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

ORIGINAL

PRINTED: 03/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435060		03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BELLA VISTA	302 ST CLOUD STREET RAPID CITY, SD 57701

(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: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/4/14 through 3/5/14 for Golden LivingCenter-Bella Vista was found not in compliance with the following requirements: F280, F281, F323, F371, and F441.	F 000	Addendums noted with an asterisk per 4/7/14 telephone to facility administrator. JK/SDDOH/MF	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		
	This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on record review, interview, and policy		See next page	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marguita Prince — TITLE: Executive Director — (X6) DATE: 04/01/14

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 280	Continued From page 1 review, the provider failed to review and revise two of thirteen sampled residents' (8 and 9) care plans to reflect their current health and condition. Findings include: 1. Review of resident 8's 1/27/14 physician's orders revealed he: *Had a diagnosis of epilepsy with recurrent seizures (spontaneous and uncontrollable body movements). *Received phenytoin sodium (medication to help control seizure activity) extended capsule 200 milligrams at bedtime. Review of his current care plan revealed no focus area or interventions in place to ensure staff had been aware of and educated on his seizure disorder. Interview on 3/5/14 at 3:40 p.m. with the director of nursing (DON) revealed resident 8's diagnosis of epilepsy should have had a focus area with interventions in place on the his care plan. Surveyor: 32333 2. Review of resident 9's 3/3/14 physician's orders revealed: *An order to administer oxygen at 2 liters per nasal cannula if oxygen was less than 90% on room air. *An order to increase oxygen to 4 liters per minute by nasal cannula. Review of resident 9's current care plan revealed no mention of her oxygen use. Interview on 3/5/14 at 1:45 p.m. with the DON revealed she would have expected resident 9's oxygen use to have been on the care plan.	F 280	F 280 1. Resident's # 8 care plan was reviewed and updated on 3/21/14, and 3/26/2014 to reflect Epilepsy with recurrent seizures and approaches. Resident # 9 oxygen order was clarified with the MD on 3/21/14. The care plan was updated on 3/21/14. Resident on comfort cares expired on 3/23/14. MDS's and diagnoses of all current residents were compared with care plans to identify other potentially affected residents. No residents were identified to have negative outcome from this practice. 2. All resident assessments, physician orders, and interdisciplinary progress notes will be compared quarterly or at change of condition and care plan will be updated by the care plan team. 3. To monitor the performance the DNS or designee will audit 5% of all patient records, assessments, physician orders, interdisciplinary progress notes, and care plans for compliance and accuracy 1 time a week for 30 days then monthly for 3 months, then quarterly for 6 months. 4. Results of audits will be presented to the QAPI committee monthly by the DNS for review, consideration, and recommendations.	04/16/2014

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F 281 SS=D	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: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Medications were given according to manufacturer's recommendations for 1of 6 residents (2) observed during one of two observed medication passes. *Two of three observed insulin pens (residents 20 and 2 had identified expiration or open dates. *Physician's orders were clarified and followed for 2 of 13 sampled residents (2 and 9). Findings include: 1. Observation on 3/4/14 at 11:35 a.m. of licensed practical nurse (LPN) G as she administered medication to resident 2 revealed she crushed the resident's levetiracetam 750 milligram tablet (a medication for seizures) and gave it to the resident in applesauce. Review of the medication pill card at that time revealed a "Do not chew or crush" statement. *Interview per telephone on 3/5/14 at 9:05 a.m. with a pharmacist with PharMerica revealed levetiracetam was not to be crushed. She stated crushing the medication could affect the absorption, and levetiracetam was available in liquid form. 2. Review of resident 2's medical record revealed: *The resident recently had a skin biopsy to her	F 281		

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F 281	Continued From page 3 right hand. -Treatment for that biopsy site per West River Dermatology, P.C. was to have been Polysporin antibiotic ointment daily after cleaning with soap and water. -It would have taken approximately three weeks for the wound to heal completely. -The February 2014 treatment administration record (TAR) had an order for the use of the Polysporin antibiotic ointment treatment for three days only. -That treatment had been documented as having been completed on February 26, 27, and 28, 2014. -The March 2014 TAR had an order for Polysporin antibiotic ointment treatment for three days to the right hand biopsy. -The treatment had not been documented as having been completed in March 2014. *A physician's order dated 2/26/14 for "Westcort Cream 45g/Nozoral Cream QSAD 60 grams Apply sparingly TID (three times a day) PRN (as needed)" (for rash). -The February 2014 medication administration record (MAR) revealed an order for the Westcort ointment three times a day and a separate order for PRN. -The March 2014 medication administration record (MAR) revealed an order for the Westcort ointment three times daily and a separate order for Westcort ointment PRN. 3. Observation on 3/5/14 at 2:00 p.m. with registered nurse D revealed: *There were two opened insulin pens for resident 21 in the east medication cart. One of those insulin pens did not have an identified expiration date. *There was one opened insulin pen in the "big	F 281	F 281 1. Resident number 2 had no negative outcome as a result of levetiracetam 750 mg tablet being crushed on 3/4/14. Resident #2 's orders were clarified on 3/6/2014 with liquid form obtained. Resident #2 was discharged to hospital on 3/9/14 (unrelated) and readmitted 3/12/14 and scheduled for a follow-up dermatology appointment on 4/3/2014. All medication carts were assessed on 3/5/2014 , undated insulin pens were destroyed. No negative outcome was identified for residents 2 or 21 . 2. All residents are potentially at risk. The physician of all residents that receive levetiracetam were reviewed for the correct form of the medication on or before 3/7/2014. 3. All charge nurses were provided with education on or before March 27, 2014. DNS or designee will complete written audits on following physician's orders, crushed medications, and open dates on all insulin. Audits to be done weekly X 4, then monthly X3, on a minimum of 5 medical records. 4. DNS or designee will report results of audits to facility QA&A for review and recommendations monthly.	04/16/2014

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F 281	Continued From page 4 south" cart for resident 20. That insulin pen did not have an identified expiration date. 4. Interview on 3/5/14 at 3:10 p.m. with the director of nurses revealed she agreed: *Levetiracetam should not have been crushed. *The Polysporin antibiotic treatment for resident 2 had not been completed as ordered. *The Westcort cream order had been incorrectly transposed to the MAR. Review of the provider's October 2007 Medication Orders policy from PharMerica revealed insulin pens had specific expiration dates. The date of opening should have been documented on the container. Surveyor: 32333 5. Review of resident 9's 3/3/14 physician's orders revealed: *An order to administer oxygen at 2 liters per nasal cannula if oxygen was less than 90% on room air. *An order to increase oxygen to 4 liters per minute by nasal cannula. *No clarification as to whether the oxygen should have been continuous or as needed. Interview on 3/5/14 at 1:45 p.m. with the director of nursing revealed the oxygen order should have been clarified.	F 281	*5. Resident 9 will be added as oxygen orders were clarified on 3/5/14. No negative outcome was identified for residents 2, 9, and 21. Resident 9 expired on 3/23/14 on comfort cares. JK/SDDOH/MF *6. All residents are potentially at risk. The physician of all residents that receive levetiracetam were reviewed for the correct form of the medication on or before 3/7/14. The DNS reviewed the oxygen orders on all patients for needed corrections. JK/SDDOH/MF	
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	F 323		

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F 323	Continued From page 5 prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, policy review, and interview, the provider failed to ensure transfer equipment was used to avoid unnecessary distress to three of three observed residents (5, 18, and 19) during transfers. Findings include: 1. Observation on 3/4/14 at 6:00 p.m. of nurse aide (NA) B and certified nurse aide (CNA) E in the main dining room while they transferred resident 19 from his wheelchair to a dining room chair revealed they did not use a gait belt. NA B and CNA E transferred resident 19 by placing their arms under his arms and lifted him. This caused a lifting stressor to his shoulder area and under his arms. 2. Observation on 3/4/14 at 6:20 p.m. of CNA F in the main dining room while she transferred resident 18 from her wheel chair to a dining room chair revealed she did not use a gait belt. CNA F stood in front of the resident and transferred her by placing her arms under the resident's arms and lifted her up. This caused a lifting stressor to resident 18's shoulder areas and under her arms. 3. Interview on 3/5/14 at 3:10 p.m. with the director of nurses (DON) confirmed she agreed the NA and CNAs should have used gait belts when they had transferred the above residents.	F 323	*All residents that are assessed to require a gait belt will be transferred using gait belts. JK/SDDOH/MF F323 1. Residents 5, 18, and 19 were assessed by DNS on 3/19/2014 for injury related to improper transfers. No negative outcome was noted. 2. All residents have the potential to be at risk by this practice. All residents will be assessed for the need of assistance with transfers.* [redacted] JK/SDDOH/MF Careplans and assignment sheets will be updated on or before 4/16/2014 by the Resident Care Coordinator or designee. Education was provided to all nursing staff by the DNS ensuring appropriate and safe transfers of residents on 3/27/2014. All employees observed to transfer residents improperly as noted on Survey Results 3/04/2014 will complete competencies by 4/16/2014 proctored by the Resident Care Coordinator or designee. 3. DNS or designee will audit by observing transfers of 7 residents 1 time weekly for 3 months then 1 time monthly for 3 months at random times and shifts for proper transfer techniques according to transfer and lift policy. 4. The DNS will provide the QAPI committee results of the above mentioned audits for further recommendations .	04/16/2014

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F 323	Continued From page 6 Surveyor: 32355 4. Review of resident 5's medical record revealed she required two staff members to assist her with all transfers. Observation on 3/4/14 at 12:20 p.m. of resident 5 in the dining room revealed: *She had been sitting in a wheelchair (w/c). *Two unidentified CNAs had assisted her from her w/c to a dining room chair. *The CNAs had not used any type of device to assist her with the transfer. *The CNAs had placed their arms underneath of her shoulders to assist her with transferring. That had caused a lifting stress to her shoulders. Observation on 3/4/14 at 3:45 p.m. of resident 5 revealed: *She had been laying in bed resting. *NA B and CNA C prepared her to be transferred from her bed to her w/c. *The CNAs had not used any type of device to transfer her from her bed to the w/c. *The CNAs had placed their arms underneath of her shoulders to assist her with transferring. That process had caused a lifting stress to her shoulders. Observation on 3/4/14 at 6:00 p.m. of resident 5 in the dining room revealed: *She had been sitting in a w/c. *Two unidentified CNAs assisted her from her w/c to a dining room chair. *The CNAs had not used any type of device to assist her with the transfer. *The CNAs had placed their arms underneath of her shoulders to assist her with the transfer. That process had caused a lifting stress to her shoulders.	F 323		

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F 323	Continued From page 7 During all of the above observations the NA and CNAs had been wearing a gaitbelt (device used to assist residents with transfers) around their waists. Review of resident 5's 10/30/13 progress note revealed: *The staff had located a bruise inside of her upper left arm. *"Due to positioning, shape, size it is probable that this is the result of transferring resident." *"Will continue to monitor." Review of the provider's 1/30/14 and 2/27/14 all staff meeting agenda revealed a reminder area for the use of gait belts. Interview on 3/5/14 at 8:00 a.m. with the assistant director of nursing (ADON) revealed: *Staff should have been using a gait belt to assist any resident who required assistance with a standing transfer. *The gait belts the staff had been wearing were for emergency use only. *All residents should have their own gait belts for staff to use. *If the staff forgot to bring the resident's own gait belt for a transfer, they were to have used the one they were wearing. Interview on 3/4/14 at 3:45 p.m. with the director of nursing (DON) confirmed all staff were to have used a gait belt for any resident who required assistance with transfers. Gait belt use by the staff had been an on-going issue and was reviewed at the all staff meetings. Review of the provider's undated Lift Program	F 323		

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F 323	Continued From page 8 Guide revealed: *"Residents identified as Totally Dependent or Extensive Assistance, for example, will be transferred by means of lift equipment and/or other resident assist devices instead of by manual lift." *"Gait/Transfer belts, including two-handled gait/transfer belts where deemed appropriate, will be used where manual assistance is required for ambulation and transfer activities." Review of the provider's 2006 Transfer Activities policy revealed: *"Purpose: To transfer the resident from bed to chair, toilet or tub safely." *"Assist the resident to a sitting position on the side of the bed." *"Apply transfer belt."	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to ensure food was prepared in a clean and sanitary environment in	F 371	See Next Page	

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F 371	Continued From page 9 the kitchen. Findings include: 1. Observation on 3/4/14 at 5:00 p.m. in the kitchen revealed: *Vinyl covered pads on both corner edges of the stove hood. *Those pads were coated with a greasy film and lint (photo 1). *The grease trap to the grill had a large amount of dark colored grease and food debris in it (photo 2). *The wall, hooks, conduit, and chain above the window in front of the steam table had a visible greasy lint covered film on it (photo 3). *The fluorescent lights above the steam table area had a visible greasy lint covered film along the edges next to the ceiling. Interview at that same time with the dietary manager and cook A confirmed: *The above areas had visibile lint and grime that had needed to be cleaned. *The grill had not been used since Saturday, three days ago, when they had grilled cheese sandwiches. *The grill drip pan was to have been cleaned after each use. Review of the Cleaning Schedules, Cleaning Procedures Introduction, and Cleaning Gas Ranges from the provider's 2011 Dining Services Policies and Procedures manual along with the Daily and Monthly Cleaning List forms received from the dietary manager revealed: *An effective cleaning schedule must be developed and posted for: -Each piece of equipment. -All areas that required routine cleaning in the Dining Services Department.	F 371	F371 1. On 3/4/2014 vinyl covered pads on the range hood, the grill grease pan, wall hooks, conduit, and chain above the window as well as the light above the steam table/window was cleaned by the cook. No residents were identified to have a negative outcome from this practice. All residents are at risk to be affected by this outcome. All residents have the potential to be affected by deficient practice. 2. The grill drip pan was added to the daily cleaning schedule; the vinyl corner pads on the range hood, the lights, conduit, and chain above the steam table were added to the monthly cleaning schedule on 3/19/2014. The Dietary Services Manager reviewed the cleaning schedule and procedure with all dietary staff on March 20, 2014. 3. The DSM or designee will complete audits on the above topics; 2014 vinyl covered pans on the range hood, the grill grease pan, wall hooks, conduit, and chain above the window as well as the light above the steam table/window , and equipment/kitchen cleanliness weekly for 3 months. 4. The DSM or designee will report findings of audits to the QAPI committee monthly for considerations and recommendations.	04/16/2014

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F 371	Continued From page 10 *Heavily soiled areas needed to be cleaned more often. *The gas range drip pans were to have been washed daily. *All of the above items except for the drip pans had not been addressed in the policies, procedures, cleaning schedules, or daily and monthly lists provided.	F 371		
F 441 SS=D	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	F 441	See Next Page	

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F 441	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation and interview, the provider failed to ensure: *The sanitary storage of resident-use items in three of three (East, West, and Rushmore) tub rooms. *Chemicals had not been stored with resident-use items in two of three tub rooms (East and West). Findings include: 1. Random observations on 3/4/14 of the East, West, and Rushmore tub rooms revealed: *All three tub rooms had plastic storage containers with multiple resident-use items stored together. Those items included dirty nail clippers, tooth brushes, and toothpaste (photo 4). *The East tub room had a bottle of Ecolab A-456 II disinfectant cleaner stored on the same shelf with an inflatable plastic bed shampoo bowl (photo 5). *The West tub room had a bottle of Ecolab A-456 II disinfectant cleaner stored on a shelf with resident- use items including shampoo, body wash, and deodorant (photo 6). Interview on 3/5/14 at 1:45 p.m. with the director of nursing revealed she agreed:	F 441	F 441 1. No residents are identified with a negative outcome related to the deficient storage practice. All residents have the potential to be affected by this practice. All personal care items were removed from all bathhouses , and storage areas for clean and soiled items were designated/organized on 3/28/2014. 2. The DNS provided in-service education to all staff regarding infection control practices, storage of personal care items, and chemicals on 3/27/2014.. 3. The DNS or designee audit all bathhouses 1 time a week for 3 months then 1x a month for 3 months. 4. The DNS will provide results of the audits to the QAPI committee monthly for recommendations.	04/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	435060		03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BELLA VISTA	302 ST CLOUD STREET RAPID CITY, SD 57701

(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 12 *Chemicals should not have been stored with resident-use items. *Dirty and clean multiple use resident items should not have been stored together. Review of the 2010 Charge Nurse Infection Control Practices revealed "Ensure contaminated items are not placed with clean items."	F 441		

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 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435060		03/05/2014

NAME OF PROVIDER OR SUPPLIER
GOLDEN LIVINGCENTER - BELLA VISTA

STREET ADDRESS, CITY, STATE, ZIP CODE
302 ST CLOUD STREET
RAPID CITY, SD 57701

(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
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/05/14. Golden LivingCenter - Bella Vista was found not 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 upon correction of deficiencies identified at K025, K046, K050, K064, K143, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 4/18/14 telephone to facility administrator. CH/SDDOH/MF	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the 30 minute fire resistive rating of smoke barrier walls. The smoke barrier	K 025	K025 1. No residents were identified or had negative outcome from this practice. The Director of Maintenance Services or designee will ensure that the television cable positioned through the damper on the 100 wing is removed and the damper is in proper working order on or by 4/16/2014. 2. All residents have potential to be affected by this deficient practice. The Director of Maintenance Services or designee will assess all smoke barrier walls and ensure that barriers are intact and not compromised on or by 4/16/2014. 3. The Director of Maintenance will audit all smoke barrier walls for breeches 1 time every 3 months . 4. The Director of Maintenance will present results of the quarterly audits to the QAPI committee quarterly for consideration or recommendations.	04/16/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Margaret Prince — Executive Director — 04-01-14

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 03 2014
SD DOH L&C

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. BUILDING 01 - MAIN BUILDING B. WING _____	03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BELLA VISTA	302 ST CLOUD STREET RAPID CITY, SD 57701

(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
K 025	Continued From page 1 wall for the 100 wing had a randomly observed unsealed damper penetration above the lay-in acoustical ceiling and smoke barrier doors. Findings include: 1. Observation at 2:00 p.m. on 3/05/14 revealed the smoke barrier wall for the 100 wing had an unsealed damper penetration above the lay-in acoustical ceiling and smoke barrier doors. The damper wiring was disconnected, and the damper was in the open position with television cabling positioned through the open damper. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He stated he was unsure of the exact layout and location for the smoke barrier walls. The deficiency affected one of three smoke barrier walls.	K 025		
K 046 SS=D	Ref. NFPA 18.3.7.3, 8.3 NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install a remote stop button for the generator. Findings include: 1. Observation at 10:45 a.m. on 3/05/14 revealed there was not an emergency stop button installed for the generator. Interview with the maintenance supervisor at the time of the observation revealed	K 046	K046 1. No residents were identified or had negative outcome from this practice. The Director of Maintenance Services or designee will ensure that a control switch to turn the generator off is installed in an accessible area on or by 04/16/2014. 2. All residents have potential to be affected by this deficient practice. The Director of Maintenance Services will ensure that a remote stop switch is in working condition 1 time a month during preventative maintenance checks. 3. The Director of Maintenance will audit generator emergency stop switch effectiveness 1 time a quarter . 4. The Director of Maintenance will present results of the quarterly audits to the QAPI committee quarterly for consideration or recommendations.	* LH/SDDCH/MF [redacted] 04/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435060		03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BELLA VISTA	302 ST CLOUD STREET RAPID CITY, SD 57701

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K 046	Continued From page 2 the generator had an on/off switch inside the (locked) housing for the generator. He confirmed there was not another remote stop installed for the generator. The deficiency affected a single location required to be equipped with remote emergency stops. Ref. NFPA 18.2.9.1, 7.9	K 046		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to ensure staff were familiar with fire drill procedures (closing the door to the simulated fire location and fire policy procedures). Findings include: 1. Observation at 2:25 p.m. on 3/05/14 revealed the charge nurse responding to the simulated fire did not pull the door closed to isolate the effects of the fire. That staff member was unsure of the procedure to follow upon discovering the	K 050	K050 1. No residents were harmed by the deficient practice. All residents have the potential to experience harm by the practice. 2. All staff were provided with education regarding the correct procedure to follow during an fire alarm on 03/27/2014 . 3. The maintenance supervisor will conduct and audit 3 fire drills monthly for 3 months to ensure proper procedure. 4. The maintenance supervisor will provide audit results to the QA&A committee monthly for 3months for recommendations	04/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435060		03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BELLA VISTA	302 ST CLOUD STREET RAPID CITY, SD 57701

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K 050	Continued From page 3 simulated fire and asked another nurse for instructions. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated the staff member was a new employee that had only been through the new employee orientation and had not been through a fire drill yet. Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected one of numerous conditions that could be varied. Ref: 2000 NFPA 101 Section 18.7.1.2	K 050		
K 064 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to conspicuously mark the locations for two randomly observed fire extinguishers mounted in wall cabinets or recesses (television room corridor and 200 wing corridor). Findings include: 1. Random observation from 10:15 a.m. to 3:00 p.m. on 3/05/14 revealed the locations of two randomly observed fire extinguishers located in the corridor to the dining room and the 200 wing corridor were not conspicuously marked.	K 064	K064 1. No residents were affected by the deficient practice. All residents had the potential to be affected by the practice 2. All fire extinguishers were identified with signage in a conspicuous manner on or before 3/27/2014 by the Director of Maintenance. 3. The Director of Maintenance will audit all fire extinguishers for proper signage 1 time monthly during fire extinguisher preventative maintenance. 4. The Director of Maintenance will present results of audits to QAPI quarterly for 2 quarters for considerations or recommendations.	04/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435060		03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BELLA VISTA	302 ST CLOUD STREET RAPID CITY, SD 57701

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K 064	Continued From page 4 Interview with the maintenance supervisor at the times of the observations confirmed those findings. The deficiency affected several fire extinguisher locations required to be marked conspicuously. Ref: 2000 NFPA 101 Section 9.7.4.1, 18.3.5.6, NFPA 10 Section 1-6.12	K 064		
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain fire barrier separation of	K 143	K 143 1. No residents were affected by the deficient practice. All residents could have been affected by the deficient practice. 2. On 3/6/2014 The Director of Maintenance cleaned the Oxygen transferring room of extra portable O2 tanks to make room for staff to be able to provide safe transfers of the O2 without holding the door open. An "IN USE" sign is also placed to be hung as needed. On 327/2014 All staff were provided with education regarding proper O2 transfers. 3. The DNS or designee will audit 5 Oxygen transfer procedures a week for 1 month , then 1 time a month . 4. Results of the audits will be provided at monthly QAPI committee meetings for consideration or recommendations.	04/16/2014

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K 143	Continued From page 5 one-hour fire resistive construction for the oxygen transferring room (located in the main entrance vestibule) during the transferring process. Findings include: 1. Observation at 2:15 p.m. on 3/05/14 revealed the liquid oxygen transferring room located in the main entrance vestibule had the proper one hour fire-rated construction. The room was less than 25 square feet in area. Two liquid oxygen dewars and several e-size gas oxygen bottles were stored in the room. A staff member entered the room and performed a refill of a smaller liquid oxygen bottle for a resident but did not shut the door during the process. There was no sign on the outside of the room indicating transferring was occurring. Interview with the maintenance supervisor at 2:25 p.m. on 3/05/14 revealed he agreed there was not enough available floor space to enter the room and perform a liquid oxygen transfer. He stated unless some of the stored gas bottles could be moved to another location to provide the needed space for the transferring process. The deficiency affected a single hazardous room location. Ref: NFPA 99 8.6.2.5.2	K 143		
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	435060		03/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BELLA VISTA	302 ST CLOUD STREET RAPID CITY, SD 57701

(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
K 144	Continued From page 6 This STANDARD is not met as evidenced by: Surveyor: 18087 A. Based on observation and interview, the provider failed to install a remote alarm in a continuously occupied location for one of one generators to indicate when the generator system was in a trouble status. Findings include: 1. Observation at 11:45 a.m. on 3/05/14 revealed the 50 kilowatt Katolight generator was located at the exterior of the building (south side of the 400 wing). Interview with the maintenance supervisor at the time of the observation confirmed that finding. The annunciator alarm had been installed in the medical records office of the 400 wing addition (adjacent to resident room 401). Interview with the administrator at 3:00 p.m. on 3/05/14 revealed that office had been designed as a continuously manned nurse station with the addition completion in 2009. The deficiency affected one of numerous generator installation requirements. Ref. NFPA 99 Section 3-4.1.1.5 B. Based on observation and interview, the provider failed to replace the generator battery per NFPA 99 guidelines in one of one generators. Findings include: 1. Observation at 1:15 p.m. on 3/05/14 revealed the battery had not been marked with the installation date. Generator batteries should be	K 144	K 144 1. No residents were affected by the deficient practice. All residents had the potential to be affected by the deficient practice. 2. The Director of Maintenance will ensure that the enunciator alarm for the generator will be relocated to the main nurses station on or before 04/16/2014 by an electrician. The Director of Maintenance will ensure that a new battery is installed and dated on or before 04/16/2014, and every two years thereafter. 3. The Director of Maintenance will check the generator 1 time monthly for compliance during monthly generator checks. 4. Results of the audits will be provided one time a quarter at QAPI committee meetings for consideration or recommendations.	04/16/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILDING** B. WING _____	(X3) DATE SURVEY COMPLETED
	435060		**03/05/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - BELLA VISTA	**302 ST CLOUD STREET** **RAPID CITY, SD 57701**

(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
K 144	Continued From page 7 scheduled for replacement every 24-30 months. Interview with the maintenance supervisor at the time of the observation revealed he did not know when the battery had been installed. He stated the generator had been installed in 2009, approximately 4.5 years prior (54 months) to this survey. The deficiency affected one of numerous generator maintenance requirements. Ref. NFPA 110 Section A5-6.5.4.1	K 144		

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: 10667	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 03/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BELLA VISTA	STREET ADDRESS, CITY, STATE, ZIP CODE 302 ST CLOUD STREET RAPID CITY, SD 57701		

(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 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 3/04/14 through 3/05/14. Golden LivingCenter - Bella Vista was found in not in compliance with the following requirement: S166.	S 000	Addendums noted with an astenisk per 4/7/14 telephone to facility administrator. JK/SDDOH/MF	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margarita Prince — TITLE: Executive Director — (X6) DATE

RECEIVED APR 03 2014 SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10667	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BELLA VISTA	STREET ADDRESS, CITY, STATE, ZIP CODE 302 ST CLOUD STREET RAPID CITY, SD 57701		

(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 166	Continued From Page 1 (7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.	S 166		
	This Rule is not met as evidenced by: Surveyor: 18087 A. Based on observation, testing, and interview, the provider failed to maintain the electrically activated audible alarm for unattended doors in an active condition. Two randomly observed exit doors at the entrance (front), and at the main dining room had the code posted to silence the alarm. Findings include: 1. Observation and testing beginning at 10:30 a.m. on 3/05/14 revealed the main dining room exit was equipped with a delayed egress magnetic lock. A keypad was mounted adjacent to the door that would release the magnet and also silence the door alarm. Interview with the maintenance supervisor at the time of the observation revealed the front door also had the code posted to allow staff and visitors to leave the building without setting off the alarm. The signs with the code for the magnetic locks were removed during the survey. Surveyor: 32333		S166 1. No resident were identified to have negative outcome due to the deficient practice. On 3/10/2014 The Maintenance Supervisor installed an alarm that sounds each time the door is opened. The posted codes were removed from all doors on 3/10/2014. The door remains locked at all times. 2. All residents have the potential to be affected by deficient practice. 3. The Maintenance or designee will audit all doors daily for 3 months for proper function. 4.Results of audits will be brought to QAPI 1 time monthly for further considerations or recommendations. * Results of the audits will be reported by the Director of Maintenance. JK/SDDOH/MF	04/16/2014

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10667	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/05/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BELLA VISTA	STREET ADDRESS, CITY, STATE, ZIP CODE 302 ST CLOUD STREET RAPID CITY, SD 57701		

(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 166	Continued From Page 2 B. Based on observation, interview, and testing, the provider failed to ensure the main entrance/exit door had an activated audible alarm or was attended at all times. Findings include: 1. Observation and testing on 3/5/14 at 3:25 p.m. of the main entrance/exit door revealed: *The alarm had not been activated. *The door had been unattended. Interview on 3/5/14 at 4:20 p.m. with the administrator revealed: *The main entrance/exit door was locked from 5:00 p.m. through 6:00 a.m. *The main entrance/exit door was not monitored at all times. *They had a Wanderguard alarm system, but not all residents wore a Wanderguard.	S 166		