

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435123	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/01/2016
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY SELBY	STREET ADDRESS, CITY, STATE, ZIP CODE 4861 LINCOLN AVENUE SELBY, SD 57472
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F 000	INITIAL COMMENTS Surveyor: 35237 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/31/16 through 6/1/16. Areas surveyed included nursing services, pharmacy services, and accidents. Good Samaritan Society Selby was found not in compliance with the following requirements: F281 and F514.	F 000	*Addendums noted with an asterisk per 6/3/16 per telephone with facility administrator. J M / S D D O H / E L	
F 281 SS=D	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: 35237 Based on observation, interview, record review, and policy review, the provider failed to follow physician's orders for a medication order change for one of one sampled resident (4) by: *Not notifying the pharmacy of the order change. *Administering the wrong dose of medication for several weeks. *Not following their policy related to medication errors. Findings include: 1. Review of resident 4's medical record revealed: *She was admitted on 12/6/14. *Her diagnoses included depression and anxiety. *She was currently receiving the following medications for her depression and anxiety: -Lexapro (antidepressant) 10 milligrams (mg) daily	F 281	F-281 1. Resident 4 is now receiving Lexapro 10 mg daily per physician order. All residents will have correct and current medications according to physician orders.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Geggy E. Williams</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/17/16</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 with a 3/11/16 start date. -Vilazodone (antidepressant) 20 mg daily with a 9/24/15 start date. *From 10/31/15 through 3/10/16 her Lexapro dose had been 20 mg daily. It was decreased to 10 mg daily by the physician on 3/10/16.</p> <p>Interview on 6/1/16 at 1:03 p.m. with resident 4's family member revealed she: *Had been told by the pharmacy the Lexapro dose did not get changed until 5/16/16. *Thought it should have been decreased in March 2016, because she had asked the doctor to decrease it at that time. *Had not been notified by the facility that it was not changed until 5/16/16.</p> <p>Interview on 6/1/16 at 2:25 p.m. with the consultant pharmacist regarding resident 4's Lexapro orders revealed: *According to the physician's orders the dose had changed from 20 mg to 10 mg on 3/10/16. *She should have been getting the 10 mg dose since 3/11/16.</p> <p>Observation, record review, and interview on 6/1/16 at 4:00 p.m. with interim director of nursing A and registered nurse (RN) B regarding resident 4's Lexapro revealed: *The current blister pack of the Lexapro in the medication cart was a 10 mg dose. -On the pharmacy label it listed 5/16/16 as the physician's order date. *They confirmed the physician's order date should have been 3/10/16 and not 5/16/16. *RN B stated 5/16/16 was the date they had noted they did not have the correct dose of Lexapro for her. At that time they had updated the pharmacy to send the 10 mg dose.</p>	F 281	<p>2. All nurses and certified medication assistants (CMAs) will be educated on the process of medication administration with an emphasis to the nurses for reviewing transcription of physician orders. As new orders are received, the procedure for order transcription will be followed, including notification to family of new and/or changes to medications. All will also be educated on the process if an error is seen. If an order is not transcribed correctly or a medication is not given as ordered an Incident Report will be completed with family and physician notification documented. The Staff Development Coordinator and the PharMerica Nurse Consultant provided this education on June 16, 2016.</p>		

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F 281	<p>Continued From page 2</p> <p>*Review of the pharmacy invoices with the interim director of nursing confirmed the pharmacy had continued to send the 20 mg dose of Lexapro on 3/17/16 and 4/11/16.</p> <p>-That indicated they had not been aware of the order change to 10 mg.</p> <p>*They confirmed:</p> <p>-They had not been following the physician's order.</p> <p>-The 3/10/16 physician's order for the Lexapro dose change had not been sent to the pharmacy.</p> <p>-The pharmacy would not have known about the order change without the facility staff notifying them.</p> <p>-Staff continued to give the 20 mg dose from 3/11/16 through 5/16/16 and had not been following the order.</p> <p>-Giving the wrong dose from 3/11/16 through 5/16/16 was a medication error.</p> <p>-They had not completed a medication error when they found the problem on 5/16/16, and they should have.</p> <p>-The physician and resident's family had not been notified of the medication error, and they should have been according to their policy.</p> <p>Review of the provider's revised May 2016 Medication Administration including Scheduling and Medication Aides policy revealed:</p> <p>*"An incident report will be completed for all medication errors."</p> <p>*The procedure included to "Follow the 'Six Rights': right medication, right dose, right resident, right route, right time and right documentation."</p> <p>Further interview on 6/1/16 at 4:30 p.m. with the consultant pharmacist confirmed:</p> <p>*The pharmacy had not been notified of resident</p>	F 281	<p>3. The DNS will audit new physician orders to assure complete and correct transcription and that families were notified of the new or changed order. The audit will include medication error incident reports including follow-up with the staff person who had the error. The DNS or designee will conduct medication pass audits to assure administration of medication is correct. [redacted] audit will be done weekly for 4 weeks and then monthly for 3 months. The DNS will report audit findings to the QAPI committee monthly and the committee will determine if further auditing is needed.</p> <p>4. Date certain: July 21, 2016</p> <p>*all JM/SDDOHEL</p> <p>*These JM/SDDOHEL</p>	7/21/16	

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F 281	<p>Continued From page 3</p> <p>4's Lexapro order change on 3/10/16.</p> <p>*The facility had been administering the wrong dose from 3/11/16 through 5/16/16.</p> <p>-That would have been a medication error.</p> <p>Review of the provider's revised May 2016 Medication Errors policy revealed:</p> <p>***When a medication error occurs, it will be reported to the attending physician promptly (and responsible family members for errors #1 through #8 and #9 only if justified) and documented in the Risk Management module of PCC [Point Click Care, electronic medical record].</p> <p>*Medication errors consist of the following:</p> <ul style="list-style-type: none"> -Wrong medication. -Wrong dose/amount. -Wrong form of medication. -Wrong route. -Wrong time. -Wrong resident given the medication/authorized medication (drug administered without a physician's order). -Omission of medication ordered (if omission is justified, reason and justification not documented). -Use of outdated medication. -Failure to document a medication." <p>*The definition of a medication error was "The observed preparation or administration of medications or biologicals which is not in accordance with the prescriber's orders, manufacturer's specifications or accepted professional standards and principles."</p>	F 281		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each</p>	F 514		

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F 514	<p>Continued From page 4</p> <p>resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, interview, record review, and policy review, the provider failed to ensure documentation was completed for one of one sampled resident (4) related to her frequent falls and interventions to prevent future falls. Findings include:</p> <p>1. Review of resident 4's medical record revealed: *She was admitted on 12/6/14. *Her Brief Interview for Mental Status score was 15 which indicated she had no memory impairment. *Her diagnoses included progressive supranuclear palsy, depression, anxiety, and urinary frequency. *She had a history of frequent falls and had several falls in April and May 2016. Those were on the following dates: -4/2/16. -4/26/16. -4/28/16. -5/2/16, twice.</p>	F 514	<p>F-514</p> <p>1. Resident 4's incidents of being found on the floor since April 2015 have been analyzed. The frequency of the incidents gradually increased to recurring monthly incidents beginning in February 2016, with all of those incidents related to the impulsivity and self-transferring. Interventions that <u>are</u> documented</p>		

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F 514	<p>Continued From page 5</p> <p>-5/12/16. -5/14/16. -5/21/16. -5/22/16. -6/1/16.</p> <p>*The 5/14/16 fall was in the bathroom when she had been left unattended and had unhooked herself from the stand-up mechanical lift. *The other falls were from her lift chair in her room.</p> <p>Review of resident 4's printed 6/1/16 care plan related to falls revealed she had a history of multiple falls related to unsteady gait and impulsiveness. Interventions had included: *Remind her not to bend over to pick up dropped items. *Ensure she was wearing appropriate footwear. *Monitor for significant changes in gait, mobility, positioning device, standing/sitting balance, and lower extremity joint function. *Tabs alarm in wheelchair/automatic lifting recliner used to alert staff to her movement. *Encourage her to not remove alarms and to call for assistance with transfers. *Ensure she was sitting back in wheelchair to avoid slipping out. *Dysom (non-slip rubber mat) in wheelchair. *Restorative nursing program to maintain strength and balance. *Those interventions had been initiated in 2014 and 2015 with revisions to a few of them. *There was no mention of: -Other interventions they had tried that might or might not have worked for her. -That most of her falls had been from the automatic lifting recliner in her room.</p> <p>Interview on 6/1/16 at 11:15 a.m. with interim</p>	F 514	<p>and in place since February 2016 include having the call light in reach, reminding resident to use call light, responding to her call light as quickly as possible, offering toileting every two hours, physical therapy for gait and balance training, restorative nursing program including walking 6-7 days per week, two staff assist with a sit to stand lift, use of a personal alarm, encouraging the resident to attend music-related activities (which have mostly been refused), providing one-to-one social visits, physical therapy for posture training and proper positioning, rearranging her room furniture per resident preferences, trial of different reclining/lift chairs, mental health services to develop coping strategies, use of dycem non-slip mats on the chair cushion, reminding resident to stay seated back in the chair, ensuring non-slip socks were on, use of a pressure pad alarm in the chair, and attempting to encourage use of bed at night for sleep rather than in the chair. Additional interventions approved by the family that will be trialed include replacing the lift</p>	
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F 514	<p>Continued From page 6</p> <p>director of nursing (DON) A regarding resident 4's falls revealed:</p> <ul style="list-style-type: none"> *She felt her falls were related to the resident being impatient and not wanting to wait for staff to help or possibly attention-seeking behavior. *She frequently slid herself down in the automatic lifting recliner and attempted to self-transfer causing her to fall. *For moving around she required a wheelchair and a stand-up mechanical lift with two staff members assistance. *Most of her falls were from sliding out of the automatic lifting recliner. *They had tried several things to prevent future falls and some of them might not have been documented. Those interventions were: <ul style="list-style-type: none"> -Different automatic lifting recliner chairs in the past to see if that would help prevent future falls, and that had not seemed to work. -Tabs alarms, the resident was able to remove on her own at times. -Physical therapy for positioning and strengthening. -Dysom in the seat of her recliner to help prevent her sliding down. -Encouraging her to use the call light, but sometimes she did not use it. -Taking her to the bathroom at least every two hours and if the resident requested in-between as well. -Encouraging activity involvement, but the resident refused most. *They should have documented all the interventions they had tried to prevent future falls. <p>Interview on 6/1/16 at 1:03 p.m. with resident 4's family member regarding her falls revealed:</p> <ul style="list-style-type: none"> *She had multiple falls and most were from her lift chair in her room. 	F 514	<p>chair with a chair that does not lift and use of an alarming seatbelt in the recliner. All residents who experience an incident are investigated and reviewed with new interventions added to the care plan. Residents and/or responsible parties will be involved in the planning of interventions for prevention of future incidents.</p> <p>2. The SDC[^] and/or designee will provide education to all staff before July 21, 2016, regarding a fall management program including staff responsibility with fall prevention, fall investigation, and identifying new interventions to prevent future falls. Falls huddles will be reviewed, as a component of fall investigations, with the expectation that staff in the area of a fall will come together and discuss/review the factors involved in the fall to help identify new interventions that may be effective.</p> <p><i>*staff development coordinator JMSDDO/H/EL</i></p> <p><i>*and fall documentation. JMSDDO/H/EL</i></p>	

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F 514	<p>Continued From page 7</p> <p>*They had tried other automatic lifting recliner chairs, physical therapy to strengthen and work on positioning, re-arranging the furniture in her room, Tabs alarms, and other interventions to try to decrease her falls.</p> <p>*The resident did not like to attend most activities but enjoyed music and certain TV shows.</p> <p>*In her room she had a TV but did not have a radio or music player.</p> <p>*She was worried if she kept falling she was going to get hurt one of these times.</p> <p>*They were unsure what else could be done to prevent more falls.</p> <p>Interview on 6/1/16 2:25 p.m. with the consultant pharmacist regarding resident 4's falls revealed:</p> <p>*She was doing the resident's monthly review and noted an increase in her falls the last few months.</p> <p>*That day she would be sending the physician a recommendation to review one of the resident's medications that might have had an effect on her falls.</p> <p>Interview on 6/1/16 with the social worker, administrator, and physical therapist C regarding resident 4's frequent falls revealed:</p> <p>*They had tried multiple interventions to prevent her from future falls. Some of those interventions included:</p> <ul style="list-style-type: none"> -Different automatic lifting recliner chairs. -Tabs alarms. -Physical therapy for strengthening and proper positioning in the lift chair. -Dysom in her lift chair to help prevent sliding. -Using two staffs assistance for transfers with the stand-up lift for safety. -Keeping her on a restorative nursing program to maintain her strength. -Re-arranging her room a few times. 	F 514	<p>3. The DNS will audit the fall incidents to determine if a huddle took place, was adequately documented, how interventions were decided, if the interventions were added to the care plan, and how new interventions were communicated to staff, the resident, and the family members. This audit will be done weekly for 4 weeks and then monthly for 3 months. Audit findings will be reported to the QAPI committee monthly with the committee to determine if further auditing is needed.</p> <p>4. Date certain July 21, 2016</p>	7/21/16	

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F 514	<p>Continued From page 8</p> <ul style="list-style-type: none"> -Having the resident see counseling services routinely to talk about things that bothered her. -Updating the physician on her falls. -Trying to get the resident to lay in her bed more versus using the lift chair. -Tracked and trended her falls to attempt to identify a pattern. -Discussed the falls every morning at daily stand-up meeting and at quality assurance meetings. *They confirmed they might not have documented all the things they had implemented or tried to prevent her from falling, and they should have. *They agreed: <ul style="list-style-type: none"> -She had an increase in her falls the last two months, and there was a lack of documentation of interventions implemented to prevent future falls. -The progress notes and investigation reports for her falls did not always specify an action to prevent future falls, and they should have. <p>Review of the provider's revised March 2015 Nursing Documentation Guidelines/Timelines policy revealed:</p> <p>***Within PCC [Point Click Care, electronic medical record], nursing documentation will occur on User Defined Assessments (UDAs) and Progress Notes (PNs). Some forms will be retained as paper and scanned into the electronic medical record."</p> <p>***Incidental Charting- day-to-day type documentation of specific occurrences will be completed by the licensed nurse in the appropriate progress note determined by the content of the note. For the purpose of generating reports, it is important to document information in the most appropriate progress note. In the case that documentation could fit into more than one</p>	F 514			

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F 514	Continued From page 9 progress note type, the nurse should determine the key content and document in the progress note type that is most appropriate." *Progress notes included but were not limited to: -Advance care planning. -Care conference note. -Care plan changes or reviews. -Communication with resident/family/physician. -Health status. -Mood/Behavior. -Teaching - resident/family. *"...Documentation should reflect nursing concerns, risk factors, potential complications and direct treatment/interventions by licensed nursing staff for condition(s) identified..."	F 514			