

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106
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F 000	INITIAL COMMENTS Surveyor: 22452 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/29/16 through 3/2/16. Golden LivingCenter - Covington Heights was found not in compliance with the following requirements: F224, F226, F241, F252, F280, F281, F309, and F425.	F 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on March 2, 2016. Please accept this plan of correction as the Living Center's Credible Allegation of Compliance with the completion date of March 31, 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.	
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, interview, record review, and policy review, the provider failed to administer personal care to 1 of 18 sampled residents (1) following an episode of incontinence (loss of bladder or bowel control). Findings include: 1. Review of resident 1's medical record revealed she: *Was admitted on 2/26/16 following a hospitalization. *Had the following diagnoses: -Sepsis (infection in the blood). -Cellulitis (infection in the skin).	F 224	F224 - Prohibit Mistreatment, Neglect or Misappropriation A thorough investigation has been completed for resident #1 allegation of neglect and submitted to the SD Department of Health. All residents have been evaluated for potential negligence with cares. Residents residing in the facility have the potential to be affected in a similar manner.	3-28-16 KTD

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rich Freeman</i>	TITLE ED	(X6) DATE 3-24-16
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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.

MAR 30 2016

SD DOH L&C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 224	<p>Continued From page 1</p> <ul style="list-style-type: none"> -Pneumonia. -Heart failure. -Atrial fibrillation (heart does not beat properly). -Anemia (low amount of red blood cells). -Chronic kidney disease. -Gastric reflux. -Underactive thyroid. <p>*Required the assistance of two staff and the use of the full-body lift for all transfers. *Was alert and oriented to person, place, and time.</p> <p>Interview on 2/29/16 at 2:35 p.m. with resident 1's family regarding an incontinent episode earlier that morning revealed: *At 11:30 a.m. she was sitting in her wheelchair and had just returned from therapy when she alerted staff she had to use the bathroom. *The staff were unable to maneuver her wider-width wheelchair through her bathroom doorway. *She was taken to the bathroom inside of the unit shower room. *While in the shower room she was incontinent of bowel. *The staff took her back to her room following the incident, and then they left to clean the shower room. *Her lunch was brought into her room while she waited to be cleaned up. *The staff assisted in cleaning her up, changing clothes, and transferring her back to bed at 1:50 p.m. after she had lunch.</p> <p>Observation and interview on 3/1/16 at 8:40 a.m. with resident 1 regarding her incontinent episode revealed she: *Waited at least two hours after she was incontinent for staff to help her clean-up.</p>	F 224	<p>The Executive Director, Director of Nursing, Social Service Director and Interdisciplinary Team have reviewed the Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation Policy</p> <p>All staff has been reeducated on the Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation Policy. All were required to attend the in-service. Staff that were not able to attend the in-service were required to read policy and complete a post-education quiz to demonstrate understanding. No staff will be allowed to return to duty without reviewing these materials.</p> <p>Executive Director or Designee will complete 5 random resident interviews weekly x4 then monthly x2 to ensure residents are satisfied with care and services. The Executive Director and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>	3-31-16

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F 224	<p>Continued From page 2</p> <p>*Stated "I felt filthy."</p> <p>*Was tearful when recalling the incident.</p> <p>Interview on 3/2/16 at 1:15 p.m. with the director of nursing (DON) regarding resident 1 revealed: *It was her expectation a resident was to be cleaned-up immediately following an episode of incontinence. *She acknowledged a two hour time frame to get the resident cleaned-up was unacceptable. *In the late afternoon of 2/29/16 the family had addressed their concerns with her regarding that incident. *Facility staff had not visited with her regarding the incident.</p> <p>Interview on 3/2/16 at 1:35 p.m. with licensed practical nurse (LPN) A regarding resident 1 revealed: *On 2/29/16 he was the nurse assigned to the resident's unit. *He was not able to transfer the resident immediately after the incident since she required a full-body lift and two staff. *The certified nursing assistant (CNA) that was to assist with her care was at lunch. *Upon the CNA's return the shower room was cleaned, and then another resident was assisted with a shower. *He acknowledged the resident had to wait a long time prior to the staff assisting her to get cleaned-up and to be transferred back to bed. *He agreed she had waited at least two hours.</p> <p>Review of the provider's 11/17/15 Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation policy revealed: *"Neglect means failure to provide goods and services necessary to avoid physical harm,</p>	F 224		
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F 224	Continued From page 3 mental anguish, or mental illness." **"It is the responsibility of all employees to immediately report any alleged violation of abuse, neglect, injuries of unknown source, and misappropriation of resident property."	F 224		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Surveyor: 26180 Based on interview, record review, and policy review, the provider failed to ensure one of one incident involving a resident-to-resident (22 and 23) altercation was investigated. Findings include: Surveyor 35625 1. Interview on 3/1/16 at 10:30 a.m. with a group of random residents revealed resident 23 had concerns regarding being struck by another resident (22). Interview on 3/1/16 at 11:10 a.m. with resident 23 and further record review of the incident revealed: *On 1/10/16 she was struck in the arm by another resident but was not injured. *She was frustrated and felt nothing had been done about the incident and was concerned it could happen again.	F 226	F226 Develop, Implement Abuse & Neglect Policies A thorough investigation has been completed for resident #22 and #23 physical altercation and submitted to the SD Department of Health. All residents have been evaluated for potential resident-to-resident altercation. 3-28-16 <i>ET DLS</i> Residents residing in the facility have the potential to be affected in a similar manner. All staff has been reeducated on the Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation Policy. All were required to attend the in-service. Staff that were not able to attend the in-service were required to read policy and complete a post-education quiz to demonstrate understanding. No staff will be allowed to return to duty without reviewing these materials.	

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F 226	Continued From page 4 Surveyor 26180 Interview on 3/2/16 at 10:00 a.m. with the social services director (SSD) revealed: *She confirmed resident 22 had hit resident 23, because she had made fun of him, mimicking the vocal sounds he made. -Resident 22 was aphasic (unable to speak due to a stroke) and made repetitive sounds. *She had been made aware of the incident immediately and spoke with the administrator about it. *She then called the South Dakota Department of Health (SD DOH) and verified the need to investigate and report to the state the above incident. -She informed the administrator of that. *The administrator and director of nurses (DON) were responsible for investigations per the administrator's directive. *The SSD had not been made aware if the incident was investigated, as she was not involved in investigations. Interview on 3/2/16 at 1:00 p.m. with the DON revealed there had not been an investigation into the above incident involving residents 22 and 23. The incident had not been reported to the SD DOH. Review of the provider's 11/17/15 Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation policy revealed: **"Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. *Physical abuse includes hitting, slapping,	F 226	Executive Director or Designee will complete 5 random resident interviews weekly x4 then monthly x2 to ensure residents are satisfied with care and services. The Executive Director and will bring results of audits to the monthly QAPI meeting for further review and recommendations.	3-31-16	

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F 226	Continued From page 5 pinching and kicking. *Federal law requires the center to have evidence of investigations of alleged violations. The attached Verification of Investigation form is completed and provided to survey agencies when requested or required by state law."	F 226	F241 Dignity A thorough investigation has been completed for resident #1 allegation of neglect and submitted to the SD Department of Health. All residents <i>have been evaluated that dignity has been maintained during personal cares.</i> Residents residing in facility have the potential to be affected in a similar manner.	
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, interview, record review, and policy review, the provider failed to ensure dignity had been maintained for one of one sampled resident (1) who had an episode of incontinence (loss of control of bowel or bladder). Findings include: 1. Review of the provider's 2/26/15 Dignity policy revealed "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality."	F 241	The Executive Director, Director of Nursing, Social Service Director and Interdisciplinary Team have reviewed the Dignity Policy Nursing Staff has been re-educated on the Dignity Policy. All Nursing Staff were required to attend the in-service. Staff that were not able to attend the in-service were required to read policy and complete a post-education quiz to demonstrate understanding. No staff will be allowed to return to duty without reviewing these materials. Director of nursing or designee will complete 5 random care observation audits weekly x4 then monthly x2 to ensure residents dignity is preserved and will bring results of audits to the monthly QAPI meeting for further review and recommendations.	<i>-3-28-16 KT DNS</i>
F 252 SS=D	Refer to F 224, finding 1. 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing	F 252		

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F 252	<p>Continued From page 6 the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on observation and interview, the provider failed to maintain a clean, homelike, and safe environment for: *One of three dining rooms (west) with 7 of 14 chairs that needed cleaning. *One of six bathing suites (500 wing) with chipped corner tiles that created rough and uncleanable surfaces. Findings include:</p> <p>1. Random observations from 2/29/16 through 3/2/16 of the west dining room revealed seven chairs had dried, sticky stains on the sitting surfaces.</p> <p>Observation and interview on 3/2/16 at 9:00 a.m. with the maintenance director confirmed the chairs had stains on the sitting surfaces. He stated housekeeping had been responsible for cleaning the chairs. Chairs that needed cleaning were to have been replaced with clean chairs, and the dirty chairs taken downstairs for cleaning.</p> <p>2. Observation on 2/29/16 at 3:00 p.m. and on 3/2/16 at 7:30 a.m. of the 500 wing bathing suite revealed: *The lower corner tile on the partition wall between the entrance and the shower area had been chipped off revealing the metal corner strip. That created rough edges and an uncleanable surface. *The lower corner tile on the partition wall</p>	F 252	<p>F 252 Safe, Clean, Comfortable & Homelike environment</p> <p>The 7 chairs in the west dining room have been cleaned or replaced. The bathing suite on the 500 wing has had the cracked/chipped tiles replaced.</p> <p>Residents residing in facility have the potential to be affected in a similar manner. Environmental rounds have been completed to identify any other areas of concern and a plan has been put in place to address any concerns identified.</p> <p>Staff were reeducated on procedure for notifying maintenance for repairs or building maintenance concerns.</p> <p>Executive Director or Designee will complete will complete environmental rounds weekly x4 then monthly x2 to ensure a Safe, Clean, Comfortable & Homelike environment is maintained and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>	3-31-16

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F 252	Continued From page 7 between the toilet area and the tub area had been chipped off creating rough edges and an uncleanable surface.	F 252	<i>Monthly Preventative checks of chairs and tub and shower tiles to be completed by maintenance supervisor or designee. - 3-28-16 KT DNS</i>	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy	F 280	F 280 Right to participate in planning care & revising care plans Resident #2, #14, #15 and #18 care plans have been revised to reflect resident's current condition. Residents residing in the facility have the potential to be affected in a similar manner. <i>All residents - 3-28-16 Care plans reviewed and revised to reflect current condition. Department managers and nursing staff have been re-educated on the care plan process.</i> Care plans will be reviewed and revised during daily clinical start up with resident condition changes to accurately drive the resident's care. Comprehensive care plans will be reviewed and revised during the next resident MDS assessment. <i>All residents with significant change care plans will be reviewed and revised with daily stand-up. - 3-28-16 KT DNS.</i>	

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F 280	<p>Continued From page 8</p> <p>review, the provider failed to ensure 4 of 18 sampled residents' (2, 14, 15, and 18) care plans had been updated and revised as changes occurred. Findings include:</p> <p>1. Review of resident 2's medical record revealed he had: *A diagnosis that included abnormal findings in his urine. *A Foley catheter (a tube inserted into the bladder to drain urine) had been inserted on 10/12/15 in the hospital. *He had been readmitted from the hospital on 10/14/15.</p> <p>Review of resident 2's 10/21/15 significant change Minimum Data Set (MDS) assessment and quarterly 1/11/16 assessment revealed he had a Foley catheter.</p> <p>Interview on 3/1/16 at 5:15 p.m. with registered nurse (RN) C regarding resident 2 revealed: *He had a Foley catheter. *He had needed that catheter due to urinary retention (inability to empty the bladder).</p> <p>Review of resident 2's revised 2/10/16 care plan revealed: *He had an alteration in the elimination of his bladder. *There was no documentation he had a Foley catheter.</p> <p>Interview on 3/1/16 at 6:00 p.m. with the director of nursing (DON) regarding resident 2 revealed: *He had a Foley catheter. *She agreed his care plan contained no documentation that he had a catheter. *She stated that any member of the care team</p>	F 280	<p>Director of nursing or designee will complete 5 random audits weekly x4 then monthly x2 to ensure residents care plan accurately reflects the resident's current care needs and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>	3-31-16
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F 280	<p>Continued From page 9</p> <p>could have updated his care plan to have included the use of a catheter. *She confirmed the placement of a catheter had needed to have been in his care plan.</p> <p>Surveyor: 34030 2. Review of resident 14's medical record revealed: *An admission date of 10/28/14. *She was originally a full code (resuscitation would be done if she were to stop breathing). *Her code status changed to do not resuscitate (DNR) on 1/18/16 and remained so to present time.</p> <p>Review of resident 14's provider's care plan revealed: *Three different print dates: most of it had been printed on 11/13/14, then there were two page 1's with print dates of 2/2/16 and 3/1/16. *She was a full code according to those pages of the care plan.</p> <p>Review of resident 14's undated 300 Wing Report Sheet the nurses and certified nursing assistants (CNA) used for resident care needs revealed she was a DNR.</p> <p>Interview on 3/2/16 at 11:05 a.m. with CNA E regarding the care for resident 14 revealed: *She usually worked with the resident and on the 300 wing. *She knew the resident's code status by what was on the 300 Wing Report Sheet.</p> <p>Interview with the MDS coordinator for the residents of the 100 through 500 wings revealed: *The unit coordinators updated the care plans. *She would expect them to have been updated</p>	F 280		

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F 280	<p>Continued From page 10</p> <p>"right away."</p> <p>*She was "frustrated" they were not being updated in a timely manner.</p> <p>Interview on 3/2/16 at 10:45 a.m. with RN C, who was also a unit coordinator regarding updating care plans revealed:</p> <p>*She usually worked Monday through Thursday.</p> <p>*She was responsible for updating care plans for the 300 wing but was frequently doing medication pass for the residents instead.</p> <p>*Resident 14 had recently moved from the 200 wing to the 300 wing.</p> <p>*She had "not really been trained on when to update care plans."</p> <p>*She would check the chart to make sure of the code status and "was stressed because the information [on the care plan] was not consistent" with the information elsewhere.</p> <p>Interview on 3/2/16 at 3:30 p.m. with the DON revealed she agreed resident 14's code status had not been updated on her care plan to reflect her current wishes.</p> <p>Review of the provider's 2/26/15 Interdisciplinary Care Plan policy revealed the interdisciplinary care plan was to have been revised/updated as necessary to address resident needs.</p> <p>Surveyor: 26180</p> <p>3. Random observations on 3/2/16 from 9:00 a.m. until 1:30 p.m. revealed resident 15 was not in the building. Interview at that time with registered nurse H revealed he was at dialysis and would be back in the early afternoon. He went to dialysis on Monday, Wednesday, and Friday.</p> <p>Review of resident 15's 4/9/15 care plan revealed</p>	F 280		
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F 280	<p>Continued From page 11 he received dialysis Tuesday, Thursday, and Saturday.</p> <p>Interview on 3/2/16 at 1:15 p.m. with the social services director regarding resident 15 revealed: *The days he went to dialysis had changed. *The days he went frequently changed. -Sometimes he refused one day, so they would change it to another day. Sometimes it changed because of the amount of fluid taken off during dialysis on a day. -They would re-arrange his schedule if needed. *She then called the dialysis unit, and they verified he had been coming on Monday, Wednesday, and Friday at least for several weeks. *She confirmed the care plan had not been updated regarding the days he went to dialysis.</p> <p>Surveyor: 22452 4. Review of resident 18's 1/18/16 physician's same day surgery discharge instructions revealed: *A vitreoretinal surgical (eye surgery to restore, preserve, and enhance the vision) procedure to the right eye had been done. *The return of vision was often slow. *Patients (residents) with a gas bubble (splint in the eye to hold the retina) in their eye might not see well until the bubble was gone. That might take several weeks or months to occur.</p> <p>Review of resident 18's 2/1/16 through 2/24/16 progress notes revealed: *2/1/16, "She has been struggling with confused thoughts. She stated her vision was greatly improved following her surgery and that she feels she is almost ready to take her driving test. During this conversation she has her hand</p>	F 280		

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F 280	<p>Continued From page 12</p> <p>stretched out and was grasping at the air. She noted that she was blind and was trying to find her room. Remains emotionally from her eye surgery and has worries of going blind."</p> <p>*2/18/16, "She stated she could only see shadows and at times only blackness."</p> <p>*2/23/16, "She has underwent eye surgery recently and since then has been refusing to get up out of bed up until few days ago when encouraged by social worker it would be good for her to get out of room and socialize."</p> <p>*2/24/16, "Resident has been notably declining in activities of daily living [ADL] [dressing, grooming, personal hygiene and bathing] and messier with her eating. Ophthalmology [eye] clinic nurse states that in resident's left eye she cannot even see light or any objects and is near blind. Her right eye she can only see hand motions directly in front of her face. Nurse states surgery did not improve her sight. She had a dying retina and they went in to clean out the back of the eye but did not help much. Did tell director of nursing [DON] and informed her so that we can move resident to a feeder table. Ophthalmology nurse states doctor wants her on eye drops to help with the pressure in her left eye or it could become a painful blind eye."</p> <p>Review of resident 18's 4/18/15 care plan with a goal date of 4/22/16 revealed:</p> <p>***Impaired vision related to glaucoma [increased pressure in eyes]."</p> <p>***Will be safe in the environment."</p> <p>***Assist with placement and cleaning with glasses as needed."</p> <p>***Encourage involvement in activities."</p> <p>***Keep environment well lit and free of clutter."</p> <p>***Medication eye drops as ordered."</p> <p>***Provide large print reading material if</p>	F 280		

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F 280	Continued From page 13 appropriate." *"Vision exam as needed." Interview on 3/2/16 at 3:00 p.m. with RN C and LPN G regarding resident 18 revealed: *They had talked about moving her to a table in the dining room with more assistance, but had not done that yet as the resident was still able to feed herself. *They had gotten her a plate guard (device to keep food from sliding off the plate) with meals to make eating independently easier. *A referral had been made to occupational therapy (OT) and physical therapy (PT) with her declining vision. *OT had been sitting with her at meals for observation. *She had been pretty much totally assisted with her ADLs before her vision loss. *She was highly anxious prior to her vision loss, but they had been giving her increased reassurance and allowing her to vent her feelings with her declining vision. *It was the responsibility of all the nurses to keep the care plan updated and revised. *The resident's care plan did not address her declining vision and any approaches that had been implemented for her blindness.	F 280		
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: 26180	F 281		

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F 281	<p>Continued From page 14</p> <p>Surveyor: 32331</p> <p>A. Based on observation, record review, interview, manufacturer's instruction reviews, and policy review, the provider failed to ensure:</p> <p>*Physician's orders were followed or clarified for:</p> <ul style="list-style-type: none"> -Insulin administration for 1 of 2 sampled residents (13) who received insulin based on the amount of carbohydrates consumed at meals. -The administration of insulin for 1 of 2 sampled residents (13) who received sliding scale insulin (amount given depending on blood sugar results). -Weighing one of three sampled residents (11) who was on dialysis. -A psychiatric evaluation for one of one sampled resident (3). -The administration of an inhaled medication for three of three sampled residents (11, 24, and 25). -The dosage of a medication for one of one sampled resident (26). <p>*A controlled pain medication had a written prescription prior to being administered for 1 of 18 sampled residents (1).</p> <p>*The correct personal alarm was used for 1 of 1 sampled residents (10).</p> <p>*Findings include:</p> <p>1a. Review of resident 13's medical record revealed:</p> <ul style="list-style-type: none"> *A diagnosis of uncontrolled diabetes. *An admission date of 6/21/12. *A 12/2/15 physician's order date for Novolog (a fast-acting insulin used to control high blood sugar (BS) with diabetes) to have been given after meals at a ratio of one unit of the Novolog for each seven grams of carbohydrate eaten. -The above order for Novolog had been changed 1/28/16 per physician's fax order to a ratio of one unit of Novolog for each six grams of 	F 281	<p>F 281 Professional Standards</p> <p>Resident #13 – no corrective action could be taken</p> <p>Resident #15 has been reweighted</p> <p>Resident #3 has had a psychiatric evaluation scheduled for March 24, 2016.</p> <p>Resident #11, #24, and #25 have inhalers replaced and have been dated upon opening</p> <p>Resident #26 medication has been discontinued</p> <p>Resident # 1 has a written prescription for the controlled pain medication. Reeducation was completed to nurse who administered medication without written prescription from physician</p> <p>Resident #10 has the correct personal alarm in place</p> <p>Residents residing in the facility with Diabetes Mellitus, weight concerns, prescribed inhalers, narcotic medications, physician ordered medications and personal alarms have the potential to be affected in a similar manner.</p>	
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F 281	<p>Continued From page 15 carbohydrate with meals. *A 2/1/16 physician's order for: -"Diabetes in the morning OK [okay] to hold Novolog prn [whenever necessary] insulin to carbohydrate ratio if she refuses breakfast. Could still use sliding scale if BS is elevated." -"Make sure she gets insulin within 15 minutes of starting meal or 15 minutes after finishing meal." -*A"Con [Consistent] CHO [carbohydrate] diet Mechanical Soft texture."</p> <p>Review of 1/21/16 through 1/22/16 nurses' note regarding resident 13 revealed: *On 1/21/16 at 1:30 a.m. she had been found unresponsive and sweating with secretions draining from her mouth. -Her BS had been checked, and she was at 31 mg/dl (milligrams/deciliter). (A normal BS range is 70-130 mg/dl). -Two Glucagon kits (medication by injection [shots] to treat severe hypoglycemia (low BS) were given, and she had remained unresponsive. -The emergency number 911 was called, and she was transported by ambulance to a local hospital. *On 1/21/16 at 5:15 a.m. documentation in the medication administration record (MAR) revealed: -On 1/20/16 at 7:00 p.m. she had been given too much Novolog insulin for her carbohydrate count coverage after the evening meal. *On 1/22/16 at 8:42 p.m. she returned to the facility.</p> <p>Interview on 2/29/16 at 6:00 p.m. with licensed practical nurse (LPN) G and medication aide (MA) M regarding resident 13 revealed: *The resident was to have been given insulin based on how much carbohydrate she consumed at meals. *She used a carb (carbohydrate) count cheat</p>	F 281	<p>Residents with Diabetes Mellitus have been reviewed for appropriateness of diet and sliding scale insulin</p> <p>Residents have been weighted and weights have been evaluated for any change in status</p> <p>Residents with inhalers that were not dated when opened have been replaced.</p> <p>Residents who receive narcotic medications have been evaluated to ensure written prescription from physician is in place.</p> <p>A system has been developed to ensure medications are easily reconciled</p> <p>Residents who use personal alarms have been evaluated to ensure appropriate device is in use.</p> <p>Nursing staff have been reeducated on the Diabetes Mellitus guidelines, weight guideline, and procedure for dating prescribed inhalers upon opening, appropriate administration of narcotic medications, and reconciliation system of physician ordered medications and appropriate placement of personal alarms.</p>	

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F 281	<p>Continued From page 16 sheet for figuring how much carbohydrate was in food items. *That cheat sheet contained information on foods with carbohydrates ranging from twelve to twenty grams per serving.</p> <p>Interview on 2/29/16 at the same time as the above with the registered dietitian (RD) revealed: *She had provided the carbohydrate counting cheat sheet and the sources of carbohydrate information to nursing. *It had been up to nursing staff to have determined the amounts of carbohydrates at the meals based on the informational sheets provided by the RD.</p> <p>Observation on 2/29/16 regarding resident 13 revealed: *At 6:10 p.m. she was eating her evening meal in the east dining room and was able to feed herself after set-up. *At 6:15 p.m. she completed her meal and walked out of the dining room to her room. *At the above time, MA M went to her place at the dining table and wrote on a sheet of paper the food she had consumed for the evening meal. *She provided the above food intake amounts to LPN G.</p> <p>Interview on 2/29/16 at 6:30 p.m. with resident 13 in her room revealed: *She had diabetes and was on a special diet. *She received a snack at bedtime, and she preferred ice cream.</p> <p>Observation on 2/29/16 at 6:35 p.m. with LPN G regarding resident 13 revealed: *She estimated the resident had consumed 75 grams of carbohydrate at the evening meal.</p>	F 281	<p>Director of nursing or designee will complete 10 random audits weekly x4 then monthly x2 to ensure Diabetes Mellitus guidelines, weight guideline, procedure for dating prescribed inhalers upon opening, appropriate administration of narcotic medications, reconciliation system of physician ordered medications and appropriate placement of personal alarms are being followed appropriately and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>	3-31-16
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F 281	<p>Continued From page 17</p> <p>-That above amount had been based on her food intake results completed by MA M.</p> <p>*She divided the grams of carbohydrate in the meal by the prescribed units of insulin for that amount.</p> <p>*She then wrote down the results of her calculation as 12 units of insulin needed for that meal.</p> <p>*She then added 4 units to the above amount for the sliding scale results from a BS obtained on the same day at 4:30 p.m. for a total of 16 units of insulin.</p> <p>*She obtained the Novolog FlexPen that contained insulin and dialed 16 units.</p> <p>Observation on 2/29/16 at 6:37 p.m. of LPN G with resident 13 revealed:</p> <p>*She injected 16 units from the above Novolog FlexPen into the resident's abdomen.</p> <p>*The resident had received the insulin twenty-two minutes after she had finished eating her evening meal.</p> <p>Observation and interview on 3/1/16 at 7:40 a.m. with registered nurse (RN) N outside of resident 13's room revealed:</p> <p>*She was in her bed with her eyes closed.</p> <p>*RN N reported the resident usually did not eat breakfast.</p> <p>*She usually got up between 9:00 a.m. to 11:00 a.m. each day.</p> <p>*She stated the physician had been made aware of the above.</p> <p>*There was a 2/1/16 physician's order to have held the Novolog insulin to carbohydrate ratio if she refused breakfast.</p> <p>-That above order had included to have used the sliding scale insulin if BS was elevated.</p>	F 281			

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F 281	<p>Continued From page 18</p> <p>Interview on 3/1/16 at 9:35 a.m. with certified nursing assistant (CNA) E regarding resident 13 revealed she usually did not ask the resident if she wanted breakfast.</p> <p>Interview on 3/1/16 at 10:05 a.m. with resident 13 in her room revealed: *She was up and had dressed for the day. *She stated she was not hungry for breakfast.</p> <p>Observation on 3/1/16 at 11:55 a.m. regarding resident 13 revealed she had received her noon meal in the east dining room.</p> <p>Observation on 3/1/16 at 12:10 p.m. regarding resident 13 revealed she had finished her noon meal in the above location and walked out of the dining room back to her room.</p> <p>Observation and interview at 3/1/16 on 12:15 p.m. with RN N regarding resident 13 revealed: *She estimated the resident had consumed 75 grams of carbohydrate at the noon meal. -That above amount had been based on her visual observation of the resident's meal place setting. -She had been unsure of the exact amount of carbohydrate she had been given and consumed at that meal. *She divided the grams of carbohydrate in the meal by the prescribed units of insulin for that amount. *She then wrote down the results of her calculation of 12 units of insulin needed for that meal. *She obtained the Novolog FlexPen that contained insulin and dialed 12 units.</p> <p>Observation on 3/1/16 at 12:26 p.m. with RN N</p>	F 281		
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F 281	<p>Continued From page 19 regarding resident 13 revealed:</p> <ul style="list-style-type: none"> *She injected 12 units from the above Novolog FlexPen into the resident's abdomen. *She had received her insulin sixteen minutes after she had completed her noon meal. <p>Review of resident 13's revised 12/17/15 care plan revealed:</p> <ul style="list-style-type: none"> *She had an alteration in BS due to insulin dependent diabetes. *Her goal was to have experienced minimal signs and symptoms associated with high or low BSs. *Her diabetes remained poorly controlled. *Any BS results of less than 60 mg/dl or greater than 500 mg/dl were to have been reported to her physician. *Insulin was to have been given for the amount of carbohydrates eaten at each meal. *She was to have been observed for low blood sugar symptoms. *Those symptoms had included: <ul style="list-style-type: none"> -Flushed face. -Sweating. -Change in usual mental status. -Lethargy. -Irritability. -Fruity breath odor. -Nervousness. -Trembling. -Difficulty concentrating. -Lightheadedness. -Coma. <p>Review of the 10/1/15 through 2/29/16 resident 13's MAR for the carbohydrate to insulin amounts for breakfast at 9:00 a.m., lunch at 1:00 p.m., and evening meal at 7:00 p.m. revealed:</p> <ul style="list-style-type: none"> *For 10/1/15 through 10/31/15 a total of thirty times were not documented for the carbohydrate 	F 281		
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F 281	<p>Continued From page 20 or insulin amounts. *For 11/1/15 through 11/30/15 a total of thirty-one times were not documented for the carbohydrate or insulin amounts. *For 12/1/15 through 12/31/15 a total of thirty-four times were not documented for the carbohydrate or insulin amounts. *For 1/1/16 through 1/31/16 a total of thirty-four times were not documented for the carbohydrate or insulin amounts. -Insulin amounts ranged from 5 through 22 units. -The above 22 units of insulin was documented on 1/20/16 for the evening meal of 45 grams of carbohydrate. -At an amount of 45 grams of carbohydrate, 6 units of insulin should have been given. -There had been an additional 16 units of insulin documented for that meal. *For 2/1/16 through 2/29/16 : -A total of thirty-seven times were not documented for the carbohydrate or insulin amounts. -Carbohydrate amounts ranged from 20 through 600 grams. -The above 600 grams of carbohydrate was documented on 2/27/16 for the lunch meal. -An amount of 600 grams of carbohydrate would have been equivalent to approximately 40 bread, fruit, or milk servings. -At that above meal a total of 10 units of insulin was documented.</p> <p>Review of an undated 300 West Report Sheet for resident 13 revealed: *She was diabetic. *BS checks were to have been done at 7:00 a.m., 11:00 a.m., 5:00 p.m., and 8:00 p.m. *She was on a Con CHO/Mech soft diet. *There was no documentation on the above</p>	F 281		
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F 281	<p>Continued From page 21</p> <p>report sheet she was to have had insulin based on how much carbohydrate she had consumed at meals.</p> <p>Review of 10/4/15 through 2/29/16 Meal Intake Detail Reports for resident 13 revealed:</p> <ul style="list-style-type: none"> *Breakfast meal intakes ranged from none to 100 percent (%) and were usually little to none. *Lunch meal intakes ranged from 25% to 100% and were usually 75% to 100%. *Evening meal intakes ranged from 25% to 100% and were usually 75% to 100%. *Bedtime snacks ranged from none to 100% and were usually 100%. *There was no documentation regarding the amount of carbohydrates offered and consumed at the meals and bedtime snack. <p>Review of the provider's undated Food Lists for Carbohydrate Counting and Carb Count Cheat Sheet revealed:</p> <ul style="list-style-type: none"> *Foods that contained carbohydrates had included: <ul style="list-style-type: none"> -Fruits. -Milk/beverages (regular pop, lemonade). -Breads/grains (cereal, noodles, rice, and crackers). -Starchy vegetables (potatoes, peas, corn, beans, and lentils). -Desserts. -Combination foods (casseroles and soups). *The amount of carbohydrate depended on the food item and the amount consumed. <p>Review of the provider's 2006 Blood Sugar Monitoring Competency 220 information revealed:</p> <ul style="list-style-type: none"> *Physician's orders were to have been followed for blood sugar testing. 	F 281		

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F 281	<p>Continued From page 22</p> <p>*For insulin dependent residents the risk of hypoglycemia was greatest during the time of peak insulin effect.</p> <p>*Elderly residents might be prone to hypoglycemia during the night.</p> <p>*Rapid acting insulins such as Novolog included the following:</p> <ul style="list-style-type: none"> -Administration must occur within fifteen minutes of mealtime due to rapid action. -Might be ordered to be administered after the meal due to rapid onset of action. -Very effective for managing mealtime glucose elevations. -Onset of action was fifteen minutes or less. -Peaked at one half to one hour. -Duration was from three to five hours. <p>1b. Review of resident 13's medical record revealed:</p> <p>*A 2/1/16 physician's order for:</p> <ul style="list-style-type: none"> - "Make sure she gets insulin within 15 minutes of starting meal or 15 minutes after finishing meal." - "Novolog Solution 100 unit/ml [milliliters] (Insulin Aspart) [a fast-acting form of insulin] inject as per sliding scale." <p>*The amount to have been given was based on blood sugar levels on a sliding scale as follows:</p> <ul style="list-style-type: none"> -170 mg/dl to 230 mg/dl: 1 unit. -231 mg/dl to 290 mg/dl: 2 units. -291 mg/dl to 350 mg/dl: 3 units. -351 mg/dl to 400 mg/dl: 4 units. -401 mg/dl to 450 mg/dl: 5 units. -451 mg/dl to 550 mg/dl: 6 units. -551 mg/dl to 600 mg/dl: 7 units. <p>-Notify physician if blood sugars above 500 mg/dl.</p> <p>Review of resident 13's BS levels on the MAR from 10/1/15 through 2/29/16 revealed:</p> <p>*On 12/9/15 at 7:00 a.m. 111 units of insulin was</p>	F 281		
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F 281	<p>Continued From page 23 documented for a BS of 213. -The above needed to have been 1 unit for that BS. -On 2/24/16 at 5:00 p.m. 10 units of insulin was documented for a BS of 263. -The above needed to have been 2 units for that BS.</p> <p>Interview on 2/29/16 at 6:00 p.m. with LPN G and MA M regarding resident 13 revealed: *Her BS had been 367 mg/dl at 4:30 p.m. before her evening meal. *She ate supper in the east dining room, and meal service started at 6:15 p.m. *Based on the resident's sliding scale schedule, she was to have been given 4 units of Novolog insulin before the meal. *The resident was also to have been given insulin based on how much carbohydrate she consumed at meals. *LPN G stated the resident had received no sliding insulin based on the BS obtained earlier because "most of the time they are given together." *She had planned to provide the sliding scale insulin at the same time as the insulin needed based on her carbohydrate intake at the evening meal.</p> <p>Observation on 2/29/16 at 6:35 p.m. with LPN G regarding resident 13 revealed: *She estimated the resident had consumed 75 grams of carbohydrate at the evening meal with a calculation of 12 units of insulin needed for that amount. *She added 4 units of insulin from the results of the BS at 4:30 p.m. to the above amount of insulin for a total of 16 units. *She obtained the Novolog FlexPen that</p>	F 281		

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F 281	<p>Continued From page 24 contained insulin and dialed 16 units.</p> <p>Observation on 2/29/16 at 6:37 p.m. of LPN G with resident 13 revealed: *She injected 16 units from the above Novolog FlexPen into the resident's abdomen. *This was a total of two hours and seven minutes since the sliding scale results from the BS had been obtained at 4:30 p.m.</p> <p>Interview on 3/1/16 at 7:40 a.m. with registered nurse (RN) N regarding resident 13 revealed her expectation for the time of Novolog as a sliding scale insulin with levels greater than 170 mg/dl was to have given it "within a few minutes or as soon as possible."</p> <p>Interview on 3/1/16 with RN L at 9:10 a.m. regarding resident 13 revealed her expectation for timing of Novolog as a sliding scale insulin based on BS level results was before eating her meal.</p> <p>Interview on 3/1/16 at 9:55 a.m. with the consultant pharmacist revealed his expectation for timing of Novolog as a sliding scale insulin based on BS level results was within one-half hour and before a meal.</p> <p>Review of the May 2015 manufacturer's information for Novolog revealed: *Subcutaneous (below the skin) injections of Novolog "should generally be given immediately (within 5 to 10 minutes) prior to the start of a meal." *Hypoglycemia (low BS) was the most common adverse effect of all insulin therapies including Novolog.</p>	F 281		

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F 281	<p>Continued From page 25</p> <p>Interview on 3/1/16 at 6:00 p.m. with the director of nursing (DON) regarding resident 13 revealed:</p> <ul style="list-style-type: none"> *Novolog insulin used for a sliding scale needed to have been given in a timely manner and according to physician's orders. *She agreed the current system for insulin administration based on the amount of carbohydrates consumed at meals needed to have been followed according to physician's orders. *She agreed additional education to the nursing staff would have decreased the risk for error and inconsistency. <p>Surveyor: 26180</p> <p>Interview on 3/2/16 at 2:00 p.m. with the clinical education coordinator revealed she:</p> <ul style="list-style-type: none"> *Did not feel prepared to train staff on a carb count diet. *Prior to the incident with resident 13 she had not been trained on carb count. -After that incident she had received about 15 minutes of training on carb count. She did not feel that was sufficient to train others. *They had contacted another health care entity to provide training but that had not occurred. <p>Surveyor: 22452</p> <p>Review of South Dakota Board of Nursing's The Practice of Nursing, 20:48:04.01:07:</p> <ul style="list-style-type: none"> **"The scope of practice of the RN and the LPN is dependent upon each nurse's basic education and demonstrated competence in additional skills acquired through in-service, continuing education, or graduate studies." **"A licensee is personally responsible for the actions that the licensee performs relating to the nursing care furnished to clients [residents] and cannot avoid this responsibility by accepting the 	F 281		

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F 281	<p>Continued From page 26</p> <p>orders or directions of another person." **"The RN shall recognize and understand the legal implications of delegation and supervision."</p> <p>Surveyor: 32331 Review of the provider's May 2012 Medication Administration - General Guidelines policy revealed: *Medications were to have been administered as prescribed in accordance with good nursing principles and practices. *Medications were to have been administered in accordance with written orders of the prescriber.</p> <p>Todd P. Semla et al., Geriatric Dosage Handbook, 16th Ed., American Pharmacists Association, Hudson, Ohio, 2011, p. 2006, revealed the before meal blood sugar level laboratory value range was 70-130 mg/dl.</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, pp. 206-208 and p. 1023, revealed: **"The nursing process is a critical thinking process that professional nurses use to apply the best available evidence to caregiving and promoting human functions and responses to health and illness." **"Assessment is the deliberate and systematic collection of information about a patient to determine his or her current and past health and functional status." **"The purpose of the assessment is to establish a database about patients perceived needs, health problems, and responses to these problems." *Hypoglycemia signs and symptoms had included sweating, shakiness, confusion, and loss of consciousness.</p>	F 281		
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F 281	<p>Continued From page 27 Surveyor: 35625 2. Review of resident 1's medical record and medication administration record revealed: *She was admitted on 2/26/16 following a hospitalization. *Had the following diagnoses: -Sepsis (infection in the blood). -Cellulitis (infection in the skin). -Pneumonia. -Heart failure. -Atrial fibrillation (heart does not beat properly). -Anemia (low amount of red blood cells). -Chronic kidney disease. -Gastric reflux. -Underactive thyroid. *Was normally oriented to person, place, and time. *On 2/26/16 at 8:55 p.m. she had been administered two tablets of Lortab 5-325 milligrams (a controlled pain medication). *A written prescription was faxed to the facility by her primary medical provider on 2/27/16 at 9:11 p.m.</p> <p>Interview on 2/29/16 at 2:35 p.m. with resident 1's family revealed: *She had been administered two pain pills during the evening of 2/26/16. *The resident and family were told during the day shift on 2/27/16 they were unable to give the same pain medication that was given the previous evening at the facility (Lortab 5-325 milligrams) until the physician submitted a written prescription as it was a controlled pain medication. *The family expressed concern regarding how they were able to administer the medication on 2/26/16 if the paperwork was not in place.</p>	F 281		
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F 281	<p>Continued From page 28</p> <p>Interview on 3/1/16 at 8:45 a.m. with resident 1 revealed her pain level had increased significantly while she was waiting for the paperwork to be in place so the Lortab could be given.</p> <p>Interview on 3/2/16 at 1:15 p.m. with the DON revealed: *She had met with the family during the late afternoon of 2/29/16 to discuss their concerns including her pain medication. *It was her expectation a controlled substance must have a written prescription before it was to be administered to a resident. *She acknowledged that a written prescription was not in place when the medication was administered on 2/26/16 at 8:55 p.m.</p> <p>Review of the provider's May 2012 Controlled Substance Prescriptions policy revealed: **"Before a controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribe. *A chart order is not equivalent to a prescription for controlled drugs."</p> <p>Surveyor: 34030 3. Observation on 3/1/16 at 9:55 a.m. of resident 10 in her wheelchair in her room on the 100 wing revealed: *She had wheeled it close to the bathroom door. *She got up out of the wheelchair and went into the bathroom. *Her TABS alarm (personal alarm) was not connected to her and did not sound. *Her call light was attached to her bed on the other side of the room.</p> <p>Interview immediately afterwards with her</p>	F 281			

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F 281	<p>Continued From page 29</p> <p>roommate revealed "she sometimes does that by herself."</p> <p>Observation and interview on 3/1/16 at 10:10 a.m. with CNA F regarding resident 10 revealed: *This surveyor put the call light on. *CNA F responded and was told what had happened. *She helped the resident back to her chair from the bathroom and replaced the TABS alarm. *Stated "she [resident 10] sometimes takes it [the TABS alarm] off." *She had reported it to a nurse "a while back but did not remember who." *She then reported it to RN C, who did not usually work in the 100 wing but stated she would check into it.</p> <p>Review of resident 10's medical record revealed she: *Required assistance from staff to get up and to go to the bathroom. *Had poor judgement and mental capacity. *Would not wait for staff to help her. *Had a physician's order for a pad alarm to be placed in her wheelchair and in her bed for safety.</p> <p>Review of resident 10's 2/29/16 treatment administration record revealed "Pad alarm (a pad placed under the resident that alarms) in w/c [wheelchair] when up and in bed at hs [night] for lack of safety awareness. Ordered 12/9/15."</p> <p>Observation on 3/2/16 at 9:15 a.m. of resident 10 in her wheelchair revealed a pad alarm on the wheelchair seat.</p> <p>Interview on 3/2/16 at 3:30 p.m. with the DON regarding resident 10 revealed the correct alarm</p>	F 281		

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F 281	<p>Continued From page 30 should have been used.</p> <p>Surveyor: 26180 4. Review of resident 15's 1/22/16 physician's orders revealed he had an order to be weighed three times a week every Monday, Wednesday, and Friday.</p> <p>Review of resident 15's weight records revealed he had been weighed: *Six times in August 2015. *Three times in September 2015. *Five times in October 2015. *Four times in November 2015. *Two times in December 2015. *Two times in January 2016. *One time in February 2016.</p> <p>Interview on 3/2/16 at 7:45 a.m. with the DON regarding resident 15 revealed: *They had not followed the physician's orders regarding weighing the resident. *She thought the registered dietitian (RD) was going to contact the physician about having the weights done at dialysis. -She did not know if that had been done.</p> <p>Interview on 3/2/16 at 10:20 a.m. with the RD regarding resident 15 revealed: *She had talked with the DON about having the resident weighed at dialysis, because she felt that was more beneficial information for care planning. -At that time they had not arranged for dialysis to communicate the weights to them routinely. -She had spoken with the dietitian at dialysis about one time per month about the resident's weights. *She confirmed they had not been weighing the</p>	F 281			

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F 281	<p>Continued From page 31 resident as the physician had ordered.</p> <p>Surveyor: 22452 5. Review of resident 3's medical record revealed: *An 11/16/15 admission date. *Diagnoses included: paraplegia (paralyzed below the waist), neuromuscular dysfunction (non-working) of the bladder, osteomyelitis (bone infection), low back pain, and stage 4 pressure ulcer (sore exposing bone).</p> <p>Interview on 3/1/16 at 1:45 p.m. with resident 3 revealed he: *Voiced a pain rating of 8 on a 1 to 10 scale (1 being minimal pain and 10 being severe pain) before he had his pressure ulcer dressing changed on his buttock area. *Had just received a morphine (narcotic pain medication) about 12:00 noon and would receive an as needed (PRN) oxycodone (narcotic pain medication) about 2:00 p.m. *Voiced a pain rating of 9 after the pressure ulcer dressing change. *Had almost constant pain in his back of about a 9 to 10. *Had a pain rating of 7 at the best. *Sometimes he got upset with the staff when they did not come soon enough with his pain medications and his PRN Ativan (anti-anxiety medication). *Wished his pain medications would be on schedule, so he would not have to wait for them so long.</p> <p>Review of resident 3's February 2016 medication administration record (MAR) revealed: *Morphine was documented as administered two to four times a day for a pain rating of 5 to 9 with</p>	F 281		
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F 281	<p>Continued From page 32</p> <p>"effective" pain relief voiced by the resident. *Oxycodone was documented as administered three to four times a day for a pain rating of 5 to 10 with "effective" pain relief voiced by the resident. *Ativan was documented as administered one to three times a day for anxiety with "effective" relief voiced by the resident.</p> <p>Review of resident 3's 11/27/15 facsimile sent to the physician revealed: *"Resident is complaining of constant pain to his back and shoulder. Taking PRN pain and anti-anxiety medications frequently." *"He is requesting his pain and anti-anxiety medications to be scheduled. He is exhibiting behaviors towards staff and is telling staff that he will drop himself to the floor if he does not get his PRN medications on time." *Physician response was "He really needs a psychiatric evaluation. I would like not to start psychiatric medications until that is completed."</p> <p>Review of resident 3's medical record revealed no documentation of a psychiatric evaluation.</p> <p>Interview on 3/2/16 at 11:30 a.m. with the DON regarding resident 3 revealed she: *Knew the nurses were routinely giving him the oxycodone and morphine about every two hours for his pain control. *Had thought the morphine had originally been scheduled three times a day by the physician. *Confirmed there had not been a psychiatric evaluation set-up yet. *Had informed social worker (SW) D on 11/27/15 when the order had been obtained, and he was to have set-up the appointment. *Had been informed by SW D today he had called</p>	F 281		

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F 281	<p>Continued From page 33</p> <p>the psychiatric clinic today to set-up the evaluation, but it would be a while due to staffing issues at the clinic.</p> <p>Interview on 3/2/16 at 11:40 a.m. with SW D regarding resident 3 revealed he did not remember being informed on 11/27/15 regarding the need to set-up a psychiatric evaluation.</p> <p>Interview on 3/2/16 at 12:15 p.m. with resident 3's physician revealed he:</p> <ul style="list-style-type: none"> *Had been informed today by the DON the psychiatric evaluation had not been set-up 11/27/15 when he had ordered it. *Knew it might be a while before the psychiatrist would be able to get out to see the resident. *Really wanted to wait until that evaluation was done before he made any changes to his pain medication regimen due to his past history of non-compliance and substance abuse issues. *Thought he was on something scheduled for pain instead of all his narcotics being PRN. He would review getting something scheduled today. <p>6. Observation on 3/2/16 at 11:00 a.m. of resident 11's Symbicort inhaler (asthma control) in the medication cart revealed:</p> <ul style="list-style-type: none"> *There were eighty-two inhalations left in the inhaler. *There was documentation the inhaler was filled by the pharmacy on 8/31/15. When full the inhaler contained one hundred twenty inhalations. *There was also an empty Symbicort inhaler box filled by another pharmacy. The inhaler for that box was not in the medication cart. <p>Interview on 3/2/16 at 11:10 a.m. with RN N regarding resident 11 revealed:</p> <ul style="list-style-type: none"> *She stated "It does not make any sense." 	F 281		

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F 281	<p>Continued From page 34</p> <p>*The resident received two puffs of the inhaler four times a day. One full inhaler (one hundred twenty doses) would last only thirty days if it had been administered according to the physician's orders.</p> <p>*There was no documentation the resident had ever refused a dose or a dose had been held.</p> <p>*She did not know why the empty Symbicort box was in the medication cart without an inhaler. She thought maybe the resident brought that inhaler into the facility, because she only had received her medication from the pharmacy that filled the inhaler on 8/31/15.</p> <p>*She agreed it could not be certain the resident had received the Symbicort inhaler two puffs four times a day as ordered by the physician.</p> <p>7. Observation on 3/2/16 at 10:30 a.m. of resident 24's Advair (control of asthma) inhaler on the medication cart revealed:</p> <p>*There were thirty doses left in the inhaler.</p> <p>*There was documentation on the inhaler box it had been opened on 2/4/16. When full the Advair inhaler contained sixty doses.</p> <p>Interview on 3/2/16 at 10:40 a.m. with RN L regarding resident 24 revealed:</p> <p>*It was not possible all the doses of the Advair had been administered to the resident according to the physician's orders.</p> <p>*The resident was to have received one puff of the Advair inhaler twice a day.</p> <p>*A full inhaler of Advair would last thirty days.</p> <p>*She knew once opened the Advair inhaler could be used for thirty days before it expired.</p> <p>*She stated there was no documentation from 2/4/16 through 3/1/16 that any doses of the Advair inhaler had been held or refused by the resident.</p> <p>*The resident had cognitive (memory) impairment</p>	F 281		
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F 281	<p>Continued From page 35</p> <p>and would not be able to remember if she had received all the doses of the Advair.</p> <p>*There should have been five doses left of the Advair inhaler instead of thirty.</p> <p>*Twenty-five doses of the Advair inhaler had been documented as administered and had not been.</p> <p>8. Observation on 3/2/16 at 1:00 p.m. of resident 25's Advair inhaler in the medication cart revealed:</p> <p>*There was no documentation of the date when the inhaler had been opened.</p> <p>*It had been filled by the pharmacy on 2/10/16 and had contained sixty doses.</p> <p>*There were forty-six doses left in the inhaler.</p> <p>*The resident was to have been administered the Advair inhaler one puff twice a day.</p> <p>*There was no documentation any doses had been held or refused since 2/10/16.</p> <p>Interview on 3/2/16 at 2:00 p.m. with the DON regarding resident 25 revealed:</p> <p>*There should have been an opened date on the Advair inhaler.</p> <p>*The inhaler was good for thirty days after it had been opened.</p> <p>*There was no way to tell when the inhaler would expire.</p> <p>*There was no control and accountability without an opened date if all the doses of the Advair inhaler had been administered according to the physician's orders.</p> <p>Review of the provider's May 2012 Medication Administration General Guidelines policy revealed:</p> <p>***Medications are administered as prescribed in accordance with good nursing principles and practices.**</p>	F 281		
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F 281	<p>Continued From page 36</p> <p>***Prior to administration, the medication and dosage schedule on the resident's MAR are compared with the medication label. If the label and the MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physicians' orders are checked for the correct dosage schedule.</p> <p>***The expiration date on the packaging/container is checked.</p> <p>***The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given.</p> <p>***If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record.</p> <p>Surveyor: 35625 B. Based on observation, interview, record, review, and policy review, the provider failed to ensure the five rights of medication administration were followed for 2 of 18 sampled residents (1 and 26). Findings include:</p> <p>1. Interview on 2/29/16 at 2:35 p.m. with resident 1's family revealed: *On 2/26/16 her son had stayed overnight. *He was awakened when RN B came in the room to administer insulin. *He stopped RN B and told her his mother was not prescribed insulin. *He verbalized the insulin was intended for the resident in the room next to his mother's (resident 30). *The son stated he spoke with RN C on 2/27/16</p>	F 281		

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F 281	<p>Continued From page 37 regarding the insulin and a grievance was completed as a result.</p> <p>Interview on 3/1/16 at 8:45 a.m. with resident 1 revealed she was very tired that night and did not clearly recall the insulin event. She knew her son had taken care of it.</p> <p>Review of resident 1's medical record revealed she: *Was admitted on 2/26/16 following a hospitalization. *Had the following diagnoses: -Sepsis (infection in the blood). -Cellulitis (infection in the skin). -Pneumonia. -Heart failure. -Atrial fibrillation (heart does not beat properly). -Anemia (low amount of red blood cells). -Chronic kidney disease. -Gastric reflux. -Underactive thyroid. *Required the assistance of two staff and the use of the full-body lift for all transfers. *Was normally oriented to person, place, and time. *Did not have an order for insulin at the time of the above event.</p> <p>Review of the medical record for resident 30 (the resident next door to resident 1) revealed she had an order for 36 units of NPH insulin (intermediate acting) to be given at bedtime.</p> <p>Interview on 3/2/16 at 9:45 a.m. with RN C regarding resident 1 revealed: *She had met with resident 1's son on 2/27/16, and he expressed the concern regarding the insulin.</p>	F 281		
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F 281	<p>Continued From page 38</p> <p>*A grievance was completed as a result of the conversation and forwarded to the director of social services.</p> <p>Interview on 3/2/16 at 10:10 a.m. with the director of social services revealed RN C had submitted a grievance. It had been passed on to the director of nursing (DON) for further investigation.</p> <p>Interview on 3/2/16 at 1:15 p.m. with the DON regarding the above insulin incident with resident 1 revealed:</p> <p>*She was currently investigating a grievance filed by the family and submitted by RN C.</p> <p>*RN B had not been interviewed yet but would be when she came in for her next shift that was scheduled for the night of 3/2/16.</p> <p>*She acknowledged resident 1 could have been given the medication had her son not stepped in.</p> <p>*It was her expectation nursing staff follow the five rights of medication and complete the triple check.</p> <p>Surveyor: 22452</p> <p>2. Observation on 3/1/16 at 7:58 a.m. during an observed medication pass revealed RN O:</p> <p>*Was preparing to administer ferrous sulfate (iron supplement) 325 mg one tablet to resident 26.</p> <p>*Compared the stock bottle of ferrous sulfate to the resident's MAR.</p> <p>*Stated the resident's MAR indicated ferrous sulfate 10 mg.</p> <p>*Stated ferrous sulfate only came in 325 mg.</p> <p>*Was unsure why the MAR said 10 mg instead of 325 mg.</p> <p>*Was going to call the physician's office to clarify the dosage before she administered it.</p> <p>*Was unsure why the other staff had been initialing 10 mg on the MAR when they had been</p>	F 281		

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F 281	<p>Continued From page 39 administering a 325 mg tablet.</p> <p>Review of the provider's May 2012 Medication Administration General Guidelines policy revealed: *"Five rights-right resident, right drug, right dose, right route, and right time, are applied for each medication being administered." *"A triple check of the five rights is recommended at three steps in the process of preparation of a medication for administration: [1] when the medication is selected, [2] when the dose is removed from the container, and finally, [3] just after the dose is prepared and the medication put away."</p> <p>Surveyor: 34030 C. Based on record review and interview, the provider failed to ensure one of five sampled residents (14) had an appropriate diagnosis for the use of an antipsychotic medication. Findings include:</p> <p>1. Review of resident 14's medical record revealed: *An admission date of 10/28/14. *She was on Zyprexa (antipsychotic medication) (a medication used to treat psychosis or delirium).</p> <p>Review of a 1/4/16 Clinical Pharmacist Letter to resident 14's physician revealed: *She had recently been discharged from the hospital with the above medication. *The current diagnosis she had for the medication was disorientation. -That diagnosis did not meet the federal regulatory guidelines. *A recommendation was made to the physician to review the diagnosis for one that was appropriate</p>	F 281		
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F 281	<p>Continued From page 40</p> <p>and if none were, to consider a dose reduction for the medication with the goal of stopping it. *At the bottom of the letter was an area for the physician's response and signature. It was blank as no response had been added.</p> <p>Interview on 3/2/16 at 10:45 a.m. with RN C regarding the above letter revealed: *It did not appear to have been sent to resident 14's physician to review. *It should have been brought to the physician's attention. *The resident had recently moved from the 200 wing to the 300 wing. *"I think it got missed."</p> <p>Interview on 3/2/16 at 3:30 p.m. with the director of nursing revealed she would have expected the recommendation made by the pharmacist for resident 14 to have been followed up in a timely manner.</p> <p>Review of the provider's pharmacy May 2012 Documentation and Communication of Consultant Pharmacist Recommendations policy revealed: *"Comments and recommendations concerning medication therapy are communicated in a timely fashion. The timing of these recommendations should enable a response prior to the next medication regimen review." *"Recommendations are acted upon and documented by the facility staff and/or the prescriber. If the prescriber does not respond to recommendation directed to him/her in a timely manner, the Director of Nursing and/or the consultant pharmacist may contact the Medical Director."</p>	F 281		
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F 281	<p>Continued From page 41 Surveyor: 22452 D. Based on observation and interview, the provider failed to follow professional standards for the documentation of medication after administration by one of six sampled nurses (G). Findings include:</p> <p>1. Observation on 2/29/16 at 5:10 p.m. of LPN G during an observed medication pass revealed she: *Administered three pills to resident 8. *Pushed "yes" and "save" on the electronic MAR.</p> <p>Interview at that time with LPN G regarding the above revealed: *By hitting "yes" and "save" prior to administering the pills to resident 8, she had documented she had administered the pills before giving them to the resident. *If resident 8 had refused the pills, she would have gone back to the electronic MAR and document refusal. *She always hit yes and save prior to administering her medications.</p> <p>Review of the South Dakota Board of Nursing statement dated 10/17/06 revealed "It is the position of the South Dakota Board of Nursing that the standard for safe administration of medication includes the practice of documenting medication following administration to the patient [resident]."</p> <p>E. Based on onbservation, interview, and record review, the provider failed to ensure communication with the interdisciplinary team regarding one of one sampled resident (18) with suicidal ideations. Findings include:</p>	F 281		

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F 281	<p>Continued From page 42</p> <p>1. Observation on 3/1/16 at 11:30 a.m. of resident 18 during an observed medication pass revealed: *The resident was sitting in her room in her wheelchair. She was talking to a counselor from a mental health facility. *She was verbally very loud and crying out about her failing vision, and that she was going blind. "I am going to kill myself if I go blind." *RN L obtained her blood sugar and administered her dose of insulin to her during the resident's above comments of killing herself. *The counselor in the room stated that was the worst he had ever seen her.</p> <p>Interview at that time with RN L regarding resident 18 revealed she: *Was not sure what was wrong with her vision. *Felt the resident had multiple behaviors and mood swings due to her diagnosis of major depressive and anxiety disorder. *Made no comment of informing any of the staff regarding the resident's comment of killing herself.</p> <p>Review on 3/2/16 at 1:30 p.m. of resident 18's medical record revealed no documentation regarding her 3/1/16 comments of killing herself.</p> <p>Interview on 3/2/16 at 2:30 p.m. with SW D regarding resident 18 revealed: *He was not the resident's usual SW. SW P was her social worker and had gone home for the day. *SW P had made no comment to him regarding the resident's comments of killing herself. There was no documentation in the medical record from SW P. *The counselor from the mental health facility had left no documentation for them. His documentation was usually received later.</p>	F 281		
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F 281	<p>Continued From page 43</p> <p>*He had called the counselor at the mental health facility today with the following comments from him: -"He stated that at no time during his conversation with the resident he felt she was making a legitimate threat to commit suicide. States the resident presents with a lot of drama when meeting with him and this is not uncommon. He states if he felt it was a legitimate threat of suicide he would have reported it to the facility staff." *"It is his understanding that the doctor that performed the eye procedure has not deemed that it is not a success yet." *He had checked with SW P if she was made aware of this situation on 3/1/16, and she stated she had not been made aware of any suicidal discussion from the resident.</p> <p>Interview on 3/2/16 at 2:45 p.m. with RN L and RN N regarding resident 18 revealed: *The resident was often dramatic and became very anxious about things. *She had made suicidal comments one other time, and they had implemented increased checks on her. They had removed all dangerous items from her room. They were unsure when that had been but thought in the last year. *They did not think the resident would ever follow-through on any of her comments. *RN L did not make an attempt to talk to the counselor on 3/1/16 after he had spoken with the resident. She did not know on 3/1/16 that the counselor was not concerned about the resident's comments. *RN L stated she should have made the other staff and SW P aware of the resident's comments since she had not gotten any report from the counselor he was not concerned.</p>	F 281		
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F 281	Continued From page 44 *The resident had made no further suicidal comments after she had spoken to the counselor on 3/1/16. *RN L had not documented anything regarding the above in the medical record on 3/1/16.	F 281			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 A. Based on record review, interview, observation, and policy review, the provider failed to ensure one of five sampled residents (9) with chronic pain received effective pain management. Findings include: 1. Review of resident 9's Minimum Data Set (MDS) assessments revealed: *7/3/15: He had seven pressure ulcers on his feet. He had occasional pain he rated as an 8 on a scale of 1 to 10. He had not received any pain medications. *1/15/16: He had four pressure ulcers on his feet. The other pressure ulcers had healed. He received no scheduled pain medications, but received as needed (PRN) pain medications. He had frequent pain, and he rated it 8 on a scale of 1 to 10.	F 309	F 309 Provide Care and Services for Highest Well Being Resident #9 has had a pain evaluation completed and a pain management program has been implemented. Resident #14 care plan has been reviewed with Hospice and has been integrated to reflect current plans to meet resident needs. Residents residing in the facility experiencing pain or are being provided with Hospice Services have the potential to be affected in a similar manner. Residents with pain requiring use of PRN pain medications have had pain evaluation completed and a pain management program has been implemented. Residents who are receiving Hospice Services have had care plans reviewed with Hospice and has been integrated to reflect current plans to meet resident needs.		

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F 309	<p>Continued From page 45</p> <p>Review of resident 9's 8/10/15 care plan revealed: Focus: "Needs Pain management and monitoring related to Osteoarthritis, Osteoporosis, Peripheral Neuropathy, Wound, Chronic back pain and Dental pain." *Interventions: Evaluate need for routinely scheduled medications rather than PRN pain med (medication) administration. *Goal: Will maintain adequate level of comfort as evidenced by no s/sx [signs and symptoms] of unrelieved pain or distress, or verbalizing satisfaction with level of comfort."</p> <p>Review of resident 9's following pain monitoring report revealed: *January 2016: He rated his pain 5 (on a scale of 1 to 10) or higher twenty-one out of thirty-seven times. *February 2016: He rated his pain 5 or higher twenty-five out of thirty-nine times.</p> <p>Review of resident 9's 1/31/16 physician's progress notes revealed "Patient is here for checks of meds and above listed problems which have been fairly stable with no new concerns raised from the NH [nursing home]. History is provided by self, chart, nursing staff. Pain is well controlled."</p> <p>Review of resident 9's February 2016 medication administration record (MAR) revealed he received the following pain medications on a PRN basis including: *Oxycodone-acetaminophen tablet 5-325 milligrams (mg) one tablet every four hours as needed for pain, nine times. *Oxycodone-acetaminophen tablet 5-325 mg two</p>	F 309	<p>The Executive Director, Director of Nursing and Interdisciplinary Team have reviewed the pain management guideline.</p> <p>Department managers and nursing staff have been re-educated on the care plan process including the integration of Hospice Services.</p> <p>Licensed Nursing staff have been reeducated on the pain management guideline.</p> <p>All Licensed Nursing Staff were required to attend the in-service. Staff that were not able to attend the in-service were required to read policy and complete a post-education quiz to demonstrate understanding. No staff will be allowed to return to duty without reviewing these materials.</p> <p>Director of nursing or designee will complete 5 random audits weekly x4 then monthly x2 to ensure residents pain management program is effective and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>	3-31-16

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F 309	<p>Continued From page 46</p> <p>tablets every four hours as needed for pain, twelve times.</p> <p>*Tramadol HCL tablet 50 mg give 100 mg by mouth every 12 hours as needed for pain, nine times.</p> <p>*Tramadol HCL tablet 50 mg give 50 mg by mouth every 12 hours as needed for pain, six times.</p> <p>*Tylenol tablet 325 mg give 650 mg by mouth every 6 hours as needed for pain related to generalized pain, none.</p> <p>Interview and review of resident 9's pain monitoring record on 3/1/16 at 8:45 a.m. with registered nurse (RN) L revealed: *He did not receive any pain medications on a scheduled basis. *All of his pain medications were ordered to be given as needed. *Based on his pain monitoring he continued to have pain. *They should have possibly considered a scheduled pain medication.</p> <p>Interview and review of resident 9's pain monitoring and MAR on 3/1/16 at 10:25 a.m. with the consulting pharmacist revealed he did not know if he would have recommended a scheduled pain medication despite the resident continuing to have pain. He was not really familiar with the patient's medical condition.</p> <p>Review of resident 9's 8/13/15 Care Area Assessment (CAA) revealed "He stated he experiences at most 8/10 pain occasionally in foot/ankles due to skin concerns and edema. He states pain can limit day to day activities. He has PRN pain meds though he has not requested despite his statement of pain. Will discuss</p>	F 309			

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F 309	<p>Continued From page 47</p> <p>possible needing scheduled pain medication though when resident first admitted to hospital in June they stopped scheduled pain meds due to AMS [altered mental status]."</p> <p>Interview on 3/2/16 at 7:15 a.m. with registered nurse (RN) H regarding resident 9 revealed: *It depended on where the resident said he had pain if he was offered a pain pill. -If the resident complained his back hurting, he would reposition him to see if that relieved the pain. *He usually waited for the resident to request a pain medication. He did not offer him one. *He had offered a pain medication to him before he did the dressing change on his feet, because he had feeling in his feet. His dressing changes were daily.</p> <p>Interview and observation of resident 9 on 3/1/16 at 12:30 p.m. revealed: *He had pain in his feet and could feel when they did the dressing change on them. *Sometimes he had pain around his catheter. *He was not always offered something for his pain, but he had pain quite a bit of the time.</p> <p>Interview on 3/2/16 at 1:50 p.m. with MDS coordinator K regarding resident 9 revealed: *She had completed the 8/13/15 CAA and acknowledged that he continued to have pain. *She agreed he might have benefited from a scheduled pain medication. *She thought she had talked to another nurse about following up on that recommendation, but there was nothing documented regarding any follow up.</p> <p>Review of resident 9's monthly pharmacy</p>	F 309		
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F 309	<p>Continued From page 48</p> <p>consultations from July 2015 through February 2016 revealed there had been no evaluation or recommendation to consider a scheduled pain medication.</p> <p>Interview on 3/2/16 at 7:50 a.m. with the director of nurses regarding resident 9 revealed: *They should have looked at the source of his pain and tried to control it. *There should have been a review of his use of PRN medications and evaluated for a scheduled pain medication. -That had not been done.</p> <p>Review of the provider's May 2012 Medication Monitoring Medication Regimen Review policy revealed the pharmacist was responsible for evaluating: *"The prescribed dose is appropriate to the resident's clinical status. *Assisting facility in defining schedules for administering medications to maximize the effectiveness."</p> <p>Review of the provider's February 2015 pain management guideline policy revealed: *"Guideline statement: To provide guidance for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life in concert with the patient's [residents] plan of care and goals for pain management." *Functions of appropriate pain management include but are not limited to: Recognize that patients who have chronic pain will benefit most from an effective, scheduled pain medication regimen." Surveyor: 34030 B. Based on record review and interview, the</p>	F 309		

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F 309	<p>Continued From page 49</p> <p>provider failed to integrate the hospice plan of care with the provider's plan of care to specify who was responsible for the care for one of two sampled hospice residents (14). Findings include:</p> <p>1. Review of resident 14's medical record revealed an admission on 10/28/14. Hospice care had started 2/6/16.</p> <p>Review of resident 14's care plan revealed: *Three different printed dates: most of it had been printed on 11/13/14, then there were two page 1's with printed dates of 2/2/16 and 3/1/16. *On the 3/1/16 page 1 of the care plan under focus for therapeutic diet was added "Transition to hospice cares." *No where else on the care plan did it mention hospice.</p> <p>Review of resident 14's undated 300 Wing Report Sheet the nurses and certified nursing assistants (CNA) used for resident care needs revealed: *"Monday eve, [hospice provider] to give 2nd shower." *No other mention was made of who was responsible for what care for the resident.</p> <p>Interview on 3/2/16 at 11:05 a.m. with CNA E regarding the care of resident 14 revealed: *She usually worked with the resident and on the 300 wing. *She knew when hospice gave the shower, otherwise "if they're not here, I do all the care." *She was unsure what other days hospice was there or what other care they gave the resident.</p> <p>Interview on 3/2/16 at 10:45 a.m. with registered nurse C regarding updating care plans revealed: *She usually worked Monday through Thursday.</p>	F 309		
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F 309	Continued From page 50 *She was responsible for updating care plans for the 300 wing but was frequently doing medication pass for the residents instead. *Resident 14 had recently moved from the 200 wing to the 300 wing. **"The aides use the Wing Report Sheet for information on how to care for the residents. There is no report except from one CNA to the next." *Stated she had "not really been trained on when to update care plans" and was unaware of the need to integrate the hospice care plan with the provider's care plan. Interview on 3/2/16 at 3:30 p.m. with the director of nursing revealed she agreed it would be difficult for staff to know what care hospice gave and what staff were to do for resident 14 based on the care plan. No hospice specific policy on resident care plans existed.	F 309		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of	F 425	F425 Pharmaceutical Services , accurate procedures RPH. All medication carts and medication rooms have been audited and any beyond use items have been removed. Liquid Medications have been reconciled for resident #27 & #28. Resident # 29 Metoprolol has been reconciled. Residents residing in the facility have the potential to be affected in a similar manner. Residents receiving high risk medication in liquid form or those requiring precise measurement medications have been reconciled.	

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F 425	<p>Continued From page 51</p> <p>a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to ensure: *Beyond-use medications had been removed from three of five medication/treatment carts (100, 300, and 400 wings) and two of two medication rooms. *The reconciliation count of a controlled liquid narcotic was accurate for two of two sampled residents (27 and 28). *The amount of a medication dispensed by the pharmacy could be reconciled to what had been administered for one of one sampled resident (29). Findings include:</p> <p>1. Observation on 3/2/16 from 10:30 a.m. to 1:30 p.m. of the above medication carts and the medication rooms revealed the following expired medications: *100 wing medication cart: Genteal eye drops expired January 2016, a bottle of hydrogen peroxide expired March 2015, and a bottle of isopropyl alcohol expired August 2015. *100 and 200 wing medication room: a bottle of potassium chloride and a box of albuteral sulfate inhalation solution expired February 2016. *300 wing medication cart: a stock bottle of geri max antacid expired December 2015, a stock bottle of liquid pain relief expired February 2016,</p>	F 425	<p>The Executive Director, Director of Nursing and Pharmacy Consultant have reviewed the CMS guidance related to LIQUID CONTROLLED DRUG ACCOUNTABILITY AND DISCREPANCIES and Medication Administration General Guideline Policy</p> <p>Licensed Nurses have been reeducated on the CMS guidance related to LIQUID CONTROLLED DRUG ACCOUNTABILITY AND DISCREPANCIES and Medication Administration General Guideline Policy. Punch cards will be dated upon first punch to assist in reconciliation.</p> <p>Director of nursing or designee will complete 5 random audits weekly x4 then monthly x2 to ensure residents liquid medication closely reflects amount documented on the accountability forms. Punch cards will be dated upon first punch to assist in reconciliation and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>	3-31-16
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F 425	<p>Continued From page 52</p> <p>twenty-four tablets of ondansetron expired October 2015, and twenty-nine tablets of promethazine expired October 2015.</p> <p>*400 wing medication cart: a bottle of Novolog insulin expired 3/1/16.</p> <p>*300, 400, and 500 wing medication room: a bottle of Renacin solution opened December 2015 in the medication refrigerator.</p> <p>Interview with pharmacy technician I regarding the Renacin solution revealed the solution expired thirty days after opened.</p> <p>Interview on 3/2/16 at 11:30 a.m. with registered nurse (RN) N regarding the other expired medications revealed it was the responsibility of all the nurses to removed expired medications from the medication/treatment carts and the medication rooms.</p> <p>2. Observation on 3/2/16 at 10:45 a.m. of resident 27's bottle of liquid hydrocodone (controlled pain medication) revealed there was 400 milliliters (ml) in the bottle.</p> <p>Review of resident 27's controlled substance accountability sheet revealed on 3/2/16 at 8:00 a.m. there was documentation 378 ml was in the bottle.</p> <p>Observation on 3/2/16 at 10:50 a.m. of resident 28's bottle of liquid hydrocodone revealed there was 420 ml in the bottle.</p> <p>Review of resident 28's controlled substance accountability sheet revealed on 3/2/16 at 8:00 a.m. there was documentation 404 ml was in the bottle.</p>	F 425		

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F 425	<p>Continued From page 53</p> <p>Interview on 3/2/16 at 10:55 a.m. with RN H regarding the hydrocodone revealed he:</p> <ul style="list-style-type: none"> *Confirmed the amounts in the bottles did not reconcile with the amount recorded on the accountability sheets. *Thought maybe the nurses were just subtracting the dose they administered to the residents from the previous amount of the reconciliation sheets instead of actually observing the bottles. *Agreed the amount of hydrocodone in the bottles should be the same amount that was recorded on the accountability sheets. *Revealed there was usually some over-fill of liquid in the bottles when they were sent from the pharmacy. That should have been documented on the reconciliation sheets for approximately how much. <p>3. Review of resident 29's 1/20/16 and 2/8/16 physician's orders revealed:</p> <ul style="list-style-type: none"> *1/20/16: Metoprolol (medication for high blood pressure) 25 milligrams (mg) twice a day (BID). Hold if systolic (top number of blood pressure) was less than 90. *2/8/16: Change Metoprolol to 12.5 mg BID. <p>Observation on 3/2/16 at 11:15 a.m. of resident 29's Metoprolol medication card revealed there was:</p> <ul style="list-style-type: none"> *Seventeen one-half tablets (25 mg tablet scored in half) that remained in the card. *Documentation the card had been filled by the pharmacy on 2/9/16 and contained thirty one-half tablets. *No documentation on the card when the first dose had been removed. *Only one Metoprolol medication card that was used for both the morning and evening doses. 	F 425			

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F 425	<p>Continued From page 54</p> <p>Interview on 3/2/16 at 11:20 a.m. with RN N regarding resident 29 revealed she:</p> <p>*Agreed the amount of one-half tablets of Metoprolol that remained in the medication card did not reconcile with what had been documented as administered since 2/9/16.</p> <p>*Agreed forty-three doses of Metoprolol 12.5 mg should have been administered from 2/9/16 at 6:00 p.m. through 3/2/16 at 8:00 a.m. Only thirteen one-half Metoprolol tablets had been removed from the medication card.</p> <p>*Stated someone from pharmacy had told her they sent fourteen whole tablets of Metoprolol (25 mg) to the facility on 1/20/16. The pharmacy had documentation thirty-six whole tablets of Metoprolol 25 mg had been removed from the automated dispensing unit (ADU) from 1/26/16 through 2/9/16 for resident 29. (That would total fifty tablets of Metoprolol 25 mg). Thirty-eight tablets of Metoprolol 25 mg should have been used from 1/20/16 at 6:00 p.m. through 2/8/16 at 8:00 a.m. when it was decreased to 12.5 mg on 2/8/16.</p> <p>*Was told by the pharmacy they had sent thirty one-half (25 mg scored in half) Metoprolol tablets to the facility on 2/9/16.</p> <p>*Agreed it was very difficult to truly determine if the amount of Metroprol sent from pharmacy and used from the ADU were accurate with the amount that had been documented for both the 25 mg BID and 12.5 mg doses.</p> <p>*Stated the DON had told them to date the medication cards when they removed the first pill, but most of the nurses had not been doing that.</p> <p>*Knew that often the nurses had a problem with getting some medications in a timely manner from the pharmacy.</p> <p>*Was unsure if the nurses were always informing the DON if they were having problems getting</p>	F 425			

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

PRINTED: 03/14/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/02/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
(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 425	<p>Continued From page 55</p> <p>medications from the pharmacy.</p> <p>*Stated the pharmacy often told them they had not received the facsimile (fax) requesting a refill or with new orders when the nurses had faxed them. The nurses would then have to call the pharmacy, so they could get the medication to administer to the resident.</p> <p>*Was uncertain why the nurses had to use the ADU for the Metoprolol 25 mg from 1/26/16 through 2/9/16, and the pharmacy had not sent any.</p> <p>Interview on 3/2/16 at 3:30 p.m. with the DON regarding resident 29 revealed she:</p> <p>*Knew there had been a couple incidences of the pharmacy being unable to get medications to the facility in a timely manner.</p> <p>*Had not had any recent complaints from the nurses they were having trouble getting medications from the pharmacy.</p> <p>*Agreed there should have been Metoprolol 25 mg tablets in the facility to administer from 1/26/16 through 2/9/16, and so many tablets should not have been necessary to remove from the ADU.</p> <p>*Stated usually the turn-around time was the next day if medications were ordered early in the day. If medications were emergency they would have been taken out of the ADU.</p> <p>*Agreed it was difficult to determine exactly how much Metoprolol either the 25 mg dose or the 12.5 mg dose had been sent by the pharmacy.</p> <p>*Stated pharmacy technician I had been working on trying to get the actual amount of Metoprolol dispensed by the pharmacy for resident 29 since 1/20/16.</p> <p>*Agreed it should not have been so difficult to determine the amount of any medication dispensed by the pharmacy reconciled to what</p>	F 425			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/02/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106		
(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 425	<p>Continued From page 56</p> <p>had been documented as administered.</p> <p>*Agreed it was difficult to determine if his Metoprolol had been administered according to the physician's orders since 1/20/16. She thought maybe the Metoprolol 25 mg whole tablets that were left over after the dose was changed on 2/8/16 had been broken in half to use by the nurses for the 12.5 mg dose.</p> <p>*Had told the nurses to date the medication cards when they removed the first pill from the cards, but she was not aware they had not been doing that.</p> <p>*Agreed there was not a system to reconcile medications sent from the pharmacy in a medication card to what actually was documented as administered to the residents.</p> <p>Review of the provider's May 2012 Medication Administration General Guidelines policy revealed:</p> <p>***"Medications are administered as prescribed in accordance with good nursing principles and practices."</p> <p>***"When administering high-risk medications in liquid form or those requiring precise measurement, such as digoxin or morphine, devices provided by the manufacturer or obtained from the provider pharmacy (oral syringes) are used to allow accurate measurement of doses."</p> <p>***"The expiration date on the packaging/container is checked."</p>	F 425			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
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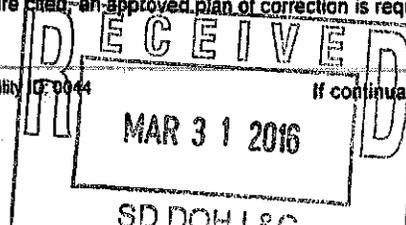
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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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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 3/3/16. Golden LivingCenter-Covington Heights (Building 01, original 1973 structure) 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 Dir. of Nursing (X6) DATE 3-24-16

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<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 3/3/16. Golden LivingCenter-Covington Heights (Building 02, 1995 acute care and therapy addition) 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		

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

TITLE

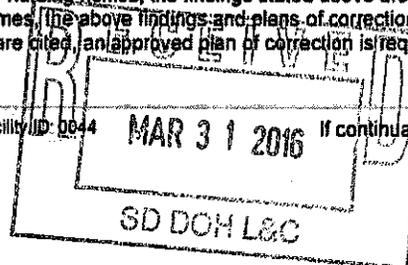
(X8) DATE

[Signature]

Dir of Nursing

3-24-16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



ORIGINAL

PRINTED: 03/15/2016
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10683	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 22452 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/29/16 through 3/3/16. Golden LivingCenter - Covington Heights was found not in compliance with the following requirement: S236.	S 000		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;	S 236	S 236 Tuberculin Screening Requirements Resident #1 has had the required TB testing completed. Residents admitted to Golden Living Center Covington Heights have the potential to be affected in a similar manner GLC -Covington Heights will adhere to the SD State Guidelines related to TB screenings. An audit of resident's files will be completed to ensure compliance to the State regulation Director of Nursing Services or designee will complete a weekly audit x 4 weeks then monthly x 2 months on all new admissions to ensure compliance. Director of Nursing will bring the results of these audits to the monthly QAPI meetings for further review and recommendations.	3-31-16

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

TITLE

Dir. of Nursing

(X6) DATE

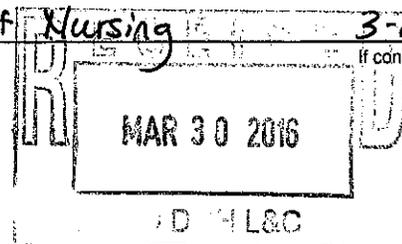
3-24-16

STATE FORM

6899

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If continuation sheet 1 of 2



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10683	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - COVINGTON HEIGHTS	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 S CATHY AVE SIOUX FALLS, SD 57106
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S 236	<p>Continued From page 1</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 22452</p> <p>Based on record review and interview, the provider failed to ensure one of one sampled newly admitted resident (1) had completed the two-step Mantoux tuberculin (TB) skin test within fourteen days of admission. Findings include:</p> <p>1. Review of resident 1's medical record revealed an 11/16/15 admission date.</p> <p>Review of resident 1's immunization record revealed: *No date: "Stated did not have first one." *There was documentation the second TB skin test had been completed on 11/26/15. "Results were area pink and a little swollen. Recheck needed." *There was no further documentation regarding any recheck.</p> <p>Interview on 3/1/16 at 1:30 p.m. with the director of nursing regarding resident 1 revealed he should have had: *The first TB skin test; she was unsure why one had not been done. *Documentation regarding follow-up for the second TB skin test.</p>	S 236	<p><i>Auditing new admissions from Jan 2016 to current for TB Testing Completion. To be completed by DCE. 3-24-16 KTRAS</i></p>	