STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045191	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Hot Springs Village	121 Cortez Rd Hot Springs Village, AR 71909

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46724 Based on observation, interview, record review and facility policy review, the facility failed to follow residents request to initiate resuscitative measures for one (Resident #1) of five residents who had a full code status. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, 483.24 (Quality of Life) at a scope and severity of J. The IJ began on [DATE] at approximately 7:40 PM when Resident #1 became unresponsive in - the resident's room. No action to perform cardiopulmonary resuscitation (CPR) was taken by facility staff. Emergency Medical Services (EMS) arrived at the facility and performed CPR. Resident #1 was transported to the hospital and was pronounced expired. The Administrator was notified of the IJ on [DATE] at 1:55 PM. A Removal Plan was accepted by the State Agency on [DATE]. The findings are: Review of the Medical Diagnosis portion of Resident #1's electronic health record revealed diagnoses of coronary artery disease, heart failure, chronic obstructive pulmonary disease, hypertension, and acute respiratory failure. The Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 14, indicating the resident was cognitively intact, and received supplemental oxygen. Review of Resident #1's Order Summary Report revealed an order for supplemental oxygen at two liters per minute, as needed for shortness of breath, that the resident used a ventilator at bedtime, and noted the resident wished to be resuscitated per their advanced directive. Review of Resident #1's Progress Notes for [DATE] at 10:09 PM revealed the resident had 2 episodes of unresponsiveness, a ventilator mask was applied, emergency medical services were called, and that Resident #1 became cyanotic as Emergency Service Personnel entered their room. (continued on next page)

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:00 PM, during an interview Certified Nursing Assistance (CNA) #1 stated on [DATE] she responded to CNA #2's call for help. She was unsure of the time. When she arrived at Resident #1's room, she saw Resident #1 sitting in a wheelchair slumped over unresponsive. After she entered the room Resident #1 became responsive and was talking to Licensed Practical Nurse (LPN) #2. CNA #1 reported a short time later, CNA #2 again called for nursing staff to come to Resident #1's room, Resident #1 had become unresponsive again. CNA #1 stated LPN #1 confirmed with LPN #2 that Resident #1 was a full code. CNA #1 reported she tried to obtain vital signs on Resident #1 but was unable to find any. She and CNA #2 requested to place Resident #1 on the floor to begin CPR. CNA #1 stated that LPN #2 denied the request to move the resident to the floor. When asked if the nurses had tried to assist the resident to the floor to begin CPR, she stated no they did not, they both (the nurses) have back problems. CNA #1 confirmed Resident #1 remained in wheelchair. On [DATE] at 3:20 PM, LPN #1, who was on duty the evening of [DATE], was interviewed and asked to explain the events of that evening pertaining to Resident #1. She responded, He was not my patient. She then said CNA #2 had called down the hall that she needed assistance right away and that resident #1 was going out. She stated LPN #2, CNA #1, and herself all went to Resident #1's room immediately. After going into room and assessing the resident, she retrieved the crash cart and brought it to Resident #1's room. When asked if staff had attempted to assist Resident #1 to the floor to start CPR, she confirmed they did not, stating, He was a large man, (clinical record documented weight at 195 pounds) and that they were unable to lift him. She stated the ambulance service initiated CPR when they arrived. On [DATE] at 11:00AM, via phone interview was conducted with LPN #2, who was Resident #1's nurse on the evening of [DATE]. She stated CNA #2 called for assistance to Resident #1's room, and all nursing personnel had responded. She stated Resident #1 was slumped over in a wheelchair in the bathroom in the resident's room, snore breathing and unresponsive. She related when resident was wheeled into the center of the room, Resident #1 became responsive. She stated Resident #1 had oxygen on via nasal cannula at 2 liters and that she replaced it with resident's tabletop positive pressure ventilation mask and that resident's saturation of peripheral oxygen (SPO2) was in the 90's according to the ventilation machine. LPN #2 stated that CNA #2 was behind the resident's wheelchair holding his head upright and the ventilation mask sealed. She reported LPN #1 brought the crash cart to the room. LPN #2 then related she had already called EMS and went to get contact information to contact the resident's family and when she got back to resident's room, Resident #1 had become unresponsive again and was snore breathing. LPN #2 then stated that the ambulance service arrived immediately. Resident #1 continued to be unresponsive and the ambulance crew immediately transferred resident from the wheelchair to the ambulance gurney and began resuscitation measures. LPN #2 was asked if the staff initiated any resuscitative measures and responded no, that resident was still responsive prior to the ambulance service arrival. LPN #2 confirmed she was CPR certified. When asked if she had contacted the doctor concerning Resident #1's change of condition she replied she had contacted the Director of Nurses on call but did not contact the doctor until notified by emergency room of resident expiring. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's clinical record failed to reveal vital signs for the evening of [DATE]. On [DATE] at 12:00 PM the Director of Nursing (DON) was asked if she could locate the vital signs in Resident #1's medical record for the evening of [DATE] and she was unable to. The DON was then asked if she was present on the evening of [DATE]. She stated she was but was not DON at that time. She stated she was in facility when she heard CNA #2 call for assistance of nursing personnel, she responded as well. She was unsure of the time, but stated, It was late. She confirmed Resident #1 had become more responsive and stable, with staff talking to them, so she left the room. She is unsure about the events of the second occurrence. When asked about staff training for code status, she confirmed staff had CPR training, but being new to the position of DON, is unsure about further training. On [DATE] at 3:13 PM a phone interview was conducted with CNA#2. When asked what took place on the evening of [DATE] pertaining to Resident #1, she stated between 7:00 and 7:15 PM she assisted Resident #1 to the bathroom, with a rolling walker. As Resident #1 was brushing their teeth, the resident stated he was lightheaded. CNA #2 stated Resident #1 became cyanotic and fell back against her. She reported she called for help with no response. She said she grabbed the rolling walker and was able to assist the resident to sit. She then exited the bathroom to find the nurse. CNA #2 stated that she was unable to locate LPN #2 and after relating the urgency, LPN #1 came to Resident #1's room. Then LPN #2 and CNA #1 arrived. CNA #2 reported the first episode lasted approximately 7 or 8 minutes, then the resident became responsive. CNA #2 stated at approximately 7:,d+[DATE]:30 PM Resident #1 became unresponsive again and it was ,d+[DATE] minutes before the ambulance service was called. She stated she was behind wheelchair holding Resident #1's head up and ventilation mask in place. She continued, CNA #1 was getting Resident #1's vital signs but could not get a blood pressure or pulse. She reported the ambulance service arrived and began resuscitative measures on the resident. On [DATE] at 10:50 AM a phone interview was conducted with Paramedic #1 Who confirmed they had responded to the event on [DATE] related to Resident #1. He stated when the ambulance service arrived there were 3 staff members in Resident #1's room. The resident was sitting in a wheelchair with what looked like a bi-level positive airway pressure (Bi-pap) mask on, was cyanotic, and in respiratory arrest. He went on to say the staff was not attempting any recitative measures. Paramedic #1 related CPR should have already been initiated. He stated Resident #1 was transferred to the gurney, CPR was initiated and they began ventilating with an artificial manual breathing unit (AMBU) bag. Paramedic #1 stated that the nursing home staff exited resident's room as soon as the ambulance service arrived. Review of LPN #2's employee record revealed documentation of CPR certification. A copy of the facility policy and procedure for, Emergency Procedure - Cardiopulmonary Resuscitation noted, immediately initiating CPR with Basic Life Support (BLS) increases the chance of surviving a sudden cardiac arrest, a licensed staff member trained in CPR should initiate CPR if a person is found unresponsive with abnormal breathing and continue with CPR/BLS until emergency medical personnel arrive. Removal Plan: 1. The facility will initiate education training of all staff on code blue. 2. The facility will initiate education training of all nurses on physician notification and CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. The facility will have a code blue drill on every shift. Onsite Verification: The IJ was removed on [DATE] at 5:30 AM, after the surveyor preformed an onsite verification that the Removal Plan had been implemented. Onsite verification of the Removal Plan began [DATE] at 10:00 AM, with verification of implementation A total of 5 staff interviews were conducted with staff for all shifts to verify training had been completed. The staff interview included certified nursing assistants, Licensed Practical Nurses, housekeeping, and maintenance. The staff interviewed verified they had been trained on: Code Blue response and participated in Code Blue drills. Licensed staff verified they had been trained on Physician notification, change of condition, and Cardiopulmonary Resuscitation and had participated in Code Blue Drills. A review of in-service sheets provided indicated 24 of 25 staff members had been provided training. In addition, 20 staff members were trained on use of an Automated external defibrillator (AED) on [DATE].