

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

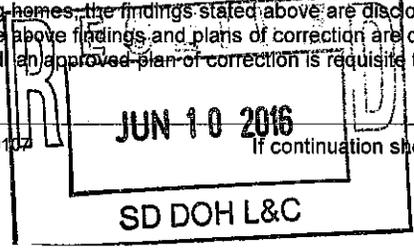
ORIGINAL

PRINTED: 06/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/18/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><i>*Addendums noted with asterisk per 430116 F 000 per telephone with facility administrator and DON. NSBDDOHEJ</i></p> <p>INITIAL COMMENTS: A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/16/16 through 5/18/16. Golden LivingCenter - Black Hills was found not in compliance with the following requirements: F253, F274, F281, F371, F387, and F431.</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/16/16 through 5/18/16. Areas surveyed included nursing services and physical environment. Golden LivingCenter - Black Hills was found in compliance.</p>		<p>STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on May 18, 2016. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of <u>July 7th, 2016</u>. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.</p>	
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, interview, and record review, the provider failed to maintain the following: *Six of six randomly observed wheelchairs had arm rests with tears, rips, and exposed padding. *The seat on one of two randomly observed round, tan-colored stools in the activity dining room was torn with exposed padding. *Three of three large brown chairs in the activity room had been free of torn or frayed surfaces.</p>	F 253	<p>F253E HOUSEKEEPING AND MAINTENANCE SERVICES</p> <p>All residents that require wheel chairs for mobility have the potential to be affected. Upon issuance of a wheel chair an initial inspection will occur to assure the safety of the equipment.</p> <p>All wheelchairs in facility have been inspected by the nursing department June 3rd to identify the number of arm rests that need to be replaced. Arm rests will be ordered and will be replaced.</p>	7/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: **ADMINISTRATOR** (X6) DATE: **6/9/2016**

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 253	<p>Continued From page 1</p> <p>*The wall area around the nurses station and staff offices had been free from gouges and missing paint.</p> <p>*Multiple residents' room doors and frames on three of three wings had gouges and chips in them.</p> <p>*Three of three building entrance doors had gaps around them that could let in insect, cold and hot air, vermin, and debris.</p> <p>*One of one door leading to the outside from the staff break room had a medium sized tear in the screen.</p> <p>*The soffit on the outside of the building by the laundry room was eroded and had holes in it.</p> <p>*Concrete sidewalk area below the laundry room window was chipped, cracked and unsafe.</p> <p>*Wooden areas on the building exterior were eroded with multiple areas of peeling paint.</p> <p>Findings include:</p> <p>1. Observation on 5/18/16 at 10:00 a.m. of the following items and areas with the director of maintenance revealed:</p> <p>*Six residents' wheelchair arms were cracked, torn, and had padding exposed making them uncleanable.</p> <p>*The seat on a round tan stool in the activity dining room had a three inch tear in it. It was one-half inch wide and the padding was exposed making it uncleanable.</p> <p>*There were many chips in the paint on the walls around the nurses station areas. Those areas were uncleanable.</p> <p>*Multiple residents' door frames and doors on the east, west, and south halls had chips, gouges, and scrapes on them that removed the finish. There was bare wood exposed, and the surfaces were uncleanable.</p> <p>*The door leading to the outside from the staff</p>	F 253	<p>The Director of Maintenance/designee will perform a random audit of 6 wheelchairs weekly x4 weeks and monthly x2 months and will report results to QAPI and follow further recommendations.</p> <p>The tan stool in the activity dining room has been thrown out. Stools and chairs in common areas and community dining rooms with cracks/rips/tears have been removed from the building as of June 7th by the Director of Maintenance.</p> <p>Housekeeping and GL staff will be educated to identify wheelchair arm rests, chairs, furniture and stools for replacement by July 7th. Education will be provided by Multi Site DCE. Any identified cracks/tears/rips will be entered into Building Engines.</p> <p>The Director of Maintenance and GL staff will observe chairs and stools for cracks/tears/rips during general usage. Any damaged surfaces will be taken out of service upon immediate identification and replaced as needed.</p> <p>The lower portion of the walls in all 3 resident halls and the walls around the nurses' station will be repaired and repainted by the maintenance department by July 7th.</p>	

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F 253	Continued From page 2 room had a hole in the screen approximately three inches in diameter. *There had been gaps in the seal around the kitchen door, the staff break room door, and the front entrance door that exposed the areas to insects, vermin, and debris getting into the facility. *The soffit on the building exterior by the laundry room was eroded, worn, and had holes in it. The paint was peeling. *The concrete sidewalk by the laundry room area on the outside had several holes and chips in it making it unsafe to walk on. *There were areas on the wooden building exterior that were eroded and had peeling paint on them. Interview on 5/18/16 at 9:45 a.m. with the administrator revealed he had not been aware of the above findings. He agreed the areas were in need of repair. Interview on 5/18/16 at 10:30 a.m. with the director of maintenance confirmed: *The above observed areas had not been properly maintained. *He planned to fix them immediately. *He had not been completing preventative maintenance for the residents' door frames and room doors. That was because he had only been working there for four months. Review of the providers May 2016 preventative maintenance log revealed residents' room inspections were part of the monthly preventative maintenance.	F 253	The damaged area on resident room doors and door frames will be sanded, stained and clear coat or paint as needed by the maintenance department by July 7 th . The Director of Maintenance/designee will observe walls and doors during weekly rounds and continue with the monthly preventative maintenance schedule. The Director of Maintenance/designee will bring results of facility physical plant observations to QAPI monthly X 3 months and follow further recommendations. The identified hole in the exterior screen door leading outside the breakroom will be repaired/replaced by the Director of Maintenance by July 7th. Gaps in the seal around the 3 exterior doors identified will be replaced by an outside vendor by July 7th. The Director of Maintenance/designee will observe the proper operation and seal of the doors weekly during facility rounds.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		

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F 253	Continued From page 2 room had a hole in the screen approximately three inches in diameter. *There had been gaps in the seal around the kitchen door, the staff break room door, and the front entrance door that exposed the areas to insects, vermin, and debris getting into the facility. *The soffit on the building exterior by the laundry room was eroded, worn, and had holes in it. The paint was peeling. *The concrete sidewalk by the laundry room area on the outside had several holes and chips in it making it unsafe to walk on. *There were areas on the wooden building exterior that were eroded and had peeling paint on them. Interview on 5/18/16 at 9:45 a.m. with the administrator revealed he had not been aware of the above findings. He agreed the areas were in need of repair. Interview on 5/18/16 at 10:30 a.m. with the director of maintenance confirmed; *The above observed areas had not been properly maintained. *He planned to fix them immediately. *He had not been completing preventative maintenance for the residents' door frames and room doors. That was because he had only been working there for four months. Review of the providers May 2016 preventative maintenance log revealed residents' room inspections were part of the monthly preventative maintenance.	F 253	Any Building Engine work order for the doors will be addressed immediately upon notification. The Director of Maintenance/designee will bring results of facility physical plant observations to QAPI monthly X 3 months and follow further recommendations. The soffit on the building exterior by the laundry room will be repaired/replaced and repainted by the maintenance department by July 7 th . The seating that had previously been on the concrete slab by the Laundry room has been removed and a sign will be installed indicating this area is "Off Limits" by July 7 th . It is not part of the exit/fire egress and is not for use by staff or residents. The Director of Maintenance/designee will complete a monthly audit of the grounds. The Director of Maintenance/designee will bring results of facility physical plant observations to QAPI monthly X 3 months and follow further recommendations.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		

The eroded and peeling paint sections of the wooden exterior of the building will be repaired/repainted within the next 90 days by the Director of Maintenance.

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F 274	<p>Continued From page 3</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to determine a significant change in condition had been coded on the Minimum Data Set (MDS) assessments for one of nine sampled residents (3) who had MDS assessments completed. Findings includes: 1. Review of resident 3's medical record revealed MDS assessments had been completed on the following dates: *9/21/15, an annual assessment *12/16/15, a quarterly assessment Review of the above MDS assessments for resident 3 revealed the following activities of daily living (ADL) (assistance with bathing, dressing, eating, and grooming) areas were coded as follows: *Bed mobility (movement in bed): -9/21/15 she needed limited assistance of one</p> <p><i>Handwritten notes:</i> *The clinical assessments/reimbursement specialists/designee will report findings of the audits to the DON. The DON will report those findings to the CPT committee monthly. The CPT committee will determine if further actions are necessary. N/S/SDM/ELC</p>	F 274	<p>F274D COMPREHENSIVE ASSESSMENT AFTER SIGNIFICANT CHANGE</p> <p>Resident #3 MDS has been reviewed and revised on June 9th by the RNAC.</p> <p>Residents residing in the facility who have a change in condition have the potential to be affected in a similar manner.</p> <p>RNAC has been reeducated on the RAI process policy concerning completion of a significant change in condition MDS when health status needs change on May 17th by the GL area Clinical Assessment Reimbursement Specialist.</p> <p>Clinical Assessment Reimbursement Specialist/designee will complete 5 audits weekly x 4 weeks then monthly x 2 months to ensure that appropriate change of condition assessments of the MDS are being done as determined by the IDT.</p> <p>*All residents status will be reviewed to ensure a significant change of condition MDS is completed if necessary N/S/SDM/ELC</p>	7/7/16

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F 274	Continued From page 4 person. -12/16/15 she needed extensive assistance of one person. *Transfers (moving from bed to chair): -9/21/15 she needed limited assistance of one person. -12/16/15 she needed extensive assistance of one person. *Locomotion (moving about when out of bed): -9/21/16 she required limited assistance of one person. -12/16/15 she required extensive assistance of two people. *Dressing: -9/21/15 she required limited assistance of one person. -12/16/15 she required extensive assistance of one person. *Personal hygiene: -9/21/15 she required limited assistance of one. -12/16/15 she required extensive assistance of one. *Urinary incontinence: -9/21/15 she was occasionally incontinent. -12/16/15 she was frequently incontinent. Interview of 5/18/16 at 10:30 a.m. with the MDS coordinator and the corporate assessment reimbursement specialist confirmed a significant change in condition MDS should have been completed for resident 3 on 12/16/15 when her health status needs had changed. Review of the provider's Version #:2, RAI Process policy revealed "All Living Centers will utilize the CMS RAI Manual for completion and compliance of the RAI Process." Review of the 2015 RAI manual online revealed:	F 274		

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F 274	Continued From page 5 "A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan."	F 274		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to: *Ensure physician's orders had been followed to obtain a laboratory (lab) test for one of nine sampled residents (9). *Ensure appropriate documentation followed standards of practice for one of one sampled resident (9). Findings include: 1. Review of resident 9's medical record revealed: *He had been admitted on 1/13/16. *His discharge diagnoses from the hospital that had been resolved included acute clostridium difficile (C-Diff) (contagious infection in the intestines that causes severe diarrhea). *He had benign prostatic hypertrophy (BPH)	F 281	<p><i>*All residents care plans are reviewed daily to ensure any changes in status are reflected.</i> <i>NS/SDD/H/EL</i></p> <p>F281D SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>Resident #9 care plan will be updated by the IDT by July 7th to include interventions regarding his diagnosis of BPH, past medical history of C. Diff and urinary retention.</p> <p>All residents residing in the facility have the potential to be affected in a similar manner.</p> <p>All current resident care plans will be reviewed and revised in conjunction with next MDS to ensure that current resident diagnosis, past histories and current individualized interventions are appropriately care planned by September 7th.</p> <p>Resident #9 - the facility is unable to correct past entry omissions in the medical record.</p>	7/7/16

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F 281	<p>Continued From page 6 (enlarged prostate gland) with a history of urine retention requiring a urinary catheter.</p> <p>Review of a 3/2/16 physician's order revealed "Received call from MD [medical doctor] with order to insert an indwelling catheter R/T [related to] retention secondary to Dx [diagnosis] BPH."</p> <p>Review of resident 9's interdisciplinary progress notes revealed no documentation of signs or symptoms of urinary retention. Those signs and symptoms could have included bladder distention, pain, decreased amounts of urination, and dry incontinence products.</p> <p>Review of a 4/26/16 physician's order revealed "Collect stool sample for possible C-Diff. Review of his interdisciplinary progress notes revealed one note on 4/27/16 at 12:57 a.m. "Resident continues to be monitored for loose stools, he has been resting comfortably so far with no complaints of pain or discomfort. No loose stools or blood in stool noted at this time." There were no other progress notes regarding his loose stools or if a stool sample had been collected.</p> <p>Review of resident 9's 4/13/16 care plan revealed: *A focus area initiated on 1/13/16 "Urinary Tract Infection, potential or actual due to: Diagnosis of BPH, Recurrent Urinary tract infections." *There were no interventions regarding his BPH with urinary retention. *There was no area regarding his loose stools and his previous diagnosis of C. Diff.</p> <p>Interview on 5/18/16 at 2:30 p.m. with registered nurse F and the field services clinical director revealed:</p>	F 281	<p>All residents residing in the facility are at risk for documentation omissions.</p> <p>All Licensed Nursing staff has been reeducated on appropriate medical documentation practices and following physician orders according to standard nursing practice; as well as care planned entries as resident care needs change by the Multi Site DCE on June 8 and 9th.</p> <p>Licensed nursing staff will audit <i>*all new NSI's</i> orders for the past 24 hours nightly and will provide results to the Director of Nursing. This process will be in place by July 7th.</p> <p>Director of Nursing/designee will complete audits of 10% of new MD orders weekly x 4 weeks then monthly x 2 months to ensure that physician orders are being followed and that appropriate documentation is in place.</p> <p>The Director of Nursing will report results to QAPI monthly X 3 months and follow further recommendations.</p>		

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F 281	Continued From page 7 *No documentation was present regarding any signs and symptoms of urinary retention. *His physician had been monitoring his laboratory tests and had ordered the urinary catheter due to those results. *They agreed the physician's order for the C. Diff test had not been followed. *They agreed the documentation or the lack of documentation had not followed nursing standards. *They stated they used Briggs Gold Manual for nursing standards. *They did not have a copy of that manual for review, and an internet search revealed no results.	F 281		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, and policy review, the provider failed to ensure: *Appropriate handwashing and glove use had been completed by five of five observed staff members (A, B, C, D, and E) for two of two observed meal services in the kitchen.	F 371	F371E FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY On the job in-servicing for handwashing/glove use was done for all 5 Dietary staff observed in non-compliance by the Multi-site DCE on May 19th. Immediate education was done for all Dietary staff present by the Director of Dining Services regarding proper hair covering on May 19 th . A plastic sleeve was placed outside the kitchen door on May 20 th and is stocked with hairnets and beard guards for staff use.	7/7/16

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F 371	<p>Continued From page 8</p> <p>*Maintain proper hair covering for three of five staff (C, D, and E) at two of two meal observations in the kitchen area.</p> <p>*One of two air conditioners in the dish machine area was kept free of lint and debris.</p> <p>*One of two cooks (D) observed the sanitary practice for draining canned fruit.</p> <p>*The undersurface of the serving bar area above steam table in the kitchen was maintained in a cleanable manner.</p> <p>*Two of two interior kitchen doors were maintained in a cleanable manner.</p> <p>Findings include:</p> <p>1. Observations on 5/17/16 from 10:50 a.m. through 12:30 p.m. during the noon meal preparation and distribution revealed:</p> <p>*Cook A was not observed to have washed her hands between numerous tasks. She was in the dishroom and loaded soiled dishes in racks for the dishwasher and also put clean dishes away three times. She retrieved serving utensils and food items from the steamer, convection ovens, and the refrigerator. She took the temperatures of all the hot food items to be served.</p> <p>*Dietary aide (DA) B used hand sanitizer before she came back into the kitchen from the dining room instead of washing her hands. That was during setting up meal trays for the restorative dining room and the assisted dining room.</p> <p>*DA C was not observed to have washed his hands between numerous tasks. He went into the soiled laundry area, was walking in the hallway, tied his shoes in the dietary manager's office, and was in the employee break room. When he returned to the kitchen he went to the preparation area and without washing his hands he dished up cottage cheese for the residents' meal.</p>	F 371	<p>The air conditioner in the dish room was cleaned May 18th by the Director of Dining Services.</p> <p>The cook that was observed improperly draining fruit received immediate education on May 18th by the Director of Dining Services.</p> <p>The undersurface of the serving bar area will be deep cleaned by the Dining Department and resurfaced by July 7th by the Director of Maintenance/designee.</p> <p>The two interior kitchen doors will be stained and recoated by July 7th by the Director of Maintenance/designee.</p> <p>The Dietary Manger will provide in-services per policy and procedures on: Handwashing and Sanitizer use, Safety and Disaster Management, Proper use of Disposable Gloves, Dining Services Employee Hair Guidelines, Cleaning Food Processors, Dish Machine Use and Care, and Proper Cleaning of Equipment to all Dietary staff by June 17th. The above in-services will cover the complete F371.</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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F 371	<p>Continued From page 9</p> <p>2. Observations on 5/17/16 from 4:50 p.m. through 6:00 p.m. during the supper meal preparation and distribution revealed: *Cook D was not observed to have washed her hands between numerous tasks. She was in the dishroom and loaded soiled dishes in racks for the dishwasher and also put clean dishes away two times. She retrieved serving utensils and food items from the steamer, convection ovens, and the refrigerator. She took the temperatures of all the hot food items to be served. *DA E was not observed to have washed his hands between numerous tasks. He retrieved several items from the refrigerators. He also took the keys off the hook in the kitchen, went to the dry storage room located in the employee break room, and then returned to the kitchen without washing his hands.</p> <p>3. Observation on 5/17/16 from 10:50 a.m. through 12:30 p.m. revealed DA C was preparing an orange drink for the noon meal. He also filled water pitchers with ice and water, and placed them on the main dining room tables. During that time he was observed to not have a hair restraint on. He also had a small growth of beard present that was uncovered.</p> <p>4. Observations on 5/17/16 from 4:50 p.m. through 6:00 p.m. during the supper meal preparation and distribution revealed: *Cook D's hair restraint did not completely cover her hair. There was hair exposed around her neck, her bangs, and around her ears. *DA E's hair restraint did not completely cover the lower one-third of his hair. He also had a beard that was moderate in length. The beard was not covered.</p>	F 371	<p>The Director of Dietary Services will do Staff Handwashing Competency Audits every other day for the month of June with varied times to cover all shifts. RD (Registered Dietician) will do Handwashing Audit once a week. On-going weekly audits will be conducted on regular basis by the Director of Dietary. The RD will do a Dietary Sanitation/ Infection Control Audit once a week for 4 weeks then once a month on a regular basis to make sure dishware and dishwashing will be processed per policy and procedure.</p> <p>The Director of Dietary Services will do a Dietary Sanitation/ Infection Control Audit once a week for 4 weeks then once a month on-going</p> <p>Results of the audits will be provided by the Director of Dining Services to the QAPI committee monthly X 3 months and recommendations followed.</p>	
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F 371	<p>Continued From page 10</p> <p>5. Observation on 5/17/16 at 5:00 p.m. revealed one of two air conditioning units in the dishroom had a moderate amount of lint on the vent grate. The air conditioner was on, and the air would blow across the clean dishes.</p> <p>6. Observation on 5/17/16 at 5:15 p.m. of cook D revealed she opened three large cans of mandarin oranges. She had not cleaned the tops of those cans before she had opened them. She had not washed her hands prior to opening those cans and had been in different areas of the kitchen. After she had opened them she used the wet sanitizing cloth, sanitized the can opener, and did not wash her hands. When she opened the cans her fingers came in contact with the juice. She drained one of the cans by holding down the lid and draining it into the sink. She was then instructed by the dietary manager to use a colander to drain the oranges.</p> <p>7. Observation on 5/17/16 from 10:50 a.m. through 12:30 p.m. revealed: *The undersurface of the serving bar was sticky and rough to the touch. That undersurface was wood and was located above the steam table. It was an uncleanable surface. *The two wood doors that led from the kitchen and the dishroom into the dining room were rough to the touch and had gouges in the wood. There was dark staining noted in the grain of the wood on both sides of the doors.</p> <p>8. Interview on 5/18/16 at 10:00 a.m. with the dietary manager revealed she: *Provided education on glove use to all the dietary staff throughout the year. She did not perform any audits of the handwashing. *Told all staff that hand sanitizer was not to be</p>	F 371			

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F 371	<p>Continued From page 11 used.</p> <p>*Agreed cook C had improperly drained the oranges.</p> <p>*Agreed the hair restraints for cook D and DAs C and E had not been maintained in a proper manner.</p> <p>*Was not aware the air conditioner in the dishroom needed cleaning and stated it was on a cleaning schedule.</p> <p>*Agreed the doors were in need of cleaning and refinishing.</p> <p>Review of the provider's reviewed 2/12/15 Infection Control - Hand Washing for Dining Services policy revealed:</p> <p>"Dining services employees must effectively clean hands at appropriate kitchen hand sinks with proper cleaning compounds prior to handling, preparing, serving, and distributing food, working with clean utensils, dishes and equipment."</p> <p>*Hands were to have been washed:</p> <ul style="list-style-type: none"> -Upon entering the dining services department. -Before handling food, clean equipment, utensils, dishes, or service wear. -Before any food handling, preparation, or service. -As often as necessary to remove soil and contamination and to prevent cross-contamination. -After handling any soiled or contaminated equipment, cleaning cloths, utensils, dishes, trays, soiled aprons, or trash can lids. -After obtaining food supplies for preparation. <p>Review of the provider's undated Dining Services Hair Guidelines revealed:</p> <p>*Dining services employees must wear hair restraints and beard restraints.</p>	F 371		

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F 371	Continued From page 12 *When wearing a hair restraint it must cover all hair completely.	F 371		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to ensure the required physicians' thirty, sixty, and ninety day recertification visits were completed for two of nine sampled residents (1 and 3). Findings include: 1. Review of resident 3's medical record revealed she had been admitted on 9/14/15. She had been seen by her physician on 9/22/15. That was eight days after her admission. The next physician's visit she had was on 1/8/16. Interview on 5/15/16 at 10:00 a.m. with registered nurse F confirmed resident 3 had not been seen by her physician for thirty, sixty, or ninety day recertification visits. She stated the clinic had no record of a physician's visit for her during the above times.	F 387	F387D FREQUENCY & TIMELINESS OF PHYSICIAN VISITS Resident #3 was admitted to the facility on 9-14-15. We are unable to recreate the required (PCP) Primary Care Physician visits for 30, 60 and 90 days. She was seen at the Medical clinic by the PCP on May 13 th . Progress notes have been requested. Resident #1 was originally admitted to the facility on 4-11-11. He was readmitted 9-6-14. We are unable to recreate PCP visits between 12-22-15 and 3-25-16 which resulted in greater than 60 days between PCP visits. He was seen by his PCP in the facility on 5-19-16. Progress notes have been requested. All residents admitted to the facility are at risk for missing appropriate visits by the PCP/provider according to the CMS guidelines.	7/7/16

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F 387	Continued From page 13 Surveyor: 23059 2. Review of resident 1's physician's progress notes revealed he had been seen by the physician on 12/22/15, and not again until 3/25/16. More than sixty days had elapsed between those visits. Interview on 5/17/16 at 1:40 p.m. with the assistant director of nursing revealed she had called the clinic to obtain progress notes from resident 1's physician's visits. She stated the clinic had no record of him being seen between the above dates. 3. Interview on 5/17/16 at 2:00 p.m. with registered nurse F revealed the clinic where resident 1 had been seen was staffed by resident physicians. Sometimes when resident physician's changed the need to see the residents at nursing homes was not communicated. Surveyor 29162: Review of the provider's Frequency of Physician Visits-Federal Regulation policy revealed the resident was to have been seen by a physician: *At least once every thirty days for the first ninety days after admission. *Then at least once every sixty days thereafter.	F 387	Tracking of PCP/provider visits will be completed by the Medical Records staff by completing a spreadsheet of last visit, next projected visit. Provider letters will be prepared and sent monthly to alert the provider as to the residents that need to have a Physician visit completed. Follow-up reminders will be completed by the Medical Records staff monthly requesting response within 48 hours of receipt for alternate MD visits. Delinquent Provider visits will be reported to the facility ED/DNS and Medical Director monthly for follow up. Results of Provider visits will be reported by the Medical Records staff to QAPI monthly X 2 months and quarterly X 1 with further recommendations followed.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431	F431D DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The 4 expired medications indicated during the survey that were in the medication room refrigerator were disposed of by a Licensed Nurse on May 19 th .	7/7/16

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F 431	<p>Continued From page 14 controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, narcotic review, record review, and policy review, the provider failed to ensure: *Expiration dates were monitored for four medications in the medication room refrigerator. *Narcotics were accounted for in one of four observed medication carts (east wing) and in one of one medication refrigerators.</p>	F 431	<p>No residents actually received any of these expired medications.</p> <p>All residents remain at risk for expired medications.</p> <p>Licensed Nursing staff was reeducated on weekly monitoring of medication room refrigerator for outdated medications by the Director of Nursing on June 23rd.</p> <p>Outdated medications will be promptly removed from service and disposed of by signature of 2 Licensed Nurses per State requirements upon discovery.</p> <p>The unidentified resident, whose narcotic medication was placed in a container and labeled with a marker and was secured in the narcotic box in the medication cart, has been discharged. The medication was returned to the original container and counted by 2 Licensed Nurses.</p> <p>The medication remained in the facility and destroyed per facility policy on June 8th. No further corrective action could be taken as the resident discharged on June 1st to the Hospital and subsequently to Hospice.</p> <p>All Residents residing in the facility have the potential to be affected in a similar manner.</p>	

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F 431	<p>Continued From page 15</p> <p>Findings include:</p> <p>1. Observation on 5/18/16 at 11:00 a.m. in the medication room revealed the following medications in the refrigerator had expired: *Influenza vaccine dated 4/25/16. *Pneumonia vaccine dated 5/6/16. *Atropine sulfate eye drops 4/16 (two bottles).</p> <p>Interview with licensed practical nurse (LPN) G on 5/18/16 at 11:00 a.m. revealed the Sunday night nurses were supposed to check for expired dates on medications weekly as posted in the medication room.</p> <p>The field services clinical director and registered nurse (RN) F were unable to provide any documentation of that process or a policy for expired medications.</p> <p>2. Observation on 5/18/16 at 11:20 a.m. revealed: *A small container held medication tablets in the narcotic (controlled medication) medication cart drawer. *On the outside of the container was handwritten Norco #30 (narcotic used for pain) and the name of resident. -That container was sealed with scotch tape.</p> <p>Interview on 5/18/16 at 11:20 a.m. with LPN G revealed: *That above medication came 180 tablets at a time, and they had put some of the tablets (30) in a small container so they did not have as many pills to count. *She signed that all tablets were counted, but she did not count the pills in the small container.</p>	F 431	<p>All controlled substances including those secured in refrigerator are maintained and reconciled at each change of shift.</p> <p>A locked refrigeration storage area for liquid controlled substances will be obtained by July 7th.</p> <p>Licensed Nursing staff will be reeducated on appropriate labeling of medication and the storage of liquid narcotics by the Director of Nursing on June 23rd.</p> <p>A Licensed Nurse will complete weekly Medication cart/Medication Room audits. Results of the audits will be provided to the Director of Nursing.</p> <p>The Director of Nursing or designee will complete 5 alternating Medication cart/Medication Room audits weekly x 4 weeks then monthly x 2 months to ensure proper labeling and storage of medication.</p> <p>Results of the audits will be presented by the Director of Nursing/designee to the QAPI committee monthly X 3 months and further recommendations followed.</p>		
	Interview on 5/18/16 at 11:20 a.m. with LPN H				

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F 431	<p>Continued From page 16 revealed:</p> <p>*She agreed with LPN G and stated she did not count the tablets in the container each time the narcotics were counted.</p> <p>*She signed that all tablets were counted, but she did not count the pills in the small container.</p> <p>Interview on 5/18/16 at 11:40 a.m. with RN F revealed her expectations would have been all narcotics were accounted for at change of shift or whenever nurses keys were exchanged.</p> <p>3. Observation on 5/18/16 at 11:25 a.m. revealed codeine cough syrup (a narcotic) on the east hall cart had read 50 milliliters (ml) on the bottle. However 70 ml was recorded on the narcotic record.</p> <p>Interview on 5/18/16 at 11:30 a.m. with LPN G revealed she did not always look at the bottle to actually measure how much medication had been left in the bottle after she had given a dose.</p> <p>Interview on 5/18/16 at 11:45 a.m. with the field services clinical director and RN F revealed they agreed there was 20 ml unaccounted for in the bottle of codeine cough syrup.</p> <p>4. Observation on 5/18/16 at 11:15 a.m. revealed the Ativan (controlled medication) in the refrigerator was 9.5 ml (ten vials, one had been opened), and they had not been counted with the routine narcotic counts.</p> <p>*The date on the controlled substance accountability sheet was 11/21/15, that was the last dose that had been given.</p> <p>Interview on 5/18/16 at 11:20 a.m. with RN J revealed:</p>	F 431		

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F 431	<p>Continued From page 17</p> <p>*Ativan was only counted when it was used. *Ativan was not under a double-lock system.</p> <p>Interview on 5/18/16 at 12:15 p.m. with RN F revealed the Ativan should have been double-locked and counted with the narcotic count according to their policy.</p> <p>Review of the narcotic records on 5/18/16 at 11:25 a.m. revealed the remaining quantity of codeine cough syrup was 70 ml.</p> <p>5. Review of the provider's May 2012 Controlled Substance policy Schedule 2-5 revealed: *All controlled medications were to be stored in a double-locked compartment, if in the refrigerator the locked box must have been attached to the inside of refrigerator. *At change of shift or when keys were transferred a physical inventory of all controlled substances including refrigerated items must have been conducted by two licensed nurses and documented.</p>	F 431			

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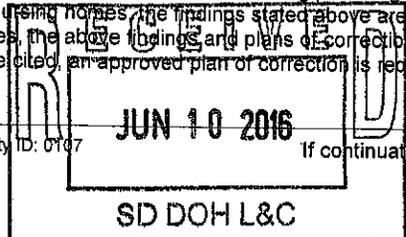
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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K 000	<p><i>*Addendums noted with per email with facility administrator.</i></p> <p>INITIAL COMMENTS on asterisk per 000 Surveyor: 20031 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/17/16. Golden LivingCenter - Black 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 the deficiencies identified at K018, K027, K038, K050, K064, K066, K0141, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>		<p>STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on May 18, 2016. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of <u>July 7th, 2016</u>. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.</p>	
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by:</p>	K 018	<p>K 018</p> <p>Both door closures to the kitchen from the Dining room were adjusted to positively shut to insure proper separation of the two spaces during survey and are working properly at this time.</p> <p>The Director of Dietary Services/designee will observe the operation of the doors daily to ensure they are closing properly. All Dietary staff will monitor the operation of the proper closing of the doors to ensure proper seal and will log into Building Engines any non-compliance issues.</p>	7/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 6-9-16
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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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/18/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701
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K 018	Continued From page 1 Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain proper separation for the kitchen because two of two one hour rated self-closing doors would not close and latch. Findings include: 1. Observation and testing at 10:30 a.m. revealed both doors to the kitchen from the dining room would not close and latch under the power of the self-closers. The doors would begin to close and then stay open approximately three inches. Interview with the maintenance supervisor at the time of the observation and testing confirmed the above. He was aware those doors would not close when the hood fan was on in the kitchen. The deficiency had the potential to affect one hundred percent of the residents in the smoke compartment.	K 018	The Director of Maintenance/designee will check for the proper operation and seal of the doors weekly. The Dietary staff will be educated on proper closing of the kitchen doors by the Director of Dietary Services and the Director of Maintenance by July 7th. Any Building Engines work order for the doors will be addressed and repaired as soon as possible by the Director of Maintenance/designee. The door operation will be reviewed with the Administrator, and work order summary/trends will be presented by the Director of Maintenance to the QAPI meeting monthly and recommendations followed.	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, testing, and interview, the provider failed to maintain one of four sets of smoke barrier doors (northeast corridor) that led	K 027	K027 The set of smoke doors from the Main Dining to the Administrative hub were repaired during survey, and are working properly at this time. Staff will be educated on proper door seal and fire door closing by the Director of Maintenance/Administrator at the staff meeting June 23rd.	7/7/16

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K 027	Continued From page 2 to the main dining room because they would not close. Findings include: 1. Observation and testing at 10:15 a.m. revealed the set of smoke barrier doors between the main dining room and administrative hub would not close. The doors would stop on the door coordinator and not close. Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. He was not aware those doors would not close, as he had tested them last month for his preventative maintenance.	K 027	Staff will enter into Building Engines for repair any smoke doors that do not work correctly. The Maintenance Director will check all fire doors for proper operation monthly as part of the preventative maintenance program and will be checked during all fire drills for proper operation.	
K 038 SS=D	The deficiency had the potential to affect any residents in two of five smoke compartments, the dining room and the administrative hub. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to ensure one of two exits from the laundry room (north exit to the outside) was readily accessible at all times. Findings include: 1. Observation at 10:20 a.m. revealed the laundry room's north exit door with exit signage was completely blocked by a full clean laundry cart. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated the laundry room was so small staff had to park the clean laundry cart by the exit door when they folded laundry throughout the day.	K 038	Any Building Engines work orders for non-compliant working smoke doors will be brought to the attention of the Administrator by the Director of Maintenance as soon as they have been identified. <i>*The director of maintenance attends the monthly QAPI meetings and will report the findings. CRV/DP/HEL</i> All fire doors will be checked by the Director of Maintenance monthly and per the preventative maintenance program for compliance and proper operation. The Director of Maintenance will present the results of preventative maintenance audits to the Administrator and the results will be reviewed and discussed in the QAPI meeting and recommendations followed. K038 The laundry cart blocking the exit door in laundry was immediately moved to allow a clear egress to the exit door during the survey process on May 19 th by the Director of Maintenance.	<i>7/7/16</i>

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K 027	Continued From page 2 to the main dining room because they would not close. Findings include: 1. Observation and testing at 10:15 a.m. revealed the set of smoke barrier doors between the main dining room and administrative hub would not close. The doors would stop on the door coordinator and not close. Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. He was not aware those doors would not close, as he had tested them last month for his preventative maintenance. The deficiency had the potential to affect any residents in two of five smoke compartments, the dining room and the administrative hub. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to ensure one of two exits from the laundry room (north exit to the outside) was readily accessible at all times. Findings include: 1. Observation at 10:20 a.m. revealed the laundry room's north exit door with exit signage was completely blocked by a full clean laundry cart. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated the laundry room was so small staff had to park the clean laundry cart by the exit door when they folded laundry throughout the day.	K 027	The Housekeeping Supervisor from Health Care Services was directed to ensure that no cart should block the exit door in laundry at any time to allow proper exit from laundry if needed. The Housekeeping Supervisor was made aware of this when the cart was moved. A yellow tape line will be installed by July 7 th to the floor in this section as a reminder that the area cannot be blocked at any time. The Health Care Services Supervisor will educate their staff to maintaining a clear exit path by July 7th. The Health Care Services Supervisor will make periotic rounds during the day to ensure compliance of their staff. The Director of Maintenance will check the space on opening morning rounds and random daily checks to ensure compliance. Findings will be presented by the Director of Maintenance in monthly QAPI, and recommendations for additional actions followed.	
K 038 SS=D		K 038		

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K 038	Continued From page 3 The deficiency had the potential to affect all occupants in that laundry room.	K 038		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Surveyor: 20031 A. Based on observation, testing, and interview, the provider failed to conduct a fire drill in a safe efficient manner. Findings include: 1. Observation at 2:15 p.m. of a fire drill in the kitchen revealed the following: *A red revolving light was placed on the counter in the kitchen. *The kitchen staff asked if it was a real drill. The maintenance supervisor replied "yes." *The dietary manager (DM) stated she had not had a fire drill in the kitchen since she had started over eighteen months ago. *The DM asked if she should actually pull the fire alarm. The maintenance supervisor replied "yes." *The DM pulled the fire alarm in the kitchen. *All staff left the kitchen, closed the doors, and an overhead announcement was made to alert all staff the fire was in the kitchen.	K 050	K 050 Fire drills (fire) will be done per regulations, policy, and have the ability to affect all residents', staff, and visitors. Fire drills will be performed weekly on all shifts for one month by the Administrator and Director of Maintenance. There after a fire drill will be performed monthly on all shifts to ensure compliance by the Director of Maintenance. Instructions and education will be provided to all staff by the Administrator and Director of Maintenance to ensure safety in the event there was a real emergency situation. The Administrator and Director of Maintenance will conduct the fire drills once per week for a month on all shifts for training purposes.	7/17/16

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K 050	<p>Continued From page 4</p> <ul style="list-style-type: none"> *An unidentified cook re-entered the kitchen to get a fire extinguisher. She did not check the temperature of the door before she entered. *No one had relayed the status of the fire to alert staff. Other staff began to crowd the door and hold it open to see what was happening. *The unidentified cook stated she had extinguished the fire, and it was all out. *An overhead announcement was made "code red all clear, code red all clear." *All staff reported to the nurses station after the drill. *No assessment of the drill or training was given. *No report of a head count for residents was given. <p>Interview with the MS after the above drill confirmed the failure of the procedures and staff training for a fire drill.</p> <p>Review of the 2015 Fire Emergency Evacuation revealed: **R.A.C.E.:</p> <ul style="list-style-type: none"> -Remove anyone from the immediate fire area. -Alert others and pull the manual fire alarm pull station. -Confine the fire by closing doors. -Extinguish or Evacuate. <p>*If there is danger from smoke or fire in you work area, evacuate the smoke compartment. When escaping from fire or smoke danger, evacuate beyond the fire/smoke rated doors."</p> <p>No other policies or guidelines were given to the surveyor in regards of procedures during a fire drill when requested from the administrator.</p>	K 050	<p>All fire drills will have an assessment performed for compliance, and a head count will be performed and reported on each fire drill sign sheet. A review of R.A.C.E., P.A.S.S., fire extinguisher use, and procedures of fire rescue and safety will also be reviewed. All fire drills will be critiqued upon completion for compliance and effectiveness.</p> <p>Results of the cubulations of completed drills will be presented at the monthly QAPI with further recommendations followed.</p> <p>Golden Living Black Hills will perform a fire drill on each shift every month to ensure compliance of the regulation for one per quarter per shift.</p> <p><i>CHKV/JP/2016/EC</i> *The director of maintenance will critique each fire drill at the completion of each drill. A copy of each drill will be provided to the administrator for additional comments with the director of maintenance monthly. The director of maintenance will report the assessment of each drill to monthly QAPI.</p>	
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This deficiency affects one hundred percent of *will report the assessment of each drill to monthly QAPI.*

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K 050	Continued From page 5 the occupants in the building. B. Based on document review and interview, the provider failed to ensure fire drills were conducted at least once per shift per quarter for one of three quarters (first quarter of 2016). Findings include: 1. Document review of the fire drill records from 7/7/15 through 5/9/16 revealed an afternoon drill had not been conducted January, February, and March 2016. Four daytime drills and one overnight drill had been completed for that quarter. Interview at 4:00 p.m. with the maintenance supervisor revealed he was not aware he had not conducted an afternoon drill for the first quarter of 2016. He was aware a drill must be conducted once per shift per quarter. No policy was provided on the frequency of fire drills for the facility when requested form the administrator. This deficiency could potentially affect all occupants of the building.	K 050		
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10.18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation, record review, and interview, the provider failed to maintain three of three extinguishers in two of two hazardous areas	K 064	<p>K 064</p> <p>Fire extinguisher checks will be done per regulations, policy, and have the ability to affect all residents, staff, and visitors.</p> <p>Fire extinguisher checks will be performed following Black Hills preventative maintenance schedule.</p>	7/7/16

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K 064	Continued From page 6 (the boiler room and the kitchen). Findings include: 1. Observation and fire extinguisher inspection tag review from 10:00 a.m. to 11:15 a.m. revealed: *The fire extinguisher in the maintenance/boiler room had not had a monthly visual inspection in January, February, March, and April 2016. *Two fire extinguishers in the kitchen had not had a monthly visual inspection in January, February, and March 2016. Interview with the maintenance supervisor revealed he had started the first part of January. He stated he was aware he had missed the extinguishers in the kitchen. He was not aware of the extinguisher in his maintenance/boiler room where his office was located. This deficiency could potentially affect all occupants in the building.	K 064 <i>*The director of maintenance/designee will check all fire extinguishers monthly and sign and date the check off map. A copy of the signed map will be provided to the administrator monthly for review.</i> <i>CHRISTOPHER</i>	The Director of Maintenance will create a separate map with all the facility fire extinguishers. The map will be initialed per each extinguisher check and signed off when complete to ensure all fire extinguishers are checked monthly. The Director of Maintenance will provide a copy of the fire extinguisher map signed sheet to the Administrator monthly, and the results will be discussed in monthly QAPI. Any fire extinguisher that is found to be out of compliance will be brought back into compliance immediately.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.	K 066	K 066 The parking located at the back area of the building designated as the auxiliary entrance door will have a sign ordered and posted identifying it as "NO SMOKING" by July 7th. Other areas of the building/grounds have also been identified for additional signage. All staff will be re-educated to the NO SMOKING regulations and restrictions on June 23 rd by the Administrator.	7/7/16

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K 066	Continued From page 7 (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to post precautionary NO SMOKING OXYGEN IN USE signage on one of four entrance doors (east door). Findings include: 1. Observation at 10:45 a.m. revealed a new exit door with a key pad had been installed on the east exit. That exit door led to a new parking lot for employees. A key pad was installed on the outside of that door, so employees could enter the building. Precautionary oxygen signage had not been posted on the outside of that door. All other entrance doors had precautionary signage. Interview with the maintenance supervisor at the time of the observation revealed he was not aware of the requirement to post precautionary signage on all major entrances. He stated they had just allowed staff to park on the east side this spring, as there was minimal parking at the facility. This deficiency could potentially affect all occupants in the building.	K 066	The Director of Maintenance/designee will perform weekly checks of the area to ensure compliance. The results of those rounds will be presented by the Director of Maintenance and discussed in the monthly QAPI meeting X 3 months and further recommendations followed.	
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage areas shall have a precautionary sign, readable from a distance of 5	K 141		

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K 141	Continued From page 8 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99) This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to post a conspicuous precautionary sign on the east side of the enclosure where flammable gases were stored outside. Findings include: 1. Observation at 10:50 a.m. revealed a new parking lot for employees located on the east side of the building. The caged enclosure for the flammable gases was located on the outside of that east entrance. Precautionary signage had been posted on the north side of the enclosure. It was not visible from the east side of the building. Interview with the maintenance supervisor at the time of the observation confirmed he could not see the north facing sign on the oxygen storage enclosure. He was not aware of the requirement to post precautionary signage that was visible from five feet on each side of the enclosure. He stated they had just allowed staff to park on the east side this spring as there was minimal parking at the facility. This deficiency could potentially affect all occupants in the building.	K 141	K 141 The Oxygen Storage area will have a sign posted on the cage door cautioning "NO Smoking within 50 feet". The campus of the Golden Living Black Hills is a "Non Smoking" facility. Currently there are 2 residents that are allowed to smoke in the "Resident Only" designated area due to prior privileges. See information for K066 for signage and education to be provided. The Director of Maintenance/designee will perform weekly checks of the area to ensure compliance. The results of those rounds will be presented by the Director of Maintenance and discussed in QAPI X 3 months and further recommendations followed.	7/7/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in	K 147		

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

PRINTED: 06/02/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/18/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 NORTH 7TH STREET RAPID CITY, SD 57701	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 9 accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Surveyor: 20031 Based on observation and interview, the provider failed to maintain a three foot clear depth of working space in front of two main electrical panels in one of one electrical room. Findings include: 1. Observation at 10:20 a.m. revealed two floor scrubber machines, a mop bucket, boxes of supplies, and other various items were stored directly in front of the electrical panels in the electrical room. Those items were stored within a red taped line that was marked on the floor three feet from the two panels. Interview with the maintenance supervisor at the time of the observation confirmed that condition. He stated he was aware housekeeping stored their equipment and supplies in that room. He stated there was no other space to store those items. The deficiency affected one of numerous requirements for maintaining electrical equipment in the main electrical panel location.	K 147	K 147 The failure to maintain a 3 foot clearance in front of the electric panels located in the electric room was immediately corrected on May 18 th . All items stored and equipment was removed by the Director of Maintenance. The electrical room will not be used for storage of items except for the bottled water by the door. This area meets the 3 foot code requirement. The locks to this space have been changed on May 20 th by the Director of Maintenance and only essential facility personnel have been issued a key. The Director of Maintenance/designee will check weekly to ensure compliance of the regulation. Any non-compliance will be immediately reported to the Administrator. The results will be presented by the Director of Maintenance and discussed in QAPI X 3 months and further recommendations followed.	7/7/16

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10665	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/18/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N 7TH ST RAPID CITY, SD 57701
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S 000 Compliance/Noncompliance Statement *Addendum noted with an asterisk per 6/30/16 per telephone with facility administrator and DON. NS/SDDOH/EL

Surveyor: 20031
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 5/16/16 through 5/18/16. Golden LivingCenter - Black Hills was found not in compliance with the following requirements: S294 and S323.

S 294 44:73:07:09 Written Menus

Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, shall be written, prepared, and served as prescribed by each resident's physician, physician assistant, nurse practitioner, or qualified dietitian. Each planned menu shall be approved, signed, and dated by the dietitian for each facility. Any menu changes from month to month shall be reviewed by the dietitian and each menu shall be reviewed and approved by the dietitian at least annually if applicable. Each menu as served shall meet the nutritional needs of the residents in accordance with the physician's, physician assistant's, or nurse practitioner's orders and the Dietary Guidelines for Americans, 2010. A record of each menu as served shall be filed and retained for 30 days.

This Administrative Rule of South Dakota is not met as evidenced by:
Surveyor: 26632
Based on interview and record review, the provider failed to ensure the spring menu for all residents on oral diets was reviewed and approved by the consultant registered dietitian (RD). Findings include:

S 294

STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on May 18, 2016. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of July 7th, 2016. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.

S294

The facility was without a Registered Dietician between Jan 15th and April 15th. Therefore, we are unable to recreate signed menus as required.

All regular and therapeutic diet menu extensions are printed on legal paper. They will be signed weekly by RD. A summary sheet will be created to provide all changes to the menu by the Director of Dining Services so they can be readily identified and approved by RD by July 7th. The Director of Dietary Services will make sure copies of

7/7/16

1. Record review and interview on 5/17/16 at 2:30

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

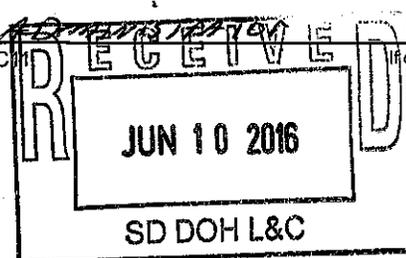
TITLE

(X6) DATE

STATE FORM

6899

BY BC



6/9/16

If continuation sheet 1 of 4

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10665	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/18/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - BLACK HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 N 7TH ST RAPID CITY, SD 57701
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S 294	Continued From page 1 p.m. with the dietary manager regarding the spring menu revealed no documentation it had been reviewed and signed by the RD. She stated the previous RD had signed the winter menu in December 2015. She was not aware each menu was required to have been reviewed and signed by the RD before they were put in use. The current RD had started in April 2016.	S 294	seasonal menus and the summary sheet with all prospective changes will be available to the RD for approval as needed. Education was provided to the RD upon hire (April 2016) regarding the requirement to sign the seasonal menus and signed copies have been maintained since then.	
S 323	44:73:08:06 Documentation of Drug Disposal Legend drugs not controlled under SDCL chapter 34-20B shall be destroyed or disposed of by a nurse and another witness. Destruction or disposal of medications controlled under SDCL chapter 34-20B shall be witnessed by two persons, both of whom are a nurse or pharmacist, as designated by facility policy. Methods of destruction or disposal may include: (1) Disposal by using a professional waste hauler to take the medications to a permitted medical waste facility or by facility disposal at a permitted municipal solid waste landfill. Prior to disposal all medications shall be removed from original containers and made unpalatable by the addition of adulterants and alteration of solid dosage forms by dissolving or combination into a solid mass; (2) Return to the dispensing pharmacy for destruction or dispose according to federal and state regulations; (3) Return to an authorized reverse distributor company licensed by the South Dakota Board of Pharmacy; or (4) Release to resident upon discharge after authorization by the resident's prescribing practitioner.	S 323	S323 Resident #14 was discharged from the facility and therefore no corrective action can be taken. All residents discharging from the facility are at risk to have medications sent home without a PCP order. Licensed Nurses will be educated on the requirement to request clarification orders from the PCP for the specific medications to be sent home with the resident as part of the Discharge orders Education to be provided on June 23 rd by the Director of Nurses.	7/7/16

SD Department of Health Vital Records

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S 323	<p>Continued From page 2</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure a physician's order had been obtained for release of medications to one of one sampled resident (14) upon discharge to home. Findings include:</p> <p>1. Review of resident 14's drug disposition record revealed two medications had been sent home with her upon her 2/25/16 discharge. Review of her 2/24/16 physician's order revealed there was an order to discharge her to her home. There was no order to send medications with her at the time of discharge.</p> <p>Interview on 5/18/16 at 10:05 a.m. with licensed practical nurse G confirmed there was no physician's order to release medications to resident 14 at the time of her discharge. Interview at the same time with the field services clinical director confirmed a physician's order should have been obtained prior to sending those medications home with the resident.</p> <p>Review of the provider's May 2012 Discharge With Medications policy revealed: **"Medications may be sent with the resident on discharge if ordered by the prescriber. *The prescriber should list the medications to be released upon discharge."</p>	S 323	<p>Audits of 10% of all future discharged residents will be completed beginning June 24th for 4 weeks then monthly X 2 months to ensure the specific order is obtained for medications to be sent with the resident by the Director of Nursing/designee.</p> <p>Results of the audits will be presented by the Director of Nursing/Designee to the QAPI committee X 3 months and further recommendations followed.</p> <p><i>S294 continued ↓ *Dietary Manager will monitor all menus to ensure the registered Dietician has reviewed and signed them. The dietary manager will be responsible to report her findings to the QAPI committee monthly until further directions are given. NS/SDRCH/EC</i></p>	
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide</p>	S 000		

SD Department of Health Vital Records

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S 000	Continued From page 3 training programs, was conducted from 5/16/16 through 5/18/16. Golden LivingCenter - Black Hills was found in compliance.	S 000		