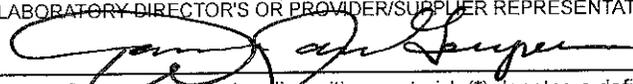


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435091</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/26/2014</b>
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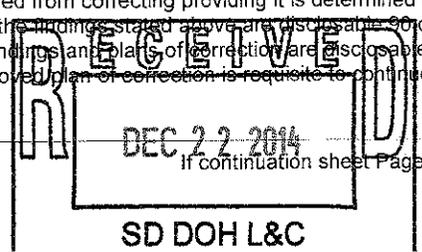
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY TRIPP</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 N DOBSON ST TRIPP, SD 57376</b>
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F 000	INITIAL COMMENTS  Surveyor: 22452 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/24/14 through 11/26/14. Areas surveyed included nursing services and professional standards. Good Samaritan Society Tripp was found not in compliance with the following requirement: F281.483.20(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: 22452 Based on record review, interview, and policy review, the provider failed to ensure: *Professional standards were followed regarding nursing communication for one of one sampled resident (1) who had an acute episode. *Nursing documentation was thorough and complete for one of one sampled resident (1) who had an acute episode. Findings include:  1. Review of resident 1's 10/19/14 at 6:38 p.m. nursing progress notes by registered nurse (RN) A revealed: **Resident eating orange in dining room and certified nursing assistant (CNA) summoned nurse to table." **Resident gasping, becoming cyanotic and not able to speak. Heimlich maneuver (abdominal thrust to dislodge objects from the airway)	F 000		
F 281 SS=D		F 281	The center is unable to change the events of this incident. Acute changes in a resident condition will be communicated to other staff involved in a verbal manner. Each staff person will be responsible for their own documentation of any occurrence and documentation will be thorough and complete. The Director of Nursing Services (DNS) will provide education to all nursing staff on 01/15/15 regarding the responsibilities of each staff member during an acute or emergent situation especially related to communication, documentation, and follow-up. Good Samaritan Society (GSS) Policy # II.D.8, Documentation and GSS Procedure #II.D.8b, Nursing Documentation will be reviewed and given to nursing staff. GSS Policy #I.C, Safety and Health Policy Statement will also be reviewed and (continued on page 2)	01/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>Administrator</b>	(X6) DATE <b>12/18/14</b>
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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 and disclosable 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 281	<p>Continued From page 1</p> <p>performed and partial airway obtained and resident able to speak and color recovered." *"Stated to get me out of here and taken to nurses station and monitored by nurse as vocal quality was gurgly and then again became cyanotic (purple color) and non-responsive." *"Attempts to clear airway with further Heimlich and suction were unsuccessful and vitals (blood pressure, pulse, and respirations) ceased at 6:38 p.m." *"Resident code status confirmed as do not resuscitate (DNR) and physician notified of event." *"Son notified and stated would not be coming tonight and that funeral home could contact him tomorrow regarding further arrangements."</p> <p>Review of all the nurses cardiopulmonary certification (CPR) revealed they were all current</p> <p>Interview on 11/24/14 at 2:30 p.m. with the director of nursing (DON) regarding resident 1 revealed: *She knew RN A had asked CNA B to bring the resident from the dining room to the nurses station. *RN C was at the nurses station to keep an eye on the resident. *The nurses had not called 911 as things were going on so fast. She was unsure what time the resident actually started to choke and thought maybe 6:00 p.m. but was not sure. *The resident was in bed when RN A and RN B performed the Heimlich maneuver and suctioned her. The nurses had manually transferred her to bed. *She had reviewed at the 11/13/14 nurses meeting how things had gone and ways to prevent an event like that from happening again.</p>	F 281	(continued from page 1) given to nursing staff. The DNS will review the facility's 72 hour report to determine if an acute situation has occurred. The DNS will audit the communication that took place and also audit the medical record to determine if documentation was thorough and complete. These audits will be done weekly for four weeks then monthly for three months. The DNS will report audit findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and the QAPI Committee will determine if further auditing is needed when the four months of audits are complete.		

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F 281	<p>Continued From page 2</p> <p>*They had formed a performance improvement plan (PIP) group consisting of herself, the quality assurance coordinator, and the dietary manager to evaluate the event. The group had not had a chance to formally meet yet.</p> <p>*The resident had no history of choking and was on a regular diet.</p> <p>Interview on 11/24/14 at 4:25 p.m. with RN C regarding resident 1 revealed:</p> <p>*CNA B brought the resident to the nurses station on 10/19/14 at 6:30 p.m. CNA B told her that RN A wanted her to watch the resident. She really did not know what she should have been watching the resident for.</p> <p>*Usually when a resident was ill or had an acute episode the nurses communicated with each other instead of relying on a CNA to inform the nurse of a resident's condition.</p> <p>*CNA B did not tell her the resident had been choking, and RN A had performed the Heimlich maneuver on her.</p> <p>*After the resident had been at the nurses station a few minutes she was informed by CNA B that RN had performed the Heimlich maneuver on the resident. The resident had choked on a piece of orange, and the Heimlich maneuver was able to dislodge the piece of orange.</p> <p>*She was told RN A had given the resident a sip of water after the piece of orange had been dislodged, and the resident was talking to them before she left the dining room.</p> <p>*She had been told the resident was cyanotic in the dining room, but once she got to the nurses station she was very pale (white).</p> <p>*She tried to ask the resident a question, and she just kept coughing. Her chest was gurdy, and she thought by coughing the resident might be able to cough up something.</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>*The resident could not have been at the nurses station more than five minutes. She became unresponsive and more pale after a couple minutes.</p> <p>*She asked CNA B to go get RN A. They lifted her into bed, had tried the Heimlich maneuver again, and tried to suction her. They obtained only a small amount of fluid when they suctioned her.</p> <p>*RN A went to nurses station after they had gotten her into bed to check her code status. She was a DNR, so they did not try to revive her.</p> <p>*RN A had completed all the documentation in the nursing progress notes regarding the event, even though she had not been with the resident at the nurses station.</p> <p>Interview on 11/24/14 at 5:07 p.m. with CNA B regarding resident 1 revealed:</p> <p>*She had been feeding two other residents at the table diagonally across from her when she had started to choke.</p> <p>*Another CNA had patted her back a couple times, and she had continued to cough. RN A tried to perform the Heimlich maneuver. The resident was gagging. She had not seen anything come out of her mouth when the Heimlich maneuver had been performed.</p> <p>*The resident hollered to get her out of the dining room. She was surprised she could talk if she was choking.</p> <p>*RN A told her to bring the resident to the nurses station where RN C was. She had told her if RN C was not able to watch her to bring her back, and she would watch her. She was not told by RN A to tell RN C anything else.</p> <p>*The resident was gagging, and "I thought she was going to throw up." RN C got her an emesis (vomiting) basin.</p> <p>*When the resident got to the nurses station "the</p>	F 281		

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F 281	<p>Continued From page 4</p> <p>color just went out of her and she was very pale. It was like a curtain was pulled over her." *She thought it was maybe about five minutes from the time she took her to the nurses station until the time she expired.</p> <p>Interview on 11/25/14 at 9:30 a.m. with RN A regarding resident 1 revealed: *She was unsure what time the resident actually started to choke but thought 6:00 p.m. was way too early. *She was in the middle of passing her supper pills when she saw a CNA patting her back, and it appeared she was coughing and choking. *I asked the resident if she could speak initially. She was cyanotic and unable to talk to me. I had the CNAs at the table stand her and I tried the Heimlich maneuver. She did not dislodge anything initially so I tried more force. *After a couple minutes the resident appeared to swallow something, her color got better, and she was able to speak. *The resident stated she wanted to get out of the dining room. I had CNA B bring her to the nurses station, so RN C could watch her while I completed my medication pass. **"I assumed since CNA B had been in the dining room the whole time she would pass on to RN C what had happened with the resident." **"I was not aware no report what had happened to the resident had not been passed on initially to RN C. I guess I should have informed RN C myself." *The resident's voice was still raspy and wet sounding so she knew she needed to be watched yet. *When she left the dining room the resident was in no respiratory distress and was talking to the staff.</p>	F 281		

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F 281	<p>Continued From page 5</p> <p>*About five minutes after the resident had left the dining room CNA B came back to get me.</p> <p>*It all happened so fast. There was no reason to call 911 as she appeared stable, and RN C would have called the physician if she had felt it was necessary.</p> <p>*RN C probably should have documented her assessment of the resident while she was at the nurses desk, as she had been in the dining room passing medications during that time frame.</p> <p>*She had documented the resident was cyanotic at the nurses station when RN C had said she was very pale. She should have documented the actual time the choking incident had happened, but "things happened so fast." She had looked at the clock only two times at 6:30 p.m. when the resident was taken to the nurses station and at 6:38 p.m. when she had passed away.</p> <p>*She had planned on updating the physician if the resident continued to have problems while she was at the nurses station.</p> <p>*She knew as a result of that event the residents were no longer able to have oranges unless a family member brought them for the resident.</p> <p>Review of the provider's September 2012 Documentation policy revealed: **"Documentation of all nursing care and observations, assessments and treatments, and effects will be written by an authorized professional." **"All documentation is expected to be legible, accurate, understandable, timely and pertinent and held in confidence."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th ED., St. Louis, MO, pg. 362, revealed: **"The medical record is a legal document and</p>	F 281		

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F 281	Continued From page 6 requires information describing the care that is delivered to a patient." **"Interdisciplinary communication is essential within the health care team." **"A nurse's signature on an entry in a record designates accountability for that entry."	F 281		