

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

ORIGINAL

PRINTED: 02/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/12/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MEADOWBROOK</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 ARROWHEAD DR RAPID CITY, SD 57702</b>
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F 000	<p><i>Addendums noted with an asterisk per 2/10/14 telephone to facility administrator. KW/SDDH/ME</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 26632 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/10/14 through 2/12/14. Golden LivingCenter - Meadowbrook was found not in compliance with the following requirements: F279, F280, F281, F371, and F441.</p>	F 000	<p>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 fault by the facility, the Executive Director 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 agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</p>	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on interview and record review, the</p>	F 279	<p><b>F279</b></p> <p>1. All residents are at risk. Resident 4 has a complete comprehensive care plan.</p> <p>2. The Director of Nursing Services (DNS) or designee will in-service the care plan team regarding completing a comprehensive care plan in a timely manner by March 12, 2014.</p>	4/3/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> Executive Director	TITLE	(X6) DATE <b>3/10/14</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 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.

MAR 12 2014

If continuation sheet Page 1 of 17

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F 279	Continued From page 1 provider failed to ensure one of six recently admitted resident's (4) comprehensive care plan had been completed within the allotted time frame according to the resident assessment instrument (RAI) manual. Findings include:  1. Review of resident 4's medical record revealed she had been admitted on 12/24/13.  Review of resident 4's 12/24/13 immediate care plan revealed the following focus areas: pain, nutritional risk, urinary incontinence risk, and pressure ulcer risk. A complete comprehensive care plan had not been developed for the resident.  Interview on 2/12/14 at 2:45 p.m. with the Minimum Data Set coordinator revealed: *She had not completed the nursing part of the comprehensive care plan. She stated she had missed that portion. *She agreed care plans should have been accurate and updated to reflect the current status of the resident.	F 279	3. The DNS or designee will audit all new admits to ensure that they have a comprehensive care plan within the allotted time frame weekly for four weeks and then monthly thereafter. Results of audits will be presented by DNS or designee for discussion at monthly Quality Assurance and Assessment (QA&A) meeting for further review and recommendations and/or continuation/discontinuation of audit.  4. April 3, 2014	4/3/14	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280			

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F 280	<p>Continued From page 2</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to ensure 4 of 13 residents' (6, 7, 9, and 11) care plans reflected the resident's current status. Findings include:</p> <p>1. Review of resident 7's medical record revealed a 12/26/13 physician's order for Remeron for dementia (diminished thought process) with behavioral disturbances and failure to thrive (weight loss).</p> <p>Review of resident 7's 6/19/13 care plan had a problem area of dysphagia (difficulty eating). The goals were to have her weight not exceed 120 pounds, and to improve her intake to 75% (percent) per meal to help sustain her current weight. The interventions listed did not include the medication Remeron to assist as an appetite stimulant.</p> <p>2. Review of resident 9's medical record revealed his intake at meals had been greater than 75%, and his weight had increased to 141 pounds. He had a steady weight gain and had reached 137.6 pounds by 1/1/14.</p>	F 280	<p><b>F280</b></p> <p>1. All residents are at risk. Residents 6,7,9, and 11 care plans have been updated so that they are accurate.</p> <p>2. DNS or designee will in-service the care plan team and nursing staff regarding updating care plans so that they reflect the resident's current status by March 12, 2014.</p> <p>3. The DNS or designee will audit 10 care plans to ensure they accurately reflect the resident's current status weekly for four weeks and then monthly thereafter. Results of audits will be presented by DNS or designee for discussion at the monthly QA&amp;A for further review and recommendations and/or continuation/discontinuation of audits</p> <p>4. April 3, 2014</p>	2/3/14

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F 280	<p>Continued From page 3</p> <p>Review of resident 9's 12/19/13 care plan had an area that stated he left 25% or more of his food uneaten and had a low BMI (measurement of body fat). The goals were to have his weight remain stable and stay around 129 pounds with a gradual weight gain to 137 pounds.</p> <p>3. Interview on 2/12/14 at 10:00 a.m. with the director of nursing (DON) confirmed she would have expected the care plan to reflect the resident's current status.</p> <p>Interview on 2/12/14 at 10:15 a.m. with the certified dietary manager confirmed the Remeron should have been included on resident 6's care plan to reflect his current status. She also confirmed resident 9's problems and goals should have been updated.</p> <p>Surveyor: 32333</p> <p>4. Review of resident 11's revised 1/8/14 care plan revealed: *A focus area for a risk of smoking related injury related to smoking independently and having limited mobility. *A goal she would have no smoking related injuries with current interventions.</p> <p>Interview on 2/12/14 at 1:15 p.m. with unlicensed assistive personnel C regarding resident 11 revealed she had quit smoking a long time ago.</p> <p>Review of resident 11's medical record revealed she had a cardiac pacemaker. Her current care plan had not addressed her pacemaker.</p> <p>Interview on 2/12/14 at 2:45 p.m. with the Minimum Data Set coordinator revealed she</p>	F 280		

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F 280	<p>Continued From page 4</p> <p>agreed care plans should have been accurate and updated to reflect the current status of the resident.</p> <p>Surveyor: 23059</p> <p>5. Review of resident 6's December 2013 bowel record revealed there were two occasions where she went more than three days without a bowel movement (BM). No BM had been recorded between 12/5/13 and 12/13/13 nor between 12/23/13 and 12/28/13.</p> <p>Review of the provider's undated Guidelines for Bowel Care revealed:</p> <ul style="list-style-type: none"> <li>*The desired outcome of the treatment strategy was a comfortable BM at least every several days. That was to have occurred with the minimum use of laxatives as well as satisfaction of the resident and/or family.</li> <li>*Normal BMs varied from person to person.</li> <li>*Resident preferences were to have been considered when determining bowel regimen.</li> <li>*Three days without a BM required "intervention or treatment of non-pharmacological or pharmacological agents."</li> <li>*Staff were to have watched for anything unusual and any problems related to elimination. Any concerns were to have been reported or documented immediately.</li> </ul> <p>Review of resident 6's December 2013 nurses' notes revealed no mention of any interventions for no BM within the above time frames.</p> <p>Review of resident 6's revised 2/14/14 care plan revealed there was no mention of BM variances, preferences, or interventions.</p> <p>Interview on 2/12/14 at 1:20 p.m. with the DON</p>	F 280		

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F 280	Continued From page 5 revealed she did not have any concerns regarding resident 6's bowel management. She stated the resident had been taking bowel medications daily and if a problem had occurred that would have been discussed at their morning stand-up meeting. She stated she was confident the nurses would have addressed the lack of a BM for resident 6 if they felt it had been a problem. She confirmed the care plan had not addressed any bowel variances or interventions for the resident.  Surveyor 32572 6. Review of the provider's undated Care Plan policy revealed "Care plans must be realistic, specific and achievable goals that are individualized for each resident. The care plan must be updated as there are changes in the resident's condition....new MD (physician) orders must be added to the care plan as the event occurs."	F 280	<b>F281</b>  1. All residents are at risk. No immediate action could be taken for residents 3,6,11,12,13. All UAPs have a copy of their high school diploma, GED or the equivalent in their personnel file. <i>* including D, E &amp; F. KW/SDDAH/JMF</i> 2. DNS or designee will educate all staff that pass medications regarding Medication Administration time by March 12, 2014. ED or Designee will educate DNS and Director of Clinical Education regarding having high school diploma, GED or equivalent in the personnel file by March 12, 2014.  3. DNS or designee will audit 10 resident's EMARs for timeliness of medication administration per week for four weeks and then monthly thereafter.* ED or designee will audit all UAP's personnel files for high school diploma, GED or equivalent monthly. DNS and ED will present results of audits for discussion at monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits.  4. April 3, 2014 <i>Residents 3,6,11,12 and 13's EMARs will be monitored monthly x 2 months. KW/SDDAH/JMF</i>	4/3/14
F 281 SS=E	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: 23059 A. Based on interview, record review, and policy review, the provider failed to ensure professional standards were maintained for: *The administration of insulin according to physician's orders and facility policy for four of five sampled residents (3, 6, 11, and 13) who received insulin.	F 281		

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F 281	<p>Continued From page 6</p> <p>*The administration of a medication according to physician's orders and facility policy for one of thirteen sampled residents (12). Findings include:</p> <p>1. Review of resident 6's 12/16/13 physician's orders revealed orders for Levemir Flexpen (Insulin Detemir, long-acting insulin) twelve units to have been given twice daily at 7:00 a.m. and 5:00 p.m. There was also an order for Novolog Flexpen (Insulin Aspart, rapid-acting insulin) to have been given according to a sliding scale (based on blood sugar results) before meals three times a day at 7:30 a.m., 11:30 a.m., and 5:00 p.m. Meal times were scheduled for 7:30 a.m., noon, and 5:30 p.m.</p> <p>Review of resident 6's December 2013 through February 2014 electronic Medication Administration Record (eMAR) revealed: *December 2013: -Levemir insulin: --Seventeen times it had been documented as given more than an hour after it had been scheduled. --Four of those were given more than two hours after the scheduled time. -Novolog insulin: --Twenty-one times it had been documented as given more than an hour after it had been scheduled. --Seven of those had been administered more than an hour after the scheduled meal time. --Three of those medications had been administered more than two hours after the scheduled time. *January 2014: -Levemir insulin: --Eleven times it had been documented as given</p>	F 281			

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F 281	<p>Continued From page 7</p> <p>more than an hour after it had been scheduled. --Six of those had been documented as given between two and nearly five hours after the scheduled time. -Novolog insulin: --Eight times it had been documented as given more than an hour after it had been scheduled. --Seven of those had been given between one and three hours after the scheduled meal time. --Five of those medications had been given more than two hours after the scheduled time. *February 1-12, 2014: -Levemir insulin: --Six times it had been documented as given more than an hour after it had been scheduled. --Three of those times it had been given between two and five hours after the scheduled time. -Novolog insulin: --Six times it had been documented as given more than an hour after it had been scheduled. --Three of those had been given more than an hour after the scheduled meal time. --Two of those medications had been given more than two hours after the scheduled time. There had been no documentation on any of the above times as to the reason for the delay in the administration. There was no documentation to indicate what time meals had been served on any of the above occasions.</p> <p>2. Review of resident 13's medical record revealed she had been admitted on 1/13/14. Her physician's orders on that same date through 2/11/14 revealed orders for Lantus insulin to have been given twice daily at 7:00 a.m. and 8:00 p.m. The dosages had been revised, but the time schedule remained the same. There was also an order for Novolog Flexpen (Insulin Aspart) to have been given according to a sliding scale before</p>	F 281		

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F 281	<p>Continued From page 8</p> <p>meals three times a day at 7:30 a.m., 11:30 a.m., and 5:00 p.m., and at bedtime at 8:00 p.m.</p> <p>Review of resident 13's January 2014 through February 2014 eMAR revealed:</p> <p>*January 2014:</p> <ul style="list-style-type: none"> <li>-There were two times the Lantus insulin had been documented as given more than two hours after it had been scheduled.</li> <li>-There were twelve times the Novolog had been documented as given more than an hour after it had been scheduled.</li> <li>-Of those, two had been documented as given more than an hour after the scheduled meal time.</li> <li>-Four of those medications had been documented as given more than two hours after the scheduled time.</li> </ul> <p>*February 1-12, 2014:</p> <ul style="list-style-type: none"> <li>-There were three times the Novolog had been documented as given more than an hour after it had been scheduled.</li> <li>-Of those, two had been given more than one hour after the scheduled meal time.</li> </ul> <p>There had been no documentation on any of the above times as to the reason for the delay in the administration. There had been no documentation to indicate what time meals had been served on the above occasions.</p> <p>Interview on 2/11/14 at 1:07 p.m. with resident 13 revealed she was given her insulin at varying times of the day. Sometimes she received it before meals and sometimes after meals.</p> <p>Surveyor: 32333</p> <p>3. Review of resident 3's 1/6/14 physician's orders revealed an order for a Humalog Flexpen three units three times a day.</p>	F 281		

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F 281	<p>Continued From page 9</p> <p>Review of resident 3's January and February 2014 eMAR revealed:</p> <p>*Humalog pen solution three units subcutaneously three times a day at 7:00 a.m., 11:30 a.m., and 5:00 p.m.</p> <p>*On 1/6/14 the 5:00 p.m. scheduled dose had been documented as given at 10:13 p.m.</p> <p>*On 1/17/14 the 5:00 p.m. scheduled dose had been documented as given at 10:47 p.m.</p> <p>*On 2/9/14 the 5:00 p.m. scheduled dose had been documented as given at 10:23 p.m.</p> <p>4. Review of resident 11's 1/7/14 physician's orders revealed an order for Novolog flex pen sliding scale four times a day subcutaneously at 7:00 a.m., 11:30 a.m., 5:00 p.m., and 8:00 p.m.</p> <p>Review of resident 11's February 2014 eMAR revealed:</p> <p>*On 2/2/14 the 8:00 p.m. dose had been documented as given at 9:29 p.m.</p> <p>*On 2/3/14 the 8:00 p.m. dose had been documented as given at 10:18 p.m.</p> <p>*On 2/4/14 the 8:00 p.m. dose had been documented as given at 9:23 p.m.</p> <p>Interview on 2/12/14 at 3:00 p.m. with the DON confirmed medication administration should have been documented onto the eMAR after administration.</p> <p>5. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of nursing, 8th Ed., St. Louis, MO., 2013, p. 586 revealed "Nurses and other health care providers use accurate documentation to communicate with one another. Many medication errors result from inaccurate documentation. Therefore always document medications accurately at the time of</p>	F 281			

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435051</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MEADOWBROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2500 ARROWHEAD DR RAPID CITY, SD 57702</b>		
(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	
F 281	<p>Continued From page 10</p> <p>administration and verify any inaccurate documentation before giving medications.</p> <p>Surveyor 23059</p> <p>6. Review of the provider's February 2009 Insulin Tip Sheet revealed for rapid-acting insulins "In general, administration must occur within 15 minutes of mealtime due to rapid action."</p> <p>7. Interview on 2/12/14 at 1:20 p.m. with the director of nursing (DON) revealed insulin was to have been administered within one hour on either side of the time it had been scheduled. If there was a reason the time frame had not been met it should have been documented. She stated she had not been concerned about the timing of rapid acting insulin to have been given before meals, because all of the medication carts had snacks on them. The nurses were to have monitored residents for any insulin reactions.</p> <p>8. Review of Todd Semla et al, Geriatric Dosage Handbook, 16th edition, Hudson, Ohio, 2011, page 916, revealed rapid acting insulin should have been administered within thirty to sixty minutes before a meal.</p> <p>Surveyor: 20031</p> <p>9. Review of resident 12's 12/1/13 physician's orders revealed an order for Seroquel (medication to alter mood) 50 milligrams to have been given every day at the hour of sleep. Review of resident 12's February 2014 eMAR revealed the provider had scheduled the medication to have been given at 6:00 p.m.</p> <p>Review of the provider's 1/9/14 quarterly clinical health status for resident 12 revealed her bedtime</p>	F 281			

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F 281	<p>Continued From page 11 sleep pattern was listed as "Between 8-8:30 p.m."</p> <p>Interview on 2/12/14 at 2:00 p.m. with the Minimum Data Set coordinator revealed she agreed the provider had not followed the physician's orders for the time the medication was to have been given to resident 12.</p> <p>10. Review of the provider's September 2010 Medication Administration General Guidelines policy revealed: *Medications were to have been administered in accordance with written orders of the prescriber. *Medications to have been given on an empty stomach or before meals were to have been scheduled for administration thirty minutes to two hours prior to meals. *Medications were to have been administered within sixty minutes of the scheduled time, except before or after meal orders which were to have been administered based on mealtimes. *If a dose of a regularly scheduled medication was withheld, refused, or given at other than the scheduled time an explanation should have been documented.</p> <p>Surveyor: 26632 B. Based on personnel record review and interview, the provider failed to ensure three of three unlicensed assistive personnel (UAP) (D, E, and F) had evidence of a high school diploma or graduate equivalency degree (GED) in their personnel in accordance with the South Dakota Board of Nursing Medication Administration Training Program requirements, chapter 20:48:04.01:09. Findings include:</p> <p>1. Review of UAPs D, E, and F's personnel</p>	F 281			

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F 281	Continued From page 12 records revealed no copies of a high school diploma or a GED certificate.	F 281	<b>F371</b>	
F 371 SS=D	Interview on 2/12/14 at 10:00 a.m. with the director of clinical education revealed she had not been aware of that requirement. <b>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b>  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  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and policy review, the provider failed to ensure appropriate handwashing and glove use had been completed by three of five observed staff members (G, H, and I) for two of two observed meal services in the kitchen. Findings include:  1. Observation on 2/10/14 from 5:15 p.m. through 6:30 p.m. in the kitchen revealed: *Dietary aide G wore gloves and placed juice and dishes of jello on the residents' trays. She wiped her gloved hands onto her apron several times. She washed her gloves in the handwashing sink while she prepared resident food trays. *Cook H wore gloves and during that time she	F 371	1. All residents are at risk. No immediate action could be taken regarding hand hygiene and glove use.  2. Dietary manager or designee will educate all dietary staff regarding hand hygiene and gloving procedure by 3/12/2014 <i>*including G, H and I KMSDDH/MF</i>  3. Dietary Manager or designee will audit 5 meal passes for proper hand hygiene and gloving weekly for 4 weeks and then monthly thereafter. Dietary manager or designee will present results of audits for discussion at monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits.  4. April 3, 2014	<i>4/3/14</i>

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F 371	Continued From page 13 made ready-to-eat food items that included sandwiches and toast. She had not washed her hands or changed her gloves after touching multiple surfaces in the kitchen.  2. Observation on 2/11/14 between 11:05 a.m. and 1:00 p.m. of cook I in the kitchen revealed: *She had been dishing residents' noon meals. *She pulled the drain plug to drain the water that had sat in a sink. *She then continued to dish up residents' food. *She had not washed her hands after pulling the plug to drain the water.  Interview on 2/12/14 at 8:50 a.m. with the dietary manager revealed: *She would have expected staff to wash their hands for twenty seconds before and after glove use and anytime they had contaminated their hands. *Staff should have washed their hands and put on a clean pair of gloves before handling ready-to-eat food items. *It was not an acceptable practice to wash and reuse gloves.  Review of the provider's undated Handwashing policy revealed hands should have been washed: *Before any food handling, preparation, or service. *Before putting on gloves and after glove removal. *After handling any soiled or contaminated equipment, cleaning cloths, utensils, dishes, trays, soiled aprons, or trash can lids. *Before handling cooked or ready-to-eat food items.	F 371		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=F	Continued From page 14 SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	<b>F441</b>  1. All residents are at risk. Resident items are no longer commingled in the noted bathrooms. Bed pan was moved from noted bathroom floor. Urinary drainage bags have been discarded. Items noted in the bathroom for rooms 24 and 25 have been removed. The noted torn blue mats have been replaced.  2. DNS or designee will educate all nursing staff regarding infection control and prevention, and noted issues in deficiency by March 12, 2014.  3. DNS or designee will audit 10 resident bathrooms and rooms for infection control issues weekly for four weeks and then monthly thereafter. DNS or designee will present results of audits for discussion at monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits.  4. April 3, 2014	4/3/14	

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F 441	Continued From page 15  This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation and interview, the provider failed to ensure: *Eleven of seventeen shared residents' bathrooms (rooms 1 and 2, 3 and 4, 5 and 6, 7 and 8, 10 and 11, 20 and 21, 22 and 23, 43 and 44, 45 and 46, and 49 and 50) had resident care items stored separately to reduce cross-contamination. *One of one residents' shared bathroom (rooms 37 and 38) had a bedpan stored properly. *One of one residents' shared bathroom (rooms 13 and 14) had urinary drainage bags stored in a sanitary manner. *One of one residents' shared bathroom (rooms 24 and 25) had a toilet plunger, soiled gloves, and resident care supplies stored on the floor. *Two of three blue floor mats (rooms 6 and 8) had been maintained in a cleanable manner. Findings include:  1. Random observations on: *2/10/14 from 3:00 p.m. to 6:30 p.m., 2/11/14 from 7:15 a.m. to 6:00 p.m., and 2/12/14 from 7:15 a.m. to 5:15 p.m. revealed: *Eleven of seventeen shared residents' bathrooms had commingled or unlabeled resident personal care supplies on the sink countertops (photo's 1 and 6). *Resident room 37 and 38's shared bathroom had a bed pan stored on the bathroom floor for two of the above days (photo 3). *Resident room 13 and 14's shared bathroom had an overnight urinary drainage bag with urine in the tubing stored in a three drawer plastic caddy. Two urinary drainage leg bags were soiled	F 441		

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F 441	<p>Continued From page 16</p> <p>and laid adjacent to the overnight urinary drainage bag. The bags were not labeled to indicate which resident used them (photo 4). *Resident room 24 and 25's shared bathroom had a toilet plunger, used gloves, and a sack of personal disposable cleaning cloths laying on the floor for two of the above days (photo 5). *Two of three blue floor mats (rooms 6 and 8) had cracks in them making them uncleanable surfaces (photo 2).</p> <p>Interview on 2/12/14 at 9:00 a.m. with the director of nursing and the maintenance supervisor confirmed the residents' personal care items were to have been stored in a hygienic manner. Nothing was to have been stored on the floors.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, MO., 2013, p. 411, revealed "Failure to comply with basic (resident) procedures (infection control) places the patient (resident) at risk for an infection that can seriously impair recovery or lead to death."</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435051	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/11/2014
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - MEADOWBROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 ARROWHEAD DR RAPID CITY, SD 57702
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/11/14. Golden LivingCenter - Meadowbrook was found not 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 upon correction of deficiency identified at K029 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p><b>K029</b></p> <p>1. All residents are at risk. East Hall soiled linen room door does close and latch properly. Penetrations noted in the laundry room have been repaired.</p> <p>2. ED or designee will educate maintenance supervisor regarding maintaining proper separation of hazardous areas by March 12, 2014.</p> <p>3. ED or designee will audit facility weekly for proper separation weekly for 4 weeks and then monthly thereafter. ED or designee will present results of audits for discussion at monthly QA&amp;A for further review and recommendations and/or continuation/discontinuation of audits.</p>	4/3/14
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K 029 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 20031 A. Based on observation, testing, and interview, the provider failed to maintain proper separation for one of two soiled linen rooms. The door to the east hall soiled linen room would not latch into the</p>	K 029	<p>4. April 3, 2014</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 3/10/14

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.

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K 029	<p>Continued From page 1 frame. Findings include:</p> <p>1. Observation and testing on 2/11/14 at 8:50 a.m. revealed the one-hour rated self-closing door to the east hall soiled linen room would not close and latch into the frame. Interview with the maintenance supervisor (MS) at the time of the observation confirmed that finding. He revealed he had not noticed that door was not properly latching on his last monthly preventative maintenance rounds.</p> <p>B. Based on observation and interview, the provider failed to maintain proper separation of hazardous areas for one of one laundry room. Several openings around pipe penetrations in the laundry room were not sealed with an appropriate firestop material. Findings include:</p> <p>1. Observation on 2/11/14 at 9:05 a.m. revealed openings around two penetrations of the east wall behind the washers in the laundry room. Those penetrations were around the plumbing pipes that lead to the washers and were not firestopped with an approved material. Interview with the MS at the time of observation confirmed those findings. He stated he had recently replaced the plumbing connections to the washers and had not enclosed the penetrations around the new pipes.</p>	K 029		

ORIGINAL

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 000	Initial Comments  Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/10/14 through 2/12/14. Golden LivingCenter - Meadowbrook was found not in compliance with the following requirement: S206.	S 000	<b>S206</b>	
S 206	44:04:04:05 PERSONNEL-TRAINING  The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents.  ...Additional personnel education shall be based on facility identified needs.	S 206	1. All residents are at risk. No immediate action could be taken regarding previous hires orientation. Restraints and Hydration will be added to facility orientation program.  2. ED or designee will educate DNS and DCE regarding requirements for new hire orientation by March 12, 2014.  3. ED or designee will audit all new hires for proper orientation weekly for 4 weeks and then monthly thereafter. ED or designee will present results of audits for discussion at monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits.  4. April 3, 2014	4/3/14

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

TITLE

(X6) DATE

Executive Director 2/10/14

STATE FORM

021199

0Z1Z11

If continuation, sheet 1 of 2

MAR 12 2014  
SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 206	Continued From Page 1  This Rule is not met as evidenced by: Surveyor: 20031 Based on record review and interview, the provider failed to ensure three of five newly hired employees (A, B, and C) were initially trained on two of the ten required in-services (restraints and hydration). Findings include:  1. Review of the provider's initial training for newly hired employees A, B, and C revealed they had no training in restraints or hydration. Interview on 2/12/14 at 10:00 a.m. with the director of clinical education revealed she could find no specific training for those two areas. Interview on that same day at 4:35 p.m. with the executive director revealed their program covered about thirty in-services. But, they had failed to include restraints and hydration among those topics.  Review of the provider's 7/1/08 Orientation policy revealed "...each new employee will be oriented within the first two (2) days of employment, in accordance with State and Federal regulations...". Review of the summary of topics on that policy revealed no mention of restraints or hydration.	S 206		