

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

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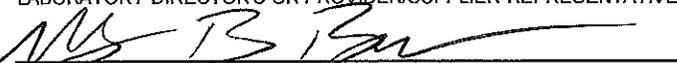
PRINTED: 05/22/2014  
FORM APPROVED  
OMB NO. 0938-0391

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 05/13/2014
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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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(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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<p>F 000 INITIAL COMMENTS</p> <p>Surveyor: 26180 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/12/14 through 5/13/14. Areas surveyed included abuse and neglect. Southridge Health Care Center was found not in compliance with the following requirements: F221, F226, F280, and F309.</p> <p>F 221 SS=D 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, record review, interview, and policy review, the provider failed to assess and update care plans for two of two sampled residents (2 and 3) who had side rails on their beds. Findings include:</p> <p>1. Observation on 5/12/14 at 3:15 p.m. of resident 2's bed revealed a side rail up on the top half of her bed. The side rail had been in the up position.</p> <p>Review of resident 2's medical record revealed: *She had a physician's order for the use of the side rail. *The side rail was to have been used for bed mobility. *The side rail had not been care planned.</p>	<p>F 000</p> <p>F 221</p>	<p>Update Resident (2) &amp; (3) and all other residents who have side rails care plans to include an individual resident assessment of side rail and the use of the side rail for mobility. Administrator, DON and ID team to review and revise as necessary the policy and procedure about what constitutes a restraint on or before June 7, 2014.</p> <p>Document to include side rails used for transfer and/or mobility.</p> <p>All staff will be educated on the correct use of side rails for all residents and all other potential physical restraints on or before June 7, 2014.</p>	<p>6/7/2014</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 6-24-14
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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 requisite to continued program participation.

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If continuation sheet Page 1 of 15  
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F 221	Continued From page 1  Review of resident 2's 5/9/14 monthly summary report revealed she had a side rail on the outside of her bed. The side rail was to have been used for mobility.  Review of resident 2's 9/9/13 annual Minimum Data Set (MOS) Care Area Assessment documentation revealed: *She had required assistance with bed mobility and transfers from the staff. *No documentation to support she had used the side rail to assist the staff with bed mobility and transfers.  Review of resident 2's 2/21/14 quarterly MOS revealed no documentation found in the interdisciplinary progress notes from the nursing department to support that assessment.  Interview on 5/13/14 at 8:25 a.m. with the director of nursing (DON) revealed: *The side rail should have been care planned. *The monthly summary report had been the only document of the side rail found in the chart. *She would have expected to see further documentation by the MOS case managers to support the use of the side rail and the MOS assessments.  Surveyor: 26180 2. Random observation of resident 3 on 5/12/14 and 5/13/14 revealed when the resident was in bed a side rail that extended to the top half of her bed was pulled up on both sides of her bed. The resident's bed was also up against the wall.  Review of resident 3's monthly nursing summaries revealed:	F 221	DON or designee will audit resident (2) and two other random residents utilizing side rails regarding assessments, care plans, documentation and appropriateness weekly x 12 and report results to QAPI monthly until deemed acceptable by QAPI team.

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F 221	<p>Continued From page 2</p> <p>*The 1/1/14 evaluation said she had no restraints including side rails.</p> <p>*The 3/28/14 evaluation said she had no restraints including side rails.</p> <p>*The 4/28/14 evaluation had not answered the question regarding restraints.</p> <p>Review of resident 3's 4/21/14 MOS revealed she had no restraints including side rails.</p> <p>Interview on 5/12/14 at 3:15 p.m. with registered nurse/care coordinator A regarding resident 3 revealed:</p> <p>*They had not considered her side rails a restraint.</p> <p>*The resident used the side rails to reposition herself in bed.</p> <p>*They had not completed a side rail assessment that verified the resident's use of the side rail as a positioning device rather than a restraint.</p> <p>Review of resident 3's May 2014 physician's orders revealed there was not an order for a side rail which described the reason for using the side rail.</p> <p>Review of resident 3's care plan revealed the care plan:</p> <p>*Had been updated on 4/28/14 after she had fallen from her bed, because the side rail had not been secured in the up position.</p> <p>*Had not addressed the intended use of the side rails.</p> <p>Review of the entire medical record revealed there was not a resident or family side rail consent form signed.</p> <p>Interview on 5/13/14 at 1:45 p.m. with the DON</p>	F 221	

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<p>F 221   Continued From page 3 i confirmed side rail assessments had not been . completed.</p> <p>Review of the provider's March 2005 restraint policy revealed: **Physical restraints: any device which inhibits free movement and which cannot be removed by the resident." *The policy included a list of items that might be considered a restraint. -Side and bed rails was not included on that list.</p> <p>F 226 483.13(c) DEVELOP/IMPLMENT SS=E ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure a thorough investigation and required reporting to the state agency for two of two resident falls (2 and 3) resulting in injury. Findings include:</p> <p>1. Review of resident 3's interdisciplinary progress notes revealed: *On 4/28/14 at 3:15 a.m. she was found on the floor near her bed. -There was a pool of blood around her head, and she had a bloody nose. -She had a small cut on her forehead. -She complained her teeth hurt.</p>	<p>F 221</p> <p>F 226</p>	<p>F 221</p> <p>F 226</p>	<p>Administrator, DON, and those responsible for initial reporting, investigation and reporting reviewed and revised as necessary the policy and procedure about investigating and reporting resident accident, injury or abuse and neglect on or before May 29, 2014.</p> <p>Education relating to resident (2) &amp; (3) resulting with falls with injury's has been discussed as part of education to nursing staff on May 30, 2014.</p> <p>Serious Bodily Injury is defined as: -In general – The term 'serious bodily injurt' means an injury -Involving extreme physical pain -Involving substantial risk of death -Involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or -requiring medical intervention such as surgery, hospitalization, or physical rehabilitation</p>	<p>6/7/2014</p>

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F 226 Continued From page 4

-She then began to panic and stated "I'm having an anxiety attack. I think I'm dying."  
\*On 4/28/14 at 2:15 p.m. the resident was noted to have facial bruising.  
\*The fall from 4/28/14 was reviewed on 4/30/14 by the registered nurse/care coordinator A and was concluded:  
-"It was noted that the siderail had fallen down which startled resident who reached for railing [siderail] which wasn't there. She fell out of bed."  
-Bed found in mid height.  
-Staff reminded to put bed at proper height.  
-Resident has a diagnosis of blindness.  
-Call light was within reach.  
-Also it was determined that there was no evidence of abuse/neglect associated with this fall.  
\*The documentation had not addressed:  
-How they determined the resident had fallen out of bed, because she had been startled when the side rail fell down.  
-Who they had interviewed.  
-How they determined staff had not been neglectful when they had documented the bed was not at the proper height.  
-How they had evaluated the functioning of the siderail and if it was determined to be malfunctioning. If not, why had the side rail not been applied.  
-How they determined the resident had not had the call light when the fall review occurred two days later.

Interview on 5/12/14 at 4:45 p.m. with the care coordinator revealed the above documentation was the investigation of the fall. There was no further documentation.

Interview on 5/13/14 at 7:45 a.m. with the director

F 226 Education referencing any future falls with injury, to ensure reporting in timely manner has been discussed to nursing staff on May 30, 2014.

Resident (3) bedrail was assessed on May 27, 2014 by DON, and found to be in good condition, all other bedrails will be assessed on or before June 7<sup>th</sup>, 2014 by DON or designee.  
Investigation of Resident (3) fall on 4/28/14 will be conducted by MDS Case Manager to complete missing documentation on or before June 7, 2014.

Further investigation of Resident (2) fall on January 17, 2014 was not able to be conducted because of time lapse.

In ther future, resident falls with or without injury will be assessed at time of fall for any potential contributing factors by nursing staff to ensure a safe resident environment.

Team huddles following a fall will be established by June 7, 2014, also performance improvement project as a part of QAPI. Care plan will be brought to huddle and updated as needed.

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F 226 Continued From page 5

of nursing and the administrator regarding resident 3 revealed:

- \*Whenever a fall occurred they reviewed the fall the next day at the stand-up meeting.
- \*They had not completed an investigation following her fall, because it had not resulted in a serious injury. A serious injury was something like a fracture.
- \*They had not considered if neglect had occurred based on the above documented review by the care coordinator.
- They concurred the care plan had neglected to have been followed regarding positioning of the bed.
- \*They had not reported any of that to the state agency (South Dakota Department of Health).
- They had not thought it was serious enough.

Further review of resident 3's entire medical record revealed the required nursing facility event reporting form had not been completed.

Review of the provider's November 2012 Resident Abuse/Neglect policy and procedure revealed:

- \*\*3.1.9 Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.
- \*3.2.6.5. The administrator or designee will notify the Department of Social Services, the ombudsman, Department of Health and the resident's attending physician immediately after being informed of the incident."

Surveyor: 32355

2. Review of resident 2's medical record revealed:

- \*She had been found sitting on the floor next to her bed on 1/17/14 at 10:00 p.m.

F 226

Education on nursing event reporting with significance of immediately investigation completed with nursing/MOD of event reporting by DON on May 30, 2014.

DON or designee will audit two random residents with falls to ensure proper investigation and reporting procedures were met weekly x 12 and report results to QAPI monthly until deemed acceptable by QAPI team.

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F 226 Continued From page 6

F 226

\*She was attempting to answer her phone.  
\*No injuries had been found at the time of the fall.  
\*On 1/18/14 through 1/20/14 she had complained of left rib pain.  
\*Her physician had been sent a fax on 1/19/14 in regards to her complaints of pain.  
\*On 1/20/14 she had been seen by her physician and was given a diagnosis of fractured ribs related to osteopenic (brittle) bones and a fall on 1/17/14.

Review of resident 2's required nursing facility event reporting document revealed:  
\*The document had been initiated on 1/20/14.  
\*Physical harm or injury had been substantiated : (confirmed).  
\*The department of social services, local Ombudsman, and the state Department of Health had not been notified until 1/23/14 at 4:00 p.m. in regards to the above fall with injury.

Interview on 5/13/14 at 3:15 p.m. with the DON , and administrator confirmed the provider should ' have notified the state Department of Health immediately or within twenty-four hours upon the : identification of the fracture on 1/20/14.

Review of the provider's February 2009 Reportable Events policy and procedure revealed "The facility will ensure that all alleged violation involving mistreatment, neglect, or abuse, including injuries of unknown source, are reported immediately (within twenty-four hours) to the administrator or designated representative of the facility and other officials in accordance with state law through established procedures (including the state survey and certification agency and licensed social worker/Ombudsman)."

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F 280 Continued From page 7  
F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO  
SS=D PARTICIPATE PLANNING CARE-REVISE CP

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.

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.

This REQUIREMENT is not met as evidenced by:

Surveyor: 32331  
Based on observation, record review, interview, and policy review, the provider failed to review and revise care plans related to fall prevention for two of five sampled residents (1 and 2). Findings include:

1. Observation on 5/12/14 at 3:20 p.m. with certified nursing assistant (CNA) B in resident 1's room revealed no fall mat on the resident's floor next to her bed.

F 280  
F 280

DON and ID team will review and revise as necessary the policy and procedure about care plan review and revision on or before June 7, 2014.

6/7/2014

DON and ID team will review and revise resident's (1) & (2) care plans to ensure that they are comprehensive for each resident and that they include measurable objectives and time tables to meet the resident's medical, nursing and psychsocial needs on May 30, 2014. Other residents assessed to be at high risk falls will be re-evaluated on an ongoing basis.

Resident (1) & (2) will be in high/low beds with fall mats at bedside. Beds will be in low position when resident is bed.

Any resident found on floor or on mat will be considered a fall and assessed for injury will interventions on assessment.

All nurses will be re-educated by DON on developing and updating care plans to individually to specific residents, including assessment and utilization mattresses with scoop sides on May 30, 2014. All nurses need to include pocket care plans with changes on care plans.

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F 280 Continued From page 8

Review of resident 1's current care plan revised on 1/14/14 revealed:

- \*She was at risk for falls.
- \*She had a focus area of falls.
- : \*Interventions included that she was to have had:
  - A "Hi-lo [High-low] bed with mat at bedside."
  - Bed was to have been in lowest position when occupied.
  - If bed was in low position and resident was found on the mat, "it will not be counted as a fall but rather an intentional change of position."

Review of resident 1's 5/12/14 Pocket Care Plan (used by CNAs for resident care) revealed she was a fall risk.

Review of resident 1's 3/11/14 Minimum Data Set (MOS) assessment section J revealed she had a fall with a major injury since her prior assessment on 12/16/13.

Interview on 5/13/14 at 8:20 a.m. with the director of nursing regarding resident 1's care plan revealed she would:

- \*Have considered it a fall if the resident had been found on the fall mat.
- \*Not have considered it "an intentional change of position."

Interview on 5/13/14 at 8:45 a.m. with resident 1's physician C revealed:

- \*She was a fall risk.
- \*She had recently had a fall that resulted in an injury.
- \*He agreed if she ever had been found on the fall mat it should have been considered a fall and not an intentional change of position.

Interview on 5/13/14 at 10:20 a.m. with CNA B

F 280

DON or designee will audit four random care plans with recent falls, weekly X 12 and report results to QAPI monthly until deemed acceptable by QAPI team.

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F 280	<p>Continued From page 9</p> <p>: and CNA D regarding resident 1 revealed: *She currently did not use or have a fall mat next to her bed. *They had not observed a fall mat ever being used in her room at any time.</p> <p>Interview on 5/13/14 at 4:45 p.m. with registered nurse E regarding resident 1's care plan revealed: *The resident had not used a fall mat. *She agreed if she ever had been found on a fall mat it should have been counted as a fall and not an intentional change of position. *She confirmed the care plan for fall prevention had not been reviewed and revised.</p> <p>Surveyor: 32355</p> <p>2. Review of resident 2's medical record revealed she had: *The diagnoses of Alzheimer's (memory loss) with psychoses (thinking process and emotions were impaired), and history of falls. *Moderate memory loss and frequently transferred herself into bed without calling for assistance from the staff. *Required staff support for bed mobility and transfers. *An unwitnessed fall in her room on 1/17/14. The fall resulted in two osteopenic (brittle bones) rib fractures. Her rib fractures had not been determined until 1/20/14.</p> <p>Observation on 5/12/14 at 3:15 p.m. of resident 2's room revealed a mattress on her bed with scooped sides.</p> <p>Review of resident 2's current care plan revised on 2/26/14 revealed: *She was at risk for falls.</p>	F 280	

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F 280	<p>Continued From page 10</p> <p>*She had a focus area of falls.</p> <p>*Interventions included she was to have had:</p> <ul style="list-style-type: none"> <li>-Assistance from one staff member to move from one place to another.</li> <li>-Remembered to lock her brakes on the wheelchair (w/c) when she had tried to transfer herself.</li> <li>-Remembered to call for assistance.</li> </ul> <p>*No intervention for utilizing a mattress with scooped sides.</p> <p>Review of resident 2's 5/12/14 CNA pocket care plan revealed she was a fall risk. The pocket care plan had been utilized by the nursing staff daily to ensure appropriate care for the residents occurred. No interventions had been listed for the staff to utilize in helping to prevent falls for resident 2.</p> <p>Interview on 5/12/14 at 4:20 p.m. with registered nurse (RN) F regarding resident 2 confirmed:</p> <ul style="list-style-type: none"> <li>*She was a fall risk and had poor memory recall.</li> <li>*She required staff assistance with bed mobility and transfers.</li> <li>*She had a history of transferring herself into bed without asking for assistance by the staff.</li> <li>*She agreed the above care plan interventions had not been appropriate for resident 2.</li> <li>*The mattress with elevated sides should have been added to the care plan.</li> </ul> <p>Interview on 5/12/14 at 5:15 p.m. with the director of nursing (DON) revealed:</p> <ul style="list-style-type: none"> <li>*The care plan for fall prevention had not been reviewed and revised to appropriately reflect resident 2's fall prevention needs.</li> <li>*She agreed the above interventions had not been appropriate for resident 2 because of her impaired memory recall.</li> </ul>	F 280		

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	(xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/13/2014
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F 280 Continued From page 11  
 \*She confirmed resident 2 would not have remembered to have used her call light or locked the brakes on her w/c while transferring herself.  
 \*There should have been interventions listed on the pocket care plan to guide the staff in helping resident 2 from falling.  
 \*The mattress with elevated sides should have been added to the care plan under fall prevention.  
 3. Review of the provider's January 2009 Care Plan policy and procedure revealed:  
 \*\*\*It is the policy of this facility to develop a comprehensive care plan for each resident that includes measurable objectives and time tables to meet the resident's medical, nursing and psychological needs."  
 \*\*\*An interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor), develop and maintain a comprehensive care plan for each resident."  
 \*\*\*Care plans are revised as changes in the resident's condition dictates. Reviews are made at least quarterly."

F 280

F 309 | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  
 SS=D  
 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 309

DON and ID team have reviewed and revised the policy and procedure regarding pain management on May 29, 2014. 6/7/2014  
 DON has provided education of the policy\procedure of pain management to all staff responsible for assessment and interventions to complaint of pain on May 30, 2014.

This REQUIREMENT is not met as evidenced by:  
 Surveyor: 32355

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(X4) 1D 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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<p>F 309 Continued From page 12</p> <p>Based on record review, interview, and policy review, the provider failed to ensure effective pain management for one of one sampled resident (2) with complaints of pain after a fall. Findings include:</p> <p>1. Review of resident 2's medical record revealed she had:</p> <ul style="list-style-type: none"> <li>*The diagnoses of Alzheimer's (memory loss) with psychoses (thinking process and emotions were impaired), and a history of falls.</li> <li>*Moderate memory loss and frequently transferred herself into bed without calling for assistance from the staff.</li> <li>*Required staff support for bed mobility and transfers.</li> <li>*An unwitnessed fall in her room on 1/17/14. The fall resulted in two osteopenic (brittle bones) rib fractures. Her rib fractures had not been determined until 1/20/14.</li> </ul> <p>Review of resident 2's interdisciplinary progress notes from 1/17/14 through 1/20/14 revealed on:</p> <ul style="list-style-type: none"> <li>*1/17/14 she had an unwitnessed fall in her room at 10:00 p.m. attempting to answer her phone. She had been assessed by the charge nurse on duty. No injury had been identified.</li> <li>*1/18/14 at 10:00 a.m. she had complaints of pain with Tylenol (pain medication) given for her pain. The Tylenol had been effective in relieving her pain.</li> <li>*1/19/14 at 10:00 a.m. she had complaints of pain under her left breast. Pain had also been identified during physical touch by the charge nurse. Tylenol was given for complaints of pain with some relief. A fax had been sent to her physician in regards to the complaints of pain.</li> <li>*1/20/14 she was seen by the physician for continued complaints of increased pain. A</li> </ul>	<p>F 309</p> <p>DON or designee will audit three to five random residents with falls to assess pain management interventions (Pharmacological and non-pharmacological) weekly X 12 and report results to QAPI monthly until deemed acceptable by QAPI team</p> <p>Resident (2) pain assessment within care plan reviewed and revised to reflect current status of pain on May 30, 2014 by MDS Case Manager.</p> <p>Residents experiencing pain will have pain assessment tool updated on care plan by DON or designee on or before June 7, 2014</p>
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F 309	<p>Continued From page 13</p> <p>diagnosis of two osteopenic rib fractures had been given. Tylenol 500 milligrams one tablet three times a day was ordered for pain.</p> <p>Review of resident 2's 1/9/14 weekly/monthly summary evaluation form revealed she had no pain. No further monthly summary evaluation form had been found in her chart for the month of January.</p> <p>Review of resident 2's current care plan dated 9/18/13 and 2/26/14 revealed no focus area for pain management from the fall on 1/17/14 and diagnosis of two rib fractures on 1/20/14. No pharmacological or non-pharmacological (no medicine) interventions were found.</p> <p>Interview on 5/13/14 at 3:15 p.m. with the administrator revealed there had been several nurses assessing resident 2's pain after the fall. He had supported the nurses judgement and assessment skills for not contacting the doctor upon the first complaints of pain. He had been more concerned with the timeliness of the reporting of resident 2's fall with fractures to the state Department of Health.</p> <p>Interview on 5/13/14 with the director of nursing at the same time as the administrator revealed she would have expected the staff nurses to have notified the doctor by phone and not by fax as soon as the resident's pain was identified.</p> <p>Review of the provider's 4/3/13 Standard of Care for Southridge Healthcare revealed pain assessments were to be done quarterly and as needed.</p> <p>Review of the provider's June 2009 Pain</p>	F 309		
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F 309	Continued From page 14 Management policy revealed: *"When pain has been identified and described it may also be necessary to perform a comprehensive exam which may include physical exam and diagnostic tests." *Both non-pharmacological and pharmacological interventions shall be implemented."	F 309		
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