

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/11/2015
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401	
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F 000	INITIAL COMMENTS Surveyor: 23059 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/10/15 through 3/11/15. Areas surveyed included accidents, assessments, and quality of care. Avera Mother Joseph Manor Retirement Community was found not in compliance with the following requirement: F514.	F 000	<i>Addendums noted with an asterisk per 4/14/15 telephone to facility DON. NSJSDDOH/MF</i>	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure sufficient and accurate documentation following an injury was completed for one of ten sampled residents (5). Findings include: 1. Review of resident 5's medical record revealed	F 514	Resident #5 was discharged from facility on 02/02/2015. Policy N300 "Change in a Resident's Condition or Status" was reviewed by Administrator, DON and interdisciplinary team. Education on Policy N300 "Change in a Resident's Condition or Status" will be provided to all staff responsible for documenting resident care and services by April 1, 2015. All nurses will be required to complete an eLearning course, "Not Documented-Not Done: The Importance of Accurate Documentation" by April 1, 2015. Audits of documentation by staff responsible for resident care and services will be completed by ADON or designee <i>*on 10 random charts two times a month for two months then monthly until advised by the dia committee to discontinue. NSJSDDOH/MF</i>	04/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **3-26-15**

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 6

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F 514	<p>Continued From page 1</p> <p>she had been admitted from the hospital on 1/29/15 and discharged back to the hospital on 2/2/15. At the hospital it was discovered she had a pathological 9 (due to weakening from a disease process) fracture (break in the bone) as a result of the spread of cancer to that area.</p> <p>Review of resident 5's 1/29/15 admission orders revealed she had no restrictions on her activity. She was able to do what she could tolerate. She had narcotic pain medications ordered for chronic pain.</p> <p>Review of her 1/29/15 hospital discharge summary revealed she had been hospitalized due to a severe infection following a diagnosis of stage 4 cancer (had spread to other areas than the primary source). She had been walking on her own. She was being admitted to a nursing home for further physical and occupational therapy.</p> <p>Review of the resident's 1/31/15 provider notification note to the physician revealed there was no documentation as to why the physician had been notified at that time. That documentation by the nurse included: **"Elevate the head of the bed." There was no documentation as to why the head of the bed needed to have been elevated. **"Elevate arm on pillow for comfort." There was no documentation as to which arm or why comfort needed to have been provided. **"Assist resident with 2 people for transfers." That had been a change from the assessment and ongoing evaluation of assistance needs from 1/29/15 through 1/31/15 to use extensive assistance of one person for transfers. **"Ibuprofen [pain medication] PO [per mouth] 800</p>	F 514	<p>Audits will include:</p> <ul style="list-style-type: none"> -Why/reason physician is notified. -Accurate assessment as applicable. -Physician orders and/or care instructions. -Cause of pain if applicable. -Why/reason resident is sent to ER, Physician or Clinic. <p>Audits will be reported quarterly to the QA Committee by ADON until advised to discontinue by committee.</p>	

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F 514	<p>Continued From page 2</p> <p>mg [milligrams] every 8 hours for pain PRN [as needed]. There was no documentation as to what the pain was related to.</p> <p>*Sling and swathe (provide mechanical support and wrap). There was no indication what body part needed to have been wrapped and supported.</p> <p>**Resident may be transferred to Emergency room for evaluation if resident requests via personal vehicle." There was no reason documented as to why a transfer to the emergency room (ER) might have been needed." The above documentation was also found within a 1/31/15 physician's telephone order. No documentation of an assessment was found within those notes.</p> <p>Review of her 2/2/15 at 6:30 a.m. nurse's note revealed: **Resident refused transfer to the emergency room x [times] 3." **Resident was asked daily 1/31/15, 2/1/15, 2/2/15." There was no documentation as to why the resident would have needed to have been transferred to the ER.</p> <p>Review of her 2/2/15 at 10:23 a.m. provider notification note revealed a call had been placed to her physician. Those notes stated "nurse returned call and asked what restrictions remain for right arm, resident c/o [complained of] numbness/tingling to right side of mouth, which she stated has been there 2 days before discharge from hospital and when and if Dr. would like to see resident - nurse stated she would return call."</p> <p>Review of her 2/2/14 at 12:17 p.m. provider</p>	F 514		

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F 514	<p>Continued From page 3</p> <p>notification note revealed the physician's office had returned the call. The physician had requested to see resident 5 at 2:15 p.m. that day. There was no documentation regarding the resident's condition at that time.</p> <p>Review of her 2/2/15 at 6:24 p.m. nurse's note revealed: **"Per [physician]: Resident has been admitted to [hospital] for right humerus [upper arm bone] fracture." **"Will be having surgery tomorrow on 2-3-15."</p> <p>Review of resident 5's 2/2/15 hospital history and physical revealed: *The resident had seen her physician for complaints of right hand pain. *She had right shoulder pain from the spread of her cancer. *Two days prior she had been trying to "lift herself out of a chair. She heard a 'pop' in her right shoulder area." *She had been primarily using her left hand. *X-rays had shown a right upper arm bone fracture.</p> <p>Interview on 3/11/15 at 9:20 a.m. with resident care coordinator (RCC) A revealed all documentation in the provider notification note should have included the reason for notifying the physician.</p> <p>Interview on 3/11/15 at 9:30 a.m. with RCC B revealed she confirmed the 1/31/15 provider notification documentation had not included the reason the physician had not been notified. She also confirmed there was no documentation found to indicate why resident 5 had refused transfer to the ER on 1/31/15, 2/1/15, and 2/2/15.</p>	F 514		

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F 514	<p>Continued From page 4</p> <p>Review of the provider's revised July 2013 Change in a Resident's Condition or Status policy revealed: *The charge nurse would notify the resident's physician if the resident had been involved in an incident that resulted in an injury. *If there was a significant change in the resident's status. *The charge nurse would record in the resident's medical record any changes in the resident's medical condition or status.</p> <p>Review of the provider's 2/2/15 through 2/3/15 investigation documentation following a concern voiced by resident 5's daughter revealed: *The resident had been admitted on 1/29/15. *She had limited range of motion (ability to move) to her right arm. *She needed minimal to moderate assistance with her activities of daily living. *She had been evaluated by the occupational therapist and was care planned for minimal assistance with any transfers. *On 1/31/15 a certified nursing assistant (CNA) had been assisting the resident with a transfer to the toilet. *A gait belt and grab bars had been used during that transfer. *The resident stood and pivoted onto the toilet without complaint. *After she had been seated on the toilet she stated to the CNA she had felt something "snap in her right arm" when she had been standing at the grab bar. *The CNA reported the resident had not shown any signs or symptoms of pain during that transfer. *The CNA immediately reported the resident's</p>	F 514		

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F 514	<p>Continued From page 5 statement to the charge nurse.</p> <p>*The charge nurse assessed the resident at that time. She noted there had been no change in the resident's range of motion.</p> <p>*The resident had been given a pain medication shortly before that transfer.</p> <p>*She had applied Asperceme to the right upper arm per physician's order.</p> <p>*The charge nurse that evening continued to monitor the resident for pain and gave pain medication as needed.</p> <p>*The charge nurse had offered to call the physician, but the resident and her daughter stated they would discuss if that was needed.</p> <p>*The charge nurse had updated the physician at approximately 10:30 p.m. that night. Orders had been received at that time.</p> <p>*The charge nurse had offered twice during that night to send the resident to the ER. She stated the resident had refused both times.</p> <p>*Nursing staff had continued to monitor the resident for pain during the weekend (1/31/15 to 2/1/15). Pain medications had been given as needed.</p> <p>Interview on 3/11/15 at 1:15 p.m. with the assistant director of nursing confirmed the documentation in resident 5's medical record had not indicated what the above investigation had revealed. She confirmed there was no documentation within the nurses notes to reflect any assessment had been completed.</p>	F 514		