

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

ORIGINAL

PRINTED: 08/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435044	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/31/2014
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NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY LUTHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 W 38TH ST SIOUX FALLS, SD 57105
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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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F 000	INITIAL COMMENTS  Surveyor: 22452 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/30/14 through 7/31/14. Areas surveyed included quality of care and treatment, resident safety, nursing professional standards, and resident assessment with a death. Good Samaritan Society Luther Manor was found not in compliance with the following requirements: F157, F225, and F281.	F 000	Addendums noted with an asterisk per a phone call to facility DON and administrator. DW/SSDCH/ME	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157	Notify of Changes-Injury/Decline/Room For resident #1 the center is not able to go back to correct timely notification of changes, injury, and decline*, as well as documentation at time of death. DW/SSDCH/ME For all other potential residents the licensed nurse will notify the physician and family or responsible party immediately upon change of condition or status of the resident. The licensed nurse will not pronounce the death of a resident but will notify the physician that all vital bodily functions have ceased (no blood pressure, no pulse, no respirations, and eyes fixed). The licensed nurse will document how pronouncement of death was obtained by the physician. The licensed nurse will obtain physician orders to release the body in event of death to the mortician and personal items sent with the mortician.	* 8/27/14 DW/SSDCH/ME

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Lawrence D. Arboff</i>	TITLE Administrator	(X6) DATE 8/26/14
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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 required to continue program participation.

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F 157	<p>Continued From page 1 regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review, interview, and policy review, the provider failed to ensure: *Documentation the family was contacted in a timely manner for an acute change in condition resulting in death for one of two sampled residents (1). *A physician's order was obtained for the release of the body to the funeral home for one of two sampled residents (1). Findings include:</p> <p>1. Review of resident 1's 7/22/14 9:15 a.m. through 11:20 a.m. progress notes by registered nurse (RN) A revealed: *9:15 a.m.- "Writer walked by dining room. Resident stated I'm choking. Immediately started Heimlich maneuver and did a throat sweep. Second nurse arrived within 30 seconds. Resident became unresponsive." *9:20 a.m.- "Resident rushed into room where cardiopulmonary resuscitation [CPR] was begun." *9:25 a.m.- "Ambulance was called. [Resident unresponsive and no breathing]." *9:45 a.m.- "Ambulance personnel arrived and took over CPR." *10:12 a.m.- "Resident pronounced dead." *10:20 a.m.- "Discussed with daughter death of mother. Daughter driving from five hours away.</p>	F 157	<p><b>IN-SERVICE TRAINING:</b> Education was provided by the Director of Nursing/Designee for all licensed nurses. In-services and individual meetings held on 8/13/14, 8/15/14, 8/19/14, 8/21/14 and 8/26/14. The education includes process for notification of change in condition or resident status to physician and family/responsible party. Education will include the licensed nurses will notify the physician that all body functions have ceased (no blood pressure, no pulse, no respirations and eyes fixed). The licensed nurse will document in the medical record the physician pronounced the death and orders release of the body to the mortician.</p> <p><b>AUDITS:</b> Audits will be completed for notification of change in condition or resident status and identify the physician and resident family or responsible party had been notified timely. The audit will include that in the event of a resident's death the licensed nurse did not pronounce the death, but obtained a physician order of the death and release of body to the mortician. The audit will include review of the medical record to identify</p>	<p><i>* 3 times per week DW/ODD/IME</i></p>

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F 157	<p>Continued From page 2</p> <p>Hold body until resident's son-in-law is present." *11:20 a.m.- "Physician called with time of death of 10:12 a.m."</p> <p>Interview on 7/30/14 at 4:25 p.m. with the director of social services regarding resident 1's above incident revealed she: *Was the designated social worker (SW) for the nursing unit she resided in. *Was in the building on 7/22/14 but was not involved in notification of her family. *Knew the family had been contacted as she had seen her son-in-law (unsure of time).</p> <p>Interview on 7/31/14 at 10:10 a.m. with RN A regarding resident 1 and the above incident revealed she: *Had tried to call her daughter on 7/22/14 sometime between 9:15 a.m. and 9:45 a.m. but had not gotten an answer. *Had failed to document her attempt at trying to contact her daughter. *Knew she had spoken to her daughter prior to her death on 7/22/14 at 10:12 a.m. but agreed her above documentation showed she had spoken to her daughter at 10:20 a.m. (Eight minutes after her death). *Had not obtained an order to release her body to the funeral home after her death and should have documented that. *Had not documented she had released the body to the funeral home and should have documented that.</p> <p>Interview on 7/31/14 at 11:13 a.m. with SW C regarding resident 1 on 7/22/14 revealed she: *Saw the ambulance arrive on 7/22/14 at 9:52 a.m. and took them down to the resident's room. *Had asked RN A if her family had been</p>	F 157	<p>the documentation includes vital body functions had ceased.</p> <p>The audits will be completed by the DNS/ Designee weekly x 4 weeks and monthly x 3 months. The DNS will submit a monthly report of audit findings, root cause and other identified concerns to the QA Committee for further recommendations and follow up. <b>Date to be completed: 8/27/2014</b></p>	

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F 157	Continued From page 3 contacted. RN A had told her she had tried twice to call her daughter but had gotten no answer. *RN A should have documented she had tried to contact her daughter with no answer. *Was told by RN A she had spoken to her daughter at approximately 9:57 a.m. to 10:02 a.m.  Review of the provider's September 2012 Notification of Condition Change and Observation revealed "Notify the resident's responsible party and document in the progress notes."  Review of the provider's September 2012 Discharge Due to Death policy revealed "When the discharge is due to death, the nurse will obtain a physician's order to discharge the body to the mortuary."	F 157			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) <b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b>  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	F 225	<b>Investigate/Reports Allegations/ Individuals</b>  For resident #1 the facility is not able to go back and correct the required 5 day reporting to the SD DOH. Report to the SD DOH was submitted 7/22/14  For all other potential residents the facility must ensure reporting of investigations/injury/allegations have been submitted to the SD DOH in the required time frames.	* 8/27/14 DW/SDOCH/mr	

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F 225	<p>Continued From page 4</p> <p>immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure one of two sampled resident's (1) unexpected death was investigated and reported in a timely manner to the South Dakota Department of Health (SD DOH). Findings include:</p> <p>1. Review of resident 1's 7/22/14 incident report that was reported to the SD DOH on 7/22/14 revealed: **At 9:15 a.m. resident was at dining room table eating first bites of breakfast. Registered nurse (RN) A heard patient state I'm choking and mumbling words." **Certified nursing assistant (CNA) D assisted RN A to perform Heimlich maneuver. CNA D called</p>	F 225	<p><b>IN-SERVICE TRAINING:</b> Education will be provided by the Social Worker/Designee for all licensed nurses. In-services and individual meetings held on 8/13/14, 8/14/14, 8/15/14, 8/19/14 and 8/26/14. Education will include the GSS II.I.4 and II.I4a-Incident report policy and procedure. GSS II.R.2 policy and procedure for reporting.</p> <p><i>* 6 times per week DW/SDDOH/MP</i></p> <p><b>AUDITS:</b> Audits will be completed for Incident reports, investigations and reporting time frames. The audits will include incident report was completed, investigation was initiated and completed, the reports were sent to SD DOH per guidelines of immediate reporting/24 hour reporting and 5 day reporting. The audits will be completed by the Social worker/Designee weekly x 4 weeks and monthly x 3 months. The Social worker will submit a monthly report of audit findings, root cause and other identified concerns to the QA Committee for</p>	

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F 225	<p>Continued From page 5</p> <p>over radio system to licensed practical nurse (LPN) E to come to the dining room for an emergency. Resident not able to speak. LPN E attempted Heimlich maneuver one time."</p> <p>"RN F witnessed situation and came over to assist. RN F stated let's get her to her room and get her some oxygen. Was assisted into bed with Hoyer lift by RNs A and F with CNAs D and I while LPN E obtained oxygen mask and concentrator."</p> <p>"At 9:25 a.m. chest compressions were started by LPN E while RN A obtained crash cart."</p> <p>"LPN E, RN A, RN F, LPN G, and RN H switched roles of compressions and Ambu bag [hand held device used to provide assistance with breathing] for breaths."</p> <p>"Ambulance called at 9:20 a.m. and paramedics arrived at 9:45 a.m. Resident lowered to the floor and intravenous started. Paramedics created airway. CPR continued."</p> <p>"Resident pronounced dead at 10:12 a.m." (There was no documentation who had pronounced her dead)."</p> <p>Review of resident 1's 7/30/14 incident investigation reported to the SD DOH on 7/30/14 (four days after the required five days) revealed "The paramedic stated there was nothing in her airway when they intubated [placement of a tube into the mouth to aide in breathing] her."</p> <p>Interview on 7/30/14 at 2:00 p.m. with the director of nursing regarding resident 1's event on 7/22/14 revealed she:</p> <p>*Had not sent the investigation report from the resident's 7/22/14 unexpected death until the surveyor asked if she had done that.</p> <p>*Confirmed the investigative report should have been sent to the SD DOH on 7/26/14 which would have met the five day required time frame.</p>	F 225	<p>further recommendations and follow up.</p> <p><b>Date to be completed: 8/27/2014</b></p>	

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F 281 SS=G	<p><b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></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 A. Based on record review, interview, and policy review, the provider failed to ensure: *Emergency services were appropriately contacted for one of one sampled resident (1) who had stopped breathing. *Five of five licensed nurses (A, E, F, G, and H) failed to intervene and perform cardiopulmonary resuscitation (CPR) correctly and in a timely manner for one of one sampled resident (1) who had stopped breathing and was without a pulse. *Five of five licensed nurses (A, E, F, G, and H) failed to use emergency equipment (automated external defibrillator) (AED) for one of one sampled resident (1) who had stopped breathing. Findings include:</p> <p>1. Review of resident 1's 7/22/14, 9:15 a.m. through 11:20 a.m. progress notes by registered nurse (RN) A revealed: *9:15 a.m.- "Writer walked by dining room. Resident stated I'm choking. Immediately started Heimlich maneuver and did a throat sweep. Second nurse arrived within 30 seconds. Resident became unresponsive." *9:20 a.m.- "Resident rushed into room where cardiopulmonary resuscitation [CPR] was begun." *9:25 a.m.- "Ambulance was called. Resident unresponsive and no breathing." *9:45 a.m.- "Ambulance personnel arrived and took over CPR."</p>	F 281	<p><b>Services provided meet professional standards</b></p> <p>For resident #1 the facility is unable to go back and ensure that emergency services were contacted and CPR initiated timely and appropriately.</p> <p>For all other potential residents the facility must ensure the licensed nurse will intervene and provide cardiopulmonary resuscitation (CPR) immediately and use the automated external defibrillator (AED) if available in the center. The licensed nurse will instruct 911 (the emergency response system) be called immediately and directions followed by the emergency response team/ambulance. The licensed nurses will follow GSS policy and procedure for CPR, AED and standard American Heart Association training in the CPR certification classes for "chain of survival"</p> <p><b>*licensed nurses A, E, F, G &amp; H were included in education. DW/SD/CH/ME</b></p> <p><b>IN-SERVICE TRAINING:</b> Education will be provided by the Director of Nursing/Designee for</p>	* 8/17/14 DW/SD/CH/ME

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F 281	<p>Continued From page 7</p> <p>*10:12 a.m.- "Resident pronounced dead." *10:20 a.m.- "Discussed with daughter death of mother. Daughter driving from five hours away. Hold body until resident's son-in-law is present." *11:20 a.m.- "Physician called with time of death of 10:12 a.m."</p> <p>Interview on 7/30/14 at 10:30 a.m. with RN F regarding resident 1 revealed: *On 7/22/14 at about 9:15 a.m. she saw two nurses (A and E) standing by the resident in the dining room. **"The resident was unresponsive and ashy [gray colored]." *She heard certified nursing assistant (CNA) D page licensed practical nurse (LPN) E to the dining room, and went to the dining room to see if she could help. **"The two nurses (A and E) were doing the Heimlich maneuver." *She thought the resident had choked on bacon from the looks of her breakfast tray. The bacon was cut up on her plate. *She never heard the resident talk. She was only "unresponsive" when she saw her. **"I made the decision to move her from the dining room to her room. She was taken to her room and placed on her bed." **"Two CNA [D and I] got the mechanical lift and got her into bed." *The oxygen concentrator was obtained, but she did not know by whom. **"The resident was not breathing from the dining room to the bed." **"CPR was started first and the back board was gotten later." **"We felt the prayer room next to the dining room was too small to get the resident on the floor and start CPR."</p>	F 281	<p>all licensed nurses. Inservices and individual meetings were held on 8/13/14, 8/15/14, 8/19/14, 8/21/14 and 8/26/14. The education includes The American Heart Association training included in the certification of CPR for licensed nurses. The Heimlich maneuver for choking residents, the Emergency response system (911) and immediately providing CPR and use of the automatic external defibrillator (AED). The education will include review of GSS policy and procedure for Cardiopulmonary Resuscitation (CPR), GSS policy and procedure for automatic external defibrillation (AED) and GSS policy and procedure for Advanced Directives and care planning and GSS policy and procedure for Advanced Directive orders upon admission or re-admission. Education will be provided for all new hires with orientation of the process for calling 911, initiating CPR, where and how to use the AED and to ensure the newly hired nurses are comfortable with the emergency</p>	

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F 281	<p>Continued From page 8</p> <p>**As soon as you know the resident is not responding to treatment 911 should be called." **"I stayed in the room and did CPR." **"I did not call 911, but the decision was made to call 911 after they had started CPR." **"The ambulance did not get here very fast." **"CPR was not stopped until the ambulance arrived."</p> <p>Interview on 7/30/14 at 12:00 noon with the medical director regarding resident 1 revealed: *Emergency 911 services should have been called if she had stopped breathing and was non-responsive. *He could not imagine transferring her to the bed with the Hoyer lift (mechanical lift) if she was not breathing. *The response time for the emergency services seemed to be a long time if they had been informed it was a medical emergency. He stated "They were not as responsive as they should be."</p> <p>Interview on 7/30/14 at 1:32 p.m. with LPN G regarding resident 1 revealed: *On 7/22/14 she had been orienting RN H on another wing of the facility. **"I knew there was a problem in the focused rehab dining room on 7/22/14 I guessed about 8:00 a.m. to 8:15 a.m. A nurse (unsure who) had come down to the oxygen room. That nurse had asked her to watch the focused rehab dining room as they had an emergency with a resident. The nurse told her the ambulance needed to be watched for." *She sent RN H to the resident's room to be the "runner." RN H assisted nurses E and F with CPR. *She had not seen the resident in the dining room. When she did go into the resident's room</p>	F 281	<p><i>* at time of individual care conference during mds process or as needed DW/SD/DH/ME</i></p> <p>response and intervening with CPR when ordered by the physician or stated in the advanced directives.</p> <p><b>AUDITS:</b> Audits will be completed to identify Advanced Directives/physician orders are in medical record of PCC by using the report in PCC (Advanced Directives) for updates or changes and part of the facility's QA process to determine all residents have an advanced directive in the medical record. The audit will include review of the Advanced Directive Binder located at each nurses' station. The audit will include during the care conferences with resident and family/responsible party the advanced directives were reviewed and documentation is noted in the progress note by the social worker. The audit will include with new admission the advanced directives were received in the transfer orders or obtained timely by the licensed nurse for code status.</p> <p>The audits will be completed by the DNS/ Designee weekly x 4 weeks and monthly x 3 months.</p>	

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F 281	<p>Continued From page 9</p> <p>(unsure time) the resident was not breathing. Nurses E, F, and H were performing CPR on the resident in bed.</p> <p>***I was taught during orientation to call the non-emergent ambulance services for normal emergencies and with a non-breathing episode or stroke to call 911."</p> <p>Interview on 7/30/14 at 1:46 p.m. with CNA D regarding resident 1 revealed:</p> <p>*On 7/22/14 she had assisted her with her care and taken her to the dining room at about 8:30 a.m. to 9:00 a.m.</p> <p>*She had talked with the resident, taken her to the bathroom, and obtained her weight prior to taking her to the dining room.</p> <p>*She had brought her a plate of food that contained scrambled eggs, sausage patty, pancakes, and two slices of bacon. The resident had started to eat while she was still in the dining room.</p> <p>*Another resident wanted to go to her room, and she (CNA D) had left the dining room for about five minutes.</p> <p>*When she returned five minutes later "The resident lipped to her she was choking. There was no verbal response from the resident."</p> <p>*She had paged LPN E to come to the dining room immediately. RN F also came to the dining room.</p> <p>***RN F told her to take the resident to her room. The resident was in a wheelchair with pedals, and she was wheeled to her room. She was not breathing."</p> <p>***The nurses A, E, and F were working with the resident."</p> <p>***She assisted LPN E to put oxygen on the resident."</p> <p>***She was told to watch for the ambulance by RN</p>	F 281	<p>The DNS will submit a monthly report of audit findings, root cause and other identified concerns to the QA Committee for further recommendations and follow up.</p> <p><b>Date to be completed: 8/27/2014</b></p>	

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F 281	<p>Continued From page 10</p> <p>F. She waited for the ambulance eight to ten minutes. *She heard the ambulance had been called twice. The emergency medical technicians put the resident on the floor."</p> <p>Phone interview on 7/30/14 at 2:00 p.m. with RN H regarding resident 1 revealed: *On 7/22/14 she was in her second week of training at the facility. She was orienting that day on another area of the facility with LPN G. *On the morning of 7/22/14 (unsure time) RN A came to the oxygen room. LPN G told her to go check on resident 1. *Nurses E and F were performing CPR on the resident in bed. "I knew they needed a back board and obtained one off the crash cart. I then assisted nurses E and F with CPR. RN A had already called the ambulance." **"Myself and nurses E, F, and G took turns at performing CPR until emergency medical technicians arrived. The emergency medical technicians put her on the floor and hooked her up to the monitors." **"The first time I had seen the resident she was in bed and not breathing." *She had received no training in orientation when to call the non-emergency ambulance or 911. **"She would call 911 with a change in resident condition." *It took the ambulance about 10 to 15 minutes to come after they had been called.</p> <p>Interview on 7/30/14 at 2:15 p.m. with LPN E regarding resident 1 revealed: *On the morning of 7/22/14 (unsure time) she was helping another resident in the bathroom when she was paged by CNA E to come immediately to the focused rehab dining room.</p>	F 281		

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F 281	<p>Continued From page 11</p> <p>*She finished assisting the other resident and immediately went to the dining room. RN A and CNA D were with the resident. RN A was doing the Heimlich maneuver to the resident. She was told the resident had eaten one bite of food.</p> <p>*RN F grabbed her to get the oxygen for the resident and told her to put the oxygen concentrator on 5 liters with a mask. The oxygen was put on her after she had been assisted into bed with the Hoyer lift by CNAs D and I.</p> <p>*Myself and nurses F, G, and H took turns doing CPR.</p> <p>*The resident was not breathing in the dining room when she first had seen her at about 9:15 a.m. to 9:16 a.m.</p> <p>**"The back board was not in the room the first five minutes of CPR. RN H brought the back board to the room when she came to assist with CPR."</p> <p>*She stayed in the room while RN A called the ambulance.</p> <p>**"You call 911 or the ambulance. It depends on the circumstances."</p> <p>**"RN A told her she called the ambulance first and the call was dropped. RN A then told her she called 911."</p> <p>**"RN A told her it was taking a long time for the ambulance to come. She told her she had called the ambulance, and they told her they were enroute."</p> <p>*The ambulance usually only took about ten minutes to arrive once they were called.</p> <p>*She did not remember if they went over when to call the non-emergency number for the ambulance or 911 during her orientation.</p> <p>Phone interview on 7/30/14 at 2:35 p.m. and on 7/31/14 at 10:15 a.m. with RN A regarding</p>	F 281		

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F 281	<p>Continued From page 12</p> <p>resident 1 revealed:</p> <p>*She said she found her at the dining room table on 7/22/14 about 9:15 a.m., and the resident said she was choking. She became unresponsive and stopped breathing she thought at about 9:16 a.m. "She was getting breathless in 20 to 30 seconds with no breathing."</p> <p>*Certified nursing assistant (CNA) D came into the dining room at the same time, and they attempted the Heimlich maneuver a couple times without success. CNA D immediately paged licensed practical nurse (LPN) E to the dining room to assist them.</p> <p>*By the time LPN E got to the dining room the resident was unresponsive and not breathing. LPN E attempted the Heimlich maneuver once without success.</p> <p>*At about 9:20 a.m. RN F came into the dining room and stated to take the resident to her room, so she could get some oxygen. CNAs D and I assisted to put the resident into bed with the use of a Hoyer lift. A Hoyer lift had been used to transfer her, because she was no weight bearing due to a fractured right ankle.</p> <p>**"I know it took just a few seconds for CNAs D and I to transfer her into bed with the Hoyer lift. We started CPR immediately once the resident was in bed."</p> <p>*She was not sure why the decision was made to transport her to her room first before starting CPR. It had not been her decision. RN F had wanted to get the resident out of the room to give her some oxygen. It had taken them only a few seconds to get her to her room and lifted into bed with the Hoyer lift.</p> <p>*She thought she had called 911 first about 9:30 a.m. and had told them the resident was not breathing, and was not responsive. The emergency service did not respond, so she hung</p>	F 281		

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F 281	<p>Continued From page 13</p> <p>up and thought she just called the ambulance (non-emergency number), and they told her "They were enroute."</p> <p>*It seemed to be taking a long time for the emergency services to arrive, so she called a third time to 911 at about 9:35 a.m. and again they told her they were enroute. She waited five to ten minutes and called the ambulance a fourth time.</p> <p>*The emergency services arrived about 9:45 a.m. and took over CPR. They laid her on the floor and intubated her (tube into throat to clear airway). They told the nurses there was not anything lodged in her throat.</p> <p>*She was unsure who had pronounced her dead at 10:12 a.m. but thought it was the emergency services.</p> <p>*She did not comment when asked what training she had received during orientation when the non-emergency ambulance number should have been called or 911.</p> <p>Interview on 7/30/14 at 3:40 p.m. with RN B nurse manager regarding resident 1 revealed:</p> <p>*She arrived on 7/22/14 at 10:30 a.m. and was informed of the resident's death.</p> <p>*She was told RN A had called the ambulance (non-emergency) number about 9:25 a.m. and was disconnected, and then she made a call to 911. She agreed if the ambulance arrived at 9:45 a.m. that was a significant delay if they had been informed the resident had not been breathing since 9:16 a.m.</p> <p>*Emergency 911 services should have been called since the resident was not breathing and unresponsive. Nurses were informed in orientation to call 911 for emergency situations, and the ambulance number if the situation was non-emergent.</p>	F 281		

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F 281	<p>Continued From page 14</p> <p>*The resident should have been transferred to the floor when she had stopped breathing at 9:16 a.m. and CPR started. She was not sure why they had transported her back to her room and took the time to transfer her into bed with a mechanical lift.</p> <p>*There was discrepancy among the nurses with the interviews and the above progress notes for the following:</p> <ul style="list-style-type: none"> <li>-The actual time the resident's respirations had stopped.</li> <li>-If the emergency service number called was the emergency number 911 or non-emergency number.</li> <li>-The exact time CPR was initiated.</li> <li>-The exact time the emergency services arrived.</li> </ul> <p>Interview on 7/31/14 at 9:45 a.m. with the director of nursing regarding resident 1 revealed:</p> <ul style="list-style-type: none"> <li>*She was concerned with the ambulance response time.</li> <li>*They did not have a policy regarding when the non-emergent ambulance service or 911 should have been called. They also did not have a CPR policy.</li> <li>*She had been informed by the nurses the resident had stopped breathing at 9:16 a.m., and CPR was initiated at 9:25 a.m.</li> <li>*It had been discussed that oxygen could have been started in the dining room instead of transporting her back to her room. The resident should have been laid on the floor in the dining room or the prayer room next to the dining room, and CPR initiated at 9:16 a.m. when she had stopped breathing.</li> <li>*"I would rather have put her on the floor and not worry about any injuries that would have occurred."</li> <li>*She was not certain why there was a nine minute</li> </ul>	F 281		

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F 281	<p>Continued From page 15</p> <p>delay from when she stopped breathing until CPR had started. One of the nurses had looked at the resident's electronic medical record at 9:25 a.m. and determined she was to be resuscitated.</p> <p>*There seemed to be confusion if the 911 emergency services was called or the non-emergency service was called and the actual time they were called and arrived. Emergency 911 services should have been called since the resident was not breathing. RN A had told her the resident was unresponsive when she had called the ambulance.</p> <p>*If the emergency services were called at 9:25 a.m. initially as documented and did not arrive until 9:45 a.m. she would consider 20 minutes too long in an emergency.</p> <p>*The emergency services had informed her that the next time the nurses should call 911 for emergency situations and not the non-emergency number.</p> <p>**"The ambulance and 911 are not the same thing."</p> <p>**"The nurses should have checked her code status at 9:16 a.m. and started CPR. All interviews support the resident stopped breathing at 9:16 a.m. Her code status was not checked until 9:25 a.m. which was nine minutes after she had stopped breathing.</p> <p>Phone interview on 7/31/14 at 10:50 a.m. with the shift manager at the emergency services regarding resident 1 revealed:</p> <p>*On 7/22/14 the 911 number was not called.</p> <p>*Two calls came into the business line at the local non-emergency service. The times those calls came in were not known as calls to that number were not recorded. Calls made to that number also did not display the address or phone number the calls were being made from.</p>	F 281			

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F 281	<p>Continued From page 16</p> <p>*Calls made to the business line were dispatched to a city located in another state, and then emergency services were dispatched by them.</p> <p>*The nurse that made the two calls did not wait on the line to give any information to the secretary that answered the phone. The secretary had told the nurse both times to wait on the line.</p> <p>*The nurse made a third call on 7/22/14 at 9:49 a.m., and the secretary asked her the location she was calling from and would dispatch emergency services herself instead of forwarding her call to the other city and state. The secretary was not trained to dispatch emergency services but had conveyed to her she knew the person on the other line needed help for someone.</p> <p>*The secretary dispatched emergency services at 9:49 a.m., and they arrived at the facility at 9:52 a.m. according to their records</p> <p>*The information the resident was not breathing and was not responsive was not given to the secretary.</p> <p>*Emergency 911 services should always have been called for emergency services. The 911 calls were recorded, and they were able to track the phone number and address even if the caller had hung up.</p> <p>Phone interview on 8/11/14 at 11:15 a.m. with RN F regarding resident 1 revealed: **"We have an AED in the facility." **"The AED was not used on 7/22/14 for the resident." **"The ambulance used their AED on the resident when they arrived." **"She was not sure why they had not used their AED on the resident." **"All the nurses at the facility had been trained how to use the AED." *She was not sure if they had a CPR policy.</p>	F 281			

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F 281	Continued From page 17  Review of the provider's April 2004 CPR policy faxed to the facility on 8/11/14 at 11:30 a.m. by RN F revealed: **CPR is mandatory for all licensed nursing staff. Each shift will have a staff person scheduled who will perform CPR unless: -The resident has a do not resuscitate order. -The resident has obvious signs of clinical death. -The initiation of CPR could cause injury to the rescuer. *Each center will create a center specific procedure with input from their rehabilitation skilled care consultant to quickly access CPR status of all residents in the center."  Review of the August 2014 revised American Heart Association CPR guidelines revealed: **"The steps for CPR have not changed since 1954 when it was first introduced." **"The order of the different steps for performing CPR has always been A-B-C (airway, breathing, and compressions). This was accepted practice until recently." **"In 2010, the American Heart Association came out with a report with their recommendations, rearranging the order to C-A-B (compressions, airway, and breathing), placing emphasis on the chest compressions." **"The research concluded that the old approach creates an unnecessary delay in chest compressions." **"By beginning with chest compressions instead of postponing them until after completing the airway and breathing steps, we are able to get the blood flowing immediately." **"Immediate restoration of blood circulation has been determined to be the utmost priority for saving the victim's life."	F 281		

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F 281	<p>Continued From page 18</p> <p>Review of Patricia A. Potter and Anne Griffith Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO, p. 853, revealed:            ***If a patient's hypoxia (not breathing) is severe and prolonged, cardiac [heart] arrest [stops] results."            ***During cardiac arrest there is an absence of pulse and respirations [breathing]."            ***Permanent heart, brain, and other tissue damage occurs within four to six minutes."            ***The critical elements found to be essential for survival were chest compressions and early defibrillation [device used to administer an electrical shock through the chest wall to the heart to stop the abnormal rhythm.]"            ***The defibrillator is used to strengthen the chain of survival. Every minute of a sudden cardiac arrest without defibrillation decreases the survival rate by 7 percent (%) to 10%."            ***Early CPR with defibrillation within the first three to five minutes can result in greater than 50% long-term survival."</p> <p>Surveyor: 32331            B. Based on closed record review, interview, and policy review, the provider failed to obtain a physician's order for one of two sampled residents (1) with a change in condition. Findings include:</p> <p>1. Closed record review on 7/30/14 of resident 1's medical record revealed:            *Resident had been unresponsive and not breathing on 7/22/14 in the a.m.            *On 7/22/13 at 10:12 a.m. registered nurse (RN) A had documented "Res. [Resident] pronounced death [dead] at 10:12."            *On 7/22/14 at 11:20 a.m. RN A had documented</p>	F 281		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435044</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/31/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY LUTHER MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1500 W 38TH ST</b> <b>SIOUX FALLS, SD 57105</b>		
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F 281	<p>Continued From page 19</p> <p>"Called Dr. _____ with time of death 1012 [10:12 a.m.]."</p> <p>*There had been no physician's order to release the body to the mortician.</p> <p>Interview on 7/30/14 at 3:40 p.m. with RN B nurse manager regarding resident 1 revealed:</p> <p>*The charge nurse that had documented the death of the resident had done so without proper diagnosis from the resident's physician.</p> <p>*RN A had documented that the resident had been pronounced dead and the "pronouncement of death-can't do this as nurses."</p> <p>*Making a diagnosis was not within the scope of practice for a nurse.</p> <p>*The provider had not received a physician's order for the body to have been released to the mortician.</p> <p>Interview on 7/30/14 at 4:55 p.m. with the director of nursing services regarding resident 1 revealed:</p> <p>*The physician needed to have been called regarding no respiration, no heart beat, and no blood pressure.</p> <p>*The charge nurse that had documented the death of the resident had done so without proper diagnosis from the resident's physician.</p> <p>*There needed to have been a physician's order to release the body to the mortician.</p> <p>Review of the provider's October 2013 Physician's Orders policy regarding a discharge due to death revealed:</p> <p>*The physician was to have been notified regarding the date and time of death.</p> <p>*The nurse was to have obtained a physician's order to discharge the body to the mortuary.</p> <p>Pursuant to SDCL 34-25-18.1 Determination of</p>	F 281			

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F 281	Continued From page 20 death - Any individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death shall be made in accordance with accepted medical standards.	F 281			