

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GROTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1106 NORTH SECOND STREET GROTON, SD 57445
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 12218</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/12/13 through 11/14/13. Golden LivingCenter - Groton was found not in compliance with the following requirements: F281 and F325.</p> <p>F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on record review, interview, and policy review, the provider failed to: *Follow physician's orders for one of nine sampled residents (6). *Document sliding scale insulin units for one of one sampled resident (1) on sliding scale insulin. Findings include:</p> <p>1. Review of resident 1's November 2013 Medication Administration Record (MAR) revealed a physician's order dated 10/21/13 for sliding scale insulin four times a day. The MAR documented the site of insulin injection, the blood sugar reading, and the time of insulin administration. There had been no designated area for documentation of how many insulin units had been given as per the sliding scale insulin order.</p>	F 000	<p><i>Addendum noted with an asterisk per 01/02/14 telephone to facility DON. MJH/SDOH/MF</i></p> <p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p> <p>F 281 Services Provided Meet Professional Standards</p> <p>1. Resident 1's Medical Record reviewed in Point Click Care on 11/14/13. Health Information Manager (HIM) added necessary fields into the Electronic Medical Records (eMar) profile in order to enable documentation of the sliding scale dose of insulin to appear when the eMar is printed as a "hard copy". The omission of the fields was an oversight that was noticed after eMar software conversion which occurred on 11/12/13.</p> <p>Sliding scale insulin was being documented in the eMar system but not pulling over into the software for the printed version.</p> <p>Resident 6's Medical Record reviewed by Director of Nursing Services (DNS) regarding missing lab work. Resident 6's physician notified of missing lab work with orders received to obtain hgb-A1c. Resident 6's lab was drawn and sent to lab.</p> <p>2. All residents receiving sliding scale insulin have the potential to be effected by this practice. All residents with physicians orders have the potential to be effected by this practice.</p> <p>3. HIM reviewed all residents with sliding scale insulin medical records to verify that the appropriate fields were entered in their eMar.</p>	*01/02/14 MJH/SDOH/MF
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tom Stator</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>12/10/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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If continuation sheet Page 1 of 8
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GROTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1106 NORTH SECOND STREET GROTON, SD 57445	
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F 281	<p>Continued From page 1</p> <p>Interview on 11/13/13 at 1:20 p.m. with the director of nursing services (DNS) revealed their computerized MAR system automatically informed the nurses how many units of insulin to administer. The system had no area to document how many units of insulin had actually been administered. She confirmed there was no way to track the units of insulin administered.</p> <p>Review of the provider's Blood Sugar Monitoring policy dated 2006 revealed if insulin had been ordered based on a sliding scale document the type and amount of insulin administered and the site of the injection.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p. 885, revealed when administering injections chart medication dose, route, site, time, and date given in the medication record.</p> <p>Surveyor: 12218</p> <p>2. Review of resident 6's physician's orders dated 6/4/13 revealed an order for laboratory tests for BMP (basic metabolic panel), CBC (complete blood count), and A1c (the control of blood sugars over a 3 month period).</p> <p>Review of resident 6's laboratory test results revealed: *No A1c test results in June 2013. *No A1c test results since 2/28/13. *A1c test result on 2/28/13 was 5.0 per cent (%). Normal range was 4.8 to 6.0%. *A1c test completed prior to 2/28/13 was on 11/28/12, and the test result was 4.9%.</p> <p>Review of resident 6's medical record revealed</p>	F 281	<p>DNS or designee will provide education to nurses regarding professional standard for transcription of physician orders by 12/12/13.</p> <p>4. HIM will perform an audit to review eMar's of all residents receiving sliding scale insulin _____ . DNS or designee will perform _____ physician orders audits weekly _____ . Results of these audits will be presented to the monthly QAA committee by the Director of Nursing Services for review and recommendation. Substantial compliance will be in place by _____ .</p> <p><i>*weekly x 1A MH/SDDH/MF</i></p> <p><i>*January 3, 2014. MH/SDDH/MF</i></p> <p><i>*HIMK IA. MH/SDDH/MF</i></p>	

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F 281	Continued From page 2 he: *Was originally admitted to the skilled nursing home on 12/1/11 with a diagnosis of diabetes mellitus Type II without complication, and a weight of 240 pounds (lb). *Had a previous A1c test on 5/9/11 with a result of 6.1% which was above the normal range of 4.8 to 6.0%. *Had no diabetic medications and was on a diabetic diet. *Was put on a regular diet and no medications for the diabetes after he had returned from the hospital on 4/16/12. *Currently had physician's orders (October 2013) for a regular diet, no diabetic medications, and his diagnoses included diabetes mellitus. *Had a weight of 183 lb on 10/8/13, and 180 lb on 11/1/13. Interview with the director of nursing at 4:00 p.m. on 11/13/13 revealed: *She confirmed there was a physician's order for an A1c lab test along with a BMP and a CBC test dated 6/4/13. *She found the order for laboratory tests in the appointment book scheduled for 10/3/13. *She confirmed the appointment on that date had been for the BMP and the CBC, but the A1c was not included. *She confirmed the nurse who had transcribed the physician's order onto the appointment book and had called for the tests, had not included the A1c test. *She confirmed they had not followed the physician's 6/4/13 order for the A1c test.	F 281			
F 325 SS=E	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325	F325 Maintain Nutrition Status Unless Unavoidable	X 01/03/14 MUN/SDDH/ME	

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F 325	<p>Continued From page 3</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560</p> <p>Based on record review, interview, and policy review, the provider failed to monitor weight changes for five of nine sampled residents (1, 4, 5, 6, and 7). Findings include:</p> <p>1. Review of resident 1's weight summary form revealed: *On 9/25/13 a weight of 202.0 pounds (lb). *On 10/9/13 a weight of 195.0 lb - a weight change of 7 lb. *On 10/21/13 a weight of 187.2 lb - a weight change of 7.8 lb. There was no documentation resident 1 had been re-weighted following the weight changes.</p> <p>2. Review of resident 5's weight summary form revealed: *On 8/10/13 a weight of 134.0 lb. *On 9/4/13 a weight of 140.0 lb - a weight change of 6 lb. *On 10/8/13 a weight of 133.0 lb - a weight change of 7 lb. There was no documentation resident 5 had been</p>	F 325	<p>1. Residents 1, 4, 5, 6, and 7 Medical Records reviewed for weights on 11/14/13 by DNS. Weight loss/gain policy updated on 11/14/13 to address guidelines for re-weights.</p> <p>2. All residents have to potential to be effected by this practice.</p> <p>3. Nursing staff were educated on 11/14/13 by DNS regarding new guidelines for re-weights. All staff to be educated by 12/1213.</p> <p>4. Director of Nursing Services or designee will randomly audit resident weight deviations. Audits will be completed weekly x12. Results of these audits will be presented to the Nutrition committee and monthly QAA committee by the Director of Nursing Services for review and recommendation. Substantial compliance will be in place by February 1, 2014. * Audits on resident weights will include all residents. MJH/SDDH/MF</p>	

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F 325	<p>Continued From page 4 re-weighed following the weight changes.</p> <p>3. Interview on 11/13/13 at 1:20 p.m. with the director of nursing services (DNS) revealed residents should have been re-weighed when there was a 5 lb change. Resident weights were documented on their weight summary forms.</p> <p>Surveyor: 12218</p> <p>4. Review of resident 6's weight record since admission on 12/1/12 revealed many large weight losses and gains between months. There were no indications any reweights had been done (except for 3/3/13) to verify those large weight variances were valid. The following weights from 12/1/12 to 11/1/13 on resident 6's weight record indicated standing, sitting, or wheelchair for only five occasions otherwise it had been left blank: *Admission weight 12/1/11 was 240 lb (standing). *1/12/12: 228 lb, a loss of 12 lb. *3/30/12: 209 lb, a loss of 19 lb. *4/16/12: 207 lb, a loss of 2 lb and a total of 33 lb weight loss in over 4 months. *6/4/12: 224 lb, a gain of 17 lb. *7/7/12: 204 lb (sitting), a loss of 20 lb. *9/5/12: 194 lb (wheelchair), a loss of 10 lb. *11/7/12: 189 lb (wheelchair), a loss of 5 lb. *12/2/12: 189.4 lb, represented a loss of 50.6 lb in one year, and there were no reweights recorded. *3/3/13: 250 lb had been crossed out. *3/3/13: (taken one minute later) 185 lb (wheelchair), was a reweight that showed a 4.4 lb weight loss instead of a 60.6 lb weight gain. *8/1/13: 180 lb, a loss of 5 lb. *9/1/13: 184 lb, a gain of 4 lb. *11/1/13: 180 lb, a loss of 4 lb.</p> <p>Surveyor: 33265</p>	F 325		

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F 325	<p>Continued From page 5</p> <p>Preceptor: 16385</p> <p>5. Review of resident 4's weight records from 9/5/12 to 11/2/13 revealed:</p> <p>*12/2/12 - 167.0 lb - not documented if in a wheelchair or not.</p> <p>*1/5/13 - 162.0 lb at 2:23 p.m. - not documented if in a wheelchair or not - loss of 5 lb.</p> <p>*1/6/13 - 161.4 lb at 10:39 p.m. in a wheelchair - not reweighed within twenty-four hours - loss of 5.6 lb.</p> <p>*9/1/13 - 154.0 lb - not documented if in a wheelchair or not.</p> <p>*10/8/13 - 148.0 lb - not documented if in a wheelchair or not - loss of 6 lb - not reweighed.</p> <p>*11/2/13 - 153.0 lb - not documented if in a wheelchair or not - gain of 5 lb - not reweighed.</p> <p>6. Review of resident 7's weight records from 9/4/12 to 11/2/13 revealed:</p> <p>*4/1/13 - 162.0 lb - not documented if in a wheelchair or not.</p> <p>*5/14/13 - 140.0 lb - not documented if in a wheelchair or not - loss of 22 lb - not reweighed.</p> <p>*6/2/13 - 154.0 lb at 2:11 p.m. - not documented if in a wheelchair or not - gain of 14 lb.</p> <p>*6/3/13 - 148.2 lb at 2:29 p.m. - not documented if in a wheelchair or not - if completed as reweight was not done within twenty-four hours - showed a loss of 5.8 lb in one day - not weighed again until 7/2/13.</p> <p>*7/2/13 - 144.2 lb - in a wheelchair.</p> <p>*8/9/13 - 137.0 lb - not documented if in a wheelchair or not - loss of 7.2 lb - not reweighed within twenty-four hours - next weight on 8/13/13.</p> <p>Interview on 11/14/13 at 10:20 a.m. with the DNS and another surveyor revealed:</p> <p>*Reweights should have been done on residents 4 and 7 when their weights had changed more</p>	F 325			

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F 325	<p>Continued From page 6</p> <p>than a few pounds.</p> <p>*They had a policy to report any weight variance of 5 percent (%) in thirty days or 10% in six months.</p> <p>* Weight changes on a small person of 100 lb or less would be more significant than on a larger person.</p> <p>*She could not provide any reason why reweights on residents 4 and 7 had not been completed.</p> <p>*Certified nursing assistants could see a previous weight but not necessarily the most recent weight when they weighed residents.</p> <p>*Charge nurses were to review weights.</p> <p>*There was only one scale, but whether the residents were weighed in their wheelchairs or not was not consistently documented.</p> <p>*She confirmed they did not have a consistent system in place for reweights.</p> <p>Interview on 11/14/13 at 10:25 a.m. with registered nurse A revealed:</p> <p>*Her "unwritten standard" was to reweigh any resident whose weight had changed by more than 3 pounds, and to do a reweight within twenty-four hours and in the same position (in the wheelchair or standing).</p> <p>*She agreed residents 4 and 7 should have been reweighed according to the Weights and Vitals Summary sheets for the last year that identified the need for a second weighing when weight changed more than 5 pounds.</p> <p>*She could not provide a reason why the reweights had not been completed.</p> <p>Review of the provider's undated Weight and Height Measurement procedure revealed:</p> <p>**Notify the charge nurse or physician of all weight changes of five pounds (or 5%) or more in</p>	F 325			

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F 325	<p>Continued From page 7</p> <p>a 30-day period or ten percent in a 180-day period or per state requirements." *There were no written instructions or guidance as to when to reweigh a resident.</p> <p>Review of the provider's Re-Weight Guideline created 11/14/13 revealed if a resident's weight showed a change of plus or minus 3 or more lb a re-weight would be obtained within twenty-four hours.</p> <p>Review of Lisa Eckstein and Katheryn Adams, Dietetics in Health Care Communities Pocket Resource for Nutritional Assessment, 2013 Ed., p. 24, revealed body weight was the most useful single observation for assessment of nutritional status.</p>	F 325			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GROTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1106 NORTH SECOND STREET GROTON, SD 57445
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/13/13. Golden LivingCenter - Groton 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 the deficiency identified at K038 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per initials telephone to facility DON. CH/SDDDH/MF</p>	
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, record review, and interview, the provider failed to ensure two of four exits (north exit from the 100 wing and the main entrance/exit) were readily accessible at all times. Findings include:</p> <p>1. Observation and testing at 1:00 p.m. on 11/13/13 revealed the north exit door from the 100 wing was equipped with an access control type magnetic lock. Testing of that door during the audible fire drill revealed it did not release upon</p>	K 038	<p>K038 Life Safety Code Standard</p> <ol style="list-style-type: none"> Maintenance Director was educated on 11/18/13 regarding need for automatic release of magnetic locks when fire alarm is activated. Contractor contacted on 11/18/13 with work order to test and repair the magnetic lock by 12/5/13. Delayed egress sign to be posted by door by 12/12/13. All residents have the potential to be effected by this practice. Staff responsible for checking egress doors will be educated on 12/12/13 regarding egress exits when fire alarm system is active. Maintenance Supervisor or designee will randomly audit function of egress doors x3 month during fire drills. These audits will be presented by the Maintenance Supervisor to the monthly QAA committee for review and recommendation. <p>* [REDACTED] CH/SDDDH/MF</p>	<p>* 01/03/14 CH/SDDDH/MF</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 12/10/13
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If continuation sheet Page 1 of 2

SD DOH L&C

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K 038	Continued From page 1 activation of the fire alarm. Record review of the fire alarm inspection report dated 8/06/13 revealed the inspection company noted the magnetic locks for the doors had been checked (without further comment). Interview with the interim maintenance supervisor at the time of the observation confirmed those findings. 2. Observation and testing at 1:15 p.m. on 11/13/13 revealed the main entrance door was equipped with a magnetic lock that could be activated manually in the evenings or by a wander management device. Testing of the locked door revealed it was a delayed egress type magnetic lock. There was not a delayed egress sign posted on the door indicating how to exit the building if the door was locked. Interview with the interim maintenance supervisor at the time of the observation confirmed that finding.	K 038		

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10626	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GROTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1106 NORTH SECOND STREET GROTON, SD 57445
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 11/12/13 through 11/14/13. Golden LivingCenter - Groton was found not in compliance with the following requirement: S156.	S 000	Addendums noted with an asterisk per 11/14/13 telephone to facility DON. CH/SDDOH/MF	
S 156	44:04:02:12 VENTILATION Electrically powered exhaust ventilation must be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Rule is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install exhaust fan ventilation in one of one storage rooms (adjacent to the boiler room). Findings include: 1. Observation at 10:00 a.m. on 11/13/13 revealed there was no continuous mechanical exhaust fan installed in the 75 square foot storage room adjacent to the boiler room. The room also had a janitor's floor sink. Interview with interim maintenance supervisor at the time of the observation confirmed that finding. He stated the room had apparently never been equipped with an exhaust fan.	S 156	S156 Ventilation 1. Maintenance Director was educated on 11/18/13 regarding need for exhaust fan ventilation in storage room adjacent to boiler room. 2. All residents have to potential to be effected by this practice 3. Maintenance Director will contact and schedule contractors to install exhaust fan ventilation by 12/12/13. 4. Maintenance Director to complete audits of exhaust fan ventilation operation weekly x4 then monthly x3. Results of these audits will be presented by the Maintenance Director to the monthly QAA committee and Safety Committee for review and recommendation [Redacted] CH/SDDOH/MF	* 01/03/14 CH/SDDOH/MF

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

[Signature]

TITLE

Executive Director

RECEIVED (X6) DATE
DEC 10 2013
DEC 17 2013
SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10626	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2013
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