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

ORIGINAL

PRINTED: 10/13/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435040		C 10/01/2015

NAME OF PROVIDER OR SUPPLIER
GOLDEN LIVINGCENTER - PRAIRIE HILLS

STREET ADDRESS, CITY, STATE, ZIP CODE
916 MOUNTAIN VIEW ROAD
RAPID CITY, SD 57702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 23059 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 10/1/15. Areas surveyed included quality of care, nursing services, and adequate staffing. Golden LivingCenter - Prairie Hills was found not in compliance with the following requirements: F280, F441, F500, and F514.	F 000	*Addendums noted with an asterisk per 10/29/2015 per telephone with facility interim administrator. NS/SDDOH/EL STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on October 1, 2015. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of October 29, 2015.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 280 SS=D	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: 23059	F 280	Resident #1's comprehensive care plan was revised to include physician's order for compression stockings to have been applied in the morning and removed at night due to diagnosis of lymphedema on 10/16/15 by the DNS. Resident #3 has been discharged from living center and records are closed. Residents residing in the facility who are diagnosed with lymphedema have the potential to be affected in a similar manner.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Christina Malvern
TITLE: Executive Director
(X6) DATE: 10-19-15

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

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F 280	Continued From page 1 Based on record review, interview, and policy review, the provider failed to review and revise care plans for two of six sampled residents (1 and 3) to reflect their current status and needs. Findings include: 1. Review of resident 1's 8/4/15 physician's orders revealed an order for compression stockings to have been applied in the morning and removed at night. He was to have worn those stockings because of a diagnosis of lymphedema (excessive swelling). Review of the resident's revised 9/2/15 care plan revealed he had a focus area of being at risk for alteration in hydration related to edema, diuretic (eliminates fluid from the body) use, congestive heart failure (excessive amount of fluid build-up around the heart), fluid restriction, and diabetes (abnormal blood sugar levels). There was no mention of a current diagnosis of lymphedema nor the need for the use of the compression stockings. 2. Review of resident 3's closed (no longer in the facility) medical record revealed he had been admitted on 8/25/15. He was discharged to the hospital on 9/16/15 for excessive bleeding from his penis and sepsis (infection throughout the body). Review of his 8/25/15 admission orders revealed he was on an anti-coagulant (prevents blood from clotting) medication. That medication could contribute to excessive bleeding. Review of his 9/7/15 care plan revealed there was no mention of him being on anti-coagulants. There was no indication of signs and symptoms	F 280	Care plans for resident's who are diagnosed with lymphedema will be audited to ensure all physician orders are documented on the care plan. Residents who are prescribed an anti-coagulant have the potential to be affected in a similar manner. Care plans for resident's who are prescribed an anti-coagulant will be audited to ensure all physician orders are documented on the resident care plan. Licensed Nursing staff will be Re-educated on the Golden Living policy regarding care plans. Director of Nursing or designee will complete random audits weekly x 4 weeks then monthly x 2 months on 5 residents to ensure physician orders have been documented as appropriate to the resident care plan.Results of these audits will be brought to the monthly QAPI meeting by the Director of Nursing Service or designee for further review and recommendations.	10/29/15

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F 280	Continued From page 2 to watch for related to the use of that medication. 3. Interview on 10/1/15 with interim resident care coordinator C revealed she confirmed both of the above items should have been on residents 1 and 3's care plans. She confirmed the use of compression stockings and anti-coagulants were important components of a resident's care. She stated the Minimum Data Set coordinator was responsible for creating the care plans. She confirmed updates could have and should have been done by any nurse as any change occurred. Review of the provider's 2/24/15 Interdisciplinary Care Plan policy revealed the care plan was: *Implemented to guide the staff in caring for a resident. *To have reflected necessary care and services for a resident. *A guide to help residents maintain their highest practicable level of wellbeing. *To have been updated and revised as necessary to address the resident's needs.	F 280		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	**No specific residents were identified as being affected in the statement of deficiency.** **Residents residing in the living center have the potential to be affected. The Executive Director, Director of Nursing Services and interdisciplinary team will review, revise and implement the Golden Living Infection Control and**	

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F 441	Continued From page 3 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to maintain on ongoing infection control program to include monitoring, tracking, and trending of infections for two of two months (August and September 2015) reviewed. Findings include: 1. Interview on 10/1/15 at 1:30 p.m. with interim resident care coordinator (RCC) C and the interim director of nursing services revealed: *There had been no staff conducting tracking and	F 441	Prevention Policy. The Assistant Director of Nursing Services has been designated as the Infection Control Nurse with the Director of Nursing Services serving as the back up. All living center staff will be reeducated on the Golden Living Infection Control and Prevention Policy and their roles and responsibilities. Director of Nursing or designee will Review 5 resident charts who have been diagnosed with infection such as pneumonia, urinary tract infections and sepsis weekly x 4 weeks then monthly x 2 months to ensure the Infection Control and Prevention guidelines were applied and followed. Results of these audits will be brought to the monthly QAPI meeting by the Director of Nursing Service or designee for further review and recommendations.	10/29/15

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F 441	Continued From page 4 trending of infections for the previous two months. *There had been no monitoring of infections or infection control practices completed. *They were aware there had been several cases of pneumonia, urinary tract infections, and sepsis (infection throughout the body) in the prior two months. *They had no way of knowing if any of those infections could have been prevented if tracking, trending, and monitoring had occurred. Review of the provider's infection control policies provided revealed there were no specific guidelines for an infection control program. Review of the provider's revised August 2012 Job Description for an Infection Control Nurse revealed: *The general purpose for that nurse was to supervise and coordinate the multiple aspects of the infection control program. *High quality of resident care was to have been ensured by: -Eliminating infection risks to residents and personnel through surveillance of multiple activities and practices. -Teaching information related to infection control to all involved employees. -Implementing monitoring and surveillance programs in an effort to identify and reduce infection hazards. Surveyor: 20031 Interview on 10/1/15 at 1:20 p.m. with RCC C revealed she was aware the infection control program might not be up-to-date. She stated it should have been done by the DNS (director of nursing services). But she had been trying to do	F 441		

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F 441	Continued From page 5 it, as they have had several interim DNSs.	F 441		
F 500 SS=E	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to maintain accurate and complete documentation for the completion of orientation for three of three traveling nurses (D, E, and F) reviewed. Findings include: 1. Review of employees D, E, and F's personnel files revealed no documentation could be found regarding completion of onsite facility orientation. Review of the provider's 9/3/15 Temporary Agency Contract and Orientation Guideline policy	F 500	No specific residents were identified as being affected in the statement of deficiency. Residents residing in the living center are not affected by this deficient practice. The Executive Director, Director of Nursing Services and interdisciplinary team, as needed, will review, revise and implement the Golden Living Temporary Agency Contract and Orientation Guideline Policy. The Human Resources Coordinator and Resident Care Coordinators will be reeducated on the Golden Living Temporary Agency Contract and Orientation Guideline Policy. *7 Executive Director will audit temporary agency staff orientation documentation to ensure the Temporary Agency Contract and Orientation Guideline Policy was followed weekly x 4 weeks then monthly x 2 months. Results of these audits will be brought to the monthly QAPI meeting by the Executive Director or designee for further review and recommendations. *Employees D & E are no longer employed at the facility. Employee F has completed all of the orientation requirements. NS/SDDOH/EL	10/29/15

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F 500	Continued From page 6 revealed: *Temporary agency staff were to have received an orientation to the essential center practices and the specific duties for the position they were covering. *Documentation of orientation of temporary agency employees was to have been maintained in a location designated by the center. Surveyor: 20031 Interview on 10/1/15 at 3:45 p.m. with the interim administrator revealed: *There was no documented training record for the above three traveling nurses. *A past employee had been responsible to keep those records and the required training documentation. *The past employee had walked out on her job one day and had left several of her duties uncompleted and unfinished.	F 500		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	Resident #1 had the physician ordered stockings applied. Resident #3 has been discharged from living center and records are closed. A smoking assessment was completed on Resident #4. Medication error happened in the past for Resident #5. Resident #6's SCD was discontinued per physician's order. Residents residing in the living center have the potential to be affected. The Executive Director, Director of Nursing Services and interdisciplinary team will review,	

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F 514	Continued From page 7 This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to maintain accurate and complete documentation of: *Completion of tasks associated with physician's orders for one of six sampled residents (1). *Assessments for concerns related to infections, smoking, and monitoring side effects of a medication given in error for three of six sampled residents (3, 4 and 5). *Clarification of physician's orders for one of six sampled residents (6). Findings include: 1. Review of resident 1's 8/4/15 physician's order revealed an order for compression stockings 20-30 mmHG (millimeters of mercury) (determines the degree of compression) to have been applied in the morning and removed at night. He was to have worn those stockings because of a diagnosis of lymphedema (excessive swelling). Review of his 8/17/15 physician's order revealed "Please have [name of medical equipment supplier] come over to measure [resident's name] for 3 pairs of open-toed compression stockings 20-30 mmhg [mmHG]." Review of an 8/20/15 note written by registered nurse (RN) A revealed she had measured resident 1's calf size and given it to central supply. Review of an 8/25/15 fax to the medical equipment supplier revealed they were to come and measure the resident for the correct size of stockings. Review of an 8/27/15 response from	F 514	revise and implement the Golden Living Policy and procedure for ensuring accurate and timely documentation of individual resident care and care needs. Licensed Nursing staff will be Re-educated on the Golden Living Charting/Documentation guide and the Condition Change of Resident policy. Director of Nursing or designee will complete random audits weekly x 4 weeks then monthly x 2 months on 5 resident charts to ensure physician orders have been documented as appropriate to the resident care plan. Results of these audits will be brought to the monthly QAPI meeting by the Director of Nursing Service or designee for further review and recommendations.	10/29/15

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F 514	Continued From page 8 that supplier revealed they had ordered the stockings. Two weeks were anticipated prior to the arrival of the stockings. Review of resident 1's 9/14/15 nurse's notes revealed the stockings were to have been delivered on that day. Review of his August and September treatment administration records (TAR) revealed an entry beginning 8/4/15 through 9/30/15 for "Compression stockings 20-30 mmHG to BLLE [bilateral lower extremities] on in the AM [morning] and off in the PM [evening]." Review of those TARs revealed: *In August: -Five of the days had been documented the stockings were not available. -Two of the days had been left blank. -Twenty of the days had been initialed as having completed that order. *In September: -Four of the days had been documented the stockings were not available. -Two of the days had been documented he had been in the hospital. -Twenty-four of the days had been initialed as having completed that order. Interview on 10/1/15 at 4:30 p.m. with RN A revealed the above specific stockings had not been applied until 9/15/15. She stated resident 1 had other compression stockings, but they were not the same mmHG as ordered by the physician. She confirmed documenting the application of those stockings was in error, because they were different from what the physician had ordered.	F 514		

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F 514	Continued From page 9 Interview on 10/1/15 at 4:45 p.m. with interim resident care coordinator (RCC) C revealed she was aware the resident had always worn compression stockings. She confirmed documentation of the above specific compression stockings should not have occurred until they were actually received. 2. Review of resident 3's closed medical record revealed he had been sent to the hospital on 9/16/15. Review of his nurses' notes from that day revealed an entry at 11:19 p.m. the "Resident did not get complete tube feeding as he went to the hospital at 10:20 p.m." Another entry on 9/17/15 at 2:10 a.m. revealed "Resident was transferred via ambulance to [name of hospital] for s/s [signs and symptoms] of shock and irregular bleeding from the penis." An entry following that at 3:27 a.m. on the same day revealed "hospitalized d/t [due to] sepsis [infection throughout the body]." Review of the above nurses' notes revealed there had been no documentation of: *A completed assessment. *What signs and symptoms of shock were present. *What had caused the irregular bleeding. *Notification to physician or family of his change in condition. Further review of resident 3's nurses notes revealed he had been admitted with a Foley catheter (tube that drains urine from the bladder). Review of multiple entries from his admission on 8/25/15 through his discharge on 9/16/15 revealed he had been incontinent (loss of control) of both bowel and bladder even though he had a Foley catheter.	F 514		

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F 514	Continued From page 10 Interview on 10/1/15 at 10:30 a.m. with the interim director of nurses revealed she confirmed an assessment should have been documented prior to the resident's admission to the hospital. She confirmed there was no documentation of the events leading up to that hospitalization. She also confirmed a resident with a Foley catheter would not have been incontinent of his bladder. She confirmed that was an error in documentation. 3. Review of resident 4's 9/25/15 nurses' notes revealed a late entry for 9/24/15. That entry stated she had become lethargic and had a decrease in her oxygen saturation levels (the amount of oxygen in the blood) after coming in from smoking. Review of her 6/29/15 care plan revealed: *She had a diagnosis of multiple sclerosis. *She was at risk for a smoke related injury. *She smoked independently with supervision. *A smoking safety assessment was to have been completed. Review of resident 4's electronic and paper medical record revealed no smoking safety assessment could be found. Interview on 10/1/15 at 9:45 a.m. with RCC B revealed a smoking safety assessment should have been completed on any resident who smoked. She confirmed no smoking safety assessment was completed for resident 4. 4. Review of resident 5's 8/27/15 medication error reporting form revealed she had received a medication in error. That medication had been	F 514		

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F 514	Continued From page 11 intended for her roommate. That report revealed: *An error had occurred, because the resident was not properly identified. *An error or omission (not completed) had occurred, but monitoring confirmed the absence of negative effects. *The resident's vital signs were not monitored. *The resident had not been admitted to the hospital. Interview on 10/1/15 at 4:45 p.m. with interim RCC C revealed she had just called the previous director of nursing (DON) to get her statement regarding the medication error. Review of that statement revealed she had: *Received a phone call from the nurse who had committed the medication error. *Asked the nurse if she had called the physician. The nurse told her she had not. *Informed the nurse to notify the physician which. *The nurse indicated she had done that. *Stated the physician said to monitor the resident the rest of that night. *The most common symptoms to watch for would have been flu-like symptoms. Review of resident 5's 8/27/15 nurses' notes revealed there was no documentation the physician had been notified regarding the error. There was no documentation of any monitoring completed. Interview on 10/1/15 with RCC B and interim RCC C revealed they confirmed there was no documentation following the medication error. They confirmed the previous DON's statement had not been received until thirty-three days after the medication error had occurred.	F 514		

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GOLDEN LIVINGCENTER - PRAIRIE HILLS	916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 12 Surveyor: 20031 5. Review of resident 6's physician's orders from her hospital discharge on 9/18/15 revealed: *Sequential compression devices (SCDs) (used to limit the development of deep vein thrombosis [blood clotting disorder] and peripheral edema [excess fluid build-up in the body]) as ordered. *Hand written notes next to the order stated "Clarify new order." Those notes were dated 9/19/15. Review of resident 6's September treatment administration record (TAR) revealed the following order "SCDs at all times while in bed every shift-Order date 9/19/15." That order would have had documentation thirty-five times during the twelve days left in September. That documentation revealed: *Three days with no documentation. *One day in the hospital. *Eleven days the device was unavailable. *Three days the device was refused. *Thirteen days the resident received the treatment. Review of the October TAR revealed that same order. Interview on 10/1/15 at 10:15 a.m. with the DNS revealed she had located a fax order from resident 6's regular physician. The DNS stated she had sent a request to resident 6's physician to discontinue the SCD order. The request was dated 9/21/15 and stated "Please discontinue the order for SCD's for [resident 6], as we are unable to provide this service in our facility." The request was signed by the current interim DNS. A return fax from the physician revealed "OK to D/C [discontinue] SCD's as they are unable to provide service at NH [nursing home]." It was signed by	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 13 resident 6's physician. Interview on that same day at 10:45 a.m. with the DNS revealed she had requested the order to discontinue the SCDs. She stated she had done that because: *Staff were uneducated on the use of the devices at that time. *The provider was not accustomed to the SCD. *She felt it was not a safe situation at that time. She further stated she had spoken with resident 6's physician regarding the request, and he had stated: *It was a transfer order from the hospital, and they might have been unaccustomed to nursing home services. *He usually did not order SCDs himself. *He was okay with discontinuing the order from the hospital. She confirmed she had not updated the TAR with the new orders. She also confirmed the inaccurate TAR documentation by the staff regarding the SCD order. Surveyor 23059 Review of the provider's undated Charting/Documentation Guide revealed: *Nursing documentation should have been clear, timely, accurate, and reflective of observations. *Documentation of a change of condition should have included: -The change that had occurred. -What intervention had been tried. -The resident's response to that intervention. -Notification of the physician and family. *All specific facility policies should have been followed.	F 514		

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F 514	Continued From page 14 Review of the provider's 1/8/15 Condition Change of the Resident policy revealed: *The resident should have been assessed and the attending physician notified. *Documentation should have included: -Date and time the condition change was identified. -Observation of the resident's findings. -Emergency care provided. -Notification of the physician. -Notification of the resident's responsible party. *All observations of the resident should have been documented until the condition was stable.	F 514		