

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435097	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2015
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NAME OF PROVIDER OR SUPPLIER LAKE ANDES SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 740 EAST LAKE ST POST OFFICE BOX 130 LAKE ANDES, SD 57356
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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
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F 000	INITIAL COMMENTS Surveyor: 34030 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/27/15 through 4/29/15. Lake Andes Senior Living was found not in compliance with the following requirements: F155 and F281.	F 000	<i>Addendums noted with an asterisk per 48119 telephone to facility DON. SW/SDDOH/ME</i>	
F 155 SS=E	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on record review, interview, and policy review, the provider failed to have	F 155	F 155 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. * [REDACTED] <i>see page 2 of SW/SDDOH/ME</i> 2. [REDACTED] will be CPR certified on May 29, 2015. <i>*Nurses A, M and DNS SW/SDDOH/ME</i>	<i>June 10, 2015</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brian [Signature]</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>May 21, 2015</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.

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

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FORM APPROVED
OMB NO. 0938-0391

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F 155	<p>Continued From page 1</p> <p>cardio-pulmonary resuscitation (CPR) certified staff available at all times for three of six nurses (A, B, and the director of nursing services [DNS]). Findings include:</p> <p>1. Review of the provider's February 2015 CPR Guidelines revealed "Facility will provide adequately trained, 24 hour staffing to initiate basic life support within minutes of a resident's cardiac or respiratory arrest."</p> <p>Interview on 4/29/15 at 9:00 a.m. with the administrator regarding the provider's CPR policy and certified staff revealed "I don't think we have every shift covered."</p> <p>Review of the provider's 4/26/15 to 5/9/15 nursing staff schedule revealed: *A total of six nurses for the facility. *There was one nurse scheduled for the day shift and one for the night shift. Shifts were twelve hours long. *The DNS worked eight hours during the day. *The Minimum Data Service (MDS) coordinator worked two days a week for eight hours during the day.</p> <p>Interview on 4/29/15 at 3:00 p.m. with the administrator and the DNS revealed: *Three of the six nurses were not currently CPR certified: Those were the DNS and two of the day shift nurses (A and B). *They were aware the above staff needed to take CPR certification class, but they had not arranged for it yet.</p> <p>Further review of the above nursing staff schedule revealed: *Five out of seven twelve hour day shifts in a</p>	F 155	<p>*RN's and LPN's SW/SDDO/HMF</p> <p>3. [REDACTED] will be provided with CPR certification and upon hire if needed.</p> <p>4. ED will check each licensed nurse CPR certification monthly to assure it is current. Nurse will be notified three months prior to the end of their certification that it is time for renewal. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.</p> <p>* (continued from page 1, #1) CPR certification will be provided by Wagner Community Hospital on May 29, 2015. SW/SDDO/HMF</p>		

* to be continuous SW/SDDO/HMF
* by the ED SW/SDDO/HMF

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F 155	Continued From page 2 week were not covered with CPR certified staff. *The other two days were not covered for four hours each day after the MDS coordinator left.	F 155			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, record review, interview, and policy review, the provider failed to follow professional standards to ensure: *Current physicians' orders matched the medication administration record (MAR) for one of two random residents (11) receiving insulin and one of nine sampled residents (2) with duplicate orders on the MAR. *The pharmacy medication review recommendations were tracked and followed up on for one of nine sampled residents (2). *The allergy information was accurate in all locations of the medical records for three of nine sampled residents (2, 4, and 9). Findings include: 1. Observation on 4/28/15 at 11:30 a.m. of resident 11 receiving insulin during medication pass revealed she received eight units of Novolog insulin (diabetic medication). Review of resident 11's MAR revealed an order for Novolog insulin eight units before every meal. Review of resident 11's 3/30/15 physician's Order	F 281	F281 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. Resident #11 and Resident #2 orders have been reviewed for accuracy including the medication administration record (MAR). The pharmacy medication review for resident #2 was completed with physician response *on 4/29/15. The allergy information for resident #2, resident #4 and resident #9 has been reviewed and clarified for all	June 10, 2015 <i>SW/SDD/HMF</i>	

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F 281	<p>Continued From page 3</p> <p>Summary Report revealed:</p> <ul style="list-style-type: none"> *The orders were noted and signed by licensed practical nurse A. *There was no order for the insulin. *The insulin order had been on the previous Order Summary Report. *There was no order to stop the insulin. *The orders on the MAR and the Order Summary Report should have matched. *It appeared there were no physician's orders to give the insulin. <p>Interview on 4/29/15 at 2:00 p.m. with the director of nursing services (DNS) revealed:</p> <ul style="list-style-type: none"> **A transcription error must have occurred when the current Order Summary Report was printed." *She agreed the nurse signing off the orders should have made sure the insulin order was included and matched the order on the MAR. <p>Review of the January 2013 Omnicare LTC Facility's Pharmacy Services and Procedures Manual revealed:</p> <ul style="list-style-type: none"> *That was what the facility used for their policy. **"Facility staff should: Confirm that the MAR reflects the most recent medication order." <p>Surveyor: 33265</p> <p>2. Interview and record review on 4/28/15 at 3:30 p.m. with the DNS regarding resident 2's complete medical record revealed:</p> <ul style="list-style-type: none"> *The April 2015 MAR had two orders for the same multivitamin. -One order was written in by hand and had a start date of 6/6/14 and was to be given at 8:00 a.m. -The other order was preprinted on the MAR with a start date of 2/6/15 and was to be given at noon. *Both had been signed off as given for each of 	F 281	<p>locations of their medical records.</p> <ol style="list-style-type: none"> 2. Residents physician orders, pharmacy medication reviews and resident identified allergies have all been reviewed for accuracy as well as the MAR and all locations in the medical record. 3. DNS and/or her designee will do monthly review of physician orders and MAR's for accuracy as well as allergies. This will occur for new admissions as well. DNS will keep pharmacy regimen reviews together until all are completed and signed off prior to filing in medical record. The DNS will review/revise as needed policies and procedures regarding: Physician orders are current and correct on the medication and treatment administration records, Pharmacist medication review recommendations are forwarded to the physician for appropriate follow up 	

** to be CONTINUOUS. SW/ROD/H/MF*

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F 281	<p>Continued From page 4</p> <p>the first twenty-eight days of the month.</p> <p>*There was a physician's order for the multivitamin with the 6/6/14 start date.</p> <p>*There was no physician's order for the second multivitamin with the 2/6/15 start date.</p> <p>*The DNS stated there was a bottle of multivitamins used as stock supply that the resident's multivitamins would have come from.</p> <p>*The May 2015 MAR that was ready to use had two orders for multivitamins preprinted on the form, one with the 2/6/15 start date and a second order with a 4/1/15 start date.</p> <p>*There was no physician's order for the multivitamin with the 4/1/15 start date.</p> <p>*The DNS stated she would investigate further.</p> <p>Further interview and record review on 4/29/15 at 10:30 a.m. with the DNS regarding resident 2's complete medical record revealed:</p> <p>*The multivitamin had been mistakenly discontinued in the computer on 1/26/15. The error was noted, and the order was hand written in on the February 2015 MAR.</p> <p>*The multivitamin was again hand written in on the March 2015 MAR.</p> <p>*On the April 2015 MAR the order had been put back into the computer system. It was also hand written in causing the second order.</p> <p>*Resident 2 received her medications from her own pharmacy and had only one punch card for one multivitamin a day.</p> <p>*The DNS believed the resident only received one multivitamin a day even though both orders for the multivitamin on the MAR were initialed as given each day.</p> <p>Observation and interview on 4/29/15 at 1:25 p.m. with registered nurse A regarding resident 2 revealed:</p>	F 281	<p>and allergy information is accurately recorded in all locations of the resident record *see page 6. SWISDDHMF</p> <p>DNS will provide education for all [REDACTED] *RN'S and LPN'S responsible for these tasks SWISDDHMF</p> <p>4. DNS will audit two medical records for accuracy of physician order, MAR, TAR and allergy information in the medical record weekly for one month and then one medical record weekly for two months. The DNS will audit the pharmacist medication reviews monthly *continuously SWISDDHMF to assure the physician has appropriate follow up. The data collected will be presented to the Quarterly Quality Assurance committee by the ED. It will be reviewed/discussed and at that time the QA committee will make a decision/recommendation regarding follow-up or changes.</p>		

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F 281	<p>Continued From page 5</p> <p>*There was only one punch card filled with multivitamins for the resident in the medication cart.</p> <p>*She stated she only gave one multivitamin a day to the resident during April 2015.</p> <p>Review of the provider's 1/9/04 Changes to the Medication Sheet policy and procedure revealed:</p> <p>*The purpose was to ensure accurate and consistent documentation on the MAR.</p> <p>*The procedure included:</p> <ul style="list-style-type: none"> -Physician specified times could not be changed unless the order from the physician had been obtained. -Pharmacist was to have been informed of changes in times. -Medical records was to have received written notification of any changes that affected the following month's computerized forms. -The MAR would be reviewed for time accuracy prior to printing each month. <p>3. Interview and record review on 4/28/15 at 3:30 p.m. with the DNS concerning resident 2's complete medical record revealed:</p> <p>*All monthly consultation reports from the pharmacist for the last year including April 2015 were in the medical record except the one for March 2015.</p> <p>*The DNS stated she would look for the monthly report.</p> <p>Interview on 4/29/15 at 10:30 a.m. with the DNS regarding resident 2's March 2015 monthly pharmacist consultation report revealed:</p> <p>*That report had been misplaced but then had been found.</p> <p>*The report with recommendations had been signed and dated by the pharmacist on 3/11/15.</p>	F 281	<p><i>*(continued from page 5) to be monitored monthly on a continuous basis. SW/SDDDH/MF</i></p>		

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F 281	<p>Continued From page 6</p> <p>*The pharmacist had recommended discontinuing the potassium (substance body needs) supplement, and then rechecking the potassium level in the blood in two weeks.</p> <p>*The report had been reviewed and the recommendations accepted by a certified nurse practitioner on 4/29/15.</p> <p>*The potassium supplement was discontinued on 4/29/15.</p> <p>*Rechecking of the potassium level was scheduled to be done in two weeks.</p> <p>Review of the provider's 1/13/04 Medical Records policy and procedure revealed the medical record personnel under the supervision of the director of nursing were responsible to ensure the residents' medical records were properly maintained and filed.</p> <p>4a. Review of resident 2's complete medical record revealed:</p> <p>*The listed allergies were not the same on all current documents.</p> <p>*The admission record, the April 2015 MAR, the order summary sheet, and the undated nursing care plan stated she was allergic to penicillin (PCN [an antibiotic]) and morphine (a pain medication).</p> <p>*The allergy sticker on the inside front cover of her medical record, the nursing admission data collection form, two faxes from the Lake Andes Health Care Center dated 8/3/14, and nurse interview notes from the Lake Andes Health Care Center dated 1/7/15 listed only morphine as an allergy.</p> <p>*One fax dated 6/14/14 from the Lake Andes Health Care Center listed she had no known allergies.</p>	F 281			

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F 281	<p>Continued From page 7</p> <p>b. Review of resident 4's complete medical record revealed: *The listed allergies were not the same on all current documents. *The admission record, the undated nursing care plan, the April 2015 MAR, faxes from Lake Andes Health Care Center dated 4/19/15 and 1/4/15, and the 3/5/15 order summary report stated there were no known allergies. *The allergy sticker on the inside front cover of her medical record stated there was an allergy to latex (rubber).</p> <p>c. Review of resident 9's complete medical record revealed: *The listed allergies were not the same on all current documents. *The admission record, the 1/14/15 medication review report, the fax from Lake Andes Health Care Center dated 11/19/14, the April 2015 MAR, the 3/1/15 order summary report, and the undated nursing care plans stated he was allergic to PCN. *The nurse interview notes dated 3/6/15 from the clinic listed both PCN and acetaminophen (Tylenol) as allergies. *The allergy sticker on the inside front cover of his medical record stated he had allergies to PCN and Tylenol. The Tylenol had a line drawn through it and "Dc'd" (discontinued) written next to it.</p> <p>d. Interview on 4/29/15 at 2:30 p.m. with the DNS regarding the above documentation of allergies revealed: *She agreed the allergies listed should have matched throughout the medical record of each resident *She agreed any allergies that were added or removed should have been done consistently</p>	F 281		
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F 281	<p>Continued From page 8</p> <p>throughout the medical record of each resident. *She believed the allergy sticker in the front of resident 9's medical record was correct. The Tylenol he had been receiving was documented as being at a safe level.</p> <p>Review of the provider's November 2002 Allergies policy and procedure revealed: *All known or suspected allergies were to have been recorded on all appropriate medical records. *They were to advise the resident's physician of stated allergies.</p>	F 281		

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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/28/15. Lake Andes Senior Living 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 *[Signature]* TITLE **Executive Director** (X6) DATE **May 21, 2015**

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.

MAY 22 2015

SD DOH L&C

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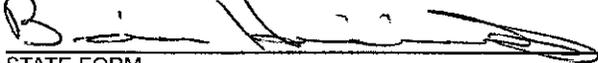
South Dakota Department of Health

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S 000	<p>Initial Comments</p> <p>Surveyor: 34030 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/27/15 through 4/29/15. Lake Andes Senior Living was found in compliance.</p>	S 000		

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



TITLE

Executive Director

(X6) DATE

May 21, 2015

STATE FORM

6899

VI2811

If continuation sheet 1 of 1

MAY 22 2015

SD DOH LSC