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

ORIGINAL

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435050		03/05/2014

NAME OF PROVIDER OR SUPPLIER
GOLDEN LIVINGCENTER - ARLINGTON

STREET ADDRESS, CITY, STATE, ZIP CODE
120 CARE CENTER ROAD POST OFFICE BOX 280
ARLINGTON, SD 57212

(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	INITIAL COMMENTS Surveyor: 30170 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/3/14 through 3/5/14. Golden LivingCenter-Arlington was found not in compliance with the following requirements: F279, F281, F323, F425, and F441.	F 000	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.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, record review,	F 279	F279 - Development Comprehensive Care Plans 1. CNA C was educated verbally by the Executive Director on 3-5-14 regarding using 2 to transfer for Resident 1 until further assessment can be made and to ensure positioning assistance is provided to Resident 1 every two hours. A lift assessment was completed on 3-26-14 for Resident, including determination of safety of resident being left unattended on the toilet. Resident 1's careplan was updated to reflect the results of the lift assessment. CNA C was also educated verbally to check for potential injury if an incident occurs and report it to the charge nurse. Any residents using a full mechanical lift or who are completely dependent have the potential to be affected by this.	4/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Sampson
TITLE: Executive Director
(X6) DATE: 3/21/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	Continued From page 1 and policy review, the provider failed to ensure staff followed a comprehensive plan of care for one of one sampled resident (1) who had mobility (moving freely) and skin issues. Findings include: 1. Observation on 3/4/14 at 8:40 a.m. in the dining room with resident 1 revealed: *She was sitting at a dining room table in her high back wheelchair (w/c) eating breakfast. *The resident stated, "My butt is so sore. My right side of my butt is so sore, I can't stand it." *Certified nursing assistant (CNA) C assisted the resident back to her room. a. Observation on 3/4/14 at 8:55 a.m. with resident 1 and CNA C revealed: *The CNA placed her in the Maxi-Move body lift and transferred her independently to the bathroom. During the transport to the bathroom the CNA bumped resident 1's right elbow on the side of the door frame of the bathroom. The CNA never check the resident for injuries and had not mentioned reporting the incident to the nurse. *She placed the resident on the toilet and left the room. *She returned three minutes later and assisted the resident out of the bathroom to the her bed. *She transferred the resident to her bed in the Maxi-Move body lift and placed her in bed on her left side. Interview after the above observation with CNA C regarding the transferring of resident 1 revealed: *She had usually performed the transferring of resident 1 in the Maxi-Move by herself. *She would usually leave the resident in the bathroom unattended for approximately five minutes, and then would return to assist her off the toilet.	F 279	F279 Continued 2. In-service training will be provided to CNA staff by April 21, 2014. In-servicing will include review of following the plan of care, checking the resident for potential injury following an incident and reporting this to charge nurse, and repositioning requirements for dependent residents.. 3. The Director of Nursing Services (DNS) or designee will audit care plans of dependent residents for transfers, toileting, bed mobility, and repositioning and will audit actual resident transfers and repositioning weekly times 4 weeks, then monthly times 3 months to ensure compliance. Results of these audits will be presented to the monthly Quality Assurance Process Improvement (QAPI) committee by the DNS for review and recommendation. Addendum "all" GRS 4/9/14	

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F 279	Continued From page 2 b. Random observations on 3/4/14 from 9:05 a.m. through 11:30 a.m. of resident 1 revealed: *She was placed on her left side in her bed and continued to stay in that position throughout the observation period. *Two staff members returned to her room at 11:30 a.m. to assist her to her w/c for the noon meal. Interview on 3/4/14 at 1:33 p.m. with CNA I regarding the transportation of resident 1 with the Maxi-Move body lift revealed: *She would always use two staff to transport the resident in the Maxi-Move body lift. *She would never have left the resident unattended in the bathroom. c. Random observation on 3/4/14 from 1:30 p.m. through 4:35 p.m. of resident 1 in her bed revealed she continued to rest on her right side. She was on that side until staff returned to assist her to the w/c for the supper meal at 4:35 p.m. Review of resident 1's 1/10/14 Minimum Data Set (MDS) revealed: *She was a total assist of two staff persons with transfers. *She was an extensive assist for toileting. Interview on 3/4/14 at 5:00 p.m. with the director of nursing and the executive director revealed: *The Maxi-Move body lift could have been used independently by staff. *CNA C could have left resident 1 in the bathroom independently as long as the breaks were on the lift. Review of resident 1's 1/17/14 comprehensive	F 279		

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F 279	Continued From page 3 care plan revealed: *She should have been repositioned every two hours. *The staff were to have stayed with the resident during toileting. *When the staff toileted the resident she should have been an extensive assist of two staff. Review of the provider's 2006 Positioning of Resident policy revealed: *The purpose was to: -Relieve pressure and prevent skin breakdown. -Relieve pain. -Promote proper body alignment. Review of the provider's undated Care Plan policy revealed: *The purpose of the policy was to ensure an interdisciplinary approach to the identification of problems and for development of solutions that would have provided individualization and coordination of resident care. *There was no specific guidelines referring to the staff following the resident's plan of care.	F 279		
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: 33488 Preceptor: 30170 A. Based on closed record review, interview, and policy review, the provider failed to ensure an	F 281		

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F 281	Continued From page 4 ongoing assessment, monitoring, intervention, and documentation had occurred for one of one newly admitted sampled resident (10) with a fall and unstable blood sugars. Findings include: 1 a. Review of resident 10's complete medical record revealed: *She had been admitted on 8/30/13. *She was alert and orientated to person, place, and time. *She expired on 9/1/13. *She had the following diagnoses: -Insulin dependence with unstable diabetes. -High blood pressure (BP). -Muscle weakness. -History of stroke. -History of carotid endarterectomy (a surgery on an artery in the neck to prevent future stroke) prior to admission. *On 8/31/14 at 3:15 p.m. she had been found face down on the floor from an unwitnessed fall. *There was one neurological (neuro) assessment (an assessment by nursing staff to check brain functioning) which included: -Vital signs (BP, temperature, pulse, and respirations). -Pupil size and reaction to light. -Level of consciousness (which would show alertness and orientation to person, place, and time). -Response to verbal questioning and pain. *On 8/31/13 at 3:15 p.m. the following neuro checks were documented: -BP was 139/72 (normal blood pressure is 120/80). -Pulse (beats [heart] per minute) was 78 (normal is 60-100). -Respirations (breathing) were 16 per minute (normal 12-20).	F 281	F281 Services provided meet professional standards 1. There is no corrective action to be taken on Resident 10, as resident passed away 9-1-13. Resident 4 oxygen was turned on upon discovery that it was off. Resident 11 ate supper after he was given the ferrous sulfate. All residents who have a fall, have diabetes with unstable blood sugars, are on oxygen, or are on any medications with restrictions to be taken with food have the potential to be affected by this practice. 2. The following policies were reviewed: Condition Change of a Resident to include appropriate assessment and follow-up care and documentation of an individual after a fall, and discussion of appropriate assessment and follow-up care and documentation of an individual with unstable blood sugars, and physician notification; documentation regarding details of CPR; appropriate assessment and use of oxygen including ensuring oxygen is flowing and safe use and storage of oxygen; and medication administration ensuring accurate and safe administration. Directed in-service training will be provided to Professional Nursing Staff on all of the aforementioned policies and procedures by April 2. Directed inservice training will provided to all staff regarding the use, monitoring, handling and storage of oxygen by April 2.	4/22/14

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F 281	Continued From page 5 -Right and left pupils were equal in size and reactive to light. -All her extremities were documented as weak. *On 8/31/13 at 8:10 p.m. her blood pressure was 126/50, and her pulse had been 65. There was no complete neuro assessment done at that time. *On 8/31/13 at 8:30 p.m. her BP was 112/57, and her pulse was 65. There was no complete neuro assessment done at that time. Review of the provider's 8/31/13 post fall investigation plan completed at 6:33 p.m. for resident 10 revealed: *She had lost her strength. *She had impaired safety awareness/judgment. *A blood sugar was to have been obtained if diabetic. *No blood sugar was documented. *She had a bruise on her left eye and left arm, and a right arm abrasion (scrape). *She had been wearing slippers at the time of the fall. *She was found soiled (incontinent of bowel or bladder). *A summary of her activities revealed: -"Resident was resting in chair before fall." -"Resident was in a lift chair, and had pushed control ahead and fell out on the floor." Review of the nursing progress notes from 8/30/13 at 6:00 p.m. through 9/1/13 at 3:17 p.m. for resident 10 revealed: *On 8/31/13 at 5:58 p.m. the nurse documented: -She had left arm pain. -She had a red mark on the left side of her face that measured three centimeters (cm) long. -Her left eye was bruised. -Her left arm had slight bruising at that time. -She had a five cm shearing (abrasion) to her	F 281	F281 Continued Deleted 4/9/14 gms 3. ~~The DNS or designee will audit compliance with the aforementioned policies and procedures weekly times 4 weeks, then monthly times 3 months. Results of these audits will be presented to the monthly QAPI committee by the DNS for review and recommendation.~~ Addendum on next page. 4/9/14 gms	

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F 281	Continued From page 6 right arm. -She was lifted off the floor by a mechanical lift with the assistance of four staff members. -Her husband had asked her if she wanted to seek a medical evaluation at the hospital to which she declined. *On 8/31/13 at 10:58 p.m. the nurse documented: -"At 8:00 p.m. her blood sugar was 30 milligrams/deciliter (mg/dl) (normal level is 70-100 mg/dl)(Blood sugar levels below 50 would be considered critical and would require treatment by emergency services)." -"She was sweaty, clammy, and not responsive." -"She was making grunting sounds." - "She got eight ounces (oz) of juice with four sugars and she did drink it down very well." -They rechecked her blood sugar at 8:10 p.m., and it was 36 mg/dl. - "Got vitals cart and glucose (sugar) gel to administer." -Vitals: BP had been 126/50, and her pulse was 65 BMP. -At 8:20 p.m. the resident received 15 grams of glucose gel. -Her blood sugar was rechecked and was 54 mg/dl. -At 8:30 p.m. the glucose gel was repeated with a follow-up blood sugar of 67 mg/dl. -Her blood pressure was 112/57, and her pulse was 65 mg/dl. -At 8:45 p.m. her blood sugar was 75 mg/dl. *The resident's physician was notified by phone forty- five minutes after the first blood sugar level. *The physician was notified of "what had taken place" and ordered a peanut butter and jelly sandwich. *The glucose gel had not been administered as ordered for blood sugar levels less than 60 mg/dl until twenty minutes after her initial blood sugar	F 281	F 281 Addendum GRS 4/9/14 3. DNS or designee will audit all newly admitted resident medical records to ensure that appropriate assessment and documentation are completed to ensure that unstable conditions are managed appropriately. All residents with continuous oxygen orders, to include Resident 4, will be monitored by the nurse on each shift to be sure oxygen is in place and functioning at the appropriate flow. Oral medication administration competency check-off will be completed with Employee A. DNS or designee will audit all residents with a change of condition noted to ensure: A) condition change of a resident is documented adequately and resident condition is being monitored, documented and treated until resident's condition is stable; B) physician is updated regarding a resident's change of condition; and C) documentation regarding the details of a code are present on the medical record. addendum continued on next page 4/9/14 GRS	

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F 281	Continued From page 7 level. *At 10:00 p.m. the blood sugar was 117 mg/dl. -The resident stated she felt better and went back to sleep. -The nurse documented she would pass the information on to the oncoming shift nurse to monitor closely. *On 9/1/13 at 4:54 a.m. the nurse documented: -"Not responding. Visual check (X) times 3 from 11:30 p.m. until staff updated charge nurse at 12:45 a.m. Admitted from ___ hospital on 8/30/13. Had Left Carotid Endarterectomy. Also diabetic. On insulin. On evening shift DR (doctor) updated regarding low blood sugars. Resident did not want to transfer to hospital. Husband aware. At 12:45, certified nursing assistant (CNA) reported to nurse aide her legs hurt and stated "could you just kill me." CNA replied "no" and told resident she would tell the charge nurse. Gave two prn (as needed) pain medication. Speech clear and she asked for a cup of tea at 1:15 a.m. cna reported resident not responding. Cool and clammy. Accu check (device used to check blood sugar) 212. No blood pressure. No pulse. Noted two shallow gasps. CPR (cardiopulmonary resuscitation) initiated. Executive director here and aware. AED (automated external defibrillator) used. Continued CPR. Received call from 911 dispatcher___ ambulance in route. Here and defib on. Flat line reading. Call placed to husband and daughter and no answer. Message left to return calls here. No calls returned. Second attempt to reach family without success." *On 9/1/13 at 7:48 a.m. the nurse documented: -"Received call from daughter. She had been at work for twelve hours and had just come home. Informed family of status of resident. Family inconsolable. Phone call interrupted by family.	F 281	F281 Addendum continued GAS 4/9/14 3 - continued. DNS or designee will audit all residents, to include Resident 4, on continuous oxygen to be sure it is being administered in accordance with physician's order. DNS or designee will audit to be sure medications are being administered in accordance with the physician's order, to include employee A in each audit sample. Audits will be done weekly for four weeks and then monthly for three months. Results of these audits will be presented to the monthly QAPI committee by the DNS for review and recommendation.	

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F 281	Continued From page 8 Waited twenty minutes and retried call and left message. Daughter would not make any decisions until her brother arrived from Minnesota and she does not know when this will happen. Condolences given. Offered family support." *On 9/1/13 at 3:17 p.m. the nurse documented: - "This am nurse called resident's husband's phone. He did not answer. Nurse did call daughter and asked daughter where she would like to have her mother's body released to. Daughter was very upset about her mother's passing. She did give her permission to have resident's body go (released) to ___ funeral home. Nurse called funeral home. ___ stated that he needed to have resident's daughter call him to give her permission for him to pick up her mother's body. Daughter did call funeral home and gave her permission for them to pick up body. Daughter and resident's husband came up and viewed body. ___funeral home came at 9:20 and picked up resident's body." *There was no documentation in the medical record the nursing staff had notified the physician, who had pronounced her deceased, how long CPR had lasted, who made the decision to discontinue CPR, or the exact time she had expired. Review of the August and September 2013 medication administration record (MAR) revealed: *Diabetic medications were as follows: -Januvia (tablet) 50 milligrams (mg) by mouth one time a day. -Lantus (insulin) 50 units given subcutaneously (injected by a needle just under the skin) at bedtime. -Metformin (tablet) 1500 mg by mouth at bedtime. -Novolog (insulin) 12 units given subcutaneously three times a day.	F 281		

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F 281	Continued From page 9 -Novolog (insulin) sliding scale to be given as instructed below for blood sugar levels as follows: -"60 to 150 give none. -151 to 200 give 2 units. -201 to 250 give 4 units. -251 to 300 give 6 units. -301 to 350 give 8 units. If over 350, call Dr. (doctor). If less than 60 give one tube glucose gel." *There was no documentation of blood sugar levels on 08/31/13 from 2:00 a.m. until 12:30 p.m. *Her blood sugar at 12:30 p.m. was 170 mg/dl. *There was no further documentation of blood sugars completed until 8:00 p.m. that evening when her blood sugar was found to have been 30 mg/dl. Review of resident 10's 9/11/13 physician's discharge summary revealed: *The admitting diagnoses for resident 10 were: -Diabetes. -Back pain. -Surgical convalescence (recovery) following carotid endarterectomy. -Weakness. *She was "admitted from ___ hospital for therapy following carotid endarterectomy. Unstable diabetic. Nearly blind. At 1:15 a.m. on 9/1/13 became non responsive. No BP (blood pressure) or pulse. CPR attempted. AED used. Ambulance arrived and their defibrillator attached with flatline reading (no electrical activity by the heart on the monitor)." *Her condition upon discharge was listed as NA (not applicable). *Her cause of death was "cerebrovascular disease secondary to diabetes mellitus." *The report had been completed by the DON on 9/11/13 and was signed by the attending	F 281		

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F 281	Continued From page 10 physician on 9/19/13. Interview and medical record review on 03/05/14 at 9:45 a.m. with the executive director and director of nursing (DON) regarding resident 10's care between her admission on 8/30/13 and her death on 9/1/13 revealed: *The above information was reviewed at the time of the interview. *The DON stated she was unsure why only one neuro check had been completed, but it "probably" had not been done since the one neuro check had been normal. *The DON was unsure why a blood sugar was not checked after her fall. *The resident had not been transported to the emergency room right away when her blood sugars were critically low as the DON stated their (the provider's) practice was to call the ER and ask for advice on a situation. *She agreed it had taken 45 minutes to call the physician on a critically low blood sugar when resident 10 had been unresponsive. *The DON stated "The order was to give glucose gel if the blood sugar had been below 60, not to call the Dr." *The DON stated when the resident's blood sugar was 117 at 10:00 p.m. there was no need to recheck her blood sugar since it was normal when she went to bed, and the resident "did get better." *The DON and the executive director both agreed the resident had been an unstable diabetic and her health and past medical history would not have been fully known to staff. *She had been new to the facility and therefore required close monitoring. *The DON and executive director confirmed there was no policy that directed the staff when they	F 281		

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F 281	Continued From page 11 should call for an ambulance in an emergency or what defined an emergency. *The DONs expectation was the nursing staff would have used their own judgment when to have called a physician. *The DON and executive director reported they had no protocols or reference materials available to guide nursing staff with resident care in relation to emergencies for critically low blood sugars. *The DON stated "They are nurses. They should just know." Interview and record review on 3/2/13 at 10:50 a.m. with the DON in her office revealed: *The provider had an undated flow sheet labeled Fall Risk/Post Fall Assessment Process. *Following a fall the nursing staff "documents a thorough assessment." *When asked what was included in a thorough assessment the DON stated "well a nurse should know that." Telephone interview on 3/5/14 at 2:10 p.m. with RN F, in the presence of the executive director and the DON revealed: *Her shift had begun at midnight on 9/1/13. *She had received report that resident 10's blood sugars were low during the evening on the previous day. *At 12:30 a.m. the resident had requested to see her. She had spoken with the resident regarding her leg pain, and had administered her Tylenol. *Resident 10 then wanted green tea. *A CNA reported to RN F the resident was not talking, so she went to assess the resident. *She checked her BP, and her pulse was "weak and thready." *She asked staff if the resident was a full code since she had not known the resident's history.	F 281		

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F 281	Continued From page 12 *She then began CPR and asked for the AED. *She had instructed the staff to call 911. *There had been no response from the ___ volunteer ambulance, so the 911 dispatcher called ___ volunteer ambulance service (approximately ten to twelve miles away). *The ambulance came; there was no reading (no heart electrical activity on the monitor). *The ambulance crew had decided to stop the full code. *She had not called the Dr. to inform him/her of resident 10's death as she was waiting for the family to call. *She stated she would have called the ___ ER (emergency room) for nursing guidance on resident health issues if she had felt she needed to. Review of the provider's 2006 Condition Change of Resident policy revealed the purpose of the policy was to have observed, recorded, and reported any condition change to the attending physician so proper treatment would have been implemented. Review of the provider's May 2001 Documentation policy revealed the medical record was a legal document. Therefore the record should have been accurate, legible, and complete. Review of the provider's January 2011 Clinical Health Status/Change of Condition Guideline revealed the process for identification for change of condition included the gathering of objective data and the documentation of assessment findings, resident response, physician, and family notification.	F 281		

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F 281	Continued From page 13 Review of the provider's undated Objectives of Cardiopulmonary Resuscitation (CPR) revealed the details of the code should have been documented. Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, Chapter One- Nursing Today, revealed: *Page 4, Standards of practice require use of the nursing process that included: -"The use of critical thinking in assessment, diagnosis, outcomes, identification and planning, implementation, and evaluation." -"The nursing process is the foundation for clinical decision making and includes all significant actions taken by nurses in providing care to patients." *Page 6, revealed "Nursing professional responsibility and roles require nurses are responsible for maintaining specific knowledge and skills for a variety of roles and responsibilities." Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, Chapter Sixteen- Nursing Assessment, pages 206-208, revealed: *"The nursing process is a critical thinking process that professional nurses use to apply the best available evidence to caregiving and promoting human functions and responses to health and illness." *"Assessment is the deliberate and systematic collection of information about a patient to determine his or her current and past health and functional status." *"The purpose of the assessment is to establish a database about patients perceived needs, health problems, and responses to these problems."	F 281		

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F 281	Continued From page 14 *"You perform assessment to gather information needed to make an accurate judgment about a patient's current condition." Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, Chapter Twenty Seven- Patient Safety, page 371, revealed: *"Successful critical thinking requires a synthesis of knowledge, experience, information gathered from patient's, critical thinking attitudes, and intellectual and professional standards." *"Clinical judgments require the nurse to anticipate necessary information, analyze the data, and make decisions regarding patient care." *"Critical thinking is an ongoing process." *"During assessment you consider all critical thinking elements and information about the specific patient to make appropriate nursing diagnoses." Review of Tracey B. Hopkins, Lab Notes, Philadelphia PA, 2009, page 66, revealed: "Patient's with a blood sugar under 50 are in danger of diabetic coma. The patient must ingest (eat) sugary foods immediately. If the patient is unconscious, 50% glucose should be administered intravenously (IV) (into the vein) STAT (immediately)." Surveyor: 12218 B. Based on observation, record review, and interview, the provider failed to ensure one of one sampled resident (4) received the appropriate volume of oxygen per physician order. Findings include:	F 281		

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F 281	Continued From page 15 1. Review of resident 4's medical record revealed: *A physician's order for 5 liters of oxygen continuously. *His eating ability coded on the Minimum Sata Set (MDS) was independent; that he could feed himself with some set-up assistance. *His cognitive ability coded on the MDS was he understood and could understand others. Observation on 3/4/14 at 8:45 a.m. of resident 4 revealed he was still in the dining room eating his breakfast. He was feeding himself slowly. He had eaten all of his bowl of hot cereal, one of two small 4 ounce (oz) glasses of milk, some of his pancake, none of his apple juice, and none of a bowl of cold cereal that he had requested. He had oxygen running through a nasal cannula (tube) into his nostils that was attached to a small oxygen cyclinder tank. The oxygen tank was in a cloth bag attached to the back of his wheelchair by two straps that were hooked on each handle of the wheelchair. There were still other residents eating and visiting leisurely at his table and several other tables around him. Further observation of resident 4 revealed his head was down, his hand was shaking, and his eyes were closed. Examination of the oxygen tank by this surveyor as well as another surveyor revealed the gauge on the tank appeared to be close to zero. A nearby CNA B who had been feeding another resident was requested to check the guage, and she stated the tank was empty. She left the dining room to get a replacement oxygen tank for resident 4. Upon her return she found that resident 4's oxygen tank had not been turned on, and that was why it was on zero. As	F 281		

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F 281	Continued From page 16 soon as she turned it on, resident 4 perked up and opened his eyes. Surveyor: 30170 C. Based on observation, interview, record review, and policy review, revealed the provider failed to ensure one of one sampled resident (11) was administered a medication (med) as prescribed by the physician. Findings include: 1. Observation on 3/3/14 at 5:45 p.m. during the supper med pass with registered nurse (RN) A revealed: *She had prepared meds for resident 11 and one of the meds was ferrous sulfate (an iron supplement) 325 milligrams (mg). *She administered all the meds to resident 11. *The resident had not received his supper tray until 6:05 p.m. Review of resident 11's 2/13/14 signed physician's orders revealed the ferrous sulfate 325 mg was to have been administered twice daily with food. Interview on 3/4/14 at 5:00 p.m. with the director of nursing and the administrator regarding the administration of the ferrous sulfate to resident 11 revealed the med should have been given with the supper meal or after the supper meal. Review of the provider's 12/12 Medication Administration policy revealed: *Medications were administered in accordance with written orders of the prescriber (physician). *Medications that were to have been given after meals or with food were to have been scheduled for administration immediately after and up to two	F 281		

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F 281	Continued From page 17 hours after meals.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to ensure 1 of 1 oxygen cylinder was safely secured during transport and 2 of 14 oxygen cylinders were safely secured during storage in storage room. Findings include: 1. Review of the 1/29/14 care plan revealed resident 4 was to have been receiving five liters of oxygen. Observation, interview, and record review on 3/4/14 at 8:45 a.m. in the dining room following the breakfast meal revealed the gauge on the oxygen cylinder attached to resident 4's wheelchair showed a pressure reading of zero. The oxygen tubing was in place in the resident's nostrils and was attached to the oxygen cylinder contained in a fabric holder attached to resident 4's wheelchair. This surveyor asked certified	F 323	F323 Free of Accident Hazards/Supervision /Devices 1. The Oxygen tanks that were unsecure were placed by CNA B in the oxygen storage rack on 3-4-14. CNA B was verbally instructed on 3-4-14 by Executive Director that oxygen tanks must be secure at all times. All residents have the potential to be affected by this practice. 2. Directed inservice training will provided to all staff regarding the proper storage and handling of oxygen cylinders by 4-2-14. ~~3. The Executive Director (ED)or designee will audit the proper use and storage of oxygen cylinders weekly times 4 weeks, then monthly times 3 months. Results of these audits will be presented to the monthly QAPI committee by the ED for review and recommendation.~~ delete 4/9/14 gas addendum on next page 4/9/14 gas	4/22/14

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F 323	Continued From page 18 nursing assistant (CNA) B to check the oxygen cylinder attached to his wheelchair. CNA B looked at the oxygen cylinder's gauge and had said the cylinder was empty. CNA B then left the dining room and retrieved an oxygen cylinder which she carried back to the dining room in her arms. She then set the oxygen cylinder standing upright on the floor behind resident 4's wheelchair. The oxygen cylinder at this time was also located behind another resident's wheelchair at the next table. CNA B then realized she did not have the key to open or close the air flow valve. She left the dining room to obtain the key. The oxygen cylinder she had carried out to the dining room was left standing upright on the floor, unattended, without being secured, behind and between two residents' wheelchairs. CNA B returned with the key and attempted to close the air flow valve on the oxygen cylinder on resident 4's wheelchair. She found the valve was in the closed position. No oxygen had been able to flow from the oxygen cylinder to resident 4. CNA B opened the valve, and the pressure was 2,400 pounds per square inch (almost a full tank of oxygen for that size cylinder). CNA B then left the oxygen cylinder with the opened valve attached to resident 4's wheelchair and picked up the extra oxygen cylinder she had brought out from storage. This surveyor accompanied CNA B to the storage area where she then set the oxygen cylinder upright on the floor, unsecured, and turned towards the doorway. 2. There were fourteen oxygen cylinders in the clean storage room. Two were placed upright on the floor and were not secured. Twelve cylinders	F 323	F323 - Addendum JAS 4/9/14 2. All residents with continuous oxygen orders, to include Resident 4, will be monitored by the nurse on each shift to be sure oxygen is in place and functioning at the appropriate flow. 3. The ED or designee will audit the proper use, replacement, and storage of oxygen cylinders, for all residents who use oxygen tanks, including Resident 4, weekly times 4 weeks, then monthly times 3 months. Results of these audits will be presented to he monthly QAPI committee by the ED for review and recommendation.	

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F 323	Continued From page 19 were in a cylinder storage containment stand on the floor. The storage stand had empty spaces for the two unsecured cylinders. Three empty single cylinder hand trucks (used to secure oxygen cylinders during transport) were also in the storage room. CNA B was asked if all the cylinders in the room contained oxygen. She answered all the cylinders in that storage room contained oxygen for resident 4's use. When asked why the oxygen cylinders were placed outside the storage containment rack she began to move them into the empty storage containment spaces. Interview on 3/5/14 at 3:45 p.m. with the executive director and the director of nursing revealed the expectation was to have oxygen cylinders secured for safety during transport and storage. Review of the provider's undated Handling and Storing Bottled Gases - Compressed Gases policy revealed: *Overview: -Without an understanding of the problems that could be caused by compressed gases (high pressure, explosive, fire, and health hazards), employees might expose themselves, others, and even property to risks which could have been avoided. *General handling precautions included: -Cylinders "must be transported" from the storage area to the user area by hand trucks. -Cylinders "must always be secured" against falling. -Cylinders "must be chained" against a wall or bench, or secured through use of authorized cylinder clamps or stands.	F 323		

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F 425	Continued From page 20	F 425		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, and policy review, the provider failed to safely store stock medication that included acetaminophen (Tylenol) 325 milligrams (mg) tablets, Tylenol 500 mg tablets, and docusate sodium (used for constipation) 100 mg capsules in one of one medication cart. Findings include: 1. Observation on 3/3/14 at 5:45 p.m. of the supper medication pass in the dining room with registered nurse (RN) A revealed:	F 425	F425 Pharmaceutical Service / Accurate procedures 1. RN A was instructed not to fill med cups with medications prior to administering the medications to the residents. Medications in the cups were destroyed on 3-4-14. 2. The ED, DNS, Pharmacist and interdisciplinary team reviewed the policy and procedure for medication administration ensuring accurate and safe administration. Directed inservice training will be provided to the professional nursing staff regarding this policy and procedure by April 2, 2014. 3. The DNS or designee will audit accurate and safe medication administration weekly times 4 weeks, then monthly times 3 months. Results of these audits will be presented monthly to the QAPI committee by the DNS for review and recommendation.	4/22/14

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F 425	Continued From page 21 *She was passing medication to the residents. *She had opened the top drawer of the medication cart. *There were three plastic medication (med) cups filled with the following: -One plastic med cup was filled with round white tablets. -One plastic med cup was filled with oblong white tablets. -One plastic med cup was filled with red and white capsules. Interview immediately following the above observation with RN A revealed: *She had been orientated to fill those med cups for easier access to the meds. *The white round tablets were Tylenol 325 mg. *The white oblong tablets were extra strength Tylenol 500 mg. *The white and red capsules were Colace (stool softener). *She agreed the practice was not safe. *The meds should have been left in their labeled containers to ensure safe medication administration. Interview on 3/4/14 at 5:00 p.m. with the director of nursing and the executive director regarding the above observation revealed the meds should have been left in their original containers for safe med administration. Review of the provider's September 2010 Storage of Medication policy revealed "Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration.	F 425		

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F 441	Continued From page 22	F 441		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 Infection Control, Prevent Spread, Linens 1. Beverage containers were removed from the clean linen carts. The razor in question was cleaned. All oxygen concentrator filters were cleaned. All residents have the potential to be affected by this practice. 2. The non-critical equipment cleaning and oxygen concentrator filter cleaning policies and procedures were reviewed by DNS and ED. Inservice training will be provided to all staff regarding infection control as it pertains to beverage containers and linens, cleaning razors, and cleaning oxygen concentrator filters by April 21, 2014. 3. The ED or designee will audit the storage of beverage containers, cleanliness of razors, and cleanliness of oxygen filters weekly times 4 weeks, then monthly times 3 months. Results of these audits will be presented monthly to the QAPI committee by the ED for review and recommendation.	4/22/14

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F 441	Continued From page 23 This REQUIREMENT is not met as evidenced by: Surveyor: 30170 Based on observation, interview, and policy review, the provider failed to ensure: *Appropriate storage of multiple staffs water containers in two of two residents clean linen carts in two of two bath areas. *One of one electric razor used for multiple residents was cleaned after each resident use. Findings include: 1. Observation on 3/3/14 at 5:50 p.m. in the 100 wing hallway revealed: *There was a linen cart placed in the hallway between resident rooms 104 and 106. *There was a closed container of water with lemon pieces in it sitting in the clean linen cart and was between the residents' gowns and pillow cases. *There was a blue electric razor placed on top of the clean linen cart in a bluish-green plastic container. It contained a large amount of whitish gray hair particles in the top of the razor. The electric razor was placed on top of pencils, pens, tongue depressors, and individual Betadine packages that were in the container. 2. Observation on 3/3/14 at 6:00 p.m. in the 200 wing hallway revealed: *The clean linen cart was placed in the hallway. *There was a large blue plastic glass with a straw inside the container that contained a clear liquid. It was sitting between the residents clean soaker pads and the clean pillow cases. 3. Observation on 3/4/14 at 8:25 a.m. in the 200	F 441		

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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
F 441	Continued From page 24 wing bath area revealed: *There was a large plastic pink container half full of a clear liquid with a straw in it. The glass was placed between the residents' clean gowns and the clean face towels. *The electric razor was placed in the greenish-blue plastic container and had whitish-gray hair particles in the top of the razor. Interview on 3/4/14 at 8:30 a.m. with CNA G regarding the above findings revealed: *She was unsure why there were containers of liquids placed in the residents' clean linen carts. She agreed the containers should not have been sitting in the residents' clean linen cart. *The razor was to have been cleaned with an alcohol pad after each resident use, and she was not sure why it had not been cleaned. 4. Random observations throughout the survey from 3/3/14 at 3:30 p.m. through 3/4/14 at 9:00 a.m. revealed: *Resident 4 had two oxygen concentrators that he had used, one in his room and the other one in the dining room where he had eaten his meals. The oxygen filters were very dusty with whitish-gray particles on the filter. *Resident 1 had an oxygen concentrator in her room that she used at night and as she needed for shortness of breath. The filter was very dusty and had a whitish gray particles on it. 5. Interview on 3/4/14 at 5:00 p.m. with the director of nursing and the executive director revealed: *The staff should not have been placing those drinking containers in with the residents' clean linen. *The razors should have been cleaned after each	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435050		03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ARLINGTON	120 CARE CENTER ROAD POST OFFICE BOX 280 ARLINGTON, SD 57212

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F 441	Continued From page 25 resident use. Review of the provider's October 2009 Infection Control policy revealed the facility's infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment. *The policies should have helped to prevent and manage transmission of disease and infections. Review of the provider's 2006 Oxygen Administration policy revealed at regular intervals check and clean oxygen equipment, masks, tubing, and cannulas.	F 441		

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

ORIGINAL

PRINTED: 03/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	(X3) DATE SURVEY COMPLETED
	435050		**03/05/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ARLINGTON	**120 CARE CENTER ROAD POST OFFICE BOX 280** **ARLINGTON, SD 57212**

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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/5/14. Golden LivingCenter-Arlington was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Sampson
TITLE: Executive Director
(X6) DATE: 3/31/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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APR 02 2014
SD DOH L&C

ORIGINAL

PRINTED: 03/18/2014
FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	10592		03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ARLINGTON	120 CARE CENTER ROAD ARLINGTON, SD 57212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments	S 000		
	Surveyor: 30170 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/3/14 through 3/5/14. Golden LivingCenter-Arlington was found not in compliance with the following requirement S206.		S206 Personnel training 1. Director of Clinical Education (DCE) was educated on the annual education requirements on 3-24-14 Dining Assistance and Nutritional risks was added to the yearly education calendar. All residents have the potential to be affected by this practice. 2. Inservice training will provided by the Registered Dietitian on Dining Assistance and Nutritional risks to all staff by April 21, 2014. 3. The ED or designee will audit the yearly educational calendar and inservice training monthly times 3 months. Results of these audits will be presented monthly to the QAPI committee by the ED for review and recommendation. 2. Addendum on next page. gms 4/9/14	4/22/14
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs.	S 206		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Sampson

TITLE: Executive Director

(X6) DATE

RECEIVED APR 10 2014 SD DOH L&C

STATE FORM 021199 YSD711 If continuation sheet 1 of 3

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10592	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 03/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD ARLINGTON, SD 57212		

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S 206	Continued From Page 1 This Rule is not met as evidenced by: Surveyor: 12218 Based on record review and interview, the provider failed to ensure all required in-service training sessions each year were offered to all the staff. Findings include: 1. Review of the annual required in-service agendas for 2013 revealed: *Dining assistance and nutritional risks of residents had not been presented. *Dining assistance included observation and awareness of resident eating requirements, assistance with encouragement, substitutions to be offered, feeding precautions to prevent choking and swallowing difficulties, types of fluids to use to prevent choking, changes in eating abilities and time requirements, necessity of encouraging residents to feed themselves or assist in feeding, social atmosphere of the dining room, room trays, and reheating of foods. *Nutritional risks usually included dangers of weight loss and weight gain, risks of nutrient deficiency, awareness of diet requirements such as dysphagia (difficulty in swallowing), diabetic, protein, lactose (allergy to dairy products), gluten (allergy to foods containing oats, wheat, barley and rye grains), fluid restrictions, nutrient requirements, poor eating habits, and importance of meal/food consumption records, and awareness of the residents at nutritional risk. The consultant registered dietitian (RD) had conducted in-services for all staff on the following: *July 2013 was on fluid and electrolyte imbalance. *February 2013 was on dignity in the dining room. Interview on 3/5/14 at 2:30 p.m. with the certified	S 206	S206 - Addendum JAS 4/9/14 2. For those staff not able to attend the inservice by 4/21/2014, they will be educated on a one-to-one basis using the written documentation of information provided by the dietitian at the inservice until all staff have received the information.	

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10592	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 03/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD ARLINGTON, SD 57212		

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S 206	Continued From Page 2 dietary manager and at 4:00 p.m. with the administrator confirmed: *The in-service had not been included in their annual required staff in-services. *They were unaware of the above requirement for nutrition and dining assistance. *They had a set agenda of in-services outlined by month that had been planned, but it did not include the above requirement.	S 206		