON, and the Administrator all stated, "No." The Quality Assurance Nurse, the DON, and the Administrator were asked, "Did you talk with [LPN # 1] about reporting/responding to reports of a residents change of condition?" The DON stated, "No, only about not documenting."

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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.

This REQUIREMENT is not met as evidenced by:
Complaint # 18093 was substantiated (all or in part) in these findings.

Based on record review, and interview the facility failed to ensure necessary care and services were provided to attain or maintain the highest practicable physical well-being for Resident #5. The facility failed to ensure to immediately assess a resident's condition for a reported change in mental and physical status for 1 of 1 (Resident # 5) case mix resident who had a change in condition. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident # 5 who had a change of condition that was reported to the charge nurse who failed to immediately assess the resident condition and had the potential to affect 50 residents who had a change of condition since 1/1/13 according to a list received from the Administrator on 2/8/13. The facility was notified of the Immediate Jeopardy on 2/8/13 at 2:30 p.m. The findings are:

1. The facility's policy titled "Condition Change, of

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the Resident (Observing, Recording and Reporting)" documented "Basic Responsibility: Licensed Nurse. Purpose: To observe, record and report any condition change to the attending physician so proper treatment will be implemented. ... Procedure: After all resident falls, injuries or changes in physical or mental function, monitor the following: 1. ... f. Observe for alterations in consciousness. ... n. Take vital signs and include temperature. ... r. Observe for dyspnea or variations in respirations (irregular). ... 2. Have someone stay with the resident while the nurse is calling the attending physician ... 6. Notify DON [Director of Nursing] or Supervisor of any falls, injuries, or changes in mental or physical condition. ..."

2. Resident # 5 was admitted to the facility on 12/28/12 with diagnoses of Dementia, Atrial Fibrillation, and Congestive Heart Failure. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/4/13 documented the resident scored 9 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status and required supervision with ambulation and locomotion.

a. A facility form titled "Concern" documented, "Date of Concern: 1/15/13. Name of Person Voicing Concerns: [OT (Occupational Therapist) # 1]. Title: OT. Nature of Concern [Be Specific]: OT entered room at [approximately] 11:30 a.m. [Patient] was only able to respond to verbal stimuli by opening eyes. No verbal response or other movement. It was noted that [patient] had severe rattling [with] breathing. OT went straight to Nurse [LPN (Licensed Practical Nurse) # 1] [and] asked how [patient] was doing this a.m. She

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stated that he was doing OK [and] had been up for breakfast earlier. I [OT]explained to her that [Resident # 5] was not responding to me like he normally does, that he sounds very congested [and] something is wrong. Nurse did not go check on [Resident # 5] at this time. I then found a CNA [Certified Nursing Assistant] and requested that she check his vitals. She did so right away. CNA stated, 'They are really low' upon leaving [patient] room. I asked what it was, she stated 84/47, as she proceeded to nurse office to tell nurse. There was still no response from nurse so I asked CNA to check [oxygen] level, which she did right away. As she came out of room she stated 'It's 90'. I then went back into room at [approximately] 11:45 a.m. to check on [patient]. I immediately noticed very shallow breathing [with] [patient] and congested sounds. I attempted to wake [patient] by shaking him on [right] shoulder [without] any response ... It appeared that [patient] was in trouble, so I ran to hallway. [LPN # 1] was at the nurses station [and] I stated, '[LPN # 1], he is in big trouble, you need to come now'. She did follow me this time into [patient] room. I then attempted to arouse [patient] by saying '[name, name, name]' and shaking his [right] shoulder. I noted 1 breath taken by [patient] [and] then [no] chest movement as [patient] stopped breathing. [LPN # 1] was also saying '[name, name]'. I then asked [LPN # 1] what I could do to help. She said [I] need [RN (Registered Nurse) Supervisor # 1]. I immediately left room and found [RN Supervisor # 1] on opposite hall [and] told him that [LPN # 1] needed his help. He went straight to [Resident # 5's] room. As he entered room and saw [Resident # 5] he stated '[It] appears that [Resident # 5] is gone'. I then left room and went to 5th floor to begin writing statement of events that had

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happened. [OT Supervisor # 1] happened to walk by so I asked her to sit down [and] explained to her what happened. We then decided at that time to meet [with] Administrator to explain what had happened. Administrator did meet [with] [OT Supervisor # 1] [and] I, [and] I was able to explain exactly what had happened."

b. The Nurse's Notes dated 1/15/13 at 11:50 a.m., signed by Registered Nurse (RN) Supervisor # 1, documented, "[Resident] event [respiratory/cardiac arrest] pupils fixed, [non responsive], [no] [breath sounds], [no] pulse ... [resident] [expired] at 11:50 a.m."

On 2/11/13 at 2:40 p.m., RN Supervisor # 1 was asked if he remembered [Resident # 5]. RN Supervisor # 1 stated "Yes." RN Supervisor # 1 was asked, "Can you tell me how you got involved with him on the day he died?" RN Supervisor # 1 stated, "[LPN # 1] came and got me when I was in the hallway on the 6th floor. She said she felt like the resident's vital signs were low and level of consciousness was decreased. She said [OT # 1] had come and reported a condition change and I needed to check him. As I walked in [Resident # 5] stopped breathing."

c. On 2/8/13 at 8:16 a.m., OT # 1 was asked, "What happened on 1/15/13 with [Resident # 5]?" OT # 1 stated, "I went into see [Resident # 5], tried to around him by calling his name and he didn't respond. He usually woke right up, so I left the room and went to the office on the 6th floor by the nursing station. I told [LPN # 1], she was just outside the office. I asked her how [Resident # 5]

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was doing and she said he was fine he'd been to breakfast and I said OK and told her he didn't look right and was not responding and his breathing was not right. She didn't do anything. I grabbed a CNA and asked them to do vital signs." OT # 1 was asked "Do you recall who the CNA was?" OT # 1 stated, "No. The CNA got stuff and went to [Resident # 5's] room and got vital signs. I sat down at the nursing station with another resident as the CNA went into the room. She came back out and said they were really low and I said what were they. She told me and they are in my written statement. She took the vital signs to [LPN # 1] in the office by the nursing station. The CNA came out and [LPN # 1] was still sitting there and I asked her [CNA] to check O2 [oxygen] level and she did. She said they were 90. At that point I stood up and went into [Resident # 5's] room. [LPN # 1] was still in the office eating lunch. I went back to [Resident # 5's] room and he was breathing really shallow and there was no response and he was in trouble. I went back to [LPN # 1] who was at a med cart and told her she had to get in there because he was in trouble. We went in and [Resident # 5] was gasping and she sent me for [RN Supervisor # 1] the RN and [RN Supervisor # 1] came right away and the resident had passed. I was really upset with this. I went down to 5th floor and grabbed a sheet of paper and started writing. My boss came by and I told her what happened and she said lets talk with [Administrator]. We went down and talked with [Administrator] within 15 minutes of this."

d. A sheet of paper dated 1/18/13, signed by CNA # 1, documented, "On January 15, 2013, I was asked [to] get [Resident # 5's] vitals by the therapist. I got them and his blood pressure was

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very low so I told the nurse, [LPN # 1]. She was in the nurses office eating. She said his vitals were low that morning during breakfast about 2 hours before [Resident # 5's] passing. She also told me not [to] worry about doing the vitals and that she would do them as well. This was before breakfast."

On 2/11/13 at 2:30 p.m., CNA # 1 was asked, "What happened on the day [Resident # 5] died?" CNA # 1 stated, "[LPN # 1] told me she was going to get vital signs that day and not to worry about it. I walked the resident from the dining room to his room and he had to stop and sit down. He said he felt weak. He sat down for a little then I walked him on to bed. After that PT [Physical Therapy] or OT came to me and asked me to get [Resident # 5's] vital signs. I did and they were really low." CNA # 1 was asked, "Did you also get a pulse and respiration?" CNA # 1 stated,, "Yes and they were low too." CNA # 1 was asked, "How was the resident breathing when you did the vital signs?" CNA # 1 stated, "Heavy, like he was short of breath and he wouldn't wake up like he normally did." CNA # 1 was asked, "After you took the vital signs, did you tell [LPN # 1] and tell her what the resident was like?" CNA # 1 stated, "Yes, she said his blood pressure was low. I told her he wasn't breathing right or acting right." CNA # 1 was asked, "What did she say when you told her about the resident not breathing right or acting right?" CNA #1 stated, "She said, 'OK," that his vital signs were low that a.m. She wasn't concerned. She didn't come check him like I thought she should have." CNA #1 was asked, "Did you tell anyone else about the resident's problems?" CNA #1 stated, "I didn't see anyone else to tell." CNA #1 was asked, "With [LPN #1],

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had you ever had this concern before with her not responding to your concerns about the residents?" CNA #1 stated, "Yes, she usually say 'Whenever I get a second I'll come.' She was never very attentive." CNA #1 was asked, "Did you tell anyone about your concerns with [LPN # 1]? CNA #1 stated, "Not [RN Supervisor # 1] or [Director of Nursing (DON)] but I did talk with the other aides." CNA # 1 was asked, "Did you tell any of the other LPNs about your concerns with [LPN # 1]?" CNA #1 stated, "No." CNA #1 was asked, "What does the '4' mean on the schedule by your name for today?" CNA # 1 stated, "That's section 4, rooms [number] to [number]. I'm working that section today and that is where I always work." CNA #1 was asked, "Did anyone talk with you before today about letting someone else know when a nurse does not respond to you about a resident's condition change?" CNA # 1 stated, "No."

e. A lined sheet of paper dated 1/17/13, signed by LPN # 1, documented, "I had personally taken [Resident # 5's] [blood pressure] after counting narcotics with the 11:00 p.m. to 7:00 a.m. shift at 7:00 a.m. He was alert and getting ready to go to the dining room for breakfast. I administered his 8:00 a.m. medication in the dining room [and] he denied pain/discomfort. He was taken back to his room [at] approximately 8:30 a.m. Some time after the OT stated [Resident # 5] did not seem as alert, no urgency in his speech. I had a CNA check his [blood pressure] [and] SpO2 [pulse oximetry] - which were within normal limits for him. He was in bed [and] appeared to be sleeping when I entered the room to give his room a 10:00 a.m. medication. I had asked the RN Supervisor to examine him and he replied he would after

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accessing [assessing] the new admission. Around 10:45 a.m. the OT call out from [Resident # 5's] room [and] I entered to find him expired."

On 2/11/13 at 2:40 p.m., RN Supervisor #1 was asked, "Are you sure it was [LPN # 1] who came to get you and not OT?" RN Supervisor #1 stated, "No, It was [LPN # 1], I never saw that [OT #1] guy." RN Supervisor #1 was asked, "Had any of the staff reported concerns with [LPN #1] not responding to their concerns about residents?" RN Supervisor # 1 stated, "Seems to me a CNA did come to talk with me about a resident's dressing being off after his shower and that it had been some time since the shower and it still wasn't on. When I went to check the dressing, it was on and the aide didn't know [LPN #1] been in. I had one LPN tell me that [LPN # 1] was slow to respond." RN Supervisor #1 was asked, "Who was the nurse?" RN Supervisor # 1 stated, "[LPN # 2.]." RN Supervisor #1 was asked, "What did you do?" RN Supervisor #1 stated, "I talked with [LPN # 1] and she said she was busy with meds." RN Supervisor #1 was asked, "Did you tell [DON] or [Administrator] about the concerns regarding [LPN #1]?" RN Supervisor #1 stated, "No, once I had words with [LPN # 1] I thought that would be the end of it. I never heard anything else so I thought it was fixed." RN Supervisor #1 was asked, "Were you asked to monitor [LPN # 1's] residents for unnoticed/unreported condition changes after 1/15/13?" RN Supervisor # 1 stated, "No, I'd check residents when she asked me to."

f. There were no documented statements from other staff regarding LPN # 1's response to reported resident condition changes provided by

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the Administrator with the DMS 7734 OLTC [Office of Long Term Care] Incident and Accident Report (I & A) as of 2/8/13. There was no assessment of other residents on 1/15/13 for possible unreported/unrecognized condition changes provided by the Administrator with the DMS 7734 as of 2/8/13. There were no documented interviews with residents regarding response to condition changes provided by the Administrator with the DMS 7734 as of 2/8/13.

g. On 2/8/13 at 9:00 a.m., LPN # 2 stated she had worked on the 6th floor for 1 1/2 years with last year being on the 7:00 a.m. to 3:00 p.m. shift. LPN # 2 was asked, "Do you work with [LPN # 1] much?" LPN # 2 stated, "Two of the four days I work every week, I worked with her. She relieved for me and the other LPN." LPN # 2 was asked, "Any concerns with [LPN # 1] not responding to resident condition changes?" LPN # 2 stated, "No. I did have CNAs come to me with concerns that she did not respond to them. I passed those on to [RN Supervisor # 1]. What I saw was a communication barrier. A CNA would tell her something and she'd say OK, then would go take care of it but never got back to the CNA who had the concern to let them know and she didn't go right away."

h. On 2/8/13 at 9:18 a.m., CNA #2 was asked, "Ever work with [LPN # 1]?" CNA # 2 stated, "Yes." CNA #2 was asked, "Did you ever tell [LPN # 1] that a resident had a condition change and have concerns that she didn't do anything?" CNA #2 stated, "Yes, about one month ago ... I told her and I didn't think she listened to me. I told [RN Supervisor # 1] about my concerns."

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i. On 2/8/13 at 10:05 a.m., the DON was asked, "Has any staff member reported a concern with a resident's condition change not being responded to?" The DON stated, "Yes, a therapist." The DON was asked, "When was this?" The DON stated, "1/15/13." The DON was asked, "Who was the resident?" The DON stated, "[Resident # 5]." The DON was asked, "What was the therapist concern?" The DON stated, "The concern went from the OT to the Administrator, who told me of the OT's concern." The DON was asked, "What was the concern?" The DON stated, "That he'd gone into [Resident # 5's] room for therapy and the resident did not arouse and he went to the charge nurse who was in the nursing office eating lunch and she did not get up to assess [Resident # 5]. Then he saw a CNA and asked the CNA to get vital signs on [Resident # 5]. The CNA got the blood pressure and told OT what it was. The OT asked the CNA to let the nurse know and then he asked if she had gotten a pulse ox and she said no. So he asked her to go back and get a pulse ox." The DON was asked, "Who was the CNA?" The DON stated, "[CNA # 1]. She got a pulse ox and was 90%. She told him and she told the nurse. His concern was the nurse still did not respond to [Resident # 5's] needs. He was there so he went back to the room and now [Resident # 5] had labored breathing and that point [LPN # 1] was in the hall and he told [LPN # 1] 'You need to come now' and then [LPN # 1] went into the room. [OT # 1] asked 'What can I do to help' and she said 'Go get [RN Supervisor # 1]. When [RN Supervisor # 1] got there, the resident had expired." The DON was asked, "This was the story/allegation as you knew it on 1/15/13?" The DON was asked, "How were you monitoring [LPN # 1]?" The DON

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stated, "The RN Supervisor was doing rounds and watching. [RN Supervisor # 1] and myself were doing that?" The DON was asked, "How often, any set times?" The DON stated, "No, I try to go out every 2 hours and [RN Supervisor # 1] is on 5 and 6 all the time, back and forth." The DON was asked, "Besides being on 6th and watching, did you do anything else?" The DON stated, "Not specifically, no." The DON was asked, "Did you go in and assess [LPN # 1's] assigned residents?" The DON stated, "No, I did not." The DON was asked, "How would you know that [LPN # 1] wasn't responding to a resident's condition change if you didn't go in and check the residents of hers?" The DON stated, "We wouldn't. I check the 24 hours report when I come in and when I go home. ..." The DON was asked, "Any reports prior to this from staff that [LPN # 1] was not responding to their reports of resident condition changes?" The DON stated, "None brought to my attention." The DON was asked, "Did [RN Supervisor #1] ever share concerns that staff was telling him that [LPN # 1] was not responding to staff concerns?" The DON stated, "No, I never heard any complaints on that about [LPN # 1]." The DON was asked, "Was [LPN # 1] terminated due to the outcome of the investigation?" The DON stated, "No, it was her 3rd disciplinary action. It's an automatic termination no matter the outcome." The DON was asked, "What was it [disciplinary action] for?" The DON stated, "She didn't document on the resident."

j. On 2/8/13 at 10:55 a.m., the Administrator was asked, "When did [OT # 1] report his concerns to you regarding [Resident # 5]?" The Administrator stated, "Initially on 1/15/13." The Administrator

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was asked, "What did you think his concern was?" The Administrator stated, "A lack of response on the part of the LPN." The Administrator was asked, "Did you go assess or have others assess [LPN # 1's] other residents on 1/15/13?" The Administrator stated, "No." The Administrator was asked, "Did you get any staff statements from the other staff regarding concerns with reported condition changes not being responded to?" The Administrator stated, "No." The Administrator was asked, "Did you question residents if they had concerns with condition changes not being identified or treated?" The Administrator stated, "No." The Administrator was asked, "Any in-services with staff on reporting condition changes since 1/15/13?" The Administrator stated, "No." The Administrator was asked, "What has happened with [LPN # 1]?" The Administrator stated, "She worked until 2/6/13. She was terminated."

1) The Weekly Time Sheets from January 15 through February 4, 2013 receved from the Director of Nursing on 2/11/13 at 4:06 p.m. documented LPN # 1 worked from 6:30 a.m. until 3:30 p.m. on 1/15/13, 1/16/13, 1/17/13, 1/22/13, 1/23/13, 1/26/13, 1/27/13, 1/28/13, 1/29/13, 2/1/13, 2/2/13, 2/3/13, and 2/4/13.

2) The letter from the State of Arkansas Department of Veterans Affairs to [LPN # 1] dated 2/5/13 documented, "... Subject: Disciplinary Action, Administrative Leave Without Pay. You are being place on Administrative Leave Without Pay, effective immediately, pending the results of an investigation of the Office of Long Term Care (OLTC) regarding possible resident abuse or neglect on January 15, 2013. Regardless of the

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outcome of the investigation, your performance in the subject incident was substandard, and because you have been the subject of progressive disciplinary actions, will lead to your termination. ..."

k. On 2/8/13 at 6:30 p.m., the Quality Assurance Nurse, the DON, and the Administrator were asked, "Any in-services with staff regarding reporting change of condition since 1/15/13?" The Quality Assurance Nurse, the DON, and the Administrator all stated, "No." The Quality Assurance Nurse, the DON, and the Administrator were asked, "Did you talk with [LPN # 1] about reporting/responding to reports of a residents change of condition?" The DON stated, "No, only about not documenting."

l. The Immediate Jeopardy was removed and the scope/severity reduced to "H" on 2/8/13 at 4:20 p.m. when the facility implemented the following Plan of Removal:

1) Identification: There are no current residents in the facility with an unstable medical condition. There are sixteen residents (16) residing on 6th floor Avenue that are at risk for the same failed practice of failure to assess following a reported change of condition and implement interventions.

2) Assessments: An assessment of all residents in the facility, including observing for respiratory distress, level of consciousness, and current complaints will be conducted by DON/RN Supervisors on 2/8/13, beginning at 3:00 p.m. and completed by 5:00 p.m. to ensure no resident has an unidentified condition change.

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F 309	Continued From page 46 3)Training: Beginning on 2/8/13 at 3:30 p.m., all nursing staff will be in-serviced at the beginning of each shift, and will be ongoing to include new hires and staff returning from leave. The in-servicing will done by the NHA [Nursing Home Administrator]/DON/RN Supervisor, and in-service sign-in sheets used. Training will take place before staff work on the floor. The in-service will include who to report a change of condition to and what to do if the Charge Nurse/RN Supervisor do not respond to the report. The in-service will include the policy on change of condition, with a signed acknowledgement of receipt. 4) Monitoring: The 24-Hour Shift Reports will be monitored by the shift RN for condition changes. The RN will make resident rounds on each resident once a shift to monitor resident condition and observe for changes in condition. Any negative findings or unreported change of condition will be addressed by the shift RN and reported to the DON for retraining of staff.	F 309		
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Complaint # 18093 was substantiated (all or in part) in these findings.	F 490		

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Based on record review, and interview, Administration and Nursing Administration failed to ensure Resident #5 received the necessary care and services to maintain the highest practicable physical well-being as evidenced by the facility failure to ensure assessment was immediately provided for a reported change in the mental and physical status of a resident for 1 of 1 (Residents # 5) case mix residents with a reported change of condition. These failed practices resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to Resident # 5 who had a change of condition that was reported to the charge nurse who failed to immediately assess the resident and had the potential to affect 50 residents who had a change in condition since 1/1/13 according to the listing received from the Administrator on 2/8/13. The facility was notified of the Immediate Jeopardy on 2/8/13 at 2:30 p.m.

The findings are:

1. The job description titled "Nursing Home Administrator" documented "... Typical Functions: Plans, implements, directs, and monitors programs and services provided for nursing home residents by developing internal policies and procedures to ensure compliance with regulations. ... Investigate and resolves complaints regarding staff, residents, and programs. Develops and revises disciplinary rules and standards operating procedure for the facility. ...".

2. The job description titled "Job Duties and Responsibilities - Director of Nursing" documented "Summary of Duties: The Director of

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Nursing is a registered nurse ... and has, in writing, administrative authority, responsibility, and accountability for the functions, activities, and training of nursing services staff, and is responsible for nursing services twenty-four hours a day, seven days a week. Specific duties and responsibilities include, but are not limited to: 1. Nursing administration - Provides guidance and direction to the nursing staff to ensure health needs of the veterans are met. Develops, implements, and evaluates departmental policies and procedures that are in accordance with accepted standards of care ... Conducts interviews and makes recommendations for hiring, and disciplining nursing personnel; ... 2. Regulatory compliance - Utilizes current knowledge of [Veteran Affairs], state and federal regulations in the long-term care setting and ensures the nursing department remains in compliance with the rules and regulations that govern the provision of care. ...".

3. The facility's policy titled "Condition Change, of the Resident (Observing, Recording and Reporting)" documented "Basic Responsibility: Licensed Nurse. Purpose: To observe, record and report any condition change to the attending physician so proper treatment will be implemented. ... Procedure: After all resident falls, injuries or changes in physical or mental function, monitor the following: 1. ... f. Observe for alterations in consciousness. ... n. Take vital signs and include temperature. ... r. Observe for dyspnea or variations in respirations (irregular). ... 2. Have someone stay with the resident while the nurse is calling the attending physician ... 6. Notify DON or Supervisor of any falls, injuries, or changes in mental or physical condition. ...".

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4. Resident # 5 was admitted to the facility on 12/28/12 with diagnoses of Dementia, Atrial Fibrillation, and Congestive Heart Failure. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/4/13 documented the resident scored 9 (8 - 12 indicates moderately impaired) on the Brief Interview for Mental Status and required supervision with ambulation and locomotion.

a. A facility form titled "Concern" documented, "Date of Concern: 1/15/13. Name of Person Voicing Concerns: [OT (Occupational Therapist) # 1]. Title: OT. Nature of Concern [Be Specific]: OT entered room at [approximately] 11:30 a.m. [Patient] was only able to respond to verbal stimuli by opening eyes. No verbal response or other movement. It was noted that [patient] had severe rattling [with] breathing. OT went straight to Nurse [LPN (Licensed Practical Nurse) # 1] [and] asked how [patient] was doing this a.m. She stated that he was doing OK [and] had been up for breakfast earlier. I [OT]explained to her that [Resident # 5] was not responding to me like he normally does, that he sounds very congested [and] something is wrong. Nurse did not go check on [Resident # 5] at this time. I then found a CNA [Certified Nursing Assistant] and requested that she check his vitals. She did so right away. CNA stated, 'They are really low' upon leaving [patient] room. I asked what it was, she stated 84/47, as she proceeded to nurse office to tell nurse. There was still no response from nurse so I asked CNA to check [oxygen] level, which she did right away. As she came out of room she stated 'It's 90'. I then went back into room at [approximately] 11:45 a.m. to check on [patient]. I immediately noticed

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very shallow breathing [with] [patient] and congested sounds. I attempted to wake [patient] by shaking him on [right] shoulder [without] any response ... It appeared that [patient] was in trouble, so I ran to hallway. [LPN # 1] was at the nurses station [and] I stated, '[LPN # 1], he is in big trouble, you need to come now'. She did follow me this time into [patient] room. I then attempted to arouse [patient] by saying '[name, name, name]' and shaking his [right] shoulder. I noted 1 breath taken by [patient] [and] then [no] chest movement as [patient] stopped breathing. [LPN # 1] was also saying '[name, name]'. I then asked [LPN # 1] what I could do to help. She said [I] need [RN (Registered Nurse) Supervisor # 1]. I immediately left room and found [RN Supervisor # 1] on opposite hall [and] told him that [LPN # 1] needed his help. He went straight to [Resident # 5's] room. As he entered room and saw [Resident # 5] he stated '[It] appears that [Resident # 5] is gone'. I then left room and went to 5th floor to begin writing statement of events that had happened. [OT Supervisor # 1] happened to walk by so I asked her to sit down [and] explained to her what happened. We then decided at that time to meet [with] Administrator to explain what had happened. Administrator did meet [with] [OT Supervisor # 1] [and] I, [and] I was able to explain exactly what had happened."

b. The Nurse's Notes dated 1/15/13 at 11:50 a.m., signed by Registered Nurse (RN) Supervisor # 1, documented, "[Resident] event [respiratory/cardiac arrest] pupils fixed, [non responsive], [no] [breath sounds], [no] pulse ... [resident] [expired] at 11:50 a.m."

On 2/11/13 at 2:40 p.m., RN Supervisor # 1 was

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asked if he remembered [Resident # 5]. RN Supervisor # 1 stated "Yes." RN Supervisor # 1 was asked, "Can you tell me how you got involved with him on the day he died?" RN Supervisor # 1 stated, "[LPN # 1] came and got me when I was in the hallway on the 6th floor. She said she felt like the resident's vital signs were low and level of consciousness was decreased. She said [OT # 1] had come and reported a condition change and I needed to check him. As I walked in [Resident # 5] stopped breathing."

c. On 2/8/13 at 8:16 a.m., OT # 1 was asked, "What happened on 1/15/13 with [Resident # 5]?" OT # 1 stated, "I went into see [Resident # 5], tried to around him by calling his name and he didn't respond. He usually woke right up, so I left the room and went to the office on the 6th floor by the nursing station. I told [LPN # 1], she was just outside the office. I asked her how [Resident # 5] was doing and she said he was fine he'd been to breakfast and I said OK and told her he didn't look right and was not responding and his breathing was not right. She didn't do anything. I grabbed a CNA and asked them to do vital signs." OT # 1 was asked "Do you recall who the CNA was?" OT # 1 stated, "No. The CNA got stuff and went to [Resident # 5's] room and got vital signs. I sat down at the nursing station with another resident as the CNA went into the room. She came back out and said they were really low and I said what were they. She told me and they are in my written statement. She took the vital signs to [LPN # 1] in the office by the nursing station. The CNA came out and [LPN # 1] was still sitting there and I asked her [CNA] to check O2 [oxygen] level and she did. She said they were 90. At that point I

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stood up and went into [Resident # 5's] room. [LPN # 1] was still in the office eating lunch. I went back to [Resident # 5's] room and he was breathing really shallow and there was no response and he was in trouble. I went back to [LPN # 1] who was at a med cart and told her she had to get in there because he was in trouble. We went in and [Resident # 5] was gasping and she sent me for [RN Supervisor # 1] the RN and [RN Supervisor # 1] came right away and the resident had passed. I was really upset with this. I went down to 5th floor and grabbed a sheet of paper and started writing. My boss came by and I told her what happened and she said lets talk with [Administrator]. We went down and talked with [Administrator] within 15 minutes of this."

d. A sheet of paper dated 1/18/13, signed by CNA # 1, documented, "On January 15, 2013, I was asked [to] get [Resident # 5's] vitals by the therapist. I got them and his blood pressure was very low so I told the nurse, [LPN # 1]. She was in the nurses office eating. She said his vitals were low that morning during breakfast about 2 hours before [Resident # 5's] passing. She also told me not [to] worry about doing the vitals and that she would do them as well. This was before breakfast."

On 2/11/13 at 2:30 p.m., CNA # 1 was asked, "What happened on the day [Resident # 5] died?" CNA # 1 stated, "[LPN # 1] told me she was going to get vital signs that day and not to worry about it. I walked the resident from the dining room to his room and he had to stop and sit down. He said he felt weak. He sat down for a little then I walked him on to bed. After that PT [Physical Therapy] or OT came to me and asked me to get

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[Resident # 5's] vital signs. I did and they were really low." CNA # 1 was asked, "Did you also get a pulse and respiration?" CNA # 1 stated,, "Yes and they were low too." CNA # 1 was asked, "How was the resident breathing when you did the vital signs?" CNA # 1 stated, "Heavy, like he was short of breath and he wouldn't wake up like he normally did." CNA # 1 was asked, "After you took the vital signs, did you tell [LPN # 1] and tell her what the resident was like?" CNA # 1 stated, "Yes, she said his blood pressure was low. I told her he wasn't breathing right or acting right." CNA # 1 was asked, "What did she say when you told her about the resident not breathing right or acting right?" CNA #1 stated, "She said, 'OK," that his vital signs were low that a.m. She wasn't concerned. She didn't come check him like I thought she should have." CNA #1 was asked, "Did you tell anyone else about the resident's problems?" CNA #1 stated, "I didn't see anyone else to tell." CNA #1 was asked, "With [LPN #1], had you ever had this concern before with her not responding to your concerns about the residents?" CNA #1 stated, "Yes, she usually say 'Whenever I get a second I'll come.' She was never very attentive." CNA #1 was asked, "Did you tell anyone about your concerns with [LPN # 1]? CNA #1 stated, "Not [RN Supervisor # 1] or [Director of Nursing (DON)] but I did talk with the other aides." CNA # 1 was asked, "Did you tell any of the other LPNs about your concerns with [LPN # 1]?" CNA #1 stated, "No." CNA #1 was asked, "What does the '4' mean on the schedule by your name for today?" CNA # 1 stated, "That's section 4, rooms [number] to [number]. I'm working that section today and that is where I always work." CNA #1 was asked, "Did anyone talk with you before today about letting someone

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else know when a nurse does not respond to you about a resident's condition change?" CNA # 1 stated, "No."

e. A lined sheet of paper dated 1/17/13, signed by LPN # 1, documented, "I had personally taken [Resident # 5's] [blood pressure] after counting narcotics with the 11:00 p.m. to 7:00 a.m. shift at 7:00 a.m. He was alert and getting ready to go to the dining room for breakfast. I administered his 8:00 a.m. medication in the dining room [and] he denied pain/discomfort. He was taken back to his room [at] approximately 8:30 a.m. Some time after the OT stated [Resident # 5] did not seem as alert, no urgency in his speech. I had a CNA check his [blood pressure] [and] SpO2 [pulse oximetry] - which were within normal limits for him. He was in bed [and] appeared to be sleeping when I entered the room to give his room a 10:00 a.m. medication. I had asked the RN Supervisor to examine him and he replied he would after accessing [assessing] the new admission. Around 10:45 a.m. the OT call out from [Resident # 5's] room [and] I entered to find him expired."

On 2/11/13 at 2:40 p.m., RN Supervisor #1 was asked, "Are you sure it was [LPN # 1] who came to get you and not OT?" RN Supervisor #1 stated, "No, It was [LPN # 1], I never saw that [OT #1] guy." RN Supervisor #1 was asked, "Had any of the staff reported concerns with [LPN #1] not responding to their concerns about residents?" RN Supervisor # 1 stated, "Seems to me a CNA did come to talk with me about a resident's dressing being off after his shower and that it had been some time since the shower and it still wasn't on. When I went to check the dressing, it was on and the aide didn't know [LPN #1] been

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in. I had one LPN tell me that [LPN # 1] was slow to respond." RN Supervisor #1 was asked, "Who was the nurse?" RN Supervisor # 1 stated, "[LPN # 2.]." RN Supervisor #1 was asked, "What did you do?" RN Supervisor #1 stated, "I talked with [LPN # 1] and she said she was busy with meds." RN Supervisor #1 was asked, "Did you tell [DON] or [Administrator] about the concerns regarding [LPN #1]?" RN Supervisor #1 stated, "No, once I had words with [LPN # 1] I thought that would be the end of it. I never heard anything else so I thought it was fixed." RN Supervisor #1 was asked, "Were you asked to monitor [LPN # 1's] residents for unnoticed/unreported condition changes after 1/15/13?" RN Supervisor # 1 stated, "No, I'd check residents when she asked me to."

f. There were no documented statements from other staff regarding LPN # 1's response to reported resident condition changes provided by the Administrator with the DMS 7734 OLTC [Office of Long Term Care] Incident and Accident Report (I & A) as of 2/8/13. There was no assessment of other residents on 1/15/13 for possible unreported/unrecognized condition changes provided by the Administrator with the DMS 7734 as of 2/8/13. There were no documented interviews with residents regarding response to condition changes provided by the Administrator with the DMS 7734 as of 2/8/13.

g. On 2/8/13 at 9:00 a.m., LPN # 2 stated she had worked on the 6th floor for 1 1/2 years with last year being on the 7:00 a.m. to 3:00 p.m. shift. LPN # 2 was asked, "Do you work with [LPN # 1] much?" LPN # 2 stated, "Two of the four days I work every week, I worked with her. She relieved

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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
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for me and the other LPN." LPN # 2 was asked, "Any concerns with [LPN # 1] not responding to resident condition changes?" LPN # 2 stated, "No. I did have CNAs come to me with concerns that she did not respond to them. I passed those on to [RN Supervisor # 1]. What I saw was a communication barrier. A CNA would tell her something and she'd say OK, then would go take care of it but never got back to the CNA who had the concern to let them know and she didn't go right away."

h. On 2/8/13 at 9:18 a.m., CNA #2 was asked, "Ever work with [LPN # 1]?" CNA # 2 stated, "Yes." CNA #2 was asked, "Did you ever tell [LPN # 1] that a resident had a condition change and have concerns that she didn't do anything?" CNA #2 stated, "Yes, about one month ago ... I told her and I didn't think she listened to me. I told [RN Supervisor # 1] about my concerns."

i. On 2/8/13 at 10:05 a.m., the DON was asked, "Has any staff member reported a concern with a resident's condition change not being responded to?" The DON stated, "Yes, a therapist." The DON was asked, "When was this?" The DON stated, "1/15/13." The DON was asked, "Who was the resident?" The DON stated, "[Resident # 5]." The DON was asked, "What was the therapist concern?" The DON stated, "The concern went from the OT to the Administrator, who told me of the OT's concern." The DON was asked, "What was the concern?" The DON stated, "That he'd gone into [Resident # 5's] room for therapy and the resident did not arouse and he went to the charge nurse who was in the nursing office eating lunch and she did not get up to assess [Resident # 5]. Then he saw a CNA and

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asked the CNA to get vital signs on [Resident # 5]. The CNA got the blood pressure and told OT what it was. The OT asked the CNA to let the nurse know and then he asked if she had gotten a pulse ox and she said no. So he asked her to go back and get a pulse ox." The DON was asked, "Who was the CNA?" The DON stated, "[CNA # 1]. She got a pulse ox and was 90%. She told him and she told the nurse. His concern was the nurse still did not respond to [Resident # 5's] needs. He was there so he went back to the room and now [Resident # 5] had labored breathing and that point [LPN # 1] was in the hall and he told [LPN # 1] 'You need to come now' and then [LPN # 1] went into the room. [OT # 1] asked 'What can I do to help' and she said 'Go get [RN Supervisor # 1]. When [RN Supervisor # 1] got there, the resident had expired." The DON was asked, "This was the story/allegation as you knew it on 1/15/13?" The DON was asked, "How were you monitoring [LPN # 1]?" The DON stated, "The RN Supervisor was doing rounds and watching. [RN Supervisor # 1] and myself were doing that?" The DON was asked, "How often, any set times?" The DON stated, "No, I try to go out every 2 hours and [RN Supervisor # 1] is on 5 and 6 all the time, back and forth." The DON was asked, "Besides being on 6th and watching, did you do anything else?" The DON stated, "Not specifically, no." The DON was asked, "Did you go in and assess [LPN # 1's] assigned residents?" The DON stated, "No, I did not." The DON was asked, "How would you know that [LPN # 1] wasn't responding to a resident's condition change if you didn't go in and check the residents of hers?" The DON stated, "We wouldn't. I check the 24 hours report when I come in and when I go home. The DON was asked,

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"Any reports prior to this from staff that [LPN # 1] was not responding to their reports of resident condition changes?" The DON stated, "None brought to my attention." The DON was asked, "Did [RN Supervisor #1] ever share concerns that staff was telling him that [LPN # 1] was not responding to staff concerns?" The DON stated, "No, I never heard any complaints on that about [LPN # 1]." The DON was asked, "Was [LPN # 1] terminated due to the outcome of the investigation?" The DON stated, "No, it was her 3rd disciplinary action. It's an automatic termination no matter the outcome." The DON was asked, "What was it [disciplinary action] for?" The DON stated, "She didn't document on the resident."

j. On 2/8/13 at 10:55 a.m., the Administrator was asked, "When did [OT # 1] report his concerns to you regarding [Resident # 5]?" The Administrator stated, "Initially on 1/15/13." The Administrator was asked, "What did you think his concern was?" The Administrator stated, "A lack of response on the part of the LPN." The Administrator was asked, "Did you go assess or have others assess [LPN # 1's] other residents on 1/15/13?" The Administrator stated, "No." The Administrator was asked, "Did you get any staff statements from the other staff regarding concerns with reported condition changes not being responded to?" The Administrator stated, "No." The Administrator was asked, "Did you question residents if they had concerns with condition changes not being identified or treated?" The Administrator stated, "No." The Administrator was asked, "Any in-services with staff on reporting condition changes since 1/15/13?" The Administrator stated, "No." The

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Administrator was asked, "What has happened with [LPN # 1]?" The Administrator stated, "She worked until 2/6/13. She was terminated."

1) The Weekly Time Sheets from January 15 through February 4, 2013 receved from the Director of Nursing on 2/11/13 at 4:06 p.m. documented LPN # 1 worked from 6:30 a.m. until 3:30 p.m. on 1/15/13, 1/16/13, 1/17/13, 1/22/13, 1/23/13, 1/26/13, 1/27/13, 1/28/13, 1/29/13, 2/1/13, 2/2/13, 2/3/13, and 2/4/13.

2) The letter from the State of Arkansas Department of Veterans Affairs to [LPN # 1] dated 2/5/13 documented, "... Subject: Disciplinary Action, Administrative Leave Without Pay. You are being place on Administrative Leave Without Pay, effective immediately, pending the results of an investigation of the Office of Long Term Care (OLTC) regarding possible resident abuse or neglect on January 15, 2013. Regardless of the outcome of the investigation, your performance in the subject incident was substandard, and because you have been the subject of progressive disciplinary actions, will lead to your termination. ..."

k. On 2/8/13 at 6:30 p.m., the Quality Assurance Nurse, the DON, and the Administrator were asked, "Any in-services with staff regarding reporting change of condition since 1/15/13?" The Quality Assurance Nurse, the DON, and the Administrator all stated, "No." The Quality Assurance Nurse, the DON, and the Administrator were asked, "Did you talk with [LPN # 1] about reporting/responding to reports of a residents change of condition?" The DON stated, "No, only about not documenting."

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F 490	Continued From page 60 I. The Immediate Jeopardy was removed and the scope/severity reduced to "H" on 2/8/13 at 4:20 p.m. when the facility implemented the following Plan of Removal: 1) Identification: There are no current residents in the facility with an unstable medical condition. There are sixteen residents (16) residing on 6th floor Avenue that are at risk for the same failed practice of failure to assess following a reported change of condition and implement interventions. 2) Assessments: An assessment of all residents in the facility, including observing for respiratory distress, level of consciousness, and current complaints will be conducted by DON/RN Supervisors on 2/8/13, beginning at 3:00 p.m. and completed by 5:00 p.m. to ensure no resident has an unidentified condition change. 3)Training: Beginning on 2/8/13 at 3:30 p.m., all nursing staff will be in-serviced at the beginning of each shift, and will be ongoing to include new hires and staff returning from leave. The in-servicing will done by the NHA [Nursing Home Administrator]/DON/RN Supervisor, and in-service sign-in sheets used. Training will take place before staff work on the floor. The in-service will include who to report a change of condition to and what to do if the Charge Nurse/RN Supervisor do not respond to the report. The in-service will include the policy on change of condition, with a signed acknowledgement of receipt. 4) Monitoring: The 24-Hour Shift Reports will be monitored by the shift RN for condition changes.	F 490		

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F 490	Continued From page 61 The RN will make resident rounds on each resident once a shift to monitor resident condition and observe for changes in condition. Any negative findings or unreported change of condition will be addressed by the shift RN and reported to the DON for retraining of staff.	F 490		