

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE SIOUX FALLS, SD 57106</b>
--	--

(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: 22452 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/22/16 through 8/24/16. Areas surveyed included resident quality of care/treatment and resident safety. Golden LivingCenter-Covington Heights was found not in compliance with the following requirements: F279, F280, F281, F309, F312, and F431.	F 000	<i>Addendums noted with an asterisk per 9/23/16 telephone to facility administrator and DSN. SB/SDDOH/LA</i>	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by:	F 279	Resident #1 has had a comprehensive care plan developed and implemented * On 9/3/16. SB/SDDOH/LA  Residents residing in the facility have the potential to be affected in a similar manner  *ALL Residents residing in the facility have had their care plans reviewed and revised as necessary to reflect the resident's current needs  Care plans of residents experiencing a change in condition, admission and/or readmission will be reviewed and revised during daily clinical start up to ensure accuracy  The interdisciplinary team was re-educated on the development and revision of care plans by the Director of Nursing on September 7, 2016	* 9/21/16 SB/SDDOH/LA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Chad [Signature]</i>	TITLE  <i>Executive Director</i>	(X8) DATE  <i>9/15/16</i>
--	--	---------------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 279	<p>Continued From page 1</p> <p>Surveyor: 22452</p> <p>Based on record review, interview, and policy review, the provider failed to implement a care plan for one of two sampled newly admitted residents (1). Findings include:</p> <p>1. Review of resident 1's medical record revealed:</p> <ul style="list-style-type: none"> <li>*An 8/3/16 admission date from an acute care hospital.</li> <li>*Diagnoses: acute kidney failure, dementia, diabetes mellitus, heart failure, acute embolism and thrombosis of deep veins, and essential hypertension.</li> <li>*He had open areas on his left hip, right elbow, and coccyx.</li> <li>*Both of his heels were red.</li> <li>*He was on intravenous antibiotics to treat a bladder infection.</li> <li>*He was alert but confused and disoriented.</li> <li>*He was on a dysphasia diet with honey thickened liquids.</li> <li>*He was to be assisted to transfer with a total lift and was dependent on the staff for all his activities of daily living.</li> </ul> <p>Review of resident 1's 8/18/16 care plan revealed:</p> <ul style="list-style-type: none"> <li>*The only problem documented was "Altered texture diet, pressure ulcer."</li> <li>*Goals documented were: <ul style="list-style-type: none"> <li>-"Average intake 75 percent or more all meals."</li> <li>-"Maintain weight 140 pounds."</li> <li>-"Wound healing."</li> </ul> </li> <li>*Interventions documented were: <ul style="list-style-type: none"> <li>-"30 milliliters Prostat mixed with honey thick juice in the afternoon."</li> <li>-"Follow in nutrition risk as needed. Reassess as needed."</li> </ul> </li> </ul>	F 279	<p><b>Statement of Compliance: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on August 24, 2016. Please accept this plan of correction as the Living Center's Credible Allegation of Compliance with the completion date of September 21, 2016. The completion and execution of this plan of correction does not constitute an admission of guilt or wrongdoing 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.</b></p> <p>The Director of Nursing or designee will complete audits of 10 residents care plans weekly x 4 weeks then monthly x 2 months to ensure accuracy. The Director of Nursing will report the results of the audits to the monthly QAPI committee for further review and recommendations.</p>		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 279	<p>Continued From page 2</p> <p>-"Monitor dietary intake daily."</p> <p>-"Pureed diet with honey-thick liquids. Assistance at meals as needed."</p> <p>*There were no other problems, goals, or interventions documented.</p> <p>Interview on 8/23/16 at 10:00 a.m. with the director of nursing regarding resident 1 revealed:</p> <p>*She confirmed a care plan had not been initiated upon his admission on 8/3/16 and should have been.</p> <p>*He had previously been a resident at the facility, and she wondered if that was why they had not initiated a new care plan.</p> <p>*His care needs had changed since his hospitalization.</p> <p>Review of the provider's 8/20/16 Resident Assessment Instrument (RAI) policy revealed:</p> <p>*"Living Centers adhere to all Center for Medicare and Medicaid Services [CMS] regulations which are considered the definitive source in completion of the RAI process."</p> <p>***This includes coding the MDS, completion of Care Area Assessments, and the development of the comprehensive plan of care."</p>	F 279		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an</p>	F 280	<p>A Care plan conference was held on 9/15/16 for resident #3 with Interdisciplinary Team and resident #3 present. An Interdisciplinary note was placed in the progress notes discussing outcome of care conference.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p>	<p>* 9/21/16 SB/SD06A/LR</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 280	<p>Continued From page 3</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to: *Revise a care plan to reflect the current status for one of four sampled residents (3). *Implement interventions and document outcomes discussed in two care conferences for one of four sampled residents (3). *Conduct an interdisciplinary care conference after a quarterly assessment for one of one sampled resident (3). Findings include:</p> <p>1a. Review of resident 3's medical record revealed: *Diagnoses of an unspecified nutritional deficiency and a history of a small bowel obstruction with a current surgical dehiscence (spontaneous opening) dating back to November 2014. *Her weight was monitored monthly.</p> <p>Review of a 12/9/15 Nutrition/Hydration/Wound meeting note indicated the attendees were the</p>	F 280	<p>Residents residing in the facility were audited to ensure a quarterly care conference had been held. An Interdisciplinary care plan conference was scheduled for those residents found in non-compliance.</p> <p>The Interdisciplinary Team has been re-educated by the Director of Nursing on September 7, 2016 including compliance with scheduling, participating, reviewing and revisions of care plans and documentation of outcomes of care conferences.</p> <p>The Director of Nursing or designee will complete audits of all residents who have had a quarterly MDS completed during that given week to ensure compliance with scheduling, IDT participation, reviewing and revisions of care plans and documentation of outcomes of care conferences have been completed weekly x 4 weeks then monthly x 2 months to ensure compliance.</p>	
-------	---	-------	--	--

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>	
(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)
F 280	<p>Continued From page 4</p> <p>director of nursing (DON) and the registered dietitian (RD). Areas of discussion had included a weight of ninety-two pounds, a loss of twelve pounds in six months. Her body mass index (BMI) was 16.8 indicating she was underweight. The decision was made to continue to monitor the weight and her ongoing open wound. The meeting notes indicated the care plan was updated at that time.</p> <p>Review of her care plan revealed: *A 1/20/16 focus indicated problems of a low body mass index, history of weight loss, and a surgical incision that had not healed. Interventions had included: -A regular diet. -Monitor weight. -Notify the physician and family of significant changes. -Remove unfinished drinks from her room. -The resident was to receive her supper meal at 5:00 p.m. at family request. -The provider was to have given her a substantial bedtime snack. -She could request snacks as she desired. -No updates in the dietary care plan were noted from the 12/9/16 meeting. *A 7/7/14 focus of a non-pressure related Abdominal Dehiscence care plan revealed: -It had been reviewed on 4/6/16. -No interventions had been revised/updated since 11/20/15. -Her undated abdominal dressing treatment intervention of a calcium alginate dressing had not matched the current 7/1/16 dressing change order for the use of a Xenofom dressing.</p> <p>Observation on 8/22/16 at 1:30 p.m. of resident 3 revealed she was sitting in the hallway beside the</p>	F 280	<p>The Director of Nursing will report the results of the audits to the monthly QAPI committee for further review and recommendations.</p>

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIoux FALLS, SD 57106</b>		
(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 280	<p>Continued From page 5</p> <p>medication cart for most of the afternoon. At 1:30 p.m. her noon meal tray remained in her room, with approximately 5% of the food consumed.</p> <p>Observation on 8/23/16 from 7:30 a.m. through 10:20 a.m. revealed: *The resident remained in her room. *A breakfast tray was delivered to her room at approximately 8:50 a.m. *The resident had spent time moving food around on the tray, but had she eaten less than 10% of the food or beverage.</p> <p>Interview on 8/23/16 at 10:20 a.m. with registered nurse (RN) C regarding resident 3 revealed: *She always ate her meals in her room. *She preferred to eat alone, away from staff and other residents. *She ate very slowly. *She became very upset if staff members attempted to feed her. *She had not been aware the care plan had not included the above information.</p> <p>Interview on 8/23/16 at 11:20 a.m. with social worker (SW) D and the DON revealed: *The dietitian was responsible for conducting the dietary part of the Minimum Data Set (MDS) assessments and for developing and updating the care plan. *The dietitian had quit her job two weeks ago. *They were not sure who was responsible for doing the dietary MDS or care plans in the absence of the dietitian. *The dietitian had not attended the care conferences. *Occasionally the dietary manager would stop in at a care conference for a few minutes but would not stay for the conference.</p>	F 280		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 280	<p>Continued From page 6</p> <p>*The family wanted the wound clinic to be involved with decision-making for her care rather than the provider's staff.</p> <p>*The family members had many requests for how and what the resident was to eat.</p> <p>*At the 5/12/16 care conference the family had requested less sugary foods and more high protein foods including peanut butter and crackers. The resident snacked throughout the day, and the family brought snacks for her.</p> <p>*They were not aware the family's request for peanut butter and high-protein foods had not been added to the care plan.</p> <p>*They were not aware the care plan had not included:</p> <ul style="list-style-type: none"> <li>-The resident's choice to eat all meals in her room.</li> <li>-She became upset if staff attempted to feed her.</li> <li>-She ate very slowly.</li> </ul> <p>b. Review of the progress notes for resident 3 and care conference attendance logs revealed:</p> <p>*The 2/4/16 and 5/12/16 attendance logs had only documented name of staff members and family members that attended the conference.</p> <p>*There was no documentation of what was discussed or any changes in care or interventions.</p> <p>*There was no documentation in the progress notes regarding care conferences.</p> <p>*The most recent MDS had been done 7/22/16. There was no attendance log or any care conference documentation noted.</p> <p>Interview on 8/23/16 at with SW D at 11:20 a.m. regarding lack of care conference documentation revealed:</p> <p>*The interdisciplinary team had been documenting care conference attendance, but</p>	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 280	<p>Continued From page 7</p> <p>"There was just not enough time" to chart the information.</p> <p>*Currently the interdisciplinary team and family just signed the conference attendance log.</p> <p>*She was not sure how the information gathered in the care conferences from family or team members was to have been communicated with other staff members.</p> <p>*The most recent 7/29/16 care conference was scheduled, but the family members were unable to attend, so it was planned to do at a later time. She had not made another meeting time.</p> <p>*The interdisciplinary team had not met to review the care plan or MDS concerns after the 7/22/16 MDS.</p> <p>c. Interview on 8/25/16 at 9:00 a.m. with registered nurse assessment coordinator (RNAC) E regarding the MDS assessments, care plans and interdisciplinary care conferences revealed:</p> <p>*She was responsible for completing the MDS assessments for residents on the 100 unit.</p> <p>*She was not responsible for developing or updating care plans.</p> <p>*She did not attend care conferences.</p> <p>*The unit coordinator updated the care plans and attended the care conferences as time allowed.</p> <p>*There was no unit coordinator at the time of resident 3's 7/22/16 MDS assessment.</p> <p>*She was not aware the care plan had not been updated to reflect the current dietary and wound care status for resident 3.</p> <p>Review of the 8/20/15 RAI [Resident Assessment Instrument] Process Policy revealed:</p> <p>*The provider would adhere to all CMS [Center for Medicare and Medicaid Services] regulations in completion of the RAI process. That process had included the development of the</p>	F 280			

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 280	<p>Continued From page 8 comprehensive plan of care. * "All living centers will utilize the CMS RAI Manual for completion and compliance of the RAI Process."</p> <p>Review of the October 2015 CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.13, Chapter 4.7, The RAI and Care Planning, revealed: *Page 4-8: -The comprehensive care plan was an interdisciplinary communication tool. -It was to have been reviewed and revised periodically, and the services provided or arranged were to have been consistent with each resident's written plan of care. *Page 4-10: A well-developed assessment and care plan: -Gave the IDT a common understanding of the resident. -Re-evaluated the resident's status at prescribed intervals such as quarterly, annually, or with significant changes, and modified the individualized care plan as appropriate and necessary. -Following a change in the resident's condition, the IDT would have reviewed and revised the current care plan and communicated with the resident and their family regarding the resident, care plans, and their wishes. *Page 4-12: The overall care plan should was to have been oriented towards: -Preventing avoidable declines in functioning. -Applying current standards of practice in the care planning process. -Using an interdisciplinary approach. -Involving the resident, resident's family, and other resident representatives. -Assessing and planning for care to meet the</p>	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>	
(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 280	Continued From page 9 resident's needs. -Involving the direct care staff with the care planning process relating to the resident's expected outcomes.	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: 22452 A. Based on observation, record review, interview, and policy review, the provider failed to ensure: *Physicians' orders were followed for the administration of an inhaler for three of three sampled residents (14, 15, and 16). *Medication errors were reported and investigated for four of four sampled residents (9, 11, 12, and 19). *Professional standards were followed for the care of a peripherally inserted central catheter (PICC) line dressing for one of two sampled residents (13). Findings include:  1. Observation on 8/22/16 at 3:20 p.m. of the 400 wing medication cart revealed: *Resident 14's Advair inhaler with documentation of an opened date of 7/30/16. *The inhaler contained sixty inhalations prior to being opened. *There were thirty-five inhalations left in the inhaler.	F 281	Resident #14, 15 & 16 Advair Inhalers have been replaced and dated with the first administration of medication.  Resident #13 PICC line dressing was not changed according to the PICC line policy due to discharge.  Resident #3 has had a Nutritional Assessment completed by the Registered Dietician. The Care plan has been reviewed and revised to reflect the resident's current needs.  Resident # 17 & #18 priming of insulin pen could not be corrected.  Resident # 6 Expired Insulin has been replaced  Residents residing in the facility who receive <del>metered</del> Inhalers have the metered dose SB/SD DOA/LA	9/21/16 SB/SD DOA/LA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 281	<p>Continued From page 10</p> <p>Review of resident 14's July 2016 and August 2016 medication administration records (MAR) revealed:</p> <ul style="list-style-type: none"> <li>*Advair, one inhalation twice a day (BID).</li> <li>*There had been no doses of Advair held or refused by the resident since 7/30/16.</li> <li>*There should have been fourteen doses of Advair left in the inhaler instead of thirty-five.</li> </ul> <p>2. Observation on 8/22/16 at 3:30 p.m. of the 500 wing medication cart revealed:</p> <ul style="list-style-type: none"> <li>*Resident 15's Advair inhaler with documentation of an opened date of 8/19/16.</li> <li>*The inhaler contained sixty inhalations prior to being opened.</li> <li>*There were forty-eight inhalations left in the inhaler.</li> </ul> <p>Review of resident 15's August 2016 MAR revealed:</p> <ul style="list-style-type: none"> <li>*Advair, one inhalation BID.</li> <li>*There had been no doses of Advair held or refused by the resident since 8/19/16.</li> <li>*There should have been fifty-three doses of Advair in the inhaler instead of forty-eight.</li> </ul> <p>3. Observation on 8/22/16 at 3:40 p.m. of the 300 wing medication cart revealed:</p> <ul style="list-style-type: none"> <li>*Resident 16's Advair inhaler with documentation of an opened date of 8/11/16.</li> <li>*The inhaler contained sixty inhalations prior to being opened.</li> <li>*There were forty-two inhalations left in the inhaler.</li> </ul> <p>Review of resident 16's August 2016 MAR revealed:</p> <ul style="list-style-type: none"> <li>*Advair, one inhalation BID.</li> <li>*There had been no doses of Advair held or</li> </ul>	F 281	<p>potential to be affected in a similar manner. An audit has been completed to identify residents who utilize inhalers and medication reconciliation has been completed utilizing EMAR and inhalations remaining. Inhalers found with a discrepancy were replaced and dated with the first administration of medication.</p> <p>Residents residing in the facility utilizing a PICC line have the potential to be affected in a similar manner. An audit was completed to identify residents utilizing a PICC Line. MD orders were obtained according to PICC Line policy and updated on the EMAR.</p> <p>Residents residing in the facility with nutritional and wound concerns have the potential to be affected in a similar manner. Residents residing in the facility with nutritional and wound concerns have had a Nutritional Assessment completed by the Registered Dietician. Care plans have been reviewed and revised to reflect the resident's current needs.</p>	<p>SB/SD DOH/LA on 9/18/16</p> <p>*All SB/SD DOH/LA</p> <p>*with metered dose counter SB/SD DOH/LA</p> <p>*metered dose SB/SD DOH/LA</p> <p>* Metered dose SB/SD DOH/LA</p> <p>* 9/19/16 all SB/SD DOH/LA</p> <p>* per PICC line flushes SB/SD DOH/LA</p>
-------	---	-------	---	---

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 281	<p>Continued From page 11 refused by the resident since 8/11/16. *There should have been thirty-seven doses in the inhaler instead of forty-two.</p> <p>4. An anonymous typed note was given to the surveyors on 8/22/16 at 6:00 p.m. that revealed on 8/18/16: *"Many med errors on 8/18/16." *"Residents [9, 11, 12, and 19's] 2:00 p.m. and 4:00 p.m. pills were marked off and not given, they were still in the slots." *"6:00 p.m. pills not passed at all." *"She left the meds in the rooms not being sure the resident took them." *"I gave this to the director of nursing [DON] after I worked the night shift. No errors written and doctor not called from what I was told."</p> <p>Interview on 8/23/16 at 11:00 a.m. with the DON regarding the above note revealed she had: *Not received the note until 8/22/16 in her mailbox in the front office. *Not had time on 8/22/16 to follow-up on the medication errors. *Been informed the note had been put under the business manager's door. The business manager had put the note in her mailbox in the front office. *Today called licensed practical nurse (LPN) F who was a travel nurse on duty 8/18/16. *Been informed by LPN F the above residents had received their medications on 8/18/16, but they had been given late. *Spoken to the registered nurse (RN) supervisor today at the travel agency where LPN F was employed. The RN had told her the anonymous writer of the note had called her on 8/18/16 and had informed her LPN F had gone off duty without administering the 6:00 p.m. medications to the above residents. The RN supervisor had</p>	F 281	<p>Residents residing in the facility utilizing insulin have the potential to be affected in a similar manner. An audit was completed to identify residents utilizing insulin, the insulin dates were checked to ensure none were expired. Any expired insulin identified in the audit was replaced.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner. New admissions, readmissions, quarterly to coincide with MDS schedule, and with any significant change will have an audit completed during daily clinical start up to ensure a comprehensive nursing assessment has been completed. *within 24 hours of the occurrence SB/SD DOH/LA</p> <p>The Director of Nursing and Interdisciplinary Team has reviewed the Medication Administration Policy. A system has been put into place to reconcile <del>at</del> <sup>at</sup> <del>meds</del> <sup>meds</sup> Inhalers daily via documentation of dosage remaining on <del>the</del> <sup>with dose counters</sup> EMAR with each administration. SB/SD DOH/LA</p> <p>The Director of Nursing and Interdisciplinary Team has reviewed the PICC Line Policy.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 281	<p>Continued From page 12</p> <p>advised LPN F to return to the facility and administer the 6:00 p.m. medications to the above residents.</p> <p>*Not followed-up with the RN supervisor from the travel agency why she had not called her on 8/18/16 to inform her of the above.</p> <p>*No idea why the anonymous writer of the note had not called her on 8/18/16 instead of putting the note under the business manager's door.</p> <p>*Given all travel nurses who worked for their facility her business card with her phone number if they needed to call her.</p> <p>*No policy regarding medication errors. All the provider had was a policy on how to complete the medication error reporting forms in their computer system.</p> <p>Interview on 8/23/16 at 2:30 p.m. with LPN F regarding the above revealed she had:</p> <p>*Been very busy on 8/18/16 and had not given the above residents their 6:00 p.m. medications on time.</p> <p>*Assumed the next nurse coming on duty would administer the medications.</p> <p>*Been called back to the facility on 8/18/16 by the RN supervisor to complete her medication administration.</p> <p>*Administered the above residents 6:00 p.m. medications to them about 8:00 p.m.</p> <p>*Not informed the DON at the facility she was very busy on her shift and had left the building without completing her medication administrations.</p> <p>*Completed medication error reporting forms for the above residents today when she had been called by the DON.</p> <p>*Faxed the physicians today the medication error reporting forms as follows:</p> <p>-Resident 19 had been administered furosemide</p>	F 281	<p>The Director of Nursing and Interdisciplinary Team have reviewed the At Risk Committee Meeting Policy</p> <p>The Director of Nursing and the Interdisciplinary Team have reviewed the Using the Novolog® FlexPen® insulin pen Competency Policy and Insulin Expiration Date Guideline</p> <p>The Director of Nursing and the Interdisciplinary Team have reviewed the Clinical Health Status Policy</p> <p>Nursing staff have been re-educated on <i>9/16/16</i> the Medication Administration Guideline and the system of documentation of remaining doses on the EMAR.</p> <p>Licensed Nursing staff have been re-educated on the PICC Line Policy <i>on 9/16/16 by the unit managers</i></p> <p>Licensed Nursing staff have received competency training according to the PICC Line Policy <i>SB/SD DON/LA</i></p>	<p><i>* by the unit manager</i></p> <p><i>9/16/16</i></p> <p><i>SB/SD DON/LA</i></p> <p><i>* on 9/16/16 by the unit managers</i></p> <p><i>SB/SD DON/LA</i></p>
-------	--	-------	--	---

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 281	<p>Continued From page 13 and Preglabin on 8/18/16 at 8:20 p.m. instead of 6:00 p.m.</p> <p>-Resident 11 had been administered burpropion and prochlorperazine maleate on 8/18/16 at 7:58 p.m. instead of 6:00 p.m.</p> <p>-Resident 12 had been administered gabapentin, omeprazole, and ferrous sulfate on 8/18/16 at 9:05 p.m. instead of 6:00 p.m.</p> <p>-Resident 9 had been administered sliding scale Novolog insulin on 8/18/16 at 8:38 p.m. instead of 6:00 p.m.</p> <p>*Observed none of the residents had a negative outcome from their medications not being given on time, but she agreed there was potential for that when medications were not given on time.</p> <p>5. Review of resident 13's medical record revealed:</p> <p>*A 7/17/16 admission date.</p> <p>*Vancomycin 900 milligrams intravenously (IV) every 12 hours for a stage 3 pressure ulcer on her right buttock.</p> <p>*The Vancomycin was to have been administered by a a PICC route.</p> <p>***IV-PICC change transparent dressing on admission, then weekly and as needed thereafter."</p> <p>***Measure catheter length on admission and with each dressing change thereafter."</p> <p>*There was no documentation the PICC line dressing had been changed since 7/17/16.</p> <p>Interview on 8/23/16 at 2:00 p.m. with the DON regarding resident 13 revealed:</p> <p>*She confirmed the PICC line dressing had not been changed until 8/22/16 by LPN A.</p> <p>*The PICC line dressing change had been omitted prior to that, because it had not been carried over onto the treatment record.</p>	F 281	<p>The Director of Nursing and Interdisciplinary Team have been re-educated on the At Risk Committee Meeting Policy</p> <p>Licensed Nursing staff have been re-educated on Using the Novolog® FlexPen® insulin pen Competency Policy and Insulin Expiration Date Guideline</p> <p>Nursing staff have been re-educated on the Clinical Health Status Policy</p> <p>The Director of Nursing or designee will complete audits of 5 residents who receive <del>medication</del> <sup>* metered dose</sup> medication weekly x 4 weeks then monthly x 2 months to ensure accurate reconciliation. The Director of Nursing will report the results of the audits to the monthly QAPI committee for further review and recommendations.</p> <p>The Director of Nursing or designee will complete audits of all residents who utilize PICC lines weekly x 4 weeks then monthly x 2 months to ensure adherence to <sup>to the dressing change</sup> policy. The Director of Nursing will report the results of the audits to the monthly QAPI committee for further review and recommendations.</p>	<p><i>including residents 14, 15, 16 SA/SD DON/LA</i></p> <p><i>SA/SD DON/LA</i></p>
-------	--	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 281	<p>Continued From page 14</p> <p>*She was unsure regarding the training for LPN A to change the PICC line dressing, and she was unsure why she had not documented the dressing change in the medical record.</p> <p>*She did not do any competencies for any of the nurses for skilled procedures unless they brought her some training records when they had been hired.</p> <p>*She knew there was training an LPN could take that would allow them to work with IVs and PICC lines.</p> <p>Interview on 8/23/16 at 2:30 p.m. with LPN A regarding resident 13 revealed she had:</p> <p>*Changed the PICC line dressing on 8/22/16 when she had realized it had not been done.</p> <p>*Not documented the dressing change as it was not on the treatment record.</p> <p>*No IV experience prior to coming to this facility in May 2016. She had moved from a state where LPNs were unable to work with IVs.</p> <p>*Observed a nurse doing another PICC line dressing change for another resident and felt comfortable doing the procedure.</p> <p>*Never had any additional training for taking care of IVs or PICC lines.</p> <p>Review of the provider's May 2012 Catheter Insertion and Care Midline Dressing Changes policy revealed:</p> <p>***"Midline catheter dressings will be changed at specified intervals, or when needed, to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings."</p> <p>***"Change midline catheter dressing twenty-four hours after catheter insertion, every five days, or if it is wet, dirty, not intact, or compromised in any way."</p>	F 281	<p>The Director of Nursing or designee will complete audits of all residents <sup>*including 3 whom resident 13</sup> who are discussed during the At Risk Meetings to ensure policy is being followed weekly x 4 weeks then monthly x 2 months. The Director of Nursing will report the results of the audits to the monthly QAPI committee for further review and recommendations.</p> <p>The Director of Nursing or designee will complete audits of 5 residents who receive Insulin medication weekly x 4 weeks then monthly x 2 months to ensure accurate administration and current expiration dates. The Director of Nursing will report the results of the audits to the monthly QAPI committee for further review and recommendations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 281	<p>Continued From page 15</p> <p>***Use sterile technique when changing a midline catheter dressing.</p> <p>***Verify with State Nurse Act the scope of practice for RNs and LPNs regarding this procedure.</p> <p>***Use a sterile, transparent, semi-permeable membrane or gauze dressing. If gauze dressing is used, cover the gauze with a transparent dressing and change the dressing every forty-eight hours."</p> <p>Surveyor: 32332</p> <p>B. Based on record review, interview, and policy review, the provider failed to maintain communication between interdisciplinary staff to ensure interdisciplinary approaches for weight and skin concerns were addressed consistently for one of one resident with a history of weight issues and current skin issues (3). Findings include:</p> <p>1. Review of resident 3's medical record revealed:</p> <p>*Diagnoses of an unspecified nutritional deficiency and a history of a small bowel obstruction with a current surgical dehiscence (spontaneous opening of the surgical site) dating back to November 2014.</p> <p>*Her weight was monitored monthly.</p> <p>*The progress notes indicated a 12/9/15 Nutrition/Hydration/Wound meeting note. The attendees at that meeting were the director of nursing (DON) and the registered dietitian (RD). Areas of discussion had included:</p> <p>-A weight of ninety-two pounds, a loss of twelve pounds in six months.</p> <p>-Her body mass index (BMI) was 16.8, indicating she was underweight.</p> <p>-"Skin concerns: See wound note 12/9."</p> <p>-The decision was made to continue to monitor her intake and weight.</p>	F 281	<p>The Director of Nursing or designee will complete <sup>comprehensive nursing audits</sup> audits of all new admissions, readmissions, quarterly assessments to coincide with MDS schedule, and residents with any significant change weekly x 4 weeks then monthly x 2 months to ensure adherence to policy. The Director of Nursing will report the results of the audits to the monthly QAPI committee for further review and recommendations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 281	<p>Continued From page 16</p> <ul style="list-style-type: none"> <li>-There was no mention of monitoring her skin concerns.</li> <li>-The care plan was to have been updated at that time.</li> <li>*There were no other Nutrition/Hydration/Wound meetings documented in the medical record.</li> </ul> <p>Review of resident 3's dietitian/dietary documentation revealed:</p> <ul style="list-style-type: none"> <li>*No further dietitian or dietary entries in the progress notes after the 12/9/15 Nutrition/Hydration/Wound meeting note.</li> <li>*A 1/28/16 Nutrition Data V2.1 quarterly note from the dietitian indicated: <ul style="list-style-type: none"> <li>-Her weight was down 8.3%, 10% in 180 days.</li> <li>-Her average food intake was 81%.</li> <li>-She continued to have a surgical wound.</li> <li>-The surgical wound was unlikely to heal according to the wound clinic notes.</li> <li>-No laboratory work had been done in the last 90 days pertaining to her nutrition/skin status.</li> <li>-There was no mention of her protein needs due to the surgical wound.</li> <li>-She would continue to monitor her weight and intake.</li> </ul> </li> <li>A 4/22/16 Nutrition Data V2.1 quarterly note from the dietitian indicated: <ul style="list-style-type: none"> <li>-There was "no change" in her weight.</li> <li>-Her weight was down 2.3% in thirty days, 4.8% in 180 days.</li> <li>-The weight had stabilized.</li> <li>-Her average food intake was 75%.</li> <li>-She continued to have an opened surgical wound.</li> <li>-No laboratory work had been done in the last 90 days pertaining to her nutrition/skin status.</li> <li>-There was no mention of her protein needs due to the surgical wound.</li> </ul> </li> </ul>	F 281			

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 281	<p>Continued From page 17</p> <p>-She would continue to monitor her weight and intake.</p> <p>A 7/27/16 Nutrition Data V2.1 quarterly note from the dietitian indicated:</p> <p>-Her weight was down 1.1% in thirty days, up 3.6% in 180 days.</p> <p>-Her average food intake was 52%.</p> <p>-She continued to have an opened surgical wound.</p> <p>-No laboratory work had been done in the last 90 days pertaining to her nutrition/skin status.</p> <p>-There was no mention of her protein needs due to the surgical wound.</p> <p>-She would continue to monitor her weight and intake.</p> <p>Review of resident 3's care plan revealed:</p> <p>*A 1/20/16 focus indicated problems of a low body mass index, history of weight loss, and a surgical incision that had not healed.</p> <p>*No updates in the dietary care plan were noted in December at the time of the meeting.</p> <p>*A 7/7/14 focus of a non-pressure related abdominal dehiscence care plan.</p> <p>*No interventions had been revised/updated to the abdominal wound care plan since 11/20/15.</p> <p>Interview on 8/23/16 at 11:20 a.m. with the director of nursing regarding resident 3 being followed by the Nutrition/Hydration/Wound team for her weight changes and chronic open wound revealed:</p> <p>*The interdisciplinary team met weekly to discuss issues with those residents who had weight concerns or skin concerns.</p> <p>*She agreed she and the dietitian had met on 12/9/15 to discuss weight and skin concerns for resident 3.</p>	F 281		
-------	--	-------	--	--

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIoux FALLS, SD 57106</b>
--	--

(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 281	<p>Continued From page 18</p> <ul style="list-style-type: none"> <li>*She was not sure if resident 3 had been discussed for weight concerns in those meetings after the 12/9/16 entry.</li> <li>*The resident had a history of weight fluctuations and was normally thin.</li> <li>*The wound nurse did report her wound assessment at those meetings.</li> <li>*Her open wound was a chronic condition, and she was being followed by the wound clinic for treatment.</li> <li>*The family wanted the wound clinic involved, so the dietitian had backed away.</li> <li>*The wound had improved since the wound clinic had been following her.</li> <li>*She was not sure what the dietitian's expectations were for resident 3.</li> <li>*She was not aware the resident had not been receiving extra protein or calories in her diet for weight and healthy skin.</li> <li>*The DON was unable to locate any Nutrition/Hydration/Wound team documentation or other dietitian documentation regarding resident 3's treatment for her weight or skin concerns.</li> <li>*She agreed resident 3 had weight fluctuations and skin concerns, and had not been followed by the Nutrition/Hydration/Wound team since 12/9/16.</li> </ul> <p>Interview on 8/23/16 at 2:10 p.m. with the provider's wound care nurse revealed:</p> <ul style="list-style-type: none"> <li>*She saw resident 3 every other week to assess her wound and change her dressing.</li> <li>*She was not aware she was not receiving extra protein in her diet.</li> </ul> <p>Review of the provider's 4/20/16 At Risk Committee Meetings policy revealed:</p> <ul style="list-style-type: none"> <li>*The IDT would meet weekly and review</li> </ul>	F 281		
-------	---	-------	--	--

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 281	<p>Continued From page 19</p> <p>residents with weight issues, skin issues, falls, and restraints.</p> <p>*The nutrition/weight issues had included: -Any resident who was determined to be at risk to ensure that all appropriate interventions were in place.</p> <p>*The skin issues would have included: -The provider would review all residents with skin concerns to ensure that all prevention measures were in place, treatments were appropriate, and staff education needs were being met.</p> <p>*The team would review the systems or processes for wounds and weight loss to ensure the current systems were working properly. If the system was not producing positive outcomes the committee would review and make changes or recommendations.</p> <p>C. Based on observation, record review, interview, and policy review, the provider failed to follow manufacturer's recommendations for: *Priming insulin pens with an airshot for two randomly observed residents (17 and 18). *Insulin usage past the expiration date for one of three randomly reviewed residents (6). Findings include?</p> <p>1. Observation and record review on 8/22/16 at 4:55 p.m. of registered nurse (RN) B administering insulin to resident 17 using a Novolog FlexPen revealed: *The resident was to have been given four units of Novolog insulin. *She removed the cap of the FlexPen and placed a needle onto the pen syringe. *She then: -Turned the dial to four units. -Entered the resident's room and cleaned the</p>	F 281		
-------	--	-------	--	--

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 281	<p>Continued From page 20</p> <p>resident's skin in preparation for the injection. -Injected the insulin into the resident's skin and allowed the needle to remain in the skin for several seconds. -Withdrew the needle, monitored the injection site, and exited the room. *She had not primed the FlexPen with an airshot prior to drawing up the insulin for injection.</p> <p>2. Observation and record review on 8/22/16 at 5:10 p.m. of RN B administering insulin to resident 18 using a Novolog FlexPen revealed: *The resident was to have been given two units of Novolog insulin. *She removed the cap of the FlexPen and placed a needle onto the pen syringe. *She then: -Turned the dial to two units. -Entered the resident's room and cleaned the resident's skin in preparation for the injection. -Injected the insulin into the resident's skin and allowed the needle to remain in the skin for several seconds. -Withdrew the needle, monitored the injection site, and exited the room. *She had not primed the FlexPen with an airshot prior to drawing up the insulin for injection.</p> <p>Surveyor: 22452</p> <p>3. Observation on 8/22/16 at 3:30 p.m. of the 300 wing medication cart revealed: *A Novolog insulin pen for resident 6 with documentation of an 8/14/16 expiration date. *The area for the opened date had been left open. *There was 50 milliliters of insulin left in the pen. *Prior to being opened a Novolog insulin pen contained 250 milliliters of insulin.</p>	F 281		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 281	<p>Continued From page 21</p> <p>Interview at that time with the DON regarding resident 6's insulin pen revealed she:</p> <ul style="list-style-type: none"> <li>*Confirmed there was not an opened date on the Novolog insulin pen.</li> <li>*Questioned whether the 8/14/16 expiration date was actually the date the pen had been opened.</li> <li>*Confirmed there would have been medication errors after calculating what Novolog insulin had been documented as administered since 8/14/16 to the resident if the pen had been opened on 8/14/16.</li> <li>*Stated there was documentation 257milliliters of Novolog insulin had been administered to the resident since 8/14/16. If that was the case the Novolog insulin pen should have been empty.</li> </ul> <p>Surveyor: 32332</p> <p>4. Interview with RN B on 8/23/16 at 5:15 p.m. regarding not performing an airshot prior to drawing up insulin in the above FlexPen insulin injections revealed:</p> <ul style="list-style-type: none"> <li>*She did not have to, because she could visualize the contents of the insulin in the syringes, and there was no air noted in the syringes.</li> <li>*She had not known she needed to prime the FlexPen with an airshot prior to dialing the dose of insulin to have been administered.</li> </ul> <p>Interview on 8/24/16 at 10:30 a.m. with the director of nursing regarding the above insulin administrations. She agreed RN B should have primed the insulin pen prior to dialing the dose of insulin each time the FlexPen was used.</p> <p>Review of the provider's June 2015 Specific Medication Administration Procedures/Injectable Medication Administration policy revealed when using pen devices, "Dial dose as instructed by pen manufacturer."</p>	F 281		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 281	<p>Continued From page 22</p> <p>Review of Cornerstones4/care, April 2015 Using Novolog FlexPen at <a href="https://www.novolog.com/type-2-diabetes/general-type-2/novolog/using-flexpen.html?campaign=000730603">https://www.novolog.com/type-2-diabetes/general-type-2/novolog/using-flexpen.html?campaign=000730603</a>, accessed on 8/25/16, revealed: *Page 2 of 8: "Step 2: Doing an airshot before each injection. Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: -Turn the dose selector to 2 units. -Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubble to the top. -Press the push-button all the way in until the doses selector is back to 0. A drop of insulin should appear at the tip of the needle. -If no drop appears, change the needle and repeat. If you still do not see a drop of insulin after 6 tries, do not use the FlexPen and contact Novo Nordisk at 1-800-727-6500. A small air bubble may remain at the needle tip, but it will not be injected."</p> <p>D. Based on record review, interview, and policy review, the provider failed to perform a baseline comprehensive nursing assessment on admission for two of two sampled residents (2 and 5). Findings include:</p> <p>1. Record review for resident 2 revealed: *She was admitted from a hospital on 3/16/16 following a fall resulting in a neck fracture. *No record of a comprehensive initial assessment on admission was located in her electronic medical record or her paper records.</p> <p>2. Record review for resident 5 revealed:</p>	F 281		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 281	<p>Continued From page 23</p> <p>*He was admitted on 3/17/16 with a diagnosis of dementia.</p> <p>*No record of a comprehensive initial assessment on admission was located in his electronic medical record or his paper record.</p> <p>3. Interview on 8/23/16 at 4:30 p.m. with the director of nursing regarding comprehensive initial nursing assessments on admission revealed:</p> <p>*She was unable to locate the initial admission assessments for residents 2 or 5.</p> <p>*She agreed if the assessment was not in the medical record it was not done.</p> <p>*Her expectation was the initial comprehensive assessment would have been completed for every newly admitted resident in the first twenty-four hours after admission.</p> <p>Interview on 8/23/16 at 4:45 p.m. with the administrator regarding comprehensive nursing assessments on admission revealed:</p> <p>*He was made aware the initial admission assessments were not being completed shortly after he had begun his position in April 2016.</p> <p>*He instituted the use of the Clinical Health Status assessment at that time.</p> <p>Review of the provider's 3/23/16 Clinical Health Status, Additional Assessments and Immediate Plans of Care policy revealed "A Clinical Health Status is completed within 24 hours of Admission and Readmission, Quarterly and with any Significant Change in Status."</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis, Mo., 2013, revealed:</p> <p>*Page 419: "The health assessment and physical</p>	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 281	Continued From page 24 examination are the first steps toward providing safe and competent nursing care." *Page 420: A physical examination was conducted as an initial evaluation to admit a patient to a hospital or long-term care facility. **Use physical examination to do the following: -Gather baseline data about the patient's health status. -Support or refute subjective data obtained in the nursing history. -Identify and confirm nursing diagnoses. -Make clinical decisions about a patient's changing health status and management. -Evaluate the outcome of care."	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: 22452 Based on observation, record review, interview, and policy review, the provider failed to assess, monitor, and investigate recurrent falls for one of one sampled resident (4). Findings include:  1. Observation of resident 4 on 8/23/16 from 8:00 a.m. through 5:00 p.m. revealed she: *Wheeled herself throughout the building in her wheelchair.	F 309	Resident #4 has had a comprehensive review of falls completed and care plan has been reviewed and revised to reflect current needs.  Residents residing in the facility have the potential to be affected in a similar manner. *All Residents who have experienced falls during the month of August 2016 to date have had a comprehensive review of falls completed and care plan has been reviewed and revised to reflect current needs.	* 9/21/16 SB/SD DCH/LA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE SIOUX FALLS, SD 57106</b>
--	--

(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 309	<p>Continued From page 25</p> <ul style="list-style-type: none"> <li>*Propelled her wheelchair with her hands.</li> <li>*Did not lay down in her bed during the day.</li> <li>*Went into other residents' rooms.</li> <li>*Had a TABs monitor on the back of her chair she was able to take off.</li> <li>*Was often restless and did not sit still in her wheelchair.</li> <li>*Had no recliner in her room to elevate her legs that were edematous.</li> <li>*Had an end room furthest from the nurses' station.</li> </ul> <p>Review of resident 4's medical record revealed: *A 7/28/16 admission date from an acute care hospital.</p> <ul style="list-style-type: none"> <li>*Diagnoses: dementia without behavioral disturbances, pain, hypertension, atrial fibrillation, anemia, and nutritional deficiency.</li> <li>*Had wounds to bilateral lower extremities as a result of leg swelling.</li> </ul> <p>Review of resident 4's 7/28/16 physician's orders revealed: *Elevate legs periodically throughout the day for swelling. *No shoes unless properly fitted. *Use gripper stockings instead every shift for foot wear.</p> <p>Review of resident 4's 7/28/16 through 8/22/16 nursing progress notes revealed: *7/28/16: "Awake, alert, disoriented, respond to verbal stimuli, able to make some needs known. Generalized weakness, ambulates with walker and one person assist. Denied pain. Appeared to be confused and not adhering well to new environment." *7/29/16: "Alert and oriented to self. Resident propels self around establishment in wheelchair.</p>	F 309	<p>The Director of Nursing and Interdisciplinary Team have reviewed the Fall Guideline Policy.</p> <p>Nursing staff have been re-educated on the Fall Guideline Policy</p> <p>The Director of Nursing or designee will complete audits of all residents who suffer a fall weekly x 4 weeks then monthly x 2 months to ensure an Interdisciplinary review and care plan has been reviewed and revised to revised to reflect current needs.</p> <p>The Director of Nursing will report the results of the audits to the monthly QAPI committee for further review and recommendations.</p>	<p><i>*on 9/16/16 by the interim DON and unit coordinators</i> <i>SD DOH/6A</i></p> <p><i>*including resident 4</i> <i>SD DOH/6A</i></p>
-------	---	-------	--	--

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 309	Continued From page 26 Needs frequent reminders that she needs to call for help and not transfer via self. Shortness of breath noted with some activities." *7/30/16 at 7:45 a.m.: "Found on floor during night. Found crawling around on the floor in the past. Reddened knees. Said knees hurt. Said she had no idea how it happened." *7/31/16 at 5:36 a.m.: "Restless and mildly agitated. Exit seeking and desiring to go to 1105 SE First Avenue via taxi. Talked with resident about work history and time served. Spoke about religion and changed channel on TV to coincide. Offered a beverage. Asked resident if she was in pain and she denied pain. Staff has to sit with resident the entire shift for safety. Resident sits at edge of wheelchair and has to have constant reminder to sit back for safety." *7/31/16 at 8:30 a.m.: "Found resident lying on floor in hallway. States was trying to open door. Alert and responds to name. Unable to answer correctly date and time and where she was. Small abrasion noted on right knee." *7/31/16 at 11:00 a.m.: "Resident out in commons area near 300 wing nursing station found kneeling in front of wheelchair. Tried to reorient multiple times. Resident wants to leave and is fidgeting and restless. Assisted back to wheelchair. Resident is at nursing station and is currently 1:1 with staff." *7/31/16 at 11:15 a.m.: "Found kneeling by bed. Very agitated and wants people out of her room. Arguing with staff. Assisted to wheelchair. Brought resident out to nursing station to sit." *7/31/16 at 9:07 p.m.: "Resident showered per certified nursing assistant [CNA]. Multiple various bruises noted to upper extremities with a couple of small old skin tears that are healing. Lower extremities with severe edema that leaks serous drainage. Had multiple falls this morning while	F 309			

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIoux FALLS, SD 57106</b>		
(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 309	Continued From page 27 attempting to self-transfer from wheelchair. She is high fall risk due to impaired cognition and safety awareness. She is under constant supervision by staff. She had not slept at all last night and the entire day shift. She slept only for an hour and half this shift on her chair." *7/31/16 at 10:07 p.m.: "Fidgeting with table, chair, walker, and bedside table. States she is strong enough to do anything she wanted as nurse tried to redirect and offer a chair. Wants a taxi to 1105 S. First Street. Sat with resident, offered fluids, encouraged to rest and allow staff to assist, gave paper and pen to write as well as engage in conversation led by resident. Interventions non-effective." *7/31/16 at 10:15 p.m.: "Resident slid to floor. Resident has an unsteady gait and lack of sleep. Has slept in short intervals not more than 1.5 hours in last 36 hours. Has an unsteady gait with generalized weakness. Impaired sleeping routine for the last 36 hours. Increased confusion. No noted injury as resident slid to a sitting position while trying to rearrange sitting area. Resident was assisted to chair and encouraged to rest in bed. Resident refused to go to room. Resident is sitting at nursing station with increased monitoring. Resident taken to bathroom without results. Offered fluids and accepted." *8/1/16 at 2:42 a.m.: "Benadryl given for restlessness. Administration was effective. Resident states she is now ready to go to bed." *8/1/16 at 7:30 a.m.: "Very confused. Swinging out at staff and kicked CNA in the back. Awoke from sleep and tried to get out of bed. Tried to reorient her. Resident continued to curse at staff and tried to get out of wheelchair. Resident very unsteady and guided back to chair. Sat with resident for awhile and with no speaking to her she seemed to calm down. Friends arrived and	F 309			

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIoux FALLS, SD 57106</b>
--	--

(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 309	<p>Continued From page 28</p> <p>she was more cooperative."</p> <p>*8/2/16 at 3:14 p.m.: "Nurse aide found resident in the resident bathroom hanging on the side rails. Resident tried to transfer herself to the toilet. History of multiple falls. Nurse and nurse aide lay resident to her bed with a lift. Kept resident comfortable. Kept bed in low position and fall mat on bedside."</p> <p>*8/4/16 at 7:10 a.m.: "Resident was found by CNA lying on the bathroom floor. The bathroom floor was wet that possibly resident had urinated on the floor and then fell in the urine. Resident states she hit her head on the left side above the ear."</p> <p>*8/5/16 at 6:50 a.m.: "The resident was found on the floor at 10:50 p.m. not the time noted in this progress note."</p> <p>*8/5/16 at 9:30 p.m.: "Benadryl as needed for restlessness."</p> <p>*8/6/16 at 2:20 a.m.: Benadryl as needed for restlessness. Administration was unknown."</p> <p>*8/11/16 at 7:00 a.m.: "Found on fall mat. History of falls. Resident found on her hands and knees on her mat by the bed. Hands on bed and knees on mat and was trying to get back in bed so was assisted into bed."</p> <p>*8/15/16 at 9:59 p.m.: "Resident remains up in wheelchair at this time. Has been going to bed late. Writer endorsed to fax primary doctor to see if she could get a sleeping aide at this time. No pain or distress noted at this time."</p> <p>*8/16/16 at 7:26 a.m.: "Went to bed after 10:00 p.m. Soon tried to get out of bed. Assisted to wheelchair and brought out to nurses station. Very negative. Finally able to assist to bed at 4:30 a.m., but did not sleep long."</p> <p>*8/17/16 at 12:10 a.m.: "Brought back to room. Had been sleeping in a recliner in an unoccupied room since about 8:00 p.m. according to staff."</p> <p>*8/17/16 at 2:15 p.m. "Resident is alert but</p>	F 309		
-------	--	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 309	<p>Continued From page 29</p> <p>confused and disoriented. History of dementia. If ask her what she wants or needs she may tell you. Did try to transfer self out of bed this morning but no attempts since. Has a TABs alarm in bed and in chair. Fall mat next to bed when she is in bed. She is a fall risk."</p> <p>*8/19/16 at 3:58 p.m.: "Resident found on another resident's room floor lying straight with extended legs on the floor facing head up. She stated that she bumped her head during the fall. According to the other resident she was trying to transfer self from wheelchair to bed but fell down before reaching the bed. Has TAB alarm but not in use when the fall happened."</p> <p>*8/20/16: "Motors around in her wheelchair by her own power. Reminded to call for help before transferring."</p> <p>*There was no progress notes for 8/1/16 or 8/2/16.</p> <p>Review of resident 4's 7/30/16 through 8/19/16 Post Fall Analysis/Plan reports revealed:</p> <p>*7/30/16 at 3:15 a.m.:</p> <ul style="list-style-type: none"> <li>-There was no fall details.</li> <li>-"Discomfort in area of trauma."</li> <li>-"Footwear was bare feet."</li> <li>-"Mat next to bed. Bed alarm, and every two hour rounds was documented to prevent reoccurrence."</li> </ul> <p>*7/31/16 at 8:30 a.m.:</p> <ul style="list-style-type: none"> <li>-"Lost balance."</li> <li>-"Prior to fall in wheelchair."</li> <li>-"1:1 staff/family, TABs monitor or chair alarm, and reorientation was documented to prevent reoccurrence."</li> <li>-There was not a report for the 11:00 a.m., 11:15 a.m., or the 10:15 p.m. falls.</li> </ul> <p>*8/1/16 at 7:30 a.m.:</p> <ul style="list-style-type: none"> <li>-"Lost balance."</li> </ul>	F 309			

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S. CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 309	<p>Continued From page 30</p> <p>- "Floor mat, chair alarm, keep close to nursing staff, and ask family to sit with resident was documented to prevent reoccurrence." *8/2/16 at 11:58 a.m.:</p> <p>- "Lost strength. Fell from shower/toilet/commode." - "Attempting to self-transfer." - "Wearing slippers." - "Keep resident in closely monitored, keep surroundings free from clutter, keep personal belongings within reach, keep call light within reach, keep bed in low position, keep floor mat at bedside when resident in bed, and reorient resident to the environment were documented to prevent reoccurrence." *8/11/16 at 7:00 a.m.</p> <p>- "Roll/slid out of bed." - "Time last toileted was left blank." - "Did not use call light." - "Encourage resident to call for help was documented to prevent reoccurrence." *8/19/16 at 4:00 p.m.</p> <p>- Fall details was left blank. - "Attempting to self transfer." - "Keep resident close to nursing station for continued observation, involve resident with activities, don't leave resident in room unattended, and TAB alarm on at all times was documented to prevent reoccurrence." *There was not a post analysis fall plan for the 8/4/16 fall at 7:10 a.m. or the 8/5/16 fall at 6:50 a.m.</p> <p>Review of resident 4's 8/16/16 care plan revealed: *Problem: "At risk for falls related to fall history, new environment, impaired safety awareness, dementia, and weakness/balance." *Goal: "No fall related injuries."</p>	F 309		

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

PRINTED: 09/08/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>	
(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 309	<p>Continued From page 31</p> <p>*Interventions:</p> <ul style="list-style-type: none"> <li>- "Assess for pain and intervene."</li> <li>- Assess that wheelchair is appropriate size; assess need for footrests, assess for need to have wheelchair locked/unlocked for safety."</li> <li>- "Bed in low position."</li> <li>- "Call light or personal items available and in easy reach or provide reacher."</li> <li>- "Chair alarm or TABs monitor."</li> <li>- "Footwear to prevent slipping."</li> <li>- "Keep environment well-lit and free of clutter."</li> <li>- "Keep resident within eye-site of nursing staff when out of room, when in room assure resident is in bed-do not leave alone when in wheelchair."</li> <li>- "Mat beside bed."</li> <li>- "Therapy referral as indicated."</li> <li>- "Toilet schedule."</li> </ul> <p>Review of resident 4's 7/28/16 through 8/19/16 toileting activities of daily living report completed by the CNAs on the days of the above falls revealed:</p> <ul style="list-style-type: none"> <li>*7/30/16: No documentation of toileting assistance.</li> <li>*7/31/16: No documentation of toileting assistance.</li> <li>*8/1/16: Toileting assistance provided at 1:54 p.m. and 3:03 p.m.</li> <li>*8/2/16: Toileting assistance provided at 4:25 a.m., 1:32 p.m., and 5:14 p.m.</li> <li>*8/4/16: Toileting assistance provided at 1:54 p.m. and 9:10 p.m.</li> <li>*8/5/16: Toileting assistance provided at 9:12 a.m. and 5:19 p.m.</li> <li>*8/11/16: Toileting assistance provided at 11:39 a.m. and 3:11 p.m.</li> <li>*8/19/16: Toileting assistance provided at 9:53 a.m. and 4:23 p.m.</li> </ul>	F 309		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 309	<p>Continued From page 32</p> <p>Review of resident 4's physical therapy 7/29/16 through 8/19/16 progress notes revealed:</p> <p>*"Fall risk. Complains of dizziness with standing and transfers."</p> <p>*"Discharge plans: Home with friend versus long term care [had been previous living arrangement prior to hospitalization]."</p> <p>*"Patient is limiting her activity at times due to cognition and motivation."</p> <p>*"Patient continues to be a high risk for falls."</p> <p>*"She requires assistance with transfers due to poor weight shifting, needing cues for sequencing and poor carry over."</p> <p>*"She has poor insight into her deficits."</p> <p>*"Functional deficits: weakness, difficulty walking, difficulty with transfers, decreased motivation, decreased endurance, poor balance, and decreased weight shifting."</p> <p>*"The patient has been incontinent during therapy sessions."</p> <p>*"Strengthening of specific muscles to improve transfers, bed mobility, ambulation, stair mobility, and stairs."</p> <p>Interview on 8/23/16 at 4:00 p.m. with the director of nursing regarding resident 4 revealed she:</p> <p>*Confirmed the post fall analysis forms were often not completely filled out and should have been.</p> <p>*Was not sure why post fall analysis forms and progress notes were not completed for every fall.</p> <p>*Was not aware the staff were not consistently toileting the resident. Some of her falls were in the bathroom when she was attempting to self transfer.</p> <p>*Stated a toileting schedule meant a resident should have been assisted to the bathroom before and after meals and at bedtime.</p> <p>*Stated the staff were relying on the TABs monitor and the chair alarm to prevent falls, but did not</p>	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>	
(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)
F 309	Continued From page 33 document if they were functioning when she fell.  Review of the provider's 10/21/15 Falls Management Guideline policy revealed: *"Continue ongoing assessment and documentation by licensed nurses." *"The interdisciplinary team [IDT] reviews the Change of Condition Report-Post Fall/Trauma and makes additional recommendations within seventy-two hours of the fall." *"Licensed nurse completes Change of Condition-Post Fall Analysis following a resident fall." *"IDT evaluation is completed on the Change of Condition Report-Post Fall and validation of individualized intervention."	F 309	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on observation, record review, interview, and policy review, the provider failed to provide fingernail and toenail care for one of one sampled resident (4) who was dependent on staff for all activities of daily living. Findings include:  1. Observation on 8/23/16 at 10:30 a.m. of resident 4 revealed: *She was sitting in her wheelchair in her room.	F 312	Resident #4 has had finger and toe nails trimmed.  * All Residents residing in the facility have the potential to be affected in a similar manner. Toe Nail and Finger Nail audits were completed for residents residing in the facility and trimming was provided if necessary.  The Director of Nursing and Interdisciplinary Team have reviewed the nail and foot care training from Mosby's' Textbook for Nursing Assistants.  * 9/21/16 SB/SDDOH/LA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 312	<p>Continued From page 34</p> <p>*Licensed practical nurse (LPN) A was changing her Vaseline gauze dressings to the three opened blistered areas on her right and left lower legs.</p> <p>*Her fingernails on both hands were long and jagged.</p> <p>*Her feet were very dry and purplish in color.</p> <p>*Her great and second toenails on both her feet were also very long and thick. The other toenails were very long on both her feet.</p> <p>Interview at that time with LPN A regarding resident 4 revealed she:</p> <p>*Was going to apply some lotion to the resident's feet, but she was unable to find any lotion in her room.</p> <p>*Stated the resident's feet had been purplish in color due to her poor circulation and vascular disease. The blistered areas had been caused by an increase in edema in her legs and feet.</p> <p>*Agreed the resident's toenails were very long and thick, and she knew a podiatrist had been mentioned if the family agreed.</p> <p>*Stated the resident was dependent on staff assistance for bathing.</p> <p>*Agreed the certified nursing assistants (CNA) should have been clipping her fingernails and toenails on a weekly basis with her shower.</p> <p>*Stated since the toenails were so thick a referral should have been made to the nurse for them to check with the family regarding the need for podiatry care.</p> <p>Review of resident 4's 8/1/16 through 8/22/16 bathing report completed by the CNAs revealed there was documentation she had:</p> <p>*Received assistance with a shower on 8/7/16 and 8/21/16.</p> <p>*Not received her weekly shower on 8/14/16.</p> <p>There was documentation "Activity of bathing did</p>	F 312	<p>Nursing staff have been re-educated on the Mosby's' Textbook for Nursing Assistants, foot care policy and Dignity policy.</p> <p>The Director of Nursing or designee will complete audits on 5 residents weekly x 4 weeks then monthly x 2 months to ensure the foot care and dignity policy are being followed.</p> <p>Director of Nursing will report the results of the audits to the monthly QAPI committee for further review and recommendations.</p>	
-------	---	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 312	Continued From page 35 not occur." "No" was documented if the resident had refused bathing assistance.  Review of resident 4's 8/21/16 nursing progress notes revealed: *"Skin assessment. Showered per CNA this shift." *"Continue with open wounds to bilateral lower extremities." *"Edema and purplish discoloration noted to feet and toes." *"Toe nails are thick, hard, and deformed. Needs to be seen per podiatrist."  Review of the provider's 1/26/15 Bathing policy revealed: *"Observe condition of the skin." *"Care of fingernails and toenails is part of the bath. Be certain nails are clean." *"If toenails are difficult to cut, inform the charge nurse." *"Apply lotion to skin as needed." *"Fingernails and toenails of diabetic residents are cut by the licensed nurse or podiatrist."	F 312			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 431	Resident #7 Narcotics could not be reconciled due to resident discharge.  Resident #8 Narcotics have been reconciled. <i>on 9/2/16 SB/SDDOH/LA</i>  Residents residing in the facility have the potential to be affected in a similar manner. Reconciliation of all narcotics was completed on all medication carts.	<i>9/2/16</i> <i>SB/SDDOH/LA</i>	

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 431	<p>Continued From page 36</p> <p>appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 2. Review of resident 7's on wing 600 8/14/16 through 8/22/16 Controlled Substance Accountability Sheet revealed: *Hydrocodone 10/325 milligrams (mg) one tablet every six hours PRN. *8/14/16 at 4:00 p.m.: Three hydrocodone tablets were in the locked box on the medication cart. At 10:30 p.m. two hydrocodone tablets were added to the locked box from Medication Dispensing Pyxis System. One tablet of hydrocodone was documented as administered. The total hydrocodone tablets documented that remained in the locked box at 10:30 p.m. was two tablets. There should have been four remaining tablets of</p>	F 431	<p>The Director of Nursing , Pharmacist and Nursing management Team have reviewed the Control Substance Storage policy.</p> <p><i>*including RN B</i></p> <p>Nursing staff have been re-educated on the Control Substance Storage policy.</p> <p><i>* on 9/16/16 by the DON, interim DON and unit manager on 8/28/16</i></p> <p>The Director of Nursing or designee will complete audits on 2-3 medication carts daily x 7 days then random cart audits daily x 7 days and then weekly x 4 weeks then monthly x 2 months to ensure the Controlled Substance Storage policy are being followed.</p> <p>The Director of Nursing will report the results of the audits to the monthly QAPI committee for further review and recommendations.</p>		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 431	<p>Continued From page 37</p> <p>hydrocodone in the locked box.</p> <p>*8/15/16 at 7:50 a.m.: One tablet hydrocodone was documented as administered. The total hydrocodone tablets documented that remained in the locked box at 7:50 a.m. was one tablet. There should have been three remaining tablets of hydrocodone in the locked box.</p> <p>*8/15/16 at 4:00 p.m.: One hydrocodone was documented as administered. The total hydrocodone tablets documented that remained in the locked box at 4:00 p.m. was no tablets. There should have been two remaining tablets of hydrocodone in the locked box.</p> <p>*There was no documentation or investigation to support what had happened for the discrepancy of the two hydrocodone tablets.</p> <p>*8/21/16 at 2:17 a.m.: There was documentation two tablets of hydrocodone remained in the locked box.</p> <p>*8/22/16 at 8:20 a.m.: There was documentation of hydrocodone two tablets were removed from the Pyxis. There was documentation one hydrocodone tablet was administered. The total hydrocodone tablets documented that remained in the locked box at 8:20 a.m. was one. There should have been three remaining tablets of hydrocodone in the locked box.</p> <p>*8/22/16 at 2:15 p.m.: There was documentation one hydrocodone tablet was removed from the Pyxis. There was documentation one tablet of hydrocodone was administered. The total hydrocodone tablets documented that remained in the locked box was zero. There should have been one remaining hydrocodone in the locked box.</p> <p>*There was no documentation or investigation to support what had happened to the discrepancy for the one hydrocodone tablet.</p>	F 431		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIoux FALLS, SD 57106</b>		
(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 431	<p>Continued From page 38</p> <p>Review of resident 7's 8/22/16 Controlled Substance Accountability Sheet revealed: *Oxycodone 5 mg one tablet every four hours. *8/22/16 at 6:30 a.m.: There was documentation two tablets of oxycodone remained in the locked box. *8/22/16 at 11:40 a.m. There was documentation two tablets of oxycodone was removed from the Pyxis. There was documentation one tablet of oxycodone was administered. The total oxycodone tablets documented that remained in the locked box at 11:40 a.m. was one. There should have been three remaining oxycodone in the locked box. *8/22/16 at 3:00 p.m.: There was documentation one tablet of oxycodone was administered. The total oxycodone tablets documented that remained in the locked box at 3:00 p.m. was zero. There should have been two tablets of oxycodone remaining in the locked box. *There was no documentation or investigation to support what had happened to the discrepancy for the two oxycodone tablets.</p> <p>3. Review of resident 8's on wing 600 8/15/16 and 8/17/16 Controlled Substance Accountability Sheet revealed: *Tramadol 50 mg one tablet every eight hours PRN. *8/15/16 at 10:45 p.m.: There was documentation two tablets of Tramadol remained in the locked box. *8/17/16 at 7:30 a.m. There was documentation one tablet of Tramadol was removed from the Pyxis. The total Tramadol tablets documented that remained in the locked box at 7:30 a.m. was one. There should have been two remaining Tramadol in the locked box. *8/17/16 at 2:00 There was documentation one</p>	F 431		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 431	<p>Continued From page 39</p> <p>tablet of Tramadol was administered. The total Tramadol tablets documented that remained in the locked box at 2:00 p.m. was zero. There should have been one Tramadol tablet remaining in the locked box.</p> <p>*There was no documentation or investigation to support what had happened to the discrepancy for the one Tramadol tablet.</p> <p>Review of resident 8's 8/21/16 and 8/22/16 Controlled Substance Accountability Sheet revealed:</p> <p>*8/21/16 at 1:00 p.m.: There was documentation one tablet of Tramadol remained in the locked box.</p> <p>*8/21/16 at 9:00 p.m.: There was documentation one tablet of Tramadol was removed from the Pyxis. There was documentation one tablet of Tramadol was administered. The total Tramadol tablets documented that remained in the locked box at 9:00 p.m. was zero. There should have been one tablet of Tramadol remaining in the locked box.</p> <p>*There was no documentation or investigation to support what had happened to the discrepancy for the one Tramadol tablet.</p> <p>4. Interview on 8/23/16 at 9:30 a.m. with the director of nursing (DON) and the administrator regarding all of the above revealed:</p> <p>*They were unaware of the above drug discrepancies. The discrepancies should have been reported by the nursing staff to the DON and investigated.</p> <p>*They knew some of the nurses removed extra narcotics from the Pyxis that would not be administered by them on their shift.</p> <p>*Some nurses did not want to take time and walk up to the Pyxis each time a resident requested a</p>	F 431		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 431	<p>Continued From page 40</p> <p>narcotic.</p> <p>*The pharmacy did send out every morning to them the amount of every narcotic that had been removed from the Pyxis machine.</p> <p>*They did not reconcile what narcotics had been removed from the pyxis on a daily basis. Reconciliation was maybe done once or twice a week.</p> <p>*They agreed it would be very possible for a drug diversion to occur. It might take several days to determine the discrepancy, or the discrepancy might go undetected like the above residents.</p> <p>*They did not have a policy that specifically stated that a nurse should only remove the narcotics from the Pyxis he/she were going to administer.</p> <p>Interview on 8/23/16 at 2:00 p.m. with registered nurse G regarding the above revealed he:</p> <p>*Stated on the 300 and 500 wings the nurses also took out more narcotic medication out of the Pyxis than they actually administered on their shift.</p> <p>*Confirmed the practice was to save the nurses from having to go to the Pyxis each time they needed to administer a narcotic medication to a resident.</p> <p>*Was unsure if there were any discrepancies in any of the controlled medications on those wings.</p> <p>*Agreed it was not a safe system for the control and accountability of controlled medications.</p> <p>Review of the provider's June 2015 Controlled Substance Disposal policy revealed:</p> <p>*"The DON, in collaboration with the consultant pharmacist, is responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications."</p> <p>*"When a dose of a controlled medication is</p>	F 431		
-------	---	-------	--	--

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 431	<p>Continued From page 41</p> <p>removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container." **"It is destroyed in the presence of two licensed nurses and the disposal is documented on the accountability record/book on the line representing that dose."</p> <p>Review of the provider's June 2015 Discrepancies, Loss and/or Diversion of Medications policy revealed: **"All discrepancies, suspected loss and/or diversion of medications, regardless of drug type or class, are investigated and reported as required." **"Upon the discovery or suspicion of a discrepancies or suspected loss through diversion, the administrator, DON, and the consultant pharmacist are notified and an investigation conducted. The DON leads the investigation." **"The DON investigates the discrepancy and researches all records related to medication administration and the supply of medication, including medication reconciliation." **"A thorough search in all drug storage areas, the residents' room, and other locations where medications may have been used/placed during medication administration are made to attempt to locate any missing container or medication supply." **"Document the loss and the investigation process." **"If the loss involves a controlled substance, all controlled drug accountability procedures and documentation should be reviewed and audited."</p>	F 431			

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>		
(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 431	<p>Continued From page 42</p> <p>Surveyor: 32332 Based on observation, record review, interview, and policy review, the provider failed to maintain a system to account for as-needed narcotic medications for four of six nursing wings (200, 300, 500, and 600). Findings include:</p> <p>1. Observation on 8/22/16 at 5:15 p.m. of registered nurse (RN) B administering medications to resident 18 on wing 200 revealed he requested hydrocodone (a controlled narcotic medication for moderate-to-severe pain) and lorazepam (a controlled medication for anxiety). RN B: *Opened the medication cart and removed a clear paper sleeve protector containing three as-needed (PRN) wrapped hydrocodone tablets for resident 18, and another empty sleeve that had previously contained PRN lorazepam for resident 18. *Removed one dose of hydrocodone from the sleeve, leaving two doses to remain in that sleeve. *Stated she needed to obtain more PRN lorazepam from the automated medication dispensing machine. *Entered the medication room and removed two doses of lorazepam from the pharmacy machine. *Returned to the medication cart and placed one dose of lorazepam in the paper protector sleeve. *Gave the other dose of lorazepam and one dose of hydrocodone to resident 18.</p> <p>Interview at that time with RN B regarding removing an extra dose of PRN lorazepam from the dispensing machine when it was not going to</p>	F 431		

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

PRINTED: 09/06/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435031</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/24/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - COVINGTON HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3900 S CATHY AVE</b> <b>SIOUX FALLS, SD 57106</b>
--	--

(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 431	<p>Continued From page 43</p> <p>be used at that time revealed:</p> <ul style="list-style-type: none"> <li>*The dispensing machine was located in another hallway.</li> <li>*Nursing staff frequently removed extra doses of PRN medications from the dispensing machine if the resident had requested those medications frequently.</li> <li>*Removing the PRN medications and storing them in the medication cart prevented extra trips to the dispensing cart and saved the nurses time.</li> <li>*The night nurse could use the extra dose during her shift, or it would still be in the medication cart for RN B to administer the next day when resident 18 requested it.</li> <li>*Those extra PRN controlled medications stored in the medication carts were counted at the end of each shift.</li> </ul>	F 431		
-------	---	-------	--	--