

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

ORIGINAL

PRINTED: 01/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435082	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/07/2015
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY LENNOX	STREET ADDRESS, CITY, STATE, ZIP CODE 404 EAST 6TH AVENUE LENNOX, SD 57039
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F 000	INITIAL COMMENTS Surveyor: 16385 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 1/7/15. Areas surveyed included quality of care and resident neglect. Good Samaritan Society Lennox was found not in compliance with the following requirement: F281.	F 000	<i>Addendums noted with an asterisk per 2/15/15 telephone to facility, DON. DK/SDOH/ME</i>	
F 281 SS=G	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: 33488 Based on closed record review, interview, and policy review, the provider failed to ensure: *A thorough and timely nurse assessment for one of one sampled resident (1) after an unwitnessed fall. *The physician was notified in a timely manner about an unwitnessed fall for one of one sampled resident (1). *There were established and written criteria for nurses reviewing appropriate assessment, monitoring, and intervening for residents following an accident or injury. *All licensed nurse staff whether facility hired or contracted were aware of when to and how to notify the physician. Findings include: 1. Review of the medical record for resident 1 revealed:	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Code M. Anderson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1-29-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	<p>Continued From page 1</p> <p>*She was admitted on 10/2/13 with diagnoses of high blood pressure, arthritis, depression and dementia (progressive mental confusion). *She had fallen on 11/21/14 at 2:05 a.m. *Licensed practical nurse (LPN) A had been on duty at the time of the fall and had filled out the incident report.</p> <p>Review of the 11/21/14 2:05 a.m. fall incident report filled out by LPN A revealed: *She had been found by an aide "lying on her right side on the floor kinda under her bed." *"Resident was wet at the time and cold laying on the floor." *"Vital signs taken at that time. Range of motion within normal limits for resident. No injury noted at that time. Will continue to monitor." *The resident was unable to give a description of the fall related to dementia. *She had been found disoriented and confused. *The fall was unwitnessed. *Vitals taken at the time of the fall were: -Blood pressure: 102/34 millimeters of mercury (mm/Hg)(normal range is 90/60 mm/Hg to 120/80 mm/Hg). The resident's blood pressure had been ranging from 120's to 140's normally/ 60's to 80's. Her blood pressure after her fall was abnormal and very low. -Heart rate: 62 beats per minute (bpm)(normal range is 60 to 100 bpm). -Oxygen saturation (O2 Sat) (how much oxygen is in the blood): 90% (normal range is 97% to 100%). Although normal, the resident's previous oxygen levels had been recorded as 95% to 96%. That showed a decrease at the time of the fall from the resident's previously documented O2 Sats. -Temperature: 97.3 degrees Fahrenheit (normal range 97.8 - 99.1 degrees Fahrenheit).</p>	F 281	<p>Resident 1 has expired. DON will in-service all licensed nurses on proper policy and protocol with falls on February 4, 2015. All unwitnessed falls will have neuro-checks completed. The physician will be notified by the charge nurse when there is a suspected head injury by phone, not fax. All staff will be in-serviced by the DON on 2-4-15 on the stop and watch as well as the SBAR. DON or designee will audit 2 falls 1 time a week times 4 weeks, then 2 falls monthly times 3, then as determined by the QAPI committee. All findings will be reported to the QAPI committee by the DON or designee for further recommendations. <i>*monthly DK/SDDH/MF</i></p> <p><i>*Temporary staff will be oriented to facility policies and procedures. DK/SDDH/MF</i></p>	2-5-15

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F 281	<p>Continued From page 2</p> <p>*No other vitals were documented from the fall at 2:05 a.m. until 12:01 p.m.</p> <p>*No pain assessment had been documented.</p> <p>*No neurological (neuro) checks (a brief neurologic assessment performed after an injury) had been documented following the fall.</p> <p>*No further monitoring had occurred from 2:05 a.m. until 12:01 p.m. that day.</p> <p>Further review of resident 1's medical record revealed:</p> <p>*The resident had vomited after breakfast on 11/21/14.</p> <p>*Breakfast was served between 7:30 a.m. and 9:00 a.m.</p> <p>*No assessment had been documented after she had vomited.</p> <p>*The physician was not notified of her worsening condition.</p> <p>*A fax to the physician regarding the initial fall had been attempted at 10:42 a.m.</p> <p>*The fax read: "Resident found on floor in middle of the night. No injuries noted. Vital signs and range of motion within normal limits for the resident. Will monitor."</p> <p>*That fax had been sent to the wrong clinic and was re-faxed back to the provider at 11:12 a.m. with a note stating "Not a doctor here at [name] clinic."</p> <p>*The provider then re-faxed to the correct physician's fax number at 11:42 a.m.</p> <p>*The physician responded back to the fax at 2:31 p.m., only noting the fall based on information that was provided in the fax.</p> <p>Further documentation in nurses progress notes regarding resident 1 after her fall on 11/21/14 revealed:</p> <p>*At 12:01 p.m. she:</p>	F 281		

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F 281	<p>Continued From page 3</p> <ul style="list-style-type: none"> -Was brought back to her room after lunch. -Vomited a small amount of "milky" looking fluid. -"Slouched to the right side with her head drooped". -Was alert and stated she did not feel well but had been unable to explain. *Pupils were equal and reactive but slow. That had been the first time nursing had performed any neuro checks since the resident had fallen earlier that morning at 2:05 a.m.. *She was noted to have increased weakness upon transfer. *The daughter was notified about the resident's condition. She stated she would be out later that afternoon to check on her. *The physician was not notified at that time of her increased worsening condition. *At 3:54 p.m.: -"Writer called to resident's room at 1:40 p.m. Resident is hunched over with mouth open and is drooling." -She was minimally responsive. -Her daughter was called again and told to come "right now." -It had been noted at that time the daughter had not wished her mother be transported to the emergency room. -Oxygen was applied through a nasal canula (oxygen tubing with prongs inserted slightly into nose) at five liters of oxygen per minute. -Her oxygen saturation had fallen to 70%. *The physician was still not notified of her rapidly declining condition. *It was unknown what was told to the daughter concerning the resident's then current condition or why they had told her to come "right now". *At 4:37 p.m.: -The resident was in bed resting. -She had apnea (absence of breathing) for ten to 	F 281		

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F 281	<p>Continued From page 4</p> <p>fifteen seconds between breaths at that time. *The physician was still not notified. *At 4:58: -"Writer was called to resident's room. The resident had no pulse, no respirations, and no blood pressure." *The resident had an order for do not resuscitate. *At that time the physician had been notified only of her cessation of vital signs and an order had been received from the physician noting time of death to be 4:55 p.m. and to release the body to the funeral home. *A full report was never given to the physician of the events or vital signs at any time after her fall.</p> <p>Interview and record review with the infection control nurse on 1/7/15 at 1:20 p.m. regarding resident 1 revealed: *She had been assigned to resident care that day beginning at noon. *She had not notified the physician of resident 1's decline in health when she first had observed it. *When asked why she had not intervened for the resident by calling the physician she stated "I should have. I didn't know they (nurses) hadn't" *Two other nurses had cared for the resident prior to her coming on duty shortly before noon. They were LPN A and LPN B. *LPN A was a temporary nurse from a contracted agency. She had not: -Performed a thorough assessment at the time of the fall to include pain and neuro checks. -Reported the resident's worsening blood pressure or possibility of a head injury. -Contacted the physician or the family at the time of the fall. *LPN A was unavailable for interview at the time of the survey. *LPN B began her shift at 6:00 a.m. that day.</p>	F 281		

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F 281	<p>Continued From page 5</p> <p>She:</p> <ul style="list-style-type: none"> -Had called the daughter and left a message regarding the fall at 10:46 a.m.. *It was unknown what was told to the daughter regarding the resident's unwitnessed fall. *LPN B was unavailable for interview at the time of the survey. <p>Interview and record review on 1/7/14 at 1:30 p.m. with the director of nursing (DON) regarding resident 1's fall and care revealed:</p> <ul style="list-style-type: none"> *He had been made aware of her fall but could not remember what time of day he had been notified. *Stated it was not their (the facility's) usual practice to call the physician with a report of a fall. They would usually wait until business hours the next day and fax the physician the notification of the fall unless there had been "obvious" signs of injury, such as a fracture. *Stated he had spoken with the resident that day and she had "seemed fine." *He was not aware nurses had not performed neuro checks or continued to assess and monitor the resident after she had an unwitnessed fall. *He was not aware of her abnormal vital signs that had been taken since the fall. *It was his expectation for all staff, facility hired or contracted, was fall policies and procedures were to be followed. *When asked how his staff appropriately assessed, monitored, and intervened for that resident he stated "By looking at the documentation, I can't say they did." <p>Review of the Long-Term Staffing agreement contract signed on 5/6/13 for temporary staffing between the facility and with (name) revealed: *"(Name) and the facility shall jointly develop</p>	F 281		
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F 281	<p>Continued From page 6</p> <p>orientation materials tailored to the facility such as requirements for reporting and appropriate documentation of patient care." *"The facility shall be responsible for the timely orientation of employees to the specific standards and requirements for patient care, establish criteria and standards for care, and patient emergency procedures."</p> <p>Review of the provider's June 2014 Fallen or Injured Resident policy revealed: *"If the fall was not witnessed neurological checks are required and must be documented in the Neuro-Check UDA" assessment. *"Use the SBAR (situation, background, assessment, and recommendation) Communication Form and Progress Note to collect information and notify the physician." *"Follow any orders as directed. Document the physician's comments." *For residents with suspected head injury, physicians should be notified by phone, not fax." *"Continue to monitor the resident's condition and communicate updates as needed." *Monitor the resident's condition and document effectiveness of interventions."</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 358, revealed, "A registered nurse makes a telephone report when significant events or changes in a patient's condition have occurred."</p> <p>Review of Neurological Checks For Head Injuries, LTC Clinical Pearls: Powered by HCPro's Long-Term Care Nursing Library, January 8, 2013, http://www.hcpro.com/print/LTC-287387-10704/Neurological-checks-for-head-injuries.html,</p>	F 281		

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F 281	<p>Continued From page 7 accessed on 1/12/15, revealed: **Assess the resident for changes in level of consciousness. Assess the resident immediately after the fall, then frequently throughout the shift. Assessment should continue for a minimum of 72 hours." **Observe the resident for obvious injuries to the scalp, including lacerations [cuts], bruises, confusion, memory loss, difficulty speaking, gait or balance problems, pupils of unequal size or reactions, headache, vomiting, visual disturbances, or periods of coherence [mental clarity] alternating with periods of confusion or lethargy [drowsy]. Monitoring must continue for a minimum of 72 hours (or until the resident is asymptomatic [without symptoms] for a specified period of time)." **Perform frequent neurologic assessments every: -15 minutes for two hours. -30 minutes for two hours. -60 minutes for four hours. -Eight hours for 16 hours. -Eight hours until at least 72 hours have elapsed and resident is stable." **Neurological assessments include (at a minimum) pulse, respiration, and blood pressure measurements; assessment of pupil size and reactivity; and equality of hand grip strength. Completing the Glasgow Coma Scale immediately, then once each shift following a head injury". Review of the May 2014 Mayo Clinic's Low blood pressure report, http://www.mayoclinic.org/diseases-conditions/low-blood-pressure/basics/causes/con-20032298?p=1, accessed on 1/20/15, revealed: *A sudden fall in blood pressure can be</p>	F 281		

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F 281	Continued From page 8 dangerous. *"Big plunges can be life threatening." *Severely low blood pressure from any cause can deprive the body of enough oxygen to carry out its normal functions, leading to heart and brain damage. *"The most appropriate treatment depends on the underlying cause. The doctor will address the primary health problem, rather than the low blood pressure itself."	F 281		
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