

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

PRINTED: 07/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/26/2013
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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET PO BOX 310 WHITE RIVER, SD 57579
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F 000	INITIAL COMMENTS	F 000		
F 281 SS=G	<p>Surveyor: 22452 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/25/13 through 6/26/13. Areas surveyed included quality of care and treatment, nursing services, infection control, and administration. White River Healthcare Center was found not in compliance with the following requirements: F281 and F309.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to appropriately assess, monitor, intervene, and document pain management and follow physician's orders for one of one sampled resident (1) who had an acute change in condition resulting in death. Findings include:</p> <p>1. Review of resident 1's medical record revealed: *A 2/25/13 admission date. *Diagnoses included: lower extremity paraplegia (paralysis), decubitus sacral ulcer (sore), history of lower extremity chronic pain, and a history of depression. *He had been hospitalized 2/27/13 through 3/4/13 at an acute care hospital related to hypoxia (without oxygen) secondary to pneumonia.</p>	F 281	<p>F 281</p> <p>No remedy can be made for resident 1 as has been discharged.</p> <p>All residents are at risk.</p> <p>The provider will have education initiated for licensed nurses by 8/1/13 and completed by 8/16/13 on the assessment, monitoring, interventions, following physician orders, and documentation in relationship to pain management.</p> <p>The Director of Nursing (DON) will review 5 medication administration records weekly by comparing to physician orders and nursing documentation x 4 weeks, then 5 reviews monthly x 4. The DON will report to the QA committee monthly.</p>	8/1/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carole M. Grogan</i>	TITLE <i>Emergency Permit Holder</i>	(X6) DATE <i>7/25/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>*He had been alert and able to verbalize his needs.</p> <p>Review of resident 1's undated care plan revealed: **"My memory is intact." **"I am paralyzed so I can not stand, walk, or transfer myself." **"I have alot of pain in my legs. I take pain medication around the clock. Please be prompt to give me my medication when I ask. Make sure you give me the right medication, in the right amount, and at the right time."</p> <p>Review of resident 1's February 2013 medication administration record (MAR) revealed he was on the following medications for pain control: *Neurontin 300 milligrams (mg) three times a day (TID). *Hydrocodone 10/325 mg one to two tablets every 4 hours as needed (PRN) for pain. (If pain rating was 1-5 give one tablet. If pain rating was 6-10 give two tablets). *Fentanyl 100 microgram (mcg) patch every three days. *Tylenol 325 mg two tablets every 4 hours PRN pain/temperature.</p> <p>Review of resident 1's February 2013 PRN pain management flowsheet revealed: *Pain rating of 1-3 was indicative of no pain to mild pain. *Pain rating of 4-6 was indicative of moderate pain. *Pain rating of 7-10 was severe pain. A pain rating of 10 was the "worst possible pain." *Hydrocodone 10/325 mg one tablet was administered on 2/26/13 at 8:20 a.m. for a pain</p>	F 281		

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F 281	<p>Continued From page 2</p> <p>rating of a 9. There was no follow-up documentation if the hydrocodone had been effective.</p> <p>*Hydrocodone 10/325 mg one tablet was administered on 2/26/13 at 8:00 p.m. There was follow-up documentation hydrocodone had been "effective."</p> <p>*Both doses of the above hydrocodone were not the correct dosage that should have been administered. Two tablets should have been administered for the pain rating of 6-10.</p> <p>Review of resident 1's March 2013 MAR revealed he was on the following medications for pain control:</p> <p>*Neurontin 300 mg TID. The Neurontin dosage was changed on 3/28/13 to 600 mg twice a day (BID) at 8:00 a.m. and 6:00 p.m. and 300 mg at noon.</p> <p>*Fentanyl 100 mcg patch every three days. The Fentanyl dosage was changed on 3/30/13 to 150 mcg patch every three days.</p> <p>*Hydrocodone 10/325 mg one to two tablets every 4 hours PRN. (If pain rating was 1-5 give one tablet. If pain rating was 6-10 give two tablets.) The hydrocodone was discontinued on 3/18/13.</p> <p>*Tylenol 325 mg two tablets every 4 hours PRN pain/fever.</p> <p>*Oxycodone 5/325 mg one to two tablets four times a day (QID) PRN. (If pain rating was 1-5 give one tablet. If pain rating was 6-10 give two tablets).</p> <p>Review of resident 1's 3/28/13 physician's order revealed:</p> <p>*Neurontin 600 mg at 8:00 a.m. and 6:00 p.m.</p> <p>*There was no documentation Neurontin 300 mg</p>	F 281		

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F 281	<p>Continued From page 3 was to have been administered at noon.</p> <p>Review of resident 1's 3/7/13 through 3/31/13 PRN pain management flowsheet revealed: *Tylenol 325 mg two tablets had been administered seventeen times. -Twelve doses of Tylenol had been administered for a pain rating of 2-4. Three doses of the Tylenol had no follow-up documentation as to it's effectiveness. -Two doses of Tylenol had been administered for a pain rating of 5-6. One dose of the Tylenol had no follow-up documentation as to it's effectiveness. -Three doses of Tylenol had been administered for a pain rating of 7-8. One dose of the Tylenol had no follow-up documentation as to it's effectiveness. *Hydrocodone 10/325 mg one tablet had been administered five times. -All the doses of the hydrocodone had been administered for a pain rating of 5-6. -Three doses of the hydrocodone had been documented as "ineffective." *Hydrocodone 10/325 mg two tablets had been administered eighteen times. -Seven doses of the hydrocodone had been administered for a pain rating of 3-4. (One tablet should have been administered.) -Four doses of the hydrocodone had no follow-up documentation as to it's effectiveness. *Oxycodone 5/325 mg one tablet had been administered nine times. -Five doses of the Oxycodone had been administered for a pain rating of 6-8. (Two tablets should have been administered.) -Two doses of the Oxycodone had no follow-up documentation as to it's effectiveness.</p>	F 281			

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F 281	<p>Continued From page 4</p> <p>*Oxycodone 5/325 mg two tablets had been administered twenty-five times. -Twelve doses of the Oxycodone had been administered for a pain rating of 2-4. (One tablet should have been administered.) -One dose had no pain rating documented. -Three doses had no documentation as to it's effectiveness.</p> <p>Review of resident 1's April 2013 MAR revealed the following medications for pain control: *Fentanyl 150 mcg patch every three days. The Fentanyl patch had been decreased to 100 mcg patch every three days on 4/2/13 related to possible sedation. *Neurontin 600 mg bid at 8:00 a.m. and 6:00 p.m. and 300 mg at noon. The Neurontin had been changed to 300 mg tid on 4/2/13 related to possible sedation. *Tylenol 325 mg two tablets every 4 hours PRN pain/fever. *Oxycodone 5/325 mg one or two tablets QID PRN. (If pain rating was 1-5 give one tablet. If pain rating was 6-10 give two tablets.)</p> <p>Review of resident 1's 4/1/13 through 4/3/13 PRN pain management flowsheet revealed: *Oxycodone 5/325 mg two tablets had been administered four times for a pain rating of 4-5. (One tablet should have been administered.) *One dose had no follow-up documentation as to it's effectiveness. *There was no documentation any PRN pain medication had been administered from 4/2/13 until his death on 4/4/13 at 10:12 a.m.</p> <p>Interview on 6/26/13 at 10:10 a.m. with the assistant director of nursing, licensed practical</p>	F 281		

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F 281	Continued From page 5 nurse A regarding resident 1 revealed: *He had often told his sister he had not been getting pain medication. *They had kept getting calls from the sister who was upset he was not receiving his pain medication. The family was told they gave him his pain medication "as needed." *When he was in the hospital from 2/26/13 through 3/4/13 he had told them his pain medications were effective pain control. He had told the hospital the same pain medication regimen was not helping at their facility. "It takes some residents time to adjust." *They thought the hydrocodone was effective pain control, but after two hours he was asking for more pain medication. *They thought the oxycodone controlled his pain better. *He often complained of more pain after his restorative exercises. They had told restorative staff to let them know about an hour before his exercises, so they could give him some pain medication. She did not work on the floor often enough to know if that had been done. *About a week before his death they had noticed he was doing more facial grimacing of pain in addition to his complaints. The physician had increased his Neurontin and Fentanyl patch but had to decrease it when he had started getting more sleepy and was not as alert. *She thought even after he was getting sleepy from the Neurontin and Fentanyl patch increase he was still consistently asking for PRN oxycodone for pain control. *She confirmed they were not following the physician's orders consistently when they had administered either one or two tablets of the hydrocodone or the oxycodone.	F 281			

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F 281	<p>Continued From page 6</p> <p>*She confirmed not doing follow-up documentation as to the effectiveness of PRN medications made it difficult to determine if he was having adequate pain control.</p> <p>*She confirmed on 3/28/13 when the physician had increased the Neurontin to 600 mg BID at 8:00 a.m. and 6:00 p.m., she had not written to administer Neurontin 300 mg daily at noon and should have. "He told me to just change the morning and evening dose and leave the noon dose as it was."</p> <p>Review of the provider's March 2006 Medication Administration General Guidelines policy revealed documentation was required for results achieved from the administration of a PRN medication.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th ED., St. Louis, MO, pp. 414-419 and pp. 477, revealed:</p> <p>*Complete and appropriate documentation was a vital aspect of nursing practice.</p> <p>**Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client (resident) outcomes, and reflect current standards of nursing practice."</p> <p>**Any significant changes in the client's (resident's) condition must be reported to the physician and documented in the chart."</p> <p>**Nurses should know and follow the policies and procedures of the institution in which they work."</p> <p>**Nurses are obligated to follow physicians' orders unless they believe the orders are in error or could be detrimental to clients."</p> <p>**All nurses should know the laws that apply to their area of practice."</p> <p>**Nurses are responsible for performing all</p>	F 281		

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F 281	Continued From page 7 procedures correctly and exercising professional judgment as they carry out physicians' orders." Review of the South Dakota Board of Nursing's Administrative Rules, Chapter 20:48, revealed: **"A licensee is personally responsible for the actions that the licensee performs relating to the nursing care furnished to clients and cannot avoid this responsibility by accepting the orders or directions of another person." **"The registered nurse is responsible for the nature and quality of nursing care that a client receives under the nurse's direction." **"The registered nurse shall recognize and understand the legal implications of delegation and supervision. The nurse may delegate to another only those nursing interventions which that person is prepared or qualified to perform and shall provide minimal or direct supervision to others to whom nursing interventions are delegated. The registered nurse may only delegate nursing tasks to unlicensed assistive personnel in accordance with the standards in chapter 20:48:04.01." **"The licensed practical nurse may practice in two general settings: with at least minimal supervision when providing nursing care in a stable nursing situation; and with the direct supervision when providing nursing care in a complex nursing situation; **"The licensed practical nurse shall consult with a registered nurse or other health team members and seek guidance as necessary and shall obtain instruction and supervision as necessary."	F 281		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	<p>Continued From page 8</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to render the necessary services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care for one of one sampled resident (1) who had a significant change in condition resulting in death. Findings include:</p> <p>1. Review of resident 1's undated care plan revealed: **"My memory is intact." **"I am paralyzed so I can not stand, walk, or transfer myself." **"I have alot of pain in my legs. I take pain medication around the clock. Please be prompt to give me my medication when I ask. Make sure you give me the right medication, in the right amount, and at the right time."</p> <p>Review of resident 1's 3/28/13 through 4/4/13 nurses' notes revealed: *3/28/13 (no time documented)- "Called physician on resident complaint of pain in legs. Changed Neurontin to 600 mg BID at 8:00 a.m. and 6:00 p.m. and 300 mg daily at noon."</p>	F 309	<p>F309</p> <p>No remedy can be made for resident 1 as has been discharged.</p> <p>All residents are at risk.</p> <p>The provider will have education initiated for licensed nurses by 8/1/13 and completed by 8/16/13 on how to help a resident achieve and maintain their highest practicable physical, mental, and psychosocial well-being.</p> <p>The DON will review 5 charts weekly x 4 weeks, then 5 charts monthly x 4, then 5 charts quarterly x 4 for documentation of appropriate interventions for residents. The DON will report to the QA committee monthly.</p>	8/1/13

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F 309	Continued From page 9 *3/30/13 at 4:10 p.m.- "Called physician on resident complaint of pain. Fentanyl patch increased from 100 mcg to 150 mcg every 3 days." *3/31/13 at 4:30 p.m.- "Resident complained of pain in legs and coccyx (tailbone) at 9:30 a.m. and PRN pain medications given. As the day progressed resident had no further complaints of pain. At 3:00 p.m. sister here for visit and he immediately began to cry and complains of being in severe pain. Said he had not received his pain medication. Sister said medication (oxycodone) was to be given scheduled and not QID PRN. Gave another dose (oxycodone) at 3:00 p.m. Asked unlicensed assistive personnel for more oxycodone at 4:00 p.m. and 5:00 p.m." *4/2/13 at 6:20 p.m.- "Has not complained of any pain all day and no pain medications (oxycodone) given. Fentanyl patch 150 mcg applied. Slept at long intervals today." *4/2/13 at 8:00 p.m.- "Noted resident appears very sleepy and sleeping alot. Very confused and has slurred speech. No pain medications (oxycodone) given as sleeping." *4/3/13 at 5:00 a.m.- "Very sleepy through entire night. No special requests for pain medications (oxycodone). Awakens when spoken to. Drinks some water but does choke a little bit on it. Color is a little grayish-looking also. Will continue to observe resident." *4/3/13 (no time) Late entry-"Talked to physician about resident being sleepy. Neurontin changed to 300 mg tid. Called back later in the evening to remove the Fentanyl 50 mcg patch and hold it until resident more alert." *4/3/13 at 7:00 a.m. (by unlicensed assistive personnel [UAP] B)- "Went into resident's room to give him his medications. He then refused by	F 309			

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F 309	Continued From page 10 shaking his head no. I asked him if he was okay and he nodded yes to me. I reported it to charge nurse he did not take his medications." *4/3/13 at 8:00 a.m. (by UAP B)- "Checked on resident to try and give him his medications and he was sleeping." *4/3/13 at 9:35 a.m. (by UAP B)- "Charge nurse asked me to give him a nebulizer treatment because his oxygen saturation was low at 80 percent [%]. [Normal oxygen saturation is greater than 90%.] She decided to send him out." *4/3/13 at 7:15 a.m. (by LPN A)- "UAP B came to me and informed me the resident did not want to take his medications. I said okay and try later." *4/3/13 at 8:30 a.m. (by LPN A)- "Received phone call from resident's wife wanting to know if he was awake. Asked aide and she said [yes he was sleeping.]" *4/3/13 at 8:40 a.m. (by LPN A)- "Went into resident's room. Manual pulse 104 (normal pulse 60-80) and breathing normal. Oxygen on at 2 liters per nasal cannula. Came out to finish my work. Received another call from his wife asking why he was sleeping so much. I informed her we are following physician's orders. Wife stated she had been with him in the hospital for a year and he never had a pain pill make him so sleepy. Told her the Fentanyl 50 mcg patch had just been removed and it would take awhile. Stated she was going to call the physician and hung up." *4/3/13 at 9:30 a.m. (by LPN A)- "Administrator came in and I went with her to check on resident. Resident had audible crackles and labored breathing. Oxygen level was 80% (normal level greater than 90%). I informed UAP B to give him a nebulizer treatment." *4/3/13 at 9:35 a.m. (by LPN A)- "I decided to send resident to the hospital."	F 309		

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NAME OF PROVIDER OR SUPPLIER WHITE RIVER HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 E 8TH STREET PO BOX 310 WHITE RIVER, SD 57579	
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F 309	<p>Continued From page 11</p> <p>*4/3/13 at 9:45 a.m. (by LPN A)- "Called for ambulance. DON was called into the room to help assess resident."</p> <p>4/3/13 at 10:10 a.m. (by LPN A)- "Ambulance arrived."</p> <p>4/3/13 at 10:12 a.m. (by LPN A)- "No breaths, pulse, or heartbeat detected."</p> <p>4/3/13 at "approximately" 10:20 a.m. (by LPN A)- Coroner was on the ambulance and pronounced death. DON informed the family."</p> <p>Interview on 6/25/13 at 11:50 a.m. with UAP B regarding the above nurse's notes on 4/3/13 regarding resident 1 revealed she:</p> <p>*Had come on duty at 6:00 a.m. on 4/3/13.</p> <p>*Thought she had first gone to his room between 6:30 a.m. and 6:45 a.m. initially to give him his morning medications. Stated he had refused his medications. "He looked alright." She had informed LPN A he had refused his medications and she had been told to try again later.</p> <p>*Had given him a nebulizer treatment as directed by LPN A but was unsure of the time.</p> <p>*Stated at about 7:15 a.m. she had tried to awaken him to take his medications again, but he would not awaken. She stated " He looked different than before. You know, more tired." She stated she went to the dining room to ask charge nurse LPN A to check on the resident. LPN A had informed her she would come to the resident's room after she had finished giving the resident she was with their medications.</p> <p>Interview on 6/26/13 at 10:10 a.m. with LPN A regarding resident 1 revealed:</p> <p>*She had been the charge nurse on 4/3/13.</p> <p>*She only worked in the charge nurse capacity "once in awhile" since she had assumed the</p>	F 309		

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F 309	Continued From page 12 assistant DON position in March 2013. *She stated on 4/3/13 she would have arrived about 5:00 a.m. to 5:30 a.m. "My shift does not start until 6:00 a.m." The night nurse left at 6:00 a.m. *She knew that on the morning of 4/3/13 it had been hard to get him to wake up for breakfast and take his medications. *The night nurse on 4/3/13 had told her he had slept all night with no complaints. He had woke up once and had requested pain pills. (Review of resident 1's as needed [PRN] pain management record for the night shift revealed no PRN oxycodone had been administered or requested by the resident.) The night nurse had not mentioned his color was "grey." The night nurse had not told her she had not taken any vital signs on him during the night, and she had omitted to ask her if she had taken any. *UAP B had told her she had first tried to give his medications between 6:30 a.m. to 6:45 a.m. *UAP B had told her he had answered her and had responded to her between 7:00 a.m. and 7:15 a.m. *UAP B had told her about 7:15 a.m. to check on him. Stated UAP B told her "He did not look right. His color was not right. He just won't wake up." She had stated she mentioned nothing about his breathing, and she had not asked her how his breathing was. Stated she told UAP B to go back to his room and stay with him until she got to his room. *She stated she went to his room about 7:30 a.m. She had to wait about ten minutes in the dining room to wait for the resident she had been administering medications to "to take all her medications. She took her pills very slowly one at a time."	F 309		

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F 309	<p>Continued From page 13</p> <p>*When asked why she had not let UAP B stay with the resident she had been administering medications to and she go immediately to his room stated "She had not thought of that. UAP B's voice had not sounded alarming when she had asked her to check on him."</p> <p>*She stated when she went into his room at 7:30 a.m. she had noticed his breathing was labored and told UAP B to "get a set of vital signs on him." The prior DON had come into the room and stated "We need to get him out of here." Stated the DON and UAP B stayed with him while she went out to call the ambulance. She had called the ambulance prior to calling the physician. She was unsure what his vital signs had been and had not documented them. "I think I put them on the transfer form." Stated his oxygen was on 3 liters and was increased to 5 liters without improvement in his breathing. Stated "He died just as the ambulance pulled up. The ambulance driver was also the coroner."</p> <p>*She stated she had not viewed him as a critically ill resident and had not checked on him from 6:00 a.m. until asked to by UAP B at 7:15 a.m.</p> <p>*She confirmed a nurse had likely not assessed him from 5:00 a.m. until 7:30 a.m.</p> <p>*She was unsure why his family had not been contacted at 5:00 a.m. when the night nurse had documented his color as "greyish looking."</p> <p>*She had no comment when asked why the times in her interview differed from her documentation in the medical record.</p> <p>Review of resident 1's 4/3/13 physician's progress notes revealed: **Nursing called yesterday reporting him to be much more somolent (sleepy) with the recent change in his Fenanyl patch. I had them remove</p>	F 309			

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F 309	<p>Continued From page 14</p> <p>that last p.m. We also returned his Neurontin back to its prior dosing levels. He was struggling some with pain over the past week and we titrated them up recently."</p> <p>**By report this a.m. he was awake, alert and conversive, but refused his medications. They subsequently checked on him in a hour at which point he was struggling to breathe. Was not complaining of chest discomfort."</p> <p>**"Emergency medical service was summoned to transport to the hospital. I do not have definitive reports on type of cardiac arrest noted. He was pronounced terminal before leaving the facility."</p> <p>Review of the provider's 2/8/07 Resident Change of Condition policy revealed: **Any staff member who notices a resident change in condition must immediately notify the nurse assigned to care for that resident." **Changes in resident condition include but are not limited to: -"Significant change in physical, mental, or psychosocial status." -"Blood pressure less than 90 systolic or above 200 systolic (top number of blood pressure reading)." -"Blood pressure less than 50 diastolic or above 110 diastolic (bottom number of blood pressure reading)." -"Pulse less than 50 or greater than 120." **An assessment by a licensed nurse will be done any time there is a change in the condition of a resident."</p> <p>Review of the South Dakota Board of Nursing's Administrative Rules, Chapter 20:48, revealed: **A licensee is personally responsible for the actions that the licensee performs relating to the</p>	F 309			

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F 309	<p>Continued From page 15</p> <p>nursing care furnished to clients and cannot avoid this responsibility by accepting the orders or directions of another person."</p> <p>***The registered nurse is responsible for the nature and quality of nursing care that a client receives under the nurse's direction."</p> <p>***The registered nurse shall recognize and understand the legal implications of delegation and supervision. The nurse may delegate to another only those nursing interventions which that person is prepared or qualified to perform and shall provide minimal or direct supervision to others to whom nursing interventions are delegated. The registered nurse may only delegate nursing tasks to unlicensed assistive personnel in accordance with the standards in chapter 20:48:04.01."</p> <p>***The licensed practical nurse may practice in two general settings: with at least minimal supervision when providing nursing care in a stable nursing situation and with the direct supervision when providing nursing care in a complex nursing situation."</p> <p>***The licensed practical nurse shall consult with a registered nurse or other health team members and seek guidance as necessary and shall obtain instruction and supervision as necessary."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th ED., St. Louis, MO, pp. 414-419 and pp. 477, revealed: *Complete and appropriate documentation was a vital aspect of nursing practice. ***Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice."</p>	F 309		

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F 309	Continued From page 16 **Any significant changes in the client's condition must be reported to the physician and documented in the chart." **Nurses should know and follow the policies and procedures of the institution in which they work."	F 309			