

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

ORIGINAL

PRINTED: 05/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
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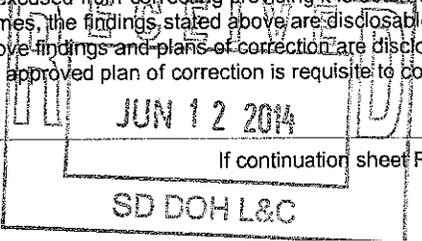
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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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F 000	<p><i>Addendums noted with an asterisk per 6/11/14 telephone to facility administrator. JAI/SDOHH/DF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/12/14 through 5/14/14. Golden LivingCenter - Black Hills was found not in compliance with the following requirements: F323, F329, and F371.</p>	F 000	<p>This facility objects to the allegations of noncompliance in this Statement of Deficiencies and disagrees with both the findings of non-compliance and the level of deficiency cited. Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p> <p>Accordingly, the facility has prepared and submitted this Plan of Correction because of the requirements under State and Federal law that mandate submission of a Plan of Correction as a condition to participate in the Title 18 and Title 19 programs. The submission of the Plan of Correction should in no way be considered or construed as agreement with the allegations of the non-compliance or admission by the facility. This plan of correction shall constitute this facility's credible allegation of compliance.</p>	
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on interview, record review, and policy review, the provider failed to ensure one of one resident (1) that smoked had been accurately assessed for safety. Findings include:</p> <p>1. Review of resident 1's 2/5/14 safe smoking evaluation revealed it had been documented the resident did not smoke.</p> <p>Review of resident 1's 4/1/14 progress notes revealed: *He had a sore on his right upper thigh. *The area was circular, and it had appeared to be a cigarette burn. *His wife took him out to smoke and assisted him</p>	F 323		-X 07/02/14 JAI/SDOHH/DF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Matthew Pan</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>06/11/14</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 323	Continued From page 1 when he smoked. Review of resident 1's careplan revealed no mention of the resident smoking. Interview on 5/14/14 at 1:30 p.m. with the director of nursing regarding resident 1 revealed: *The resident smoked when his wife came to visit. *He was not considered a smoker, because he only smoked when his wife came to visit. *They had not assessed if the resident's wife was safe to take him out to smoke. *She thought some days the wife was safe to take him out and some days she was not safe to assist him. *The facility had bought a smoking apron, but she could not remember when. *They had let the resident's wife take the smoking apron home with her. *The resident did not have the smoking apron on when he had burned himself. *There had been nothing on the careplan regarding the resident smoking. Review of the provider's undated Smoking policy revealed: *Every resident who desired to smoke was permitted to do so if the facility's interdisciplinary team had determined the practice would be safe for the resident. **"The accomodation of the desires of residents with a desire to smoke but who has not been assessed as unable to safely smoke independently, will be careplanned."	F 323	F323 1. Resident #1 has been assessed for smoking safety. 2. All residents who smoke may have the potential to be affected. However, there are currently no other smokers. To be certain that all smokers have been accurately identified, a review of each resident was done. No other smokers were identified. 3. To ensure no residents become injured by smoking, the following systemic changes have been put in place: <ul style="list-style-type: none">• Policies and procedures related to smoking have been reviewed by the Executive Director (ED), Director, Nursing Services (DNS) and Interdisciplinary Team (IDT). The policies will now include direction for accurate assessment, including when a resident smokes with a family member and when away from the facility; identification of safety risks and interventions to address these; care planning and documentation to address specifics such as who, what, where, and how; and reassessment for risks and ongoing safety.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	<p>Continued From page 2</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure: *Appropriate documentation was maintained for a specific clinical condition to warrant the use of an anti-psychotic (used to treat mental disorders) medication for one of six sampled residents (10) on anti-psychotic medications. *Appropriate documentation was maintained for the rationale for ongoing use of a prn (as needed) anti-psychotic for two of six sampled residents</p>	F 329	<p>F323 (Cont)</p> <ul style="list-style-type: none"> Staff education was provided to address all aspects of smoking safety during directed in service training on 06/09/2014. A resident council meeting was also held to reiterate the facility's policy on smoking. <p>4. To ensure sustained compliance, the DNS, Social Worker, or their designee will audit all new residents for their smoking status. Residents having the desire to smoke will receive an assessment and care plan. The accuracy and thoroughness of these assessments and care plans will also be audited. In addition, all residents who are smokers will be reviewed quarterly, and with changes of condition, for changes to their risk status and this will also be audited to ensure it is complete and accurate. These audits will continue to take place for a minimum of 6 weeks at which time they will be reported to the Quality Assurance Process Improvement (QAPI) committee by the DNS. The QAPI committee will make a determination as to the need for further auditing based on results.</p>	

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F 329	<p>Continued From page 3</p> <p>(10 and 12) on anti-psychotic medications. *A gradual dose reduction had been recommended by the pharmacist to the physician for one of six sampled residents (12) on anti-psychotic medications. Findings include:</p> <p>1. Review of resident 10's 4/8/14 physician's orders revealed an order for Haldol (anti-psychotic) 0.5 to 1.0 milligrams (mg) prn for agitation. That order had a start date of 10/3/13.</p> <p>Review of a 10/3/13 faxed request sent to the physician revealed resident 10 had frequent, un-redirectable episodes of confusion and anxiety. The resident had been yelling out for help, and she was unable to state the problem. She denied pain. Staff had requested an order for Ativan (a medication to help lower anxiety) to have been given prn. The physician had replied she preferred to use Haldol 0.5 mg to 1 mg every six hours prn for agitation.</p> <p>Review of a 2/19/14 pharmacist's note to the attending physician revealed a request to consider a gradual reduction of the medication Haldol to ensure the resident was receiving the lowest possible effective dose. The physician had replied by checking the statement "Patient has had good response to treatment and requires this does for condition stability. Dose reduction is contraindicated because benefits outweigh risks for this patient and a reduction is likely to impair the resident's function and/or cause psychiatric instability. (Please elaborate with patient specific information)." The physician had signed that request on 3/3/14. No specific information related to resident 10's need to be on anti-psychotic medication was included in that response.</p>	F 329	<p>F329</p> <p>1. Residents #10's physician has been updated regarding the requirement for dose reductions or for specific rationale for not providing a dose reduction. Resident #12's physician was informed of the duplication of medication and the requirement for dose reductions or for specific rationale for not providing a dose reduction. Dose reduction requirements were also reviewed with the pharmacist on 05/31/2014.</p> <p>2. All residents using psychoactive medication have the potential to be affected. Therefore, all residents with psychoactive meds have been reviewed and dose reductions done accordingly. Residents have also been reviewed for duplication of therapy and therapy has been changed or physician rationale has been provided.</p> <p>3. A root cause analysis was done and based on the results, the following systemic changes have taken place to ensure that residents on psychoactive medications receive appropriate assessment, monitoring, care planning, interventions, and follow up:</p> <ul style="list-style-type: none"> • Policies and procedures related to use of all psychoactive medication have been reviewed by the DNS, pharmacist and Medical Director and revised as necessary. 	X 07/03/14 JAS/DCH/NE

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F 329	<p>Continued From page 4</p> <p>Review of resident 10's 4/8/14 physician's orders sheet revealed she had diagnoses of anemia, heart failure, high blood pressure, acid reflux, thyroid disorder, restless leg syndrome, osteoporosis, vitamin D deficiency, other vitamin deficiencies, constipation, and insomnia. No psychiatric diagnosis was listed for that resident.</p> <p>Review of the provider's quarterly clinical health status questionnaire for resident 10 revealed: *9/11/13: No behaviors noted. *12/11/13: Resisted care. The use of anti-psychotics had not been checked. *3/12/14: Had been verbally abusive. Socially inappropriate and disruptive behaviors had been displayed. She had resisted care at times. She was noted to have been on anti-depressant and anti-anxiety medications. The use of anti-psychotics had not been checked.</p> <p>Review of the resident 10's medication administration records revealed she had received Haldol for agitation the following number of times: *October 2013: 0.5 mg four times and 1.0 mg ten times. *November 2013: 0.5 mg four times and 1.0 mg eleven times. *December 2013: 0.5 mg eight times and 1.0 mg three times. *January 2014: 0.5 mg four times and 1.0 mg one time. *February 2014: 0.5 mg eight times and 1.0 mg zero times. *March 2014: 0.5 mg eight times and 1.0 mg four times. *April 2014: 0.5 mg two times and 1.0 mg seven times. *May 2014: 0.5 mg one time.</p>	F 329	<p>F329 (Cont)</p> <ul style="list-style-type: none"> • Documentation and dose reduction requirements were reviewed. • Social Service and nursing staff were provided education on these requirements during directed in service training on 06/09/2014. • A system was also put into place to ensure that pharmacy requests for gradual dose reductions are addressed by the physician. The DNS will track all pharmacy recommendations and follow up as needed. • A change was also made to the Behavioral Meeting in which dose reductions will be reviewed along with appropriate behavior monitoring. • A system was also put into place to ensure that the pharmacist has updated information as to psychoactive medication orders so that dose reduction requests can be made as required. 	
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F 329	<p>Continued From page 5</p> <p>Review of resident 10's 11/8/13, 1/7/14, and 3/25/14 physician's progress notes revealed there was no documentation of clinical reasoning to justify the use of a prn anti-psychotic.</p> <p>Interview on 5/14/14 at 12:50 p.m. with the director of nursing (DON) revealed resident 10 had started having behaviors in October of rejecting care and being physically and verbally abusive to staff. She stated the nursing staff had requested Ativan (an anti-anxiety medication), but the physician had ordered Haldol, an anti-psychotic. She confirmed the nursing staff had not questioned the order for a prn anti-psychotic.</p> <p>Review of the provider's revised 2013 Behavior Management Guideline policy revealed: *Anti-psychotic drug use was to have been evaluated by the prescriber and the behavior management team within seven days after the drug had been started. *Gradual dose reduction or drug discontinuation was to have been ordered unless a clinical reason had been documented in the medical record. *The use of any medication to control behaviors should always have been considered a last resort to assist with managing a resident's behavior. *Anti-psychotic medications should not have been used unless there was documentation in the medical record the resident had a specific condition as dictated and documented by the physician. *Prior to the start of anti-psychotic medication a physician's order would have been obtained to include the diagnosis and targeted behaviors that warranted the use of that medication.</p>	F 329	<p>F329 (Cont)</p> <p>4. To ensure sustained compliance, psychoactive medications will be audited for timely dose reductions. A specific rationale will be required by the physician if a dose reduction is not attempted. Accurate documentation of behaviors and response to care plan interventions will also be audited. These audits will take place on 5 psychoactive medications per week for a minimum of 6 weeks at which time the results will be presented to the QAPI committee by the DNS for direction on continued auditing.</p>	

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F 329	Continued From page 6 Surveyor: 32572 2. Review of resident 12's medical record revealed she had been on the following medications: *Depakene (seizure medication) syrup 1000 mg /20 cc (cubic centimeter) PO (by mouth) BID (twice a day). *Depakene syrup 22.5 ml (milliliter) PO daily in the evening. *Kepra (seizure medication) 1000 mg PO BID. *Topamax (seizure medication) 250 mg PO BID. *Risperdal (antipsychotic medication used for mental illness) 3 mg PO BID. *Geodon 20 mg (antipsychotic) po every 8-12 hours PRN *Lexapro (antidepressant) 20 mg PO daily. *Ativan (antianxiety) 0.5 mg PO BID. *Ativan 0.5 mg PO every 4 hours PRN (as needed). *Multivitamin 1 tablet PO daily *Synthroid (thyroid hormone) 75 mcg (microgram) at bedtime. *Furosemide (fluid pill) 20 mg PO daily. *Tylenol (pain reliever) 650 mg PO TID (three times a day). *Acetaminophen 650 mg PO every 4 hours PRN *Atorvastatin calcium (high cholesterol medication) 10 mg PO daily. Her diagnoses were anoxia brain damage (decreased oxygen to the brain), hemiplegia (weakness in arms and legs), pain, depression, psychosis (mental illness), seizures, and hypotension (low blood pressure). From May 1 through May 13 she had received the following PRN medications: *Ativan 0.5 mg PO PRN on the 10th and 13th.	F 329		

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F 329	Continued From page 7 -Documentation rationale for use had been restless and yelling out. *Geodon 20 mg PO 8-12 hours PRN had been given on the 6th, 7th, 8th, 10th, and the 11th. -Documentation rationale for use had been agitated and yelling out. Resident 12's Geodon had been ordered by the physician on 6/5/13. The first note indicating the consulting pharmacist had been aware of the medication had been on 11/23/13. The consulting pharmacist had reviewed the chart every month. There had been no documented recommendations to the physician for needing rationale to remain on that medication. Resident 12 also had a 7/27/09 PRN order for Ativan. Within the last year the consulting pharmacist had not made a documented recommendation to the physician to decrease that dose. Interview on 5/14/14 at 3:04 p.m. with the DON confirmed resident 12 had duplication of antipsychotic medications.	F 329	F371 1. No residents were affected by these practices. 2. All residents have the potential to be affected by these practices 3. The entire kitchen was cleaned ensuring that all food debris, spills, and soiling has been addressed. Rust and unnecessary items have been removed. Utensils, dishes, and cookware was washed. A new cleaning schedule was established for ensuring that cleaning is completed as required. 4. To ensure sustained compliance with kitchen sanitation, The ED or his designee will audit the kitchen 2 days a week for a minimum of 6 weeks. Any concerns will be addressed immediately. Results of these audits will be provided to the QAPI committee by the ED for direction on the need for continued auditing.	05/03/14 JA/SDDW/MF
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure the kitchen had been maintained in a sanitary manner. Findings include:</p> <p>1. Random observations in the kitchen on 5/12/14 through 5/14/14 revealed: *The floor in the dishwashing area had a spilled food substance on the floor with a towel on top of it (photo 1). *The kitchen floor was visibly soiled with food debris scattered all around (photo 2). *The stove top had been visibly soiled with food debris from previous meal services (photo 3). *The oven front had been visibly soiled with spilled food on the front of it, and food debris on the handle (photo 4). *The refrigerators' and freezers' outside and inside surfaces had been visibly soiled with spilled liquid and food debris (photo 5). *A rack that held resident food items and clean dishes had visible dust on it in numerous areas (photo 6). *A shelf underneath the steamer was visibly soiled with a white substance, a rusted area, and it had tools and two compact disks on it (photo 7). *The shelf below the steam table that contained clean pans was visibly soiled with food debris.</p> <p>Review of the April and May 2014 daily cleaning schedule revealed there had been several shifts when the cleaning had not been documented as completed.</p>	F 371		

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F 371	Continued From page 9 Interview on 5/14/14 at 2:00 p.m. with the dietary manager revealed: *She would have expected spills to be cleaned up at least by the end of the shift. *The stove top should have been cleaned daily. *The metal rack was not on the current cleaning schedule. *She would have expected the daily cleaning to have been done and documented every shift. Review of the provider's undated Cleaning Schedules policy revealed the dietary services manager should have developed, posted, and enforced the cleaning schedules and monitored the completion of the assigned cleaning tasks to ensure a sanitary environment.	F 371			

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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/14/14. Golden LivingCenter - Black Hills was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

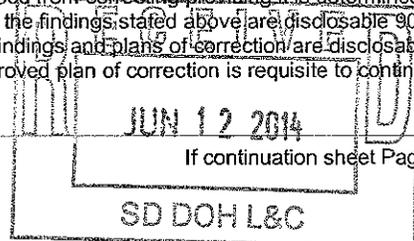
(X6) DATE

Matthew Pa...

Executive Director

6/11/14

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.



SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10665	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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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) COMPLETE DATE
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S 000	Initial Comments Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/13/14 through 5/14/14. Golden LivingCenter - Black Hills was found not in compliance with the following requirements: S398.	S 000	S398 1. No residents were affected by this practice. 2. All residents have the potential to be affected by this practice. 3. Western States Fire Protection is conducting facility visit on 06/12/2014 to provide bid to correct cited deficiency. As a result, facility is requesting a 180 day extension to accomplish this project. 4. ED is to validate that the work has been completed and notify state agency. 5. Ongoing monitoring will be reported to QA until completion of the work. <i>SODDH/LF</i>	
S 398	44:04:13:35 Vacuum Breakers Antisiphon devices or backflow preventers must be installed on hose bibs and on all fixtures to which hoses or tubing can be attached such as laboratory and janitors' sinks, bedpan flushing attachments, handheld showers...Antisiphon devices or backflow preventers must be installed on all plumbing and equipment where any possibility exists for contamination of the potable water supply. This Rule is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to have a backflow preventer on all plumbing and equipment where the possibility exists for the contamination of the potable water supply on one randomly observed location (fire sprinkler riser). Findings include: 1. Observation at 11:00 a.m. on 5/14/14 revealed a sprinkler riser supplying water to the buildings automatic fire sprinkler system in the boiler room. That riser should have been provided with a means to prevent backflow from the sprinkler system into the potable water supply. Interview with the maintenance supervisor at the time of the observation confirmed that condition. He	S 398		7/3/14 <i>SODDH/LF</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>EXECUTIVE DIRECTOR</i>	(X6) DATE <i>6/11/14</i>
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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10665	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701		
(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) COMPLETE DATE	
S 398	Continued From Page 1 stated the missing backflow preventer had been discussed prior to this survey and was an anticipated project.	S 398			