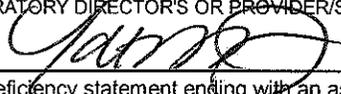


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2014
--	---	--	---

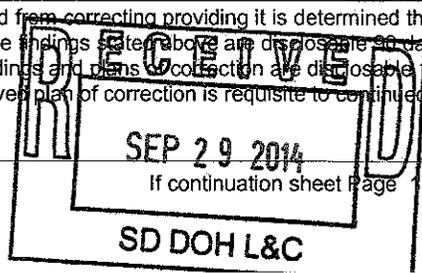
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702
--	---

(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 000	<p><i>Amendments noted with an asterisk per 10/17/14 telephone to facility administrator NS/SB/DH/MF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 23059 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/4/14 through 9/5/14. Areas surveyed included quality of care and treatment, nursing services, abuse and neglect, and discharge planning. Golden LivingCenter - Prairie Hills was found not in compliance with the following requirements: F156, F204, F250, F281, F282, and F514.</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> <p>F156</p> <p>1. All residents are at risk. No immediate action could be taken for residents 3, 6, 8, 9, or 10.</p>	10/17/14
F 156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to</p>	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 9/25/14
--	------------------------------------	-----------------------------

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 30 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.



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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 156	<p>Continued From page 1</p> <p>the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance</p>	F 156	<p>2. The Executive Director (ED) or designee will inservice MDS Coord and Social Services Director on notifying residents in a timely manner, at least 48 hours, of Medicare services ending by September 27, 2014. ✖</p> <p>3. The ED or designee will audit all Medicare non-coverage notices for timely notification weekly for four weeks and then monthly thereafter. Results of audits will be presented by ED or designee for discussion at monthly Quality Assurance and Assessment (QA&A) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. 10/17/2014</p> <p><i>Education will also be provided to the "Social Services Assistant."</i> <i>NS/SD/DH/MF</i></p>	10/17/14	

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 156	<p>Continued From page 2 directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure five of ten sampled residents (3, 6, 8, 9, and 10) had been notified in a timely manner that Medicare services would be ending. Findings include:</p> <p>1. Review of the notice for Medicare non-coverage forms for: *Resident 3 revealed it had been signed on 9/4/14. Her last day of Medicare coverage was 9/5/14. *Resident 6 revealed it had been signed on 7/16/14. His last day of Medicare coverage was 7/14/14. *Resident 8 revealed it had been signed on 9/3/14. Her last day of Medicare coverage was 9/3/14. *Resident 9 revealed it had been signed on 8/24/14. Her last day of Medicare coverage was 8/25/14.</p>	F 156			

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 156	Continued From page 3 *Resident 10 revealed it had been signed on 8/1/14. Her last day of Medicare coverage was 7/31/14. Interview on 9/5/14 at 10:00 a.m. with the licensed social worker revealed: *The Medicare non-coverage notices were given to her by the Minimum Data Set coordinators for the residents and/or their representatives to sign. *She could not remember why the above residents' notices of Medicare non-coverage forms had not been given to them at least forty-eight hours before their last day of Medicare coverage. Interview on 9/5/14 at 9:50 a.m. with the director of nursing revealed they did not have a policy regarding notification to residents for non-coverage by Medicare. He stated they followed CMS (Center for Medicare and Medicaid Services) regulations. Those regulations stated notice of non-coverage must have been given at least forty-eight hours before a resident's last day of Medicare coverage.	F 156			
F 204 SS=G	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the	F 204			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 204	<p>Continued From page 4</p> <p>transfer and adequate relocation of the residents, as required at §483.75(r).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure appropriate discharge planning had been completed for one of two sampled residents (3) who had suffered emotional upset due to lack of discharge planning. Findings include:</p> <p>1. Review of resident 3's medical record revealed: *She had been admitted on 5/29/14. *She had a diagnosis of a left side affected stroke. *She received physical, occupational, and speech therapy services. *Medicare would pay for her stay while she participated in therapy services. *Her daughter was also a resident.</p> <p>Interview on 9/5/14 at 12:05 p.m. with resident 3 revealed: *She vaguely remembered being told about her one-hundred Medicare days at the time she had been admitted. *She did not think the discharge process happening so quickly was good for her. *She had cried when she heard she was "going to be kicked out." *She and her husband had contacted the ombudsman (resident advocate) from the Department of Social Services to assist them. *She and her husband had found the ombudsman to have been the most help with the discharge planning process.</p>	F 204	<p>F204</p> <p>1. All residents are at risk. No immediate action could be taken for resident 3.</p> <p>2. GLC facility consultant will conduct in-service with Director of Nursing Services and Social Services Director regarding discharge planning requirements by September 27, 2014.</p> <p>3. The ED or designee will audit all discharges for timely notification of Medicare services ending if applicable, care conferences completed as appropriate, and discharge planning documented. Audit will be done weekly for four weeks and then monthly thereafter. Results of audits will be presented by ED or designee for discussion at the monthly QA&A for further review and recommendations and/or continuation/discontinuation of audits</p> <p>4. 10/17/2014</p>	10/17/14	

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 204	<p>Continued From page 5</p> <p>*She stated "That's the only person who got the ball rolling."</p> <p>*She and her daughter (who was also a resident) would be going home that day and had hoped "it would work out."</p> <p>*She was aware she could not completely care for her daughter, but her husband and home health services were going to help.</p> <p>Review of resident 3's interdisciplinary progress notes revealed:</p> <p>*On 6/6/14 at 8:42 a.m. an initial social services (SS) note completed by the social services assistant (SSA) included "She wishes to return to live in her home, where she was the caregiver for her daughter. She is uncertain whether she will be able to." "SS will establish care plan for resident as well as to continue to support and encourage resident. SS will also make community referrals as needed, prior to discharge, per therapy and nursing recommendations."</p> <p>*On 6/6/14 at 1:19 p.m. "SSC [social services coordinator] notified by DON [director of nursing] that resident does not want husband to visit her or _____ [name of daughter] anymore. Husband notified and stated understanding. Daughter _____ [name of daughter] was notified and son _____ [name of son] was also notified."</p> <p>*On 6/13/14 at 1:11 p.m. a fourteen day MDS note completed by the SSA included "Resident continues to attend therapy. She had a goal to return to live in home, it is uncertain whether she will attain this goal."</p> <p>*On 6/15/14 at 1:40 p.m. a nurses note "Resident was very upset off and on today. Changes her mind about _____ [husband's name] being able to come or not. Calls him several times a day.</p>	F 204			

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 204	<p>Continued From page 6</p> <p>Agreed that _____[husband's name] could come see his daughter _____[daughter's name] and she would not be around that area. Approx. [approximately] 5 -10 minutes later came out of dining room stating how she was going to be a part of that and so forth."</p> <p>*On 6/19/14 at 11:13 a.m. "Resident called this social worker [SSA] into her room today and said 'some things going down', and my daughter and the Doctor are trying to deem me incompetent because I changed my daughter's code status after all these years. _____[resident 3's name] stated she had to take all this psych [psychiatric testing]. SS asked her if she were afraid she wouldn't pass. She stated no. SS told her that this facility has to follow Doctors orders but she could ask SS for 1-1 [one-to-one] visits to express her feelings anytime. Later, her husband came to the nurses station and asked if could visit today. _____[resident 3's name] at this time was in her room crying and talking to her friend. When staff asked _____[resident 3's name] if he could visit, she said talk to _____ or _____[SSC's name and SSA's name]."</p> <p>*On 6/19/14 at 2:34 p.m. a nurses note "She is upset that she has to retake psych evaluation, and if she doesn't pass it this will be her home forever."</p> <p>*On 6/24/14 at 10:45 p.m. a nurses note "at 2215 [10:15 p.m.] CNA [certified nursing assistant] reported to this author that resident fell out of wheelchair in her room as she was attempting to self transfer. Resident hit her head at roommate's bed room. Resident stated "I have called 911 so the officer can take me away from this place. I need to get out of here." "Resident was upset because they think she is crazy (resident had neuropsych evaluation on 6/14/14.)"</p> <p>*On 6/25/14 at 11:40 a.m. a late entry nurses note</p>	F 204		

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 204	<p>Continued From page 7</p> <p>" _____[physician's name] phoned this author and wanted to discuss the multiple falls that resident has had. She stated _____[resident 3] is 'not all there after her stroke' she stated it is a bad idea to have her daughter in the same room as her because she will try to tend to every needs and she can not take care of her. She stated that she would call _____[son's name] and talk with him on moving the daughter out of the room and she would call this author back and inform us of the conversation."</p> <p>*On 6/30/14 at 11:11 a.m. a thirty day MDS note completed by the SSA included "Resident continues to attend therapy. She had a goal to return to live in home, it is uncertain whether she will attain this goal. SS will continue to support and encourage resident."</p> <p>*There were no further progress notes in relationship to her discharge goal or a discharge plan.</p> <p>Review of resident 3's 6/12/14 care conference form revealed:</p> <p>*Resident 3, SSA, certified occupational therapy assistant, physical therapist, her daughter, and her son had attended.</p> <p>*Her discharge goal when she was admitted was to return to her home.</p> <p>*The time frame for her to reach her goals were six to eight weeks.</p> <p>*That was the only care conference that had been held for her.</p> <p>Review of resident 3's initial psychosocial assessment completed on 6/6/14 revealed:</p> <p>*She was alert and oriented.</p> <p>*She wished to return home.</p> <p>Review of resident 3's psychosocial quarterly</p>	F 204		

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 204	<p>Continued From page 8</p> <p>progress note completed on 9/4/14 revealed: *She scored a fifteen on her brief interview for memory. *That score indicated she had no memory difficulties. *She could clearly make her needs known. *She planned to return home. *She had support systems (financial and emotional) when discharge occurred. *Post discharge services would be needed upon discharge. *Unsure of the extent of services she would have needed upon discharge. *She continued to work with therapies with a goal to return home.</p> <p>Review of a neuropsychiatric evaluation completed on 8/11/14 for resident 3 revealed: *She had improved cognitively (mental ability). *She was able to make her own decisions. *A report would be sent to her primary care physician. *There was no copy of the report in her medical record.</p> <p>Review of resident 3's initial 6/10/14 care plan revealed: *A focus was that she was in the facility for rehabilitation. *Her goal was to return to live in her own home. *Interventions included: -Hold regularly scheduled care conferences at least quarterly, and as required or needed. -Meet with resident and family/support persons to discuss expectations, preferences, feelings in regards to care, and barriers towards discharge. *Social services to make community referrals as needed and prior to discharge, per nursing and therapy recommendations.</p>	F 204			

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 204	<p>Continued From page 9</p> <p>Interview on 9/4/14 at 2:50 p.m. with the licensed social worker (LSW) revealed:</p> <ul style="list-style-type: none"> *Resident 3's goal was to return to her home. *She had told resident 3 on admission that she had one-hundred days of Medicare coverage. *She had not informed resident 3 until 9/4/14 that her one-hundred days of Medicare coverage would be on 9/5/14. *She agreed resident 3 had been very upset when she had been told that information. *An initial care conference was usually completed within two weeks after a resident's admission. *The next care conference would have occurred on a quarterly basis. *A care conference in-between the first and the quarterly care conference would have occurred if the provider, resident and/or family, or therapy would have requested one. *Reasons an extra care conference would have been completed was for increased or changed behaviors, psychosocial issues, changes in the plan of care for the appropriateness of discharge to home, or the resident had reached a plateau (as far as they were capable of going) in their therapy. *She agreed resident 3 had psychosocial issues that would have necessitated another care conference. *She had not asked for a copy of resident 3's 8/11/14 neuropsychiatric evaluation. *She did not know the outcome of that evaluation. *A weekly Medicare meeting had been conducted. *All residents who received Medicare services were discussed. *The residents' progress towards their goals were discussed. *Therapy would have given a general idea of 	F 204		

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 204	<p>Continued From page 10 when their services would have been finished for each resident.</p> <p>Interview on 9/4/14 at 4:36 p.m. with the director of rehabilitation services revealed: *Resident 3's goal was to return home. *She had not asked for a copy of resident 3's 8/11/14 neuropsychiatric evaluation. *She did not know the outcome of that evaluation. *She would lead the weekly Medicare meetings. *Information was provided on how the resident was doing on obtaining their therapy goals. *She would give the rest of the team a one-week advance notice of when a resident was close to obtaining their goals. *There was no discussion or documentation for resident 3 on any discharge planning. *She would have liked resident 3 to have stayed longer on part B Medicare services. *She had recommended resident 3 could go home, but she did not think she could also take care of her disabled daughter at home.</p> <p>Review of the provider's revised October 2009 Assessment, Evaluation, and Documentation for the Discharge Plan policy revealed: *The discharge plan was used to assist the resident in preparation for discharge and to address continuing care needs after discharge. *When the interdisciplinary team determined a resident had potential for discharge in the next ninety days, social services would address the following: -Mental and/or psychosocial barriers to discharge. -Necessary supportive relationship in the community to meet his/her emotional needs. -The cost of needed services and financial resources necessary to pay for services.</p>	F 204		

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 250	<p>Continued From page 12 participated in therapy services.</p> <p>Interview on 9/5/14 at 12:05 p.m. with resident 3 revealed: *She vaguely remembered being told about her one-hundred Medicare days when she had been admitted. *She did not think the discharge process happening so quickly was good for her. *She had cried when she heard she was "going to be kicked out." *She and her husband had contacted the ombudsman (resident advocate) from the Department of Social Services to assist them. *She and her husband had found the ombudsman to have been the most help with the discharge planning process. *She stated "That's the only person who got the ball rolling." *She and her daughter (who also lived in the facility) would be going home that day and had hoped "it will work out." *She was aware she could not completely care for her daughter, but her husband and home health services would help.</p> <p>Review of resident 3's interdisciplinary progress notes revealed: *On 6/6/14 at 8:42 a.m. an initial social services (SS) note completed by the social services assistant (SSA) included "She wishes to return to live in her home, where she was the caregiver for her daughter. She is uncertain whether she will be able to." "SS will establish care plan for resident as well as to continue to support and encourage resident. SS will also make community referrals as needed, prior to discharge, per therapy and nursing recommendations." *On 6/6/14 at 1:19 p.m. "SSC [social services</p>	F 250		

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 250	<p>Continued From page 13</p> <p>coordinator] notified by DON [director of nursing] that resident does not want husband to visit her or _____ [name of daughter] anymore. Husband notified and stated understanding. Daughter _____ [name of daughter] was notified and son _____ [name of son] was also notified."</p> <p>*On 6/13/14 at 1:11 p.m. a fourteen day MDS [Minimum Data Set assessment] note completed by the SSA included "Resident continues to attend therapy. She had a goal to return to live in home, it is uncertain whether she will attain this goal."</p> <p>*On 6/15/14 at 1:40 p.m. a nurses note "Resident was very upset off and on today. Changes her mind about _____ [husband's name] being able to come or not. Calls him several times a day. Agreed that _____ [husband's name] could come see his daughter _____ [daughter's name] and she would not be around that area. Approx. [approximately] 5 -10 minutes later came out of dining room stating how she was going to be a part of that and so forth."</p> <p>*On 6/19/14 at 11:13 a.m. "Resident called this social worker [SSA] into her room today and said 'somethings going down', and my daughter and the Doctor are trying to deem me incompetent because I changed my daughter's code status after all these years. _____ [resident 3's name] stated she had to take all this psych [psychiatric testing]. SS asked her if she were afraid she wouldn't pass. She stated no. SS told her that his facility has to follow Doctors orders but she could ask SS for 1-1 (one-to-one) visits to express her feelings anytime. Later, her husband came to the nurses station and asked if he could visit today. _____ [resident 3's name] at this time was in her room crying and talking to her friend. When staff asked _____ [resident 3's name] if he</p>	F 250		

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702	
(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 250	<p>Continued From page 14</p> <p>could visit, she said talk to _____ or _____ [SSC's name and SSA's name]."</p> <p>*On 6/19/14 at 2:34 p.m. a nurses note "She is upset that she has to re take psych evaluation, and if she doesn't pass it this will be her home forever."</p> <p>*On 6/24/14 at 10:45 p.m. a nurses note "at 2215 [10:15 p.m.] CNA [certified nursing assistant] reported to this author that resident fell out of wheelchair in her room as she was attempting to self transfer. Resident hit her head at roommate's bed room. Resident stated "I have called 911 so the officer can take me away from this place. I need to get out of here." "Resident was upset because they think she is crazy (resident had neuropsych evaluation on 6/14/14.)"</p> <p>*On 6/25/14 at 11:40 a.m. a late entry nurses note " _____ [physician's name] phoned this author and wanted to discuss the multiple falls that resident has had. She stated _____ [resident 3] is 'not all there after her stroke' she stated it is a bad idea to have her daughter in the same room as her because she will try to tend to every needs and she can not take care of her. She stated that she would call _____ [son's name] and talk with him on moving the daughter out of the room and she would call this author back and inform us of the conversation."</p> <p>*On 6/30/14 at 11:11 a.m. a thirty day MDS note completed by the SSA included "Resident continues to attend therapy. She had a goal to return to live in home, it is uncertain whether she will attain this goal. SS will continue to support and encourage resident."</p> <p>*There were no further progress notes in relationship to her discharge goal or a discharge plan.</p> <p>Review of a neuropsychiatric evaluation</p>	F 250		

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 250	<p>Continued From page 15</p> <p>completed on 8/11/14 for resident 3 revealed:</p> <ul style="list-style-type: none"> *She had improved cognitively (mental capacity). *She was able to make her own decisions. *A report would be sent to her primary care physician. *There was no copy of the report in her medical record. <p>Review of resident 3's initial 6/10/14 care plan revealed:</p> <ul style="list-style-type: none"> *A focus was that she was in the facility for rehabilitation. *Her goal was to return to live in her own home. *Interventions included: <ul style="list-style-type: none"> -Hold regularly scheduled care conferences at least quarterly, and as required or needed. -Meet with resident and family/support persons to discuss expectations, preferences, feelings in regards to care, and barriers towards discharge. *Social services to make community referrals as needed prior to discharge and per nursing and therapy recommendations. <p>Interview on 9/4/14 at 2:50 p.m. with the licensed social worker (LSW) revealed:</p> <ul style="list-style-type: none"> *Resident 3's goal was to return to her home. *She had told resident 3 on admission that she had one-hundred days of Medicare coverage. *She had not informed resident 3 until 9/4/14 that her one-hundred days of Medicare coverage would be completed on 9/5/14. *She agreed resident 3 had been very upset when she had been told that information. *An initial care conference was usually completed within two weeks after a resident's admission. *The next care conference would have occurred on a quarterly basis. *A care conference in-between the first and the quarterly care conference would have occurred if 	F 250		

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702	
(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 250	<p>Continued From page 16</p> <p>the provider, resident and/or family, or therapy would have requested one.</p> <p>*Reasons an extra care conference would have been completed was for increased or changed behaviors, psychosocial issues, changes in the plan of care for the appropriateness of discharge to home, or the resident had reached a plateau (as far as they were capable of going) (in their therapy.</p> <p>*She agreed resident 3 had psychosocial issues that would have necessitated another care conference.</p> <p>*She had not asked for a copy of resident 3's 8/11/14 neuropsychiatric evaluation.</p> <p>*She did not know the outcome of that evaluation.</p> <p>*A weekly Medicare meeting was conducted.</p> <p>*All residents that received Medicare services were discussed at those meetings.</p> <p>*The residents' progress towards their goals were discussed.</p> <p>*Therapy would have given a general idea of when their services would have been finished for each resident.</p> <p>Review of an undated education form in the LSW's personnel record revealed:</p> <p>*The goal was to maintain a positive relationship with all families and residents.</p> <p>*The LSW had been noticed to have a condescending conversation with a resident and family member.</p> <p>*The family member had complained the LSW had been rude.</p> <p>*The LSW was to have completed a Golden U (provider education) within one week.</p> <p>Interview on 9/5/14 at 11:15 a.m. with the administrator revealed:</p> <p>*The above incident with the LSW occurred the</p>	F 250		

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702	
(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 250	Continued From page 17 week of August 18, 2014. *She was not sure if the LSW had completed the Golden U course or not. *Continued interview at 11:45 a.m. with the administrator revealed "The LSW had told her she had not been sure which Golden U course to complete so she had not completed any." Review of the provider's 8/30/11 social services coordinator job description revealed that person was to: *Identify and provide for each resident's social, emotional, and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility. *Assist in the planning for the resident's discharge. *Develop a social history, social assessment, and care plan which identified pertinent problems and needs. *Actively participate in the interdisciplinary care plan meetings. *Document progress notes that related to each resident's care plan when necessary. *Assist the resident and resident's family in discharge planning. *The job description had been signed by the LSW on 8/13/12.	F 250		
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: 32333	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702
--	---

(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 18</p> <p>Based on record review, interview, job description review, and guideline review, the provider failed to ensure appropriate care had been provided to one of one sampled resident (4) with dementia (loss of the ability to think or reason). Findings include:</p> <p>1. Review of resident 4's complete medical record revealed he had a diagnosis of dementia, depressive disorder, and anxiety.</p> <p>Review of resident 4's 6/3/14 care plan revealed he had a focus area for the potential to show signs and symptoms of moods and behaviors. He had a history of swinging (hitting) at staff and refusing care at times. He had been short tempered with staff and had refused meals and medications. He had an intervention that when he refused care staff would leave and come back after a few minutes and try again. Staff were to explain to him why the care was needed and beneficial.</p> <p>Review of resident 4's nursing progress notes revealed on 6/22/14 at 1:00 p.m. "It was observed that resident 4 has bruising on both wrists with a scabbed laceration on his right forearm."</p> <p>Review of the provider's 6/22/14 5-day working day investigation report completed by the director of nursing (DON) revealed "It was observed on 6/22 that resident 4 had bruising on both of his wrists, and a lesion [cut] on his right forearm. I believe that the wounds may have occurred around 6/18 or 6/19. Initial staff interviews conducted on 6/22 did not reveal any cause to these bruises. Resident 4 has a history of senile dementia, anxiety, and depression. He has a documented history of physical and verbal abuse</p>	F 281	<p>F281</p> <p>1. All residents are at risk. No immediate action could be taken for resident 4.</p> <p>2. DNS or designee will educate all nursing staff regarding care of residents with dementia to include following the care plan interventions for behavior by September 27, 2014. * including CNAs NSISDDHIME</p> <p>■ DNS or designee will audit 10 instances of care with dementia residents per week for care plan interventions for behaviors being followed and appropriate care approaches being used with residents with dementia. This audit will be done weekly for 4 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.</p> <p>■ 10/17/2014</p> <p>*#3. CNA B has been removed from providing care for resident 4. NSISDDHIME</p> <p>*#4. The ED, DNS or designee will request an evaluation by the Alzheimer's Care Director at GTC Bella Vista for a review of resident 4's plan of care and further interventions. NSISDDHIME</p>	10/17/14
-------	---	-------	---	----------

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 19</p> <p>towards staff and residents. There is no documentation to show that resident 4 has had any behaviors within the last week. Resident 4 is not on any blood thinning agents which would make him prone to bruising. Interviews with staff working during that week say that resident 4 was agitated on the evening of 6/20. Resident 4 was refusing to go to bed. The aide working on that unit has worked with resident 4 for a couple of years. This aide knows that resident 4 went to sleep without incident. An interview was conducted with an overnight aide and the question was asked "how do you think it happened?" His response was that when resident 4 starts being physically abusive he would hold his wrists so resident 4 would not hit him. He was asked if he had done this in the last two weeks and he responded "yes[.]".</p> <p>Interview on 9/5/14 at 8:50 a.m. with resident 4's daughter revealed she and her two sisters had come to visit her dad on 6/22/14. They had noticed their dad had bruising to both wrists and lower arms with what had appeared to be finger marks in the bruising. He also had a skin tear to one of his arms. She stated the bruising looked like her dad had been held down by the wrists. They had been concerned with their dad and had taken pictures of his bruised wrists and skin tear. She had reported the bruising to the provider. The provider had not been aware of the bruising until the daughter had reported it to them. It was later reported to her from the DON that he had found the certified nursing assistant (CNA) that had bruised her dad's wrists. She had told the DON that she did not want CNA B around her dad again. Her dad was afraid of him. He had felt threatened with a "big guy" standing over his wheelchair. Resident 4's daughter stated her dad</p>	F 281			

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 20</p> <p>had dwelled on the incident for several days. She stated that was unusual for him with his dementia. He usually would not remember something that happened in the morning that same afternoon. She stated her dad kept telling her that a "big man tried to break his arms." She said she could tell that it really bothered him emotionally. She stated she felt like there was a lack of training, and that CNA B had not known how to care for a resident with dementia. She stated CNA B should have walked away and not tried to physically restrain her dad's wrists. She said CNA B made her dad nervous when he stood over her dad's wheelchair. She stated the incident bordered on abuse. To her knowledge CNA B was no longer allowed to work with her dad per her request.</p> <p>Review of resident 4's June 2014 Behavior Detail report revealed no physical behaviors had been documented through 6/22/14.</p> <p>Interview on 9/4/14 at 11:00 a.m. with registered nurse assessment coordinator E regarding resident 4 revealed he could become combative with care. When that happened they gave him time to cool off and then reapproached him.</p> <p>Interview on 9/4/14 at 4:50 p.m. with the director of rehabilitation revealed when interacting with a resident with dementia that became agitated staff were to keep an arm's distance away. Staff were to try redirection and give the resident down time.</p> <p>Interview on 9/4/14 at 5:15 p.m. with the education coordinator revealed when interacting with a resident with dementia became agitated staff were to stay out of the resident's personal space and reapproach the resident.</p>	F 281			

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 21</p> <p>Interview on 9/5/14 at 7:40 a.m. with the DON regarding resident 4 revealed: *CNA B should not have held his wrists down when he became physically combative. *His expectation would have been that when a resident became agitated or combative for staff to back off and reapproach the resident at a later time.</p> <p>Interview on 9/5/14 at 10:00 a.m. with the DON regarding CNA B who had held resident 4's wrists when he became combative revealed: *He should have known through his training how to appropriately handle a resident with dementia who became agitated or combative, but he had not in this circumstance. *He should not have held down the resident's wrists. *He should have reapproached the resident at a later time. *He should have followed the resident's care plan. *The CNA had not documented the behaviors, because the behavior had not seemed out of the ordinary to him. *The CNA had not reported the bruises and had stated he had not noticed a skin tear. *His expectation would have been that all behaviors should always have been documented. *The CNA had not been able to work with the resident for approximately one week during the investigation. *CNA B was currently able to work with the resident. *He was unaware the resident's family had requested for CNA B not to work with their father again.</p>	F 281			

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702	
(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	Continued From page 22 Review of the provider's 10/10/11 CNA job description revealed: **Assist with promoting a compassionate physical and psychosocial environment for the residents[.]" **Provide resident care as directed by [the] care plan and/or nursing staff[.]" **Ensure residents' comfort while assisting them in achieving their highest practicable level of functioning[.]" **Must adhere to the company's code of conduct and business ethics policy including documentation and reporting responsibilities[.]" Review of the provider's Residents Who Resist Care form revealed: **Resistance of care may be caused by fear, loss of control over the physical or environment, dementia, depression, or personal conflict with the time frame for care and treatments." **Use a calm, gentle reassuring approach." **When met with resistance, leave and return later."	F 281		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 282	<p>Continued From page 23 accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure care plans were followed for care to three of four sampled residents (2, 3, and 4). Findings include:</p> <p>1. Observation on 9/4/14 at 3:00 p.m. of resident 2 revealed she had twelve staples in a wound on the top of her head. She also had a healed area on her forehead that previously had stitches removed.</p> <p>Review of resident 2's 8/27/14 nurse's note revealed she had fallen off the toilet after being left alone by certified nursing assistant (CNA) D. CNA D had left resident 2 alone on the toilet in order to assist another resident. That fall had resulted in two two-inch lacerations (cuts) on her forehead and on the top of her head.</p> <p>Interview on 9/4/14 at 4:20 p.m. with CNA A revealed she had worked at the facility for over six years. She stated she was familiar with resident 2's care and knew she was never to have been left on the toilet alone. CNA A stated the resident was unsteady and did not have good balance.</p> <p>Interview on 9/4/14 at 4:25 p.m. with resident 2 revealed she confirmed she had been left alone on the toilet when she had fallen.</p>	F 282	<p>F282</p> <p>1. All residents are at risk. No immediate action could be taken for residents 2,3, and 4. <i>* including CNAS NS/SDDH/MF</i></p> <p>2. DNS or designee will educate all nursing staff on following the care plan for residents, proper transfer techniques to include proper use of gait belts, and care provided with dignity and following behavior interventions on the care plan by September 27, 2014.</p> <p>■ DNS or designee will audit 10 instances of resident care to ensure care plan was followed and care was provided with dignity and following the behavior interventions on the care plan. DNS or designee will audit 10 resident transfers for proper technique and gait belt usage. These audits will be done 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.</p> <p>■ 10/17/2014</p> <p><i>* #3. Additional one on one training will be provided to CNAS B and D regarding following residents care plans. NS/SDDH/MF</i></p>	10/17/14	

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 282	<p>Continued From page 24</p> <p>Review of resident 2's 6/19/14 care plan revealed: *She required the assistance of one person for all transfers. *She needed the assistance of one person to use the toilet. *She was never to have been left alone on the toilet.</p> <p>Interview on 9/4/14 at 5:20 p.m. with the director of nursing (DON) revealed all CNAs were to utilize care sheets for the residents they cared for. Those care sheets were a shortened version of the care plan and indicated if there were special needs for any of the residents. He confirmed the care plan had not been followed by CNA D for the care of resident 2.</p> <p>2. Review of complaint documents received by the South Dakota Department of Health on 7/2/14 revealed resident 3 had complained of arm pain on 6/30/14. Those documents stated the arm pain was a result of a "rough transfer."</p> <p>Review of the provider's 6/30/14 investigation report revealed resident 3 had complained of arm pain. She had stated CNA B had hurt her arm when transferring her into a wheelchair. She stated he had pulled on her arm and had not used a gait belt (adjustable belt applied to resident's waist to steady them) to transfer her.</p> <p>Review of resident 3's 6/6/14 care plan revealed she required assistance of one with transfers and toileting.</p> <p>Interview on 9/4/14 at 4:30 p.m. with the director of rehabilitation services revealed the therapy staff were responsible for training all staff on</p>	F 282		

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 282	<p>Continued From page 25</p> <p>proper transfer techniques. She stated gait belts were to have been used with all residents for any transfer. She stated all CNAs had been given instruction in the use of gait belts and transferring techniques.</p> <p>Interview on 9/4/14 at 5:20 p.m. with the DON revealed he had expected a gait belt to have been used for all transfers. He stated staff were never to grab a resident by their arm to move them. He confirmed that had happened during the 6/30/14 transfer of resident 3. He stated CNA B had been re-educated on the need for the gait belt to have been used on all residents with any transfer. He stated the provider did not have a specific policy on transferring and gait belt use. He confirmed all staff had been trained in the use of a gait belt and proper transfer techniques.</p> <p>Interview on 9/5/14 at 11:45 a.m. with resident 3 revealed she recalled the transfer that had resulted in arm pain. She stated she had been "pulled roughly" into her wheelchair and then onto the toilet. She stated she remembered no gait belt had been used for that transfer. She pointed to the gait belt that was around her waist at that time. She stated "They are always supposed to use this."</p> <p>Surveyor: 32333</p> <p>3. Review of resident 4's 6/3/14 care plan revealed he had a focus area for the potential to show signs and symptoms of moods and behaviors. He had a history of swinging (hitting) at staff and refusing care at times. He had been short tempered with staff and had refused meals and medications. He had an intervention that when he refused care staff would leave, come back after a few minutes, and try again. Staff</p>	F 282			

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 282	<p>Continued From page 26</p> <p>were to explain to him why the care was needed and beneficial.</p> <p>Review of resident 4's nursing progress notes revealed on 6/22/14 at 1:00 p.m. "It was observed that resident 4 has bruising on both wrists with a scabbed laceration on his right forearm."</p> <p>Review of the provider's 6/22/14 5-day working day investigation report completed by the DON revealed: ... "An interview was conducted with an overnight aide and the question was asked "how do you think it happened?" His response was that when resident 4 starts being physically abusive he would hold his wrists so resident 4 would not hit him. He was asked if he had done this in the last two weeks and he responded "yes[.]".</p> <p>Interview on 9/5/14 at 10:00 a.m. with the DON regarding CNA B who had held resident 4's wrists when he became combative revealed: *He should have known through his training how to appropriately handle a resident with dementia who became agitated or combative, but he had not in this circumstance. *He should not have held down the resident's wrists. *He should have reapproached the resident at a later time. *The CNA had not documented the behaviors, because the behavior had not seemed out of the ordinary. *The CNA had not reported the bruises and had stated he had not noticed a skin tear. *His expectation would have been that all behaviors should always have been documented. *The care plan should have been followed.</p> <p>Review of the provider's 10/10/11 CNA job</p>	F 282			

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702	
(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 282	Continued From page 27 description revealed: *Assist with promoting a compassionate physical and psychosocial environment for the residents. *Provide resident care as directed by the care plan and/or nursing staff. *Ensure residents' comfort while assisting them in achieving their highest practicable level of functioning. *Must adhere to the company's code of conduct and business ethics policy including documentation and reporting responsibilities.	F 282	*nursing staff including CNAs NS/SDDDH/MF	
F 514 SS=E	Refer to F281, finding 1. 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review and interview, the provider failed to ensure complete and accurate documentation had been maintained for three of four sampled residents (2, 3, and 4). Findings	F 514	F514 1. All residents are at risk. No immediate action could be taken for residents 2,3, and 4. 2. DNS or designee will educate all [redacted] regarding documentation by September 27, 2014. *behavior NS/SDDDH/MF 3. DNS or designee will audit documentation daily with Clinical Start Up (Monday-Friday) for proper documentation and follow up documentation following change of conditions. This audit will be done 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. 10/17/2014 *These audits will also review behavior documentation by CNAs. NS/SDDDH/MF	10/17/14

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 514	<p>Continued From page 28 include:</p> <p>1. Review of resident 2's 8/27/14 nurse's note revealed she had fallen off the toilet after being left alone by certified nursing assistant (CNA) D. That fall had resulted in two, two-inch lacerations, one on her forehead and one on the top of her head.</p> <p>Review of resident 2's 8/28/14 follow-up documentation from her visit to the emergency room revealed the upper gash "was down to the bone and they found paint in it."</p> <p>Review of resident 2's nurse's notes revealed there was no documentation describing the incident other than she had fallen from the toilet after being left unattended.</p> <p>Interview on 9/5/14 at 11:00 a.m. with the director of nursing (DON) revealed all charting was "done by exception." He stated they did not have a policy on what should be included in documentation. He stated charting by exception meant only documenting those concerns that were not routine or normal. He confirmed further documentation of the incident should have been included in the nurses notes.</p> <p>2. Review of resident 3's 6/30/14 verification of investigation report revealed at 12:45 a.m. that day she had been complaining of arm pain. That had occurred after a "rough transfer" to her wheelchair by a CNA. That assessment stated she had pain noted in the right arm and left groin at that time. Further documentation in those nurses notes stated the CNA had provided the resident with an ice pack for complaints of pain. The CNA had not reported that to the charge</p>	F 514			

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

PRINTED: 09/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
(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 514	<p>Continued From page 29 nurse.</p> <p>Review of resident 3's 6/30/14 nurses notes revealed she had complained of pain in her left leg. That pain was rated as a "5" on a scale of 1 to 10. There was no mention in those nurse's notes of pain in her right arm or left groin.</p> <p>Interview on 9/5/14 at 11:00 a.m. with the DON revealed he confirmed there was no documentation in the nurses notes related to the arm or groin pain after the transfer. He stated that would have been considered an "exception" and should have been documented.</p> <p>Surveyor: 32333 3. Review of resident 4's complete medical record revealed: *No documentation of alleged physical behaviors toward staff from 6/1/14 through 6/22/14. *Documentation of observed bruises to his wrists and a skin tear on 6/22/14. *No documentation his family had reported the above bruises to his wrists and his skin tear to staff on 6/22/14.</p> <p>Interview on 9/5/14 at 10:45 a.m. with the DON confirmed: *Behaviors should have always been documented. *It should have been documented the resident's family brought his bruised wrists and skin tear to their attention.</p> <p>Refer to F281, finding 1.</p>	F 514			