

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

ORIGINAL

PRINTED: 01/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><i>Addendums noted with an asterisk per 2/3/14 telephone to facility</i></p> <p>Surveyor: 28057 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/7/14 through 1/9/14. Golden LivingCenter - Prairie Hills was found not in compliance with the following requirements: F248, F276, F278, F281, and F441.</p> <p><i>Don. KG/5000H/JS</i></p>	F 000	<p>This facility objects to the allegations of noncompliance in this Statement of Deficiencies and disagrees with both the findings of non-compliance and the level of deficiency cited. Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p> <p>Accordingly, the facility has prepared and submitted this Plan of Correction because of the requirements under State and Federal law that mandate submission of a Plan of Correction as a condition to participate in the Title 18 and Title 19 programs. The submission of the Plan of Correction should in no way be considered or construed as agreement with the allegations of the non-compliance or admission by the facility. This plan of correction shall constitute this facility's credible allegation of compliance.</p>	
F 248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, and policy review, the provider failed to ensure an effective one-to-one activities program had been maintained for one of two sampled residents (11). Findings include:</p> <p>1. Review of resident 11's revised 11/15/13 care plan revealed: *A focus area of communication with others in activities was impaired due to unclear speech. *An intervention to encourage participation in structured activities and provide one-to-one activities three times weekly.</p> <p>Review of resident 11's 11/15/13 through December 2013 one-to-one activity progress</p>	F 248		

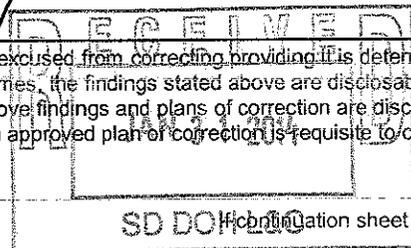
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Maria Brockel Sr ED 1-29-14

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 248	Continued From page 1 notes revealed: *November one-to-one activities had been provided on 11/21/13 and 11/28/13. *December one-to-one activities had been provided on 12/11/13, 12/16/13, and 12/23/13. Interview on 1/8/14 at 3:00 p.m. with the activities director revealed there had been no other documentation of one-to-one activities offered or provided. Interview on 1/8/14 at 5:40 p.m. with the interim director of nursing revealed: *She would have expected one-to-one activities offered three times per week as the resident's care plan stated. *She would have expected documentation of one-to-one activities being offered or refused. Review of the provider's Activities Regulations policy revealed "One-to-one programming refers to programming provided to residents who will not, or cannot, effectively plan their own activity pursuits, or residents needing specialized or extended programs to enhance their overall daily routine and activity pursuits." 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Surveyor: 28057	F 248	F248 I. No immediate correction could be made for resident #11. All residents are at risk. II. All residents with a one-to-one activity programming on their plan of care will receive the one-to-one activity according to the frequency state on the activity plan of care. All activity personnel will be in-serviced by the activity director or designee no later than 2-14-14. Education will include definition and frequency of one-to-one activity programming, care planning process and accurate documentation. III. The activity coordinator or designee will audit 3 resident one-to-one participation documentation weekly for one month and monthly for 3 months. The activity coordinator or designee will report findings to QA&A monthly for further recommendations.	2-28-14
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Surveyor: 28057	F 276		

to include resident 11. K/S/OOHH DJ

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F 276	Continued From page 2 Based on record review, interview, and policy review, the provider failed to ensure 1 of 11 sampled resident's (4) quarterly Minimum Data Set (MDS) had been completed in a timely manner. Findings include: 1. Review of resident 4's MDS records revealed an assessment reference date (ARD) of 12/12/13. It had been completed on 12/31/13, nineteen days later. Interview on 1/9/14 at 9:05 a.m. with the interim director of nursing and MDS coordinator A confirmed it had been late. It should have been completed on 12/24/13 not on 12/31/13. Review of the Timeliness Criteria in the May 2013 Centers for Medicaid/Medicare Resident Assessment Instrument Version 3.0, page 5-2, revealed all non-admission assessments were to have been completed no later than fourteen days after the ARD. On 1/9/14 at 9:30 a.m. the administrator confirmed there had been no policy that addressed the completion of the MDS. Surveyor 32572 Interview on 1/8/14 at 9:30 a.m. with the Department of Social Services nurse consultant confirmed the provider had not been in compliance with timeliness of MDS completion and submissions.	F 276	F276 I. No immediate correction could be made for resident #4. All residents are at risk. II. All MDS assessments will be up to date by 2-14-14. The MDS calendar/schedule will be followed to the date and the MDS will be completed on or before the due date. Education will be completed by the state Clinical Assessment and Reimbursement Specialist by 2-14-14 to include compliance with timeliness of MDS completion and submissions. III. The Clinical Assessment and Reimbursement Specialist will audit 5 MDS submissions for compliance of timeliness of submissions weekly for one month and monthly for 3 months. The Registered Nurse Assessment Coordinator (RNAC) or designee will report findings to QA&A monthly for further recommendations.	2-28-14 to include resident 4. KG/SOP/H/SS	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278			

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F 278	Continued From page 3 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on interview, record review, and policy review, the provider failed to ensure the Minimum Data Sets (MDS) had been completed accurately for 1 of 11 sampled residents (6). Findings include: 1. Resident 6 had quarterly MDSs completed on 5/29/13 and 8/22/13. In the section labeled C (cognitive [thinking] patterns):	F 278	F278 I. No immediate correction could be made for resident #6. All residents are at risk. II. All MDS assessments will be accurately completed by 2-14-14. The RNAC or designee will educate through an in-service to all IDT members on accuracy of MDS assessment by 2-14-14. III. The RNAC or designee will audit 5 MDS assessments for accuracy weekly for one month then monthly for 3 months. The RNAC or designee will report findings to QA&A monthly for further recommendations. <i>Any needed corrections for the MDSs will be submitted by 2/14/14 to include corrections for resident 6. KG/SOONH/JJ</i>	2-28-14

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F 278	<p>Continued From page 4</p> <p>*The MDS on 5/29/13 had been coded as the resident had been unable to complete the interview. -She had short and long term memory problems. *The resident had been unable to complete the interview and had long and short term memory issues that indicated the resident was unable to make daily decisions. -That MDS had been coded the resident had been able to make daily decisions independently. *The MDS on 8/22/13 had been coded as the resident had been unable to complete the interview. -She had short and long term memory problems. -That MDS had also been coded as the resident's daily decision making had been severely impaired. *In comparing the 5/29/13 to the 8/22/13 assessments there had been a change in mental status. *The 5/29/13 MDS revealed it had been coded as a one, but the 8/22/13 assessment had been coded as a three indicating a decline.</p> <p>Review of the MDS 3.0 Quality Measures User's Manual v 8.0 04/15/2013 revealed on page C-24 the coding instructions for C1000 were: "Code 0, independent: if the resident's decisions in organizing daily routine and making decisions were consistent, reasonable and organized reflecting lifestyle, culture, values." "Code 1, modified independence: if the resident organized daily routine and made safe decisions in unfamiliar situations, but experienced some difficulty in decision making when faced with new tasks or situations." "Code 2 moderately impaired: if the resident's decisions were poor; the resident required reminders, cues, and supervision in planning,</p>	F 278		

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F 278	<p>Continued From page 5</p> <p>organizing, and correcting daily routines." "Code 3, severely impaired: if the resident's decision making was severely impaired; the resident never (or rarely) made decisions.</p> <p>*In comparing the 8/22/13 to the 5/29/13 assessments there had been a change in overall mental status. *The 8/22/13 MDS revealed there had not been a change in mental status, that had been coded as a 0.</p> <p>Review of the MDS 3.0 Quality Measures User's Manual v 8.0 04/15/2013 revealed on page C-32 the coding instructions for C1600 were: "Code 0, no: if there is no evidence of acute mental status change from the resident's baseline." "Code 1, yes: if resident has an alteration (change) in mental status observed in the past seven days or in the Brief Interview for Mental Status (BIMS) that represent a change from baseline."</p> <p>Interview on 1/8/14 at 3:30 p.m. with MDS coordinator A confirmed the 5/29/13 and 8/22/13 MDS quarterly assessments had been coded incorrectly.</p> <p>2. Resident 6 had a quarterly MDS completed on 5/29/13 and 8/22/13 revealed: *Those MDSs had been coded with behavioral symptoms that had occurred one to three days during the assessment periods. *The 5/29/13 assessment revealed those behaviors did not have an effect on the resident or others. *The 8/22/13 assessment revealed behaviors had an impact on the resident only.</p>	F 278		

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F 278	<p>Continued From page 6</p> <p>*In comparing the 5/29/13 to the 8/22/13 assessments there had been an increase in behaviors.</p> <p>*The 8/22/13 MDS revealed that had been an improvement in behaviors rather than a decline in behaviors for the resident.</p> <p>3. Review of resident 6's annual MDS completed on 11/22/13 revealed:</p> <p>*The MDS had been coded with behavioral symptoms that had occurred one to three days during the assessment period.</p> <p>*The behaviors had an impact on the resident and on others.</p> <p>*In comparing the 8/22/13 to the 11/22/13 assessment there had been an increase in behaviors.</p> <p>*The 11/22/13 MDS had been coded as the behaviors had not changed since the last assessment period.</p> <p>Review of the MDS 3.0 Quality Measures User's Manual v 8.0 04/15/2013 revealed on page E-21 the coding instructions for E1100 were: "Code 0, same: if overall behavior is the same." "Code 1, improved: if overall behavior is improved." "Code 2, if worse: if overall behavior is worse." "Code 3, N/A (not applicable): if there was not prior MDS assessment of this resident."</p> <p>4. Interview on 1/8/14 at 3:50 p.m. with social service assistant (SSA) B confirmed the above MDSs had been coded incorrectly.</p> <p>The provider could not provide a policy on MDS accuracy.</p>	F 278			
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281	<p>F 281 I. All Physician orders are clarified and updated correctly</p>	2-28-14	

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F 281 SS=E	<p>Continued From page 7</p> <p>PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057</p> <p>Surveyor: 14477</p> <p>Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure professional standards were followed for: *Physician's orders had not been current for 11 of 11 sampled residents (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11). *Accurate medication orders had not been present for 3 of 23 sampled residents (4, 10, and 11). *One of two registered nurses (RN) C had not administered Advair inhalers correctly to 2 of 3 randomly observed residents (20 and 21). *One of two RNs C had not administered eye drops correctly to 1 of 12 randomly observed residents (4). Findings include:</p> <p>1. Review of the following 11 sampled resident's records revealed physician's orders had not been signed in a timely manner and were not current:</p> <p>Surveyor 32573 a. Resident 1's consolidated sixty day physician's orders revealed the following statement on the bottom of the page "I have approved these orders for (resident name) for the time period of</p>	F 281	<p>for residents # 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11. Medication orders are accurate for resident # 4, 10, 11. No immediate correction could be made for incorrect medication administration for residents #4, 20, 21. All residents are at risk.</p> <p>II. All physicians orders will be reviewed and clarified by the DNS or designee by 2-14-14. All new admission physician orders will be clarified prior to admit to ensure accuracy and appropriate parameters before implementation. All physician orders will be signed within the designated time frame. Signed physician orders will be in the chart prior to the 1st of every month on-going. All residents receiving an advair inhaler will be educated on the importance of rinsing and spitting mouth out after inhalation. All physician orders for administration of eye drops will be followed. All charge nurses will be inserviced by the DNS or designee on appropriate parameters and</p>	

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F 281	<p>Continued From page 8</p> <p>7/1/2013 to 8/31/13." Those orders had been printed on 9/9/13 and were signed by the physician on 9/22/13.</p> <p>b. Resident 2's consolidated sixty day physician's orders revealed the following statement on the bottom of the page "I have approved these orders for (resident name) for the time period of 7/1/13 to 8/31/13." Those orders had been printed on 9/9/13 and were by the physician signed on 10/1/13.</p> <p>Surveyor 28057</p> <p>c. Resident 3's consolidated sixty day physician's orders revealed a statement on the bottom of the page "I have approved these orders for (resident name) for the time period of 11/01/2013 to 12/31/13." -Those orders had been printed on 11/07/13 and were signed on 12/18/13.</p> <p>d. Resident 4's consolidated sixty day physician's orders revealed a statement on the bottom of the page "I have approved these orders for (resident name) for the time period of 11/01/2013 to 12/31/13." -Those orders had been printed on 11/07/2013 and were signed on 11/23/2013.</p> <p>Surveyor 14477</p> <p>e. Resident 5's consolidated sixty day physician's orders revealed a statement on the bottom of the page "I have approved these orders for (resident name) for the time period 11/01/2013 to 12/31/2013." -Those orders had been printed on 11/7/2013 and were signed on 12/5/2013.</p> <p>Surveyor 32572</p>	F 281	<p>accuracy of physician orders no later than 2-6-14. The DNS or designee will educate medical records and nurse management staff on the proper procedure to obtain timely physician signatures on all orders. The DNS or designee will educate all charge nurses and certified medication aide (CMA) on proper technique of administration of inhalers no later than 2-6-14. The DNS or designee will educate all charge nurses and CMT's on following physician orders when administering eye drops no later than 2-6-14.</p> <p>III. The DNS or designee will audit accuracy and clarification of physician orders, medication administration for following physician orders, timely signing of physician orders, for 5 residents weekly for one month then monthly for 3 months. The DNS or designee will report findings to QA&A monthly for further recommendation.</p>	

If the resident refuses to rinse and spit after the inhalation of the Advair Diskus, the physician will be notified of the resident's non-compliance. KG/SD00H/JJ

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F 281	<p>Continued From page 9</p> <p>f. Resident 6's consolidated sixty day physician's orders revealed a statement on the bottom of the page "I have approved these orders for (resident name) for the time period of 05/01/2013 to 06/30/2013." -Those orders had been printed on 07/13/13 and were signed by the physician on 7/26/13. *The next set of consolidated sixty day physician's orders had the same statement "I have approved these orders for (resident name) for the time period of 07/01/2013 to 08/31/2013." -Those orders had been printed on 09/09/13 and were signed on 09/26/13. *There had not been a set of consolidated sixty day physician's orders for 09/01/13 to 10/31/13. *The next set of consolidated sixty day physician orders had the same statement "I have approved these orders for (resident name) for the time period of 11/01/2013 to 12/31/2013." -Those orders had been printed on 11/07/13 and were signed on 11/26/2013. *There had been no consolidated physician's orders signed for the 01/01/14 to 02/28/14 time frame.</p> <p>g. Resident 7's consolidated sixty day physician's orders revealed a statement on the bottom of the page "I have approved these orders for (resident name) for the time period of 05/01/2013 to 06/30/2013." -Those orders had been printed on 07/13/13 and were signed by the physician on 8/01/13. *The next set of consolidated sixty day physician orders had the same statement "I have approved these orders for (resident name) for the time period of 07/01/2013 to 08/31/2013." -Those orders had been printed on 09/09/13 and were signed on 09/26/13. *There had not been a set of consolidated sixty</p>	F 281			

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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 281	<p>Continued From page 10</p> <p>day physician's orders for 09/01/13 to 10/31/13. *The next set of consolidated sixty day physician's orders had the same statement "I have approved these orders for (resident name) for the time period of 11/01/2013 to 12/31/2013." -Those orders had been printed on 11/07/13 and were signed on 11/26/13. *There had been no consolidated physician's orders signed for the 01/01/14 to 02/28/14 time frame.</p> <p>Surveyor 14477</p> <p>h. Resident 8's consolidated sixty day physician's orders revealed a statement on the bottom of the page "I have approved these orders for (resident name) for the time period 11/01/2013 to 12/31/2013." -Those orders had been printed on 11/7/2013 and were signed on 12/4/2013.</p> <p>Surveyor 32572</p> <p>i. Resident 9's consolidated sixty day physician's orders revealed a statement on the bottom of the page "I have approved these orders for (resident name) for the time period of 07/01/2013 to 08/31/2013." -Those orders had been printed on 09/09/13 and were signed by the physician on 10/10/13. *The next set of consolidated sixty day physician's orders had the same statement "I have approved these orders for (resident name) for the time period of 11/01/2013 to 12/31/2013." -Those orders had been printed on 11/07/13 and were signed on 11/21/13. *There had been no consolidated physician's orders signed for the 01/01/14 to 02/28/14 time frame.</p> <p>Surveyor 32333</p>	F 281		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
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F 281	<p>Continued From page 11</p> <p>j. Resident 10's consolidated sixty day physician's orders revealed a statement on the bottom of the page "I have approved these orders for (resident name) for the time period of 7/1/13 to 8/31/13." -Those orders had been printed on 9/9/13 and were signed on 9/25/13.</p> <p>k. Resident 11's consolidated sixty day physician's orders revealed a statement on the bottom of the page "I have approved these orders for (resident name) for the time period of 7/1/13 to 8/31/13." -Those orders had been printed on 9/9/13 and were signed on 9/25/13.</p> <p>Surveyor #32572 L. Interview on 1/8/14 at 11:00 a.m. with the interim director of nursing confirmed the above physicians' orders had not been signed in a timely manner and had not been current.</p> <p>Review of the provider's undated Physician Visits policy revealed the purpose of the policy had been "to ensure timely physician visits." Surveyor: 32333</p> <p>2. a. Review of resident 10's 11/26/13 physician's orders revealed: *An order for promethazine HCL (a medication that treats allergies, nausea, and vomiting) 25 milligrams (mg) rectal suppository as needed (PRN). *An order for Reglan (a medication that treats nausea and vomiting) 10 mg one tablet by mouth PRN. *No parameters had been documented for how often the above medications could be given.</p> <p>Review of resident 10's January 2014 medication</p>	F 281		

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F 281	<p>Continued From page 12</p> <p>administration record (MAR) revealed the same as the above stated orders.</p> <p>b. Review of resident 11's 11/20/13 physician's orders revealed: *An order for Artificial Tears (eye drops) 1.4% solution two times a day everyday. The order had not stated how many drops to administer or which eyes to administer them into. *Debrox (ear drops) 6.5% solution five drops PRN for cerumen impaction per facility policy. The order had not addressed how often to administer the eye drops.</p> <p>Review of resident 11's January 2014 MAR revealed: *Artificial Tears one drop each eye PRN. It had not stated how many times per day. *The physician's order had not stated how many drops to administer or in which eye to administer them.</p> <p>Interview on 1/8/14 at 5:40 p.m. with the interim director of nursing revealed: *She had been aware the physicians orders had been incorrect and incomplete. *She agreed the orders needed to be clarified.</p> <p>Surveyor 32573</p> <p>c. Review of resident 4's 1/8/14 physician's order summary revealed an order for Refresh Lacri-lube (artificial tear ointments) at bedtime only. The order had stated a "small amount" should be given.</p> <p>Interview on 1/8/14 at 4:15 p.m. with the interim director of nursing revealed she had been aware the physician's orders had been incomplete. She agreed the orders needed to be clarified.</p>	F 281			

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F 281	<p>Continued From page 13</p> <p>Surveyor: 32573</p> <p>3. a. Observation on 1/7/14 at 5:25 p.m. revealed: *Nurse C handed an Advair inhaler to resident 21. *Resident 21 administered the medication and handed the inhaler back to nurse C. *She thanked the resident and left the room. *Resident 21 had not rinsed her mouth with water and spit it out after administering the inhaler. *Nurse C did not ask the resident to rinse her mouth with water after taking the medication.</p> <p>Interview on 1/8/14 at 4:00 p.m. with nurse C revealed she did not usually ask resident 21 to rinse and spit after using the Advair inhaler. She stated the resident had refused to do that in the past.</p> <p>Surveyor 28057</p> <p>b. Random observation on 1/7/14 at 4:40 p.m. in the dining room revealed RN C administered an Advair inhaler to a resident. She then had the resident take her oral medications with a glass of water. She had not asked the resident to rinse and spit after the Advair Diskus.</p> <p>Interview on 1/8/14 at 6:10 p.m. with RN C confirmed the resident should have rinsed and spit after she had inhaled the Advair Diskus medication.</p> <p>C. Review of the provider's 2007 Oral Inhalations procedure under number 15 stated the resident was to have rinsed and spit after a steroid inhalation like the Advair Diskus.</p> <p>Surveyor 32573 Review of the Advair Diskus inhaler package</p>	F 281			

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F 281	Continued From page 14 insert revealed residents should rinse the mouth with water without swallowing after inhalation of the medication. 4. Observation on 1/7/14 at 5:30 p.m. revealed nurse C administered several eye drops to both eyes of resident 4. Review of the physician's orders dated 1/8/14 revealed an order for Refresh Tears to be given one drop in each eye four times a day. Interview on 1/8/14 at 4:00 p.m. with nurse C revealed she agreed only one eye drop should have been given in each eye.	F 281		
F 441 SS=F	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	F 441	F 441 I. a. The proper procedure to disinfect the two shower/tub rooms was immediately posted to include the 10 minute surface contact time. b. The folding countertop was removed immediately. c. No immediate corrective action could be taken for the missing tile around the washing machine. d. No immediate corrective action could be taken for the exposed raw wood underneath countertops. e. No immediate corrective action be taken for the worn wood finishes on the cabinet fronts. f. Nurse D was immediately educated by the DNS regarding the appropriate dis-infection of the glucose meter between residents. All residents are at risk.	2-28-14

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F 441	<p>Continued From page 15 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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Two of two shower/tub rooms had been properly disinfected in-between residents by two of two observed certified nursing assistants (CNA) (E and F). *A folding countertop in the laundry room did not have a chipped surface creating an uncleanable surface. *Tile had not been missing around the washing machine in the laundry room. *Three randomly observed residents' rooms (105, 220, and 222) remained free from chipped countertops that exposed raw wood underneath creating uncleanable surfaces. *Six randomly observed residents' rooms (105, 112, 204, 216, 220, and 222) remained free from worn wood finishes on the cabinet fronts underneath the sinks creating uncleanable</p>	F 441	<p>II. a. All shower/tub rooms will be properly disinfected between each use according to the posted instructions on or before 2-6-14. b. All chipped surfaces in the laundry room will be repaired or replaced to ensure a cleanable surface on or before 2-14-14. c. The missing tile was resurfaced and repaired on 1-23-14. d. The exposed raw wood will be repaired no later than 2-28-14. e. The worn wood finishes will be repaired no later than 2-14-28 f. The glucose meter will be cleaned after each use.</p> <p>The DNS or designee will educate all staff on the infection control program, appropriate dis-infection of the shower/tub rooms, identification of un-cleanable surfaces, and appropriate care and dis-infection technique of blood glucose meter between residents no later than 2-6-14.</p>	

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F 441	<p>Continued From page 16 surfaces.</p> <p>*One of three observed licensed nurses (D) had properly cleaned and disinfected the glucose meter after checking blood sugars for one of two randomly observed residents (22). Findings include:</p> <p>1. Observation and interview on 1/7/14 at 2:10 p.m. with CNA E in the first floor tub/shower room while she verbally demonstrated the cleaning of the whirlpool tub and shower revealed: *The cleaning of the whirlpool tub: -Spray the tub with Classic disinfectant cleaner. -Scrub the tub with a scrub brush. -Rinse the tub immediately after scrubbing it. -She did not run the jets during cleaning in-between residents. -She stated they ran cleaner through the jets at the end of the day. *The cleaning of the shower room: -Spray the shower with Classic disinfectant cleaner. -Let it remain wet on the surface for a few seconds and then rinse the shower. *She had not been aware of any time frame the whirlpool disinfectant cleaner had to remain wet on the surface to ensure disinfection.</p> <p>Observation and interview on 1/8/14 at 8:45 a.m. with CNA F in the second floor tub/shower room while she demonstrated the cleaning of the whirlpool tub revealed: *She followed steps 1 through 7 of the bath tub cleaning procedure that had been posted on the side of the whirlpool tub. *She then rinsed the tub. *She had been unaware of any time frame the Classic whirlpool tub cleaner had to remain wet on the tub surface to ensure disinfection.</p>	F 441	<p>III. The DNS or designee will audit infection control practices through observation of blood glucose monitor use on 3 residents and observation of 3 whirlpool/shower room cleanings weekly for one month, and inspection of 3 rooms per week for one month then monthly for 3 months. The DNS or designee will report findings to QA&A monthly for further recommendation.</p>	

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F 441	<p>Continued From page 17</p> <p>Review of the provider's bath tub cleaning procedure revealed:</p> <p>*"1. Drain tub. 2. Rinse tub, sides and bottom. 3. Be sure chair is in tub and tub drain plug is in place. 4. Run 5 gallons of water in tub (enough to cover intake valve). Pour 10 oz. of tub disinfectant solution into water. 5. Run disinfectant through the aerator holes below chair and with brush or sponge wash that part of tub using disinfectant solution. 6. Turn on the aerator (i.e. jets) and using the brush or sponge scrub tub and chair. 7. Turn on jets/aerator run for at least 20 seconds. 8. Drain tub and thoroughly rinse the tub and chair with water. Fill tub with plain water to cover intake jet and turn on jets/aerator run for 20 seconds.) 9. When done rinsing you are ready for next resident."</p> <p>*The bottom of the form stated "(use 2oz (2 oz) of the disinfectant solution Classic for every gallon of water used.)"</p> <p>*The form had not stated how long to allow the Classic whirlpool cleaner to remain wet on the tub surface to ensure disinfection.</p> <p>Interview on 1/8/14 at 3:50 p.m. with the infection control nurse revealed she:</p> <p>*Had been unaware of the proper procedure for the whirlpool tubs and showers. *Would have expected the whirlpool tubs and showers to have been disinfected in-between residents. *Agreed the bath tub cleaning procedure had been incorrect.</p>	F 441		

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F 441	Continued From page 18 2. Random observations from 1/7/14 through 1/8/14 throughout the facility revealed: *In the laundry room: -The tile around the washing machine had been missing. That created an uneven surface with screws and glue that created an uncleanable surface (photo 1). -A countertop used for folding clean resident-use items including linen and clothes had been chipped revealing a raw wood uncleanable surface (photo 2). *In residents' rooms 105, 220, and 222 the sinks had missing, chipped, and bowed out countertops that revealed uncleanable raw wood surfaces (photo 3). *In residents' rooms 112, 204, 216, 220, and 222 the cabinets underneath and next to the sinks had worn wood finishes exposing raw wood creating uncleanable surfaces (photo 4). Interview and walk-through on 1/8/14 at 3:35 p.m. with the maintenance director revealed he agreed the above identified areas needed to be corrected. Surveyor: 32573 3. Observation on 1/7/14 at 4:10 p.m. revealed nurse D had tested a randomly observed resident's blood glucose (sugar). Nurse D then returned the glucose meter (handheld device used to measure blood glucose levels) to the medication cart drawer. The glucose meter had not been cleaned after it had been used. Interview at the above time with nurse D revealed the glucose meter on the medication cart had been used to test multiple resident's blood glucose levels.	F 441		

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F 441	Continued From page 19 Review of the blood glucose monitor decontamination policy dated June 2012 revealed the blood glucose monitor "Will be cleaned and disinfected with wipes following use on each resident when monitors are shared by multiple residents."	F 441			

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K 000	<p><i>Addendums noted with an asterisk per 2/5/14 telephone to facility administrator. CH/SADOH HJJ</i></p> <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 1/08/14. Golden LivingCenter - Prairie Hills was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K020, K021, K025, K034, K046, K056, K062, K064, and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>This facility objects to the allegations of noncompliance in this Statement of Deficiencies and disagrees with both the findings of non-compliance and the level of deficiency cited. Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p> <p>Accordingly, the facility has prepared and submitted this Plan of Correction because of the requirements under State and Federal law that mandate submission of a Plan of Correction as a condition to participate in the Title 18 and Title 19 programs. The submission of the Plan of Correction should in no way be considered or construed as agreement with the allegations of the non-compliance or admission by the facility. This plan of correction shall constitute this facility's credible allegation of compliance.</p>	
K 020 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 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 one of two elevator shafts (original building) enclosed with construction having a fire-resistance rating of at least one hour. Findings include:</p> <p>1. Observation at 10:45 a.m. on 1/08/14 revealed the enclosure for the elevator in the original building had a six inch diameter hole above the</p>	K 020		

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

Mesa Brockel SRED 1-29-14

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.

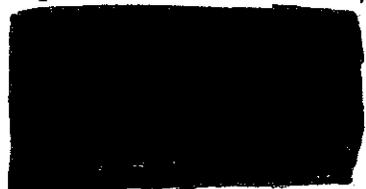
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SD DOH 120
If continuation sheet Page 1 of 10

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K 020	Continued From page 1 lay-in ceiling in the south wall of the enclosure. The hole had two large pipes and a piece of two inch by six inch wood blocking protruding from the opening. The penetration of the wall was not sealed to meet a one hour fire-resistive rating. Interview with the maintenance supervisor at the time of the observation confirmed that finding.	K 020	K020 I. No immediate corrective action could be taken. All residents are at risk.	2-28-14
K 021 SS=D	The deficiency affected one of two elevator enclosures required to be provided with one-hour fire-resistive enclosures. NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the 20 minute fire resistive	K 021	II. The penetration of the [redacted] will be sealed on or before 2-14-14. The ED will educate the maintenance personnel regarding the one hour fire resistive enclosures on or before 2-14-14. III. The environmental supervisor or designee will audit 3 areas weekly for one month then monthly x 3 months. The maintenance supervisor will report findings to QA&A monthly for further recommendation. K021 I. No immediate corrective action could be taken. All residents are at risk. II. The first floor shower room door will be equipped with a [redacted] upon activation of fire alarm system on or before 2-14-14. The ED will educate the maintenance	2-28-14

*elevator enclosure wall
* in the lower level
CH (SOASH) JJ*

*magnetic hold-open
device which will
release
CH (SOASH) JJ*

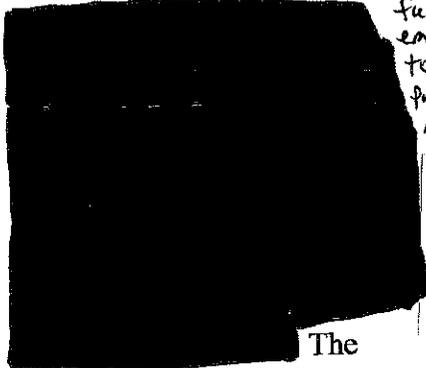
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BEVERLY HEALTH CARE CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 01/08/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 021	Continued From page 2 rating of door assemblies for a hazardous area. One randomly observed door (first floor shower room labeled whirlpool used for combustible storage) was held open with an unapproved device. Findings include: 1. Observation at 11:45 a.m. on 1/08/14 revealed the door separating the first floor shower room (labeled as whirlpool) was used for storage of combustible items (cases of vinyl gloves, adult briefs, and kleenex) and was considered a hazardous area. The corridor door was equipped with a closer but was held open with a magnet not interconnected with the fire alarm system. Interview with the maintenance supervisor at the time of the observation revealed the magnet hold-open had been installed in the past month to allow staff easier access to the room. The deficiency affected one of several hazardous areas in the building required to be provided with self-closing doors to the corridor.	K 021	personnel regarding proper installation of self-closing doors activated by fire alarm system on or before 2-14-14. III. The environmental supervisor or designee will ^{* add monthly checking} of the operation of this hazardous area door closer and magnetic hold open to the facility's preventive maintenance program. The environmental supervisor will report findings to QA&A ^{Quarterly CH/SCAH/JS}	
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	K 025	I. No immediate corrective action could be taken. All residents are at risk II. The unsealed penetration areas above the lay-in acoustical ceiling tile on 2nd floor have been properly sealed. The ED will educate the maintenance personnel regarding the penetration openings and maintaining the 30 minute fire resistive rating of smoke barrier walls on or before 2-14-14.	2-28-14

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
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K 025	Continued From page 3 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 wall for the second floor had unsealed penetration openings above the lay-in acoustical ceiling in the corridor and the social services office on the second floor. Findings include: 1. Observations beginning at 4:00 p.m. on 1/08/14 revealed the east side of the smoke barrier wall on the second floor had unsealed penetrations around control wiring (approximately one inch in diameter) and sprinkler piping (approximately six inches in diameter) in the corridor above the lay-in ceiling. There was an unsealed opening approximately two inches in diameter around control wiring in the social services office above the lay-in ceiling. Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated contractors must not have finished sealing the smoke barrier after installing wiring and piping. NFPA 101 LIFE SAFETY CODE STANDARD	K 025	III. The environmental supervisor or designee will [*]  The environmental supervisor or designee will report findings to QA&A. [*]  CH/SDDH/JT	add quarterly checking of the smoke barrier walls to the preventive maintenance program. CH/SDDH/JT	
K 034 SS=E	Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain conforming exit stairs (southeast basement stairwell and second floor at	K 034	I. No immediate corrective action could be taken. All residents are at risk II. All stair enclosures will only be used for purposes of egress with no items stored in these areas. All items will be removed on or before 2-14-14. The ED or designee will educate all staff on the importance of egress and no items being stored in the stairwells on or before 2-14-14.	2-28-14	

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

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K 034	Continued From page 4 physical therapy). Items were stored in the stair enclosure and on the exit stair landing. An exit enclosure shall not be used for any purpose that has the potential to interfere with its use as an exit and, if so designated, as an area of refuge. There shall be no enclosed, usable space within an exit enclosure, including under stairs, nor shall any open space within the enclosure be used for any purpose that has the potential to interfere with egress. Findings include: 1. Observation at 10:30 a.m. on 1/08/14 revealed wheelchairs, a rack with cushions, and paint in gallon containers were stored in the stair enclosure at the basement level of the southeast stair enclosure. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He stated he was unaware those items could not be kept in the stair enclosure. 2. Observation at 4:00 p.m. on 1/08/14 revealed two carts with wheels (one holding therapy balls and a water pass cart with a cooler) were kept on the landing of the second floor stair enclosure by the therapy department. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He stated he was unaware those items could not be kept on the stair landing. The deficiency affected two of four stair enclosures.	K 034	III. The environmental supervisor or designee will [*] [redacted] The environmental supervisor or designee will report findings to QA&A, [*] [redacted] CH/SAD04/JJ	add monthly checking of the three stairwells to the facility's preventive maintenance program CH/SAD04/JJ
K 046 SS=D	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.	K 046	K046 I. No immediate corrective action could be taken. All residents are at risk	2-28-14

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K 046	Continued From page 5 This STANDARD is not met as evidenced by: Surveyor: 18087 A. Based on observation and interview, the provider failed to install emergency lighting of at least one hour duration for the transfer switch location in the boiler room. Findings include: 1. Observation at 10:30 a.m. on 1/08/14 revealed there was not a battery pack emergency light installed at the emergency power transfer switch location in one of one areas (boiler room). Interview with the maintenance supervisor at the time of the observation revealed he was unaware the emergency light was required for that location. The deficiency affected a single location required to be illuminated with emergency backup lighting. B. 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 1/08/14 revealed there was not an emergency stop button installed for the generator. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of the remote stop requirement for the generator. The deficiency affected a single location required to be equipped with remote emergency stops. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 046	II. A battery back up emergency light for the transfer switch will be installed in the boiler room and an emergency stop button for the generator will be installed on or before 2-14-14. The ED will educate the environmental personnel on emergency lighting of at least one hour duration and all staff of a remote stop for the generator on or before 2-14-14. III. The environmental supervisor or designee will ^{* add checking the function of the emergency light to the facility's preventive maintenance program.}  The environmental supervisor or designee will report findings to QA&A monthly.  <i>CH/sadon/JJ</i>	
K 056 SS=D		K 056	K056 I. No immediate corrective action could be taken. All residents are at risk	2-28-14

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K 056	Continued From page 6 for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install a complete sprinkler system (walk-in freezer) as required. Findings include: 1. Observation at 3:30 p.m. on 1/08/14 revealed the walk-in freezer adjacent to the kitchen was not equipped with a sprinkler. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated the sprinkler had been discovered by a different building review and had been scheduled for installation. The deficiency affected a single component of the automatic sprinkler system.	K 056	II. The walk in cooler will have an automatic sprinkler system installed on or before 2-28-14. The ED will educate environmental personnel regarding importance of automatic sprinkler system throughout the facility to provide complete coverage on or before 2-14-14 III. The environmental supervisor will audit three areas to ensure sprinkler system present weekly for one month then monthly for 3 months. The environmental supervisor will report findings to QA&A monthly for further recommendation.	
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062	K062 I. No immediate corrective action could be taken. All residents are at risk	2-28-14

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K 062	<p>Continued From page 7 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 A. Based on record review and interview, the provider failed to verify the required annual testing of the backflow preventer had been performed. Findings Include:</p> <p>1. Review of the provider's sprinkler maintenance records revealed no documentation the required annual testing of the backflow preventer had been performed. Interview with the maintenance supervisor at 5:00 p.m. on 1/08/14 revealed the test had not been performed, because the city of Rapid City had not required it.</p> <p>The deficiency affected a single component of the building's automatic fire sprinkler system required annual maintenance.</p> <p>B. Based on observation and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector so the water discharge was not interrupted in one randomly observed resident's room (206). Findings Include:</p> <p>1. Observation at 4:30 p.m. on 1/08/14 revealed a single sidewall sprinkler on the exterior wall of resident room 206. The room was a double occupancy room with two privacy curtains. The sprinkler discharge pattern would have to penetrate both curtains if closed at the same time. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was unaware of the second curtains possible interruption of the sprinkler</p>	K 062	<p>II. Annual testing of the backflow preventer will be performed on or before 2-14-14. The double tract of privacy curtain in room 206 will be removed into a single tract line to ensure proper water discharge of the sprinkler system on or before 2-14-14. Education by ED to the environmental personnel regarding the state annual required backflow testing and proper sprinkler discharge patterns on or before 2-14-14.</p> <p>III. The environmental supervisor or designee will ^{add annual testing of the fire sprinkler system backflow preventer to the facility's preventive maintenance program and will modify the curtain track in three double occupancy rooms to only have a single curtain in the discharge pattern of a sprinkler.}</p> <p>The environmental supervisor or designee will report findings to QA&A ^{annually.} _____ ^{CH/SPDH/JJ}</p>	

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K 062	Continued From page 8 discharge pattern.	K 062		
K 064 SS=C	The deficiency affected a single location required to be equipped with unobstructed fire sprinkler protection. 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 fifteen of fifteen fire extinguishers mounted in wall cabinets or recesses (corridors on the first and second floors). Findings include: 1. Random observation from 10:15 a.m. to 3:00 p.m. on 1/08/14 revealed the locations of fifteen fire extinguishers located in the corridors were not conspicuously marked. Interview with the maintenance supervisor at the times of the observations confirmed those findings. The deficiency affected numerous fire extinguisher locations required to be marked conspicuously.	K 064	K064 I. No immediate corrective action could be taken. All residents are at risk II. All 15 fire extinguishers mounted in the wall or recesses will be properly marked on or before 2-14-14. The ED will educate the environmental personnel on proper signage of fire extinguisher identification on or before 2-14-14. III. The environmental supervisor or designee will audit 3 fire extinguishers weekly for one month then monthly for 3 months. The environmental supervisor or designee will report findings to QA&A monthly for further recommendation.	2-28-14
K 069 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069	K069 I. No immediate corrective action could be taken. All residents are at risk	2-28-14

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K 069	Continued From page 9 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to conduct required inspection of the cooking facility's fire suppression system within six months of the previous inspection (June 12, 2013). Findings include: 1. Review of the kitchen hood fire suppression system maintenance inspection reports revealed the system was last inspected June 12, 2013. Inspections of the fire suppression system for the kitchen range must be conducted not less than every six months. The fire suppression system was tagged indicating the last inspection of that system was June 12, 2013. Interview with the maintenance supervisor at 3:45 p.m. confirmed that finding. He stated he had scheduled an inspection with a new contractor for January 10, 2014. The deficiency affected a single element of the required preventive maintenance for the kitchen range hood fire suppression system.	K 069	II. The kitchen hood fire suppression inspection will be completed on or before 2-14-14. The ED will educate the environmental personnel regarding the semi-annual inspection on or before 2-14-14, III. The environmental supervisor or designee will complete a semi-annual audit of the kitchen hood fire suppression and report findings to QA&A semi-annually for further recommendation.	

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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10669	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 916 MT VIEW RD RAPID CITY, SD 57702
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S 000	Initial Comments Surveyor: 28057 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 1/7/14 through 1/9/14. Golden LivingCenter - Prairie Hills was found not in compliance with the following requirement: S315.	S 000	<p>This facility objects to the allegations of noncompliance in this Statement of Deficiencies and disagrees with both the findings of non-compliance and the level of deficiency cited. Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or an agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p> <p>Accordingly, the facility has prepared and submitted this Plan of Correction because of the requirements under State and Federal law that mandate submission of a Plan of Correction as a condition to participate in the Title 18 and Title 19 programs. The submission of the Plan of Correction should in no way be considered or construed as agreement with the allegations of the non-compliance or admission by the facility. This plan of correction shall constitute this facility's credible allegation of compliance.</p>	
S 315	<p>44:04:08:04 STORAGE AND LABELING OF MEDICATIONS</p> <p>All drugs or medications must be stored in a well illuminated, locked storage area which is well ventilated, maintained at a temperature appropriate for drug storage, and inaccessible to...residents or visitors at all times. Medications suitable for storage at room temperature must be maintained between 59 and 86 degrees Fahrenheit (15 and 30 degrees centigrade). Medications that require refrigeration must be maintained between 36 and 46 degrees Fahrenheit (2 and 8 degrees centigrade). Poisons and medications prescribed for external use must be stored separately from internal medications, locked and made inaccessible to...residents.</p> <p>This Rule is not met as evidenced by: Surveyor: 32573 Based on record review and interview, the provider failed to maintain the temperature for three of three refrigerators in medication rooms used to store medication (med). Findings include:</p> <p>1. Review of the refrigeration temperature logs for the refrigerator in the second floor medication</p>	S 315		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Theresa Brockel Sr ED 2-4-14</i>	TITLE	(X6) DATE
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SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10669	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
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S 315	Continued From Page 1 room and the two refrigerators in the first floor medication room revealed: *The acceptable temperature range written on the top of the log sheet had been 33 to 41 degrees Fahrenheit (F). *The November 2013 log for the first floor medication refrigerator had been out of that temperature range every day. *The December 2013 log for the first floor medication refrigerator had been out of that temperature range twenty of thirty-one days. *The November 2013 log for the first floor med pass refrigerator had no temperature recorded for the first five days of the month. From the fifth to the end of the month, the refrigerator had been out of that temperature range twenty-one of twenty-five days. *The December 2013 log for the first floor medpass refrigerator had been out of that temperature range twenty of thirty-one days. *There had been no indication on any of the above logs if steps had been taken to bring the temperature of the refrigerators back into the acceptable range. *The December 2013 log for the second floor medication room refrigerator had been out of that temperature range twenty of thirty-one days. There had been notes on six of those days stating the refrigerator had been "turned down" or "adjusted." *Many of the temperatures recorded had been below 32 degrees F. Review of package inserts for several of the common medications (nasal spray, flu vaccines, and tuberculin injections) in the above refrigerators revealed they should have been stored between 36 and 46 degrees F and should not be frozen. Interview on 1/8/14 at 5:35 p.m. with the	S 315	S315 I. No immediate correction could be made. New refrigerators without freezer will be placed in medication rooms on or before 2-14-14. All residents are at risk. II. All medication refrigeration logs have been updated to include parameters and corrective action taken to adjust temperature accordingly and to notify the pharmacy and environmental department. The DNS or designee will educate all staff regarding appropriate temperature parameters and interventions on or before 2-14-14. III. The DNS or designee will audit medication refrigerators 3 times per week for one month then monthly for 3 months. The DNS or designee will report findings to QA&A monthly for further recommendations.	2-28-14

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10669	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MT VIEW RD RAPID CITY, SD 57702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 315	Continued From Page 2 administrator revealed: *The night nurse recorded the refrigerator temperatures. *Staff would have been expected to notify maintenance if a temperature had been out of range. *The facility did not have a written policy for monitoring temperatures of medication refrigerators. *She had been unsure if the thermometers in the refrigerators had ever been calibrated.	S 315		