

ORIGINAL

PRINTED: 07/21/2014
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10593	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARMOUR	STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK ARMOUR, SD 57313
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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: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/7/14 through 7/9/14. Golden LivingCenter - Armour was found not in compliance with the following requirement: S206.	S 000	<i>Addendums noted with an asterisk per 8/11/14 telephone to facility administrator and DNS. PE/DOH/IME</i>	
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	S 206 PERSONNEL TRAINING 1. All three facility Unlicensed Medication Aides (UAPs) received the competency test, using the Med Pass Observation checklist, by either the Staff Development RN or Executive Director (ED) (who is an RN) on 7-14-14 and 7-24-2014. All demonstrated competency and passed the checklist test without error. 2. All residents had the potential to be affected by this failure. 3. Competency testing of Unlicensed Medication aides has been added to the yearly required training schedule to be conducted by the Staff Development RN. 4. Monitoring will be conducted by either the DNS or ED annually	

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

Barbara J Woods, RN

TITLE

EXECUTIVE DIRECTOR

(X6) DATE

STATE FORM

8899

FBO011

Stamp: EXECUTIVE DIRECTOR, JUL 31 2014, SD DOH L&C

Stamp: If continuation sheet of 2

South Dakota Department of Health

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S 206	<p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180</p> <p>Based on record review, interview, and guideline review, the provider failed to ensure three of three unlicensed assisted personnel/medication aides (UAP) (A, B, and C) received their annual competency reviews. Findings include:</p> <p>1. Review of UAPs A, B, and C's training records revealed their last competency review had been completed in December 2012. There had been no further competency reviews since then.</p> <p>Interview on 7/8/14 at 5:00 p.m. with the staff development coordinator (SDC) revealed she was unable to find any further competency reviews for those three UAPs since 2012.</p> <p>Interview on 7/9/14 at 8:00 a.m. with the director of nursing revealed there had been a personnel change in the SDCs position several months ago. During the change the competency reviews of UAPs A, B, and C had not been completed.</p> <p>Review of the provider's January 2011 Medication Administration competency guideline revealed "Nurses/medication aides are observed at least annually using the Med Pass Observation checklist and demonstrate competency."</p>	S 206	<p>to ensure that competency testing is complete for all medication aides (UAPs) ✕</p> <p>5. Completion date: 7-31-2014 and on-going.</p> <p><i>Any negative findings will be taken by the DNS or designee to the DAPI monthly meeting.</i> PEISDDHMF</p>	7-31-14

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARMOUR	STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK POST OFFICE BOX 489 ARMOUR, SD 57313
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F 000	INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/7/14 through 7/9/14. Golden LivingCenter - Armour was found not in compliance with the following requirements: F221 and F281.	F 000	Addendums noted with an asterisk per 8/11/14 telephone to facility administrator and DNS. PEJ/DDH/MF	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (3) with a wheelchair tray had been appropriately assessed and careplanned for its use. Findings include: 1. Random observations from 7/7/14 through 7/9/14 of resident 3 revealed she had a tray attached to her wheelchair. Review of resident 3's complete medical record revealed: *She had a diagnosis of dementia (impaired mental thinking) with behavioral disturbance. *There had been no assessment for the use of the wheelchair tray. *There had been no physician's order for the use of the wheelchair tray.	F 221	F 221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS 1. Resident #3 had a Restraint Assessment completed on 7-8-2014 for use of the half-tray attached to her wheel-chair, by the Director of Nursing Services (DNS). Family was informed and the care plan regarding use of this tray was updated to indicate that it was not a positioning device but a device that is being used as a diversional and activity table for Resident #3 2. All residents were evaluated with a team lead by the ED, and including the IDT, to determine if any device, previously unidentified as a restraint, is now determined to meet the definition of a restraint. 3. Nurses were re-trained on 7-10-2014 by the Staff Development RN on restraint definitions, appropriate	7-31-14

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

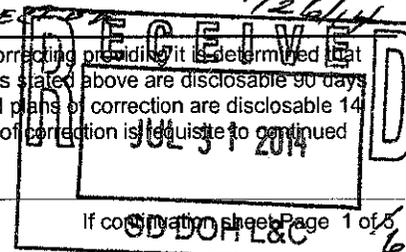
Barbara S. Woods, RN, ED

EXECUTIVE DIRECTOR

(X6) DATE

7/26/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARMOUR		STREET ADDRESS, CITY, STATE, ZIP CODE 106 BRADDOCK POST OFFICE BOX 489 ARMOUR, SD 57313		
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F 221	<p>Continued From page 1</p> <p>Review of resident 3's 4/9/14 Minimum Data Set assessment revealed she had a brief interview for mental status (BIMS) (mental thinking assessment) of zero which indicated she had severely impaired cognition (mental status).</p> <p>Review of resident 3's current careplan updated on 7/7/14 revealed: *A focus area for a risk of falls. *A goal for no fall related injuries. *An intervention for a "1/2 [half] moon w/c [wheelchair] tray to help keep her seated." *An intervention to "Attempt to prevent falls by having resident sit in wheelchair equipped with half table."</p> <p>Interview on 7/9/14 at 1:45 p.m. with the director of nursing regarding resident 3 revealed: *There had been no assessment or physician's order for the use of the wheelchair tray. *She had not considered the tray to be a restraint. *The resident could physically lift the tray up and down, but would not have been able to remove the tray upon command because of her impaired cognition. *She confirmed the wheelchair should have been assessed for its use and careplanned appropriately.</p> <p>Review of the provider's undated Restraint Devices, Physical policy revealed: **Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body." *The assessment guidelines included:</p>	F 221	<p>assessment, physician orders\ for restraints, etc. (see details in the Directed In-service grid).</p> <p>On 7-22-2014 and 7-24-24, members of the Interdisciplinary Team, IDT, and all department heads were re-educated by the Executive Director on how to determine if a resident would benefit from the use of a physical restraint. These training sessions also included a review of the Golden Living policy and procedure related to physical restraints. (Refer to the detailed "Directed In-service Training" grid for further details.)</p> <p>The RN Assessment Coordinator, (RNAC) and members of the IDT who are responsible for accurate and appropriate documentation on care plans was re-educated by the ED on 7-9-2014 and 7-22-14, with respect to restraints and or assistive devices and the appropriate verbiage needed on the care plan.</p> <p>Restraint Assessments will be completed by the DNS or RNAC in such cases where it is believed that a resident might benefit from the use of a physical restraint. Continued use of a physical restraint, once</p>	

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F 221	Continued From page 2 -The ability to understand instructions and to make self understood. -Behavior and mood state. -Functional ability. -Safety. -Change in level of consciousness. -Dehydration and fluid balance. -Potential for injury. -Cooperation with care. -Delirium. -Ability to move in bed and transfer safely. -Customary routine. -Bowel and bladder control. *The procedure to follow included: -Assess resident's need for the restraint device. -Obtain informed consent. -Obtain a physician's order for the restraint. -Develop careplan.	F 221	a device is in use, will be reviewed quarterly by the RNAC and/or member of the IDT to assess whether a less restrictive device could be used, or if the device could be eliminated completely. *for all residents who are due for a scheduled quarterly MDS assessment. 4. Monitoring will be conducted quarterly during the completion of required assessments, which would include Restraint Assessments, should a physical restraint be in use. Such monitoring will be conducted by the DNS or Designee. Any negative findings will be reported to the QAPI committee for discussion and action. 5. Completion date: 7-31-2014	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Surveyor: 32333 Based on record review, interview, and policy review, the provider failed to ensure: *One of ten sampled residents (5) had the frequency of use for a medication on the medication administration record (MAR) and on the signed physician's orders. *Four of ten sampled residents (4, 6, 9, and 10) had the time and or frequency of use for	F 281	F 281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS 1. Resident #5's Dulcolax order was clarified with the physician and her Medication Administration Record (MAR) was updated to include frequency of the medication. Resident #5's physician's orders were reconciled with the Medication Administration Record (MAR) and all missing information with respect to medication order details was added.	

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F 281	<p>Continued From page 3</p> <p>medications on their signed physicians' orders. Findings include:</p> <p>1. Review of resident 5's 5/14/14 physician's orders revealed an order for Dulcolax 10 milligrams (mg) suppository rectally as needed (PRN). There had been no directions or orders as to how often the medication could have been given.</p> <p>Review of resident 5's MAR revealed Dulcolax 10 mg suppository rectally PRN. There had been no directions or orders as to how often the medication could have been given.</p> <p>Interview on 7/9/14 at 1:45 p.m. with the director of nursing confirmed resident 5's Dulcolax order and her MAR should have included how often the medication could have been used.</p> <p>2. Review of residents 4, 6, 9, and 10's current signed physicians' orders on the Order Review Report sheets revealed numerous medications had no indication as to how often those medications could have been given. There had been no time or frequency on those signed physicians' medication orders. The time and or frequency had been on the MAR and in the computer system, but not on the signed physicians' orders. Some of those medications included but were not limited to: psychotropic (affect mental activity) medications, pain medications, insulin injections, nebulizers (respiratory treatments), blood pressure medications, and vitamins.</p> <p>Surveyor: 26180</p>	F 281	<p>Residents # 4, 6, 9 and 10 had their physician orders reprinted and their MARs reviewed, to include medication frequency, using the Point Click Care (PCC application "Physician Order Summary", rather than the "Physician Order Review" tool (the software application that was omitting the medication frequency.)</p> <p>2. All residents will have their newly printed Physician Order Summaries re-signed by the physician upon the next physician visit to the facility. These orders have all been reviewed by the DNS and determined to be complete with resident's name, date, name of medication, strength of medication, dose, time or frequency of administration, route of administration, quantity or duration of therapy, allergies and diagnoses.</p> <p>3. Nurses were informed during an in-service held on 7-14-2014 by the Director of Nursing Services to use the PCC "Physician Order Summary" and never use the "Physician Order Review" when printing orders for physician review and signature.</p>	

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F 281	<p>Continued From page 3</p> <p>medications on their signed physicians' orders. Findings include:</p> <p>1. Review of resident 5's 5/14/14 physician's orders revealed an order for Dulcolax 10 milligrams (mg) suppository rectally as needed (PRN). There had been no directions or orders as to how often the medication could have been given.</p> <p>Review of resident 5's MAR revealed Dulcolax 10 mg suppository rectally PRN. There had been no directions or orders as to how often the medication could have been given.</p> <p>Interview on 7/9/14 at 1:45 p.m. with the director of nursing confirmed resident 5's Dulcolax order and her MAR should have included how often the medication could have been used.</p> <p>2. Review of residents 4, 6, 9, and 10's current signed physicians' orders on the Order Review Report sheets revealed numerous medications had no indication as to how often those medications could have been given. There had been no time or frequency on those signed physicians' medication orders. The time and or frequency had been on the MAR and in the computer system, but not on the signed physicians' orders. Some of those medications included but were not limited to: psychotropic (affect mental activity) medications, pain medications, insulin injections, nebulizers (respiratory treatments), blood pressure medications, and vitamins.</p> <p>Surveyor: 26180</p>	F 281	<p>The DNS contacted Point Click Care (a Canadian software provider) and discussed with their Information Technology Department (IT) the error that occurred with our use of this application.</p> <p>4. Monitoring of MARs and Physician orders will be conducted by the DNS or designated RN on a weekly basis for four weeks, then monthly for two months.</p> <p>All negative results will be taken to the facility QAPI committee for review and action.</p> <p>5. Completion date: 7-31-2014</p> <p><i>* with each due date for physician recertification (some of which are every 30 days, some every 60 days)</i> PEKDDO4/MP</p>	7.31.14

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F 281	<p>Continued From page 4</p> <p>Interview on 7/8/14 at 3:00 p.m. with the director of nursing revealed:</p> <p>*She confirmed the order summary form the physicians signed had not always included the frequency a resident was to have received that medication.</p> <p>*All of the required information was in the computer, but if the nurse had not printed off the correct form, it had not always included the frequency of the medication to have been administered to the resident.</p> <p>*She agreed the document signed by the physician was the current orders for the resident, and it should have included the frequency that medication could be given.</p> <p>Review of the provider's October 2007 Prescriber Medication orders policy revealed:</p> <p>**"Medications are administered only upon the receipt of a clear and complete, and signed order by a person lawfully authorized to prescribe."</p> <p>**"Medication orders include the following specifics: Residents name, Date, Name of medication, strength of medication, Dose, Time or frequency of administration, route of administration, quantity or duration of therapy, diagnosis, any other state or federal requirements."</p>	F 281		

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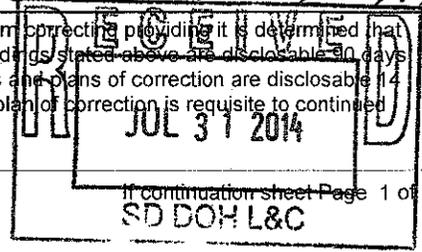
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/08/14. Golden LivingCenter-Armour was found not in compliance with 42 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 and the Fire Safety Evaluation System (FSES) dated 7/11/14.</p> <p>Please mark an "F" in the completion date column for the deficiency identified as meeting the FSES to indicate the provider's intent to correct the deficiency identified at K066 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		<i>F</i> <i>Wood</i>
K 033 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain a protected path of egress from</p>	K 033		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Barbara B. Wood RN ED</i>	TITLE EXECUTIVE DIRECTOR	(X6) DATE 7/26/14
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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 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.



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K 033	<p>Continued From page 1</p> <p>the basement to the exterior of the building. One of two basement stairways (west stairway) discharged onto the main level and was not provided with a one hour fire resistive enclosure to the exterior of the building. Findings include:</p> <p>1. Observation at 3:30 p.m. on 7/08/14 revealed the west basement stairway discharged onto the main level of the building without maintaining one hour fire rated assemblies to the exterior of the building. Review of the previous life safety code survey confirmed that condition had existed since the building had been constructed in 1967.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p>	K 033		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435057	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 7/8/2014
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 066	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on document review and interview, the provider failed to adopt a complete smoking policy that dealt with staff and resident smoking. Findings include:</p> <p>1. Review of the provider's policies revealed they prohibited smoking by residents who were classified as not responsible. The smoking policy did not allow for the non-responsible resident who desired to smoke to do so with direct supervision (family member, friend, or staff). Interview with the administrator at 3:30 p.m. on 7/08/14 revealed the smoking policy would be changed to reflect that option.</p>
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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

The above isolated deficiencies pose no actual harm to the residents

