

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD POST OFFICE BOX 280 ARLINGTON, SD 57212
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F 000	<p><i>Addendums noted with an asterisk per Willis email from facility administrator. JVE/SDD/HMF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/12/15 through 5/14/15. Golden LivingCenter-Arlington was found not in compliance with the following requirements: F226, F248, F281, F309, and F329.</p>	F 000	<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
F 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate three of five reviewed resident's (9, 12, and 13) grievances to determine there had been no abuse or neglect. Findings include:</p> <p>1. Review of a grievance form completed on 1/15/15 regarding resident 12 revealed: *His brother had been concerned about how certified nursing assistant (CNA) E had treated him. *The action plan had been "[Resident name] does not want to move wings. Education on communication with elderly to be reviewed with CNA." *The nature of the resolution was "CNA was</p>	F 226	<p>F226: Development/Implement abuse/neglect, etc policies</p> <p>1. No immediate corrective action to be taken as events have concluded 2. Residents residing in the facility have the potential to be affected by this practice. 3. Policies and procedures on investigation and documentation process for resident and family grievances were reviewed. *all Directed in-service will be provided to staff on their role in the procedures for investigating and documenting resident and family grievances by 6/09/15.</p> <p><i>* 6/10/15 JVE/SDD/HMF</i></p> <p><i>* see page 2 JVE/SDD/HMF</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 6/5/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	<p>Continued From page 1</p> <p>disciplined accordingly and educated." *There had been no documentation of when the incident occurred nor what had happened.</p> <p>Review of CNA E's employee file revealed: *On 1/16/15 there had been a disciplinary action taken against her. *The description of the violation was "Rude or disrespectful behavior or conduct towards a resident, patient, or family member." *The section where they were to have described the incident in detail stated "see attached grievance." *The corrective action had been "Education given on communicating with elderly." *The employee comments were "Resident does not want TV - asks to have it on." There had been no further documentation on the actual incident or investigation.</p> <p>2. Review of a grievance form completed on 3/8/15 regarding resident 9 revealed: *Visitors had reported when they had come to visit between 4:30 p.m. and 5:00 p.m. they had found the resident in bed with feces on him, on his clothing, and on the floor all the way into the bathroom. *The CNA had been in the hall "speaking with someone." *The action plan was "Speak with employees on floor at this time." *The resolution had been "Spoke with employees on the floor at that time about the importance of checking on residents regularly. Also spoke with family about communicating needs to staff when necessary." *There had been no further investigation into how long he might have been in his bed, when the last time he had been assisted to the toilet, or past</p>	F 226	<p>*4. going forward all resident grievances must be signed off by two members for the IST team to ensure investigation was completed appropriately and meet policy standards. All grievances or up to 5, to include residents 9, 12 and 13, will be audited monthly for three months and brought to QAPI monthly to ensure compliance. Auditing and report to QAPI to be done by Executive Director or designee. JVE/RODDOH/MF</p>		

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F 226	<p>Continued From page 2</p> <p>incidents that might have occurred with the resident.</p> <p>3. Review of a grievance form completed on 5/11/15 regarding resident 13 revealed: *The daughter had informed staff her mother had stated CNAs had complained about her weight, and that it was hard on their backs to move her. The resident had stated "they complain about my weight a lot." *The resolution was "spoke with CNAs all express understanding. Staff meeting on 5/21/15 - ED [executive director] spoke with resident - resident thankful for addressing issues. ED also reinforced resident right to bring forth grievances as resident was mildly concerned of retribution [getting even] from staff. ED reassured and confirmed retribution was not tolerated here and would be dealt with appropriately if it were to occur." *There had been no investigation into who had made the comments about the resident's weight to determine that verbal abuse had not occurred by one or more of the CNAs.</p> <p>4. Interview on 5/14/15 at 8:20 a.m. with the administrator revealed they had not thoroughly investigated the above incidents to determine if abuse or neglect had occurred.</p> <p>Review of the provider's 1/15/15 Reporting Alleged Abuse Violation policy revealed: *The center should have investigated any alleged violation which involved mistreatment, neglect, abuse, injuries of unknown origin, and misappropriation of property thoroughly. *The investigation should have included interviews of employees, visitors, or residents who might have had knowledge of the incident.</p>	F 226			

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F 226	Continued From page 3 *The medical record should have been reviewed to determine the resident's past history. *The verification of investigation form should have been filled out after the investigation was completed.	F 226			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, record review, interview, and policy review, the provider failed to ensure an effective individualized activities program had been implemented and documented for one of one sampled dependent resident (7). Findings include: 1. Random observations of resident 7 from 5/13/15 at 11:15 a.m. through 5/14/15 at 8:10 a.m. revealed: *He utilized a reclining high-back wheelchair when he was not in his bed. *He had severe contractures (tightening of his muscles and joints) to both arms and legs. *Staff assisted him with wheeling the wheelchair. *He was assisted to eat and drink. *He had a radio in his room that had not been on during any of the above observation periods. Review of resident 7's 1/24/15 Recreation	F 248	F248: Activities meet interests/needs of each resident *7 JVEKSDOHMF 1. Activity program for resident was reviewed and ensured effective individualized program was in place. 2. Dependent residents have the potential to be affected by this practice. Activity programs for residents who receive 1:1 have been reviewed and revised as appropriate to ensure effective individualized programs are in place. 3. Policies and procedures about the provision of activities in the facility were reviewed. Directed in-service was provided on 6/09/15 to activities staff to ensure interaction/activities done with dependent resident and that documentation occurred when interacting and implementing activities program.  see page 5. JVEKSDOHMF *dependent JVEKSDOHMF	5/14/15 JVEKSDOHMF	

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F 248	Continued From page 4 Services Assessment done by activities revealed: *He was alert and non-responsive (unable to react to people) with poor cognition (memory). *He had limited gross and fine motor abilities (movements of muscles to enable activities of daily living [ADLs]). *His interests included: -Noon exercise on occasion. -Television and movies for noise. -Liked music. -Liked to be read to. -Would hold pets when they were brought in. -Liked to go outside. -Attended monthly mass. -Liked to have visitors. *His program preferences included: -One-to-one visits. -Visits with friends/family. -Going outside. *The above information was indicated as received by staff. Review of resident 7's revised 4/13/15 care plan revealed: *He had poor memory and severely impaired decision making ability. *He was rarely understood and rarely understood others. *He was dependent on staff for ADLs due to his cognitive and physical deficits. *One-to-one activities had been an intervention related to cognitive deficits. -There had been no specific mention of how often one-to-one activities should have been done. *Other interventions related to his poor response to others due to brain damage included: -Read mail to him. -He enjoyed going outdoors when the weather was nice.	F 248	* Activity documentation to be audited weekly for 3 weeks then monthly for 3 months, on all dependent residents or up to 5 residents and brought to AAPI monthly to ensure programs are being carried out appropriately. Auditing and report to AAPI to be done by Activity Director or designee. JVE/SDDDH/MF		

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F 248	<p>Continued From page 5</p> <p>-He enjoyed when his family and friends visited. -There had been no mention of how often those interventions should have been done.</p> <p>Review of resident 7's February, March, April, and May 2015 one-to-one documentation forms revealed he had received:</p> <ul style="list-style-type: none"> *Four visits in February that totaled 50 minutes. *Ten visits in March that totaled 110 minutes. *Nine visits in April that totaled 120 minutes. *Four visits in May that totaled 45 minutes, prior to survey. <p>Interview on 5/13/15 at 1:30 p.m. with the activities director revealed:</p> <ul style="list-style-type: none"> *She would be the one who did the one-to-one activities with resident 7. *He did not come out to group activities or anything else. *She took him outside sometimes when it was nice. *He used the radio all the time in his room. *She talked to him about music and his son's art work at times. *She did not document all her interactions with him. <p>Interview on 5/13/15 at 1:20 p.m. with certified nursing assistant E regarding resident 7 revealed:</p> <ul style="list-style-type: none"> *He used a total lift for transfers. *He did not talk much but would say a word or two at times. <p>Interview on 5/13/15 at 2:35 p.m. with housekeeper F regarding resident 7 revealed he sometimes attended music activities. He would go outside with the activity coordinator when it was nice.</p>	F 248			

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F 248	<p>Continued From page 6</p> <p>Interview on 5/13/15 at 4:40 p.m. with licensed practical nurse G regarding resident 7 revealed: *He normally listened to country music on his radio in his room. *Sometimes he attended group activities like music.</p> <p>Further interview on 5/14/15 at 8:15 a.m. with the activity coordinator regarding resident 7 revealed: *She agreed his radio had not been on during the above observations until she had turned it on yesterday afternoon. -She agreed that if he liked the radio to be on that it should have been on the care plan for all staff to be aware of. *She agreed the care plan did not mention how often one-to-one visits should have been done. *She stated the resident's family had been visiting less lately. *She agreed the documentation on the one-to-one forms was all she had for his activity participation for those months. *She stated she had many interactions with the resident that had not been documented, but agreed there was no documentation to support those interactions. *She was the primary activity staff for the provider. -There were a few casual staff that filled in when she was on vacation. *She was unsure of who covered for activities when she took off time unexpectedly the week before. *She worked closely with the dietary staff and sometimes they would cover for activities if needed. *The total activity hours and therefore the hours she worked were based on resident census. -Recently census had been lower, and she had</p>	F 248		

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F 248	<p>Continued From page 7 been working less hours.</p> <p>Interview on 5/14/15 at 9:00 a.m. with the executive director revealed: *The activity coordinator was the primary activity staff. -They also had a few cross trained staff to assist in activities if needed. *Activities staff hours were based on resident census. -For the current week, activities staff would have had thirty-three total hours available.</p> <p>Interview on 5/14/15 at 9:10 a.m. with the director of nursing revealed: *She agreed there would be no way to know if activities had been offered or completed if they had not been documented. *She agreed resident 7 was dependent on staff and would have had interactions with nursing staff related to ADLs. *Activities would have been done by the activity staff.</p> <p>Review of the provider's 8/30/11 Activity Specialist job description revealed: *The general purpose was to "plan, organize, and direct a program of activities that provides opportunity for entertainment, exercise, relaxation, and expression and fulfills basic psychological, social, and spiritual needs, which will be available to all residents of the facility." *Essential job duties included: -"Initiate and promote activities both within facility and outside facility and stimulate resident interests and well-being. -Regulate programs in accordance with residents' capabilities, needs and interests. -Prepare progress reports for medical staff</p>	F 248			

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F 248	<p>Continued From page 8</p> <p>reflecting resident's reactions and evidence of progress or regression.</p> <p>-Maintain all activity related records required by the regulations and Medical Records Department."</p> <p>Review of the provider's 2009 Recreation Services Guide: Individual Programming policy revealed:</p> <p>*The purpose was that individual programming ensured that all residents who were unable to or chose not to participate in group programs would have consistent, goal-oriented and individualized recreation opportunities.</p> <p>*The process included:</p> <p>-"Structured individual interventions will be developed based on each resident's history and assessed needs and preferences.</p> <p>-Each resident's individual program will include interventions which meet the resident's assessed social, emotional, physical, and cognitive functioning needs.</p> <p>-The length, duration, and content of specific one-to-one activities are determined by the specific needs of the individual resident, such as several short interventions (rather than a few longer activities) if someone has extremely low tolerance, or if there are behavioral issues."</p> <p>-It is important to remember that activities can take place at anytime and in anyplace.</p> <p>-Examples of individualized activities include: sensory stimulation or cognitive therapy, social engagement, spiritual support, nurturing, creative, task oriented activities, and support of self directed activity."</p> <p>Surveyor: 35237</p>	F 248			

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F 281 F 281 SS=D	Continued From page 9 483.20(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: 29354 A. Based on observation, interview, record review, and policy review, the provider failed to ensure professional standards were followed for one of one sampled resident (5) who had a coughing episode in the dining room. Findings include: 1. Observation on 5/12/15 from 5:50 p.m. through 6:04 p.m. of resident 5 in the dining room revealed: *At 5:50 p.m. she was at the dining room table with her evening meal in front of her. *At 5:55 p.m. she began to cough. *From 5:56 p.m. through 6:01 p.m.: -She continued to cough. -Registered nurse (RN) A was administering medications to different residents throughout the dining room. -RN A had never approached the resident to check on her. -The administrator continued to pass trays to several residents and had not stopped to check on her. -Several certified nursing assistants and dietary assistants continued to pass trays and had not stopped to check on the resident. -She took her lower dentures out of her mouth during the coughing episode. -Her table mates told her to take a drink of water.	F 281 F 281	F281: Services provided meet professional standards--A 1. Dentist appointment made for resident to see if dentures fit properly, however resident in conversation with DNS on 6/4/15 refused appointment saying her dentures fit fine and she does not want to go to the dentist. 2. Residents residing in the facility have the potential to be affected by this practice. 3. Policies and procedures surrounding staff response to potential resident episode or event that may be life threatening Directed in-service was provided on staff response to resident episode or event that may be life threatening and Insulin administration by 6/09/15. 4. An evaluation of staff response will be completed if a resident episode or event that maybe life threatening occurs will be completed to ensure appropriate actions were taken by staff. This will be monitored monthly for 3 months during QAPI monthly meetings to ensure staff actions were carried out appropriately. *reviewed. JVE/SDDH/MF	* 6/10/15 * 5 JVE/SDDH/MF JVE/SDDH/MF	

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F 281	<p>Continued From page 10</p> <p>*At 6:02 p.m. she pushed her wheelchair (w/c) away from the table.</p> <p>*At 6:03 p.m.:</p> <ul style="list-style-type: none"> -She self-propelled her w/c to the dining room exit door. -She waved her hand at RN A who was at a table next to her. -RN A had not noticed resident 5. <p>*At 6:04 p.m. the surveyor informed the DON of the above events.</p> <p>*At 6:05 p.m. the DON removed the resident from the dining room.</p> <p>*Observation at 6:07 p.m. of her plate revealed a half eaten hamburger and bun.</p> <p>*Interview at 6:10 p.m. with the DON regarding resident 5 revealed:</p> <ul style="list-style-type: none"> -She had told her she had two coughing episodes today. -She felt her lower denture was too big. <p>Interview on 5/12/15 at 6:20 p.m. with the DON and RN A regarding resident 5 revealed:</p> <ul style="list-style-type: none"> *RN A had been unaware of the resident's coughing episode. *RN A stated she had a problem with swallowing and was suppose to take small bites. *The DON's expectations were for the staff to have intervened if aware of a resident having a coughing or choking episode. <p>Interview on 5/12/15 at 6:25 p.m. with the administrator regarding resident 5's coughing episode revealed she had been unaware of the incident during the meal service.</p> <p>Review of resident 5's medical record revealed:</p> <ul style="list-style-type: none"> *An admission date of 3/10/14. *She had been on a regular diet. *There was no diagnosis or supporting 	F 281			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARLINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD POST OFFICE BOX 280 ARLINGTON, SD 57212	
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F 281	<p>Continued From page 11</p> <p>documentation for a swallowing or choking problem.</p> <p>*The 3/10/15 annual Minimum Data Set (MDS) assessment revealed:</p> <p>-The Brief Interview for Mental Status exam revealed a score of 10. (A score of 15 was alert and oriented).</p> <p>-There were no signs or symptoms of possible swallowing disorder identified.</p> <p>-Oral/Dental status was marked as "no natural teeth or tooth fragment(s) (edentulous) [no teeth].</p> <p>*There was no documentation on the 3/26/14 care plan of a swallowing or choking problem.</p> <p>*There was no documentation of any dental examinations.</p> <p>Interview on 5/13/15 at 9:00 a.m. with the DON regarding resident 5 revealed:</p> <p>*She was not sure when resident 5 had her last dental exam.</p> <p>*Dental exams were scheduled by the social worker or the charge nurses.</p> <p>*She had spoken with resident 5's daughter last evening about a dental exam.</p> <p>*The family had indicated the resident had refused to have her dentures "checked out."</p> <p>Observation and interview on 5/13/15 at 10:30 a.m. with resident 5 and the DON revealed:</p> <p>*Resident 5:</p> <p>-Had removed her bottom dentures.</p> <p>-Felt her bottom dentures were loose when she ate.</p> <p>-Put denture adhesive cream on the bottom dentures and placed them back into her mouth.</p> <p>-Confirmed she had not been to a dentist lately.</p> <p>Review of the provider's 1/26/15 Emergency Care, General Guidelines policy revealed:</p>	F 281		

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F 281	<p>Continued From page 12</p> <p>*Procedure purpose: -"To provide emergency care to a resident in need of urgent service." -"To prevent complications." **"Provide emergency care as necessary."</p> <p>Review of the provider's undated Nursing Responsibilities at Meal Service policy revealed: **"Staff from the Nursing and Dining Services departments work cooperatively to ensure that each patient [resident] has a pleasant dining experience and is served according to regulations." **"Nursing staff should accommodate individual patient's needs and preferences." **"Assure personally that the dining experience is enhanced through observation and conversation with the patients."</p> <p>Review of the provider's "Welcome to our Living Center" handbook revealed "Dental care: We will help you arrange to see a dentist when needed. The dentist may conduct his or her checkups in the LivingCenter or a mobile van nearby, or you may go to their office."</p> <p>Request for a Dental policy was not received from the provider.</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to ensure physician's orders were followed for one of one sampled resident (11) who was administered insulin by one of one registered nurse (RN) (A). Findings include:</p> <p>1. Observation and interview on 5/12/15 at 6:30 p.m. with RN A regarding resident 11 revealed: *She checked the medication administration</p>	F 281	<p>F281: Services provided meet professional standards--B</p> <p>1. Order was changed to 8am, 12pm, and 6pm administration to allow for meeting residents' individual needs.</p> <p>2. Diabetic residents residing in the facility who receive insulin treatment have the potential to be affected by this practice. All orders for residents receiving insulin have been reviewed in order to ensure proper administration.</p>	

*X 11
NEEDS CHANGING*

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F 281	<p>Continued From page 13 record (MAR) for the resident. *She confirmed the MAR order was to administer Novolog 5 units subcutaneous before meals. *She stated "I never give the insulin before meals. I want to see how much the resident ate first." *The resident had finished eating supper by 6:30 p.m. *She went to resident 11's room and administered the insulin.</p> <p>Review of resident 11's medical record revealed: *A 4/16/15 physician's order for Novolog solution 100 unit/ml (milliliter). Inject 5 units subcutaneous before meals. *The May 2015 MAR schedule for Novolog solution 100 units/ml. Inject 5 units subcutaneous before meals.</p> <p>Interview on 5/13/15 at 9:05 a.m. with the director of nursing (DON) revealed: *Her expectations were for physician's orders to be followed. *If the physician's order said to give insulin before meals then she would have expected the nurse to have followed the order.</p> <p>Review of the undated and untitled piece of paper received from the DON and interview with the DON on 5/13/15 at 10:30 a.m. revealed: *The provider did not have a policy for physician's orders. *The undated and untitled piece of paper revealed "44:04:05:02. Medical orders in hospitals and nursing facilities. All medical orders must be in writing and signed by the physician or physician extender." *She confirmed the facility used the above as the policy for following physician's orders.</p>	F 281	<p>F281-Continued</p> <p><i>[Redacted]</i></p> <p><i>[Handwritten: WEJSDOH/ME]</i></p> <p>*3. Policies and procedures on medication administration by IDT team. In-service given to licensed staff on 6/9/15 to include RN A.</p> <p>4. Insulin administration will be monitored weekly times 3 weeks then monthly for 3 months to ensure compliance of all residents or up to 5 receiving insulin treatment. Auditing and report to QAPI to be done by DNS or designee. <i>[Handwritten: WEJSDOH/ME]</i></p>		

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F 281	Continued From page 14 Review of the provider's May 2012 Specific Medication Administration Procedures Injectable Medication Administration policy revealed to "Check order on the medication administration record to see that an injection is currently ordered and due."	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Surveyor: 35237 Based on interview, record review, and guideline review, the provider failed to ensure they had an agreement with the dialysis provider for one of one sampled resident (6) receiving dialysis. Findings include: 1. Review of resident 6's medical record revealed: *He was admitted on 8/7/14. *He had been receiving dialysis three times a week at the dialysis provider in another town since admission. Review of the provider's revised May 2008 Health Care Services Agreement for Dialysis Services -	F 309	F309: Provide Care/Services for highest well being 1. No corrective action in regards to the patient was necessary as dialysis services never ceased. [REDACTED] 3. New contract was initiated between Avera McKennan d/b/a Avera Dialysis Brookings and GGNSC Arlington LLC, d/b/a Golden LivingCenter-Arlington [REDACTED] see page 10. JVE/KDDO/HMF *a. Dialysis residents who had received dialysis at the Avera Dialysis Brookings had the potential to be affected by this practice. Any new dialysis patients will be covered under the new contract per contract terms. JVE/KDDO/HMF	*6/12/15 JVE/KDDO/HMF

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F 309	<p>Continued From page 15</p> <p>Outpatient revealed: *The agreement had been between five different Golden Living Centers including Arlington and Prairie Lakes Health System. *It had begun on March 1, 2009 and expired on February 28, 2010 unless terminated earlier. -After that time it would have automatically renewed for successive terms of one year unless either party gave written notice of non-renewal.</p> <p>Interview with the executive director (ED) on 5/13/15 at 8:45 a.m. revealed: *The ED would have received an email every year to renew the agreement. *She stated resident 6's current dialysis provider was part of the Prairie Lakes Health System.</p> <p>Interviews with the director of nursing (DON) on 5/13/15 at 9:50 a.m. and on 5/14/15 at 9:55 a.m. regarding resident 6's dialysis revealed: *He had been receiving dialysis three times a week in another town. *The dialysis provider had been owned by Prairie Lakes Health System but had changed to another owner. -That above change of ownership had been one to two years ago. *She agreed the provider should have had an agreement with the current dialysis provider who was now under new ownership.</p> <p>Further interview with the ED on 5/14/15 at 2:45 p.m. regarding resident 6's dialysis revealed: *She confirmed the agreement had been with Prairie Lakes Health System. *She agreed they did not have an agreement with the current dialysis provider. *She agreed it should have been updated when the dialysis provider had changed ownership.</p>	F 309	<p>* 4. No further monitoring is necessary as contract is in place bringing us into compliance and will be renewed per ED and Golden Living procedure and updated according to the terms of the contract. JVE/SDO/H/INF</p>		

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F 309	Continued From page 16	F 309			
F 329 SS=G	<p>Review of the provider's 2013 Dialysis Guideline revealed: **Care interventions required when a resident is on hemodialysis may exceed the usual identified problems and interventions provided to residents in long-term care setting. *Residents receiving hemodialysis are transported routinely out of the center. *Communication is essential for continuity of care."</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>	F 329	<p>F329: Drug Regimen free from unnecessary drugs</p> <ol style="list-style-type: none"> 1. Resident 1's comprehensive plan of care has been reviewed and discussed with resident's physician and consulting pharmacist. 2. Residents receiving a psychotropic medication have the potential to be affected by this practice. All residents receiving psychotropic medications care plans have been reviewed to ensure proper monitoring of side effects/symptoms. 3. Policy and procedure about the use of psychotropic medications and pharmacy and physician duties in the process was reviewed. Licensed nursing staff will be in serviced on 6/09/15. <p>* [REDACTED]</p> <p>see page 1B. JNE/SDDCH/MF</p>	<p>x6/12/15 JNE/SDDCH/MF</p>	

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F 329	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to monitor medication side effects, individualized behaviors, and effectiveness of medications and notify the physician in a timely manner for one of one sampled resident (1) who had developed a tremor (shaking) in her right hand and began to drool excessively resulting in her not participating in activities, becoming more anxious, and had become uncomfortable and restless. Findings include:</p> <p>1. Observation on 5/12/15 from 11:45 a.m. through 12:15 p.m. of resident 1 in the dining room revealed her right hand was shaking. She ate independently and had eaten 100 percent (%) of her food.</p> <p>Random observations from 5/12/15 through 5/14/15 of resident 1 revealed she sat in the main area by the nurses station in a recliner. She would occasionally get up and walk. She had fallen asleep in the recliner on 5/13/15 and 5/14/15. She was friendly and talkative. She participated in the special nurses week activities, and the music activity held on 5/13/15. She had drooled a small amount when she was interviewed by this surveyor.</p> <p>Review of resident 1's 2/20/15 Minimum Data Set (MDS) assessment revealed: *Her Brief Interview for Mental Status score was fifteen. Her thinking ability was not impaired. *She had moderately severe depression.</p>	F 329	<p>* 4. Audit of documentation of symptoms to be done weekly for 3 weeks then monthly for 3 months of 5 residents, by the DNS or designee to ensure compliance. JVEKDDO/HMF</p>	

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F 329	<p>Continued From page 18</p> <p>*She had been taking an antipsychotic (mood altering medication), antidepressant (for sadness), and antianxiety (for nervousness) medication during the seven day look back period for the assessment.</p> <p>Interview on 5/13/15 at 1:25 p.m. with resident 1 revealed:</p> <p>*She had developed the tremor in her right hand after being admitted into the facility.</p> <p>*She had also begun to drool excessively after being admitted into the facility.</p> <p>*She stated both of those issues were due to medications she had been taking.</p> <p>Review of resident 1's May 2015 medication administration record (MAR) revealed she was taking the following psychotropic medications (mood altering):</p> <p>*Amitriptyline (antidepressant) HCl tablet 10 milligram (mg) give one tablet by mouth at bedtime for excessive drooling.</p> <p>*Haloperidol (antipsychotic) tablet 2 mg give one and a half tablet by mouth at bedtime related to agoraphobia (an anxiety disorder related to an environment's openness or crowdedness) with panic disorder.</p> <p>*Remeron (antidepressant) tablet 30 mg give one tablet by mouth at bedtime related to depressive disorder not elsewhere specified.</p> <p>*Lorazepam (antianxiety) tablet 0.5 mg give one tablet by mouth two times a day and as needed related to anxiety state, unspecified.</p> <p>*Side effects of those medications had not been monitored on the MAR.</p> <p>Review of resident 1's medical record revealed:</p> <p>*She had been admitted on 11/21/14 from a behavioral health agency.</p>	F 329			

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F 329	<p>Continued From page 19</p> <p>*The admission paperwork into the behavioral health agency included the following information:</p> <ul style="list-style-type: none"> -She had been admitted on 11/3/14 for depression and anxiety. -She was unable to eat and had been compulsively washing her hands to the point of damaging her skin. -She had been anemic (decrease in red blood cells in the blood) and very tired. -She denied any symptoms of psychosis (symptom of mental illness that changes a person's personality). -She had no hallucinations, illusions, delusions or paranoia (perception of something not present). <p>*The psychotropic medications upon admission into the behavioral health agency had been:</p> <ul style="list-style-type: none"> -Effexor XR (antidepressant) 150 mg orally two times per day. -Klonopin (antianxiety) 0.5 mg orally two times per day. -Zyprexa (antipsychotic) 5 mg orally at bedtime. -Ativan (antianxiety) 0.5 mg orally every 4 hours as needed for anxiety/agitation. <p>*There had not been a discharge summary of her stay at the behavioral health agency in the resident's record.</p> <p>*The medications upon admission into the facility included the following psychotropic medications:</p> <ul style="list-style-type: none"> -Haloperidol 5 mg two times a day for psychiatric disorder. -Lorazepam 0.5 mg three times per day for anxiety. -Remeron 15 mg at bedtime for mood. <p>Interview on 5/12/15 at 5:15 p.m. with the director of nursing (DON) revealed the tremor and excessive drooling started shortly after the resident had arrived in the facility. She was unable to provide the onset date. Those</p>	F 329		

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F 329	<p>Continued From page 20</p> <p>symptoms could have been side effects of the medications she had been taking. She was uncertain what specific behaviors or symptoms the psychotropic medications were ordered for. They had not been documenting individualized behaviors. The resident had not had any behaviors since her admission according to her. The physician had been changing her psychotropic medications.</p> <p>Review of resident 1's behavioral documentation revealed they had not been monitoring individualized behaviors that the psychotropic medications required. The behaviors listed were wandering, verbal behavior towards others, physical behavior towards others, behaviors not directed towards others, and rejection of care.</p> <p>Review of resident 1's current care plan revealed a handwritten note dated 12/23/14 that stated "Decreasing Lyrica [pain medication] due to increase in drooling and tremors."</p> <p>Review of resident 1's interdisciplinary progress notes from 11/21/14 through 5/4/15 revealed: *The first documentation regarding the drooling had been on 1/20/15. *That note had been from a quality care meeting. *It stated "Activity participation - Observes unable to participate due to drooling." *On 1/25/15 the note stated "Resident ate nothing for dinner. She is continually drooling. Resident's rt [right] hand had increased tremor today. Resident has paced all day between her room and the nurses station. Will continue to monitor." *That had been the first note regarding the tremor. *On 1/26/15 they wrote "Faxed Dr. [physician's name] regarding increase in wandering and</p>	F 329			

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F 329	<p>Continued From page 21</p> <p>pacing. Asked if we needed to change any orders regarding resident's current orders on Remeron, Haloperidol, and Ativan [Lorazepam]. Orders changed to increase Remeron to 30 mg at HS [bedtime]."</p> <p>*On 1/28/15 and 1/29/15 the resident had complained about the tremor and drooling causing her to be anxious, uncomfortable, and unable to sleep.</p> <p>*There had been no notification to the physician on either of those days as he was coming to the facility on 1/30/15.</p> <p>*On 2/5/15 "Res [resident] continues to have some drooling and hand shaking noted. Currently receiving decreasing dose of Lyrica."</p> <p>*On 2/7/15 "Resident has been extremely restless all shift. Became more and more anxious after supper d/t [due to] continual shaking in R [right] hand. Resident given a prn [as needed] Ativan, but it did not take effect until a few hours after taking it. She was very frustrated at not being able to control the shaking of her hand, and was unable to settle into bed to sleep."</p> <p>*On 2/18/15 there had been a change of condition note stating the following: -"Situation: Restless esp [especially] in evening." -"Continues to drool excess amts [amounts] of time." -"Background: Remeron was increased to 30 mg on 1/26 for increase in wandering and pacing." -"Response: 1. Would you like labs checked? 2. Could we have something to slow up her drooling? 3. ? [question] side effects from haldol. 4. ? fluid restriction." *The physician faxed back with the following change in orders: -Decrease Haldol to 5 mg orally at bedtime. -Lorazepam 0.5 mg orally two times per day and as needed.</p>	F 329			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARLINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD POST OFFICE BOX 280 ARLINGTON, SD 57212		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 22</p> <p>-Amitriptyline 10 mg orally at bedtime.</p> <p>*The documentation had not accurately reflected when the drooling and tremor had started. The care plan indicated prior to 12/23/14.</p> <p>*The physician was notified on 2/18/15 in regards to questioning the drooling and tremors as potential side effects of the Haldol.</p> <p>*That had been approximately two months after the first documentation of the drooling and tremors.</p> <p>Review of resident 1's MARs from 12/1/14 through 3/31/15 revealed there was no documentation or monitoring for the potential side effects for the psychotropic medications she had received.</p> <p>Interview on 5/13/15 at 3:00 p.m. with the DON and MDS coordinator regarding resident 1 revealed they had not:</p> <p>*Documented the onset of the drooling or tremors but both had stated they began "shortly after she had been admitted."</p> <p>*Monitored for:</p> <p>-Individualized behaviors.</p> <p>-The effectiveness of the medication changes.</p> <p>-Potential side effects for the medications she had received.</p> <p>Interview on 5/13/15 at 5:00 p.m. with the activities coordinator regarding resident 1 revealed she had stopped participating in the food activities due to the excessive drooling.</p> <p>Interview on 5/14/15 at 9:30 a.m. with licensed practical nurse G revealed she was unaware of the side effects for Amitriptyline. She stated low blood pressure was a side effect of Haldol but was unsure of any others. She stated "I will have</p>	F 329			

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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARLINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD POST OFFICE BOX 280 ARLINGTON, SD 57212		
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F 329	<p>Continued From page 23</p> <p>to get back to you." She was not sure where they would document side effects.</p> <p>Interview on 5/14/15 at 9:35 a.m. with registered nurse I revealed the side effects of Amitriptyline were dry mouth and sleepiness. The side effects for Haldol would be extra movements and drooling. They would have documented side effects in the progress notes.</p> <p>Interview on 5/14/14 at 9:40 a.m. with the DON revealed they had not been completing the psychoactive medication informed consent form prior to starting any psychotropic medication.</p> <p>Review of the provider's 5/4/15 Antipsychotic Medication Review policy revealed staff should have reviewed:</p> <ul style="list-style-type: none"> *The care plan for the following: <ul style="list-style-type: none"> -Antipsychotic medication. -Reason for the medication. -Side effects. -Behaviors. -Suggested interventions. *That behaviors were being monitored and documented on the care tracker and/or on the behavioral sheet. *Nursing notes for documentation of daily side effect monitoring and follow-up on side effects. *That a consent form or documentation noting the risks and benefits for the use of antipsychotic medication had been discussed with the resident or responsible party. *That psychiatric consultations were in the medical record and they contained documentation, that supported the therapeutic benefit for the antipsychotic medication without serious side effects. 	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435050	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2015
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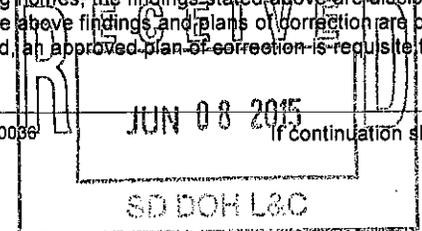
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD POST OFFICE BOX 280 ARLINGTON, SD 57212
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/12/15. Golden LivingCenter-Arlington was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>C. D. Boyd</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>6/5/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



ORIGINAL

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10592	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/14/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER RD ARLINGTON, SD 57212
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	Initial Comments Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/12/15 through 5/14/15. Golden LivingCenter - Arlington was found not in compliance with the following requirement: S236.	S 000	Addendums noted with an asterisk per 6/11/15 email from facility administrator. JVEISDDH/MF	
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 Based on employee file review, interview, and policy review, the provider failed to ensure three of four sampled newly hired employees (B, C,	S 236	S236-TB Screening 1. TB Screenings had been completed on employees (3) prior to survey entering so no immediate action taken on those employees 2. Going forward TB Screening to be completed within 14 days of hire in accordance with SD Administrative Rule. 3. New hire employee files will be audited by DNS for the next 4 months going forward to ensure TB Screening is done within 14 days of hire. The audits will be reported by DNS and discussed monthly by IDT team at QAPI meeting. * [REDACTED] JVEISDDH/MF	* 6/13/15 JVEISDDH/MF

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

TITLE

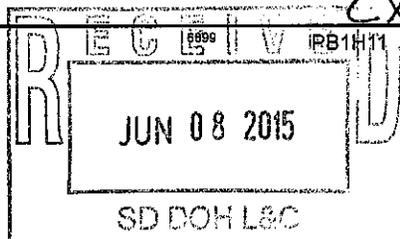
(X6) DATE

Abbey Rand

Executive Director 6/5/15

STATE FORM

If continuation sheet 1 of 2



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10592	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/14/2015
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S 236	<p>Continued From page 1</p> <p>and D) received the two-step Tuberculin (TB) screening within two weeks of being employed. Findings include:</p> <ol style="list-style-type: none"> 1. Review of dietary aide B's employee file revealed she had been hired on 10/21/14. She had received the second step of the TB testing on 11/12/14. That had exceeded the two week requirement. 2. Review of certified nursing assistant (CNA) C's employee file revealed she had been hired on 12/12/14. She had received the second step of the TB testing on 1/7/15. That had exceeded the two week requirement. 3. Review of certified nursing assistant (CNA) D's employee file revealed she had been hired on 2/12/15. She had received the second step of the TB testing on 3/1/15. That had exceeded the two week requirement. 4. Interview on 5/13/15 at 5:15 p.m. with the director of clinical education revealed they had not provided the two-step TB screening within two weeks of being hired for the above mentioned staff members. <p>Review of the provider's 12/1/14 Tuberculosis Screening - Administration and Interpretation of Tuberculin Skin Tests policy revealed they had not identified the skin test needed to be completed within fourteen days of employment or admission into the facility.</p>	S 236		