

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

ORIGINAL

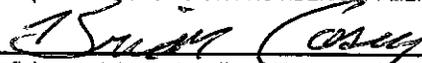
PRINTED: 06/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/19/2016
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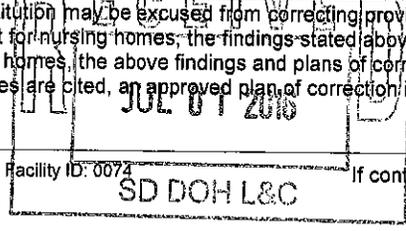
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105
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F 000	INITIAL COMMENTS	F 000		
F 280 SS=E	<p>Surveyor: 18560 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 5/19/16. Areas surveyed included quality of care/treatment and nursing services. Southridge Health Care Center was found not in compliance with the following requirements: F280 and F281.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560</p>	F 280	<p>Residents #2, #3 and #4 and all other residents were assessed on 5/20/16 to determine if their care plans and pocket care plans were up-to-date with all current oxygen orders by the DON and/or designee. DON and/or designee assessed all of the care plans to ensure that each has a care plan in place to specify the liter flow of oxygen was correct with physician and that oxygen rate was being monitored at least every shift. All nursing staff will be educated on this procedure by the DON and/or designee by 6/09/16. Resident #3 has since expired since date of survey on 5/19/16. Oxygen orders with correct flow rate will be documented in each of the resident's EMR and included on each EMAR/ETAR, care plan, and pocket care plan after the physician orders are obtained. The facility policy/procedure on oxygen therapy and care plans was reviewed/revise on 6/01/16 by the DON, interdisciplinary team and the Pharmacy Consultant. The DON and/or designee will educate all facility staff who are responsible to assess, implement, and monitor the use of oxygen on the updated Oxygen Administration Policy and Procedure by 6/09/16. Education will also be provided on the policies and procedures for Care Planning-Interdisciplinary Team, Care Plans-Comprehensive, and Using the Care Plan/Pocket Care Plan by 6/09/16.</p>	6/09/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6-9-2016
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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 280	<p>Continued From page 1</p> <p>Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure care plans had been updated and revised to reflect the residents' current needs for three of four sampled residents (2, 3, and 4). Findings include:</p> <p>1. Observation on 5/19/16 at 2:10 p.m. in resident 2's room revealed an oxygen concentrator. The resident had not been in the room at that time.</p> <p>Review of resident 2's medical record revealed: *On 4/4/16 physician's order for: -Oxygen at 2-4 liters per minute as needed to keep saturation (sat) level of (oxygen level) greater than 92% with an original date of 1/13/16. -Oxygen sats as needed. *There was no documentation on the current care plan for oxygen. *There was no documentation on the certified nursing assistant (CNA) pocket care plan for oxygen. *The May 2016 treatment administration record (TAR) revealed: -"3/7/16 oxygen at 2-4 liters per minute prn (as needed) to keep sats greater than 92% inhalation as need. -3/7/16 oxygen sats prn as needed."</p> <p>Interview on 5/19/16 at 3:00 p.m. with Minimum Data Set nurse A regarding resident 2's care plan revealed: *She agreed oxygen had not been on the care plan or the CNA pocket care plan. *Her expectations would have been for oxygen to have been on the care plan but not on the CNA pocket care plan.</p>	F 280	<p>Audits will be completed weekly for 1 month and monthly for the next 3 months on resident #2, #4 and 5 other residents at random with oxygen to be sure orders are in place; that nurses, med techs, and all others that monitor the use of oxygen are following the oxygen therapy policy/procedure, that care plans and pocket care plans are up-to-date with oxygen orders, and that current orders along with monitoring oxygen saturations are documented in their EMR. The audits will be conducted by the DON and/or her designee who will also be responsible for overall compliance.</p> <p>The DON and/or designee will be responsible for conducting audits and for overall compliance. The DON and/or designee will report audit findings at the monthly QAPI meeting for 3 months and then as deemed necessary by the QAPI committee.</p>	
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F 280	<p>Continued From page 2</p> <p>*Resident 2 had returned from the hospital on 4/19/16, and the nurses should have updated the care plan at that time.</p> <p>2. Review of resident 3's medical record revealed: *Diagnoses of hypoxemia (abnormal low level of oxygen in the blood) and oxygen dependence. *A 4/19/16 physician's order for continuous oxygen at 3 liters per nasal cannula, and 1-5 liters as needed. *The CNA pocket care plan did not have oxygen listed on it.</p> <p>3. Review of resident 4's medical record revealed: *A 1/24/16 physician's order for oxygen at one liter continuously noted on her May 2016 TAR. *A 3/1/16 physician's order for oxygen at one liter noted on her May 2016 medication administration record. *A 1/29/16 original date care plan had no documentation of her oxygen use. *The undated CNA pocket care plan had no documentation of her oxygen use.</p> <p>4. Interview on 5/19/16 at 3:10 p.m. with the director of nursing regarding residents who used oxygen revealed: *Her expectations would have been for oxygen to be on the care plan and the CNA pocket care plan. *They did not have a CNA pocket care plan policy.</p> <p>Review of the provider's 7/8/15 Care Plans-Comprehensive policy revealed: **An individualized comprehensive care plan that includes measurable objectives and timetables to</p>	F 280		
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F 280	Continued From page 3 meet the resident's medical, nursing, mental and psychological needs is developed for each resident. -Each resident's comprehensive care plan is designed to: --Incorporate identified problem areas. --Incorporate risk factors associated with identified problems. --Reflect treatment goals, timetables, and objectives in measurable outcomes. --Identify the professional services that are responsible for each element of care. *The care planning/interdisciplinary team is responsible for the review and updating of care plans: -When there has been a significant change in the resident's condition. -When the desired outcome is not met. -When the resident has been readmitted to the facility from a hospital stay and at least quarterly." Review of the provider's undated Oxygen Administration policy revealed "Review the resident's care plan to assess for any special needs of the resident."	F 280			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to: *Assess, monitor, and document for two of three	F 281	Residents #3 and #4 and all residents receiving oxygen therapy were reviewed on 5/20/16 to ensure physician orders on EMAR/ETAR along with oxygen saturation monitoring each shift. All residents, new and long term, with oxygen orders will be placed on EMAR/ETAR on day of order or day of admit along with monitoring oxygen saturations each shift for any order of oxygen including PRN oxygen. Monitoring will be done by the floor nurse or assigned med-tech. If a med-	6/09/16	

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F 281	<p>Continued From page 4</p> <p>sampled residents (3 and 4) with orders for continuous oxygen. *Follow physician's order for one of four sampled residents (1) with orders for oxygen. Findings include:</p> <p>1. Observation on 5/19/16 at 12:17 p.m. in the main dining room revealed resident 3 had been sitting at a table and eating her noon meal. She had a large portable oxygen tank connected to her walker. The oxygen liter flow was set at zero. The oxygen canister indicated there was oxygen left in the tank.</p> <p>Observation and interview on 5/19/16 at 12:19 p.m. in the main dining room with certified nursing assistant (CNA) B regarding resident 3's oxygen revealed: *Resident 3 had just come to the main dining room. *CNA B turned the oxygen liter (L) flow to 4 liters. *CNA B confirmed resident 3 would: -Change the oxygen nasal cannula from the oxygen concentrator and put on the large oxygen tank. -Would turn on the oxygen liter flow herself. *The staff checked the oxygen liter flow several times throughout the day to ensure she had the oxygen at the correct liter flow.</p> <p>Observations on 5/19/16 at 12:35 p.m., 12:40 p.m., 1:00 p.m., 1:20 p.m., 2:12 p.m., 2:35 p.m., and 4:00 p.m. revealed resident 3 had oxygen running at 4 liters per minute.</p> <p>Review of resident 3's medical record revealed: *An admission date of 4/19/16. *Diagnoses of hypoxemia (below normal level of oxygen in the blood), dependent on oxygen, and</p>	F 281	<p>tech is assigned and the oxygen sat is found to be low, they are to notify the nurse immediately for assessment. oxygen on the updated Oxygen Administration Policy and Procedure by 6/09/16. Education will also be provided on the Care Planning-Interdisciplinary Team, Care Plans-Comprehensive and Using the Care Plan/Pocket Care Plan Policies and Procedures by 6/09/16.</p> <p>Audits will be conducted weekly for 1 month and monthly for the next 3 months on resident #4 and 5 other residents at random with oxygen to be sure orders are in place and being followed; that nurses, med-techs, and all others that monitor the use of oxygen are following the oxygen therapy policy/procedure; that care plans and pocket care plans are up-to-date with oxygen orders, and that current orders along with monitoring oxygen saturations are documented in their EMR. Monitoring will be done by the floor nurse or assigned med-tech. If a med-tech is assigned and the oxygen sat is low, they are to notify the nurse immediately for assessment. The audits will be conducted by the DON and/or her designee who will also be responsible for overall compliance.</p>	
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F 281	<p>Continued From page 5</p> <p>anxiety.</p> <p>*On 4/19/16 physician's order were for oxygen 3 liters with rest, activity, and at night, and 1 to 5 liters as needed for shortness of breath.</p> <p>*The 4/21/16 care plan stated "Oxygen per NC [nasal cannula] continuous, 3 L with rest, activity, and at night. Oxygen as directed by MD (physician)."</p> <p>*The certified nursing assistant pocket care plan had not included oxygen usage.</p> <p>Review of resident 3's 4/19/16 admission Minimum Data Set (MDS) assessment revealed:</p> <p>*A Brief Interview for Mental Status score of fourteen indicating she was alert and oriented.</p> <p>*She:</p> <ul style="list-style-type: none"> -Required set-up assistance of one staff for moving from her room and around the corridor. -Was independent with dressing, toilet use, and personal hygiene. -She had no problems with mobility or functional limitations. -Received antianxiety medication daily. -Was on oxygen therapy. <p>*Resident and staff believed she was capable of increased independence with some of her activities of daily living.</p> <p>Review of resident 3's 4/30/16 Care Area Assessment Areas revealed she:</p> <ul style="list-style-type: none"> *Had anxiety, dyspnea (shortness of breath), hypoxemia, oxygen dependent, anxiety, and agitation. *Wore oxygen. *Became short of breath with exertion. *Was alert and oriented to person, place, and time. 	F 281		
	Review of resident 3's May 2016 medication			

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F 281	<p>Continued From page 6</p> <p>administration record (MAR) and TAR revealed there was no documentation for oxygen usage.</p> <p>Review of resident 3's 5/15/16 interdisciplinary progress notes revealed at:</p> <p>*10:00 a.m.: "Was extremely anxious. Puts on her emergency call light several times and when this recorder answer the light she does not know what she wants. Has been up to the nurses station several times and states she wants this recorder to stay by her all the time. Resident is redirected. Oxygen tank was checked and was set on right setting and was still halfway full. Oxygen at 92%."</p> <p>*12:58 p.m.: "Resident approached this nurse in the dining during lunch. Her tank was low on oxygen, this recorder directed her to the nurses station. CNA [name of person] was putting a new tank on. this recorder than went to the oxygen room to retrieve a concentrator for resident to use in the dining room instead of her tank. During this time resident wandered into the family room and called 911. Paramedics did not take report and did not say where they were taking her. POA (power of attorney) called and message left to call facility."</p> <p>*3:56 p.m.: "Resident returns from evaluation at the ER (emergency room). No new orders or changes.</p> <p>*3:57 p.m.: "Resident would like to speak to this recorder. she states "She would never do anything on purpose to try to hurt this recorder." This recorder ask resident what she means by this. Resident stated "she just needed some attention and she was sorry."</p> <p>*11:28 p.m.: "Resident frequently uses the staff assist button instead of using her call light for help, many times when staff gets to her room she say she doesn't need anything. Resident checked on frequently through out the evening. She</p>	F 281		
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F 281	<p>Continued From page 7</p> <p>appears very anxious. Oxygen sat (level of oxygen in the blood) in 80s when not wearing oxygen continuously, sat up to 93 when in bed with oxygen on for a few minutes. Writer advised resident to remain in bed for the night and to keep her oxygen on."</p> <p>Review of resident 3's 5/15/16 ER physician's orders revealed: *Diagnosis of dyspnea. *Care plan: Continue your medications. Make sure oxygen is hooked up at all times.</p> <p>Review of resident 3's 5/16/16 physician's orders following assessment in the facility by the physician revealed "Some increase in shortness of breath with exertion. Stable exam - no dullness and continue same."</p> <p>Interview on 5/19/16 at 1:20 p.m. with resident 3 regarding her oxygen revealed: *She had been able to turn the oxygen on and off by herself. *She had been able to go from the oxygen concentrator to the large oxygen tank without problems. *The oxygen rate was to be set at 4 liters per minute.</p> <p>Interview on 5/19/16 at 3:00 p.m. with MDS nurse A regarding resident 3 revealed: *The resident had turned her oxygen off and on whenever she had wanted to. *The staff monitored the oxygen and would set the liter flow at the correct liters. *They had not done a self-administration of oxygen assessment for her. *They had not done a self-administration of oxygen assessment for any resident on oxygen.</p>	F 281		
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F 281	<p>Continued From page 8</p> <p>Interview on 5/19/16 at 3:10 p.m. with the director of nursing (DON) regarding resident 3 revealed: *The current MAR and TAR had not had a place to document the resident's oxygen level. *She had just added information to the TAR for the nurses to monitor and document resident 3's oxygen level. *The resident had been turning on and off her oxygen. -The staff would check her oxygen. -The staff had continued to reeducate the resident to let the staff regulate her oxygen.</p> <p>Further interview on 5/19/16 at 4:30 p.m. with the DON regarding resident 3 revealed: *Her expectations for any resident who received continuous oxygen would have been to: -Check oxygen sats every shift, and document the findings. -Have the nurses physically assess each resident for oxygen needs. *The treatment record had not included documentation of oxygen use nor oxygen saturations. *The nurses had checked the resident when short of breath or having respiratory problems but had not always documented their findings. *The last oxygen training was in July 2015. *New employees received oxygen training during orientation and on the floor training. *They did not have an oxygen self-administration policy. *On 5/15/16 during resident 3's oxygen incident: -The nurse was in the process of assessing the resident and getting an oxygen concentrator. -The paramedics had come to the facility and had refused to listen to the nurse and took the resident to the hospital.</p>	F 281		
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F 281	<p>Continued From page 9</p> <p>*They used the current policies as their professional standards.</p> <p>Review of the provider's undated Oxygen Administration policy revealed:</p> <p>***Preparation:</p> <p>-Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.</p> <p>-Review the resident's care plan to assess for any special needs of the resident."</p> <p>***Assessment:</p> <p>-Before administering oxygen, and while the resident is receiving oxygen therapy, assess for:</p> <p>--Signs and symptoms of cyanosis (low oxygen in the blood), hypoxia, oxygen toxicity (too much oxygen in the blood), vital signs, lung sounds, and oxygen saturation."</p> <p>***Documentation:</p> <p>-After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record:</p> <p>--Date and time procedure was performed.</p> <p>--The rate of oxygen flow, route, and rationale.</p> <p>--The frequency and duration of the treatment.</p> <p>--The reason for prn (when necessary) administration.</p> <p>--All assessment data obtained before, during, and after the procedure.</p> <p>--If the resident refused the procedure, the reason(s) why and the intervention taken.</p> <p>--The signature and title of the person recording the data."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, page 4, revealed "The Standards of Practice describe a competent level of nursing care. The levels of care are</p>	F 281		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2016
NAME OF PROVIDER OR SUPPLIER SOUTHRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105		
(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
F 281	<p>Continued From page 10</p> <p>demonstrated by the critical thinking model known as the nursing process: assessment, diagnosis, outcomes identification and planning, implementation, and evaluation. The nursing process is the foundation of clinical decision making and includes all significant actions taken by nurses in providing care to patients [resident]." Surveyor: 18560</p> <p>2. Review of resident 4's medical record revealed: *A 1/24/16 physician's order for oxygen at one liter continuously noted on her May TAR. *A 3/1/16 physician's order for oxygen at one liter each shift noted on her May MAR. *No documentation on either of the above records related to monitoring and assessing the oxygen administration.</p> <p>Interview on 5/19/16 at 4:40 p.m. with the DON confirmed nurses should have been monitoring, assessing, and documenting on residents who had oxygen administration.</p> <p>3. Review of resident 1's medical record revealed: *She had been hospitalized from 3/14/16 to 3/22/16 for pneumonia. *Her 3/22/16 discharge instructions/orders noted she was to have oxygen continuously at 2 liters. *Her May 2016 MAR and TAR indicated no orders for oxygen.</p> <p>Interview on 5/19/16 at 4:45 p.m. with the DON confirmed: *Resident 1 should have been on continuous oxygen since her return from the hospital. *Resident 1's May 2016 MAR and TAR had not noted she was on oxygen.</p>	F 281		

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F 281	Continued From page 11 Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, page 305, revealed "Nurses follow health care providers' orders unless they believe the orders are in error or harm patients."	F 281		
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